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New Jersey Department of Human Services
Division of Medical Assistance and Health Services
CORE MEDICAID and MLTSS
External Quality Review
Annual Technical Report
Review Period: January 1, 2024–December 31, 2024
(2024–2025 Reporting Cycle)

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Executive Summary

Purpose of Report

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

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

To comply with *Title 42 CFR § 438.364 External review results* (*a)* through *(d)* and *Title 42 CFR § 438.358 Activities related to external quality review*, the New Jersey (NJ) Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), contracted with IPRO, an EQRO, to conduct the 2024 EQR activities (reporting cycle 2024–2025) for five MCOs contracted to furnish Medicaid services in the state. During the period under review, January 1, 2024–December 31, 2024, DMAHS's participating NJ FamilyCare MCOs included Aetna Better Health of New Jersey (ABHNJ), Fidelis Care (FC/WCHP), Horizon NJ Health (HNJH), UnitedHealthcare Community Plan (UHCCP), and Wellpoint New Jersey, Inc. (WPNJ). No MCOs were exempt from EQR in calendar year (CY) 2024. As per DMAHS, enrollment in ABHNJ, FC/WCHP, HNJH, UHCCP, and WPNJ for the Core Medicaid and Managed Long-Term Services and Supports (MLTSS) Programs was 1,728,928 as of 12/31/2024. This report presents aggregate and MCO-level results of these EQR activities for ABHNJ, FC/WCHP, HNJH, UHCCP and WPNJ. *NOTE: WellCare Health Plans of New Jersey, Inc. began doing business as Fidelis Care effective August 1, 2023. For the purposes of this report, this MCO will be designated as FC/WCHP. Additionally, Amerigroup New Jersey, Inc. began doing business as Wellpoint New Jersey, Inc. as of January 1, 2024. For the purposes of this report, the MCO will be designated as WPNJ.*

Scope of External Quality Review Activities Conducted

This EQR annual technical report (ATR) focuses on the four mandatory and five optional EQR activities that were conducted. EQR activities conducted from January 2024–December 2024 included validation of performance improvement projects (PIPs), performance measure (PM) validation, annual assessment of MCO operations, network adequacy, as well as focus studies, which include Core Medicaid care management (CM) audits, and MLTSS CM audits, encounter data validation (EDV), Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey, and calculation of additional PMs. It should be noted that the protocols for this year were based on the February 2023 CMS *External Quality Review (EQR) Protocols.*[1]

The updated protocols stated that an "Information Systems Capabilities Assessment (ISCA) is a mandatory component of the EQR as part of Protocols 1, 2, 3, and 4." As set forth in *Title 42 CFR § 438.358 Activities related to external quality review* (b)(1), these activities are:

- ***CMS Mandatory Protocol 1*: Validation of Performance Improvement Projects (PIPs) –** This activity validates that MCO performance improvement projects (PIPs) were designed, conducted, and reported in a methodologically sound manner, allowing for real improvements in care and services.
- ***CMS Mandatory Protocol 2:* Validation of Performance Measures –** This activity assesses the accuracy of performance measures reported by each MCO and determines the extent to which the rates calculated by the MCO follow state specifications and reporting requirements.
- ***CMS Mandatory Protocol 3:* Review of Compliance with Medicaid and CHIP Managed Care Regulations –** This activity determines MCO compliance with its contract and with state and federal regulations.
- ***CMS Mandatory Protocol 4:* Validation of Network Adequacy -** This activity assesses MCO adherence to state standards for distance for specific provider types, as well as the MCO's ability to provide an adequate provider network to its Medicaid population.
- ***CMS Optional Protocol 5:* Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan –** This activity evaluates the accuracy and completeness of encounter data that are critical to effective MCO operation and oversight.
- ***CMS Optional Protocol 6:* Administration or Validation of Quality-of-Care Surveys –** In 2024, satisfaction surveys were conducted for adult and child Medicaid members. This activity measures satisfaction with care received, providers, and health plan operations.
- ***CMS Optional Protocol 7:* Calculation of Additional Performance Measures –** This activity specifies that the external quality review organization (EQRO) may calculate performance measures in addition to those specified by the state for inclusion in MCOs' Quality Assurance and Performance Improvement (QAPI) programs.
- ***CMS Optional Protocol 8:* Implementation of Additional Performance Improvement Projects –** This activity validates that additional MCO performance improvement projects (PIPs) were designed, conducted, and reported in a methodologically sound manner, allowing for real improvements in care and services.
- ***CMS Optional Protocol 9:* Conducting Focus Studies of Health Care Quality –** This activity conducts clinical and nonclinical focus studies to assess quality of care at a point in time.

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

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

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

High-Level Program Findings and Recommendations

IPRO used the analyses and evaluations of 2024–2025 EQR activity findings to assess the performance of NJ Medicaid MCOs in providing quality, timely, and accessible healthcare services to Medicaid members. The individual MCOs were evaluated against state and national benchmarks for measures related to the quality, access, and timeliness domains, and results were compared to previous years for trending when possible.

The following provides a high-level summary of these findings for the NJ FamilyCare Managed Care Program. The overall findings for MCOs were also compared and analyzed to develop overarching conclusions and

recommendations for each MCO. These plan-level findings are discussed in each EQR activity section, as well as in the **MCO Strengths and Opportunities for Improvement, and EQR Recommendations** section.

Strengths Related to Quality, Timeliness and Access

The EQR activities conducted from January 1, 2024, through December 31, 2024, demonstrated that DMAHS and the MCOs share a commitment to improvement in providing high-quality, timely, and accessible care for members. The strengths, opportunities for improvement and recommendations relating to quality of, timeliness of, and access to care are outlined here and detailed in each corresponding section of this report.

Validation of Performance Improvement Projects

For January 2024–December 2024, this ATR includes IPRO's evaluation of the April 2024 PIP updates and August 2024 PIP report submissions. In addition, IPRO reviewed two PIP proposals: one for Core Medicaid on Immunizations for Adolescents (IMA), and one for MLTSS on 10-Day Post-Discharge Visit with Assessment, and provided feedback and guidance to all five MCOs. IPRO's PIP validation process provides an assessment of the overall study design and implementation to ensure the PIP met specific criteria for a well-designed project that meets the CMS requirements as outlined in the EQRO protocols. Full validation results for the Core Medicaid and MLTSS 2024 PIPs are described in **the Validation of Performance Improvement Projects** section.

Core Medicaid

The following three Core Medicaid PIPs were conducted by the MCOs during the ATR review period. One Core Medicaid PIP is clinical, and two PIPs are nonclinical.

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

One PIP Proposal (PIP implemented in January 2025) on Immunizations for Adolescents (IMA) was developed by each MCO during the ATR review period.

MLTSS

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

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

One PIP Proposal (PIP to be implemented in January 2025) on 10-day Post-Discharge Visit with Assessment was developed by each MCO during the ATR review period.

Validation of Performance Measures

Information Systems Capabilities Assessment

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

The MCO's information system assessment reviews included:

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

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

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

MY 2023 New Jersey HEDIS Performance Measures

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

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

Notable HEDIS Measure Changes from MY 2022 to MY 2023

- For measurement year (MY) 2023, NCQA removed Breast Cancer Screening (BCS) and Annual Dental Visit (ADV) from Medicaid reporting. NOTE: BCS was moved to an ECDS measure.
- For MY 2023, NCQA added two new dental care measures to be reported for this Medicaid population: Oral Evaluation, Dental Services (OED) and Topical Fluoride for Children (TFC). They also added ECDS measures Cervical Cancer Screening (CCS-E) and Social Need Screening and Intervention (SNS-E).
- For MY 2023, NCQA advised against allowing trending by breaking the link to the prior year's measure results for measures Depression Remission or Response for Adolescents and Adults (DRR-E) and Adult Immunization Status (AIS-E). For Colorectal Cancer Screening (COL, COL-E), NCQA revised age stratifications from 46–49 years to 46–50 years and from 50–75 years to 51–75 years of age.
- In MY 2023, NCQA added new data element tables for race and ethnicity stratification reporting (data not shown) for the following measures: Well-Child Visits in the First 30 Months of Life (W30), Immunization for Adolescents (including IMA-E), Asthma Medication Ratio (AMR), Follow-Up After Emergency Department Visit for Substance Use (FUA), Pharmacotherapy for Opioid Use Disorder (POD), Initiation and Engagement of Substance Use Disorder Treatment (IET), Colorectal Cancer Screening (COL-E) and Adult Immunization Status (AIS-E).

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

Overall, most measures remained constant from MY 2022 to MY 2023 (< 5 percentage point [pp] change). Significant improvement (≥ 5 pp change) in performance from MY 2022 to MY 2023 were noted for one or more rates of:

- Appropriate Testing for Pharyngitis (CWP),
- Colorectal Cancer Screening (COL),
- Blood Pressure Control for Patients with Diabetes (BPD),
- Kidney Health Evaluation for Patients with Diabetes (KED),
- Follow-Up after Hospitalization for Mental Illness (FUH),
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) Blood Glucose and Cholesterol Testing,
- Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E).

Significant declines (≥ 5 pp change) in performance from MY 2022 to MY 2023 were noted for one or more rates of:

- Asthma Medication Ratio (AMR),
- Persistence of Beta-Blocker Treatment After a Heart Attack (PBH), and
- Initiation and Engagement of Substance Use Disorder Treatment (IET).

MY 2023 New Jersey State-Specific Performance Measures and Core Set Measures

Measures reported for MY 2023 by the MCOs can be categorized as follows:

There are two required NJ State-Specific PMs:

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

There are eight Child Core Set Measures:

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

There are nine Adult Core Set Measures:

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

The changes from MY 2022 to MY 2023 were:

1. The following measures were reported for the first year:
    a. Prenatal and Postpartum Care: Age 21 and Older (PPC2-AD)
    b. Prenatal and Postpartum Care: Under Age 21 (PPC2-CH)
    c. Concurrent Use of Opioids and Benzodiazepines (COB)
    d. Use of Opioids at High Dosage without Cancer (OHD)

2. All measures experienced updates to codes found in the value set directory.

Overall performance for the Preventive Dental measure showed significant improvements from MY 2022 for all MCOs.

Significant improvement (≥ 5 pp change) in performance from MY 2022 to MY 2023 were noted for one or more rates of:

- Preventive Dental Visit (NJD)
- Multiple Lead Testing in Children through 26 Months of Age (MLT)
- Contraceptive Care – Postpartum Women (CCP)
- Sealant Receipt on Permanent First Molars (SFM-CH)

No Significant declines (≥ 5 pp change) in performance from MY 2022 to MY 2023 were noted for one or more rates. Details of these results can be found in the **Validation of Performance Measures** section.

MLTSS Performance Measure Validation

Waiver year ending (WYE) 2022 refers to the period July 1, 2021, through June 30, 2022.
WYE 2023 refers to the period July 1, 2022, through June 30, 2023.
WYE 2024 refers to the period July 1, 2023, through June 30, 2024.

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

All MLTSS PMs are validated annually. IPRO reviews source code, member-level files, and rates for each MCO. PM #04 is reported on a monthly basis. Three HEDIS measures and two MLTSS-specific measure (PM #47 and #54) are reported annually. All other PMs are reported on a quarterly and annual cycle. In 2022, PM #52a and PM #53a Advanced Care Planning was retired in WYE2022. In addition to annual validation of all PMs, IPRO monitored all ongoing reporting to the state on a quarterly basis. Details of these results can be found in the **Validation of Performance Measures** section.

Final validation of WYE 2024 PMs is still ongoing. A list of all MLTSS PMs validated in WYE 2022, WYE 2023, and WYE 2024 can be found in the **Validation of Performance Measures** section.

WYE 2023 MLTSS Performance Measure #13

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

The MLTSS services assessed in PM #13 are: Assisted Living Services/Programs, Chore Services, Community Residential Services, Home Delivered Meals, Medical Day Services, Medication Dispensing Device Monthly

Monitoring, PCA/Home-Based Supportive Care, PERS Monitoring, and Private Duty Nursing. In WYE 2022, as directed by DMAHS, IPRO added the compliance score ranges for the delivery of MLTSS services.

MLTSS services that occurred between July 01, 2022, and June 30, 2023, were evaluated. POCs that only contained information regarding the members' self-directed services (e.g., Personal Preference Program) or traumatic brain injury (TBI)-specific services were excluded. If the POC indicated that a service was to begin before the measurement period, the start date of service was set at July 01, 2022. If a service extended beyond the measurement period, the end date of service was set at June 30, 2023. Details of these results can be found in the **Validation of Performance Measures** section.

WYE 2024 MLTSS Performance Measure #13

PM #13 evaluates delivery of MLTSS services to members compared with services identified in the POC. This measure ensures MLTSS HCBS services are delivered in accordance with the POC, including the type, scope, amount, frequency, and duration. The MLTSS services assessed in PM #13 are: Assisted Living Services/Program, Chore Services, Community Residential Services, Home Delivered Meals, Medical Day Services, Medication Dispensing Device Monthly Monitoring, PCA/Home-Based Supportive Care, PERS Monitoring, and Private Duty Nursing for the measurement period (July 01, 2023–June 30, 2024). This audit is currently in progress. Details can be found in the **Validation of Performance Measures** section.

Review of Compliance with Medicaid and CHIP Managed Care Regulations

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

In 2024, the annual assessment audits were conducted remotely. For the review period July 1, 2023–June 30, 2024, ABHNJ, FC/WCHP, HNJH, UHCCP and WPNJ scored above NJ's minimum threshold of 85%. In 2024, the average compliance score for five standards (Quality Management, Member Disenrollment, Credentialing and Re-Credentialing, Utilization Management, and Management Information Systems) showed increases ranging from 1 to 4 pp. In 2024, 10 standards (Emergency and Post-Stabilization Services, QAPI, Efforts to Reduce Healthcare Disparities, Committee Structure, Programs for the Elderly and Disabled, Provider Training and Performance, Enrollee Rights and Responsibilities, Utilization Management, Administration and Operations, and Management Information Systems) had an average score of 100%. Average compliance for eight standards (QAPI, Efforts to Reduce Healthcare Disparities, Committee Structure, Programs for the Elderly and Disabled, Provider Training and Performance, Satisfaction, Enrollee Rights and Responsibilities, and Administration and Operations) remained the same from 2023 to 2024. One standard (Access) decreased 4 pp from 2023 to 2024. Access had the lowest average compliance score at 65%. Findings from this review can be found in the **Review of Compliance with Medicaid and CHIP Managed Care Regulations** section.

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

Validation of Network Adequacy

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

accessibility information is presented in these look-up systems. The study methodology aligns with the CMS *External Quality Review (EQR) Protocol 4 – Validation of Network Adequacy*. In 2024, IPRO's evaluation included the NJ FamilyCare networks of ABHNJ, FC/WCHP, HNJH, UHCCP, and WPNJ. Study findings can be found in the **Validation of Network Adequacy** section.

Encounter Data Validation

Encounter data validation is an ongoing process, involving the MCOs, the state Encounter Data Monitoring Unit (EDMU), and the EQRO. In 2017, DMAHS partnered with its EQRO, IPRO, to conduct an MCO system and encounter data process review to include a baseline evaluation of the submission and monitoring of encounter data. As of October 2017, IPRO has been attending the monthly EDMU calls with the MCOs. In 2024, IPRO continued to monitor encounter data submissions and patterns. Study findings can be found in the **Encounter Data Validation** section.

Quality-of-Care Surveys

Member Satisfaction – 2024 CAHPS Survey

IPRO subcontracted with a certified survey vendor to receive the Medicaid adult and child CAHPS data from the MCO's certified vendors for the reporting aspect of the survey. The five health plans included were: ABHNJ, FC/WCHP, HNJH, UHCCP and WPNJ. Aggregate reports were produced for the adult and child surveys, and a separate report for the CAHPS Children with Chronic Conditions (CCC) survey results. In addition, the certified vendor fielded one statewide CHIP-only survey. All of the members surveyed required continuous enrollment from July 1, 2023, through December 31, 2023, with enrollment in that MCO at the time of the survey. A statewide aggregate report was produced for the CHIP survey. Details on these surveys can be found in the **Administration or Validation of Quality-of-Care Surveys** section.

Focus Studies

2024 Prenatal and Postpartum Care Focus Study

In 2024, at the request of DMAHS this focus study was undertaken to further understand disparities in prenatal/postpartum care access among New Jersey Medicaid beneficiaries. While a previous focus study examined sociodemographic disparities in the timely receipt of prenatal and postpartum care visits for NJ Medicaid beneficiaries in MY 2021, this focus study analyzed data for MYs 2021, 2022, and 2023, with the additional goal of identifying any notable data trends in year-over-year comparisons. Details of this study can be found in the **Conducting Focus Studies of Health Care Quality** section.

2025 MCO Verification of Enrollment in Care Management Focus Study

On behalf of DMAHS, IPRO was requested to conduct a focus study titled, *MCO Verification of Enrollment in Care Management*. The purpose of this focus study is to evaluate the MCOs' CM enrollment process(es) for compliance with the NJ FamilyCare Contract and the *NJ Care Management Workbook* requirements for the enrollees under the Division of Developmental Disabilities (DDD) and enrollees under the Division of Child Protection and Permanency (DCP&P) populations. The review period for this study is July 1, 2023, through December 31, 2024, and includes an offsite desk audit to review selected files, and a system review conducted virtually via Microsoft® Teams®. Details of this study can be found in the **Conducting Focus Studies of Health Care Quality** section.

Care Management Audits

2024 Core Medicaid Care Management Audits

IPRO undertook Core Medicaid CM Audits of ABHNJ, FC/WCHP, HNJH, UHCCP and WPNJ. The purpose of the CM audit and annual assessment was to evaluate the effectiveness of the contractually required CM program. DMAHS established CM requirements to ensure that the services provided to enrollees with special health

care needs were consistent with professionally recognized standards of care. The populations included in this audit include general population (GP) enrollees, enrollees under DDD, and enrollees under DCP&P.

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

The Care Management and Continuity of Care standard is reviewed in conjunction with comprehensive file reviews. For the Core Medicaid population, up to 300 DDD, DCP&P and GP charts are reviewed for each MCO. The actual number of charts reviewed depended on the population size that meets the sample criteria for the audit. In addition to the Core Medicaid CM chart review audit, in 2024, the MCOs were required to provide pre-offsite documentation as evidence of compliance of the Care Management and Continuity of Care standard. To assist in submission of appropriate documentation, IPRO developed *the Core Medicaid Care Management Document Submission Guide*. This document closely follows the NJ FamilyCare Managed Care Contract and was developed to assess MCO compliance.

The annual assessment of the Care Management and Continuity of Care standard covered the period from January 1, 2023, to December 31, 2023. There were 30 elements in this review based on contractual provisions, which are subject to review annually. Remote interviews with the MCOs were held with key MCO staff in April 2024. Overall compliance scores for the five MCOs ranged from 57% to 90% in MY2023. Results of this review can be found in the **Care Management Audits** section.

2024 MLTSS Nursing Facility/Special Care Nursing Facility Ancillary Review

The purpose of the MLTSS Nursing Facility (NF)/Special Care Nursing Facility (SCNF) Ancillary Review was to evaluate MCO compliance with DMAHS NJ FamilyCare Contract Article 9.11.G, MLTSS Performance Measures. IPRO conducted a review of the following MLTSS PMs: PM #8, PM #9, PM #9a, PM #11, and PM #16 for the review period September 1, 2022, through June 30, 2023. Results of this review can be found in the **Care Management Audits** section.

2024 MLTSS Nursing Facility/Special Care Nursing Facility Care Management Audits

The purpose of the MLTSS NF/SCNF CM audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, DMAHS established MLTSS CM requirements to ensure that the services provided to special needs members who met MLTSS eligibility requirements as specified in Article 9, *Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF)*, were consistent with professionally recognized standards of care. Specifically, the populations included in this audit were members who met the eligibility requirements for MLTSS and were receiving services in a NF/SCNF for at least six consecutive months within the review period from July 1, 2023, through June 30, 2024.

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

2024 MLTSS HCBS Care Management Audits

The purpose of the MLTSS CM audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, DMAHS established MLTSS CM requirements to ensure that the services provided to special needs members who met MLTSS eligibility requirements as specified in *Article 9, Home and Community Based Services (HCBS) and Institutionalization for Long-Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF)*, were consistent with professionally recognized standards of care. The U.S. Department of Health and Human Services (HHS) declared an end to the public health emergency (PHE) for the (COVID-19) pandemic on May 11, 2023. The state issued COVID-19 flexibilities related to specific MLTSS

Care Management activities ended prior to this review period (July 1, 2023–June 30, 2024), except for the NJ DHS, Division of Aging Services (DoAS), *Temporary Waiver of Clinical Eligibility Requirements for MLTSS Enrollment for MCO Members in a Community Setting.* Effective July 5, 2023, the use of the screen for community services (SCS) as presumptive eligibility was discontinued. The populations included in this audit were members who met eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or community alternative residential setting (CARS) for at least 6 consecutive months within the review period from July 1, 2023 to June 30, 2024.

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

Conclusion and MCO Recommendations

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

New Jersey Medicaid Managed Care Program

Managed Care in New Jersey

The NJ FamilyCare Managed Care Program, administered by DMAHS, provides healthcare benefits to children and adults with low-to-moderate incomes. Per DMAHS, as of December 2024, there were approximately 1,728,928 individuals enrolled in MMC; therefore, the number decreased from 2,021,931 in December 2023 (**Table 1**). Of the 1,728,928 individuals enrolled in MMC, 68,996 were receiving MLTSS services as of December 2024. More than 94% of managed-care–eligible beneficiaries receive services through the managed care program (data not shown).

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

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

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

Five MCOs (ABHNJ, FC/WCHP, HNJH, UHCCP and WPNJ) participated in the NJ FamilyCare Managed Care Program for Core Medicaid and MLTSS in December 2023–December 2024. **Table 1** presents respective enrollment figures in December 2023 and December 2024.

Table 1: December 2023–December 2024 Medicaid MCO Enrollment

MCO	Acronym	Medicaid Enrollment		MLTSS-Eligible Enrollment[1]	
		December 2023	December 2024	December 2023	December 2024
Aetna Better Health of New Jersey	ABHNJ	130,429	115,802	6,079	6,686
Fidelis Care/WellCare Health Plans of New Jersey, Inc.	FC/WCHP	102,136	87,851	13,729	13,285
Horizon NJ Health	HNJH	1,148,311	986,839	22,674	23,783
UnitedHealthcare Community Plan	UHCCP	398,784	334,936	13,017	14,181
Wellpoint New Jersey, Inc.	WPNJ	242,271	193,500	10,757	11,061
	Total	2,021,931	1,728,928	66,256	68,996

[1] Managed long-term services and supports (MLTSS) members are included in the December 2023–2024 Medicaid enrollment figures.
Source: DMAHS

Figure 1 shows each MCO's NJ FamilyCare Managed Care enrolled population for Medicaid and MLTSS-eligible enrollment for December 2023 and December 2024 in relation to the entire NJ MMC population.

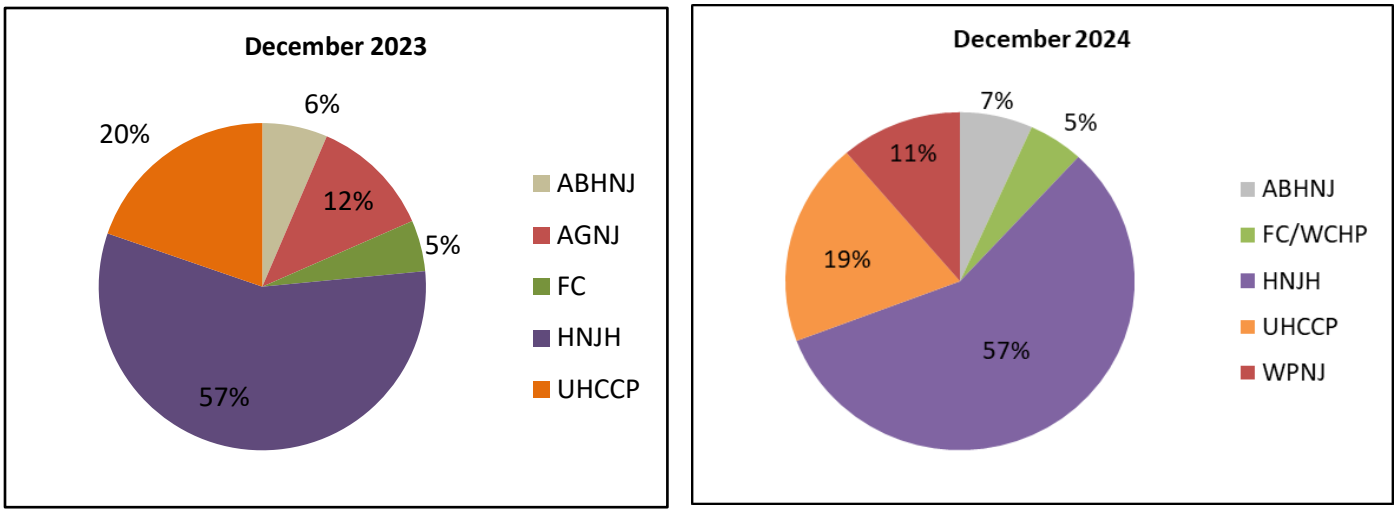

Figure 1: December 2023–December 2024 Medicaid Managed Care Enrollment by MCO Enrollment in MMC for each MCO reported as of December 2023 (left panel) and December 2024 (right panel) are depicted as the percentage of all enrolled members. ABHNJ: Aetna Better Health of New Jersey (grey); FC: Fidelis Care/WellCare Health Plans of New Jersey, Inc. (green); HNJH: Horizon NJ Health (purple); UHCCP: UnitedHealthcare Community Plan (orange). WPNJ: Wellpoint New Jersey, Inc. (red). WPNJ was formally known as Amerigroup New Jersey Inc. (AGNJ). Percentages may not add to 100% due to rounding. **Table 2** shows the activities discussed in this report and the MCOs included in each EQR activity.

Table 2: 2024 EQR Activities by MCO

EQR Activity	ABHNJ	FC/WCHP	HNJH	UHCCP	WPNJ
Annual Assessment of MCO Operations	Yes	Yes	Yes	Yes	Yes
PMs	Yes	Yes	Yes	Yes	Yes
Core Medicaid/MLTSS PIPs	Yes	Yes	Yes	Yes	Yes
Focus Quality Studies	Yes	Yes	Yes	Yes	Yes
CAHPS Surveys	Yes	Yes	Yes	Yes	Yes
PDV/Network Adequacy[1]	Yes	Yes	Yes	Yes	Yes
Core Medicaid CM Audits	Yes	Yes	Yes	Yes	Yes
MLTSS HCBS CM Audits	Yes	Yes	Yes	Yes	Yes
MLTSS NF CM Audits	Yes	Yes	Yes	Yes	Yes
ISCA Assessments[2]	Yes	Yes	Yes	Yes	Yes

[1] Provider Directory Validation (PDV) was conducted in 2024 for Network Adequacy.

[2] A full ISCA was conducted in 2024. Healthcare Effectiveness Data and Information Set (HEDIS) information systems (IS) assessments are conducted every year, including 2024.

Yes: activity was performed; No: activity was not performed.

EQR: external quality review; MCO: managed care organization; PM: performance measure; MLTSS: managed long-term services and supports; PIP: performance improvement project; CAHPS: Consumer Assessment of Healthcare Providers and Systems; PDV: provider directory validation; CM: care management; HCBS: home- and community-based services; NF: nursing facility; ISCA: information systems capabilities assessment.

New Jersey – 2024 State Initiatives

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

1115 Renewal Proposal

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

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

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

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

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

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

New Jersey continues to work with our federal partners at CMS to implement elements of the Demonstration throughout the renewal period. Implementation updates for 2024 include:

- The first phase of behavioral health services was integrated into managed care. Those services, previously covered under fee-for-service (FFS), went live with members' managed care networks January 1, 2025. Further phases of the integration will continue to add services to managed care coverage.
- Implementation planning continued for housing services. Also delivered through managed care, extensive stakeholder engagement and program design activities were completed in 2024, including amending the managed care organization (MCO) contract to support a July 1, 2025 launch of this new service, which includes tenancy and pre-tenancy supports, modification and remediations, as well as move-in supports.
- In partnership with the Children's System of Care (CSOC) in the Department of Children and Families (DCF), DMAHS has been working to design and implement an expansion of the Children's Support Services Program.
- New Jersey's Home Visitation Pilot, also in partnership with DCF, is being implemented for a second quarter 2025 launch of services.
- Finally, the Community Health Workers (CHW) pilot has received proposals from NJ's managed care organizations (MCOs) and is in the process of evaluating them ahead of submission to CMS for final approval and launch in 2025.

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

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

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

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

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

Health Information Technology and the Medicaid Enterprise System

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

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

The Public Health Emergency (PHE) unwinding was a major focus in FFY 2024. This required dedicated attention and resources to support the resumption of normal operations. In the midst of this challenging period, DMAHS was able to maintain operational stability and deliver on key program policy initiatives:

- Workability: Since going live on April 1, 2023, the Workability program increased enrollment by ~20% to about 8,000 members. This program improves access by offering working people with disabilities and whose income would otherwise make them ineligible for Medicaid the opportunity to receive full Medicaid coverage. The State Plan Amendment (SPA) for the Phase 2 expansion of the program was submitted to CMS for an effective date of February 1, 2024, and operational pieces are being implemented.
- Money Follows the Person (MFP): New Jersey's MFP program was recognized by CMS in a report to Congress for outstanding performance in six (6) out of nine (9) best practices in administering the program. The program supports independence for older adults and people with disabilities and aims to increase availability of home and community-based services (HCBS), reduce reliance on institutional services, provide for choice of community settings and ensure continuous quality improvement. Efforts that lean into close stakeholder collaboration and accountability reviews are underway to sustain effective strategies for this program.
- 1115 Comprehensive Demonstration: Stakeholder consultations and development of key model components for implementation continued in FFY 2024. These innovative projects are authorized from April 1, 2023, through June 30, 2028, and are aimed at:
    - Addressing members' housing physical-related needs;
    - Integrating behavioral and health services;
    - Launching the Behavioral Health Promoting Interoperability Program (BH PIP); and
    - Providing new and creative approaches to care.

Medicaid Management Information System (MMIS)

DMAHS continues with modernization initiatives for the MMIS (MMIS-M), which is a key component in the operation of DMAHS programs for providing comprehensive health coverage to approximately 2 million New Jersey residents. While the PHE unwinding was a major focus in FFY 2024, DMAHS made strides in MMIS modernization efforts and was able to:

- Advance Provider Management Module (PMM) procurement efforts via the National Association of State Procurement Officials (NASPO) ValuePoint Cooperative Purchasing program. Commercial discussions are underway with the preferred vendor and will culminate in an award in FFY 2025. The implementation of a new PMM will help realize efficiencies and benefits to business operations and improve the provider experience;
- Finalize the components for the Pilot Integration Platform and the scope for the legacy MMIS vendor integration requirements. The Pilot Integration Platform will support the modular upgrade and enhancement of the legacy MMIS system and validate the initial design for the end-state integration platform;
- Complete the foundational integration between the Medicaid Master Client Index (MCI) and NJ Health Information Network (NJHIN) Master Patient Index (MPI) to facilitate the exchange of protected health information (PHI) across the State;
- Transition the manual process for enabling systems access into an automated process that leverages the workflow capabilities of SimpliGov and the unified identity platform of SailPoint for more effective identity and access management;
- Develop the web-enabled Designated Authorized Representative (DAR) and Revocation forms in support of furthering Fee-for-Service member access control to their health information via the Patient Access Application Programming Interface (API);
- Develop a Tableau dashboard to improve visibility on operational metrics for CMS required and state-specific outcomes; and
- Select a software product that will function as a Centralized Enterprise Test Management tool to support testing in a multi-vendor environment using a scaled agile framework (SAFe).

DMAHS has also prioritized data completeness and quality to support Transformed Medicaid Statistical Information System (TMSIS) reporting. To this end, a concerted effort involving collaboration among cross-functional disciplines from policy, technical, and operations units has effectively addressed outstanding issues identified from the Outcomes Based Assessment (OBA). These efforts have been instrumental in achieving and maintaining a "Blue Status" for T-MSIS for the entire FFY 2024 period which indicates that New Jersey has met Outcomes Based Assessment (OBA) targets and passed on critical priority, high priority and expenditures. DMAHS will continue to refine its MMIS modernization roadmap to ensure alignment with program goals and priorities and utilize an outcomes-focused investment strategy.

NJ FamilyCare Integrated Eligibility System

New Jersey continued leadership in the cloud-based eligibility system field through enhancements and improvements to the NJ FamilyCare Integrated Eligibility System (IES). Utilizing agile methodology and modularity in the development and implementation, the State is able to deliver services in a timely and cost-effective manner while reducing the overall risk associated with traditional software development. Using a cloud-based solution, New Jersey continued enhancing the online applications for Modified Adjusted Gross Income (MAGI), Aged, Blind and Disabled (ABD), and Presumptive Eligibility (PE) programs. The online application is used by citizens, county workers, assistors and health benefits coordinators. Along with the online application, New Jersey continued enhancing the online worker portal that enables county workers to complete eligibility determinations. The worker portal automates verification, MAGI and non-MAGI eligibility determination, and NJ FamilyCare program determination.

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

In 2024, New Jersey started to embark on a strategic plan to modernize the current IES, which was initially deployed to achieve the goals of the Patient Protection and Affordable Care Act (ACA). This is an ongoing process that aims to improve the functionality of the existing IES and transition the legacy mainframe Medicaid Eligibility System. The NJ FamilyCare IES made system enhancements in support of policy updates to accommodate the unwind from the COVID-19 public health emergency continuous eligibility. Some of these enhancements and module deployment include:

- Upgrades to processing of electronic renewal applications, which allows applicants to submit and renew their application online;
- Enhancements to ex-parte application processing to improve procedural renewals and minimize procedural terminations;
- Expanding automatic upload functionality to the mainframe Medicaid Eligibility System to streamline county eligibility determination;
- Enhanced income verification processes by including additional State income data source; and
- Updates to member change of address from Managed Care Organization data and National Change of Address data from the United States Postal Service (USPS).

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

Health Information Technology and the New Jersey Health Information Network

The Division of Medical Assistance and Health Services (DMAHS) is committed to advancing Health Information Technology (HIT) initiatives in New Jersey to enhance care coordination and improve health outcomes for New Jersey Medicaid beneficiaries. In January 2024, the NJ Health Information Network (NJHIN) reached a milestone of exchanging over 1 billion messages, underscoring its role in facilitating secure and efficient data sharing among healthcare providers. DMAHS oversees NJHIN operations, tracking performance metrics and reporting to CMS to ensure transparency and impact. Collaborating with the Department of Health (DOH) and New Jersey Innovation Institute (NJII), DMAHS is considering to pilot a partnership with Managed Care Organizations (MCOs), with Aetna Better Health of New Jersey as the first participant. The potential expansion of NJHIN connectivity and services could enhance MCO-driven care coordination and data exchange across the State.

NJHIN has been instrumental in Medicaid enrollment outreach during the unwinding efforts. This effort has highlighted the importance of continuous Medicaid redeterminations to maximize the continuity of coverage

for approximately two million Medicaid beneficiaries. DMAHS will continue leveraging NJHIN's Trusted Data Sharing Organizations (TDSOs) to optimize continuous Medicaid redetermination through provider outreach.

DMAHS continues collaboration with the Division of Consumer Affairs (DCA) and leverages the New Jersey Prescription Monitoring Program (NJPMP) data to report the drug utilization report (DUR) under the requirements of Section 5042 of the SUPPORT Act. DMAHS has received CMS approval for the operational support funding request for the NJPMP under Medicaid Enterprise Systems (MES). This affirms that CMS recognizes NJPMP's critical role in benefiting Medicaid providers that serve Medicaid beneficiaries to improve their health outcomes and impact the opioid crisis in the state.

DMAHS continues to oversee the state-funded milestone-based Substance Use Disorder Promoting Interoperability Program (SUD PIP) and introduced two new milestones this year: Behavioral Health electronic Consent Management (eCMS – to address the 42CFR part 2 privacy concerns) and telehealth integration.

Additionally, the Behavioral Health Promoting Interoperability Program (BH PIP) was successfully implemented under the funding authority of NJ's 1115 Demonstration waiver renewal. This milestone-based program modeled after the SUD PIP, incentivizes the BH facilities to invest in health IT and expands data-sharing capabilities for the behavioral health facilities serving to improve care for beneficiaries with mental health needs.

Maternal Health

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

New Jersey's 2024 maternal health initiatives include:

- *Piloting innovation in quality improvement*: In April 2022, NJ FamilyCare launched its perinatal episode of care pilot. The program is a three-year pilot to test a new alternative payment for prenatal, labor, and postpartum services statewide. Its goal is to improve the quality of maternity care by incentivizing obstetrical providers to broadly engage in all aspects of their patient's care. In 2024, hospital-affiliated and community practices caring for 75% of NJ FamilyCare births annually volunteered to participate in the episode pilot's third Performance Period. For more information, please see https://www.nj.gov/humanservices/dmahs/info/perinatalepisode.html.
- *Quality Improvement Program – New Jersey (QIP-NJ):* In conjunction with DMAHS, the Department of Health continues its administration of the QIP-NJ program, a hospital pay-for-performance initiative that launched in 2021. QIP-NJ has a dual focus of quality improvement with maternal health and behavioral health components. In 2024, fifty-seven acute care hospitals were participating in Year 4 of a proposed 5-year program, with forty-three participating in the maternal health component and fifty-four participating in the behavioral health component. For more information, please see https://qip-nj.nj.gov/.

Child Health

New Jersey's 2024 child health initiatives include:

CMMI's Integrated for Kids Model: The NJ Integrated Care for Kids (NJ InCK) Model has been available to pediatric NJ FamilyCare members residing in Ocean and Monmouth counties since 2022. DMAHS continues its support for NJ's grantees (led by Hackensack Meridian Health), who have received funding through a cooperative agreement from the federal Center for Medicare and Medicaid Innovation (CMMI) to implement the InCK Model in NJ. The NJ InCK Model has two components. One is a comprehensive screening that is

available to all NJ FamilyCare children. The second is voluntary, family-centered, community-based care coordination available only to the subset of children identified to have significant health complexity through screening. Both of these components are supported by a state payment model designed by the grantees and paid for by NJ FamilyCare. This initiative is expected to continue through December 2026. For more information, please see https://innovation.cms.gov/innovation-models/integrated-care-for-kids-model.

Expansion of NJ WorkAbility

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

Of note, CMS has not approved eligible applicants to remain enrolled for up to a year after a job loss if not the fault of the member in the state plan amendment (SPA). CMS provided guidance that this request may be submitted through New Jersey's 1115 Comprehensive Demonstration.
In 2023, New Jersey had extensive stakeholder engagement as well as consultation with and technical assistance from CMS. Phase 2 system changes were completed in early 2024.

As of February 1, 2024, NJ WorkAbility:

- Is open to people aged 16 and over who have a disability determination
- No longer counts spouse's income when determining eligibility or premiums
- No longer limits eligibility based on assets
- No longer limits eligibility based on income. People with countable income over 250% of the Federal Poverty Level must agree to pay a premium

New Jersey DMAHS Quality Strategy

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

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

CMS Aim 1: Better Care

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

CMS Aim 2: Smarter Spending

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

CMS Aim 3: Healthier People, Healthier Communities

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

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

Table 3: NJ DMAHS 2022 Quality Strategy Goals

DMAHS Goal	DMAHS Objective	Measure Name	Measure Specification	Target
CMS Aim 1: Better Care				
Goal #1: Serve people the best way possible through benefits, service delivery, quality, and equity	1.1: Improve maternal/child health outcomes	Prenatal and Postpartum Care (PPC)	HEDIS PPC	NCQA 75th percentile
		Perinatal Risk Assessment (PRA) completion	N/A	Annual increase against baseline
		Well Child Visits (WCV)	HEDIS W30, HEDIS WCV	NCQA 75th percentile
		Pediatric Dental Quality	CMS-416, NJ State Specific Measures	55% for NJ Specific
	1.2: Help members with physical, cognitive, or behavioral health challenges get better coordinated care	Care Management Audits	EQRO	85%
		Autism service utilization	Measures in development	TBD
	1.3: Support independence for all older adults and people with disabilities who need help with daily activities	MLTSS Care Management Audits	EQRO	86%
		HCBS Unstaffed Cases/ Workforce Challenges	MCO Accountability Reporting	0% of cases > 30 days
		Nursing Facility Transition/Diversion Reporting	MLTSS Performance Measures	> 246 transitions per month; < 18 admissions to NF per month
CMS Aim #2: Smarter Spending				
Goal #2: Experiment with new ways to solve problems	2.1: Monitor fiscal accountability and manage risk	Minimum Loss Ratio (CMS Final Managed Care Rule)	DMAHS Finance	85% (non-MLTSS), 90% (MLTSS)

DMAHS Goal	DMAHS Objective	Measure Name	Measure Specification	Target
through innovation, technology, and troubleshooting				
	2.2: Demonstrate new value-based models that drive outcomes	Perinatal Episode of Care Payment Metrics	Measures in development	
		MCO Primary Care Home Models	Measures in development	TBD
		COVID-19 Vaccine Incentives	MCO Reporting	90th percentile among State Medicaid programs
	2.3: Use new systems and technologies to improve program operations	Eligibility Redeterminations – measures under development	CMS Reporting	TBD
		MMIS provider module	Measures in development	TBD
		Electronic Visit Verification (EVV) Compliance	DMAHS Managed Care Reporting	100%
CMS Aim 3: Healthier People, Healthier Communities				
Goal #3: Focus on integrity and real outcomes through accountability, compliance, metrics, and management	3.1: Address racial and ethnic disparities in quality of care and health outcomes	Breast Cancer Screening (BCS)	HEDIS BCS	NCQA 75th percentile
		COVID-19 Vaccination Rates	MCO Reporting	90th percentile among State Medicaid programs
		Cervical Cancer Screening (CCS)	HEDIS CCS	NCQA 75th percentile

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

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

IPRO's Assessment of the New Jersey DMAHS Quality Strategy

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

Recommendations to New Jersey DMAHS

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

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

Protocol 1: Validation of Performance Improvement Projects

Objectives

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

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

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

For January–December 2024, this ATR includes IPRO's evaluation of the April 2024 PIP update and August 2024 PIP report submissions as well as two PIP proposal submissions. IPRO's PIP validation process provides an assessment of the overall study design and implementation to ensure the PIP met specific criteria for a well-designed project that meets the CMS requirements as outlined in the EQR protocols. The MCOs will continue to submit project updates in April and August progress reports each year.

In June 2024, IPRO conducted the annual PIP training for the MCOs. The training focused on PIP development, implementation, and current PIP issues, as well as review of new PIP proposals.

Title 42 CFR § 438.356(a)(1) and *Title 42 CFR § 438.358(b)(1)* establish that state agencies must contract with an EQRO to perform the annual validation of PIPs. To meet these federal regulations, the DMAHS contracted with IPRO to validate the PIPs that were underway in 2024 (**Table 4**). Unless indicated as nonclinical, PIPs were clinical. PIPs that were at the final report stage or proposal are noted.

Table 4: Core Medicaid and MLTSS PIP Topics

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

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

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

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

Technical Methods of Data Collection and Analysis

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

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

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

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

Table 5: PIP Validation Scoring and Compliance Levels

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

PIP: performance improvement project; CMS: Centers of Medicare and Medicaid Services; MLTSS: managed long-term services and supports; MCO: managed care organization; N/A: not applicable.

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

Description of Data Obtained

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

Conclusions and Comparative Findings

IPRO reviewed the August 2024 Submission Reports and provided scoring and suggestions to the MCOs to enhance their studies (**Tables 6–11**). Note: Amerigroup New Jersey, Inc. (AGNJ) began doing business as Wellpoint NJ (WPNJ) on 1/1/2024. Current MCO-specific PIP scoring reports along with IPRO findings can be found in **Appendix A: January 2024–December 2024 NJ MCO-Specific Review Findings**.

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

New Jersey MCO PIP Scoring Report **PCP Access and Availability (Nonclinical)** **MY = Measurement Year**	**IPRO 2024 Scoring** **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ MY 3[1]	**FC/WCHP Final**	**HNJH Final**	**UHCCP Final**	**WPNJ Final**
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale).					
1a. Attestation signed & Project Identifiers completed	M	M	M	M	M
1b. Impacts the maximum proportion of members that is feasible	M	M	M	M	M
1c. Potential for meaningful impact on member health, functional status or satisfaction	M	M	M	M	M
1d. Reflects high-volume or high risk-conditions	M	M	M	M	M
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	M	M	M	M	M
Element 1 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 1 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 1 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals).					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	M	M	M	M	M
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	M	M	M	M	M
2c. Objectives align aim and goals with interventions	M	M	M	M	M
Element 2 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 2 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 2 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures).					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	M	M	M	M	M
3b. Performance Indicators are measured consistently over time	M	M	M	M	M
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	M	M	M	M	M

New Jersey MCO PIP Scoring Report PCP Access and Availability (Nonclinical) MY = Measurement Year	IPRO 2024 Scoring M=Met PM=Partially Met NM=Not Met				
	ABHNJ MY 3[1]	FC/WCHP Final	HNJH Final	UHCCP Final	WPNJ Final
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	M	M	M	M	M
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	M	M	M	M	M
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	M	M	N/A	M	M
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	M	M	M	M	M
3h. Study design specifies data analysis procedures with a corresponding timeline	M	M	M	M	M
Element 3 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 3 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 3 Weighted Score	**15.0**	**15.0**	**15.0**	**15.0**	**15.0**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	M	M	M	M	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	M	M	M	M	M
4c. Provider input at focus groups and/or Quality Meetings	M	M	M	M	M
4d. QI Process data (“5 Why’s”, fishbone diagram)	M	M	M	M	M
4e. HEDIS® rates (or other performance metric, e.g., CAHPS)	M	M	M	M	M
4f. Literature review	M	M	M	M	M
Element 4 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 4 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 4 Weighted Score	**15.0**	**15.0**	**15.0**	**15.0**	**15.0**
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	PM	M	M	M	M
5b. Actions that target member, provider and MCO	M	M	M	M	M
5c. New or enhanced, starting after baseline year	PM	M	M	M	M
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	M	M	M	M	M
Element 5 Overall Review Determination	**PM**	**M**	**M**	**M**	**M**
Element 5 Overall Score	**50**	**100**	**100**	**100**	**100**
Element 5 Weighted Score	**7.5**	**15.0**	**15.0**	**15.0**	**15.0**
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	M	M	M	M	M

New Jersey MCO PIP Scoring Report PCP Access and Availability (Nonclinical) MY = Measurement Year	IPRO 2024 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ MY 3[1]	**FC/WCHP Final**	**HNJH Final**	**UHCCP Final**	**WPNJ Final**
Element 6 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 6 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 6 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	M	M	M	M	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	M	M	M	M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity	M	M	M	M	M
7d. Lessons learned & follow-up activities planned as a result	PM	M	M	M	M
Element 7 Overall Review Determination	**PM**	**M**	**M**	**M**	**M**
Element 7 Overall Score	**50**	**100**	**100**	**100**	**100**
Element 7 Weighted Score	**10.0**	**20.0**	**20.0**	**20.0**	**20.0**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	M	M	M	M	M
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	PM	PM	M	M	M
Element 8 Overall Review Determination	**PM**	**PM**	**M**	**M**	**M**
Element 8 Overall Score	**50**	**50**	**100**	**100**	**100**
Element 8 Weighted Score	**10.0**	**10.0**	**20.0**	**20.0**	**20.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed **Y=Yes/N=No**	**N**	**N**	**Y**	**N**	**N**

	Findings	Findings	Findings	Findings	Findings
Maximum Possible Weighted Score	**100**	**100**	**100**	**100**	**100**
Actual Weighted Total Score	**72.5**	**90.0**	**100.0**	**100.0**	**100.0**
Validation Rating Percent	**72.5%**	**90.0%**	**100.0%**	**100.0%**	**100.0%**
Validation Status	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**
Validation Rating	**Moderate**	**High**	**High**	**High**	**High**

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

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

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

New Jersey MCO PIP Scoring Report EPSDT Well Child Visits, Childhood Immunizations (Clinical) MY = Measurement Year	IPRO 2024 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ MY 3	**FC/WCHP MY 3**	**HNJH MY 3**	**UHCCP MY 3**	**WPNJ MY 3**
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale).					
1a. Attestation signed & Project Identifiers completed	M	M	M	M	M
1b. Impacts the maximum proportion of members that is feasible	M	M	M	M	M
1c. Potential for meaningful impact on member health, functional status or satisfaction	M	M	M	M	M
1d. Reflects high-volume or high risk-conditions	M	M	M	M	M
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	M	M	M	M	M
Element 1 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 1 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 1 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals).					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	M	M	M	M	M
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	M	M	M	M	M
2c. Objectives align aim and goals with interventions	M	M	M	M	M
Element 2 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 2 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 2 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures).					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	M	M	M	M	M
3b. Performance Indicators are measured consistently over time	M	M	M	M	M
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	M	M	M	M	M
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	M	M	M	M	M
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	M	M	M	M	M
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	M	M	M	M	N/A
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	M	M	M	M	M
3h. Study design specifies data analysis procedures with a corresponding timeline	M	M	M	M	M
Element 3 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 3 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 3 Weighted Score	**15.0**	**15.0**	**15.0**	**15.0**	**15.0**

New Jersey MCO PIP Scoring Report EPSDT Well Child Visits, Childhood Immunizations (Clinical) MY = Measurement Year	IPRO 2024 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ MY 3	**FC/WCHP MY 3**	**HNJH MY 3**	**UHCCP MY 3**	**WPNJ MY 3**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	M	M	M	M	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	PM	M	M	M	PM
4c. Provider input at focus groups and/or Quality Meetings	M	M	M	M	PM
4d. QI Process data ("5 Why's", fishbone diagram)	M	M	M	M	M
4e. HEDIS® rates (or other performance metric, e.g., CAHPS)	M	M	M	M	M
4f. Literature review	M	M	M	M	M
Element 4 Overall Review Determination	**PM**	**M**	**M**	**M**	**PM**
Element 4 Overall Score	**50**	**100**	**100**	**100**	**50**
Element 4 Weighted Score	**7.5**	**15.0**	**15.0**	**15.0**	**7.5**
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	PM	PM	M	PM	M
5b. Actions that target member, provider and MCO	M	PM	M	M	M
5c. New or enhanced, starting after baseline year	M	M	M	M	M
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	M	M	M	M	M
Element 5 Overall Review Determination	**PM**	**PM**	**M**	**PM**	**M**
Element 5 Overall Score	**50**	**50**	**100**	**50**	**100**
Element 5 Weighted Score	**7.5**	**7.5**	**15.0**	**7.5**	**15.0**
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	M	M	M	M	M
Element 6 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 6 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 6 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	M	M	M	M	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	M	M	M	M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity	M	M	M	M	M
7d. Lessons learned & follow-up activities planned as a result	M	M	M	M	M
Element 7 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 7 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 7 Weighted Score	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**

New Jersey MCO PIP Scoring Report EPSDT Well Child Visits, Childhood Immunizations (Clinical) MY = Measurement Year	IPRO 2024 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ MY 3	**FC/WCHP MY 3**	**HNJH MY 3**	**UHCCP MY 3**	**WPNJ MY 3**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	PM	M	PM	M	M
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	PM	PM	M	PM	M
Element 8 Overall Review Determination	**PM**	**PM**	**PM**	**PM**	**M**
Element 8 Overall Score	**50**	**50**	**50**	**50**	**100**
Element 8 Weighted Score	**10.0**	**10.0**	**10.0**	**10.0**	**20.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed **Y=Yes/N=No**	**Y**	**Y**	**Y**	**Y**	**Y**

	Findings	Findings	Findings	Findings	Findings
Maximum Possible Weighted Score	**100**	**100**	**100**	**100**	**100**
Actual Weighted Total Score	**75.0**	**82.5**	**90.0**	**82.5**	**92.5**
Validation Rating Percent	**75.0%**	**82.5%**	**90.0%**	**82.5%**	**92.5%**
Validation Status	**Y**	**Y**	**Y**	**Y**	**Y**
Validation Rating	**Moderate**	**Moderate**	**High**	**Moderate**	**High**

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

Table 8: PIP State Topic #3: Core Medicaid Member Grievances

New Jersey MCO PIP Scoring Report Member Grievances (Nonclinical) MY = Measurement Year	IPRO 2024 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ MY 1	**FC/WCHP MY 1**	**HNJH MY 1**	**UHCCP MY 1**	**WPNJ MY 1**
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale).					
1a. Attestation signed & Project Identifiers completed	M	M	M	M	M
1b. Impacts the maximum proportion of members that is feasible	M	M	M	M	M
1c. Potential for meaningful impact on member health, functional status or satisfaction	M	M	M	M	M
1d. Reflects high-volume or high risk-conditions	M	M	M	M	M
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	M	M	M	M	M
Element 1 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 1 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 1 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals).					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	M	M	M	M	M

New Jersey MCO PIP Scoring Report Member Grievances (Nonclinical) MY = Measurement Year	IPRO 2024 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ MY 1	**FC/WCHP MY 1**	**HNJH MY 1**	**UHCCP MY 1**	**WPNJ MY 1**
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	M	M	M	M	PM
2c. Objectives align aim and goals with interventions	M	M	M	M	M
Element 2 Overall Review Determination	**M**	**M**	**M**	**M**	**PM**
Element 2 Overall Score	**100**	**100**	**100**	**100**	**50**
Element 2 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**2.5**
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures).					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	M	M	M	M	PM
3b. Performance Indicators are measured consistently over time	M	M	M	M	M
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	M	M	M	M	M
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	M	M	M	M	M
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	M	M	M	M	M
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	N/A	N/A	N/A	N/A
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	M	M	M	M	M
3h. Study design specifies data analysis procedures with a corresponding timeline	M	M	M	M	M
Element 3 Overall Review Determination	**M**	**M**	**M**	**M**	**PM**
Element 3 Overall Score	**100**	**100**	**100**	**100**	**50**
Element 3 Weighted Score	**15.0**	**15.0**	**15.0**	**15.0**	**7.5**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	M	M	M	M	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	M	M	M	M	M
4c. Provider input at focus groups and/or Quality Meetings	M	M	M	M	M
4d. QI Process data ("5 Why's", fishbone diagram)	M	M	M	M	M
4e. HEDIS® rates (or other performance metric, e.g., CAHPS)	M	M	M	N/A	M
4f. Literature review	M	M	M	N/A	M
Element 4 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 4 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 4 Weighted Score	**15.0**	**15.0**	**15.0**	**15.0**	**15.0**
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	M	M	M	M	M
5b. Actions that target member, provider and MCO	M	M	PM	M	M

New Jersey MCO PIP Scoring Report Member Grievances (Nonclinical) MY = Measurement Year	IPRO 2024 Scoring M=Met PM=Partially Met NM=Not Met				
	ABHNJ MY 1	FC/WCHP MY 1	HNJH MY 1	UHCCP MY 1	WPNJ MY 1
5c. New or enhanced, starting after baseline year	M	N/A	M	N/A	M
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	M	M	PM	M	M
Element 5 Overall Review Determination	**M**	**M**	**PM**	**M**	**M**
Element 5 Overall Score	**100**	**100**	**50**	**100**	**100**
Element 5 Weighted Score	**15.0**	**15.0**	**7.5**	**15.0**	**15.0**
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	M	PM	M	M	M
Element 6 Overall Review Determination	**M**	**PM**	**M**	**M**	**M**
Element 6 Overall Score	**100**	**50**	**100**	**100**	**100**
Element 6 Weighted Score	**5.0**	**2.5**	**5.0**	**5.0**	**5.0**
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	M	M	M	M	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	M	M	M	M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity	M	M	M	M	M
7d. Lessons learned & follow-up activities planned as a result	M	M	M	M	M
Element 7 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 7 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 7 Weighted Score	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There were ongoing, additional or modified interventions documented	N/A	N/A	N/A	N/A	N/A
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	N/A	N/A
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed. **Y=Yes/N=No**	N	N	N	N	N

	Findings	Findings	Findings	Findings	Findings
Maximum Possible Weighted Score	**80**	**80**	**80**	**80**	**80**
Actual Weighted Total Score	**80.0**	**77.5**	**72.5**	**80.0**	**70.0**
Validation Rating Percent	**100.0%**	**96.9%**	**90.6%**	**100.0%**	**87.5%**
Validation Status	**Yes**	**Yes**	**Yes**	**Yes**	**Yes**

New Jersey MCO PIP Scoring Report Member Grievances (Nonclinical) MY = Measurement Year	IPRO 2024 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ MY 1	FC/WCHP MY 1	HNJH MY 1	UHCCP MY 1	WPNJ MY 1
Validation Rating	High	High	High	High	High

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

Table 9: PIP Proposal State Topic: Core Medicaid Member IMA

New Jersey MCO PIP Scoring Report IMA Proposal Year[1]	IPRO 2024 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ	FC/WCHP	HNJH	UHCCP	WPNJ
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale).					
1a. Attestation signed & Project Identifiers completed	N/A	N/A	N/A	N/A	N/A
1b. Impacts the maximum proportion of members that is feasible	N/A	N/A	N/A	N/A	N/A
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A	N/A	N/A	N/A	N/A
1d. Reflects high-volume or high risk-conditions	N/A	N/A	N/A	N/A	N/A
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A	N/A	N/A	N/A	N/A
Element 1 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 1 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 1 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals).					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	N/A	N/A	N/A	N/A
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A	N/A	N/A	N/A	N/A
2c. Objectives align aim and goals with interventions	N/A	N/A	N/A	N/A	N/A
Element 2 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 2 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 2 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures).					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	N/A	N/A	N/A	N/A
3b. Performance Indicators are measured consistently over time	N/A	N/A	N/A	N/A	N/A
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	N/A	N/A	N/A	N/A
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	N/A	N/A	N/A	N/A
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	N/A	N/A	N/A	N/A
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	N/A	N/A	N/A	N/A

New Jersey MCO PIP Scoring Report IMA Proposal Year[1]	IPRO 2024 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ	**FC/WCHP**	**HNJH**	**UHCCP**	**WPNJ**
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	N/A	N/A	N/A	N/A
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	N/A	N/A	N/A	N/A
Element 3 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 3 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 3 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	N/A	N/A	N/A	N/A
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	N/A	N/A	N/A	N/A
4c. Provider input at focus groups and/or Quality Meetings	N/A	N/A	N/A	N/A	N/A
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	N/A	N/A	N/A	N/A
4e. HEDIS® rates (or other performance metric, e.g., CAHPS)	N/A	N/A	N/A	N/A	N/A
4f. Literature review	N/A	N/A	N/A	N/A	N/A
Element 4 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 4 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 4 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	N/A	N/A	N/A	N/A	N/A
5b. Actions that target member, provider and MCO	N/A	N/A	N/A	N/A	N/A
5c. New or enhanced, starting after baseline year	N/A	N/A	N/A	N/A	N/A
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	N/A	N/A	N/A	N/A
Element 5 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 5 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 5 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	N/A	N/A	N/A	N/A
Element 6 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 6 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 6 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	N/A	N/A	N/A	N/A

New Jersey MCO PIP Scoring Report IMA Proposal Year[1]	IPRO 2024 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ	**FC/WCHP**	**HNJH**	**UHCCP**	**WPNJ**
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	N/A	N/A	N/A	N/A
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity	N/A	N/A	N/A	N/A	N/A
7d. Lessons learned & follow-up activities planned as a result	N/A	N/A	N/A	N/A	N/A
Element 7 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 7 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 7 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There were ongoing, additional or modified interventions documented	N/A	N/A	N/A	N/A	N/A
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	N/A	N/A
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed. **Y=Yes/N=No**	N/A	N/A	N/A	N/A	N/A

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

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

Table 10: PIP State Topic #4: MLTSS Improving Coordination of Care and Ambulatory Follow-Up for Mental Health in the MLTSS HCBS Population

New Jersey MCO PIP Scoring Report Improving Coordination of Care and Ambulatory Follow-Up for Mental Health in the MLTSS HCBS Population (Clinical) MY = Measurement Year	IPRO 2024 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ MY 3	**FC/WCHP MY 3**	**HNJH MY 3**	**UHCCP MY 3**	**WPNJ MY 3**
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale)					
1a. Attestation signed & Project Identifiers Completed	M	M	M	M	M
1b. Impacts the maximum proportion of members that is feasible	M	M	M	M	M
1c. Potential for meaningful impact on member health, functional status or satisfaction	M	M	M	M	M
1d. Reflects high-volume or high risk-conditions	M	M	M	M	M
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	M	M	M	M	M

New Jersey MCO PIP Scoring Report Improving Coordination of Care and Ambulatory Follow-Up for Mental Health in the MLTSS HCBS Population (Clinical) MY = Measurement Year	IPRO 2024 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ MY 3	**FC/WCHP MY 3**	**HNJH MY 3**	**UHCCP MY 3**	**WPNJ MY 3**
Element 1 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 1 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 1 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals)					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	M	M	M	M	M
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	M	M	M	M	M
2c. Objectives align aim and goals with interventions	M	M	M	M	M
Element 2 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 2 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 2 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators). Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures)					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	M	M	M	M	M
3b. Performance indicators are measured consistently over time	M	M	M	M	M
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	M	M	M	M	M
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	M	M	M	M	M
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	M	M	M	M	M
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	M	N/A	N/A	N/A	N/A
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	M	M	M	M	PM
3h. Study design specifies data analysis procedures with a corresponding timeline	M	M	M	M	M
Element 3 Overall Review Determination	**M**	**M**	**M**	**M**	**PM**
Element 3 Overall Score	**100**	**100**	**100**	**100**	**50**
Element 3 Weighted Score	**15.0**	**15.0**	**15.0**	**15.0**	**7.5**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	M	M	M	M	M
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	M	M	M	M	M
4c. Provider input at focus groups and/or Quality Meetings	M	M	M	M	M
4d. QI Process data (“5 Why’s”, fishbone diagram)	M	M	M	M	M

New Jersey MCO PIP Scoring Report Improving Coordination of Care and Ambulatory Follow-Up for Mental Health in the MLTSS HCBS Population (Clinical) MY = Measurement Year	IPRO 2024 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ MY 3	**FC/WCHP MY 3**	**HNJH MY 3**	**UHCCP MY 3**	**WPNJ MY 3**
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	M	M	M	M	M
4f. Literature review	M	M	M	M	M
Element 4 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 4 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 4 Weighted Score	**15.0**	**15.0**	**15.0**	**15.0**	**15.0**
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	M	M	M	M	M
5b. Actions that target member, provider and MCO	M	M	M	M	M
5c. New or enhanced, starting after baseline year	M	M	M	M	M
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	M	M	M	M	M
Element 5 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 5 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 5 Weighted Score	**15.0**	**15.0**	**15.0**	**15.0**	**15.0**
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	M	M	M	M	M
Element 6 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 6 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 6 Weighted Score	**5.0**	**5.0**	**5.0**	**5.0**	**5.0**
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	M	M	M	M	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	M	M	M	M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	M	M	M	M	M
7d. Lessons learned & follow-up activities planned as a result	M	M	M	M	M
Element 7 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 7 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 7 Weighted Score	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	M	M	M	M	M
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	N/A	N/A
Element 8 Overall Review Determination	**M**	**M**	**M**	**M**	**M**
Element 8 Overall Score	**100**	**100**	**100**	**100**	**100**
Element 8 Weighted Score	**20.0**	**20.0**	**20.0**	**20.0**	**20.0**

New Jersey MCO PIP Scoring Report Improving Coordination of Care and Ambulatory Follow-Up for Mental Health in the MLTSS HCBS Population (Clinical) MY = Measurement Year	IPRO 2024 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ MY 3	FC/WCHP MY 3	HNJH MY 3	UHCCP MY 3	WPNJ MY 3
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed **Y=Yes/N=No**	**Y**	**Y**	**Y**	**Y**	**Y**

	Findings	Findings	Findings	Findings	Findings
Maximum Possible Weighted Score	**100**	**100**	**100**	**100**	**100**
Actual Weighted Total Score	**100.0**	**100.0**	**100.0**	**100.0**	**92.5**
Validation Rating Percent	**100.0%**	**100.0%**	**100.0%**	**100.0%**	**92.5%**
Validation Status	**Y**	**Y**	**Y**	**Y**	**Y**
Validation Rating	**High**	**High**	**High**	**High**	**High**

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

Table 11: PIP Proposal State Topic: MLTSS Increasing 10 Day Post Discharge Visits with Assessments

New Jersey MCO PIP Scoring Report MLTSS 10 Day Post Discharge Proposal Year[1]	IPRO 2024 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ	FC/WCHP	HNJH	UHCCP	WPNJ
Element 1. Topic/ Rationale (5% weight) Item 1a located in PIP Report Section 1. Items 1b-1e in Section 3: Project Topic, bullet 1 (Describe Project Topic and Rationale).					
1a. Attestation signed & Project Identifiers completed	N/A	N/A	N/A	N/A	N/A
1b. Impacts the maximum proportion of members that is feasible	N/A	N/A	N/A	N/A	N/A
1c. Potential for meaningful impact on member health, functional status or satisfaction	N/A	N/A	N/A	N/A	N/A
1d. Reflects high-volume or high risk-conditions	N/A	N/A	N/A	N/A	N/A
1e. Supported with MCO member data (e.g., historical data related to disease prevalence)	N/A	N/A	N/A	N/A	N/A
Element 1 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 1 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 1 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 2. Aim (5% weight) Items 2a-2c located in PIP Report Section 3, bullet 2 (Aim Statement, Objectives, and Goals).					
2a. Aim specifies Performance Indicators for improvement with corresponding goals	N/A	N/A	N/A	N/A	N/A
2b. Goal sets a target improvement rate that is bold, feasible, & based upon baseline data & strength of interventions, with rationale, e.g., benchmark	N/A	N/A	N/A	N/A	N/A
2c. Objectives align aim and goals with interventions	N/A	N/A	N/A	N/A	N/A
Element 2 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 2 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 2 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 3. Methodology (15% weight) Items 3a-3c located in PIP Report Section 4, bullet 1 (Performance Indicators).					

New Jersey MCO PIP Scoring Report MLTSS 10 Day Post Discharge Proposal Year[1]	IPRO 2024 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ	**FC/WCHP**	**HNJH**	**UHCCP**	**WPNJ**
Items 3d-3h in PIP Report Section 4, bullet 2 (Data Collection and Analysis Procedures).					
3a. Performance Indicators are clearly defined and measurable (specifying numerator and denominator criteria)	N/A	N/A	N/A	N/A	N/A
3b. Performance Indicators are measured consistently over time	N/A	N/A	N/A	N/A	N/A
3c. Performance Indicators measure changes in health status, functional status, satisfaction or processes of care with strong associations with improved outcomes	N/A	N/A	N/A	N/A	N/A
3d. Eligible population (i.e., Medicaid enrollees to whom the PIP is relevant) is clearly defined	N/A	N/A	N/A	N/A	N/A
3e. Procedures indicate data source, hybrid vs. administrative, reliability [e.g., Inter-Rater Reliability (IRR)]	N/A	N/A	N/A	N/A	N/A
3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	N/A	N/A	N/A	N/A
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	N/A	N/A	N/A	N/A
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	N/A	N/A	N/A	N/A
Element 3 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 3 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 3 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 4. Barrier Analysis (15% weight) Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	N/A	N/A	N/A	N/A
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	N/A	N/A	N/A	N/A
4c. Provider input at focus groups and/or Quality Meetings	N/A	N/A	N/A	N/A	N/A
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	N/A	N/A	N/A	N/A
4e. HEDIS® rates (or other performance metric, e.g., CAHPS)	N/A	N/A	N/A	N/A	N/A
4f. Literature review	N/A	N/A	N/A	N/A	N/A
Element 4 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 4 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 4 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 5. Robust Interventions (15% weight) Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	N/A	N/A	N/A	N/A	N/A
5b. Actions that target member, provider and MCO	N/A	N/A	N/A	N/A	N/A
5c. New or enhanced, starting after baseline year	N/A	N/A	N/A	N/A	N/A
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	N/A	N/A	N/A	N/A
Element 5 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 5 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 5 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

New Jersey MCO PIP Scoring Report MLTSS 10 Day Post Discharge Proposal Year[1]	IPRO 2024 Scoring **M**=Met **PM**=Partially Met **NM**=Not Met				
	ABHNJ	**FC/WCHP**	**HNJH**	**UHCCP**	**WPNJ**
Element 6. Results Table (5% weight) Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	N/A	N/A	N/A	N/A
Element 6 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 6 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 6 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 7. Discussion and Validity of Reported Improvement (20% weight) Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	N/A	N/A	N/A	N/A
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	N/A	N/A	N/A	N/A
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity	N/A	N/A	N/A	N/A	N/A
7d. Lessons learned & follow-up activities planned as a result	N/A	N/A	N/A	N/A	N/A
Element 7 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 7 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 7 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8. Sustainability (20% weight) Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There were ongoing, additional or modified interventions documented	N/A	N/A	N/A	N/A	N/A
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	N/A	N/A
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed. **Y=Yes/N=No**	N/A	N/A	N/A	N/A	N/A

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

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

Table 12 presents comparative performance for all MCOs across all PIP topics reviewed August 2024.

Table 12: 2024 PIP Validation Results

MCO	ABHNJ	FC/WCHP	HNJH	UHCCP	WPNJ
PIP 1: Access and Availability[1,4]	72.50%	90.00%	100.00%	100.00%	100.00%
PIP 2: EPSDT – Well-Child Visits & Childhood Immunizations[1]	75.00%	82.50%	90.00%	82.50%	92.50%
PIP 3: Member Grievances[1,4]	100.00%	96.90%	90.60%	100.00%	87.50%
PIP Proposal: Immunizations for Adolescents (IMA)[1,2]	N/A	N/A	N/A	N/A	N/A
PIP 4: Improving Coordination of Care and Ambulatory Follow-up for Mental Health Hospitalization in the MLTSS HCBS Population[3]	100.00%	100.00%	100.00%	100.00%	92.50%
PIP Proposal: MLTSS 10 Day Post Discharge Visit with Assessment[2,3]	N/A	N/A	N/A	N/A	N/A

[1] Performance improvement projects (PIPs) 1, 2 and 3 are Core Medicaid PIPs.
[2] Managed care organizations (MCOs) are at the proposal stage for this PIP and will be scored in measurement year (MY) 1.
[3] PIPs 4 and 5 are managed long-term services and supports (MLTSS) PIPs.
[4] PIPs 1 and 3 are nonclinical PIPs.
EPSDT: Early and Periodic Screening, Diagnostic, and Treatment; HCBS: Home and Community Based Services.

Strengths

ABHNJ – Of the 4 PIPs scored, 1 performed above the 85% threshold for Core Medicaid, indicating high performance; 1 PIP scored above the 86% threshold for MLTSS, indicating high performance.

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

HNJH – Of the 4 PIPs scored, 3 performed above the 85% threshold for Core Medicaid, indicating high performance; 1 PIP scored above the 86% threshold for MLTSS, indicating high performance.

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

WPNJ – Of the 4 PIPs scored, 3 PIPs performed above the 85% threshold for Core Medicaid, indicating high performance; 1 PIP scored above the 86% threshold for MLTSS, indicating high performance.

Opportunities for Improvement

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

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

HNJH – Overall, HNJH was compliant in presentation of data and analysis of results. Opportunities for improvement include more detailed analysis of performance indicator results and disparities presented.

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

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

All five MCOs engaged in a Core Medicaid PIP relating to Access and Availability. **Table 13** lists the interventions that each MCO implemented for this project and were provided verbatim by the MCOs.

Table 13: PIP Interventions Summary 2023–2024 for Access and Availability

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

PIP	Interventions
	providers the remaining quarters of the MY. This information will be shared with PCP practice for opportunities of improvement and monitored for performance through quarterly surveys.
FC/WCHP–Medical Primary Care Physician Access and Availability	• Telephonic outreach to members (quarterly) who had two or more visits to the Emergency Room or the Urgent Care Center in the past six (6) months - During these calls, Fidelis Care will provide the member with the: ▪ Name and contact information of their assigned PCP ▪ Offer assistance to schedule an appointment, if requested. ▪ The number for the transportation line, if transportation is an obstacle for the member ▪ The 24-hour Nurse line will be provided - Fidelis Care staff will also try to identify why the member chose to visit the ER/Urgent Care rather than their PCP to see if there are additional interventions that may be appropriate to address these issues/barriers. Below are some of the topics that will be discussed during the member outreach: ▪ Transportation ▪ PCP answering machine ▪ Timely Appointments. (“Was the next available appointment not soon enough?”) ▪ Does your provider speak your preferred language? ▪ Were there any other reasons that might have stopped you from seeing your PCP? - The frequency of this intervention will be quarterly starting in Q3 2022. • For members who stated that their PCP had an answering machine as an issue, Fidelis Care will outreach the provider offices after normal business hours, to determine if those providers had an answering system that meets Medicaid standards. ▪ The providers that did not meet the Medicaid Appointment Availability standards will be outreached telephonically and educated on the After-Hour standards. After speaking with these providers, they will be sent the Medicaid Appointment and Availability Standards via fax or email. • For those members who indicated that they could not receive timely appointments, Fidelis Care reviewed the list of providers associated with those members. ▪ The above providers will be outreached telephonically and educated on the After-Hour standards. After speaking with these providers, they will be sent the Medicaid Appointment and Availability Standards via fax or email. • For those members that the plan believed could have had their issues addressed with their PCPs, Fidelis Care reviewed the associated IPA ▪ The above providers will be outreached telephonically and educated on the After-Hour standards. After speaking with these providers, they will be sent the Medicaid Appointment and Availability Standards via fax or email. • The Provider Relations team will add the member education handout to their targeted calendar of agenda items to be discussed during the quarterly provider visits and to encourage display of the handout in their office.

PIP	Interventions
	• Implementation of provider outreach to update their demographic profile - Utilizing email and telephonic outreach to providers in the cohort to request any demographic changes, if needed. ▪ Confirm current availability vs pre-pandemic availability - Expand provider demographic outreach survey calls to include providing assigned Network Representative contact information to facilitate the exchange of demographic changes with their identified contacts. - Document and track in a shared folder • Ensure providers are aware that their patients have been utilizing care in a setting other than their office by: - Review monthly emergency high utilizer report to identify members who have received care in an Emergency Room or Urgent Care setting - Network will contact provider quarterly to discuss services which were rendered in the Emergency Room or Urgent Care setting that could have been provided in their office based on the NYU ER Algorithm - Network will document quarterly conversations or visit in the tracking system - Educate providers quarterly on Access & Availability standards for emergent/urgent care
HNJH - Increasing PCP Access and Availability for members with low acuity, non-emergent ED visits-Core Medicaid Membership	• **Educational materials** mailed to any member annually that experiences a LANE ED visit and has not had a PCP visit within the last 12 months. Education would be personalized to include the assigned PCP contact information, telemedicine alternatives, importance of annual visits, including preventive health screenings and immunizations, information on transportation and if additional assistance is needed. Education would also include when and when not to utilize the ED. • **Visit reminders** sent to members biannually. Reminders are personalized to include the PCP contact information, contact information for transportation and if additional assistance is needed. Members may receive both the annual information and the visit reminders if no PCP visit has been completed. Because of the inherent lag with claims data, a member may receive annual information, or a PCP visit reminder and may have already completed a PCP visit. • **Quarterly touchpoint meetings** with providers and staff in participating practice groups to focus on progress, newly encountered issues, or barriers of having members complete annual and follow-up visits. • **Bi-monthly list** sent to providers in participating practice groups of members with a LANE ED visit that have not been seen by the provider within 12 months.
UHCCP – Decreasing Emergency Room Utilization for Low Acuity Primary Care	• **Contact** Newark Community Health Centers, Rhomur Medical Services, and Forest Hills Family Health Associates adult Medicaid members who had an avoidable ED visit. Interview them about barriers to receiving care from a PCP on the day of the ED visit, educate them about appropriate ED usage, alternative sites of care and annual wellness visit. • **Assist in scheduling an appointment** with PCP for the adult Medicaid members assigned to Newark Community Health Centers, Rhomur Medical Centers and Forest Hills Family Health Associates who had an avoidable ED visit in the past quarter and are overdue for their annual physical.

PIP	Interventions
Conditions and Improving Access to Primary Care for Adult Medicaid Members	• **If the Newark Community Health Center, Rhomur Medical Services and Forest Hills Family Health Associates** adult Medicaid member indicates lack of transportation as a barrier to visiting the PCP office, educate them on medical transportation benefits offered by Medicaid. • **Work collaboratively** with identified practices to increase and monitor urgent appointment availability in order to reduce avoidable ED utilization. • **Refer adult Medicaid members** assigned to Newark Community Health Centers, Rhomur Medical Services and Forest Hills Family Health Associates who are high ED utilizers (4+ visits per calendar year) to NJUHCCP Case Management department for evaluation for services.
WPNJ - Increasing Primary Care Physician (PCP) Access and Availability for the Amerigroup Members	• **Education** via fax to all in-network provider groups regarding improving access and availability (including Telehealth options). (Quarterly) • **Monitoring the number of telehealth visits** of the identified provider groups who received faxed telehealth education. • **Quarterly meeting** with identified provider groups for education and discussion of barriers, appointment availability and PCP visit data. • **Monitoring the number of PCP visits** (any type) of the identified provider groups who received education and barrier discussions. • **Text messaging** (3 times per year) to members attributed to the identified provider groups who have not had a PCP visit to stress the importance of preventative health visits to avoid inpatient admissions. • **Telephonic outreach** to members of the identified provider groups with failed text. • **Educational mailing** targeting members of the identified provider groups with failed texts and/or call restrictions (do not call carve outs) regarding the importance of PCP visits. • **Faxed list of attributed** members who have not had a PCP visit (well and sick) in the last year for the identified provider groups. • **Promotion and tracking** of provider incentive for well visits.

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

All five MCOs engaged in a Core Medicaid PIP relating to EPSDT. **Table 14** lists the interventions that each MCO implemented for this project and were provided verbatim by the MCOs.

Table 14: PIP Interventions Summary 2023–2024 for EPSDT: Increasing Early and Periodic Screening, Diagnostic, and Treatment Visits and Childhood Immunizations

PIP	Interventions
ABHNJ - Increasing Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Visits	• **Educate non-adherent members** with well child visits and/or immunizations about importance of visits and safety of vaccines via IVR through mPulse (formerly known as HealthCrowd). The Plan will be specifically tracking the African American children for non-adherence due to vaccine hesitancy and lack of trust in the medical community. • **Identify members** without PCP claims in the system on a quarterly basis (12-month look-back) and conduct member outreach for engagement and/or PCP reassignment. • **Provide roster to select providers** in targeted counties identifying new members on the panel with no well-child visits and/or no CIS combo 10 (formerly combo 9) vaccinations. Appointments to be monitored through quarterly claims data.

PIP	Interventions
and Childhood Immunizations	• **Send letter to members** with a brochure who do not have claims for well-child visits and/or CIS combo 10 (formerly combo 9) vaccinations on behalf of PCP for select provider offices that ABHNJ manages and mailings which include incentive information. The member letter will include the provider and Plan logo with the provider signature.
FC/WCHP-Improving Early and Periodic Screening Diagnostic and Diagnosis (EPSDT) Well Child Visits and Childhood Immunizations	• **Member Outreach** by Care Coordinator to educate screen and engage in care management • **Provide the following educational website** for parent/guardian education: Share and discuss the *NEW Bright Futures Family Tip Sheet* consistent with *Bright Futures Guidelines*, *The Well-Child Visit: Why Go and What to Expect*. https://brightfutures.aap.org/Bright%20Futures%20Documents/BF_Family_Tipsheet.pdf • **Provide the following educational materials** via mailings for parent/guardian education: Childhood Vaccine Schedule Krames; Well Child Check-up Krames; Preventative Guidelines Ages 2-18 Krames. • **Educate parent/guardian** on the MyHealthPays Rewards Program. **Implementation of monthly** parent/guardian outreach to educate new mothers on the importance of well-child visits and immunizations. • **Quarterly Engagement** of 2 pilot providers to include: - Provider Education of the PIP - Delivery of Provider Score Card to include WCV/Immunization Care Gaps - Familiarize provider with the Bright Futures Performing Preventive Services Handbook, which provides guidance on the most effective way to deliver the preventive services recommended in the *Bright Futures Guidelines,* 4th Edition. https://brightfutures.aap.org/clinical-practice/Pages/default.aspx> • **Provide prenatal education** regarding Bright Futures Vaccine Schedule and Well Child Visits • **Mail expectant mothers** the 2021 Bright Futures Vaccine Schedule and Well Child Visits • **To outreach parents/guardians** with members having open W30 and CIS care gaps that may be due to a potential language barrier in a particular county • **To identify parents/guardians** with members having open W30 and CIS care gaps who confirmed language barriers in a particular county and transition them to a provider who spoke their chosen language
HNJH - Improving Childhood Immunization and Well-Child Visit Rates While Strengthening the Relationship to a Pediatric Medical Home in the HNJH Population.	• **Parent/guardians** of new HNJH members less than 30 months of age will be sent targeted mailer highlighting recommended immunization schedule and the ability to obtain combination doses. Phone number for scheduling assistance will also be included. • **Quarterly member gap lists** to primary care providers caring for children less than 30 months of age with list of members due for upcoming WCV and CIS to better assist in appointment scheduling prior to recommended WCVs and CIS. • **Parent/guardians** of HNJH members sent a reminder postcard that the member is behind schedule to complete six (6) well-child visits with their PCP by 15 months of age. Children 12 months of age or older with no well-child visits on record will be targeted for the reminder. • **Parent/guardians of HNJH** members sent a reminder postcard that the member is behind schedule to complete two (2) well-child visits with their PCP by 30 months of age. Children 22 months of age or older with no well-child visits on record will be

PIP	Interventions
	targeted for the reminder. • **Semi-annually deliver flier** to PCPs explaining ModivCare availability and how members may utilize their services to access the PCP. Information can be disseminated when attempting to schedule members with transportation challenges.
UHCCP - Improving Frequency of Well Visits in the First 30 Months of Life and Compliance with Childhood Immunizations.	• **Outreach to the parents/caregivers** of members assigned to Practice 1, 2 and 3 to remind them to schedule/keep their scheduled well baby appointments, educate on importance of preventive care. • **Provide case management** referral to parents/caregivers of members assigned to Practice 1, 2 and 3 who express that social determinants of health (relating to food, housing, or transportation) present a barrier to bringing their child for the well-baby visits. • **Monthly practice outreach/education** by UHCCP Clinical Practice Consultants (CPCs) to the staff at Practice 1, 2 and 3 regarding scheduling the well-baby appointment before the parent/caregiver leaves the office after a well-baby visit and reinforcing the importance of providing education to the member parent/caregiver regarding adherence to the recommended immunization and well-baby visit schedule.
WPNJ - Improving Well-Child Visits and Immunization Rates for Members Ages 0-30 Months	• **Parent/guardian education** on the importance of well visits and immunizations. • **Telephonic outreach** to parents/guardians of children ages 0-30 months identified as missing well visits. • **Parents/guardians** with children ages 0-30 months identified as missing well visits that required transportation assistance during telephonic outreach. • **Web-based member education** regarding vaccine safety. • **Outreach to providers** identified as having 10% or more of eligible members with gaps in care for well visits and immunizations. • **Targeted education for pediatricians** and family practice physicians on correct coding of well visits via fax blast. • **Implementation and promotion** of provider incentive for vaccine administration. • **Outreach to Passaic County provider groups** with gaps in care for well visits and immunizations to provide best practices and education (15 or more gaps in care for identified membership with disparity in Passaic County). • **Targeted education via text or telephonic outreach** to identified parents/guardians of children ages 0-30 months identified as missing well visits and immunizations (Passaic County membership with disparity - Hispanic).

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

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

Table 15: PIP Interventions Summary 2023–2024 for Member Grievances

PIP	Interventions
ABHNJ – Decreasing Member Grievances Related to	• **Educate new members** about Plan requirements (par and non-par, covered services, what requires pre-cert) and what to do if balance-billed through the updated Hello to Health magazine and Member Handbook.

PIP	Interventions
Balance Billing	• **Outreach existing members** who submitted two or more grievances categorized as balance billing for par providers within the quarter to educate members on Plan requirements and balance billing regulations. • **Send a revised cease and desist letter** to all providers who balance billed a member within the quarter. • **Provider Relations will outreach par providers** who have a high volume of grievances (defined as 10 or more) categorized as balance billing. Providers will be outreached by email or phone and provided with the list of members who submitted a grievance and will be given 30 days to respond. If no response is received from the provider, a face to face visit will be arranged. • **Par providers with 4-9 member grievances** categorized as balance billing will be sent a roster informing them of the members the Plan has received balance billing grievances from within the quarter. • **Monitor non-par providers** where a single case agreement was put in place and for whom the Plan received a grievance categorized as balance billing that were outreached by Provider Relations and were subsequently added to the network. • **Develop and implement a new form** for verbal member grievances received by the Member Call Center staff to ensure complete and accurate documentation of all data necessary for grievance resolution.
FC/WCHP-Addressing Medicaid Members' Complaints and Grievances	• **We will use our quarterly newsletter** to remind our members about their rights under Medicaid and provide clarity regarding balance billing practices. • **We will conduct quarterly outreach** to our Medicaid members who have opened a balance billing grievance to provide clarity regarding balance billing practices and their rights. • **During our in-person and virtual visits**, we will educate our providers with a one-page flyer that outlines facts regarding balance billing Medicaid members. • **We have added a slide to the existing onboarding material** for new providers to the plan regarding balance billing. • **Quarterly education regarding balance billing** added to calendar of provider trainings. • **Enhancement of Fidelis Care's Explanation of Payment (EOP)** to include language regarding not balance billing Medicaid members. • **Executive Leadership outreaching providers** who continue to balance bill members (identified by new balance billing grievances being opened) to ensure they cease billing members
HNJH - Complaints and Grievances – Core Medicaid Membership	• **Quarterly educational materials and training** provided to Medicaid providers regarding positive member interaction topics including, but not limited to de-escalation, thoughtful responding, and supporting people experiencing crisis. • **Quarterly educational materials** regarding top trending complaints provided to Medicaid practitioners, hospital facilities, and stand-alone diagnostic centers.
UHCCP – Reducing Member Grievances for Medicaid Members	• **Educate all in-network provider practices and facilities** on proper Medicaid billing, as outlined in the Provider Manual. • **Post an annual provider bulletin** on the NJUHCCP provider website to review Medicaid rules related to member billing as outlined in the Provider Manual. • **Implement ongoing quarterly training** via assigned learning modules for all member service representatives to improve quality of member interactions

PIP	Interventions
	• **Monitor post-call member surveys** for indicators of dissatisfaction and provide individual call center representative coaching to improve performance and call handling • **Implement ongoing Small Group Training** for member service representatives identified as needing additional training to improve the quality of member interactions • **Monitor percent of post-call member surveys** that indicated member dissatisfaction with the call experience. • **Inform members about their rights and responsibilities** regarding balance-billing through an annual article in the member newsletter.
WPNJ - Decreasing Member Grievances Related to Balance Billing	• **Follow-up education via fax related to balance billing** of Medicaid members directed to providers/groups who had a member grievance reported under the balance billing category in the prior month. • **Follow-up education on balance billing** of Medicaid members conducted by the Provider Relations team to the unique out-of-network providers/groups who had a member balance billing grievance in the prior month. • **Follow-up education on balance billing** of Medicaid members conducted by the Provider Relations team to the unique in-network providers/groups who had a member balance billing grievance in the prior month • **Include educational information** about balance billing rights for Medicaid members in new member orientation • **Fax education on timely filing requirements** to providers/groups with balance billing grievances associated with untimely claims filing. • **Provide general education** on balance billing rights to members at community events • **New member text message campaign** for members who recently filed a balance billing grievance to educate on what to do when you receive a provider bill. • **Annual member educational mailing** targeted to Medicaid members with dual coverage (i.e., Medicaid and Medicare) on the importance of providing correct health insurance information to healthcare providers and managing multiple health insurance cards

PIP: performance improvement project

All five MCOs engaged in an MLTSS PIP relating to Improving Coordination of Care and Ambulatory Follow-up after Mental Health Hospitalization in the MLTSS HCBS Population. **Table 16** lists the interventions that each MCO implemented for this project and were provided verbatim by the MCOs.

Table 16: PIP Interventions Summary 2023–2024 for Improving Coordination of Care and Ambulatory Follow-up After Mental Health Hospitalization in the MLTSS HCBS Populations

PIP	Interventions
ABHNJ - Improving Coordination of Care and Ambulatory Follow-up After Mental Health Hospitalization in the MLTSS	• **Increase documented interactions** between BH UM and MLTSS CM at least 3 times before member is discharged to ensure outpatient follow-up needs are met. Documented interactions can be defined as: communication via telephone, email, or in-person after admission, following concurrent review and at the time of discharge, participation in a BH UM rounds. • **BH UM will send** the discharge clinical information to the MLTSS CM within 48 hours following receipt from the hospital. • **Formalized information** gathering for social determinants of health for all members will occur during the BH UM discussions to facilitate discharge planning.

PIP	Interventions
Home and Community Based (HCBS) Populations	• **MLTSS HCBS members** with a behavioral health inpatient admission that have an identified SDoH issue or have been identified as being at high risk for nonadherence to discharge plan (based on the *Immediate Outreach Trigger List*) will receive outreach post discharge by their MLTSS CM within 48 business hours of the BH UM receiving discharge information from the facility to troubleshoot and resolve any barriers to attending behavioral health follow-up. • **BH UM will coordinate** the scheduling of a MH follow-up visit pre-discharge. If appointment is scheduled > 7 days from discharge, BH UM will educate providers regarding BH appointment standards. If the scheduled appointment is not shared before discharge or the appointment is outside of the 7- and 30-day timeframe, the MLTSS care manager will work with the member to get an appointment scheduled within the appropriate timeframe. • **MLTSS care manager** will coordinate the scheduling of a BH follow-up visit post-discharge if an appointment is not scheduled.
FC/WCHP-Improving Coordination of Care and Ambulatory Follow-up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations	• **Fidelis Care to coordinate provider** training on a quarterly basis on the identification of factors impacting member follow-up and adherence to treatment protocols among members with a behavioral health diagnosis. • **Screening for SDoH factors** that present barriers for follow-up treatment for members who have been recently discharged from an acute care setting with behavioral health diagnosis. • **Track referrals made** to community based MLTSS services for SDoH needs identified through the post-discharge screening, including nutritional counseling, food insecurities, utility and/or financial services. • **Track referrals made** to community based resources for SDoH needs identified through the post-discharge screening, including nutritional counseling, food insecurities, utility and/or financial services. • **Outreach members** identified with a recent behavioral health acute inpatient discharge and complete the Initial Contact for Behavioral Health Discharges Screening tool. • **Document member preference** of either in-person or telehealth follow-up visits with primary care/specialist. Track utilization of telehealth services for 30-day follow-up visit among the members meeting criteria for the project.
HNJH - Improving Coordination of Care and Ambulatory Follow-up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations	• **The MLTSS care manager** will review generalized educational material with the member (regarding the stigma of mental illness, the importance of treatment and where to find help) emphasizing the importance of routine wellness visits to members with a HEDIS-defined MH diagnosis. • **The CM will outreach** to engage and collaborate with any identified personal representatives, assisted living staff or house managers (boarding homes/group homes) as possible, regarding the importance of post-facility ambulatory care within 10 business days of hospital discharge. • **The CM will outreach** the member and provide generalized education emphasizing the importance of routine wellness visits to members with a HEDIS-defined MH diagnosis. • **The CM will escalate and refer** any member with a mental health related hospital readmission during the review period for the bi-weekly "Readmission Rounds Meeting" to be further reviewed by the MLTSS and BH Interdisciplinary Team meeting. • **The MLTSS care manager** will conduct outreach within 3 business days of an identified inpatient mental health related hospital discharge, this will allow the care managers to address the members needs with mental health related conditions sooner than the

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

PIP	Interventions
	advise/assist the member in utilizing telehealth to complete a follow up visit with a mental health practitioner. • **If the Behavioral Health Advocate Health Care manager** determines that lack of transportation prevents the member from completing the follow up appointment, they assist the member in arranging medical transportation to complete a follow up visit with a mental health practitioner • **Behavioral Health Advocate Care Manager** and MLTSS care manager follow up that member who declines to complete a follow up visit with a mental health provider within 30 days of discharge completes a follow up visit with a primary care provider within 30 days of discharge.
WPNJ - Improving Coordination of Care and Ambulatory Follow-up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations	• **Increase network of telehealth** mental health practitioners to improve appointment availability. • **Behavioral health team** to contact mental health provider to schedule/reschedule follow-up appointment for MLTSS HCBS members (within 7- and 30-days post discharge). • **Face-to-face or telephonic visits** by a Behavioral Health Case Manager for hard-to-reach MLTSS HCBS members discharged from the hospital • **Implementation and promotion** of provider incentive for FUH Compliance (7 Day-follow up and 30- Day follow-up). • **Monthly fax blast to outlier facilities due to late discharge notification**. Education material details importance of prompt discharge planning and notification**.**

PIP: performance improvement project; MLTSS: managed long-term services and supports; BH: behavioral health; CM: care management/care manager; UM: utilization management; SDoH: social determinants of health; MH: mental health; FUH: follow-up after hospitalization; HEDIS: Healthcare Effectiveness Data and Information Set.

Protocol 2: Validation of Performance Measures

Objectives

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

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

Technical Methods of Data Collection and Analysis

Using a standard evaluation tool, IPRO reviewed each MCO's HEDIS rates based upon the HEDIS FAR prepared by an NCQA-licensed audit organization for each MCO as required by NCQA. IPRO's review of the FAR helped determine whether each MCO appropriately followed the HEDIS Guidelines in calculating the measures and whether the measures were deemed to be unbiased and reportable **(Table 17).** In determining whether rates are reportable, licensed audit organizations evaluate the MCOs' transaction and information systems, their data warehouse and data control procedures, all vendors with delegated responsibility for some aspect of the HEDIS production process, all supplemental data sources used, and medical record review procedures relevant to the calculation of the hybrid measures.

Description of Data Obtained

The five MCOs with performance data for MY 2023 (ABHNJ, FC/WCHP, HNJH, UHCCP and WPNJ) reported HEDIS MY 2023 data. The MCOs' independent auditors determined that the rates reported by the MCOs were calculated in accordance with NCQA's defined specifications, and there were no data collection or reporting issues identified by the MCOs' independent auditors.

IPRO reviewed each of the NJ MCOs' HEDIS MY 2023 FARs to determine compliance with ISCA standards. The FARs revealed that all MCOs met all standards for successful reporting **(Table 17).**

Table 17: MCO Compliance with Information System Standards – MY 2023

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

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

Information Systems Capabilities Assessments

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

On February 9, 2024, IPRO uploaded the NJ ISCA tool to Research Electronic Data Capture (REDCap®), and the NJ MCOs were requested to complete and return the responses by March 18, 2024. In May 2024, virtual meetings were held with each MCO (ABHNJ, FC/WCHP, HNJH, UHCCP, and WPNJ) to discuss the MCO's ISCA responses. IPRO interviewed the MCO's staff and conducted a review of the MCO's IS capabilities. DMAHS attended the meetings. The meetings included a section to discuss the MCO's grievance systems and regulatory reporting requirements.

The MCO's information system assessment reviews included:

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

Assessment dates for 2024 ISCA review meetings with NJ MCOs are listed in **Table 18**.

Table 18: 2024 ISCA Review Meetings

MCO	Assessment Dates
ABHNJ	May 8, 2024
FC/WCHP	May 7, 2024, and May 14, 2024
HNJH	May 6, 2024
UHCCP	May 1, 2024
WPNJ	May 2, 2024

MCO: managed care organization.

At the conclusion of the ISCA review, IPRO compiled and analyzed the information gathered through the preliminary ISCA review and from the MCO staff interviews to produce individual MCO ISCA reports. A statement of findings about the MCO's IS review and an assessment level were assigned in MCO reports. During the 2024 ISCA review, the MCO's were assessed on the topics in **Table 19**. All NJ MCO's met assessment rating standards, and no issues were noted. The assessment for the submission to Transformed Medicaid Statistical Information System (T-MSIS) was not applicable to NJ MCO's since the MCOs submit encounter data to the state.

Table 19: 2024 ISCA Findings by MCO

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

MCO: managed care organization; NJ: New Jersey; NCQA: National Committee for Quality Assurance; CMS: Centers for Medicare and Medicaid Services.

HEDIS MY 2023 Performance Measures

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

Conclusions and Comparative Findings

All MCOs (ABHNJ, FC/WCHP, HNJH, UHCCP, and WPNJ) provided audited HEDIS rates for MY 2023. For most measures, if the measure's rate was higher than last year, it was considered an improvement. For inverse measures, however, it was considered an increase in performance if the measure's rate was lower than last year. A more than 5 pp change is considered a significant change. Due to the impact of the COVID-19 pandemic, caution should be exercised in interpreting year-over-year performance for the MCOs.

The eligible population for the AMB measure is the reported member years. Ambulatory measure rates are a measure of utilization rather than performance. All five MCOs reported the rates for all breakouts as required by DMAHS.

Overall, most measures remained constant from MY 2022 to MY 2023 (< 5 pp change). Significant increases and decreases (≥ 5 percentage point change) in performance from MY 2022 are noted below.

Improvements in performance from MY 2022 to MY 2023:

1. Colorectal Cancer Screening (COL) (Note: COL had a change in age bands in MY 2023)
   a. 46-50 Years improved by 6.28 pp
2. Appropriate Testing for Pharyngitis (CWP)

   a. 18-64 Years improved by 5.10 pp
3. Blood Pressure Control for Patients with Diabetes (BPD) improved by 5.31 pp
4. Kidney Health Evaluation for Patients with Diabetes (KED)
   a. 65–74 Years improved by 6.74 pp
   b. 75–85 Years improved by 6.84 pp
   c. Total Rate improved by 5.79 pp
5. Follow-Up after Hospitalization for Mental Illness (FUH)
   a. 6-17 Years 30-Day Follow-Up improved by 10.42 pp
   b. 6-17 Years 7-Day Follow-Up improved by 5.65 pp
   c. 18-64 Years 30-Day Follow-Up improved by 6.39 pp
   d. 65+ Years 30-Day Follow-Up improved by 9.77 pp
   e. 65+ Years 7-Day Follow-Up improved by 7.94 pp
   f. Total 30-Day Follow-Up improved by 7.09 pp
6. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) Blood Glucose and Cholesterol Testing
   a. 12-17 Years improved by 7.73 pp
   b. Total improved by 6.04 pp
7. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)
   a. Blood Glucose Testing - 1-11 Years improved by 7.22 pp
   b. Blood Glucose Testing - 12-17 Years improved by 10.33 pp
   c. Blood Glucose Testing – Total improved by 8.96 pp
   d. Blood Glucose and Cholesterol Testing - 12-17 Years improved by 7.73 pp
   e. Blood Glucose and Cholesterol Testing – Total improved by 6.04 pp

Decreases in performance from MY 2022 to MY 2023:

1. Asthma Medication Ratio (AMR)
   a. 5-11 Years decreases by 7.73 pp
   b. 12-18 Years decreases by 7.20 pp
2. Persistence of Beta-Blocker Treatment After a Heart Attack (PBH) decreased by 17.07 pp
3. Initiation and Engagement of Substance Use Disorder Treatment (IET)
   a. Total 13-17 Years Initiation decreased by 6.17 pp
   b. Opioid 18-64 Years Initiation decreased by 5.45 pp
   c. Opioid 65+ Years Initiation decreased by 5.30 pp
   d. Opioid Total Years Initiation decreased by 7.99 pp

IPRO aggregated the MCO rates for the 55 measures included in the NJ Medicaid HEDIS grid and calculated weighted statewide averages to provide methodologically appropriate, comparative information for all MCOs consistent with guidance included in the EQR protocols issued in accordance with *Title 42 CFR § 438.352(e)*. HEDIS rates produced by the MCOs were also reported to the NCQA. Complete audit review tables (ARTs) for each MCO are provided in **Appendix A: January 2024–December 2024 NJ MCO-Specific Review Findings.**

For this report, the MCOs' reported rates were compared to the NCQA HEDIS MY 2023 Quality Compass® national percentiles for Medicaid health maintenance organizations (HMOs) for all measures where the NCQA

HEDIS MY 2023 Quality Compass national percentiles are available. The HEDIS rates are color coded to correspond to national percentiles (**Table 20**).

Table 20: Color Key for HEDIS Performance Measure Comparison to NCQA HEDIS MY 2023 Quality Compass National Percentiles

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

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

HEDIS data presented in this section include: Effectiveness of Care, Overuse/Appropriateness, Access/Availability of Care, Utilization and Risk Adjusted Utilization, and Electronic Clinical Data System measures. **Table 21** displays the HEDIS PMs for MY 2023 for all MCOs and the NJ Medicaid Average. The Medicaid average is the weighted average of all MCO data.

Table 21: HEDIS MY 2023 Performance Measures

HEDIS MY 2023 Performance Measures	ABHNJ	FC/WCHP[1]	HNJH	UHCCP	WPNJ[2]	NJ Medicaid Average[3]
Childhood Immunization (CIS)						
Combination 3	55.72%	57.18%	63.99%	53.53%	61.07%	61.11%
Combination 7	43.31%	44.04%	54.01%	43.07%	47.69%	50.23%
Combination 10	27.01%	27.49%	34.55%	26.76%	26.03%	31.21%
Well-Child Visits in the First 30 Months of Life (W30)						
Well-Child Visits in the First 15 Months (6 or more visits)	53.71%	52.98%	57.04%	54.62%	58.20%	56.52%
Well-Child Visits for Age 15 Months - 30 Months (2 or more visits)	71.93%	73.77%	73.09%	69.16%	75.13%	72.85%
Child and Adolescent Well-Care Visits (WCV)						
3 - 11 years	64.62%	69.80%	69.36%	67.94%	70.61%	69.07%
12 - 17 years	55.25%	63.93%	63.44%	62.55%	64.11%	63.06%
18 - 21 years	30.78%	37.56%	39.13%	40.79%	40.44%	39.27%
Total Rate	56.40%	62.17%	61.95%	61.16%	63.65%	61.80%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)						
BMI percentile - 3-11 Years	88.54%	84.41%	87.43%	85.02%	86.64%	86.81%
BMI percentile - 12-17 Years	86.18%	90.54%	86.89%	84.24%	86.57%	86.40%
BMI percentile - Total	87.83%	86.62%	87.21%	84.67%	86.62%	86.64%
Counseling for Nutrition - 3-11 Years	81.60%	79.09%	86.34%	70.04%	83.03%	82.36%
Counseling for Nutrition - 12-17 Years	75.61%	85.14%	86.07%	70.65%	82.09%	82.05%
Counseling for Nutrition - Total	79.81%	81.27%	86.23%	70.32%	82.73%	82.25%
Counseling for Physical Activity - 3-11 Years	79.17%	74.52%	80.87%	63.44%	79.78%	77.15%

HEDIS MY 2023 Performance Measures	ABHNJ	FC/WCHP[1]	HNJH	UHCCP	WPNJ[2]	NJ Medicaid Average[3]
Counseling for Physical Activity - 12-17 Years	76.42%	85.81%	86.89%	67.39%	82.09%	81.92%
Counseling for Physical Activity - Total	78.35%	78.59%	83.28%	65.21%	80.54%	79.04%
Immunizations For Adolescents (IMA)						
Meningococcal	81.02%	85.40%	89.05%	85.16%	88.56%	87.75%
Tdap/Td	83.70%	90.27%	93.19%	89.78%	91.97%	91.87%
HPV	25.55%	31.87%	36.74%	29.93%	28.22%	33.67%
Combination 1	79.56%	84.18%	88.56%	84.43%	88.32%	87.18%
Combination 2	23.84%	29.68%	35.04%	28.22%	27.01%	32.01%
Lead Screening in Children (LSC)	72.51%	78.59%	74.70%	76.40%	75.31%	75.06%
Cervical Cancer Screening (CCS)	48.91%	51.34%	59.05%	58.64%	63.26%	58.52%
Chlamydia Screening (CHL)						
16-20 Years	61.29%	63.15%	55.64%	59.46%	60.38%	57.49%
21-24 Years	66.31%	65.38%	67.50%	66.26%	62.10%	66.33%
Total	64.27%	64.35%	61.37%	62.46%	61.32%	61.82%
Oral Evaluation, Dental Services (OED)[4]						
0-2 Years	15.71%	23.42%	23.39%	22.92%	17.10%	21.83%
3-5 Years	41.02%	55.60%	56.35%	59.98%	54.48%	55.77%
6-14 Years	46.86%	61.40%	63.20%	66.17%	61.91%	62.89%
15-20 Years	31.42%	43.04%	46.73%	50.82%	43.38%	46.47%
Total	37.02%	50.54%	52.96%	56.62%	49.80%	52.43%
Topical Fluoride for Children (TFC)[4]						
1-2 Years	9.45%	15.15%	12.24%	16.16%	14.31%	13.13%
3-4 Years	12.20%	18.56%	20.01%	26.40%	19.00%	20.36%
Total	10.80%	16.88%	16.22%	21.41%	16.68%	16.82%
Adults' Access to Preventive/Ambulatory Health Services (AAP)						
20-44 Years	63.16%	66.23%	74.67%	75.29%	70.34%	73.10%
45-64 Years	75.32%	83.76%	84.98%	86.49%	81.02%	84.16%
65+ Years	77.14%	84.21%	91.42%	94.22%	91.22%	89.99%
Total	68.45%	77.22%	78.83%	82.47%	75.68%	78.41%
Colorectal Cancer Screening(COL)[9]						
46-50 Years	18.57%	23.08%	28.00%	28.17%	24.05%	26.82%
51-75 Years	30.65%	41.76%	47.20%	54.32%	43.11%	46.92%
Total	28.24%	39.25%	42.62%	49.35%	38.98%	42.60%
Asthma Medication Ratio (AMR)						
5-11 Years	59.09%	57.69%	68.50%	61.68%	59.83%	65.32%
12-18 Years	66.67%	63.49%	67.35%	54.42%	51.34%	61.99%
19-50 Years	70.83%	61.93%	73.15%	57.35%	56.37%	67.51%
51-64 Years	78.42%	61.01%	78.32%	57.73%	62.10%	70.93%
Total	70.92%	61.45%	72.89%	57.77%	57.67%	67.20%
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)						
3 months to 17 Years	66.22%	59.42%	62.07%	60.92%	64.70%	62.27%
18 to 64 Years	41.78%	39.73%	34.73%	40.38%	45.07%	37.59%
65+ Years	60.00%	55.47%	30.18%	28.94%	34.86%	37.52%
Total	59.11%	52.40%	52.92%	52.28%	57.84%	53.64%

HEDIS MY 2023 Performance Measures	ABHNJ	FC/WCHP[1]	HNJH	UHCCP	WPNJ[2]	NJ Medicaid Average[3]
Appropriate Treatment for Upper Respiratory Infection (URI)						
3 Months-17 Years	92.87%	92.18%	91.80%	90.70%	92.84%	91.81%
18-64 Years	64.72%	56.69%	62.18%	62.11%	66.67%	62.53%
65+ Years	67.24%	67.01%	51.51%	49.55%	48.33%	54.05%
Total	86.72%	82.55%	84.63%	82.84%	87.12%	84.62%
Appropriate Testing for Pharyngitis (CWP)						
3-17 Years	86.90%	77.84%	70.28%	78.57%	88.42%	75.68%
18-64 Years	57.96%	42.25%	42.82%	55.47%	61.93%	48.29%
65+ Years	38.89%	10.89%	33.24%	32.33%	27.88%	28.32%
Total	77.42%	64.48%	61.38%	71.61%	80.76%	67.06%
Hemoglobin A1c Control for Patients with Diabetes (HBD)						
HbA1c Poor Control (>9.0%)[5]	28.47%	29.68%	32.19%	25.79%	26.76%	29.75%
HbA1c Control (<8.0%)	61.31%	61.07%	60.93%	64.48%	66.42%	62.36%
Eye Exam for Patients With Diabetes (EED)	54.26%	52.80%	59.21%	62.53%	51.09%	58.34%
Blood Pressure Control for Patients With Diabetes (BPD)	70.80%	66.18%	71.99%	69.34%	69.59%	70.60%
Kidney Health Evaluation for Patients With Diabetes (KED)						
18–64 years	40.06%	42.56%	37.18%	42.48%	39.55%	38.92%
65–74 years	39.29%	39.78%	47.99%	52.55%	50.66%	48.30%
75–85 years	36.71%	31.15%	46.71%	50.10%	49.29%	44.74%
Total Rate	39.66%	39.91%	38.40%	45.98%	42.65%	40.85%
Controlling High Blood Pressure (CBP)	69.83%	73.72%	72.61%	64.48%	69.59%	70.22%
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	54.05%	NA	67.84%	57.35%	74.07%	64.87%
Statin Therapy for Patients with Cardiovascular Disease (SPC)						
21-75 years (Male) - Received Statin Therapy	65.87%	73.45%	85.22%	82.63%	84.40%	82.18%
40-75 years (Female) - Received Statin Therapy	59.71%	70.19%	81.67%	80.10%	79.71%	78.90%
Total - Received Statin Therapy	63.56%	71.98%	83.68%	81.36%	82.39%	80.70%
21-75 years (Male) - Statin Adherence 80%	70.16%	76.62%	76.24%	79.15%	70.18%	75.98%
40-75 years (Female) - Statin Adherence 80%	68.67%	79.06%	77.84%	78.01%	71.57%	77.04%
Total - Statin Adherence 80%	69.64%	77.69%	76.92%	78.58%	70.75%	76.45%
Follow-Up After Emergency Department Visit for Substance Use (FUA)[6]						
13-17 years - 30 Day Follow-Up	NA	NA	18.75%	16.51%	22.50%	18.40%
13-17 years - 7 Day Follow-Up	NA	NA	13.07%	11.01%	15.00%	12.83%
18 and older - 30 Day Follow-Up	34.64%	28.46%	40.41%	34.44%	32.49%	37.48%
18 and older - 7 Day Follow-Up	24.37%	20.55%	29.00%	24.50%	21.66%	26.64%
Total - 30 Day Follow-Up	34.18%	28.42%	39.63%	33.75%	32.28%	36.86%
Total - 7 Day Follow-Up	24.10%	20.54%	28.43%	23.98%	21.52%	26.20%

HEDIS MY 2023 Performance Measures	ABHNJ	FC/WCHP[1]	HNJH	UHCCP	WPNJ[2]	NJ Medicaid Average[3]
Follow-Up After Hospitalization for Mental Illness (FUH)[6]						
6-17 years - 30-Day Follow-Up	39.08%	NA	37.74%	NA	52.96%	47.80%
6-17 years - 7-Day Follow-Up	17.24%	NA	22.64%	NA	28.46%	25.61%
18-64 years - 30-Day Follow-Up	35.83%	57.35%	54.08%	54.91%	40.70%	43.67%
18-64 years - 7-Day Follow-Up	19.01%	34.56%	32.65%	32.76%	24.05%	25.29%
65+ years - 30-Day Follow-Up	35.29%	NA	50.75%	49.28%	54.84%	49.38%
65+ years - 7-Day Follow-Up	20.59%	NA	29.85%	31.88%	30.65%	29.37%
Total - 30-Day Follow-Up	36.04%	56.77%	51.95%	53.77%	43.03%	44.47%
Total - 7 Day Follow-Up	18.93%	32.90%	31.25%	32.66%	24.94%	25.61%
Follow-Up After Emergency Department Visit for Mental Illness (FUM)[6]						
6-17 years - 30-Day Follow-Up	67.52%	57.71%	72.28%	64.59%	59.19%	69.02%
6-17 years - 7-Day Follow-Up	58.55%	45.27%	61.96%	53.55%	49.38%	58.59%
18-64 years - 30-Day Follow-Up	55.63%	59.06%	62.23%	59.68%	57.32%	60.47%
18-64 years - 7-Day Follow-Up	45.30%	50.31%	52.83%	46.75%	46.27%	50.19%
65+ years - 30-Day Follow-Up	NA	75.00%	56.67%	59.57%	62.86%	61.25%
65+ years - 7-Day Follow-Up	NA	63.89%	41.67%	48.23%	57.14%	50.31%
Total - 30-Day Follow-Up	58.38%	59.48%	66.79%	61.67%	58.19%	64.03%
Total - 7 Day Follow-Up	48.30%	49.59%	56.93%	49.58%	47.78%	53.67%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)						
1-11 Years	62.50%	NA	59.68%	63.03%	55.17%	59.84%
12-17 Years	57.50%	64.10%	69.58%	62.87%	50.97%	65.48%
Total	59.72%	60.71%	65.87%	62.91%	52.11%	63.53%
Use of Opioids at High Dosage (HDO)[5]	12.54%	10.61%	10.74%	9.48%	8.73%	10.33%
Use of Opioids From Multiple Providers (UOP)[5]						
Multiple Prescribers	22.91%	12.85%	16.97%	11.28%	15.29%	15.57%
Multiple Pharmacies	2.50%	1.80%	2.54%	1.77%	1.83%	2.25%
Multiple Prescribers and Multiple Pharmacies	1.55%	1.01%	1.02%	0.81%	0.88%	0.98%
Risk of Continued Opioid Use (COU)[5]						
18-64 years - >=15 Days covered	5.90%	8.64%	5.49%	6.62%	4.20%	5.70%
18-64 years - >=31 Days covered	3.60%	5.17%	3.43%	3.83%	2.88%	3.52%
65+ years - >=15 Days covered	17.05%	20.63%	11.39%	13.40%	15.46%	14.29%
65+ years - >=31 Days covered	9.66%	12.84%	6.88%	8.05%	8.07%	8.46%
Total - >=15 Days covered	6.47%	11.13%	5.67%	7.66%	5.29%	6.30%
Total - >=31 Days covered	3.91%	6.76%	3.54%	4.47%	3.38%	3.87%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)	55.98%	69.79%	68.72%	70.80%	68.87%	68.65%
Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications (SSD)	87.21%	77.69%	87.05%	87.74%	85.01%	86.30%

HEDIS MY 2023 Performance Measures	ABHNJ	FC/WCHP[1]	HNJH	UHCCP	WPNJ[2]	NJ Medicaid Average[3]
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) Blood Glucose and Cholesterol Testing						
1-11 Years	27.87%	34.69%	28.79%	34.39%	28.31%	29.79%
12-17 Years	46.39%	61.36%	41.84%	48.65%	47.36%	44.33%
Total	39.24%	51.82%	37.39%	44.56%	41.92%	39.58%
Antidepressant Medication Management (AMM)						
Effective Acute Phase Treatment	61.29%	64.63%	58.85%	65.56%	64.23%	61.11%
Effective Continuation Phase Treatment	46.77%	51.53%	44.37%	48.00%	46.48%	45.77%
Follow-Up Care for Children Prescribed ADHD Medication (ADD)						
Initiation Phase	34.62%	45.64%	35.39%	39.46%	35.13%	36.37%
Continuation and Maintenance Phase	37.04%	51.52%	37.40%	44.40%	39.33%	39.13%
Initiation and Engagement of Substance Use Disorder Treatment (IET)						
Alcohol - 13-17 Years Initiation	NA	NA	NA	NA	NA	CNC
Alcohol - 13-17 Years Engagement	NA	NA	NA	NA	NA	CNC
Opioid - 13-17 Years Initiation	NA	NA	NA	NA	NA	CNC
Opioid - 13-17 Years Engagement	NA	NA	NA	NA	NA	CNC
Other - 13-17 Years Initiation	NA	NA	NA	NA	27.88%	CNC
Other - 13-17 Years Engagement	NA	NA	NA	NA	0.96%	CNC
Total - 13-17 Years Initiation	27.50%	NA	NA	NA	29.75%	28.99%
Total - 13-17 Years Engagement	5.00%	NA	NA	NA	0.83%	2.37%
Alcohol - 18-64 Years Initiation	42.63%	40.74%	40.12%	44.76%	39.93%	41.26%
Alcohol - 18-64 Years Engagement	8.91%	5.56%	7.56%	6.05%	7.70%	7.91%
Opioid - 18-64 Years Initiation	64.10%	39.53%	34.87%	50.00%	61.98%	58.13%
Opioid - 18-64 Years Engagement	36.39%	11.63%	15.13%	17.81%	37.39%	32.36%
Other - 18-64 Years Initiation	51.22%	53.97%	38.46%	44.28%	42.70%	45.38%
Other - 18-64 Years Engagement	12.06%	6.35%	6.41%	7.38%	7.20%	8.63%
Total - 18-64 Years Initiation	50.00%	45.63%	37.99%	45.71%	45.72%	46.45%
Total - 18-64 Years Engagement	15.21%	7.50%	9.14%	9.17%	13.83%	13.34%
Alcohol - 65+ Years Initiation	46.43%	40.85%	38.16%	35.69%	36.42%	37.73%
Alcohol - 65+ Years Engagement	3.57%	1.41%	3.29%	4.46%	2.31%	3.33%
Opioid - 65+ Years Initiation	NA	21.05%	28.00%	32.81%	55.93%	33.50%
Opioid - 65+ Years Engagement	NA	4.21%	9.00%	7.03%	13.56%	8.82%
Other - 65+ Years Initiation	NA	17.65%	37.31%	41.25%	35.00%	36.24%
Other - 65+ Years Engagement	NA	0.00%	5.97%	2.50%	2.50%	2.91%
Total - 65+ Years Initiation	49.45%	26.73%	34.80%	36.62%	39.74%	36.23%
Total - 65+ Years Engagement	8.79%	2.30%	5.64%	4.49%	4.49%	4.68%
Alcohol - Total Years Initiation	42.52%	40.80%	39.20%	40.04%	39.56%	40.46%
Alcohol - Total Years Engagement	8.62%	3.20%	5.56%	5.22%	7.06%	6.96%
Opioid - Total Years Initiation	64.04%	26.81%	32.14%	41.97%	61.53%	53.06%
Opioid - Total Years Engagement	36.19%	6.52%	12.70%	12.77%	35.65%	27.51%
Other - Total Years Initiation	50.58%	37.72%	38.28%	42.79%	41.39%	43.71%
Other - Total Years Engagement	11.65%	3.51%	6.27%	5.72%	6.57%	7.74%
Total - Total Years Initiation	49.60%	34.75%	36.86%	41.45%	44.80%	44.42%
Total - Total Years Engagement	14.79%	4.51%	7.85%	7.08%	12.74%	11.69%

HEDIS MY 2023 Performance Measures	ABHNJ	FC/WCHP[1]	HNJH	UHCCP	WPNJ[2]	NJ Medicaid Average[3]
Prenatal and Postpartum Care (PPC)						
Timeliness of Prenatal Care	87.10%	74.70%	84.03%	82.00%	89.29%	84.51%
Postpartum Care	83.21%	82.24%	84.72%	83.21%	82.24%	83.80%
Ambulatory Care - Outpatient Visits per Thousand Member Years (AMB)[7]						
Total - Total Member Years	3727.80	6433.22	4551.50	5197.39	4877.97	4771.04
Ambulatory Care - Emergency Room Visits per Thousand Member Years (AMB)[7]						
Total - Total Member Years	518.14	502.59	630.77	548.42	467.94	579.87
Plan All-Cause Readmissions (PCR)[8]						
Index Stays per Year - 18-44	10.47%	9.92%	10.67%	10.16%	10.03%	10.48%
Index Stays per Year - 45-54	11.20%	9.84%	12.17%	11.76%	10.62%	11.73%
Index Stays per Year - 55-64	11.07%	10.99%	13.14%	13.71%	12.60%	12.90%
Index Stays per Year - Total	10.79%	10.31%	11.67%	11.59%	10.99%	11.45%
Observed-to-Expected Ratio	1.04	0.95	1.20	1.13	1.13	

[1] Wellcare Health Plans of New Jersey, Inc. (WCHP) began doing business as Fidelis Care (FC) effective 8/1/2023.
[2] Amerigroup NJ began doing business as Wellpoint NJ (WPNJ) on 1/1/2024.
[3] New Jersey Medicaid average is the weighted average of all managed care organization (MCO) data.
[4] OED and TFC are new measures for this year.
[5] Higher rates for HBD HbA1c Poor Control, COU, HDO, and UOP indicate poorer performance.
[6] FUH and FUM are mental health measures. FUA is a chemical dependency measure. FUH requires full mental health benefits (inpatient and outpatient). FUM and FUA only require partial mental health or chemical dependency benefits.
[7] Measurement year (MY) 2023 the eligible population for the AMB measure is the reported member years. Ambulatory measure rates are a measure of utilization rather than performance.
[8] PCR's rate is based on observed count of 30-day readmission/count of index stays, and the ratio is observed-to-expected ratio with risk adjustment. For PCR, a lower ratio is indicative of better performance.
[9] COL MY 2023 age stratifications were revised from 46–49 years to 46–50 years and from 50–75 years to 51–75 years of age.
Designation NA: for non-ambulatory measures, indicates that the MCO had a denominator less than 30. For ambulatory measures, indicates that the MCO had 0 member years in the denominator.
Designation NR: indicates that the MCO did not report for the measure.
Designation CNC: averages were only calculated if two or more MCOs had a reported rate with an eligible population greater than or equal to 30.

Table 22a: HEDIS MY 2023 Electronic Clinical Data Systems (ECDS) Performance Measures

HEDIS MY 2023 ECDS Performance Measures	ABHNJ	FC/WCHP[1]	HNJH	UHCCP	WPNJ[2]	NJ Medicaid Average[3]
Childhood Immunization Status (CIS-E)						
DTaP	59.30%	59.55%	64.22%	57.70%	64.29%	62.73%
IPV	74.29%	73.40%	78.93%	71.56%	78.71%	77.25%
MMR	80.69%	81.39%	83.01%	78.85%	83.39%	82.22%
HiB	76.73%	76.71%	81.11%	74.05%	80.93%	79.54%
Hepatitis B	44.15%	62.58%	72.05%	51.13%	72.30%	66.69%
VZV	79.79%	81.12%	82.35%	77.72%	82.50%	81.45%
Pneumococcal Conjugate	56.48%	57.00%	61.46%	55.58%	61.55%	60.08%
Hepatitis A	68.49%	71.74%	74.10%	68.82%	71.21%	72.36%
Rotavirus	56.04%	53.82%	62.07%	53.37%	55.08%	58.90%
Influenza	36.07%	42.11%	43.86%	37.75%	34.76%	40.87%
Combination 3	31.24%	43.35%	49.52%	36.72%	50.05%	46.21%
Combination 7	23.74%	33.15%	40.54%	29.91%	36.68%	36.91%
Combination 10	13.58%	20.61%	25.06%	19.82%	19.32%	22.41%
Immunizations for Adolescents (IMA-E)						
Meningococcal	79.65%	82.28%	88.43%	84.67%	85.07%	86.69%
Tdap	81.41%	86.71%	91.17%	87.94%	88.73%	89.68%
HPV	23.74%	30.94%	33.73%	28.54%	27.18%	31.36%
Combo1	77.88%	81.13%	87.70%	83.43%	83.87%	85.75%
Combo2	22.59%	28.57%	32.43%	27.07%	25.64%	29.97%
Breast Cancer Screening (BCS-E)	45.86%	54.08%	58.61%	62.66%	56.95%	58.35%
Cervical Cancer Screening (CCS-E)	47.38%	50.28%	55.57%	57.80%	57.50%	55.48%
Colorectal Cancer Screening (COL-E)[4]						
46-50 Years	18.57%	23.08%	28.00%	28.17%	24.05%	26.82%
51-75 Years	30.65%	41.75%	47.20%	54.33%	43.09%	46.95%
Total	28.24%	39.24%	42.62%	49.35%	38.97%	42.63%
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)						
Initiation	34.62%	45.64%	35.41%	39.51%	35.13%	36.39%
Continuation	37.04%	51.52%	37.40%	44.40%	39.33%	39.13%
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)						
Blood Glucose Testing - 1-11 Years	37.70%	44.90%	44.48%	50.32%	45.18%	45.30%
Blood Glucose Testing - 12-17 Years	63.92%	75.00%	63.59%	65.60%	62.98%	64.19%
Blood Glucose Testing - Total	53.80%	64.23%	57.08%	61.21%	57.90%	58.02%
Cholesterol Testing - 1-11 Years	27.87%	42.86%	29.86%	35.35%	28.31%	30.90%
Cholesterol Testing - 12-17 Years	47.42%	64.77%	42.71%	49.81%	49.28%	45.43%
Cholesterol Testing - Total	39.87%	56.93%	38.33%	45.65%	43.30%	40.68%
Blood Glucose and Cholesterol Testing - 1-11 Years	27.87%	34.69%	28.79%	34.39%	28.31%	29.79%
Blood Glucose and Cholesterol Testing - 12-17 Years	46.39%	61.36%	41.84%	48.65%	47.36%	44.33%
Blood Glucose and Cholesterol Testing - Total	39.24%	51.82%	37.39%	44.56%	41.92%	39.58%

HEDIS MY 2023 ECDS Performance Measures	ABHNJ	FC/WCHP[1]	HNJH	UHCCP	WPNJ[2]	NJ Medicaid Average[3]
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)						
Screening - 12-17	0.06%	0.00%	0.02%	0.20%	0.00%	0.06%
Screening - 18-64	1.05%	0.01%	0.21%	0.51%	0.02%	0.28%
Screening - 65+	1.87%	0.14%	0.43%	0.84%	0.07%	0.57%
Screening - Total	0.99%	0.04%	0.17%	0.48%	0.02%	0.25%
Follow Up - 12-17	NA	NA	100.00%	NA	NA	CNC
Follow Up - 18-64	85.00%	NA	49.57%	60.71%	100.00%	57.59%
Follow Up - 65+	92.86%	100.00%	22.86%	40.00%	0.00%	47.16%
Follow Up - Total	86.49%	100.00%	43.71%	57.58%	66.67%	55.12%
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)						
Time Period 1 - 12-17	0.00%	0.00%	0.03%	0.00%	0.00%	0.02%
Time Period 1 - 18-44	2.73%	0.00%	0.07%	0.75%	0.00%	0.35%
Time Period 1 - 45-64	7.13%	0.00%	0.43%	1.19%	0.08%	0.89%
Time Period 1 - 65+	22.09%	0.33%	2.25%	1.41%	0.00%	2.07%
Time Period 1 - Total	5.66%	0.13%	0.28%	0.94%	0.03%	0.68%
Time Period 2 - 12-17	0.00%	0.00%	0.00%	0.14%	0.00%	0.03%
Time Period 2 - 18-44	4.44%	0.18%	0.12%	0.08%	0.07%	0.39%
Time Period 2 - 45-64	11.06%	0.28%	0.44%	0.00%	0.08%	0.88%
Time Period 2 - 65+	10.90%	0.52%	1.23%	0.00%	0.00%	0.85%
Time Period 2 - Total	6.93%	0.33%	0.26%	0.04%	0.05%	0.57%
Time Period 3 - 12-17	0.00%	0.00%	0.04%	0.00%	0.00%	0.03%
Time Period 3 - 18-44	6.85%	0.00%	0.11%	0.00%	0.13%	0.53%
Time Period 3 - 45-64	18.56%	0.29%	0.26%	0.00%	0.00%	1.22%
Time Period 3 - 65+	21.64%	2.89%	1.82%	0.00%	0.21%	1.96%
Time Period 3 - Total	11.82%	1.16%	0.22%	0.00%	0.08%	0.87%
Time Period All - 12-17	0.00%	0.00%	0.02%	0.04%	0.00%	0.02%
Time Period All - 18-44	4.68%	0.06%	0.10%	0.28%	0.07%	0.42%
Time Period All - 45-64	12.36%	0.19%	0.38%	0.41%	0.05%	1.00%
Time Period All - 65+	18.37%	1.21%	1.77%	0.47%	0.07%	1.63%
Time Period All - Total	8.15%	0.54%	0.25%	0.34%	0.06%	0.71%
Depression Remission or Response for Adolescents and Adults (DRR-E)						
Follow-Up - 12-17	NA	NA	NA	NA	NA	CNC
Follow-Up - 18-44	NA	NA	NA	NA	NA	CNC
Follow-Up - 45-64	NA	NA	NA	NA	NA	CNC
Follow-Up - 65+	NA	NA	NA	NA	NA	CNC
Follow-Up - Total	NA	NA	NA	0.00%	NA	CNC
Remission - 12-17	NA	NA	NA	NA	NA	CNC
Remission - 18-44	NA	NA	NA	NA	NA	CNC
Remission - 45-64	NA	NA	NA	NA	NA	CNC
Remission - 65+	NA	NA	NA	NA	NA	CNC
Remission - Total	NA	NA	NA	0.00%	NA	CNC
Response - 12-17	NA	NA	NA	NA	NA	CNC
Response - 18-44	NA	NA	NA	NA	NA	CNC

HEDIS MY 2023 ECDS Performance Measures	ABHNJ	FC/WCHP[1]	HNJH	UHCCP	WPNJ[2]	NJ Medicaid Average[3]
Response - 45-64	NA	NA	NA	NA	NA	CNC
Response - 65+	NA	NA	NA	NA	NA	CNC
Response - Total	NA	NA	NA	0.00%	NA	CNC
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)						
Screening - 18-44	2.11%	0.03%	0.00%	0.00%	0.00%	0.13%
Screening - 45-64	7.05%	0.16%	0.00%	0.00%	0.00%	0.45%
Screening - 65+	12.71%	0.62%	0.00%	0.00%	0.00%	0.93%
Screening - Total	4.57%	0.22%	0.00%	0.00%	0.00%	0.30%
Follow Up - 18-44	0.00%	NA	NA	0.00%	NA	0.00%
Follow Up - 45-64	1.54%	NA	NA	NA	NA	CNC
Follow Up - 65+	7.14%	0.00%	NA	NA	NA	0.45%
Follow Up - Total	2.42%	0.00%	NA	0.00%	NA	0.15%
Adult Immunization Status (AIS-E)						
Influenza - 19-65	12.31%	16.66%	15.22%	10.87%	13.06%	14.04%
Influenza - 66+	28.47%	28.69%	44.77%	27.09%	36.99%	32.67%
Influenza - Total	13.73%	20.31%	16.34%	13.65%	15.31%	15.77%
TdTdap - 19-65	19.95%	20.89%	28.28%	29.60%	26.75%	27.42%
TdTdap - 66+	10.94%	11.43%	17.84%	19.16%	15.34%	16.19%
TdTdap - Total	19.16%	18.02%	27.89%	27.81%	25.68%	26.38%
Zoster - 50-65	6.38%	8.77%	10.00%	9.85%	5.56%	9.15%
Zoster - 66+	7.03%	8.78%	16.97%	11.21%	7.77%	11.26%
Zoster - Total	6.55%	8.78%	10.96%	10.40%	6.23%	9.74%
Pneumococcal - 66+	27.46%	30.32%	43.38%	29.96%	37.65%	33.82%
Prenatal Immunization Status (PRS-E)						
Influenza	18.13%	16.46%	18.02%	16.31%	13.71%	16.86%
Tdap	38.71%	31.36%	40.13%	31.91%	30.06%	36.40%
Combination	13.68%	10.77%	12.80%	11.05%	9.11%	11.78%
Prenatal Depression Screening and Follow-Up (PND-E)						
Screening	9.36%	0.00%	0.02%	4.03%	0.00%	1.30%
Follow Up	66.67%	NA	NA	80.00%	NA	18.00%
Postpartum Depression Screening and Follow-Up (PDS-E)						
Screening	0.06%	0.00%	3.49%	0.31%	0.00%	1.93%
Follow Up	0.00%	NA	41.67%	NA	NA	22.36%
Social Need Screening and Intervention (SNS-E)						
Food Screening - 0-17	0.00%	0.00%	0.00%	0.00%	1.30%	0.17%
Food Screening -18-64	0.00%	0.00%	0.00%	0.01%	4.13%	0.52%
Food Screening - 65+	0.00%	0.00%	0.00%	0.00%	43.37%	5.50%
Food Screening - Total	0.00%	0.00%	0.00%	0.00%	4.95%	0.64%
Food Intervention - 0-17	NA	NA	NA	0.00%	4.46%	0.60%
Food Intervention - 18-64	NA	NA	NA	0.00%	4.73%	0.59%
Food Intervention - 65+	NA	NA	NA	NA	5.61%	CNC

HEDIS MY 2023 ECDS Performance Measures	ABHNJ	FC/WCHP[1]	HNJH	UHCCP	WPNJ[2]	NJ Medicaid Average[3]
Food Intervention - Total	NA	NA	NA	0.00%	5.17%	0.67%
Housing Screening - 0-17	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Housing Screening - 18-64	0.00%	0.00%	0.00%	0.01%	2.71%	0.34%
Housing Screening - 65+	0.00%	0.00%	0.00%	0.00%	43.44%	5.50%
Housing Screening - Total	0.00%	0.00%	0.00%	0.00%	3.67%	0.47%
Housing Intervention - 0-17	NA	NA	NA	NA	NA	CNC
Housing Intervention - 18-64	NA	NA	NA	0.00%	0.00%	0.00%
Housing Intervention - 65+	NA	NA	NA	NA	0.00%	CNC
Housing Intervention - Total	NA	NA	NA	0.00%	0.00%	0.00%
Transportation Screening - 0-17	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Transportation Screening - 18-64	0.00%	0.00%	0.00%	0.01%	2.75%	0.34%
Transportation Screening - 65+	0.00%	0.00%	0.00%	0.00%	43.94%	5.57%
Transportation Screening - Total	0.00%	0.00%	0.00%	0.00%	3.71%	0.48%
Transportation Intervention - 0-17	NA	NA	NA	NA	NA	CNC
Transportation Intervention - 18-64	NA	NA	NA	0.00%	0.00%	0.00%
Transportation Intervention - 65+	NA	NA	NA	NA	0.42%	CNC
Transportation Intervention - Total	NA	NA	NA	0.00%	0.25%	0.03%

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

[2]Amerigroup New Jersey, Inc. began doing business as Wellpoint NJ (WPNJ) on 1/1/24.

[3]New Jersey Medicaid Average, is the weighted average of all MCO data.

[4]COL-E MY 2023 age stratifications are revised from 46–49 years to 46–50 years and from 50–75 years to 51–75 years of age.

Designation NA: Indicates that the MCO had a denominator less than 30.

Designation NR: Indicates that the MCO did not report for the measure.

Designation CNC: Averages were only calculated if two or more MCOs had a reported rate with an eligible population greater than or equal to 30 (for e-measures, initial population is the eligible population).

MY 2023 New Jersey State-Specific Performance Measures

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

The required measures were:

- Preventive Dental Visit (NJD)
- Multiple Lead Testing in Children Through 26 Months of Age (MLT)

The Preventive Dental measure is defined by eligibility categories: Total Medicaid, Medicaid/Medicare Dual-Eligibles, Medicaid-Disabled, and Medicaid-Other Low Income. Every member in the total Medicaid population is assigned to one eligibility category. The sum of the categories equals the total Medicaid results.

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

Conclusions and Comparative Findings

1. For MY 2023, ABHNJ, FC/WCHP, HNJH, UHCCP, and WPNJ included FIDE SNP dual members in the Preventive Dental Visit measure.
2. Overall performance for the Preventive Dental measure showed significant improvements from MY 2022 for all MCOs.
3. Overall, most measures remained constant from MY 2022 to MY 2023 (< 5 pp change). Significant increases (≥ 5 pp change) in performance from MY 2022 are noted below.

Improvements in performance from MY 2022 to MY 2023:

1. Preventive Dental Visit (NJD)
   a. Disabled 2-3 years improved by 7.49 pp
2. Multiple Lead Testing in Children through 26 Months of Age (MLT)
   a. Screening at 18 Months through 26 Months improved by 5.58 pp
   b. Screening total age groups improved by 5.54 pp

No Significant declines (≥ 5 pp change) in performance from MY 2022 to MY 2023 were noted for one or more rates.

Table 22 shows state-specific PMs for MY 2023 for all MCOs and the NJ Medicaid average.

Table 23: MY 2023 NJ State-Specific Performance Measures

MY 2023 NJ-Specific Performance Measures	ABHNJ	FC/WCHP[1]	HNJH	UHCCP	WPNJ[2]	NJ Medicaid Average[3]
Preventive Dental Visit (NJD)						
Total - 1 Year	12.94%	18.87%	18.28%	19.76%	10.88%	17.03%
Total - 2-3 Years	33.27%	44.21%	45.35%	47.35%	37.84%	43.64%
Total - 4-6 Years	49.38%	61.27%	63.04%	69.85%	62.38%	63.51%
Total - 7-10 Years	53.03%	65.93%	67.44%	73.68%	65.89%	67.87%
Total - 11-14 Years	48.71%	59.86%	63.33%	69.14%	61.02%	63.64%
Total - 15-18 Years	39.04%	49.93%	53.18%	59.89%	49.32%	53.57%
Total - 19-21 Years	22.95%	30.00%	34.90%	42.17%	32.16%	35.41%

MY 2023 NJ-Specific Performance Measures	ABHNJ	FC/WCHP[1]	HNJH	UHCCP	WPNJ[2]	NJ Medicaid Average[3]
Total - 22-34 Years	20.97%	23.44%	30.97%	36.24%	25.61%	30.08%
Total - 35-64 Years	22.30%	28.33%	31.41%	35.85%	27.60%	31.15%
Total - 65+ Years	24.52%	27.82%	27.53%	28.47%	27.93%	27.70%
Total - Total	29.19%	35.18%	42.72%	46.88%	39.47%	42.05%
Dual Eligibles - 1 Year	NA	NA	NA	NA	NA	CNC
Dual Eligibles - 2-3 Years	NA	NA	NA	NA	NA	CNC
Dual Eligibles - 4-6 Years	NA	NA	NA	NA	NA	CNC
Dual Eligibles - 7-10 Years	NA	NA	NA	NA	NA	CNC
Dual Eligibles - 11-14 Years	NA	NA	NA	NA	NA	CNC
Dual Eligibles - 15-18 Years	NA	NA	NA	NA	NA	CNC
Dual Eligibles - 19-21 Years	NA	NA	44.12%	40.26%	NA	41.87%
Dual Eligibles - 22-34 Years	24.74%	27.54%	36.38%	38.80%	32.69%	35.62%
Dual Eligibles - 35-64 Years	27.04%	31.54%	36.08%	37.35%	29.51%	35.06%
Dual Eligibles - 65+ Years	26.01%	28.99%	28.79%	29.20%	29.69%	28.86%
Dual Eligibles - Total	26.23%	29.32%	31.37%	31.74%	29.76%	30.79%
Disabled - 1 Year	NA	NA	13.97%	14.71%	2.70%	11.99%
Disabled - 2-3 Years	38.89%	31.11%	52.02%	55.64%	37.40%	49.35%
Disabled - 4-6 Years	39.60%	53.16%	56.11%	63.46%	50.42%	56.33%
Disabled - 7-10 Years	41.21%	56.45%	60.75%	62.33%	52.40%	59.52%
Disabled - 11-14 Years	36.00%	46.49%	55.37%	56.93%	51.03%	54.59%
Disabled - 15-18 Years	34.90%	35.33%	47.43%	49.63%	38.07%	46.50%
Disabled - 19-21 Years	24.04%	26.54%	35.65%	38.60%	27.34%	34.76%
Disabled - 22-34 Years	24.85%	27.34%	35.26%	35.84%	25.77%	33.41%
Disabled - 35-64 Years	24.76%	28.80%	28.16%	30.02%	26.13%	28.23%
Disabled - 65+ Years	16.47%	19.83%	19.85%	19.63%	16.42%	19.17%
Disabled - Total	24.86%	27.80%	35.52%	36.76%	29.07%	34.19%
Other Low Income - 1 Year	13.00%	18.90%	18.32%	19.80%	10.94%	17.07%
Other Low Income - 2-3 Years	33.21%	44.42%	45.23%	47.26%	37.85%	43.55%
Other Low Income - 4-6 Years	49.66%	61.58%	63.31%	70.09%	62.65%	63.78%
Other Low Income - 7-10 Years	53.44%	66.30%	67.74%	74.22%	66.31%	68.23%
Other Low Income - 11-14 Years	49.14%	60.40%	63.72%	69.75%	61.34%	64.06%
Other Low Income - 15-18 Years	39.17%	50.55%	53.46%	60.46%	49.75%	53.90%
Other Low Income - 19-21 Years	22.82%	30.28%	34.83%	42.40%	32.38%	35.42%
Other Low Income - 22-34 Years	20.76%	23.03%	30.58%	36.12%	25.48%	29.69%
Other Low Income - 35-64 Years	21.55%	27.74%	31.30%	36.30%	27.55%	30.98%
Other Low Income - 65+ Years	15.81%	18.83%	23.51%	24.87%	18.06%	22.27%
Other Low Income - Total	29.89%	38.19%	44.33%	51.31%	41.15%	44.18%
Multiple Lead Testing in Children through 26 Months of Age (MLT)						
Screening between 9 Months and 18 Months	61.31%	66.03%	61.35%	61.17%	65.21%	62.13%
Screening at 18 Months through 26 Months	46.61%	51.63%	47.21%	47.90%	52.92%	48.37%

MY 2023 NJ-Specific Performance Measures	ABHNJ	FC/WCHP[1]	HNJH	UHCCP	WPNJ[2]	NJ Medicaid Average[3]
Screening between 9 Months and 18 Months AND Screening at 18 Months through 26 Months	33.73%	38.51%	33.03%	32.74%	38.85%	34.19%

[1] WellCare Health Plans of New Jersey, Inc. (WCHP) began doing business as Fidelis Care (FC) effective 08/01/2023.
[2] Amerigroup New Jersey, Inc. (AGNJ) began doing business as Wellpoint NJ (WPNJ) on 1/1/2024
[3] New Jersey (NJ) Medicaid average is the weighted average of all managed care organization (MCO) data.
Designation NR: Indicates the rate is not reported based on MCO submissions.
Designation NA: Indicates that MCO had a denominator less than 30.
Designation CNC: An unweighted average can only be calculated if 2 or more MCOs have a reportable rate.
MY: measurement year.

MY 2023 New Jersey Core Set Performance Measures

DMAHS requested the MCOs to submit 17 Core Set Measures in MY 2023:

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

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

The changes from MY 2022 to MY 2023 were:
1. The following measures are being reported for the first year:
    a. Prenatal and Postpartum Care: Age 21 and Older (PPC2-AD)
    b. Prenatal and Postpartum Care: Under Age 21 (PPC2-CH)
    c. Concurrent Use of Opioids and Benzodiazepines (COB)
    d. Use of Opioids at High Dosage without Cancer (OHD)

2. All measures experienced updates to codes found in the value set directory.

Conclusions and Comparative Findings

Overall, most measures remained constant from MY 2022 to MY 2023 (< 5 pp change). Significant increases (≥ 5 pp change) in performance from MY 2022 are noted below.

Improvements in performance from MY 2022 to MY 2023:
1. Contraceptive Care – Postpartum Women (CCP)
    a. Postpartum Women Ages 15-20 – LARC – 90 days improved by 5.84 pp
2. Sealant Receipt on Permanent First Molars (SFM-CH)
    a. Rate 1 (At Least One Sealant) improved by 5.39 pp

No Significant declines (≥ 5 pp change) in performance from MY 2022 to MY 2023 were noted for one or more rates.

Table 23 shows the NJ Core Set Measures for MY 2023 for all MCOs and the NJ Medicaid average.

Table 24: MY 2023 NJ Core Set Measures

MY 2023 NJ Core Set Performance Measures	ABHNJ	FC/WCHP[1]	HNJH	UHCCP	WPNJ[2]	NJ Medicaid Average[3]
Developmental Screening (DEV-CH)						
1 year old	33.92%	32.26%	44.34%	30.70%	21.33%	37.39%
2 years old	48.61%	39.23%	52.47%	43.19%	46.70%	49.36%
3 years old	43.31%	37.55%	45.02%	37.54%	44.82%	43.58%
Total - 1-3 years	43.17%	36.98%	47.60%	38.10%	39.47%	44.20%
Diabetes Short-Term Complications Admission (PQI01) – Admissions per 100,000 Member Months[4,5]						
18 - 64 Years	6.92	9.03	14.34	11.06	7.01	12.05
65 Years and Older	5.42	7.79	11.82	11.23	12.40	10.39
Total	6.77	8.67	14.24	11.09	7.54	11.89
Contraceptive Care - Postpartum Women (CCP)						
Postpartum Women Ages 15-20 - Most or moderately effective contraception - 3 days	1.96%	3.23%	3.45%	2.34%	4.35%	3.27%
Postpartum Women Ages 15-20 - Most or moderately effective contraception - 90 days	31.37%	32.26%	44.00%	42.11%	40.22%	42.43%
Postpartum Women Ages 15-20 - LARC - 3 days	0.00%	0.00%	0.28%	0.00%	1.09%	0.28%
Postpartum Women Ages 15-20 - LARC - 90 days	5.88%	9.68%	13.52%	15.20%	11.96%	13.18%
Postpartum Women Ages 21-44 - Most or moderately effective contraception - 3 days	6.26%	7.73%	10.25%	7.15%	5.24%	8.42%
Postpartum Women Ages 21-44 - Most or moderately effective contraception - 90 days	38.75%	42.64%	41.51%	43.33%	42.89%	41.95%
Postpartum Women Ages 21-44 - LARC - 3 days	0.09%	0.15%	0.16%	0.03%	0.21%	0.14%
Postpartum Women Ages 21-44 - LARC - 90 days	9.47%	10.10%	9.32%	9.87%	8.74%	9.35%
Contraceptive Care - All Women (CCW)						
All Women Ages 15-20 - Provision of most or moderately effective contraception	11.91%	10.47%	14.21%	11.23%	11.21%	13.04%

MY 2023 NJ Core Set Performance Measures	ABHNJ	FC/WCHP[1]	HNJH	UHCCP	WPNJ[2]	NJ Medicaid Average[3]
All Women Ages 15-20 - Provision of LARC	1.03%	0.75%	1.17%	0.82%	0.87%	1.05%
All Women Ages 21-44 - Provision of most or moderately effective contraception	20.94%	19.96%	22.65%	21.91%	23.68%	22.44%
All Women Ages 21-44 - Provision of LARC	2.43%	2.46%	2.89%	2.94%	3.23%	2.90%
Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)						
12-17 Years	1.27%	3.03%	2.18%	2.03%	3.52%	2.31%
Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)						
18 to 64 Years	2.91%	4.88%	3.70%	3.89%	3.08%	3.67%
65 Years and older	3.76%	5.93%	7.37%	8.58%	5.87%	7.05%
Oral Evaluation, Dental Services (OEV-CH)						
< 1 Year	0.35%	1.99%	1.18%	1.42%	1.67%	1.27%
1 to 2 Years	17.19%	25.50%	26.21%	25.83%	19.27%	24.42%
3 to 5 Years	37.99%	51.58%	53.44%	56.98%	51.81%	52.77%
6 to 7 Years	46.79%	59.96%	61.85%	64.70%	61.31%	61.52%
8 to 9 Years	45.22%	59.63%	62.59%	64.92%	60.88%	61.94%
10 to 11 Years	43.29%	58.88%	61.48%	63.23%	59.29%	60.68%
12 to 14 Years	41.04%	55.00%	58.11%	61.07%	55.77%	57.62%
15 to 18 Years	33.57%	45.23%	49.20%	52.72%	45.74%	48.79%
19 to 20 Years	19.91%	29.08%	33.36%	37.83%	31.37%	33.33%
Total: <1 to 20 Years	34.63%	47.52%	50.58%	54.00%	47.59%	49.96%
Topical Fluoride for Children (TFL-CH)						
1 to 2 Years	10.59%	17.09%	14.55%	17.49%	15.97%	15.09%
3 to 5 Years	15.71%	24.66%	27.95%	33.19%	25.18%	27.61%
6 to 7 Years	17.05%	28.58%	30.54%	37.30%	29.43%	31.05%
8 to 9 Years	15.86%	26.76%	29.80%	36.06%	27.96%	30.15%
10 to 11 Years	15.67%	24.78%	28.82%	35.06%	26.68%	29.20%
12 to 14 Years	11.91%	21.64%	24.89%	31.08%	22.73%	25.36%
15 to 18 Years	6.80%	12.45%	16.14%	20.13%	12.40%	16.11%
19 to 20 Years	1.31%	2.86%	5.80%	8.16%	3.52%	5.73%
Total: 1 to 20 Years	12.14%	20.02%	22.43%	27.57%	20.80%	22.69%
Sealant Receipt on Permanent First M olars (SFM-CH)						
Rate 1 (At Least One Sealant)	37.88%	49.64%	7.60%	42.62%	51.18%	22.72%
Rate 2 (All Four Molars Sealed)	24.10%	33.95%	3.89%	25.17%	33.27%	13.66%
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)[4]						

MY 2023 NJ Core Set Performance Measures	ABHNJ	FC/WCHP[1]	HNJH	UHCCP	WPNJ[2]	NJ Medicaid Average[3]
18 to 64 Years	59.81%	53.86%	48.31%	39.86%	49.36%	47.49%
65 to 75 Years	NA	66.67%	44.59%	45.21%	56.04%	51.17%
Use of Pharmacotherapy for Opioid U se Disorder (OUD-AD): Ages 18 to 64						
Total rate (Rate 1)	60.83%	40.51%	46.17%	47.13%	65.79%	58.48%
Buprenorphine (Rate 2)	45.15%	28.48%	28.09%	24.20%	43.77%	38.91%
Oral naltrexone (Rate 3)	1.83%	0.63%	2.16%	2.07%	1.91%	1.89%
Long-acting, injectable naltrexone (Rate 4)	1.41%	0.63%	0.39%	1.27%	1.80%	1.41%
Methadone (Rate 5)	18.01%	12.03%	18.86%	23.73%	23.61%	21.09%
Prenatal and Postpartum Care (PPC)[6]						
Timeliness of Prenatal Care - Age under 21	69.23%	72.09%	61.01%	62.18%	70.21%	62.72%
Timeliness of Prenatal Care - Age 21 and older	70.18%	68.33%	71.63%	75.56%	75.81%	72.91%
Postpartum Care - Age under 21	72.31%	58.14%	66.37%	68.91%	66.67%	66.82%
Postpartum Care - Age 21 and older	70.66%	72.54%	70.30%	77.99%	78.65%	73.37%
Concurrent Use of Opioids and Benzodiazepines (COB)[4,6]						
Ages 18 to 64 years	19.15%	23.31%	18.43%	21.05%	20.05%	19.31%
Ages 65 years and above	17.01%	16.75%	17.07%	18.07%	17.17%	17.44%
Total - 18 years and above	18.84%	21.47%	18.33%	20.21%	19.34%	19.04%
Use of Opioids at High Dosage without Cancer (OHD)[4,6]						
Ages 18 to 64 years	14.20%	12.81%	12.37%	12.31%	10.10%	12.25%
Ages 65 years and above	13.18%	14.01%	7.79%	7.25%	7.01%	8.31%
Total - 18 years and above	14.05%	13.12%	12.05%	10.88%	9.33%	11.67%

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

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

[3] New Jersey Medicaid average is the weighted average of all managed care organization (MCO) data.

[4] A lower rate indicates better performance.

[5] The year-over-year change for PQI-O1 represents a change in utilization per 100,000 member months and is not a percentage point change.

[6] Measurement year (MY) 2023 is the first year NJ is reporting this as a core set measure.

Designation NR: indicates the rate is not reported based on MCO submissions.

Designation NA: indicates that MCO had a denominator less than 30.

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

WYE 2022 MLTSS Performance Measures

The MLTSS contract year ran from July–June of WYE 2022 (July1 2021–June 30, 2022). Specifications were updated in 2021 for the July 2021–June 2022 measurement period for the PMs listed below. All MLTSS PMs

are validated annually. IPRO reviews source code, member-level files, and rates for each MCO. Except for PM #04, which is reported monthly, PMs are reported on a quarterly and annual cycle. In the list below, PMs that are reported only on the annual cycle are identified with an asterisk (*). PM #20a was retired in 2021.

The following are the measures for validation, showing the NJ MLTSS PM number associated with the measure for WYE 2022 (7/1/2021–6/30/2022):

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

The following measures are monitored quarterly and reviewed annually:

2. PM #18a – Percent of Critical Incidents that the MCO became aware of during the measurement period that were reported to the state at the Total and Category level
3. PM #18b – Percent of Critical Incidents that the MCO became aware of during the measurement period that were reported by the MCO to the state within 2 business days at the Total and Category level
4. PM #18c – Percent of Critical Incidents that the MCO became aware of during the measurement period for which a date of occurrence was available at the Total and Category level
5. PM #18d – The average number of days from the date of occurrence for Critical Incidents in the Numerator of 18C to the date the MCO became aware of the CI at the Total and Category level
6. PM #20 – MLTSS Members receiving MLTSS services – All MLTSS population
7. PM #20b – Percentage of MLTSS HCBS members receiving any MLTSS services during the measurement period
8. PM #21 – MLTSS Members who Transitioned from NF to the Community
9. PM #23 – MLTSS NF to HCBS Transitions who returned to NF within 90 days
10. PM #26 – Acute Inpatient Utilization by MLTSS HCBS Members (HEDIS IPU)
11. PM #27 – Acute Inpatient Utilization by MLTS NF Members (HEDIS IPU)
12. PM #28 – All Cause Readmissions of MLTSS HCBS Members to Hospital within 30 Days (HEDIS PCR)
13. PM #29 – All Cause Readmissions of MLTSS NF members to Hospital within 30 days: (HEDIS PCR)
14. PM #30 – Emergency Department Utilization by MLTSS HCBS Members (HEDIS AMB)
15. PM #31 – Emergency Department Utilization by MLTSS NF Members (HEDIS AMB)
16. PM #33 – MLTSS services used by MLTSS HCBS members: PCA services only
17. PM #34 – MLTSS services used by MLTSS HCBS members: Medical Day services only
18. PM #36 – Follow-Up after Mental Health Hospitalization for MLTSS HCBS Members (HEDIS FUH)
19. PM #38 – Follow-up after Mental Health Hospitalization for MLTSS NF members (HEDIS FUH)
20. PM #41 – MLTSS services used by MLTSS HCBS members: PCA services and Medical Day services only
21. PM #42 – Follow-Up after Emergency Department Visit for Alcohol or Other Drug Dependence for MLTSS HCBS Members (HEDIS FUA)
22. PM #43 – Follow-up after Emergency Department visit for Alcohol or Other Drug Dependence for MLTSS NF members (HEDIS FUA)
23. PM #44 – Follow-Up after Emergency Department Visit for Mental Illness for MLTSS HCBS Members (HEDIS FUM)
24. PM #45 – Follow-up after Emergency Department visit for Mental Illness for MLTSS NF members: (HEDIS FUM)
25. PM #47* – Post-hospital Institutional Care for MLTSS HCBS Members
26. PM #48* – Hospitalization for MLTSS HCBS Members with Potentially Preventable Complications (HEDIS HPC)
27. PM #49* – Hospitalization for MLTSS NF Members with Potentially Preventable Complications: (HEDIS HPC)
28. PM #50* – Follow-Up After Emergency Department Visit for MLTSS HCBS Members with High-Risk Multiple Chronic Conditions (HEDIS FMC)

29. PM #51* – Follow-Up After Emergency Department Visit for MLTSS NF Members with High-Risk Multiple Chronic Conditions (HEDIS FMC)
30. PM #52* Care for Older Adults for HCBS MLTSS Members (HEDIS COA)
    a. 52a Advance care planning – HCBS
    b. 52b Medication review – HCBS
    c. 52c Functional status assessment – HCBS
    d. 52d Pain assessment – HCBS
31. PM 53* Care for Older Adults for NF MLTSS Members (HEDIS COA)
    a. 53b Medication review – NF
    b. 53c Functional status assessment – NF
    c. 53d Pain assessment – NF
32. PM #54a and #54b* New MLTSS and new HCBS members receiving PCA, MDC and/or MLTSS services.

Validation Results of WYE 2022 MLTSS Performance Measures

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

In addition, throughout the year, IPRO monitored all ongoing reporting to the State on a quarterly basis. In 2025, IPRO produced an annual report which detailed the annual validation process and results, as well as the results of the monitoring activities.

The following results are for the July 2021–June 2022 measurement period:

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

MCO rates ranged from 0% to 12.1% from July 2021 to June 2022, and the statewide rates remained steady between 0% and 3.9%.

PM #18: Critical Incident Reporting

Rate A – Percent of Critical Incidents (CI) that the managed care plan (MCP) became aware of during the measurement period that were reported to the State at the Total and Category level: MCP rates ranged from 99.3% to 100%, and the statewide rates remained steady between 99.8% and 99.9%.

Rate B – Percent of Critical Incidents that the MCP became aware of during the measurement period that were reported by the MCP to the State within 2 business days at the Total and Category level: MCP rates ranged from 93.8% to 99.9%, and the statewide rates remained steady between 95.1% and 98.3%.

Rate C – Percent of Critical Incidents that the MCP became aware of during the measurement period for which a date of occurrence was available at the Total and Category level: MCP rates ranged from 96.6% to 100%, and the statewide rates remained steady between 98.2% and 98.9%.

Rate D – The average number of days from the date of occurrence for Critical Incidents in the Numerator of Rate C to the date the MCP became aware of the CI at the Total and Category level: The average days range from 10 days to 23.4 days for the MCP to be aware of the CI. At the statewide level, it took averagely from 13.5 to 14.8 days throughout the measurement year.

PM #20: MLTSS Members Receiving MLTSS Services

The quarterly MCP rates varied from 57.9% to 79.7%. The statewide rates remained steady between 71% and 71.5%.

PM #20b: MLTSS HCBS Members Receiving MLTSS Services
The quarterly MCP rates varied from 33.1% to 68.6%. The statewide rates remained steady between 57.2% and 57.7%.

PM #21: MLTSS Members Transitioned from NF to Community
The quarterly MCP rates remained low, from 0.1% to 1%, and the statewide rates varied from 0.6% to 0.7%.

PM #23: MLTSS NF to HCBS Transitions who Returned to NF within 90 Days
The MCP rates varied from 0% to 33.3%. The statewide rates ranged from 3.2% to 10.2%.

PM #26: Acute Inpatient Utilization by MLTSS HCBS Members
The quarterly MCP rates varied from 20.9 to 64.4 utilization per 1,000 member months, and the statewide rates ranged from 39.9 to 41.9 utilization per 1,000 member months.

PM #27: Acute Inpatient Utilization by MLTSS NF Members
The quarterly rates varied from 22.1 to 53.3 utilization per 1000 member months, and the statewide rates ranged from 35.5 to 38.1 utilization per 1000 member months.

PM #28: All-Cause Readmissions of MLTSS HCBS Members to Hospital Within 30 Days
The quarterly rates ranged from 0% to 29.4% and the statewide rates varied from 19.8% to 21.3%

PM #29: All-Cause Readmissions of MLTSS NF Members to Hospital Within 30 Days
The quarterly rates ranged from 6.7% to 38.1% and the statewide rates varied from 22.8% to 26.9%.

PM #30: Emergency Department Utilization by MLTSS HCBS Members
The quarterly rates varied from 36.4 to 89.2 utilization per 1,000 member months, and the statewide rates stayed relatively stable, from 59.8 to 69.5 utilization per 1,000 member months.

PM #31: Emergency Department Utilization by MLTSS NF Members
The quarterly rates varied from 3.2 to 23.9 utilization per 1,000 member months, and the statewide rates stayed relatively stable, from 9.2 to 10.6 utilization per 1,000 member months.

PMs #33, #34, and #41: MLTSS PCA and Medical Day Services Used only by MLTSS HCBS Members
PM #33 PCA used only: the quarterly rates ranged from 5.4% to 19%, and the statewide rates stayed stable between 14.2% and 14.5%.

PM #34 Medical Day used only: the quarterly rates ranged from 1% to 21.1%, and the statewide rates stayed stable between 7.1% and 7.3%.

PM #41 PCA and Medical Day used only: the quarterly rates ranged from 2.4% to 14%, and the statewide rates stayed stable between 6.4% and 6.6%.

PM #36: Follow-up After Mental Health Hospitalization for MLTSS HCBS Members
The quarterly rates ranged from 18.2% to 75%. The statewide rates ranged from 46.7% to 51.4%.

PM #38: Follow-up After Mental Health Hospitalization for MLTSS NF Members
The quarterly rates ranged from 0% to 50%. The statewide rates ranged from 0% to 12.5%.

PMs #42: Follow-up After Emergency Department Visit for Alcohol or other Drug Dependences for MLTSS HCBS Members
The quarterly rates ranged from 0% to 52%. The statewide rates varied from 27% to 34.8%.

PMs #43: Follow-up After Emergency Department Visit for Alcohol or other Drug Dependences for MLTSS NF Members
The quarterly rates ranged from 0% to 100%. The statewide rates varied from 7.1% to 52.4%.

PMs #44: Follow-up After Emergency Department Visit for Mental Illness for MLTSS HCBS Members
The quarterly rates ranged from 0% to 100%. The statewide rates were relatively stable, varying between 46.4% and 67.6%.

PMs #45: Follow-up After Emergency Department Visit for Mental Illness for MLTSS NF Members
The quarterly rates ranged from 0% to 100%. The statewide rates were relatively stable, varying between 0% and 50%.

PMs #47: Post-hospital Institutional Care for MLTSS HCBS Members
The Yearly rates ranged from 14.3% to 57%. The statewide rate was 44.7%.

PMs #48: Hospitalization for MLTSS HCBS Members with Potentially Preventable Complications
The Yearly rates ranged from 3.5% to 12.3%. The statewide rate was 7.9%.

PMs #49: Hospitalization for MLTSS NF Members with Potentially Preventable Complications
The Yearly rates ranged from 4% to 8.1%. The statewide rate was 5.8%.

PMs #50: Follow-Up After Emergency Department Visit for MLTSS HCBS Members with High-Risk Multiple Chronic Conditions
The Yearly rates ranged from 46.6% to 57.8%. The statewide rate was 53.4%.

PMs #51: Follow-Up After Emergency Department Visit for MLTSS NF Members with High-Risk Multiple Chronic Conditions
The Yearly rates ranged from 23.4% to 44.1%. The statewide rate was 34.8%.

PMs #52B: Medication review, Care for Older Adults for MLTSS HCBS Members
The Yearly rates ranged from 28.0% to 77.9%. The statewide rate was 57.1%.

PMs #52C: Functional status assessment, Care for Older Adults for MLTSS HCBS Members
The Yearly rates ranged from 21.4% to 98.5%. The statewide rate was 70.1%.

PMs #52D: Pain assessment, Care for Older Adults for MLTSS HCBS Members
The Yearly rates ranged from 25.6% to 98.3%. The statewide rate was 73.6%.

PMs #53B: Medication review, Care for Older Adults for MLTSS NF Members
The Yearly rates ranged from 6.1% to 63.8%. The statewide rate was 40.4%.

PMs #53C: Functional status assessment, Care for Older Adults for MLTSS NF Members
The Yearly rates ranged from 1.7% to 99.5%. The statewide rate was 67.5%.

PMs #53D: Pain assessment, Care for Older Adults for MLTSS NF Members
The Yearly rates ranged from 4.4% to 96.4%. The statewide rate was 71.2%.

PMs #54A: New MLTSS members receiving PCA, Medical day, MLTSS services
The Yearly rates ranged from 48.7% to 84.2%. The statewide rate was 74.1%.

PMs #54B: New MLTSS HCBS members receiving PCA, Medical day, MLTSS services
The Yearly rates ranged from 54% to 78.5%. The statewide rate was 68.1%.

WYE 2023 MLTSS Performance Measures

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

The following are the measures for validation, showing the NJ MLTSS PM number associated with the measure for WYE 2023 (7/1/2022-6/30/2023):

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

The following measures are monitored quarterly and reviewed annually:

2. PM #18a – Percent of Critical Incidents that the MCO became aware of during the measurement period that were reported to the state at the Total and Category level
3. PM #18b – Percent of Critical Incidents that the MCO became aware of during the measurement period that were reported by the MCO to the state within 2 business days at the Total and Category level
4. PM #18c – Percent of Critical Incidents that the MCO became aware of during the measurement period for which a date of occurrence was available at the Total and Category level
5. PM #18d – The average number of days from the date of occurrence for Critical Incidents in the Numerator of 18C to the date the MCO became aware of the CI at the Total and Category level
6. PM #20 – MLTSS Members receiving MLTSS services – All MLTSS population.
7. PM #20b – Percentage of MLTSS HCBS members receiving any MLTSS services during the measurement period
8. PM #21 – MLTSS Members who Transitioned from NF to the Community
9. PM #23 – MLTSS NF to HCBS Transitions who returned to NF within 90 days
10. PM #26 – Acute Inpatient Utilization by MLTSS HCBS Members (HEDIS IPU)
11. PM #27 – Acute Inpatient Utilization by MLTS NF Members (HEDIS IPU)
12. PM #28 – All Cause Readmissions of MLTSS HCBS Members to Hospital within 30 Days (HEDIS PCR)
13. PM #29 – All Cause Readmissions of MLTSS NF members to Hospital within 30 days: (HEDIS PCR)
14. PM #30 – Emergency Department Utilization by MLTSS HCBS Members (HEDIS AMB)
15. PM #31 – Emergency Department Utilization by MLTSS NF Members (HEDIS AMB)
16. PM #33 – MLTSS services used by MLTSS HCBS members: PCA services only
17. PM #34 – MLTSS services used by MLTSS HCBS members: Medical Day services only
18. PM #36 – Follow-Up after Mental Health Hospitalization for MLTSS HCBS Members (HEDIS FUH)
19. PM #38 – Follow-up after Mental Health Hospitalization for MLTSS NF members (HEDIS FUH)
20. PM #41 – MLTSS services used by MLTSS HCBS members: PCA services and Medical Day services only
21. PM #42 – Follow-Up after Emergency Department Visit for Alcohol or Other Drug Dependence for MLTSS HCBS Members (HEDIS FUA)
22. PM #43 – Follow-up after Emergency Department visit for Alcohol or Other Drug Dependence for MLTSS NF members (HEDIS FUA)
23. PM #44 – Follow-Up after Emergency Department Visit for Mental Illness for MLTSS HCBS Members (HEDIS FUM)
24. PM #45 – Follow-up after Emergency Department visit for Mental Illness for MLTSS NF members: (HEDIS FUM)
25. PM #47* – Post-hospital Institutional Care for MLTSS HCBS Members
26. PM #48* – Hospitalization for MLTSS HCBS Members with Potentially Preventable Complications (HEDIS HPC)
27. PM #49* – Hospitalization for MLTSS NF Members with Potentially Preventable Complications: (HEDIS HPC)

28. PM #50* – Follow-Up After Emergency Department Visit for MLTSS HCBS Members with High-Risk Multiple Chronic Conditions (HEDIS FMC)
29. PM #51* – Follow-Up After Emergency Department Visit for MLTSS NF Members with High-Risk Multiple Chronic Conditions (HEDIS FMC)
30. PM #52* – Care for Older Adults for MLTSS Members (HEDIS COA)
31. PM #53* – Care of Older Adults for NF Members (HEDIS COA)
32. PM #54a*– New MLTSS members receiving PCA, MDC, and or MLTSS services
33. PM #54b* – New MLTSS HCBS Members receiving PCA, MDC, and/or MLTSS Services

Validation Results of WYE 2023 MLTSS Performance Measures

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

In addition, throughout the year, IPRO monitored all ongoing reporting to the State on a quarterly basis. In 2025, IPRO produced an annual report which detailed the annual validation process and results, as well as the results of the monitoring activities. This report also provided annual rates for the July 2021–June 2022 measurement period.

The following results are for the July 2022 through June 2023 measurement period:

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

MCO rates ranged from 0% to 11.9% from July 2022 to June 2023, and the statewide rates remained steady between 0% and 3.7%

PM #18: Critical Incident Reporting

Rate A – Percent of Critical Incidents that the MCP became aware of during the measurement period that were reported to the State at the Total and Category level: MCP rates ranged from 99.8% to 100%, and the statewide rates remained steady between 99.9% to 100%

Rate B – Percent of Critical Incidents that the MCP became aware of during the measurement period that were reported by the MCP to the State within 2 business days at the Total and Category level: MCP rates ranged from 86.7% to 99.3%, and the statewide rates remained steady between 92.3% to 95.9%.

Rate C – Percent of Critical Incidents that the MCP became aware of during the measurement period for which a date of occurrence was available at the Total and Category level: MCP rates ranged from 93.1% to 100%, and the statewide rates remained steady between 98% to 99.2%.

Rate D – The average number of days from the date of occurrence for Critical Incidents in the Numerator of Rate C to the date the MCP became aware of the CI at the Total and Category level: The average days ranged from 11.1 days to 26 days for the MCP to be aware of the CI. At the statewide level, it took on average from 15.2 to 17.8 days throughout the MY.

PM #20: MLTSS Members Receiving MLTSS Services

The quarterly MCP rates varied from 54.6% to 81.3%. The statewide rates remained steady between 71.6% and 72.5%.

PM #20b: MLTSS HCBS Members Receiving MLTSS Services
The quarterly MCP rates varied from 31% to 69.5%. The statewide rates remained steady between 56.9% and 58.8%.

PM #21: MLTSS Members Transitioned from NF to Community:
The quarterly MCP rates remained low, from 0.3% to 0.7%, and the statewide rates varied from 0.5% to 0.6%.

PM #23: MLTSS NF to HCBS Transitions who Returned to NF within 90 Days
The MCP rates varied from 0% to 18.2%. The statewide rates ranged from 5.3% to 11.3%.

PM #26: Acute Inpatient Utilization by MLTSS HCBS Members
The quarterly MCP rates varied from 20.6 to 63.4 utilization per 1,000 member months, and the statewide rates ranged from 40.3 to 43.2 utilization per 1,000 member months.

PM #27: Acute Inpatient Utilization by MLTSS NF Members
The quarterly rates varied from 22.9 to 53.2 utilization per 1,000 member months, and the statewide rates ranged from 34.1 to 38 utilization per 1,000 member months.

PM #28: All-Cause Readmissions of MLTSS HCBS Members to Hospital Within 30 Days
The quarterly rates ranged from 14.3% to 31%, and the statewide rates varied from 20.4% to 23.8%

PM #29: All-Cause Readmissions of MLTSS NF Members to Hospital Within 30 Days
The quarterly rates ranged from 11.1% to 30.6%, and the statewide rates varied from 18.1% to 22.2%.

PM #30: Emergency Department Utilization by MLTSS HCBS Members
The quarterly rates varied from 40.1 to 92.6 utilization per 1,000 member months, and the statewide rates stayed relatively stable, from 71.1 to 76.6 utilization per 1,000 member months.

PM #31: Emergency Department Utilization by MLTSS NF Members
The quarterly rates vary from 6.2 to 23.8 utilization per 1000 member months, and the statewide rates stay relatively stable, from 10.1 to 13.8 utilization per 1000 member months.

PMs #33, #34, and #41: MLTSS PCA and Medical Day Services Used only by MLTSS HCBS Members:
[PM #33 PCA used only] the quarterly rates ranged from 5.3% to 20.1%, and the statewide rates stayed stable between 14.5% to 15.3%.
[PM #34 Medical Day used only] the quarterly rates ranged from 1.1% to 15.8%, and the statewide rates stayed stable between 4.8% to 6.5%.
[PM #41 PCA and Medical Day used only] the quarterly rates ranged from 2% to 15.8%, and the statewide rates stayed stable between 5.6% to 6.9%.

PM #36: Follow-up After Mental Health Hospitalization for MLTSS HCBS Members
The quarterly rates ranged from 0% to 100%. The statewide rates ranged from 39.8% to 55.4%.

PM #38: Follow-up After Mental Health Hospitalization for MLTSS NF Members
The quarterly rates ranged from 0% to 100%. The statewide rates ranged from 0% to 42.9%.

PM #42: Follow-up After Emergency Department Visit for Alcohol or other Drug Dependences for MLTSS HCBS Members
The quarterly rates ranged from 0% to 52.3%. The statewide rates varied from 29% to 42.9%.

PM #43: Follow-up After Emergency Department Visit for Alcohol or other Drug Dependences for MLTSS NF Members
The quarterly rates ranged from 0% to 100%. The statewide rates varied from 11.8% to 52.6%.

PM #44: Follow-up After Emergency Department Visit for Mental Illness for MLTSS HCBS Members
The quarterly rates ranged from 0% to 75.9%. The statewide rates were relatively stable, varying between 55.7% and 64.3%.

PM #45: Follow-up After Emergency Department Visit for Mental Illness for MLTSS NF Members
The quarterly rates ranged from 0% to 100%. The statewide rates were relatively stable, varying between 30% and 57.1%.

PM #47: Post-hospital Institutional Care for MLTSS HCBS Members
The yearly rates ranged from 13.3% to 53.4%. The statewide rate was 38.8%.

PMs #48: Hospitalization for MLTSS HCBS Members with Potentially Preventable Complications
The yearly rates ranged from 4.1% to 13%. The statewide rate was 8.4%.

PMs #49: Hospitalization for MLTSS NF Members with Potentially Preventable Complications
The yearly rates ranged from 3.4% to 9%. The statewide rate was 6.4%.

PMs #50: Follow-Up After Emergency Department Visit for MLTSS HCBS Members with High-Risk Multiple Chronic Conditions
The yearly rates ranged from 45.1% to 56.2%. The statewide rate was 52.7%.

PMs #51: Follow-Up After Emergency Department Visit for MLTSS NF Members with High-Risk Multiple Chronic Conditions
The yearly rates ranged from 16.8% to 37.2%. The statewide rate was 27.4%.

PMs #52B: Medication review, Care for Older Adults for MLTSS HCBS Members
The yearly rates ranged from 48.7% to 86.4%. The statewide rate was 70.7%.

PMs #52C: Functional status assessment, Care for Older Adults for MLTSS HCBS Members
The yearly rates ranged from 28.7% to 98.5%. The statewide rate was 74%.

PMs #52D: Pain assessment, Care for Older Adults for MLTSS HCBS Members
The yearly rates ranged from 37.7% to 98.5%. The statewide rate was 81.9%.

PMs #53B: Medication review, Care for Older Adults for MLTSS NF Members
The yearly rates ranged from 23.4% to 88.1%. The statewide rate was 51.2%.

PMs #53C: Functional status assessment, Care for Older Adults for MLTSS NF Members
The yearly rates ranged from 19% to 99.5%. The statewide rate was 75.8%.

PMs #53D: Pain assessment, Care for Older Adults for MLTSS NF Members
The yearly rates ranged from 31.1% to 99%. The statewide rate was 81.2%.

PMs #54A: New MLTSS members receiving PCA, Medical day, MLTSS services
The yearly rates ranged from 49.7% to 88.2%. The statewide rate was 76.7%.

PMs #54B: New MLTSS HCBS members receiving PCA, Medical day, MLTSS services
The yearly rates ranged from 60.2% to 79.3%. The statewide rate was 71.3%.

WYE 2024 MLTSS Performance Measures
Specifications were updated in 2023 for the July 2023–June 2024 measurement period for the PMs listed below. All MLTSS PMs are validated annually. IPRO reviews source code, member-level files, and rates for each MCO. PM #04 was reported on a monthly basis. wo HEDIS measures and three MLTSS-specific measures (PM

#33, PM #47 and PM #54) were reported annually. All other PMs were reported on a quarterly and annual cycle. In the list below, PMs that are reported only on the annual cycle are identified with an asterisk (*).

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

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

The following measures are monitored quarterly and reviewed annually:

2. PM #18a – Percent of Critical Incidents that the MCO became aware of during the measurement period that were reported to the state at the Total and Category level.
3. PM #18b – Percent of Critical Incidents that the MCO became aware of during the measurement period that were reported by the MCO to the state within 2 business days at the Total and Category level.
4. PM #18c – Percent of Critical Incidents that the MCO became aware of during the measurement period for which a date of occurrence was available at the Total and Category level.
5. PM #18d – The average number of days from the date of occurrence for Critical Incidents in the Numerator of 18C to the date the MCO became aware of the CI at the Total and Category level.
6. PM #20 – MLTSS Members receiving MLTSS services – All MLTSS population.
7. PM #20b – Percentage of MLTSS HCBS members receiving any MLTSS services during the measurement period
8. PM #21 – MLTSS Members who Transitioned from NF to the Community
9. PM #23 – MLTSS NF to HCBS Transitions who returned to NF within 90 days
10. PM #26 – Acute Inpatient Utilization by MLTSS HCBS Members (HEDIS IPU)
11. PM #27 – Acute Inpatient Utilization by MLTS NF Members (HEDIS IPU)
12. PM #28 – All Cause Readmissions of MLTSS HCBS Members to Hospital within 30 Days (HEDIS PCR)
13. PM #29 – All Cause Readmissions of MLTSS NF members to Hospital within 30 days: (HEDIS PCR)
14. PM #30 – Emergency Department Utilization by MLTSS HCBS Members (HEDIS AMB)
15. PM #31 – Emergency Department Utilization by MLTSS NF Members (HEDIS AMB)
16. PM #33 – MLTSS services used by MLTSS HCBS members: PCA services only
17. PM #34 – MLTSS services used by MLTSS HCBS members: Medical Day services only
18. PM #36 – Follow-Up after Mental Health Hospitalization for MLTSS HCBS Members (HEDIS FUH)
19. PM #38 – Follow-up after Mental Health Hospitalization for MLTSS NF members (HEDIS FUH)
20. PM #41 – MLTSS services used by MLTSS HCBS members: PCA services and Medical Day services only
21. PM #42 – Follow-Up after Emergency Department Visit for Alcohol or Other Drug Dependence for MLTSS HCBS Members (HEDIS FUA)
22. PM #43 – Follow-up after Emergency Department visit for Alcohol or Other Drug Dependence for MLTSS NF members (HEDIS FUA)
23. PM #44 – Follow-Up after Emergency Department Visit for Mental Illness for MLTSS HCBS Members (HEDIS FUM)
24. PM #45 – Follow-up after Emergency Department visit for Mental Illness for MLTSS NF members: (HEDIS FUM)
25. PM #47* – Post-hospital Institutional Care for MLTSS HCBS Members
26. PM #48* – Hospitalization for MLTSS HCBS Members with Potentially Preventable Complications (HEDIS HPC)
27. PM #49* – Hospitalization for MLTSS NF Members with Potentially Preventable Complications: (HEDIS HPC)
28. PM #50* – Follow-Up After Emergency Department Visit for MLTSS HCBS Members with High-Risk Multiple Chronic Conditions (HEDIS FMC)
29. PM #51* – Follow-Up After Emergency Department Visit for MLTSS NF Members with High-Risk Multiple Chronic Conditions (HEDIS FMC)

30. PM #52* – Care for Older Adults for MLTSS Members (HEDIS COA)
31. PM #53* – Care of Older Adults for NF Members (HEDIS COA)
32. PM #54a* – New MLTSS members receiving PCA, MDC, and or MLTSS services
33. PM #54b* – New MLTSS HCBS Members receiving PCA, MDC, and/or MLTSS Services

Validation Results of WYE 2024 MLTSS Performance Measures

The final validation report for WYE 2024 is in progress and will be reflected in next year's ATR.

WYE 2023 MLTSS Performance Measure #13

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

IPRO was tasked with assessing the feasibility of producing PM #13 using administrative data rather than CM record review. The result of this assessment was the determination that the use of administrative data, based on comparison of authorization data and claims data to calculate PM #13, was not feasible. PM #13 is calculated using POCs and claims data. In WYE 2022, as directed by DMAHS, IPRO added the compliance score ranges for the delivery of MLTSS services

For the measurement period (July 01, 2022–June 30, 2023), random samples of 110 records were selected for each MCO. The MCOs submitted POCs, claims and black-out period files which allow the MCOs to list the dates where services were not delivered due to member choice or absence from the home. The final PM #13 reports were submitted to DMAHS in February 2025.

Plan of Care Services Assessed

MLTSS services assessed in the methodology, derived from the *MLTSS Service Dictionary*, are presented in **Table 24**. DMAHS provided IPRO with a crosswalk of acceptable MLTSS procedure codes for the services. As directed by DMAHS, Adult Family Care was excluded from the measurement study.

Table 25: MLTSS Assessment Inclusion Status

MLTSS Services	Included/Excluded
Assisted Living Services/Programs	Included
Chore Services	Included
Community Residential Services	Included
Home Delivered Meals	Included
Medical Day Services	Included
Medication Dispensing Device Monthly Monitoring	Included
PCA/Home-Based Supportive Care	Included
PERS Monitoring	Included
Private Duty Nursing	Included
Adult Family Care	Excluded
Behavioral Health Services	Excluded
Cognitive Therapy	Excluded
Caregiver Participant Training	Excluded
Community Transition Services	Excluded

MLTSS Services	Included/Excluded
Non-Medical Transportation	Excluded
Occupational Therapy	Excluded
Physical Therapy	Excluded
Residential Modifications	Excluded
Respite	Excluded
Social Adult Day Care	Excluded
Structured Day Program	Excluded
Supported Day Services	Excluded
Speech, Language, and Hearing Therapy	Excluded
TBI Behavioral Management	Excluded
Vehicle Modifications	Excluded

MLTSS: managed long-term services and supports; PCA: personal care assistant; PERS: personal emergency response system; TBI: traumatic brain injury.

Performance Measure Methodology

Service data from the POCs were used to construct a timeline of expected services for each recurring service in the POC. The timeline of the expected services was structured on a weekly or monthly basis,[1] and reflected the amount (in units) of service the member was expected to receive for each week/month in the measurement period, according to the POC.

MLTSS services are often provided on a weekly schedule that is customized for the member's needs; for instance, a member may require 16 units of personal care assistant (PCA) service per day on weekdays, but only 8 units per day on weekends. Due to the lack of day-to-day homogeneity in service schedules, it was inappropriate to use partial weeks in this analysis; the cutoff date on a partial week could arbitrarily misrepresent the expected service delivery. Therefore, the timeline of expected services used POC data for full weeks only. Weeks of the service span were divided into weeks starting on Sunday and ending on Saturday, and any incomplete weeks were dropped from the timeline of expected services. For example, PCA services from September 1, 2022 (Thursday) to September 30, 2022 (Friday) were broken down into 4 complete weeks (i.e., week 10 was September 2 to September 8, . . . week 13 was September 23 to September 29). The first incomplete week of September 1 and final incomplete week of September 30 were dropped from the timeline of expected services. Similarly, for monthly services, timelines were constructed using full months only; partial months at the start/end of the service span were dropped from the timeline.

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

IPRO validated the member-level roll-up file, which showed services provided based on claims for each week in the review period, against the MCOs' claims systems during a review meeting with each MCO. For each service, the timelines were compared to assess the percentage of service delivery for each week/month. The percentage of service delivery could never exceed 100% for any given week/month. Where claims indicated that more than 100% of the expected service units were delivered, the percentage was capped at 100%. This

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

strategy was applied so that, in aggregating services over a span of weeks, claims in excess of expected services in one particular week would not offset deficiencies in delivery of expected services in another week.

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

Performance Measure Results

As shown in **Table 25**, a total of 93 records were excluded, resulting in a study population of 457 members across all MCOs. Records could be excluded for several reasons; including no POC submitted in the file, POCs submitted did not have the necessary information to produce quantifiable expected services, and POCs contained only documented services that were not evaluated for this measure (e.g., Respite Care or Personal Preference Program).

The total study population was 457, an increase of 8 cases from the 449 cases included in the prior year's measure (**Table 25**). Among the MCOs, WPNJ study population increased the most by 9 cases, from 89 in the previous year to 98 in the current year; UHCCP study populations decreased the most by 8 cases, dropping from 74 in the previous year to 66 in the current year. Among the MCOs, UHCCP had the lowest sample size of 66 cases.

Table 26: WYE 2023 MLTSS Performance Measure #13 Results Summary

MCO	Total Sampled	2023 Total Excluded	2023 Study Population	2022 Total Excluded	2022 Study Population	Change in Study Population from Prior Year
ABHNJ	110	18	92	15	95	-3
FC/WCHP	110	8	102	14	96	+6
HNJH	110	11	99	15	95	+4
UHCCP	110	44	66	36	74	-8
WPNJ	110	12	98	21	89	+9
Total	550	93	457	101	449	+8

MCO: managed care organization.

Table 25 shows compliance at the service level for the individual MCOs, while **Table 26** shows compliance at the service level across all plans. The denominators displayed in **Table 26** and **Table 27** are the number of members who had the indicated service documented in their POC during the measurement period, while the numerators are the number of members whose average service delivery was above the 95% threshold. Note that a member can be represented in more than one service.

Across all MCOs, the most common MLTSS service was PERS Monitoring; of the 253 members who had PERS Monitoring, 170 (67.2%) received, on average, 95% or more of the planned amount. Across all MCOs, Assisted Living Service was associated with the highest proportion of members reaching the 95% average threshold of the MLTSS services listed; of the 34 members who had Assisted Living Services planned, 27 (79.4%) received, on average, 95% or higher of the planned amount.

For services with a denominator greater than or equal to 10 in **Table 27**, improvement was seen from the prior year for the Assisted Living Services/Programs. Rates with a denominator of less than 10 are listed for reference only. Rates for services for which the denominator is less than 30 should be reviewed with caution. For rates across all MCOs, the compliance rate of Assisted Living Services/Programs with a denominator of more than 10 increased the most, showing an increase of 2.9 pp from 76.5% in the prior year to 79.4% in the current year; the performance of Home Delivered Meals decreased the most, showing a decrease of 20.6 pp from 38.5% in the prior year to 17.9% in the current year.

Table 27: Proportion of MLTSS Services at or above the 95% Average Service Delivery Threshold, by MCO

	ABHNJ				FC/WCHP				HNJH				UHCCP				WPNJ			
Services Evaluated	D	N	2023 %	2022 %	D	N	2023 %	2022 %	D	N	2023 %	2022 %	D	N	2023 %	2022 %	D	N	2023 %	2022 %
Assisted Living Services/Programs	13	11	84.6%[b1]	87.5%[a]	2	2	100.0%[a]	75.0%[a]	14	13	92.9%[b5]	66.7%[a]	3	0	0.0%[a, b8]	60.0%[a]	2	1	50.0%[a, b10]	80.0%
Chore Services																				
Community Residential Services				0.0%[a]					6	0	0.0%[a]	0.0%[a]					1	0	0.0%[a]	
Home Delivered Meals	17	3	17.6%[b2]	21.1%	24	5	20.8%	33.3%	38	6	15.8%[b6]	51.1%	14	0	0.0%[b9]	47.8%	30	8	26.7%[b11]	27.8%
Medical Day Services	37	23	62.2%[b3]	35.3%	57	23	40.4%	47.1%	12	3	25.0%	55.6%	10	0	0.0%	37.5%[a]	32	9	28.1%[b12]	40.0%
Medication Dispensing Device Monthly Monitoring	1	1	100.0%[a]		5	2	40.0%[a]	0.0%[a]	2	2	100.0%[a]						1	1	100.0%[a]	50.0%[a]
PCA/Home-Based Supportive Care	40	24	60.0%[b2]	45.2%	51	24	47.1%[b4]	43.2%	42	16	38.1%[b7]	46.8%	46	2	4.3%	43.5%	49	18	36.7%	46.9%
PERS Monitoring	40	30	75.0%[b2]	82.4%	62	43	69.4%	78.8%	63	54	85.7%[b5]	74.2%	26	23	88.5%	81.5%	62	20	32.3%	60.0%
Private Duty Nursing	1	0	0.0%[a]	0.0%[a]					1	0	0.0%[a]	100.0%[a]	3	0	0.0%[a]	0.0%[a]				0.0%[a]

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

[b1] Both denominator and numerator increased this year for Assisted Living Services/Programs, the denominator increased from 8 to 13 and the numerator increased from 7 to 11. However, there is no statistically significant difference between the 2023 and 2022 rates.

[b2] Both denominator and numerator decreased this year for Home Delivered Meals, the denominator decreased from 19 to 17 and the numerator decreased from 4 to 3; for PCA/Home-Based Supportive Care, the denominator decreased from 62 to 40 and the numerator decreased from 28 to 24; for PERS Monitoring, the denominator decreased from 51 to 40 and the numerator decreased from 42 to 30. However, there is no statistically significant difference between the 2023 and 2022 rates.

[b3] Both denominator and numerator increased this year for Medical Day Services, the denominator increased from 34 to 37 and the numerator increased from 12 to 23. The rates for 2023 are statistically significantly higher than the rate for 2022.

[b4] Both denominator and numerator increased this year for PCA/Home-Based Supportive Care, the denominator increased from 44 to 51 and the numerator increased from 19 to 24. However, there is no statistically significant difference between the 2023 and 2022 rates.

[b5] Both denominator and numerator increased this year for Assisted Living Services/Programs, the denominator increased from 3 to 14 and the numerator increased from 2 to 13; for PERS Monitoring, the denominator increased from 62 to 63 and the numerator increased from 46 to 54. However, there is no statistically significant difference between the 2023 and 2022 rates.

[b6] Both denominator and numerator decreased this year for Home Delivered Meals, the denominator decreased from 47 to 38 and the numerator decreased from 24 to 6. The rate for 2023 is statistically significantly lower than the rate for 2022.

[b7] Both denominator and numerator decreased this year for PCA/Home-Based Supportive Care, the denominator decreased from 47 to 42 and the numerator decreased from 22 to 16. However, there is no statistically significant difference between the 2023 and 2022 rates.

[b8] Both denominator and numerator decreased this year for Assisted Living Services/Programs, the denominator decreased from 5 to 3 and the numerator decreased from 3 to 0.
[b9] Both denominator and numerator decreased this year for Home Delivered Meals, the denominator decreased from 23 to 14 and the numerator decreased from 11 to 0. The rate for 2023 is statistically significantly lower than the rate for 2022.
[b10] Both denominator and numerator decreased this year for Assisted Living Services/Programs, the denominator decreased from 10 to 2 and the numerator decreased from 8 to 1.
[b11] Both denominator and numerator decreased this year for Home Delivered Meals, the denominator decreased from 36 to 30 and the numerator decreased from 10 to 8. However, there is no statistically significant difference between the 2023 and 2022 rates.
[b12] Both denominator and numerator increased this year for Medical Day Services, the denominator increased from 20 to 32 and the numerator increased from 8 to 9. However, there is no statistically significant difference between the 2023 and 2022 rates.
MLTSS: managed long-term services and supports; D: Denominator; N: Numerator; PCA: personal care assistant; PERS: personal emergency response system.
Gray shading: 0 denominator for the service, so numerator and rate is not applicable.

Table 28: Proportion of MLTSS Services At or Above the 95% Average Service Delivery Threshold, All Plans

Services Evaluated	2023 D	2023 N	2023 %	2022 D	2022 N	2022 %	Change from 2022
Assisted Living Services/Programs	34	27	79.4%	34	26	76.5%	2.9%
Chore Services							
Community Residential Services	7	0	0.0%[a]	8	0	0.0%[a]	0.0%
Home Delivered Meals	123	22	17.9%	143	55	38.5%	-20.6%
Medical Day Services	148	58	39.2%	122	52	42.6%	-3.4%
Medication Dispensing Device Monthly Monitoring	9	6	66.7%[a]	8	2	25.0%[a]	41.7%
PCA/Home-Based Supportive Care	228	84	36.8%	248	112	45.2%	-8.4%
PERS Monitoring	253	170	67.2%	242	181	74.8%	-7.6%
Private Duty Nursing	5	0	0.0%[a]	9	1	11.1%[a]	-11.1%

[a] Fewer than 10 members in the denominator. These rates should be reviewed with caution.
Gray shading: Zero denominator for the Service; numerator and rate are not applicable.
MLTSS: managed long-term services and supports; D: Denominator; N: Numerator; PCA: personal care assistant; PERS: personal emergency response system.

Table 28 presents compliance rates by MCO and for the overall sample. The overall compliance rate across all MCOs was 31.1%, a decrease of 6.3 pp from the rate of 37.4% for the prior year. It is observed that only one MCO demonstrated a better performance this year: ABHNJ's compliance rate increased by 19.6 pp from 33.7% in the prior year to 53.3%. Other MCOs demonstrated lower performance this year: FC/WCHP's compliance rate decreased by 9.2 pp from 39.6% in the prior year to 30.4% in the current year, HNJH's compliance rate decreased by 1.5 pp from 38.9% in the prior year to 37.4% in the current year, UHCCP's compliance rate decreased by 27.2 pp from 37.8% in the prior year to 10.6% in the current year, and WPNJ's compliance rate decreased by 18.7 pp from 37.1% in the prior year to 18.4% in the current year (**Table 28**). ABHNJ achieved the highest compliance rate, with a rate of 53.3%.

As noted above, compliance with PM #13 is based on the average service delivery percentage for all weeks/months for each service. To be compliant, the average service delivery must score at or above 95% for each service documented in the POC for each member. Of the 457 total members in the denominator, 142 (31.1%) received, on average, 95% of the planned service amount for all services documented in the POC (**Table 28**).

Table 29: Compliance Rates

MCO	2023 D	2023 N	2023 Compliance Rate	2022 D	2022 N	2022 Compliance Rate	Change in Rate from Prior Year
ABHNJ	92	49	53.3%	95	32	33.7%	+19.6
FC/WCHP	102	31	30.4%	96	38	39.6%	-9.2
HNJH	99	37	37.4%	95	37	38.9%	-1.5
UHCCP	66	7	10.6%	74	28	37.8%	-27.2
WPNJ	98	18	18.4%	89	33	37.1%	-18.7
Total	457	142	31.1%	449	168	37.4%	-6.3

MCO: managed care organization; D: denominator; N: numerator.

WYE 2024 MLTSS Performance Measure #13

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

IPRO was tasked with assessing the feasibility of producing PM #13 using administrative data rather than Care Management record review. The result of this assessment was the determination that the use of administrative data, based on comparison of authorization data and claims data to calculate PM #13, was not feasible. PM #13 is calculated using POCs and claims data.

For the measurement period (July 01, 2023–June 30, 2024), random samples of 110 records were selected for each MCO. The MCOs submitted POCs, claims and black-out period files which allow the MCOs to list the dates where services were not delivered due to member choice or absence from the home. The audit is in progress and final results will be reflected in next year's ATR.

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

Objectives

IPRO assessed each MCO's operational systems to determine compliance with the BBA regulations governing MMC programs, as detailed in the CFR. To meet these federal requirements, DMAHS has contracted with IPRO, an EQRO, to conduct the review of compliance with Medicaid and CHIP managed care regulations. The annual assessment of MCO operations determines MCO compliance with the NJ FamilyCare Managed Care Contract requirements and with State and federal regulations in accordance with the requirements of *Title 42 CFR § 438.360(a)(1)*. The annual assessment of MCO operations is designed to assist with validating, quantifying, and monitoring the quality of each MCO's structure, processes, and the outcomes of its operations. All five MCOs participated in a 2024 compliance review: ABHNJ, FC/WCHP, HNJH, UHCCP and WPNJ. *Note: Amerigroup New Jersey Inc. began doing business as Wellpoint New Jersey Inc. in January 2024.*

In 2024, all audits were conducted virtually (offsite). Staff interview questions were not provided prior to the offsite interview. The interview process was a structured process which focused on IPRO's current findings based on the documentation provided prior to the offsite interview. The Plan was provided with an opportunity to clarify responses and to provide requested documentation after the virtual interviews.

Effective 2019, the state moved to a new annual assessment audit cycle: two consecutive years of partial audits followed by one year of full audit. If the MCO scores less than 85% in the first partial audit, the MCO will have a full audit the following year. In 2024, partial reviews were conducted for ABHNJ, HNJH, UHCCP, and WPNJ. FC/WCHP participated in a full review. The reviews evaluated each health plan on 15 standards based on contractual requirements. In 2024, the MCOs were required to provide documentation on one additional standard (Emergency and Post-Stabilization Services).

The assessment type applied to ABHNJ, FC/WCHP, HNJH, UHCCP, and WPNJ in 2024 is outlined in **Table 29.**

Table 30: 2024 Annual Assessment Type by MCO

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

MCO: managed care organization.

Technical Methods of Data Collection and Analysis

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

The review consisted of pre-offsite review of documentation provided by the MCO as evidence of compliance with the 15 standards under review; review of randomly selected files; interviews with key staff; and post-audit evaluation of documentation and audit activities. To assist in submission of appropriate documentation, IPRO developed the *Annual Assessment of MCO Operations Review Submission Guide*. In 2024, enhancements were made to the submission guide for the Access category for the *2024 Core Medicaid/MLTSS Annual Assessment*. Elements A1 and A2 were removed from the Access category and moved to a new separate

category – Emergency and Post-Stabilization Services, with other emergency and post-stabilization requirements (elements EPS1–EPS6). Several new requirements were also added to a few of the remaining Access elements, specifically elements A3, A4, and A4a–A4f. This document closely follows the NJ FamilyCare Managed Care Contract and was developed to assess MCO compliance. Each element is numbered and organized by review standard (e.g., Access, Quality Assessment and Performance Improvement, Quality Management) and includes the contract reference. The submission guide was provided to the plans and covered the specific elements subject to review for the current cycle. The review period for this assessment was July 1, 2023–June 30, 2024.

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

Description of Data Obtained

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

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

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

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

The standard designations and assigned points used are shown in **Table 30.**

Table 31: New Jersey Medicaid Managed Care Compliance Monitoring Standard Designation

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

Conclusions and Comparative Findings

As part of the annual assessment of MCO operations, IPRO performed a thorough evaluation of the MCO's compliance with CMS's Subpart D and QAPI standards. CMS requires each MCO's compliance with these 14 standards to be evaluated. **Table 31** provides a crosswalk of individual elements reviewed during the annual assessment to the CMS QAPI standards.

Table 32: Crosswalk of Standards Reviewed by EQRO to the Subpart D and QAPI Standards

Subpart D and QAPI Standards[1]	CFR Citation	Annual Assessment Review Categories	Elements Reviewed	Last Compliance Review[2]
Disenrollment	438.56	1 – Member Disenrollment	MD1-MD8, MD10	1 – 2023–2024
Enrollee Rights	438.100	1 – Enrollee Rights and Responsibilities	ER1, ER3 - ER4	1 – 2022–2023 and 2023–2024
Emergency and Post-Stabilization[3]	438.114	1- Emergency and Post-Stabilization	EPS1	1 – 2022–2023 and 2023–2024
Availability of services	438.206	1 – Access, 2 – Credentialing and Recredentialing 3 – Administration and Operations	A3, A4a – A4e, A4f, A7, CR7, CR8 AO1, AO2	1 – 2022–2023 and 2023–2024 2 – 2022–2023 and 2023–2024 3 – 2022–2023 and 2023–2024
Assurances of adequate capacity and services	438.207	1 – Access	A4	1 – 2022–2023 and 2023–2024
Coordination and continuity of care	438.208	1 – Care Management and Continuity of Care	CM2, CM7 – CM11, CM14, CM26, CM29, CM34, CM38	1 – 2022–2023 and 2023–2024
Coverage and authorization of service	438.210	1 – Utilization Management	UM3, UM11, UM14, UM15, UM16, UM16e, UM16j	1 – 2022–2023 and 2023–2024
Provider selection	438.214	1 – Credentialing and Recredentialing 2 – Care Management and Continuity of Care	CR2, CR3, CM27	1 – 2022–2023 and 2023–2024 2 – 2022–2023 and 2023–2024

Subpart D and QAPI Standards[1]	CFR Citation	Annual Assessment Review Categories	Elements Reviewed	Last Compliance Review[2]
Confidentiality	438.224	1 – Provider Training and Performance	PT9	1 – 2022–2023 and 2023–2024
Grievance and appeal systems	438.228	1 – Utilization Management 2- Quality Management	UM16a – UM16d, UM16f- UM16i, QM5	1 – 2022–2023 and 2023–2024 2 – 2022–2023 and 2023–2024
Subcontractual relationships and delegation	438.230	1 – Administration and Operations	AO5, AO8–AO11	1 – 2022–2023 and 2023–2024
Practice guidelines	438.236	1 – Quality Assessment and Performance Improvement (QAPI) 2 – Quality Management 3 – Programs for the Elderly and Disabled	Q4 QM1, QM3 ED3, ED10, ED23, ED29	1 – 2022–2023 and 2023–2024 2 – 2022–2023 and 2023–2024 3 – 2022–2023 and 2023–2024
Health information systems	438.242	1 – Management Information Systems	IS1–IS17	1 – 2022–2023 and 2023–2024
Quality assessment and performance improvement (QAPI)	438.330	1 – Quality Assessment and Performance Improvement (QAPI)	Q1-Q3, Q5-Q9	1 – 2022–2023 and 2023–2024

[1] The categories QAPI and Care Management and Continuity of Care are reviewed annually. The Division of Medical Assistance and Health Services (DMAHS) requires specific elements to be reviewed annually.
[2] All five managed care organizations (MCOs) had a partial compliance review in 2022–2023. Four MCOs (ABHNJ, HNJH, UHCCP, WPNJ) had a partial compliance review in 2023–2024. One MCO (FC/WCHP) had a full compliance review in 2023–2024.
[3] Emergency and Post-Stabilization was formerly (2022-2023) reviewed and scored in the Access category under element A1.
EQRO: external quality review organization; CFR: Code of Federal Regulations.

Of the 232 elements reviewed during the 2024 Core Medicaid and MLTSS annual assessments, 94 elements crosswalk to the 14 CMS QAPI standards. **Table 32** provides a list of elements evaluated and scored by MCO for each of the Subpart D and QAPI standards identified by CMS.

Table 33: Subpart D and QAPI Standards – Scores by MCO

Subpart D and QAPI Standards	CFR Citation	AA Review Elements	# of Elements Reviewed	ABHNJ	FC/ WCHP	HNJH	UHCCP	WPNJ
Disenrollment	438.56	MD1-MD8, MD10	9	100%	78%	100%	100%	100%
Enrollee rights	438.100	ER1, ER3 -ER4	3	100%	100%	100%	100%	100%
Emergency and post-stabilization[1]	438.114	EPS1	1	100%	100%	100%	100%	100%
Availability of services	438.206	A3, A4a – A4e, A4f, A7, CR7, CR8 AO1, AO2	12	67%	67%	75%	67%	50%
Assurances of adequate capacity and services	438.207	A4	1	100%	100%	100%	100%	100%

Subpart D and QAPI Standards	CFR Citation	AA Review Elements	# of Elements Reviewed	ABHNJ	FC/ WCHP	HNJH	UHCCP	WPNJ
Coordination and continuity of care	438.208	CM2, CM7 – CM11, CM14, CM26, CM29, CM34, CM38	11	73%	73%	64%	82%	64%
Coverage and authorization of services	438.210	UM3, UM11, UM14, UM15, UM16, UM16e, UM16j	7	100%	100%	100%	100%	100%
Provider selection	438.214	CR2, CR3, CM27	3	100%	100%	100%	100%	100%
Confidentiality	438.224	PT9	1	100%	100%	100%	100%	100%
Grievance and appeal systems	438.228	UM16a – UM16d, UM16f-UM16i, QM5	9	100%	100%	100%	100%	100%
Subcontractual relationships and delegation	438.230	AO5, AO8– AO11	5	100%	100%	100%	100%	100%
Practice guidelines	438.236	Q4 QM1, QM3 ED3, ED10, ED23, ED29	7	100%	100%	100%	100%	100%
Health information systems	438.242	IS1–IS17	17	100%	100%	100%	100%	100%
Quality assessment and performance improvement program	438.330	Q1-Q3, Q5-Q9	8	100%	100%	100%	100%	100%
Total elements reviewed			**94**					
Compliance percentage				**93%**	**90%**	**93%**	**93%**	**89%**

[1] Emergency and Post-Stabilization was formerly reviewed and scored in the Access category under element A1.

All five MCOs participated in the 2024 compliance review. A total of 232 elements were reviewed by each MCO for a total of 1,160 elements reviewed overall (data not shown). All five NJ MCOs showed strong performance in the CMS Subpart D and QAPI standards. All five MCOs received 100% compliance for 11 or more of the 14 standard domains. All five MCOs were non-compliant in Availability of Services, and Coordination and Continuity of Care (**Table 32**).

Table 33 displays a comparison of the overall compliance score for each of the five MCOs from 2023 to 2024. For the review period July 1, 2023–June 30, 2024, ABHNJ, FC/WCHP HNJH, UHCCP, and WPNJ scored above NJ's minimum threshold of 85%. The 2024 compliance scores from the annual assessment ranged from 95% to 99% (**Table 33)**. ABHNJ's compliance score increased from 96% to 98%; FC/WCHP's compliance score increased from 93% to 95%; HNJH's compliance score increased from 97% to 99%; UHCCP's compliance score remained consistent at 98%; WPNJ's compliance score increased from 95% to 97% (**Table 33**).

Table 34: Comparison of 2023 and 2024 Compliance Scores by MCO

MCO	2023 Compliance %	2024 Compliance %	% Point Change from 2023 to 2024
ABHNJ	96%	98%	+2%
FC/WCHP	93%	95%	+2%
HNJH	97%	99%	+2%
UHCCP	98%	98%	0%
WPNJ	95%	97%	+2%

MCO: managed care organization.

In 2024, the average compliance score for five standards (Quality Management, Member Disenrollment, Credentialing and Re-Credentialing, Utilization Management, and Management Information Systems) showed increases ranging from 1 to 4 pp (**Table 34**). In 2024, 10 standards (Emergency and Post-Stabilization Services, QAPI, Efforts to Reduce Healthcare Disparities, Committee Structure, Programs for the Elderly and Disabled, Provider Training and Performance, Enrollee Rights and Responsibilities, Utilization Management, Administration and Operations, and Management Information Systems) had an average score of 100%. Average compliance for eight standards (QAPI, Efforts to Reduce Healthcare Disparities, Committee Structure, Programs for the Elderly and Disabled, Provider Training and Performance, Satisfaction, Enrollee Rights and Responsibilities, and Administration and Operations) remained the same from 2023 to 2024 (**Table 34**). One standard (Access) decreased 4 pp from 2023 to 2024. Access had the lowest average compliance score at 65% (**Table 34**).

Table 35: 2023 and 2024 Compliance Scores by Review Category

Review Category[1]	MCO Average 2023[2]	MCO Average 2024[2]	% Point Change from 2023 to 2024
Care Management and Continuity of Care – Core Medicaid[1]	75%	77%	+2
Care Management and Continuity of Care – MLTSS[1]	100%	100%	0
Access	69%	65%	-4
Emergency and Post-Stabilization Services[4]	N/A	100%	N/A
Quality Assessment and Performance Improvement	100%	100%	0
Quality Management	93%	97%	+4
Efforts to Reduce Healthcare Disparities	100%	100%	0
Committee Structure	100%	100%	0
Programs for the Elderly and Disabled	100%	100%	0

Review Category[1]	MCO Average 2023[2]	MCO Average 2024[2]	% Point Change from 2023 to 2024
Provider Training and Performance	100%	100%	0
Satisfaction	96%	96%	0
Enrollee Rights and Responsibilities	100%	100%	0
Member Disenrollment	94%	97%	+3
Credentialing and Recredentialing	96%	98%	+2
Utilization Management	96%	100%	+4
Administration and Operations	100%	100%	0
Management Information Systems	99%	100%	+1
Total[3]	**96%**	**97%**	**+1**

[1] In 2023 and 2024, the Care Management scores were not included in the overall compliance score.
[2] Managed care organization (MCO) average is the average of the compliance scores for the five MCOs (ABHNJ, FC/WCHP, HNJH, UHCCP, and WPNJ).
[3] Total is the average of compliance scores listed in **Table 33**.
[4] Emergency and Post-Stabilization Services is a new standard reviewed in 2024.
MLTSS: managed long-term services and supports; N/A: not applicable.

Individual MCO 2024 annual assessment scores by element can be found in **Appendix A: January 2024–December 2024 NJ MCO-Specific Review Findings**.

Figure 2 depicts compliance scores in 2022–2024. Compliance scores for the five MCOs (ABHNJ, FC/WCHP, HNJH, UHCCP and WPNJ) have remained at or above 93% for all 3 years.

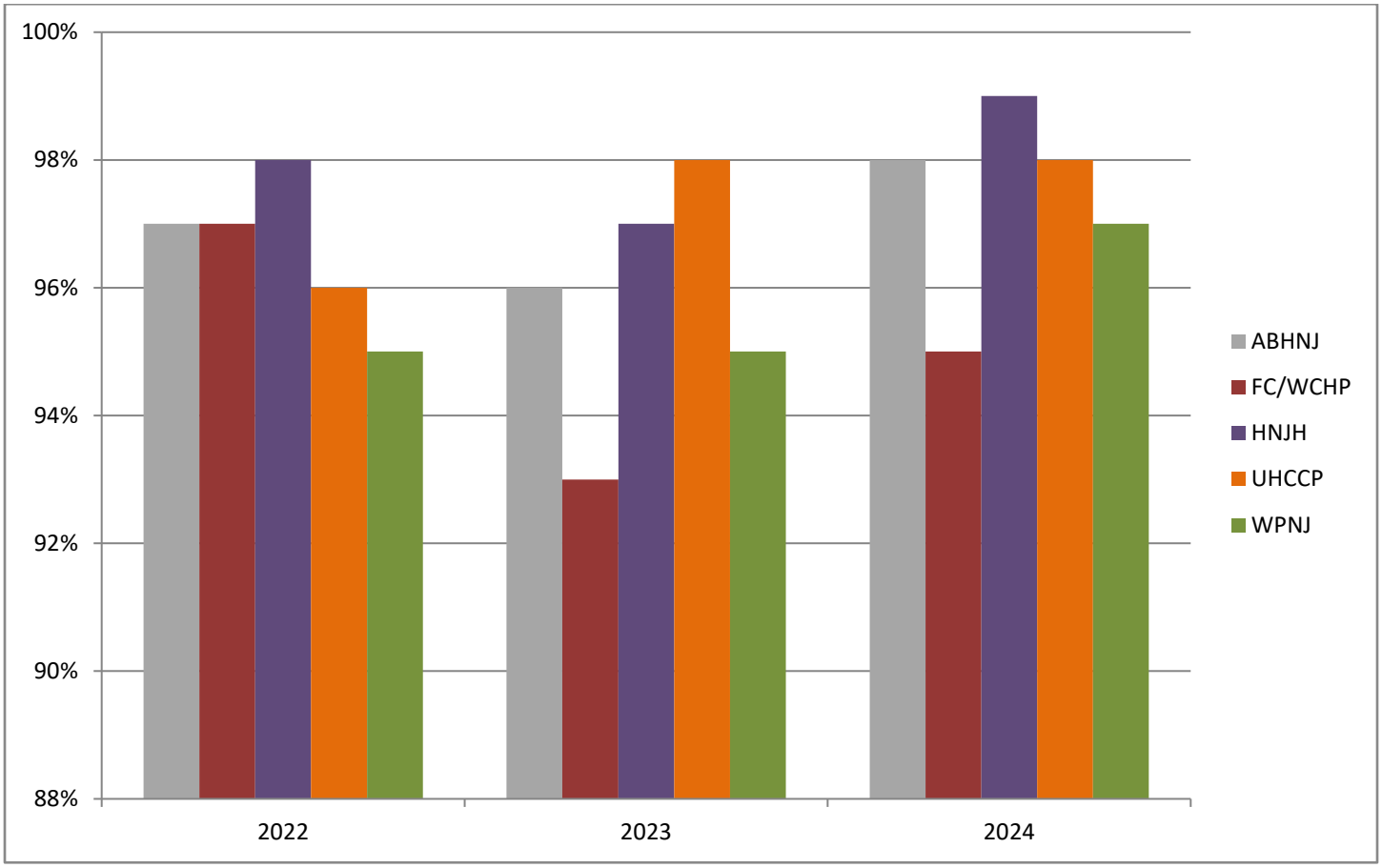

Figure 2: MCO Compliance Scores by Year (2022–2024) Compliance scores for Aetna Better Health of New Jersey (ABHNJ, gray); Fidelis Fare (FC/WCHP, red); Horizon NJ Health (HNJH, purple), UnitedHealthcare Community Plan (UHCCP, orange); and Wellpoint New Jersey, Inc. (WPNJ, green) are shown for 2022–2024.

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 2024 annual assessment of MCO operations are:

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

Recommendations and Opportunities for Improvement

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

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

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

Protocol 4: Validation of Network Adequacy

Objectives

Title 42 CFR § 438.356 State contract options for external quality review and *Title 42 CFR § 438.358 Activities related to external quality review* establish that state agencies must contract with an EQRO to perform the annual validation of network adequacy. To meet these federal regulations, DMAHS contracted with IPRO to validate the accuracy of provider information available to Medicaid members through the provider look-up systems on each MCO's website, and to evaluate the breadth and scope of how accessibility information is presented in these look-up systems. The study methodology aligns with CMS's *External Quality Review (EQR) Protocol 4 – Validation of Network Adequacy*. In 2024, IPRO's evaluation included the NJ FamilyCare networks of ABHNJ, FC/WCHP, HNJH, UHCCP, and WPNJ.

IPRO's evaluation aimed to:

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

Technical Methods of Data Collection and Analysis

Validation of the Accuracy of Information Reported in the Provider Directory

IPRO accessed NJ Medicaid MCO provider look-up systems between May 2024 and July 2024 to prepare the MCO samples. **Table 35** displays the website addresses of the MCO provider look-up systems, the date range the look-up systems were accessed by IPRO to prepare the sample, and the date range IPRO administered the survey.

Table 36: Survey Administration Summary

MCO	Website Address of Provider Directory/Date
ABNJH	https://www.aetnabetterhealth.com/newjersey/find-provider
FC/WCHP	https://findaprovider.fideliscarenj.com/location
HNJH	https://www.horizonnjhealth.com/findadoctor
UHCCP	https://member.uhc.com/communityplan
WPNJ	https://www.wellpoint.com/nj/medicaid/search-providers
Website access dates	5/20/2024–6/12/2024
Survey date range	5/28/2024–7/25/2024

MCO: managed care organization.

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

- practices primary care, pediatric specialty, dentistry, or is an MLTSS provider, and
- participates in the NJ FamilyCare network, and
- accepts new patients enrolled with one of the five Medicaid MCOs.

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

Evaluation of Accessibility Information Reported in the Provider Directory

IPRO reviewed the MCOs' provider look-up systems to assess the availability of accessibility information and how this information is presented to users. The breadth of accessibility information in the online provider directories was evaluated through a desk review. This review included assessing the search capabilities that

allow members to identify providers with accessibility features and the extent of information available to help members identify providers with specific accessibility features.

Provider Directory Access Results

Provider directory access was determined based on whether the provider could be contacted via telephone, was still contracted with the specified managed care plan, and was accepting new patients. As presented in **Table 36**, the overall provider directory access rate was 47.3%**,** with the highest compliance rate observed among pediatric specialists (**Table 37**).

Individual *MCO 2024 Provider Directory Validation Survey* reports and scores by element can be found in **Appendix G.**

Table 37: Provider Directory Access Rate

Total Providers Surveyed[1]	Compliant Providers[2]	Access Rate
1,750	827	47.3%

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

Table 38: Provider Directory Access Rates by Specialty

Provider Specialty (Reporting Group)	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary care	1,000	456	45.6%
Pediatric specialists	250	141	56.4%
Dental	250	108	43.2%
Managed long-term services and supports	250	122	48.8%
Total	1,750	827	47.3%

[1] Providers who positively confirmed participation with the managed care organization (MCO) and open panel status for the listed specialty.

Conclusions and Comparative Findings

The overall response rate for the provider directory validation survey was 47.3% (**Table 37**). Pediatric specialists responded at a higher rate than any other provider type, at 56.4%. Response rates varied by MCO as follows: 35.7% for ABHNJ, 50.3% for FC/WCHP, 50.3% for HNJH, 56.3% for UHCCP, and 43.7% for WPNJ (**Appendix G**).

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

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

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

Encounter data validation is an ongoing process, involving the MCOs, Encounter Data Monitoring Unit (EDMU), and the EQRO. In 2017, DMAHS partnered with its EQRO, IPRO, to conduct an MCO system and encounter data process review to include a baseline evaluation of the submission and monitoring of encounter data. As of October 2017, IPRO has been attending the monthly EDMU calls with the MCOs. In 2024, IPRO continues to monitor encounter data submissions and patterns.

On a monthly basis since 2013, IPRO receives eligibility and encounter data extracts from Gainwell Technologies (formerly DXC Technology). IPRO loads the following data to IPRO's Statistical Analysis Software (SAS®) data warehouse: member eligibility, demographic, third-party liability (TPL) information, state-accepted institutional inpatient and outpatient, professional, pharmacy, dental, home health, transportation, and vision encounter data. Starting June 2020, IPRO also began receiving a monthly supplemental pharmacy file that includes additional data elements. During 2024, IPRO worked closely with Gainwell Technologies to address any changes to the eligibility and encounter data extracts and to ensure the monthly file receipt.

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

Objectives

Results from the HEDIS CAHPS 2024 5.1H Surveys for NJ FamilyCare enrollees provide a comprehensive tool for assessing consumers' experiences with their health plan. The following two survey vendors conducted the adult and Children with Chronic Conditions (CCC) surveys on behalf of NJ FamilyCare MCOs: Center for the Study of Services (CSS) and SPH Analytics. IPRO subcontracted with a certified survey vendor to receive the data from these vendors for the reporting aspect of the survey. The health plans included were: ABHNJ, FC/WCHP, HNJH, UHCCP, and WPNJ. In addition, the certified vendor fielded one statewide CHIP-only survey. All the members surveyed required continuous enrollment from July 1, 2023, through December 31, 2023, with enrollment in that MCO at the time of the survey. Aggregate reports were produced for the adult, child and CCC surveys. In addition, a statewide aggregate report was produced for the CHIP survey.

Technical Methods of Data Collection and Analysis

The survey drew, as potential respondents, adult enrollees over the age of 18 years, and children under the age of 18 years who were covered by NJ FamilyCare. The survey was administered in English and Spanish during the spring of 2024 using a mixed-mode protocol that consisted of two waves of survey mailings and a phone follow-up to all members who had not responded to the mailings. All five MCOs utilized the mail and telephone protocol. Additionally, all MCOs offered the option to complete the survey online. For the Child CAHPS survey, ABHNJ opted to send a third survey mailing to those who had not responded to the first two mailings.

Description of Data Obtained and Conclusion

For the adult survey, a total random sample of 8,236 adult enrollees from the NJ FamilyCare plans was drawn. This consisted of a random sample of 1,688 ABHNJ, 1,350 FC/WCHP, 1,755 HNJH, 1,890 UHCCP, and 1,553 WPNJ enrollees (data not shown). To be eligible, enrollees had to be over the age of 18 years and continuously enrolled for at least 6 months prior to the sample selection with no more than one enrollment gap of 45 days or less. Completed surveys were obtained from 1,348 NJ FamilyCare adult enrollees, and the NJ FamilyCare adult survey response rate was 16.7%, which was an increase compared to the previous year's response rate of 15.5% (data not shown).

For the child survey, a total random sample of 21,135 parent/caretakers of child enrollees from the NJ FamilyCare plans was drawn (data not shown). This consisted of a random sample of 4,728 ABHNJ, 3,490 FC/WCHP, 5,239 HNJH, 4,188 UHCCP, and 3,490 WPNJ enrollees (data not shown). To be eligible, enrollees had to be under the age of 18 years and continuously enrolled for at least 6 months prior to the sample selection with no more than one enrollment gap of 45 days or less. Completed surveys were obtained from 4,090 NJ FamilyCare child enrollees, and the NJ FamilyCare child survey response rate was 19.7%, which was an increase compared to the previous year's response rate of 18.0% (data not shown).

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

than one enrollment gap of 45 days or less. Complete CCC surveys were obtained from 2,751 NJ FamilyCare child CCC enrollees, and the NJ FamilyCare child CCC response rate was 20.2% (data not shown).

For the CHIP survey, a total random sample of 4,150 parent/caretakers of CHIP child enrollees was drawn (data not shown). To be eligible, enrollees had to be under the age of 18 years and continuously enrolled for at least 6 months prior to the sample selection with no more than one enrollment gap of 45 days or less. Completed surveys were obtained from 837 NJ FamilyCare CHIP enrollees, and the NJ FamilyCare CHIP survey response rate was 20.4%, which was a decrease from last year's response rate of 21.9% (data not shown).

The CAHPS rates are color coded to correspond to the national percentiles as shown in **Table 38**.

Table 39: Color Key for CAHPS Rate Comparison to NCQA HEDIS MY 2023 Quality Compass National Percentiles

Color Key	How Rate Compares to the NCQA MY 2023 Quality Compass National Percentiles
Orange	Less than 25th percentile
Yellow	Greater than or equal to 25th and less than 50th percentile
Green	Greater than or equal to 50th and less than 75th percentile
Blue	Greater than or equal to 75th and less than 90th percentile
Purple	Great than or equal to the 90th percentile

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

Conclusions and Comparative Findings

To determine common strengths and opportunities for improvement across all MCOs, IPRO compared the NJ FamilyCare overall statewide weighted averages for adults and children (**Tables 39–41)** to the national Medicaid benchmarks presented in the MY 2023 Quality Compass. Measures performing at or above the 75th percentile and below the 90th percentile, and greater than or equal to the 90th percentile were considered strengths; measures performing at the 50th percentile and below the 75th percentile were considered average, while measures performing below the 50th percentile were identified as opportunities for improvement.

Composite results of the adult NJ FamilyCare overall weighted responses for the five MCOs were: 92.2% for how well doctors communicate; 90.0% for customer service; 80.2% for getting needed care; and 77.2% for getting care quickly (**Table 39**).

Table 40: CAHPS MY 2023 Performance – Medicaid Adult Survey

Adult Survey – CAHPS Measure	ABHNJ	FC/WCHP	HNJH	UHCCP	WPNJ	Statewide Weighted Average
Getting Needed Care	80.6%	78.7%	80.6%	78.5%	81.2%	80.2%
Getting Care Quickly	76.0%	84.1%	76.2%	77.2%	78.5%	77.2%
How Well Doctors Communicate	93.0%	92.6%	92.3%	91.8%	91.6%	92.2%
Customer Service	88.8%	92.9%	90.8%	87.3%	89.8%	90.0%
Rating of All Health Care[1]	71.3%	72.7%	75.6%	74.6%	74.4%	74.8%
Rating of Personal Doctor[1]	76.2%	85.1%	85.9%	80.6%	83.3%	83.9%
Rating of Specialist Seen Most Often[1]	83.7%	84.5%	84.9%	79.0%	79.9%	83.2%

Adult Survey – CAHPS Measure	ABHNJ	FC/WCHP	HNJH	UHCCP	WPNJ	Statewide Weighted Average
Rating of Health Plan[1]	71.9%	75.9%	82.8%	75.1%	79.7%	79.8%

[1] For rating of health care, personal doctor, specialist seen most often and health plan, Medicaid rates are based on survey scores of 8, 9 and 10.
Color key for how rate compares to the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measurement year (MY 2022) Quality Compass national percentiles: orange shading – less than 25th percentile; yellow shading – greater than or equal to 25th and less than 50th percentile; green shading is greater than or equal to 50th and less than 75th percentile; blue shading – greater than or equal to 75th and less than 90th percentile; purple shading – greater than or equal to the 90th percentile.
CAHPS: Consumer Assessment of Healthcare Providers and Systems.
The composite results of the Child NJ FamilyCare overall weighted responses for the five MCOs were: 92.3% for how well doctors communicate; 88.4% for customer service; 84.3% for getting needed care; and 77.8% for getting care quickly (**Table 40**).

Table 41: CAHPS MY 2023 Performance – Medicaid Child Survey

Child Survey – CAHPS Measure	ABHNJ	FC/WCHP	HNJH	UHCCP	WPNJ	Statewide Weighted Average
Getting Needed Care	82.2%	82.2%	84.6%	83.7%	85.0%	84.3%
Getting Care Quickly	79.9%	74.2%	76.6%	77.5%	83.0%	77.8%
How Well Doctors Communicate	92.9%	89.8%	92.5%	91.6%	92.9%	92.3%
Customer Service	87.3%	87.4%	89.3%	87.8%	86.6%	88.4%
Rating of All Health Care[1]	84.3%	84.4%	86.9%	86.3%	88.3%	86.8%
Rating of Personal Doctor[1]	87.5%	87.4%	90.5%	90.6%	89.3%	90.1%
Rating of Specialist Seen Most Often[1]	82.3%	86.8%	90.0%	83.3%	88.5%	88.0%
Rating of Health Plan[1]	82.9%	85.9%	89.3%	87.5%	83.7%	87.7%

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

The composite results of the Child CCC NJ FamilyCare overall weighted responses for the five MCOs were: 92.9% for how well doctors communicate; 88.7% for customer service; 82.8% for getting needed care; and 79.2% for getting care quickly (**Table 41**).

Table 42: CAHPS MY 2023 Performance – Medicaid Child CCC Survey

Child CCC Survey – CAHPS Measure[1]	ABHNJ	FC/WCHP	HNJH	UHCCP	WPNJ	Statewide Weighted Average
Getting Needed Care	82.1%	80.8%	82.8%	82.9%	83.1%	82.8%
Getting Care Quickly	81.0%	75.5%	79.6%	76.8%	81.7%	79.2%
How Well Doctors Communicate	93.5%	91.9%	93.8%	90.9%	92.7%	92.9%
Customer Service	86.8%	88.4%	90.2%	87.6%	86.4%	88.7%
Access to Specialized Services	65.2%	61.0%	64.5%	61.9%	63.0%	63.6%

Child CCC Survey – CAHPS Measure[1]	ABHNJ	FC/WCHP	HNJH	UHCCP	WPNJ	Statewide Weighted Average
Family Centered Care[2]	86.4%	87.9%	90.3%	86.6%	88.2%	88.9%
Coordination of Care	61.8%	64.4%	62.5%	67.8%	65.5%	64.1%
Rating of All Health Care[1]	82.7%	84.3%	85.0%	85.9%	88.2%	85.6%
Rating of Personal Doctor[1]	85.4%	87.9%	92.1%	91.2%	89.5%	91.1%
Rating of Specialist Seen Most Often[1]	82.8%	84.5%	89.8%	83.7%	89.7%	88.0%
Rating Of Health Plan[1]	82.8%	85.0%	89.2%	87.7%	83.0%	87.5%

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

Composite results of the CHIP NJ FamilyCare overall statewide responses were divided into two categories: general population and CCC population. The composite results for the general population were 94.8% for how well doctors communicate, 83.0% for customer service, 85.8% for getting needed care, and 78.0% for getting care quickly (data not shown). The composite results for the CCC population were 95.0% for how well doctors communicate, 83.8% for customer service, 79.9% for getting needed care, and 82.5% for getting care quickly (data not shown).

Weighted statewide average rates ranked at or above the NCQA national 50th percentile for three of the eight adult measures (**Table 39**). Opportunities for improvement are evident for the five adult measures (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Rating of All Health Care, and Rating of Specialist Seen Most Often). Weighted statewide average rates ranked at or above the NCQA national 50th percentile for five of the eight child measures (**Table 40**). Opportunities for improvement are evident for three of the eight child measures (Getting Care Quickly, How Well Doctors Communicate, and Rating of All Health Care). Weighted statewide average rates ranked at or above the NCQA national 50th percentile for four of the eleven child CCC measures (**Table 41**). Opportunities for improvement are evident for six CCC measures (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Customer Service, Access to Specialized Services, and Coordination of Care). There was no benchmark available for Family Centered Care.

For the adult survey measures, ABHNJ had two measures between the 50th and 75th percentiles, FC/WCHP had one measure above the national 90th percentile, one measure between the 75th and 90th percentiles, and two measures between 50th and 75th percentiles (**Table 39**). HNJH had three measures between the 75th and 90th percentiles and one measure between the 50th and 75th percentiles. All eight measures were below the 50th percentile for UHCCP. WPNJ had two measures between 50th and 75th percentiles (**Table 39**).

For the child survey measures, all eight measures were below the 50th percentile for ABHNJ and FC/WCHP (**Table 40**). HNJH had two measures between the 75th and 90th percentiles and three measures between the 50th and 75th percentiles. UHCCP had two measures between the 50th and 75th percentiles. WPNJ had three measures between the 50th and 75th percentiles (**Table 40**).

For the CCC survey measures, ten measures were below the 50th percentile for ABHNJ (**Table 41**; Family Centered Care does not have a benchmark available). FC/WCHP had one measure between the 50th and 75th percentiles. HNJH had two measures greater than the 90th percentile, and one measure between the 50th and 75th percentile. UHCCP had one measure greater than the 90th percentile, one measure between the 75th and 90th percentiles, and one measure between the 50th and 75th percentile. WPNJ had three measures between the 50th and 75th percentiles (**Table 41**).

Protocol 9: Conducting Focus Studies of Health Care Quality

2022 and 2023 Prenatal and Postpartum Care Focus Study

Background

Maternal morbidity and mortality is a significant public health concern in the United States (US), with notable disparities in maternal mortality rates seen across the spectrum of maternal age, education level, geography, and race/ethnicity.[1,2] Timely prenatal and postpartum care visits are recommended by the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG) as important for ensuring favorable maternal and infant health outcomes.[3,4] Disparities in maternal health outcomes among several sociodemographic characteristics persist among New Jersey Medicaid beneficiaries.[2] In New Jersey (NJ), Medicaid insures a high percentage of non-Hispanic Black and Hispanic birthing individuals, who have historically experienced maternal health outcome disparities. This focus study was undertaken to further understand disparities in prenatal/postpartum care access among New Jersey Medicaid beneficiaries. While a previous focus study examined sociodemographic disparities in the timely receipt of prenatal and postpartum care visits for New Jersey Medicaid beneficiaries in measurement year (MY) 2021, this focus study analyzed data for measurement years 2021, 2022, and 2023, with the additional goal of identifying any notable data trends in year-over-year comparisons.

Methods

Analysis was conducted of data obtained from administrative member-level files of all five NJ MCOs between October 8, 2020, and October 7, 2023. The primary outcomes for this study were timely prenatal care and postpartum care, as measured by the HEDIS Prenatal and Postpartum Care (PPC) measure. This measure includes Medicaid beneficiaries who delivered a live birth and met continuous enrollment criteria. The PPC measure has two subcomponents: 1) Timeliness of Prenatal Care, and 2) Postpartum Care. To assess the presence of disparities, variables that were examined in this study include age, race/ethnicity, county, and ZIP code. Although administrative data underestimates PPC rates compared to MCO-reported hybrid rates, member-level analysis necessitated use of the former.

Frequency tables were developed to describe the sample in terms of the number of deliveries/birthing individuals, age group, race/ethnicity, county, and ZIP code. Crosstabulations (contingency tables) were created to report PPC rates (Timeliness of Prenatal Care and Postpartum Care) by age group, race/ethnicity, county, and ZIP code. Contingency tables reporting the distribution of members by county with the corresponding PPC rates for each race/ethnicity subgroup and for each age subgroup were generated to assess interactions between race/ethnicity and county as well as age and county. Frequency tables reporting PPC rates at the ZIP-code level were also produced for PPC rates for the top-20 ZIP codes by number of live births, PPC rates for the top-20 ZIP codes (by highest performance), and PPC rates for the bottom-20 ZIP codes (by lowest performance). Single year, as well as year-over-year comparisons were reported to identify sociodemographic disparities and trends in PPC performance. *Z*-scores were used to identify the presence of statistically significant differences within a 99% confidence interval (CI)[1].

A supplementary analysis was conducted identifying additional county-level sociodemographic subareas that could influence the timeliness of prenatal and postpartum care. Using the county health rankings, selected component measures were assessed for association with PPC rates at the county level by calculating correlation coefficients. Heatmaps were generated using Mapbox® and OpenStreetMap®. In part, these heatmaps provided an ordinal ranking of timeliness of prenatal and postpartum care performance alongside sociodemographic composite measures produced by the University of Wisconsin Population Health Institute.

These sociodemographic composite measures were also compared to the proportion of Medicaid members by county.

The findings for the *2022 and 2023 Prenatal and Postpartum Care Focus Study* are in progress and will be reflected in next year's ATR.

2024 MCO Verification of Enrollment in Care Management Focus Study

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

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

Sampling

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

System Review

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

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

The findings for the *2025 MCO Verification of Enrollment in Care Management Focus Study* are in progress and will be reflected in next year's ATR.

Care Management Audits

2024 Core Medicaid Care Management Audits

The purpose of the CM audits was to evaluate the effectiveness of the contractually required CM program. DMAHS established CM requirements to ensure that the services provided to Enrollees with special health care needs were consistent with professionally recognized standards of care. The populations included in this audit include GP, DDD, and DCP&P enrollees.

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

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the prior year's report, contract references, *NJ Care Management Workbook*, and *CDC Immunization Schedules*. For 2024, at the direction of DMAHS, the MCO CM audit evaluation process changed for GP, DDD, and DCP&P enrollees. For the GP population, IPRO evaluated enrollees new to the MCO and new to CM between 1/1/2023 and 11/16/2023 and existing enrollees enrolled in CM between 3/1/2023 and 11/16/2023. For the DDD and DCP&P populations, IPRO evaluated newly eligible enrollees new to CM during the 2023 review period and existing enrollees enrolled in CM prior to 1/1/2023. Audit questions are limited exclusively to "Yes" or "No" answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool, where appropriate, to determine whether an enrollee met the criteria for a subsequent section or question. Therefore, for some audit questions, enrollees represented in the numerator and denominator represent only those who met the specific applicable criteria.

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

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

Assessment Methodology

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

Summary of Core Medicaid Care Management Audit Performance

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

Table 43: Core Medicaid Care Management Summary of Performance

Determination by Category[1]	ABHNJ MY 2023	FC/WCHP MY 2023	HNJH MY 2023	UHCCP MY 2023	WPNJ MY 2023
GP	n = 98	n = 100	n = 100	n = 100	n = 46
Identification[2]	72.1%	83.1%	77.9%	77.4%	82.6%
Outreach	100.0%	90.0%	82.6%	100.0%	93.8%
Preventive Services	100.0%	100.0%	99.0%	99.4%	95.9%
Continuity of Care	98.1%	94.8%	98.2%	100.0%	95.3%
Coordination of Services	98.5%	97.2%	96.6%	100.0%	98.0%
DDD	n = 100	n = 100	n = 100	n = 100	n = 100
Outreach	88.2%	97.0%	100.0%	98.2%	100.0%
Preventive Services	85.0%	96.8%	74.1%	93.6%	99.0%
Continuity of Care	78.5%	99.4%	86.4%	95.6%	92.1%
Coordination of Services	81.0%	96.9%	58.8%	95.1%	68.4%
DCP&P	n = 55	n = 37	n = 90	n = 100	n = 100
Outreach	100%	N/A	95.0%	N/A	85.7%
Preventive Services	82.8%	96.4%	96.9%	99.6%	98.3%
Continuity of Care	86.8%	99.5%	97.0%	99.4%	88.7%
Coordination of Services	91.3%	94.6%	89.5%	99.2%	90.7%

[1] The populations included in this audit include general population (GP) enrollees, enrollees under the Division of Developmental Disabilities (DDD), and enrollees under the Division of Child Protection and Permanency (DCP&P).
[2] The Identification category is not evaluated for the DDD and DCP&P populations.
N/A: not applicable, no DCP&P enrollees met criteria for this measure as all comprehensive needs assessments (CNAs) were completed timely; MY: measurement year.

ABHNJ's 2024 audit results ranged from 72.1% to 100% across all populations for the five audit categories, FC/WCHP's results ranged from 83.1% to 100%, HNJH's results ranged from 58.8% to 100%, UHCCP's results ranged from 77.4% to 100%, and WPNJ's 2024 audit results ranged from 68.4% to 100% across all populations for the five audit categories (**Table 42**).

Core Medicaid Care Management and Continuity of Care Annual Assessment

Assessment Methodology

The CM review examines if the MCO has an effective CM service structure. This structure includes written policies, procedures, processes, and systems to identify, assess, and manage its enrollee population in CM. This review also examines whether the MCO has developed and implemented CM for all enrollees who may benefit from these services in accordance with State requirements. The program should utilize the Initial Health Screening (IHS) outreach for all new enrollees in GP, and the comprehensive needs assessment (CNA) protocol(s) and tool(s) to identify and to provide an appropriate level of service for enrollees with special needs, or those in GP who would benefit from CM services. The CM program must address inpatient, outpatient, and catastrophic care; coordinate services; provide linkage to community support services and agencies; and coordinate with the appropriate state divisions for individuals with special needs.

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

The 2024 CM assessment covered the period from January 1, 2023, to December 31, 2023. Interviews with key MCO staff were held remotely in May 2024.

There were 30 elements in this review based on contractual provisions, which are subject to review annually. Review of the elements CM2, CM4–CM8, CM11, CM14–CM17, and CM19 was based on results from the 2024 Core Medicaid file review. Overall compliance scores for the five MCOs ranged from 57% to 90% (**Table 43**). Where appropriate, the assessment of other elements was informed by both documents submitted for review and the file review. This audit evaluated Core Medicaid CM files for CY 2023 for three populations: namely the enrollees in the general, DDD and DCP&P populations. **Table 43** presents an overview of the results by MCO.

Table 44: Summary of Findings for 2024 Core Medicaid Care Management and Continuity of Care

MCO	Total Elements Reviewed	Total Elements Met	Total Elements Not Met	Compliance Percentage
ABHNJ	30	23	7	77%
FC/WCHP	30	26	4	87%
HNJH	30	17	13	57%
UHCCP	30	27	3	90%
WPNJ	30	22	8	73%

MCO: managed care organization.

Table 44 presents the findings for the Core Medicaid Care Management and Continuity of Care elements reviewed in 2024. Complete findings and IPRO's recommendations for each MCO can be located in **Appendices B–F.**

Table 45: Findings for 2024 Core Medicaid Care Management and Continuity of Care

Element	ABHNJ	FC/WCHP	HNJH	UHCCP	WPNJ
CM1	X	X	X	X	X
CM2	-	-	-	X	-
CM3	X	X	X	X	X
CM4	X	X	-	X	X
CM5	X	X	-	X	-
CM6	-	-	-	-	-
CM7	-	-	-	-	-
CM8	X	X	-	X	X
CM9	X	X	-	X	X
CM10	X	X	-	X	X
CM11	X	X	-	X	-
CM12	X	X	X	X	X
CM13	X	X	X	X	X
CM14	-	-	-	-	-
CM15	X	X	X	X	X
CM16	-	X	X	X	X

Element	ABHNJ	FC/WCHP	HNJH	UHCCP	WPNJ
CM17	X	X	X	X	X
CM18a	X	X	X	X	X
CM18c	X	X	-	X	X
CM18d	X	X	X	X	X
CM19	-	X	-	X	-
CM20	X	X	X	X	X
CM21	X	X	X	X	X
CM22	X	X	X	X	X
CM23	X	X	-	X	X
CM24	X	X	X	X	X
CM25	X	X	X	X	X
CM26	X	X	X	X	X
CM27	X	X	X	X	X
CM37[1]	-	X	X	X	-
Total elements = 30	**23**	**26**	**17**	**27**	**22**
Compliance percentage	**77%**	**87%**	**57%**	**90%**	**73%**

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

FC/WCHP and UHCCP met the compliance threshold of 85% or above (**Table 44**). All MCOs were provided recommendations for elements that were Not Met. These recommendations can be found in the **MCO Strengths and Opportunities for Improvement, and EQR Recommendations** section, and also in **Appendices B–F**.

2024 MLTSS Nursing Facility/Special Care Nursing Facility Ancillary Review

The purpose of the MLTSS NF/SCNF ancillary review was to evaluate MCO compliance with DMAHS NJ FamilyCare Contract Article 9.11.G, MLTSS Performance Measures. IPRO conducted a review of the following MLTSS PMs: PM #8, PM #9, PM #9a, PM #11, and PM #16 for the review period September 1, 2022, through June 30, 2023.

Methodology

A random sample of 35 NF/SCNF members new to MLTSS and/or new to the MCO during the review period and 25 NF/SCNF members enrolled in MLTSS and the MCO prior to 9/1/2022 was selected to meet a minimum of 60 files (including a 20% oversample required for substitutions or exclusions) for each MCO. IPRO reviewed a total of 50 member files were evaluated for each MCO for compliance with MLTSS PMs #8, #9, #9a, #11, and #16.

Evaluation of MLTSS Performance Measures

The following MLTSS PMs were evaluated to determine MCO compliance: PM #8: Plans of Care established within 45 days of MLTSS enrollment; PM #9: Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination; PM #9a: Plan of Care for MLTSS Members amended based on change of Member condition; PM #11: Plans of Care for MLTSS Members are developed using "Person-Centered Principles"; and PM #16: MCO provided training to MLTSS Member on identifying/reporting Critical Incidents. Results for each MLTSS PM for all five MCOs are shown in **Table 45**.

Table 46: MLTSS Performance Measures Results

Performance Measure	ABHNJ	FC/WCHP	HNJH	UHCCP	WPNJ
#8. Plans of care established within 45 days of MLTSS enrollment.[1]	93.3%	83.3%	86.7%	20.0%	90.0%
#9. Plan of care reassessment for MLTSS members conducted within 30 days of annual LOC re-determination.[2]	100.0%	100.0%	100.0%	86.7%	100.0%
#9a. Plan of care for MLTSS members amended based on change of member condition.[3]	66.7%	N/A	100.0%	N/A	100.0%
#11. Plans of care for MLTSS members are developed using "person-centered principles."[4]	100.0%	100.0%	100.0%	100.0%	100.0%
#16. MCO provided training to MLTSS member on identifying/reporting critical incidents.	100.0%	100.0%	100.0%	60.0%	100.0%

[1] Compliance with this measure includes completion of the Initial Plan of Care (POC) and timeliness of completion. The denominator includes all NF/SCNF Members new to MLTSS and/or new to the managed care organization (MCO) during the review period.
[2] Members included in this measure (denominator) have an annual level of care (LOC) re-determination that was due and completed during the review period and a POC on file.
[3] Members who did not have a documented change in condition during the study period are excluded from this measure.
[4] For compliance with this measure members must have a POC on file during the review period that contains documentation 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 be addressed in the POC.
N/A: not applicable; there were no members who met the criteria for this measure.

The MCOs were not required to provide responses to opportunities for improvements for this ancillary review. The complete reports can be found in **Appendices B–F**.

ABHNJ's MLTSS NF/SCNF Ancillary Audit Results

Overall, ABHNJ scored 86% or above for the following MLTSS Performance Measures (Table 45):

- PM #8: Plans of care established within 45 days of MLTSS enrollment.
- PM #9: Plan of care reassessment for MLTSS members conducted within 30 days of annual LOC re-determination.
- PM #11: Plans of care for MLTSS members are developed using "person-centered principles."
- PM #16: MCO provided training to MLTSS member on identifying/reporting critical incidents.

Opportunities for improvement for performance measures scored below 86% for the following MLTSS Performance Measures (Table 45):

- PM #9a: Plan of care for MLTSS members amended based on change of member condition.

FC/WCHP's MLTSS NF/SCNF Ancillary Audit Results

Overall, FC/WCHP scored 86% or above for the following MLTSS Performance Measures (Table 45):

- PM #9: Plan of care reassessment for MLTSS members conducted within 30 days of annual LOC re-determination.
- PM #11: Plans of care for MLTSS members are developed using "person-centered principles."

- PM #16: MCO provided training to MLTSS member on identifying/reporting critical incidents.

Opportunities for improvement for performance measures scored below 86% for the following MLTSS Performance Measures (Table 45):

- PM #8: Plans of care established within 45 days of MLTSS enrollment.

HNJH's MLTSS NF/SCNF Ancillary Audit Results

Overall, HNJH scored 86% or above for the following MLTSS Performance Measures (Table 45):

- PM #8: Plans of care established within 45 days of MLTSS enrollment.
- PM #9: Plan of care reassessment for MLTSS members conducted within 30 days of annual LOC re-determination.
- PM #9a: Plan of care for MLTSS members amended based on change of member condition.
- PM #11: Plans of care for MLTSS members are developed using "person-centered principles."
- PM #16: MCO provided training to MLTSS member on identifying/reporting critical incidents.

No Opportunities for improvement for performance measures scored below 86% were identified for this review (Table 45).

UHCCP's MLTSS NF/SCNF Ancillary Audit Results

Overall, UHCCP scored 86% or above for the following MLTSS Performance Measures (Table 45):

- PM #9: Plan of care reassessment for MLTSS members conducted within 30 days of annual LOC re-determination.
- PM #11: Plans of care for MLTSS members are developed using "person-centered principles."

Opportunities for improvement for performance measures scored below 86% for the following MLTSS Performance Measures (Table 45):

- PM #8: Plans of care established within 45 days of MLTSS enrollment.
- PM #16: MCO provided training to MLTSS member on identifying/reporting critical incidents.

WPNJ's MLTSS NF/SCNF Ancillary Audit Results

Overall, WPNJ scored 86% or above for the following MLTSS Performance Measures (Table 45):

- PM #8: Plans of care established within 45 days of MLTSS enrollment.
- PM #9: Plan of care reassessment for MLTSS members conducted within 30 days of annual LOC re-determination.
- PM #9a: Plan of care for MLTSS members amended based on change of member condition.
- PM #11: Plans of care for MLTSS members are developed using "person-centered principles."
- PM #16: MCO provided training to MLTSS member on identifying/reporting critical incidents.

No Opportunities for improvement for performance measures scored below 86% were identified for this review (Table 45).

2024 MLTSS Nursing Facility Care Management Audits

The purpose of the Managed Long-Term Services and Supports (MLTSS) Nursing Facility/Special Care Nursing Facility (NF/SCNF) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, DMAHS established MLTSS CM requirements to ensure that the services provided to special needs members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), were consistent with professionally recognized standards of care. Specifically, the populations included in this audit were members who met the eligibility requirements for MLTSS and were receiving services in a NF/SCNF for at least six consecutive months within the review period from July 1, 2023, through June 30, 2024.

HHS declared an end to the PHE for COVID-19 on May 11, 2023. State issued COVID-19 flexibilities related to specific CM activities and NFs with visitation protocols (restricting care manager access) discontinued prior to this review period.

In addition to the CM audit, MLTSS PMs #8 (Plans of Care established within 45 days of MLTSS enrollment), #9 (Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination), #9a (Plan of Care for MLTSS Members amended based on change of Member condition), #11 (Plans of Care for MLTSS Members are developed using “Person-Centered Principles”), and #16 (MCO provided training to MLTSS Member on identifying/reporting Critical Incidents) were calculated.

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

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the NJ FamilyCare Contracts (Article 9), dated July 2023 and January 2024. A representative sample of files were selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities, and post-audit activities.

Pre-Audit Planning Activities

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the NJ Choice Assessment System, POC, contract references, and revision of elements for review. Audit questions were limited exclusively to ”Yes” or ”No” answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool in 2024, where appropriate, to determine whether a member met the criteria for a subsequent section or question. Therefore, for some audit questions, members represented in the numerator and denominator represent only those who met the specific applicable criteria. IPRO prepared an audit tool structured to collect requirement-specific information related to Facility and MCO Plan of Care, MLTSS Initial Plan of Care and Ongoing Plans of Care, Ongoing Care Management, Reassessment of the Plan of Care and Critical Incident Reporting, and Preadmission Screening and Resident Review (PASRR) Communications for Transitions to NF/SCNF. In addition, MLTSS PMs #8, #9, #9a, #11, and #16 were calculated for the applicable NF/SCNF population. Rates calculated from these audit tool sections are utilized to determine MCO performance.

Separate rates were calculated on requirement-specific questions related to MLTSS members who transitioned between HCBS and NF/SCNF settings during the review period. These rates are utilized solely for informational purposes.

In order to collect additional information for MLTSS members who transitioned between HCBS and NF/SCNF settings during the review period, the selected MLTSS NF/SCNF population was further identified as one of the four subgroups listed in **Table 46**.

Table 47: MLTSS NF/SCNF Population Subgroups

MLTSS NF/SCNF Population Subgroups	
Group 1	Members permanently residing in an NF/SCNF at least 6 consecutive months from July 1, 2023, to June 30, 2024, with the MCO of record on June 30, 2024.
Group 2	Members residing in an NF/SCNF for at least 6 consecutive months from July 1, 2023, to June 30, 2024, and transitioned to HCBS during the review period with no transition from HCBS to another NF.
Group 3	Members residing in HCBS for at least 1 month between July 1, 2023, and June 30, 2024, and transitioned to an NF/SCNF for at least 6 consecutive months during the review period (and still residing in the NF/SCNF as of June 30, 2024).
Group 4	Members residing in HCBS for at least 1 month between July 1, 2023, and June 30, 2024, transitioned to an NF/SCNF for at least 6 consecutive months, and transitioned back to HCBS for at least 1 month during the review period.

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

The 2024 MLTSS NF/SCNF Audit Results are presented in **Table 47**.

2024 MLTSS NF/SCNF Audit Results

Table 48: 2024 MLTSS NF/SCNF Audit Results

Category for Measurement Period July 1, 2023, to June 30, 2024	ABHNJ N	ABHNJ D	ABHNJ Rate	FC/WCHP N	FC/WCHP D	FC/WCHP Rate	HNJH N	HNJH D	HNJH Rate	UHCCP N	UHCCP D	UHCCP Rate	WPNJ N	WPNJ D	WPNJ Rate	NJ Weighted Average
Facility and MCO Plan of Care																
Member's care management record contained **copies of any Facility Plans of Care on file** during the review period.	86	100	86.0%	89	100	89.0%	82	100	82.0%	82	100	82.0%	96	100	96.0%	87.0%
Documented review of the Facility Plan of Care by the Care Manager.	84	86	97.7%	89	89	100.0%	82	82	100.0%	81	82	98.8%	96	96	100.0%	99.3%
MLTSS Plan of Care on file includes information from the Facility Plan of Care.	96	100	96.0%	100	100	100.0%	100	100	100.0%	99	100	99.0%	100	100	100.0%	99.0%
MLTSS Initial Plan of Care and Ongoing Plans of Care																
The Member's individualized Plan of Care (including obtaining Member's signature) **was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program** (for Members newly enrolled in MLTSS).	4	5	80.0%	6	6	100.0%	1	1	100.0%	9	13	69.2%	3	4	75.0%	79.3%

Category for Measurement Period July 1, 2023, to June 30, 2024	ABHNJ N	ABHNJ D	ABHNJ Rate	FC/WCHP N	FC/WCHP D	FC/WCHP Rate	HNJH N	HNJH D	HNJH Rate	UHCCP N	UHCCP D	UHCCP Rate	WPNJ N	WPNJ D	WPNJ Rate	NJ Weighted Average
Care Managers used a person-centered approach regarding the Member's assessment and needs; taking into account not only covered services, but also formal and informal support services.	96	96	100.0%	100	100	100.0%	100	100	100.0%	98	99	99.0%	100	100	100.0%	99.8%
Plan of Care reassessment for MLTSS Members conducted within 30 days of annual level of care (LOC) re-determination.	86	87	98.9%	87	90	96.7%	97	99	98.0%	70	80	87.5%	93	93	100.0%	96.4%
Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems, and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process.	96	96	100.0%	100	100	100%	100	100	100%	99	99	100%	100	100	100.00%	100.0%

Category for Measurement Period July 1, 2023, to June 30, 2024	ABHNJ N	ABHNJ D	ABHNJ Rate	FC/WCHP N	FC/WCHP D	FC/WCHP Rate	HNJH N	HNJH D	HNJH Rate	UHCCP N	UHCCP D	UHCCP Rate	WPNJ N	WPNJ D	WPNJ Rate	NJ Weighted Average
Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	96	96	100.0%	100	100	100.0%	100	100	100.0%	99	99	100.0%	100	100	100.0%	100.0%
Member's agreement/disagreement with the Plan of Care statements were documented on the Member's Plan of Care and maintained in the Member's electronic CM record.	96	96	100.0%	98	100	98.0%	100	100	100.0%	96	99	97.0%	100	100	100.0%	99.0%

Category for Measurement Period July 1, 2023, to June 30, 2024	ABHNJ N	ABHNJ D	ABHNJ Rate	FC/WCHP N	FC/WCHP D	FC/WCHP Rate	HNJH N	HNJH D	HNJH Rate	UHCCP N	UHCCP D	UHCCP Rate	WPNJ N	WPNJ D	WPNJ Rate	NJ Weighted Average
Updated Plan of Care for a significant change. For any significant change in Member condition, Member's Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative.	2	2	100.0%	0	0	N/A	2	3	66.7%	10	10	100.0%	0	0	N/A	CNC[1]
Ongoing Care Management																
Member was identified for transfer to HCBS and was offered options, including transfer to the community.	3	3	100.0%	3	3	100.0%	12	12	100.0%	5	5	100.0%	6	6	100.0%	100.0%
Evidence of the **Care Manager's participation in at least one interdisciplinary team (IDT) meeting** during the review period. (Participation in an IDT meeting may be substituted for one Member visit).	93	100	93.0%	36	100	36.0%	18	100	18.0%	30	100	30.0%	64	100	64.0%	48.2%
Member was present at each onsite visit or had involvement from the Member's authorized representative regarding the Plan of Care. (If the Member was not able to	97	100	97.0%	100	100	100.0%	97	100	97.0%	100	100	100.0%	96	100	96.0%	98.0%

Category for Measurement Period July 1, 2023, to June 30, 2024	ABHNJ N	ABHNJ D	ABHNJ Rate	FC/WCHP N	FC/WCHP D	FC/WCHP Rate	HNJH N	HNJH D	HNJH Rate	UHCCP N	UHCCP D	UHCCP Rate	WPNJ N	WPNJ D	WPNJ Rate	NJ Weighted Average
participate in an onsitevisit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable).																
Timely onsite review of Member placement and services. Onsite visits were timely and occurred within at least 180 calendar days for non-pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability).	44	97	45.4%	86	99	86.9%	89	100	89.0%	66	90	73.3%	62	96	64.6%	72.0%
Members requiring coordination of care had coordination of care by the Care Manager.	2	2	100%	0	0	N/A	1	1	100%	35	35	100.0%	0	0	N/A	CNC[1]
Reassessment of the Plan of Care and Critical Incident Reporting																
Member had a NJCA completed during the review period.	94	97	96.9%	95	98	96.9%	100	100	100.0%	94	95	98.9%	97	97	100.0%	98.6%
Plan of Care was updated, reviewed, and signed by the Member and/or	96	96	100.0%	95	100	95.0%	99	100	99.0%	85	99	85.9%	82	100	82.0%	92.3%

Category for Measurement Period July 1, 2023, to June 30, 2024	ABHNJ N	ABHNJ D	ABHNJ Rate	FC/WCHP N	FC/WCHP D	FC/WCHP Rate	HNJH N	HNJH D	HNJH Rate	UHCCP N	UHCCP D	UHCCP Rate	WPNJ N	WPNJ D	WPNJ Rate	NJ Weighted Average
representative, and a copy was provided to the Member and/or representative.																
Care Manager reviewed the Member's rights and responsibilities.	97	100	97.0%	100	100	100.0%	100	100	100.0%	99	100	99.0%	100	100	100.0%	99.2%
Care Manager educated the Member on how to file a grievance and/or an appeal.	96	100	96.0%	99	100	99.0%	100	100	100.0%	74	100	74.0%	100	100	100.0%	93.8%
Member and/or representative had **training on how to report a critical incident**, specifically including how to identify abuse, neglect and exploitation.	94	100	94.0%	99	100	99.0%	100	100	100.0%	74	100	74.0%	100	100	100.0%	93.4%
PASRR Communications for Transitions to NF/SCNF																
Care Manager completed or confirmed PASRR Level I prior to Member transition to NF/SCNF.	10	10	100.0%	1	1	100.0%	2	2	100.0%	17	19	89.5%	5	5	100.0%	94.6%
Communication of PASRR Level I to OCCO documented by the Care Manager in the NJCA.	10	10	100.0%	1	1	100.0%	2	2	100.0%	16	17	94.1%	5	5	100.0%	97.1%
Care Manager completed or confirmed PASRR Level II, prior to Member transition to NF/SCNF.	2	2	100.0%	0	0	N/A	0	0	N/A	1	2	50.0%	0	0	N/A	CNC[1]

Category for Measurement Period July 1, 2023, to June 30, 2024	ABHNJ N	ABHNJ D	ABHNJ Rate	FC/WCHP N	FC/WCHP D	FC/WCHP Rate	HNJH N	HNJH D	HNJH Rate	UHCCP N	UHCCP D	UHCCP Rate	WPNJ N	WPNJ D	WPNJ Rate	NJ Weighted Average
Communication of PASRR Level II to OCCO documented by the Care Manager (within 1 business day of receipt of determination).	1	2	50.0%	0	0	N/A	0	0	N/A	1	1	100.0%	0	0	N/A	CNC[1]
Members who had a PASRR Level II indicating a need for Specialized Services setting had coordination with DDD/DMAHS.	0	0	N/A	0	0	N/A	0	0	N/A	0	0	N/A	0	0	N/A	CNC[1]
Transitions to HCBS																
Member had a Person-Centered Transition plan on file.	0	0	N/A	1	1	100.0%	2	2	100.0%	0	0	N/A	1	1	100.0%	CNC[1]
Cost effectiveness evaluation was completed for the Member prior to discharge from a NF/SCNF.	0	0	N/A	0	1	0.0%	1	2	50.0%	0	0	N/A	0	1	0.0%	CNC[1]
Plan of Care updated prior to discharge from a facility. Plan of Care was developed and agreed upon by the Member and/or representative prior to the effective date of transfer to the community.	0	0	N/A	0	1	0.0%	1	2	50.0%	0	0	N/A	1	1	100.0%	CNC[1]
Participation in an interdisciplinary team (IDT) meeting related to transition. Care Manager participated in the	0	0	N/A	1	1	100.0%	2	2	100.0%	0	0	N/A	1	1	100.0%	CNC[1]

Category for Measurement Period July 1, 2023, to June 30, 2024	ABHNJ N	ABHNJ D	ABHNJ Rate	FC/WCHP N	FC/WCHP D	FC/WCHP Rate	HNJH N	HNJH D	HNJH Rate	UHCCP N	UHCCP D	UHCCP Rate	WPNJ N	WPNJ D	WPNJ Rate	NJ Weighted Average
coordination of an IDT meeting related to transition planning.																
Authorizations and procurement of transitional services for the Member were done prior to NF/SCNF transfer.	0	0	N/A	1	1	100.0%	2	2	100.0%	0	0	N/A	1	1	100.0%	CNC[1]
Care Manager conducted a **face-to-face visit within 10 business days following a NF/SCNF discharge to the community.**	0	0	N/A	1	1	100.0%	2	2	100.0%	0	0	N/A	1	1	100.0%	CNC[1]
Services initiated upon NF/SCNF discharge were according to the Member's Plan of Care.	0	0	N/A	1	1	100.0%	2	2	100.0%	0	0	N/A	1	1	100.0%	CNC[1]
Transitions to NF/SCNF																
Care Manager determined during the reassessment process that changes in placement or services were indicated, and a **discussion with the Member occurred prior to the change in service/placement.**	3	3	100.0%	0	0	N/A	1	1	100.0%	5	5	100.0%	2	2	100.0%	CNC[1]

[1] CNC: for the NJ weighted average to be calculated, a compliance rate must be determined for each review element across all managed care organizations (MCOs). N/A: not applicable; there were no Members who met criteria to evaluate compliance with the review element.

Results of MLTSS NF Performance Measures

The expansion of the NF/SCNF audit components included evaluation of MLTSS PMs. Population-specific findings are presented in **Table 48**, which include results for the following five MLTSS PMs: #8 (Plans of Care established within 45 days of MLTSS enrollment), #9 (Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination), #9a (Plan of Care for MLTSS Members amended based on change of Member condition), #11 (Plans of Care for MLTSS Members are developed using Person-Centered Principles), and #16 (MCO provided training to MLTSS Member on identifying/reporting Critical Incidents).

Table 49: Results of MLTSS Performance Measures –July 1, 2023, to June 30, 2024

Performance Measures July 1, 2023, to June 30, 2024	ABHNJ N	ABHNJ D	ABHNJ Rate	FC/WCHP N	FC/WCHP D	FC/WCHP Rate	HNJH N	HNJH D	HNJH Rate	UHCCP N	UHCCP D	UHCCP Rate	WPNJ N	WPNJ D	WPNJ Rate	NJ Weighted Average
#8. Plans of Care established within 45 days of MLTSS enrollment.[1]	4	5	80.0%	6	6	100.0%	1	1	100.0%	9	13	69.2%	3	4	75.0%	79.3%
#9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination.[2]	86	87	98.9%	87	90	96.7%	97	99	98.0%	70	80	87.5%	93	93	100.0%	96.4%
#9a. Plan of Care for MLTSS Members amended based on change of Member condition.[3]	2	2	100.0%	0	0	N/A	2	3	66.7%	10	10	100.0%	0	0	N/A	CNC[5]
#11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles."[4]	96	96	100.0%	100	100	100.0%	100	100	100.0%	98	99	99.0%	100	100	100.0%	99.8%
#16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents.	94	100	94.0%	99	100	99.0%	100	100	100.0%	74	100	74.0%	100	100	100.0%	93.4%

[1] Compliance with this measure includes completion of the Initial Plan of Care, Member signature, and a copy provided to the Member within 45 calendar days of the MLTSS enrollment date. The denominator includes all NF/SCNF Members new to MLTSS and/or new to the MCO during the review period.

[2] Members included in this measure (denominator) have an annual LOC re-determination that was due and completed during the review period and a Plan of Care on file.

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

[4] For compliance with this measure Members must have a Plan of Care on file during the review period that contains documentation 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 be addressed in the Plan of Care.
N/A: Not Applicable. Fidelis Care and Wellpoint had no Members that met criteria for evaluation of PM #9a, therefore the compliance rate was unable to be determined.
[5] CNC: For the NJ Weighted Average to be calculated, a compliance rate must be determined for each Performance Measure across all MCOs.

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

ABHNJ's MLTSS NF/SCNF Audit Results

Overall, ABHNJ scored 86% or above in the following review elements (Table 47):

- Member's Care Management record contained copies of any Facility Plans of Care on file during the review period. (86.0%)
- Documented review of the Facility Plan of Care by the Care Manager. (97.7%)
- MLTSS Plan of Care on file includes information from the Facility Plan of Care. (96.0%)
- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems, and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process. (100.0%)
- Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this). (100.0%)
- Member's agreement/disagreement with the Plan of Care statements were documented on the Member's Plan of Care and maintained in the Member's electronic CM record. (100.0%)
- Member was identified for transfer to HCBS and was offered options, including transfer to the community. (100.0%)
- Evidence of the Care Manager's participation in at least one interdisciplinary team (IDT) meeting during the review period. (93.0%)
- Member was present at each onsite visit or had involvement from the Member's authorized representative regarding the Plan of Care. (If the Member was not able to participate in an onsite visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable). (97.0%)
- Members requiring coordination of care had coordination of care by the Care Manager. (100.0%)
- Member had a NJCA completed during the review period. (96.9%)
- Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative. (100.0%)
- Care Manager reviewed the Member's rights and responsibilities. (97.0%)
- Care Manager educated the Member on how to file a grievance and/or an appeal. (96.0%)
- Care Manager completed or confirmed PASRR Level I prior to Member transition to NF/SCNF. (100.0%)
- Communication of PASRR Level I to OCCO documented by the Care Manager in the NJCA. (100.0%)
- Care Manager completed or confirmed PASRR Level II, prior to Member transition to NF/SCNF. (100.0%)

ABHNJ's opportunities for improvement for review elements scored below 86% exist in the following elements (Table 47):

- Timely onsite review of Member placement and services. Onsite visits were timely and occurred within at least 180 calendar days for non-pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability). (45.4 %)
- Communication of PASRR Level II to OCCO documented by the Care Manager (within 1 business day of receipt of determination). (50.0%)

Overall, ABHNJ scored 86% or above in the following MLTSS PMs (Table 48):

- PM #9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination. (98.9%)
- PM #9a. Plan of Care for MLTSS Members amended based on change of Member condition. (100.0%)
- PM #11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles." (100.0%)
- PM #16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents. (94.0%)

ABHNJ's opportunities for improvement for scores below 86% exist for the following MLTSS PMs (Table 48):

- PM #8. Plan of Care established within 45 days of MLTSS enrollment. (80.0%)

FC/WCHP's MLTSS NF/SCNF Audit Results

Overall, FC/WCHP scored 86% or above in the following review elements (Table 47):

- Member's Care Management record contained copies of any Facility Plans of Care on file during the review period. (89.0%)
- Documented review of the Facility Plan of Care by the Care Manager. (100.0%)
- MLTSS Plan of Care on file includes information from the Facility Plan of Care. (100.0%)
- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems, and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process. (100.0%)
- Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this). (100.0%)
- Member's agreement/disagreement with the Plan of Care statements were documented on the Member's Plan of Care and maintained in the Member's electronic CM record. (98.0%)
- Member was identified for transfer to HCBS and was offered options, including transfer to the community. (100.0%)
- Member was present at each onsite visit or had involvement from the Member's authorized representative regarding the Plan of Care. (If the Member was not able to participate in an onsite visit for reasons such as not applicable). (100.0%)
- Timely onsite review of Member placement and services. Onsite visits were timely and occurred within at least 180 calendar days for non-pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability). (86.9%)
- Member had a NJCA completed during the review period. (96.9%)
- Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative. (95.0%)
- Care Manager reviewed the Member's rights and responsibilities. (100.0%)
- Care Manager educated the Member on how to file a grievance and/or an appeal. (99.0%)
- Care Manager completed or confirmed PASRR Level I prior to Member transition to NF/SCNF. (100.0%)
- Communication of PASRR Level I to OCCO documented by the Care Manager in the NJCA. (100.0%)

FC/WCHP's opportunities for improvement for review elements scored below 86% exist in the following elements (Table 47):

- Evidence of the Care Manager's participation in at least one interdisciplinary team (IDT) meeting during the review period. (36.0%)

Overall, FC/WCHP scored 86% or above in the following MLTSS PMs (Table 48):

- PM #8. Plans of Care established within 45 days of MLTSS enrollment. (100.0%)
- PM #9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination. (96.7%)
- PM #11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles." (100.0%)
- PM #16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents. (99.0%)

FC/WCHP's opportunities for improvement for scores below 86% exist for the following MLTSS PMs (Table 48):

- None

HNJH's MLTSS NF/SCNF Audit Results

Overall, HNJH scored 86% or above in the following review elements (Table 47):

- Documented review of the Facility Plan of Care by the Care Manager. (100.0%)
- MLTSS Plan of Care on file includes information from the Facility Plan of Care. (100.0%)
- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems, and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process. (100.0%)
- Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this). (100.0%)
- Member's agreement/disagreement with the Plan of Care statements were documented on the Member's Plan of Care and maintained in the Member's electronic CM record. (100.0%)
- Member was identified for transfer to HCBS and was offered options, including transfer to the community. (100.0%)
- Member was present at each onsite visit or had involvement from the Member's authorized representative regarding the Plan of Care. (If the Member was not able to participate in an onsite visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable). (97.0%)
- Timely onsite review of Member placement and services. Onsite visits were timely and occurred within at least 180 calendar days for non-pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability). (89.0%)
- Members requiring coordination of care had coordination of care by the Care Manager. (100.0%)
- Member had a NJCA completed during the review period. (100.0%)
- Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative. (99.0%)
- Care Manager reviewed the Member's rights and responsibilities. (100.0%)
- Care Manager educated the Member on how to file a grievance and/or an appeal. (100.0%)

- Care Manager completed or confirmed PASRR Level I prior to Member transition to NF/SCNF. (100.0%)
- Communication of PASRR Level I to OCCO documented by the Care Manager in the NJCA. (100.0%)

HNJH's opportunities for improvement for review elements scored below 86% exist in the following elements (Table 47):
- Member's Care Management record contained copies of any Facility Plans of Care on file during the review period. (82.0%)
- Evidence of the Care Manager's participation in at least one interdisciplinary team (IDT) meeting during the review period. (18.0%)

Overall, HNJH scored 86% or above in the following MLTSS PMs (Table 48):
- PM #8. Plans of Care established within 45 days of MLTSS enrollment. (100.0%)
- PM #9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination. (98.0%)
- PM #11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles." (100.0%)
- PM #16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents. (100.0%)

HNJH's opportunities for improvement for scores below 86% exist for the following MLTSS PMs (Table 48):
- PM #9a. Member's Plan of Care is amended based on change of Member condition. (66.7%)

UHCCP's MLTSS NF/SCNF Audit Results

Overall, UHCCP scored 86% or above in the following review elements (Table 47):
- Documented review of the Facility Plan of Care by the Care Manager. (98.8%)
- MLTSS Plan of Care on file includes information from the Facility Plan of Care. (99.0%)
- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems, and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process. (100.0%)
- Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this). (100.0%)
- Member's agreement/disagreement with the Plan of Care statements were documented on the Member's Plan of Care and maintained in the Member's electronic CM record. (97.0%)
- Member was identified for transfer to HCBS and was offered options, including transfer to the community. (100.0%)
- Member was present at each onsite visit or had involvement from the Member's authorized representative regarding the Plan of Care. (If the Member was not able to participate in an onsite visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable). (100.0%)
- Members requiring coordination of care had coordination of care by the Care Manager. (100.0%)
- Member had a NJCA completed during the review period. (98.9%)
- Care Manager reviewed the Member's rights and responsibilities. (99.0%)
- Care Manager completed or confirmed PASRR Level I prior to Member transition to NF/SCNF. (89.5%)
- Communication of PASRR Level I to OCCO documented by the Care Manager in the NJCA. (94.1%)

- Communication of PASRR Level II to OCCO documented by Care Manager (within 1 business day of receipt of determination. (100.0%)

UHCCP's opportunities for improvement for review elements scored below 86% exist in the following elements (Table 47):

- Member's Care Management record contained copies of any Facility Plans of Care on file during the review period. (82.0%)
- Evidence of the Care Manager's participation in at least one interdisciplinary team (IDT) meeting during the review period. (30.0%)
- Timely onsite review of Member placement and services. Onsite visits were timely and occurred within at least 180 calendar days for non-pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability). (73.3%)
- Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative. (85.9%)
- Care Manager educated the Member on how to file a grievance and/or an appeal. (74.0%)
- Care Manager completed or confirmed PASRR Level II, prior to Member transition to NF/SCNF. (50.0%)

Overall, UHCCP scored 86% or above in the following MLTSS PMs (Table 48):

- PM #9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination. (87.5%)
- PM #9a. Plan of Care for MLTSS Members amended based on change of Member condition. (100.0%)
- PM #11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles." (99.0%)

UHCCP opportunities for improvement for scores below 86% exist for the following MLTSS PMs (Table 48):

- PM #8. Plans of Care established within 45 days of MLTSS enrollment. (69.2%)
- PM #16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents. (74.0%)

WPNJ's MLTSS NF/SCNF Audit Results

Overall, WPNJ scored 86% or above in the following review elements (Table 47):

- Member's Care Management record contained copies of any Facility Plans of Care on file during the review period. (96.0%)
- Documented review of the Facility Plan of Care by the Care Manager. (100.0%)
- MLTSS Plan of Care on file includes information from the Facility Plan of Care. (100.0%)
- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems, and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process. (100.0%)
- Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this). (100.0%)
- Member's agreement/disagreement with the Plan of Care statements were documented on the Member's Plan of Care and maintained in the Member's electronic CM record. (100.0%)
- Member was identified for transfer to HCBS and was offered options, including transfer to the community. (100.0%)

- Member was present at each onsite visit or had involvement from the Member's authorized representative regarding the Plan of Care. (If the Member was not able to participate in an onsite visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable). (96.0%)
- Member had a NJCA completed during the review period. (100.0%)
- Care Manager reviewed the Member's rights and responsibilities. (100.0%)
- Care Manager educated the Member on how to file a grievance and/or an appeal. (100.0%)
- Care Manager completed or confirmed PASRR Level I prior to Member transition to NF/SCNF. (100.0%)
- Communication of PASRR Level I to OCCO documented by the Care Manager in the NJCA. (100.0%)

WPNJ's opportunities for improvement for review elements scored below 86% exist in the following elements (Table 47):

- Evidence of the Care Manager's participation in at least one interdisciplinary team (IDT) meeting during the review period. (64.0%)
- Timely onsite review of Member placement and services. Onsite visits were timely and occurred within at least 180 calendar days for non-pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability). (64.6%)
- Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative. (82.0%)

Overall, WPNJ scored 86% or above in the following MLTSS PMs (Table 48):

- PM #9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination. (100.0%)
- PM #11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles." (100.0%)
- PM #16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents. (100.0%

WPNJ's opportunities for improvement for scores below 86% exist for the following MLTSS PMs (Table 48):

- PM #8 Plans of Care established within 45 days of MLTSS enrollment. (75.0%)

2024 MLTSS HCBS Care Management Audits

The purpose of the MLTSS CM audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, DMAHS established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community Based Services (HCBS) and Institutionalization for Long-Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), were consistent with professionally recognized standards of care. HHS declared an end to the PHE for COVID-19 on May 11, 2023. The state issued COVID-19 flexibilities related to specific MLTSS CM activities ended prior to this review period (July 1, 2023–June 30, 2024), except for the NJ DHS DoAS, *Temporary Waiver of Clinical Eligibility Requirements for MLTSS Enrollment for MCO Members in a Community Setting*. Effective July 5, 2023**,** the use of the SCS as presumptive eligibility was discontinued.

The populations included in this audit were members who met eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or CARS for at least 6 consecutive months within the review period from July 1, 2023, to June 30, 2024.

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

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the NJ FamilyCare Contracts (Article 9), dated July 2023 and January 2024 (**Table 49**). A representative sample of files were selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities, and post-audit activities.

Table 50: Sampling Methodology

Subpopulations	Criteria
Group C: Members New to Managed Care and Newly Eligible for MLTSS between 7/1/2023 and 6/30/2024.	• The Member must have been initially enrolled in MLTSS HCBS between 7/1/2023 and 1/1/2024. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2024 in the *same* MCO with no gaps in enrollment.
Group D: Current Medicaid Managed Care Members enrolled in MLTSS between 7/1/2023 and 6/30/2024.	• The Member must have been initially enrolled in MLTSS HCBS between 7/1/2023 and 1/1/2024. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2024 in the *same* MCO with no gaps in enrollment. • On the first day of the month prior to the initial MLTSS HCBS enrollment, the Member was enrolled in the *same* Medicaid MCO as the MLTSS HCBS MCO.
Group E: Current Medicaid Managed Care Members enrolled in MLTSS prior to 7/1/2023 and continuously enrolled in MLTSS through 6/30/2024.	• The Member must have been initially enrolled in MLTSS HCBS prior to 7/1/2023. • The Member must have remained enrolled in MLTSS HCBS through 6/30/2024 in the *same* MCO with no gaps in enrollment.

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

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

MLTSS HCBS subpopulations were identified depending on different enrollment criteria. A stratified methodology was used to randomly select 100 MLTSS HCBS members across subgroups C and D, and 30 MLTSS HCBS members in subgroup E as a base sample. A 20% oversample across subgroups C and D, and subgroup E was drawn for substitution of exclusions.

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

All MLTSS HCBS members were included if there were fewer than 100 members across subgroups C and D, or fewer than 30 members in subgroup E. Members could only be excluded by the MCO if they could provide evidence that the member did not meet eligibility requirements. An oversample was selected for the MCO to replace any excluded files, as well as ensure an adequate denominator to evaluate PMs.

Planning

IPRO and DMAHS discussed the proposed audit methodology, necessary source documents, contract references, and DoAS, Office of Community Choice Options (OCCO) new contract requirements for MLTSS CM. Effective November 15, 2023, as part of the NJ Choice Assessment system, MCOs are required to complete a NJ specific options counseling summary (OCS) form, whereas the interim plan of care (IPOC) was no longer contractually required.

As directed by DMAHS, the audit methodology was revised to include an enhancement to MLTSS PM #9a (Plan of Care for MLTSS Members amended based on change of Member condition). IPRO utilized the State-produced (NJ Choice Assessment Data) list of MLTSS HCBS members across all MCOs derived from the NJ Choice Assessment data reason for assessment code; 3-Return assessment (assessment conducted upon return from hospital due to significant change in condition); 4-Significant change in status reassessment (exclude significant change due to hospital stay); and 5-Discharge assessment, covers last 3 days of service (existing MLTSS member who appears to no longer meet NF LOC).

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

Population Selection

The sample was determined by using the following capitation codes to identify MLTSS HCBS enrollment presented and applying the sampling methodology described in **Table 50**.

Table 51: MLTSS Capitation Codes

Capitation Code	Description
89399	MLTSS Eligible Without Medicare – HCBS
79399	MLTSS Eligible With Medicare – HCBS

MLTSS: managed long-term services and supports; HCBS: home and community-based services.

MLTSS HCBS Results by Category

Table 51 presents a summary based on file reviews of the MCOs' performance. Based on the audit tool, there were six categories of review elements: Assessment, Member Outreach, Face-to-Face Visits, Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans), Ongoing Care Management, and Gaps in Care/Critical Incidents. The results of individual review elements under each topic were calculated and combined to produce a compliance score for each category.

Rates for each subpopulation and a combined score calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 51**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

Table 52: 2024 MLTSS HCBS Results by Category

Determination by Category 7/1/2023–6/30/2024[1]	ABHNJ Group C	ABHNJ Group D	ABHNJ Group E	ABHNJ Total	FC/WCHP Group C	FC/WCHP Group D	FC/WCHP Group E	FC/WCHP Total	HNJH Group C	HNJH Group D	HNJH Group E	HNJH Total	UHCCP Group C	UHCCP Group D	UHCCP Group E	UHCCP Total	WPNJ Group C	WPNJ Group D	WPNJ Group E	WPNJ Total	NJ Weighted Average[2]
Assessment	100.0%	97.9%	100.0%	99.0%	100.0%	99.0%	96.4%	98.5%	100.0%	97.6%	100.0%	99.0%	98.0%	90.4%	96.6%	94.2%	100.0%	100.0%	98.3%	99.5%	98.0%
Member Outreach[3]	100.0%	90.0%		95.0%	90.9%	96.4%		94.0%	82.0%	68.0%		75.0%	46.0%	38.0%		42.0%	95.8%	84.6%		90.0%	79.2%
Face-to-Face Visits	84.7%	90.2%	86.2%	87.2%	98.9%	100.0%	96.2%	98.8%	96.4%	98.0%	93.5%	96.4%	95.8%	94.1%	98.2%	95.7%	98.1%	98.2%	99.1%	98.4%	95.3%
Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans)[4]	98.8%	97.8%	97.1%	97.9%	99.8%	99.4%	98.0%	99.2%	96.4%	96.4%	95.6%	96.2%	92.9%	91.9%	95.5%	93.2%	98.1%	96.8%	99.8%	98.0%	96.9%
Ongoing Care Management	83.8%	86.8%	83.0%	84.8%	95.4%	99.0%	89.9%	96.0%	86.9%	90.5%	82.2%	87.4%	73.3%	69.4%	55.6%	68.3%	84.4%	79.9%	72.0%	79.6%	83.2%
Gaps in Care/Critical Incidents	98.8%	100.0%	93.2%	97.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.8%	95.0%	91.4%	95.4%	100.0%	96.1%	100.0%	98.4%	98.3%

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

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

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

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

The following MCOs scored **86% or above** at the total level, for all applicable MLTSS subpopulations for the following categories (**Table 51**):

- Assessment: ABHNJ, FC/WCHP, HNJH, UHCCP, and WPNJ.
- Member Outreach: ABHNJ, FC/WCHP, and WPNJ.
- Face-to-Face Visits: ABHNJ, FC/WCHP, HNJH, UHCCP, and WPNJ.
- Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans): ABHNJ, FC/WCHP, HNJH, UHCCP, and WPNJ.
- Ongoing Care Management: FC/WCHP and HNJH.
- Gaps in Care/Critical Incidents: ABHNJ, FC/WCHP, HNJH, UHCCP, and WPNJ.

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

- Member Outreach: HNJH and UHCCP.
- Ongoing Care Management: ABHNJ, UHCCP, and WPNJ.

Strengths and Opportunities for Improvement

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

ABHNJ

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

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

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

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

FC/WCHP

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

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

No opportunities for improvement were noted for this review period.

HNJH

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

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

- Ongoing Care Management (Group C, D and Combined)
- Gaps in Care/Critical Incidents (Groups C, D, E and Combined)

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

UHCCP

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

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

WPNJ

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

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

2024 MLTSS HCBS Performance Measures Findings

In review of this year's NJ weighted average scores that include all three MLTSS subpopulations (July 1, 2023–June 30, 2024), among all five MCOs, the results ranged from 45.0% to 100.0% across all seven MLTSS PMs **(Table 52)**.

Table 53: 2024 MLTSS HCBS Performance Measures Results

Performance Measure for Review Period July 1, 2023, to June 30, 2024	Group[1]	ABHNJ	FC/WCHP	HNJH	UHCCP	WPNJ	NJ Weighted Average[6]
#8. Plans of Care established within 45 days of MLTSS enrollment.	C	96.0%	100.0%	92.0%	50.0%	81.2%	83.5%
	D	94.0%	98.2%	96.0%	40.0%	82.7%	82.6%
	E[4]	N/A	N/A	N/A	N/A	N/A	N/A
	TOTAL	95.0%	99.0%	94.0%	45.0%	82.0%	83.0%
#9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination.	C[5]	N/A	N/A	N/A	N/A	N/A	N/A
	D[5]	N/A	N/A	N/A	N/A	N/A	N/A
	E	100.0%	96.3%	86.7%	82.8%	96.7%	92.4%
	TOTAL	100.0%	96.3%	86.7%	82.8%	96.7%	92.4%
#9a. Plan of Care for MLTSS Members amended based on change in Member condition.[2]	C	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	D	100.0%	100.0%	100.0%	83.3%	87.5%	94.3%
	E	100.0%	100.0%	100.0%	50.0%	100.0%	91.7%
	TOTAL	100.0%	100.0%	100.0%	69.2%	95.0%	94.5%
#10. Plans of Care for MLTSS Members are aligned with Member needs identified during the NJ Choice Assessment.	C	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	D	100.0%	100.0%	100.0%	100.0%	98.0%	99.6%
	E	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	TOTAL	100.0%	100.0%	100.0%	100.0%	99.2%	99.8%
#11. Plans of Care for MLTSS Members are developed using “Person-Centered Principles.”	C	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	D	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	E	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	TOTAL	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
#12. MLTSS Home and Community Based Services (HCBS) Plans of Care that include a Back-up Plan.[3]	C	100.0%	100.0%	93.1%	93.5%	97.1%	96.8%
	D	100.0%	100.0%	98.0%	95.7%	96.1%	98.0%
	E	92.6%	100.0%	95.2%	92.9%	100.0%	96.3%
	TOTAL	98.1%	100.0%	96.0%	94.3%	97.4%	97.2%
#16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents.	C	98.0%	100.0%	100.0%	98.0%	100.0%	99.2%
	D	100.0%	100.0%	100.0%	94.0%	96.2%	98.1%
	E	93.3%	100.0%	100.0%	86.7%	100.0%	96.0%
	TOTAL	97.7%	100.0%	100.0%	93.8%	98.5%	98.0%

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

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

[3] Members in community alternative residential settings (CARS) are excluded from this measure.
[4] Group E members are excluded from this measure as they are not new to MLTSS.
[5] Members who have not been enrolled in MLTSS for at least one year are excluded from this measure.
[6] The weighted average is the sum of all compliant charts (numerator) divided by the sum of all charts (denominator) and includes all three subpopulations.
N/A: not applicable; there were no Members who met the criteria for this measure.

The following MCOs scored ***86% or above*** at the total level, for all applicable MLTSS subpopulations for the following MLTSS PMs (**Table 52**):

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

The following MCOs scored ***below 86%*** at the total level, for all applicable MLTSS subpopulations for the following MLTSS PMs (**Table 52**):

- **PM #8.** Plans of Care established within 45 days of MLTSS enrollment: United and Wellpoint.
- **PM #9.** Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination: United.
- **PM #9a.** Plan of Care for MLTSS Members amended based on change of Member condition: United.

2024 MLTSS Care Management and Continuity of Care Annual Assessment

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

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

Assessment Methodology

The review consisted of a pre-offsite review of documentation provided by the five MCOs, as evidence of compliance of the standards under review; interviews with key MCO staff (held remotely in December 2024), and a post-audit evaluation of additional documentation provided by the MCOs were also reviewed.

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

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

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

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

This review category also examines whether the MCO has developed and implemented MLTSS CM programs for enrollees who may benefit from these services in accordance with State requirements. The rating scale for Met and Not Met elements is presented in **Table 53**.

Table 54: Rating Scale for the MCO MLTSS Annual Assessment Review of Care Management

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

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

There were 10 contractual provisions in the 2024 MLTSS CM category. **Table 54** presents the total compliance scores, which were 100% for all five MCOs.

Table 55: Compliance Scores for the 2024 MLTSS Care Management and Continuity of Care Annual Assessment Elements

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

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

Table 55 presents the summary of findings for each element reviewed during the 2024 MLTSS Annual Assessment Care Management Audit.

Table 56: Summary of Findings for 2024 MLTSS Care Management and Continuity of Care Audit

2024 Annual Assessment CM Element[1]	ABHNJ	FC/WCHP	HNJH	UHCCP	WPNJ
CM18b	X	X	X	X	X
CM28	X	X	X	X	X
CM29	X	X	X	X	X
CM30	X	X	X	X	X
CM31	X	X	X	X	X
CM32	X	X	X	X	X
CM34	X	X	X	X	X
CM36	X	X	X	X	X
CM37	X	X	X	X	X
CM38	X	X	X	X	X
Total Elements = 10	**10**	**10**	**10**	**10**	**10**
Compliance Percentage	**100%**	**100%**	**100%**	**100%**	**100%**

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

No deficiencies were identified in the MLTSS 2024 Care Management and Continuity of Care Annual Assessment Review **(Table 55)**.

MCO Responses to the Previous EQR Recommendations

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

ABHNJ Response to Previous EQR Recommendations

Table 56 displays ABHNJ's progress related to the *State of New Jersey DMAHS, Aetna Better Health of New Jersey Annual External Quality Review Technical Report FINAL REPORT: April 2024,* as well as IPRO's assessment of ABHNJ's response.

Table 57: ABHNJ Response to Previous EQR Recommendations

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
The MCO should continue to address pediatric specialist access in the identified counties by pursuing contracts with applicable providers.	ABHNJ network team continues to apply various recruitment strategies aimed at identifying pediatric specialists in deficient counties. Ongoing research through Quest analytics tool, Medi find, Healthgrades, NJMMIS, NPPES sites via Google search. ABHNJ has remediated pediatric gaps in the following counties Bergen, Hudson, Mercer, Monmouth, Ocean, Passaic, Sussex, and Warren. However, ABHNJ will continue to work on closing gaps in other counties, the plan has had barriers in closing gaps in south jersey due to challenges in pediatric specialty groups and children's hospitals. The network team will continue to document and track all outreach efforts, barriers, and opportunities to improve gap closure.	Addressed
The MCO should continue to address hospital access in Warren County by finalizing negotiations with St. Luke's Hospital.	ABHNJ has since remediated this via contracting with St Luke's hospital thereby closing this hospital access in Warren County.	Addressed
The MCO should continue to focus on improving specialist – urgent care, behavioral health, and OB/GYN at-risk appointment availability and PCP after-hours availability.	ABHNJ 2023 resurvey of Accessibility and After-Hours studies showed improvement in Ob/Gyn appointment types which exceeded the 90% threshold, and no re-contact was needed. For afterhours care, upon re-contact, all providers are compliant (100%). Among total specialists re-contacted, all exceeded goal for afterhours care as well as wait time in office. (100%). Urgent care and non-urgent care remain below goal. Among Cardiology and Oncology re-contacted, most exceed goal (100%), except for non-urgent care (Cardiology) and urgent care (Oncology). For behavioral health among those re-contacted, Prescribers exceed the goal for urgent and after-hours care. Scores remain below goal for wait time among Prescribers, after	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	hours care for Non-Prescribers and Social Workers, and non-life threating care for Social Workers. For those specialists were the scores that did not meet the goal, letters will be mailed to each failed provider advising of requirements.	
The MCO should update its Member Handbook and/or Member Disenrollment policy to list the specific good cause reasons for member disenrollment requests.	ABHNJ Member Disenrollment Policy has been updated to include contract language to specify good cause reason for member disenrollment requests. Re-education was provided to ensure ABHNJ remains compliant with this requirement.	Addressed
The MCO should update its Member Rights and Responsibilities policy to specifically address that it does not discriminate based on creed, religion, ancestry, marital status, sexual orientation, or gender identity.	ABHNJ Member Rights and Responsibilities Policy has been updated to address that the plan does not discriminate based on creed, religion, ancestry, marital status, sexual orientation, or gender identity. Re-education was provided to ensure ABHNJ remains compliant with this requirement.	Addressed
The MCO should update its Member Disenrollment/ Disruptive Member Transfer policy to specifically address situations when the enrollee is out of State for care provided/authorized by the Contractor, full-time students, or Clients of DCP&P who are temporarily residing in a state adjacent to New Jersey but are still in the custody of DCP&P.	ABHNJ Member Disenrollment/Disruptive and Member Transfer Policies have been updated to address situations when the member is out of State for care provided/authorized by the Contractor, full-time students, or Clients of DCP&P who are temporarily residing in a state adjacent to New Jersey but are still in the custody of DCP&P. Re-education was provided to ensure ABHNJ remains compliant with this requirement.	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
The MCO should update its Member Disenrollment/Disruptive Member Transfer policy to specifically address instances when the MLTSS member declines to consent to care management services.	ABHNJ Member Disenrollment/Disruptive policy has been updated specifically to address instances when the MLTSS member declines to consent to care management services. Re-education as provided to ensure ABHNJ remains compliant with this requirement.	Addressed
The MCO should ensure its processes and policies include the review of performance indicators, utilization management statistics, member grievances, and critical incidents during the re-credentialing process.	ABHNJ Recredentialing policy has been updated to indicate that review of performance indicators, utilization management statistics, member grievances, and critical incidents at the time of re-credentialing. In addition, a re-education on policy and process has been completed to ensure compliance with this requirement.	Addressed
For MLTSS member appeals, the MCO should ensure that the correct information is in the resolution letter and resolution letters are timely.	Appeals and Grievance team has developed a standard process which includes timely closure of appeals. Part of oversight includes the internal audit team conducting sample cases to provide feedback to analyst and to confirm the correct information is in resolution letters before being mailed.	Addressed
Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, ABHNJ should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their	ABHNJ demonstrated improvement in MY2022 and achieved 3.5 Star Rating by NCQA. ABHNJ submitted a 2023 HEDIS Workplan to the State for review which included a barrier analysis and interventions to address each measure that fell below the NCQA 50th percentile. An interdisciplinary HEDIS workgroup continues to meet monthly to monitor rate improvement and update the workplan on a quarterly basis. An increase in member outreach includes holding clinical events at PCP offices and the community in targeted areas with identified disparity. ABHNJ continues to work with targeted provider groups to improve member outcomes by Quality Management and Population Health Specialists by frequently meeting with providers, reviewing medical records, claims data, and member rosters to identify opportunities for improvement	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
respective benchmarks for more than one reporting period.	specific to each practice. The Plan continues to collect medical record data year-round to improve results.	
The MCO should continue to work to improve Adult and Child CAHPS scores that perform below the 50th percentile.	ABHNJ submitted a 2023 CAHPS Workplan to the State for review which includes a barrier analysis and interventions to address each composite and measure that fell below the NCQA 50th percentile. Plan Leadership continued to meet monthly to discuss and monitor interventions through an interdisciplinary CAHPS workgroup. Beginning in 2024, the Plan will realign meetings to create smaller, more frequent departmental meetings to monitor and evaluate interventions. The Plan sent a CAHPS informational postcard to all members prior to the 2024 survey to increase participation and will implement a CAHPS SMS txt campaign in 2025 as an additional reminder. The Plan continues to administer a Pre-CAHPS (mock) survey via IVR to identify actionable results related to provider groups and/or geographical areas, and outreaches to providers to discuss practice specific barriers and opportunities for improvement. In 2024, members enrolled in ICM who complete the Pre-CAHPS survey with unfavorable results will be outreached by their Care Manager for additional assistance and education on appointment standards. In addition, the Plan continues Leadership call listening sessions with member services to identify opportunities for improvement and has begun to hold meetings with Call Center leadership to provide NJ specific training to Call Center Staff serving ABHNJ members. In 2024 the Plan will implement call listening session to review provider calls and identify additional opportunities for improvement.	Addressed
ABHNJ should address the deficiencies noted in the Core Medicaid - 2023 CM Review in the following areas: General Population: Identification, Preventive Services, and all CM element specific deficiencies noted in the review.	**CM2: ABHNJ should ensure that for Enrollees who are hospitalized, adequate discharge planning is performed.** Care manager will complete Discharge planning for ICM members who are hospitalized. ICM manager will review Inpatient alerts to manager timely Discharge planning and post discharge outreach. **CM3- For New and Existing Enrollees, ABHNJ should ensure that they appropriately identify Enrollees with potential CM needs.** Identification GP-ABHNJ uses a Core 2.0 stratification process which allows for Identification of member with multiple health needs for new and existing enrollees.	Remains an opportunity for improvement

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
• **CM2:** ABHNJ should ensure that for Enrollees who are hospitalized, adequate discharge planning is performed. • **CM3:** For New and Existing Enrollees, ABHNJ should ensure that they appropriately identify Enrollees with potential CM needs. • **CM6:** ABHNJ should ensure that the IHS was completed for the Enrollee within 45 days of Enrollment (applies to New Enrollees only), and when the initial outreach for the IHS was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment (applies to New Enrollees only). • **CM7:** ABHNJ should ensure the	**CM6- ABHNJ should ensure that the IHS was completed for the Enrollee within 45 days of Enrollment (applies to New Enrollees only), and when the initial outreach for the IHS was unsuccessful, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment (applies to New Enrollees only).** Initial Health Screening (I.H.S) score is used to identify members with case management needs. Staffing was increased to outreach new GP enrollees to complete a I.H.S within 45 days of enrollment. Evaluation outreach timeframes to allow more time to get ahold of members. Re-education on pre-call research. **CM7- ABHNJ should ensure the Comprehensive Needs Assessment is completed timely, within 30 days following an IHS score of 5 or greater.** CM staff will attempt to outreach members for a C.N.A within 30 days of the I.H.S. To determine compliance with timeliness, ABHNJ will conduct internal audits. Staff was re-educated on the escalation process for UTR DCPP population. New CM dashboard to track C.N.A timeliness. All new DDD and DCPP members will have aggressive outreach to complete a C.N.A within 45 day or enrollment. **CM-11-DCPP ABHNJ should ensure that the Care Plan is updated upon a change in the Enrollee's care needs or circumstances.** Care Plans will be developed with all components Short /long term goals, care manager will review compliance dashboard to view care plan timeliness. Staff receive ongoing education on care plan development and revision. **CM14-ABHNJ should ensure that Enrollee's (aged 0 through 20) EPSDT exam is up to date per periodicity exam schedule, and status is confirmed by a reliable source. ABHNJ should ensure that appropriate vaccines are administered for Enrollees (aged 19 and above. ABHNJ should ensure that a dental visit occurs during the review period for Enrollees (aged 1 through 20).** Preventive Services for GP Members, all staff have been reeducated on how to verify preventative screening using claims or provider verification. Staff will complete provider	

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
Comprehensive Needs Assessment is completed timely, within 30 days following an IHS score of 5 or greater. • **CM11:** DCPP ABHNJ should ensure that the Care Plan is updated upon a change in the Enrollee's care needs or circumstances. • **CM14:** ABHNJ should ensure that Enrollee's (aged 0 through 20) EPSDT exam is up to date per periodicity exam schedule, and status is confirmed by a reliable source. ABHNJ should ensure that appropriate vaccines are administered for Enrollees (aged 19 and above. ABHNJ should ensure that a dental visit occurs during the review period for Enrollees (aged 1 through 20). • **CM15:** ABHNJ should ensure	outreach to verify preventative using aggressive outreach if the provider is not available on the 1st call. Staff will encourage members to complete preventative screenings and immunizations. ICM staff will verify Liberty Dental claims and give members dental reminders. Lead reminder will be sent to members under 6 and caregivers. Staff are required to ensure that the Enrollee's immunization are up to date for Enrollees aged 0-18) and the status is confirmed by a reliable source. Staff will ensure Enrollee's 0-20 EPSDT exam is up to date and will be verified by a reliable source. Staff will provide EPSDT reminder to members and caregivers Staff should ensure appropriate vaccines are administered for enrollees (aged 19 and above). Staff will verify claims from Liberty Dental, QNXT or other reliable sources. Staff will complete provider outreach to verify preventative/immunizations using aggressive outreach if the provider is not available on the 1st call. Dental reminders will be given for members 1-20, staff will verify dental claims using the Liberty Dental portal and mail dental reminder letters. **CM15: ABHNJ should ensure that for Enrollees demonstrating needs requiring a treatment plan, the Enrollee is given a comprehensive treatment plan to address the Enrollee's specific needs.** For enrollees demonstrating a treatment plan staff will verify and collaborate with the member and the provider about the treatment plan and add goals to the members care plan. **CM17: For Enrollees who are given a treatment plan, ABHNJ should ensure that the treatment plan progresses in a timely manner without unreasonable interruption.** Staff will coordinate with internal departments UM/MLTSS. CM will verify treatment plan has started and escalate UM authorization issues that prevent interruption in care.	

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
that for Enrollees demonstrating needs requiring a treatment plan, the Enrollee is given a comprehensive treatment plan to address the Enrollee's specific needs. • **CM17:** For Enrollees who are given a treatment plan, ABHNJ should ensure that the treatment plan progresses in a timely manner without unreasonable interruption.		
ABHNJ should address the deficiencies noted in the Core Medicaid - 2023 CM Review in the following areas: DDD: Preventive Services, and all CM element specific deficiencies noted in the review. • **DDD-CM 14:** ABHNJ should ensure that Enrollee's (aged 0 through 20) EPSDT exam is up to date per periodicity exam schedule, status is confirmed by a	**DDD-CM 14-A BHNJ should ensure that Enrollee's (aged 0 through 20) EPSDT exam is up to date per periodicity exam schedule, status is confirmed by a reliable source, and the Care Manager sent EPSDT reminders. ABHNJ should ensure that the Enrollee's immunizations are up to date for Enrollees (aged 0 through 18), and immunization status is confirmed by a reliable source. ABHNJ should ensure that the appropriate vaccines have been administered for Enrollees (aged 19 and above). For Enrollees (aged 1 through 20), ABHNJ should ensure that a dental visit occurs during the review period, and dental reminders are sent. ABHNJ should ensure that lead screening reminders are sent to all Enrollees (aged 9 months to 72 months).** The care management team will collaborate with provider/care team to verify the members preventative services. Special needs members are referred to Liberty Dental CM for assistance with getting specialized dental services. Case manager address and educate caregivers on importance of preventative screening. If the member	Remains an opportunity for improvement

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
reliable source, and the Care Manager sent EPSDT reminders. ABHNJ should ensure that the Enrollee's immunizations are up to date for Enrollees (aged 0 through 18), and immunization status is confirmed by a reliable source. ABHNJ should ensure that the appropriate vaccines have been administered for Enrollees (aged 19 and above). For Enrollees (aged 1 through 20), ABHNJ should ensure that a dental visit occurs during the review period, and dental reminders are sent. ABHNJ should ensure that lead screening reminders are sent to all Enrollees (aged 9 months to 72 months).	needs providers CM will link member to providers and resources. Staff provides EPSDT reminder to members and caregivers. Staff will verify claims from Liberty Dental, QNXT or other reliable sources staff will outreach. Manager will review charts and send dental reminder letter with each quarterly contact. Dental reminder will be given or mailed the members with missed dental visits. Lead reminder will be sent to members and caregivers for members (9mo-72mo). Staff will complete provider outreach to verify preventative using aggressive outreach if the provider is not available on the 1st call. Care Plans will be developed with all components Short /long term goals, manager will review compliance dashboard to view care plan timeliness. Staff will have ongoing education on care plan development and revision. Care plans will be updated and revised on an ongoing basis based on needs or circumstances.	
ABHNJ should address the deficiencies noted in the Core Medicaid - 2023 CM Review in the following areas:	**CM7: ABHNJ should ensure the Comprehensive Needs Assessment is completed timely (within 45 days of the Enrollee's enrollment).** All new DDD and DCPP members will have aggressive outreach to complete a C.N.A within 45 day or enrollment.	Remains an opportunity for improvement

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
DCP&P: Preventive Services, and all CM element specific deficiencies noted in the review. • **CM7:** ABHNJ should ensure the Comprehensive Needs Assessment is completed timely (within 45 days of the Enrollee's enrollment). • **CM8:** ABHNJ should ensure the Enrollee's completed Care Plan includes all required components. • **CM11:** ABHNJ should ensure that the Care Plan is updated upon a change in the Enrollee's care needs or circumstances. • **CM14**: ABHNJ should ensure the Enrollee's (aged 0 through 20) EPSDT exam is up to date per periodicity exam schedule, status is confirmed by a reliable source, and the Care Manager sends EPSDT reminders. ABHNJ should	UTR DCPP are assigned to clinical staff for immediate outreach and file review to complete the C.N.A within 45 day of enrollment. UTR member are escalated to the DCPP CHU nurse and supervisor. Re-education of staff on timeliness of the C.N.A, manager use of a C.N.A dashboard to track timely outreach. **CM8: ABHNJ should ensure the Enrollee's completed Care Plan includes all required components**. **CM11: ABHNJ should ensure that the Care Plan is updated upon a change in the Enrollee's care needs or circumstances**. Care Plans will be developed with all components Short /long term goals, Manger will review compliance dashboard to view care plan timeliness. Staff will have ongoing education on care plan development and revision. Further, to monitor compliance to care plan update and revision. **CM14: ABHNJ should ensure the Enrollee's (aged 0 through 20) EPSDT exam is up to date per periodicity exam schedule, status is confirmed by a reliable source, and the Care Manager sends EPSDT reminders. ABHNJ should ensure that the Enrollee's immunizations are up to date for Enrollees (aged 0 through 18), and immunization status is confirmed by a reliable source. For Enrollees (aged 1 through 20), ABHNJ should ensure a dental visit occurs during the review period and dental reminders are sent. ABHNJ should ensure that lead screening reminders are sent to all Enrollees (aged 9 months to 72 months).** ABHNJ Care Management team has collaborated with DCP&P nurse and resource parents. The case manager links with the resource parents to ensure that members EPSDT exams are updated. Care Mangers have also been reeducated on the importance of process. In addition, the team provides EPSDT reminders to members and caregivers. The team will verify dental claims from Liberty Dental, QNXT or other reliable sources. Staff will outreach and collaborate with providers and DCP&P nurse on health needs. Manager meet with Liberty Dental monthly. ICM members under 6 will have a lead reminder call/letter.	

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
ensure that the Enrollee's immunizations are up to date for Enrollees (aged 0 through 18), and immunization status is confirmed by a reliable source. For Enrollees (aged 1 through 20), ABHNJ should ensure a dental visit occurs during the review period and dental reminders are sent. ABHNJ should ensure that lead screening reminders are sent to all Enrollees (aged 9 months to 72 months).	improvements, manual chart reviews were conducted, and findings were discussed with Care managers.	
ABHNJ should address the deficiencies noted in the MLTSS – HCBS 2023 CM Review for elements within groups that scored below 86%.	1. PACE Flyer was added to the MLTSS welcome packet, which is provided to members during initial, annual, and significant change visits. PACE must be reviewed with member and indicated on the Options Counseling Summary Form **IPRO Recommendations: Face to Face Visits or Telephonic Monitoring** Group C: ABHNJ should ensure that PACE is discussed with the Member during Options Counseling and that a cost-effective analysis (CEA) is completed during the review period. Group D: ABHNJ should ensure that PACE is discussed with the Member during Options Counseling. Group E: ABHNJ should ensure that PACE is discussed with the Member during Options Counseling, the Interim Plan of Care (IPOC) is completed and signed, and that a cost-effective analysis (CEA) is completed during the review period.	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	MCO Response: 1. 100% of NJCA are reviewed internally prior to submission to OCCO. Reviewer will ensure the PACE is offered via OCS and members are provided this option 2. MLTSS Leadership meets with ABH Audit Team to review monthly file audits and identified trends. MLTSS Leadership implements intervention for staff who score below 90% via an individualized retraining and feedback on performance. Additional training may be scheduled with the Clinical Trainer as needed. The Supervisor will schedule a field observation with the CM as appropriate. For sustained results below 90%, CM may receive formal remediation. **IPRO Recommendations: Ongoing Care Management** Group C: ABHNJ should ensure that the Member has MLTSS services in place timely, within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45-calendar day standard). ABHNJ should ensure that the Member has a documented face-to-face/telephonic visit to review Member placement and services during the review period, that is held within the appropriate timeframes (An ongoing face- to-face/telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit). ABHNJ should ensure that for Member files that indicate a change from the initial Plan of Care has documentation that the Member's Plan of Care was updated and/or reviewed, Member agrees with the Plan of Care, Member signed/verbally acknowledged and is provided with a copy of the Plan of Care. ABHNJ should ensure that for Members who are discharged to an HCBS setting, the onsite review occurs timely, within 10 days of discharge. ABHNJ should ensure that for Plans of Care that have been reviewed and amended due to a significant change, the Care Manager obtains Member/authorized representative's signature and/or verbal acknowledgement. Group E: ABHNJ should ensure that the Member has a documented face-to-face/telephonic visit to review placement and services during the review period that is held within the appropriate timeframes (An ongoing face-to-face/telephonic visit to review Member placement and services should occur at least every 90 days for Members	

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	in the community setting and at least every 180 days for Members in CARS from the date of the initial visit). MCO Response: 1. MLTSS Leadership meets with ABH Audit Team to review monthly file audits and identified trends. MLTSS Leadership implements intervention for staff who score below 90% via an individualized retraining and feedback on performance. Additional training may be scheduled with the Clinical Trainer as needed. The Supervisor will schedule a field observation with the CM as appropriate. For sustained results below 90%, CM may receive formal remediation. Supervisors utilize data to ensure that initial visits are scheduled on CM calendar within 30 calendar days of enrollment unless member-directed otherwise. Leadership reviews and ensures any member going past 30 days is scheduled/ completed by day 45 and for members unable to be seen (such as members inpatient), documentation and follow up is present. If initial members were not seen face to face timely, the cause is reviewed and if not member-driven, CM received reeducation. Trends in non-compliance may result in formal remediation 2. Supervisors utilize data to ensure that visits "coming due" are scheduled on CM calendar within 90/180 days of previous visit (dependent on setting) unless member-directed otherwise. If members were not seen face to face timely, the cause is reviewed and if not member-driven, CM received reeducation. Trends in non-compliance may result in formal remediation 3. Supervisors utilize data to ensure number of visits and care plans reviewed align, any discrepancies are investigated and reviewed to ensure all visits received a care plan update as required 4. Supervisors review inpatient alerts that trigger in the ABH system based on claims data with the CM during regularly scheduled 1:1 meeting. In review of those inpatient reports, Supervisor will review with the CM the scheduled date for face-to-face review with member and that it is scheduled within 10 days. For Transition members: the HCBS case manager is identified prior to member transition from the NF (when notice is provided to ABH). ABH facilitates a biweekly NF Transition Workgroup in which the Supervisor continually reviews data to ensure transitions are completed in accordance with the contract. Supervisor ensures post discharge visit to occur timely and any barriers or member-direction is documented clearly.	

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	5. Monthly, MLTSS Leadership reviews the number of significant changes NJCA completed and addresses trends; reviewed with CM to monitor that POC were updated with the NJC **IPRO Recommendations: Gap in Care/Critical Incidents** Group E: For Members receiving MLTSS services (excludes Members residing in CARS), ABHNJ should ensure the Care Manager reviews the process for immediately reporting gaps in service delivery and the Member's rights and responsibilities under the MLTSS program; including the procedures for filing a grievance and/or an appeal and how to report a critical incident. MCO Response: 1. Monthly, MLTSS Leadership meets with ABH Audit Team to review monthly file audits and identified trends. MLTSS Leadership implements intervention for staff who score below 90% via an individualized retraining and feedback on performance. Additional training may be scheduled with the Clinical Trainer as needed. The Supervisor will schedule a field observation with the CM as appropriate. For sustained results below 90%, CM may receive formal remediation **IPRO Recommendations: Performance Measure 8** Group C: ABHNJ should ensure that Plans of Care are signed/verbally acknowledged by the Member and/or authorized representative, and a copy is provided to the Member and/or authorized representative within 45 days of MLTSS enrollment. 1. MLTSS Leadership meets with ABH Audit Team to review monthly file audits and identified trends. MLTSS Leadership implements intervention for staff who score below 90% via an individualized retraining and feedback on performance. Additional training may be scheduled with the Clinical Trainer as needed. The Supervisor will schedule a field observation with the CM as appropriate. For sustained results below 90%, CM may receive formal remediation. 2. Supervisors utilize data to ensure that initial visits are scheduled on CM calendar within 30 calendar days of enrollment unless member-directed otherwise. Leadership reviews and ensures any member going past 30 days is scheduled/ completed by day 45 and for members unable to be seen (such as members inpatient), documentation and follow up is present. If initial members were not seen face to face timely, the cause is	

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	reviewed and if not member-driven, CM received reeducation. Trends in non-compliance may result in formal remediation **IPRO Recommendations: Performance Measure 9a** Group C: ABHNJ should ensure that an amended Plan of Care is signed by the Member and/or authorized representative. MCO Response: 1. MLTSS Leadership meets with ABH Audit Team to review monthly file audits and identified trends. MLTSS Leadership implements intervention for staff who score below 90% via an individualized retraining and feedback on performance. Additional training may be scheduled with the Clinical Trainer as needed. The Supervisor will schedule a field observation with the CM as appropriate. During field observation, Supervisor will assess if CM attempts to obtain signatures and provide coaching opportunities. For sustained results below 90%, CM may receive formal remediation. IPRO Recommendations: Performance Measure 11 Group E: ABHNJ should ensure the Member's Plan of Care developed using "Person-Centered Principles" is signed/verbally acknowledged by the Member and/or authorized representative. MCO Response: 1. Monthly, MLTSS Leadership meets with ABH Audit Team to review monthly file audits and identified trends. MLTSS Leadership implements intervention for staff who score below 90% via an individualized retraining and feedback on performance. Additional training may be scheduled with the Clinical Trainer as needed. The Supervisor will schedule a field observation with the CM as appropriate. For sustained results below 90%, CM may receive formal remediation. **IPRO Recommendations: Performance Measure 11** Group E: ABHNJ should ensure the Member's Plan of Care developed using "Person-Centered Principles" is signed/verbally acknowledged by the Member and/or authorized representative. MCO Response: 1. On 8/1/23, ABHNJ MLTSS implemented a new template for progress notes to meet NCQA requirements. This template is more robust and requires the CM to add more detail than was previously required to comprehensively evaluate the members' needs. It also	

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	requires more detailed input regarding the CM's assessment of specific factors including using a person-centered approach regarding the Member's assessment and needs, taking into account not only covered services, but also formal and informal support services. 2. Care managers are required to use a person-centered approach with members utilizing their assessment and needs IPRO Recommendations: Performance Measure 12 Group E: ABHNJ should ensure that MLTSS HCBS Plans of Care include a completed Back-up Plan signed by the Member and/or authorized representative. MCO Response: 1. Face to face visit workflows updated to indicate that CM must add to task for subsequent visit to print and bring to member any signatures not obtained at prior visit 2. MLTSS Supervisors review CM task lists during 1:1. 1:1 template was updated to require the CM to demonstrate to Supervisor a recently completed visit; if signatures were not obtained during the visit, the CM is required to have a task for self to obtain the signature at the subsequent face to face visit. If signature/ task is not present, CM is reeducated. Trends in non-compliance may result in formal remediation **IPRO Recommendations: Performance Measure 16** Group E: ABHNJ should ensure that the Care Manager provides training to MLTSS Members on identifying/reporting Critical Incidents. MCO Response: 1. On 8/1/23, ABHNJ MLTSS implemented a new template for progress notes to meet NCQA requirements. This template is more robust and requires the CM to add more detail than was previously required to comprehensively evaluate the members' needs. It also requires more detailed input regarding the CM's assessment of specific factors including reviewing the importance of reporting fraud/ waste/ abuse/ exploitation, how to report critical incidents, and to contact 911 for any situation that poses immediate threat to member's life/safety.	
ABHNJ should address all deficiencies noted in the MLTSS – NF/SCNF	**Facility and MCO Plan of Care** **IPRO Recommendation:**	Addressed

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
2023 CM Review for elements that scored below 86%.	Member's Care Management record contained copies of any Facility Plans of Care on file during the review period (79%) MCO Response: 1. MLTSS Initial Outreach Job Aid was updated to indicate that CMA must follow up on requested documents after 48 hours. 2. Reeducation with Authorization team to ensure required documentation is included with the PA request in order to process authorization. If support staff are faced with challenge in receiving documentation, escalation to Support team Supervisor **MLTSS Initial Plan of Care and Ongoing Plans of Care** **IPRO Recommendation:** Aetna's MLTSS Care Managers should ensure that the Member's care management record contains a copy of the Facility Plan of Care during the review period, ensure the Member's individualized Plan of Care was developed in collaboration with the Member and a copy is mailed to the Member within forty-five (45) calendar days of MLTSS enrollment MCO Response: 1. ABHNJ requires initial visits to be completed within 30 calendar days of enrollment 2. MLTSS Supervisors monitor Dashboard weekly for compliance of timeliness of initial visits 3. ABHNJ requires POC Letter to be mailed to member within 1 business day of the face-to-face visit 4. ABHNJ developed a compliance report: MLTSS Manager analyzes data weekly and reviews with each Supervisor to ensure CM remain timely with visits 5. ABHNJ enhanced process for geo-mapping to assign members to CMs based on proximity to CM's to reduce travel time. ABHNJ also implemented placement-based assignments (Facility Teams and Community Teams) to allow CMs to hone their expertise for those respective demographics. 6. ABHNJ reviewed NF workflows to optimize efficiency and reduce time required to complete documentation to allow for increased visit productivity in an attempt to improve compliance timeliness. **IPRO Recommendation:** Care Managers should utilize a person-centered approach when assessing the Member's needs and in the development of the care plan, addressing both formal and informal supports and services. MCO Response:	

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	1. On 8/1/23, ABHNJ MLTSS implemented a new template for progress notes to meet NCQA requirements. This template is more robust and requires the CM to add more detail than was previously required to comprehensively evaluate the members' needs. It also requires more detailed input regarding the CM's assessment of specific factors including using a person-centered approach regarding the Member's assessment and needs, taking into account not only covered services, but also formal and informal support services. 2. Care managers are required to use a person-centered approach with members utilizing their assessment and needs. **IPRO Recommendation:** Care Managers should utilize a person-centered approach when assessing the Member's needs and in the development of the care plan, addressing both formal and informal supports and services. MCO Response: 1. On 8/1/23, ABHNJ MLTSS implemented a new template for progress notes to meet NCQA requirements. This template is more robust and requires the CM to add more detail than was previously required to comprehensively evaluate the members' needs. It also requires more detailed input regarding the CM's assessment of specific factors including using a person-centered approach regarding the Member's assessment and needs, taking into account not only covered services, but also formal and informal support services. 2. Care managers are required to document member's informal supports in the member POC. **IPRO Recommendation:** Care Managers should ensure Member goals, developed during the Plan of Care process, are built on Member's identified needs, strengths, support systems, and include measures to achieve their goals, and ensure the Member's agreement/disagreement with Plan of Care statements are documented in the file. MCO Response: 1. Goals must be written in member-centric language and outline expectations in a manner member can understand. Care managers are required to amend care plan letters to identify services that are members are authorized for in plain language and goals are documented in member's own words.	

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	IPRO Recommendation: Care Managers should ensure Member goals, developed during the Plan of Care process, are built on Member's identified needs, strengths, support systems, and include measures to achieve their goals, and ensure the Member's agreement/disagreement with Plan of Care statements are documented in the file. MCO Response: 1. MLTSS Supervisors monitor Dashboard weekly for compliance of timeliness of visits 2. ABHNJ developed a compliance report: MLTSS Manager analyzes data weekly and reviews with each Supervisor to ensure CM remain timely with visits 3. On 8/1/23, ABHNJ MLTSS implemented a new template for progress notes to meet NCQA requirements. This template is more robust and requires the CM to add more detail than was previously required in order to comprehensively evaluate the members' needs. It also requires more detailed input regarding the CM's assessment of specific factors including documenting progress and barriers toward member goals. **IPRO Recommendation:** Care Managers should ensure Member goals, developed during the Plan of Care process, are built on Member's identified needs, strengths, support systems, and include measures to achieve their goals, and ensure the Member's agreement/disagreement with Plan of Care statements are documented in the file. MCO Response: 1. MLTSS Supervisors review CM task lists during 1:1. 1:1 template was updated to require the CM to demonstrate to Supervisor a recently completed visit; if signatures were not obtained during the visit, the CM is required to have a task for self to obtain the signature at the subsequent face to face visit. If signature/ task is not present, CM is reeducated. Trends in non-compliance may result in formal remediation 2. Reeducation to care management team to task their Support Team CMA to obtain signature on documents if not collected during face-to-face visit 3. ABHNJ enhanced process for geomapping to assign members to CMs based on proximity to CM's to reduce travel time. ABHNJ also implemented placement-based assignments (Facility Teams and Community Teams) to allow CMs to hone their expertise for those respective demographics. 4. ABHNJ reviewed NF workflows to optimize efficiency and reduce time required to complete documentation to	

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	allow for increased visit productivity in an attempt to improve compliance timeliness. **Transition Planning** **IPRO Recommendation:** Care Managers should identify Members for transfer to HCBS and offer options including transfer to the community. MCO Response: 1. Members options counseling is captured by the Options Counseling (Interim Plan of Care), which is completed at initial, annual, and significant change visits. NJCA are reviewed at 100% and are reviewed to confirm members are offered opportunity to transition. 2. Biannual progress note template was updated requiring CM to document provision of options counseling and community transition during interval visits. **IPRO Recommendation:** Care Managers should participate in at least one Interdisciplinary Team meeting during the review period. MCO Response: 1. MLTSS Supervisors review IDT completion/ requirements during 1:1. 1:1 template was updated- Supervisor is to provide CM a copy of the IDT report and review progress towards completing overdue IDT and scheduling upcoming IDT. If progress is not made, CM is reeducated. Trends in non-compliance may result in formal remediation. 2. MLTSS Supervisors process and review a report weekly that indicates IDT not held within 365 days (overdue and upcoming). CM who are noncompliant with visit timeliness are required to submit a written compliance plan at minimum every 3 weeks to indicate the members upcoming and overdue and the date the visit will be completed; IDT data is added to this plan. 3. ABHNJ developed a compliance report: MLTSS Manager analyzes data weekly and reviews with each Supervisor to ensure CM remain timely with visits. **IPRO Recommendation**: Care Managers should ensure the Member is present at each onsite/telephonic visit or have involvement from the Member's authorized representative regarding the Plan of Care. MCO Response: 1. ABHNJ MLTSS implemented a new template for progress notes to meet NCQA requirements. This template is more robust and requires the CM to add more detail than was	

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	previously required to comprehensively evaluate the members' needs. It also requires more detailed input regarding the CM's assessment of specific factors including details of the members ability to participate in the visit IPRO Recommendation: Care Managers should ensure onsite/telephonic visits are timely and occurred within at least 180 calendar days for non-pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members. MCO Response: 1. MLTSS Supervisors monitor Dashboard weekly for compliance of timeliness of visits 2. ABHNJ developed a compliance report: MLTSS Manager analyzes data weekly and reviews with each Supervisor to ensure CM remain timely with visits 3. CM are required to see members timely in accordance with the contract 4. ABHNJ enhanced process for geo-mapping to assign members to CMs based on proximity to CM's to reduce travel time. ABHNJ also implemented placement-based assignments (Facility Teams and Community Teams) to allow CMs to hone their expertise for those respective demographics. 5. ABHNJ reviewed NF workflows to optimize efficiency and reduce time required to complete documentation to allow for increased visit productivity in an attempt to improve compliance timeliness. **IPRO Recommendation:** Care Managers should explain and discuss any payment liability relating to the Member's NF/SCNF admission (if applicable). MCO Response: 1. On 8/1/23, ABHNJ MLTSS implemented a new template for progress notes to meet NCQA requirements. This template is more robust and requires the CM to add more detail than was previously required in order to comprehensively evaluate the members' needs. It also requires more detailed input regarding the CM's assessment of specific factors including explaining and discussing any payment liability. **Reassessment of the Plan of Care and Critical Incident Reporting** **IPRO Recommendation:** Care Managers should ensure NJCA is completed to assess the Member upon any of the following conditions: significant changes in Member	

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	condition, prior to a discharge from NF/SCNF, permanent change in living arrangement, or annual re-assessment. MCO Response: 1. MLTSS Supervisors monitor Dashboard weekly for compliance of timeliness of annual NJCA completion 2. ABHNJ developed a compliance report: MLTSS Manager analyzes data weekly and reviews with each Supervisor to ensure CM remain timely with visits 3. ABHNJ implemented an NF Transition Workgroup. During the workgroup, members discharging from NF/SCNF are discussed and reviewed 4. Significant change NJCA are monitored monthly for overall completion. **IPRO Recommendation:** Care Managers should ensure that the Plan of Care is updated, reviewed, and signed by the Member and/or representative and a copy is provided to the Member and/or representative. MCO Response: 1. MLTSS Supervisors review CM task lists during 1:1. 1:1 template was updated to require the CM to demonstrate to Supervisor a recently completed visit; if signatures were not obtained during the visit, the CM is required to have a task for self to obtain the signature at the subsequent face to face visit. If signature/ task is not present, CM is reeducated. Trends in non-compliance may result in formal remediation 2. Reeducation to care management team to task their Support Team CMA to obtain signature on documents if not collected during face-to-face visit. **IPRO Recommendation:** Care Managers should review the Member's Rights and Responsibilities under the MLTSS program. MCO Response: 1. MLTSS Supervisors review CM task lists during 1:1. 1:1 template was updated to require the CM to demonstrate to Supervisor a recently completed visit; if signatures were not obtained during the visit, the CM is required to have a task for self to obtain the signature at the subsequent face to face visit. If signature/ task is not present, CM is reeducated. Trends in non-compliance may result in formal remediation 2. Reeducation to care management team to task their Support Team CMA to obtain signature on documents if not collected during face-to-face visit	

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	3. On 8/1/23, ABHNJ MLTSS implemented a new template for progress notes to meet NCQA requirements. This template is more robust and requires the CM to add more detail than was previously required in order to comprehensively evaluate the members' needs. It also requires more detailed input regarding the CM's assessment of specific factors including reviewing MLTSS helpful phone numbers, member rights & responsibilities, the process to file an appeal & rights to fair hearings 4. MLTSS Supervisors monitor Dashboard weekly for compliance of timeliness of visits 5. ABHNJ developed a compliance report: MLTSS Manager analyzes data weekly and reviews with each Supervisor to ensure CM remain timely with visits 6. CM who are noncompliant with visit timeliness are required to submit a written compliance plan at minimum every 3 weeks to indicate the members upcoming and overdue and the date the visit will be completed. **IPRO Recommendation:** Care Managers should educate the Member on how to file a grievance and/or an appeal. MCO Response: 1. On 8/1/23, ABHNJ MLTSS implemented a new template for progress notes to meet NCQA requirements. This template is more robust and requires the CM to add more detail than was previously required in order to comprehensively evaluate the members' needs. It also requires more detailed input regarding the CM's assessment of specific factors including reviewing MLTSS helpful phone numbers, member rights & responsibilities, the process to file an appeal & rights to fair hearings. **IPRO Recommendation:** Care Managers should provide Member training on how to identify/report a critical incident, and how to identify abuse, neglect, and exploitation. MCO Response: 1. On 8/1/23, ABHNJ MLTSS implemented a new template for progress notes to meet NCQA requirements. This template is more robust and requires the CM to add more detail than was previously required to comprehensively evaluate the members' needs. It also requires more detailed input regarding the CM's assessment of specific factors including reviewing the importance of reporting fraud/ waste/ abuse/ exploitation, how to report critical incidents, and to contact 911 for any situation that poses immediate threat to member's life/safety.	

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	Performance Measure #8 **IPRO Recommendation:** ABHNJ's MLTSS Care Managers should ensure that the Initial Plan of Care is established within 45 days of enrollment into MLTSS. MCO Response: 1. ABHNJ requires initial visits to be completed within 30 calendar days of enrollment 2. MLTSS Supervisors monitor Dashboard weekly for compliance of timeliness of initial visits 3. ABHNJ developed a compliance report: MLTSS Manager analyzes data weekly and reviews with each Supervisor to ensure CM remain timely with visits 4. ABHNJ enhanced process for geo-mapping to assign members to CMs based on proximity to CM's to reduce travel time. ABHNJ also implemented placement-based assignments (Facility Teams and Community Teams) to allow CMs to hone their expertise for those respective demographics. 5. ABHNJ reviewed NF workflows to optimize efficiency and reduce time required to complete documentation to allow for increased visit productivity to improve compliance timeliness. **Performance Measure #9** **IPRO Recommendation:** ABHNJ's MLTSS Care Managers should review Member's Plan of Care annually within 30 days of the Member's anniversary and as necessary. MCO Response: 1. MLTSS Supervisors monitor Dashboard weekly for compliance of timeliness of annual NJCA completion 2. ABHNJ developed a compliance report: MLTSS Manager analyzes data weekly and reviews with each Supervisor to ensure CM remain timely with visits 3. ABHNJ enhanced process for geo-mapping to assign members to CMs based on proximity to CM's to reduce travel time. ABHNJ also implemented placement-based assignments (Facility Teams and Community Teams) to allow CMs to hone their expertise for those respective demographics. 4. ABHNJ reviewed NF workflows to optimize efficiency and reduce time required to complete documentation to allow for increased visit productivity to improve compliance timeliness. **Performance Measure #11**	

Recommendation for ABHNJ	ABHNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	IPRO Recommendation: ABHNJ's MLTSS Care Managers should develop Member's Plan of Care using "person-centered principles". MCO Response: 1. On 8/1/23, ABHNJ MLTSS implemented a new template for progress notes to meet NCQA requirements. This template is more robust and requires the CM to add more detail than was previously required in order to comprehensively evaluate the members' needs. It also requires more detailed input regarding the CM's assessment of specific factors including using a person-centered approach regarding the Member's assessment and needs; taking into account not only covered services, but also formal and informal support services. 2. Care managers are required to use a person-centered approach with members utilizing their assessment and needs **Performance Measure #16** **IPRO Recommendation**: MLTSS Care Managers should provide Member training on identifying/reporting critical incidents. MCO Response: 1. On 8/1/23, ABHNJ MLTSS implemented a new template for progress notes to meet NCQA requirements. This template is more robust and requires the CM to add more detail than was previously required to comprehensively evaluate the members' needs. It also requires more detailed input regarding the CM's assessment of specific factors including reviewing the importance of reporting fraud/ waste/ abuse/ exploitation, how to report critical incidents, and to contact 911 for any situation that poses immediate threat to member's life/safety.	

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

FC/WCHP Response to Previous EQR Recommendations

Table 57 displays FC/WCHP's progress related to the *State of New Jersey DMAHS, Fidelis Care Annual External Quality Review Technical Report FINAL REPORT: April 2024,* as well as IPRO's assessment of FC/WCHP's response.

Table 58: FC/WCHP Response to Previous EQR Recommendations

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
Fidelis Care should address the MLTSS PIP validation elements that were determined to be not met or partially met.	In review of IPRO's recommendation to address MLTSS PIP validation elements that were determined to be not met or partially me, Fidelis Care implemented activities to define specific data monitoring with clarification to impact performance outcomes to address PIP validation elements. In complete response, the below were addressed: **PIP Topic: Improving Coordination of Care and Ambulatory Follow-up after Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) populations** The MCO should clarify and justify the use of this assisted living facility exclusion. MCO Response: Indicator #1, 30-day follow-up after inpatient discharge for BH diagnosis, the MCO noted an exclusion of members who transition to an assisted living facility post-acute inpatient discharge. Per HEDIS specifications, exclusions appear to be limited to acute and non-acute inpatient. In response to IPRO's feedback, Assisted Living Facility has not been excluded and was incorrectly noted in the methodology section of the proposal. Revisions have been made to remove the reference ALF as part of the exclusion criteria. In response to IPRO's recommendation, "The MCO should review the identified barriers, document potential interventions that may overcome these barriers and what interventions the MCO might address", Fidelis Care identified a number of barriers in the August 2023 update, however the Fishbone Diagram (pg.46) was not updated to reflect each barrier identified. Fidelis Care reviewed the identified barriers and determined the section was erroneously included in the "barrier section" in the August 2023 submission. Fidelis Care included explanations next to each statement as most of the "barriers" listed were actually "limitations" and were updated in the appropriate section of the August 2024 update. No updates were required to the fishbone diagram as a result. **PIP Topic: Improving Early and Periodic Screening Diagnostic and Diagnosis (EPSDT) Well Child Visits and Childhood Immunizations** The MCO lists a number of barriers, however, has not provided interventions to these barriers. Also, the fishbone diagram should be reviewed for potential active	Remains an opportunity for improvement

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	interventions to remedy the barriers noted. Fidelis Care erroneously included in the "barrier section" in the August 2023 submission. Each barrier was accompanied by a description of an action taken to overcome these barriers. These actions are all processes that are already part of the care managers' routine. These processes are already in place and therefore were not added to the fishbone as new interventions. It was noted there were possible integrity issues in capturing vaccine records due to potential providers submitting deprecated procedure codes and/or state vaccination registry utilizing deprecated procedure codes (ex: Hep B 90731). Fidelis Care's mitigation plan for the possible data integrity issue was to map the old or invalid CPT Code that are not within HEDIS guidelines to valid code which results in higher data accuracy. The manager of QI reached out and submitted two tickets to the Data Quality and Interface Specialist at NJIIS and the resolution is still outstanding. The registry also has the up-to-date newborn IDs which had helped account for the lag with the newborn Medicaid IDs.	
The MCO should develop policies and procedures to address requirements of section 1902(kk) provider screening and enrollment, including termination of any provider immediately upon State notification that the provider cannot be enrolled or when the 120-day time period has expired.	In response to IPRO's recommendation, the Network team has reviewed the process in effort to identify opportunities to ensure accountability. Policies are being reviewed to determine if updates are required to existing policies. Currently the plan has policies and procedures in place to address this requirement. Fidelis Care currently has policies and procedures CC. CRED.01 AND CC. CRED.06 in place that outline the process of provider screening to ensure enrollment eligibility which are in alignment with the requirements of section 1902(kk). The credentialing department reviews providers on OIG, ensuring they are eligible per State requirements. Should a provider be identified "not eligible" at any time during the initial Credentialing/enrollment period, re-credentialing, or during the monthly monitoring sweep, the provider will be immediately denied/terminated as outlined in the provider contract. A certified notice is sent to the provider notifying them of the denial or termination.	Addressed
The MCO should continue to address pediatric PCP access in Sussex County by pursuing contracts	In response to IPRO's recommendation to address pediatric PCP access in Sussex County, Fidelis Care monitors the Pediatric Primary Care Provider (PCP) network for compliance to ensure our members have access to care. Geo Access reports are generated and reviewed quarterly. The Network Management team	Remains and opportunity for improvement

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
with applicable providers.	meets daily to review Network Adequacy where targeted providers are identified and sources for lead generation are discussed. In Sussex County, there is a time and distance standard deficiency of 2 in 10 miles and 15 minutes where we are currently at 89.40% adequacy. Fidelis Care has been in negotiations with Advocare, who has providers that would cure this deficiency. On 6/10/2024, the group indicated they would be ready to proceed shortly, and they are aiming to be participating with Fidelis Care in time for open enrollment. Advocare has proposed a rate which Fidelis Care NJ finds unacceptable thus contracting efforts have ceased currently. No additional providers have been identified within the time and distance standards.	
The MCO should continue to address pediatric specialist access in identified counties by pursuing contracts with applicable providers.	In response to IPRO's recommendation, Fidelis Care confirms, in the counties that Fidelis Care is operational, we have the following Pediatric Specialty Gaps: Adolescent Medicine, Child Development, Pediatric Allergy and Immunology, Pediatric Cardiology, Pediatric Endocrinology, Pediatric Gastroenterology, Pediatric Hematology, Pediatric Infectious Disease, Pediatric Nephrology, Neonatology, Pediatric Emergency Medicine, Plastic Surgery, Pediatric Oncology, Pediatric Psychiatry, Pediatric Pulmonary, Pediatric Rheumatology and Pediatric Sleep Medicine. In the Q2 2024 submission Fidelis Care requested waivers for 201 Pediatric Specialty gaps based on inability to locate a Pediatric provider in the geographic area for this specialty after exhausting all resources for the area and time in question. To identify Pediatric Specialty providers, Fidelis Care utilized the following resources: NJMISS, Google Search, Competitors website and the NPI registry. The American Board of Pediatrics website was also reviewed but does not have the ability to search for providers with the board certification. Fidelis Care has been in negotiations with Advocare who have providers that would cure six Pediatric Specialist deficiencies and with CHOP would have providers that would cure forty-five. Both providers have proposed a rate which Fidelis Care finds unacceptable, thus contracting efforts have ceased. They will continue to see our members on a single case agreement basis.	Remains and opportunity for improvement
The MCO should continue to address general dentist access	In response to IPRO's recommendation to address general dentist access in Burlington, Hudson, and Sussex Counties by pursuing contracts with applicable providers, the dental	Addressed

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
in Burlington, Hudson, and Sussex Counties by pursuing contracts with applicable providers.	provider network is monitored for compliance to ensure provider network requirements are met and to assure enrollees access to all benefits covered under the contract. Fidelis Care continues to collaborate with our dental vendor Liberty Dental Plan to increase our network of providers for both General Dentists and other specialties. The Network Management recruitment team evaluates physical access for members with disabilities, and cultural background factors including, but not limited to, ethnicity, country of origin, customs, and documented community outreach activities. Information gathered through these sources are reviewed and analyzed for consideration in increasing our provider network. The Network Management team also works to develop recruitment strategies to ensure the standards for provider to member ratio are compliant with program, state, and federal requirements. Provider to Member ratios are monitored on an ongoing basis by the Provider Relations team with support from their Analysts. These ratios and capacity limits are considered during a variety of activities carried out by the Provider Relations team which includes, but are not limited to, Dental Home assignment, Provider terminations and/or member transfers, recruitment, and network growth activities. Provider recruitment logs are reviewed and monitored monthly as well. When analyzing the entire credentialed dental provider network per county by distance and time, Fidelis Care meets or exceeds the 90% benchmark for dental access in all counties except Hudson at 89.5% for General Dentists by end of Q2 2024. Gaps that are noted when analyzing the active network of existing providers (general dentists, Pedodontists, and oral surgeons) and reviewing those dentists that have less than ten claims or under 600 dollars in spending, additional steps are taken to ensure that these underutilizing providers are still active in network. Providers are required to submit a quarterly provider attestation form and update their office information on the provider portal or through mail. The Liberty Dental provider relations team also places personal calls to about 60 provider offices monthly to encourage outreach to their non-utilizing members.	
The MCO should continue to address hospital access in Burlington County by	In response to IPRO's recommendation regarding hospital access, in Burlington County, Fidelis Care has confirmed all Burlington County Hospitals provide General Acute Care Services and their profile has been updated. We anticipate	Addressed

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
pursuing contracts with applicable providers.	this will cure this gap. We will provide transportation as necessary for members to access in network hospitals with general acute care and will also provide SCA's for any out of network hospital to ensure access for care.	
The MCO should continue to focus on improving behavioral health care provider routine, urgent, and emergency appointment availability.	In response to IPRO's recommendation to focus on improving behavioral health care provider routine, urgent, and emergency appointment availability, Fidelis Care reviewed its process for monitoring the timeliness of access to care within its provider network via Appointment Accessibility and After-Hours telephone surveys per requirements outlined by regulatory agencies, contractual requirements, and/or accrediting bodies. Based on A&A results, the Network Management Manager and Supervisors continue to monitor the A&A activities of the team to ensure that all failed providers are outreached and educated. Fidelis Care continues to have discussions with staff regarding A&A standards at Network team meetings. Access & Availability standards for providers are also outlined in the Provider Manual and discussed during provider visits.	Addressed
The MCO should update its MLTSS Disenrollment Request Step Action document to include written notification requirements for members who decline to consent to clinical eligibility reassessment or face-to-face visits after counseling and a minimum of two contacts to obtain consent.	Based on the IPRO recommendation, Fidelis Care's MLTSS disenrollment step action has been updated to include the following language: Upon notification of refusal to comply with the MLTSS required visits/assessments, the CM will send the member written notification utilizing the Involuntary Disenrollment Notification Letter Template. The member will be given a minimum of ten calendar days to respond to the notification. a. If the member wishes to Voluntarily Withdraw, the CM will follow the Voluntary Withdrawal Disenrollment steps listed above. b. If the member fails to respond to the notification within 10 calendar days, the CM will complete the request for Involuntary Disenrollment.	Addressed
The MCO should ensure MLTSS providers submit an attestation as evidence for conducting criminal background checks as per Contract requirements.	In response to IPRO's recommendation to ensure MLTSS providers submit an attestation as evidence for conducting criminal background checks as per Contract requirements, the plan created an attestation form that has been in place since May 2023, that addresses compliance with N.J.S.A. 45:1-30 et seq., requiring a criminal history background check for every person who possesses a license or certificate as a health care professional as well as a fingerprint based background checks for all Providers and	Addressed

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	their employees who provide face-to-face services to Members, when required by statute or regulation and compliance with 42 Code of Federal Register (CFR) Section 441.301 (c) (4) (5). The plan requires that MLTSS providers submit a signed attestation as part of the credentialing and recredentialing process.	
Provider Grievance Core Medicaid - The MCO should ensure that provider grievance resolution timeliness is met (within 30 days).	In response to IPRO's recommendation to ensure that provider grievance resolution timeliness is met (within 30 days), we have confirmed our State approved policy outlines our resolution timeframe is 45 days. We will continue to monitor the Teams performance and address barriers that prevent timeliness.	Addressed
Provider Appeals Core Medicaid - The MCO should ensure that accurate information is provided for all documentation within the case and a letter of notification is provided in the files.	In response to IPRO's recommendation to ensure that accurate information is provided for all documentation within the case and a letter of notification is provided in the files, the Appeals team confirmed the following is completed: 1. Team refresher trainings on processing appeals and letter verbiage, 2. Review of entire file documentation storage that is used for internal and external audits, 3. Monthly internal quality audits of cases, 4. Real-time updated inventory checks 2x per day, and 5. Development of letter and case notation templates.	Addressed
Provider Grievance MLTSS - The MCO should ensure that provider grievance resolution timeliness is met (within 30 days).	In response to IPRO's recommendation to ensure that provider grievance resolution timeliness is met (within 30 days) Fidelis Care confirmed our approved policy outlines our resolution timeframe is 45 days. We will continue to monitor the Teams performance and address barriers that prevent timeliness.	Addressed
Provider Appeals MLTSS – The MCO should ensure that accurate information is provided for all documentation within the case and a letter of notification is provided in the files.	In response to IPROs recommendation to ensure that accurate information is provided for all documentation within the case and a letter of notification is provided in the files, Fidelis Care confirmed Appeals completes the following to ensure accurate information is provided for the case and letters provided: 1. Team refresher trainings on processing appeals and letter verbiage, 2. Review of entire file documentation storage that is used for internal and external audits, 3. Monthly internal quality audits of cases, 4. Real-time updated inventory checks 2x per day, and	Addressed

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	5. Development of letter and case notation templates.	
Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, WCHP should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.	Fidelis Care's goal is to increase HEDIS ® rates to the NCQA 50th percentile or higher. Plan submits, annually, a quality work plan as per contract and State/IPRO request where clinical performance fell below the NCQA 50th percentile. Planned and ongoing interventions include Fidelis Care conducts quality focused provider education visits to providers/group practices. These visits focus on educating provider/office manager regarding coding and claims submission, review Care Gaps for their members. Provider Toolkits, which includes information on all HEDIS measures, best practices guidelines and medical record documentation guidelines, left behind as a resource. Quality team coordinate efforts to close care gaps, educate providers on the importance of closing care gaps, and assists the provider with care gap reports and missed opportunities, this process includes reviewing a medical record to identify coding deficiencies then re-educating providers/practice manager Fidelis Care also provides a laminated coding sheet with the current codes for the billing staff to ensure claims are processed accurately and timely. Fidelis Care leadership and Quality team monitor visits monthly via QI metric reports. Fidelis Care Preventive Service Outreach (PSO) program to make outbound calls to non-compliant members for various Medicaid measures notifying/educating them of their need for preventive services and assist with setting appointments. In addition, due to the continuous NJ Lead crisis within its water system, the Plan implemented an initiative for lead text message to assist with alerting parent/guardian and education on the importance of testing. Targeted in person Pediatrics Providers visits which will focus on improving, Lead screening, Well Child visits and Child and Adolescent immunizations administration. NJ QI Performance Improvement Team (PIT) Work Group - Weekly Team Meeting to discuss tracking of projects, rate, progress on measures, programs/initiatives, possible community outreach by health educator for focused HEDIS measures. This meeting invite is extended to cross-functional departments within the organization for collaboration on quality initiatives.	Addressed
The MCO should ensure that its FIDE SNP population is included in MY 2023	In response to IPRO's recommendation to ensure that our FIDE SNP population is included in MY 2023 HEDIS, NJ Specific, and Core Set measure reporting, Fidelis Care worked with data analytics team to include FIDE SNP	Addressed

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HEDIS, NJ Specific, and Core Set measure reporting.	population for MY 2023 to be included in HEDIS, NJ Specific, and Core Set measure. We have created a new internal process, which has included identifying roles, responsibilities, and accountabilities and ensures that the data specifications are properly vetted and reviewed.	
The MCO should submit performance measures timely and accurately according to the appropriate Waiver Year Timeline provided.	In response to IPROs recommendation to ensure Fidelis Care submits performance measures timely and accurately according to the appropriate Waiver Year Timeline provided, Fidelis Care has implemented an internal tracking report to ensure performance measures are submitted timely and accurately on or before state deadlines.	Addressed
The MCO should continue to work to improve Adult and Child CAHPS scores that performed below the 50th percentile.	Fidelis Care's goal is to increase Adult and Child CAHPS scores to the NCQA 50th percentile or higher. The work plan is divided into categories for each CAHPS measure identified as not meeting the 50th percentile. Categories include: CAHPS Measure, Current and Previous year rate, Barriers, Interventions, Goals, Monitoring Plan, Responsible Party List, and Updates which include progress metrics toward goals. Planned and ongoing interventions: Fidelis Care has established a monitoring process (CAHPS Customer Service calls) in which recorded customer services calls are analyzed and training opportunities for Customer Service reps are identified. Goal is to improve the quality of care provided to members during inbound customer service calls. Fidelis Care collects data and identifies opportunities of improvement by reviewing all Surveys including the Provider Satisfaction Survey results to help create actionable interventions. Quality Team visits to targeted groups/practitioners for education regarding use of the Provider Portal, Specialist in network, Access, and Availability standards. This information was distributed to practitioners within the network by the Quality Practice Advisors and Provider Relations teams. The Quality Provider toolkit is an easy-to-understand education resource that displays HEDIS, CAHPS/HOS and Quality standards in a nicely packaged, colorful folder for practitioners and their staff to reference. In addition, the document, titled "Coordination of Care" is also included in the Provider toolkit. Phone numbers for Customer Service, Care Management and Community Connection are shared with practitioners and staff to strengthen partnership for member care.	Addressed

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	The CAHPS workgroups to meet regularly and on an ad hoc basis to track the Medicaid CAHPS work plan to discuss progress and outcomes. All provider and member facing teams are now required to complete CAHPS training annually.	
FC/WCHP should address the deficiencies noted in the Core Medicaid - 2023 CM Review in the following areas: General Population: Identification, Preventive Services, and all CM element specific deficiencies noted in the review. • **CM3:** Fidelis Care should ensure that New and Existing Enrollees with potential CM needs are appropriately identified. • **CM6**: Fidelis Care should ensure that for New Enrollees, an IHS is completed within 45 days of enrollment, and aggressive outreach is attempted and documented when initial outreach is unsuccessful, within 45 days of the Enrollee's enrollment. • **CM8:** Fidelis Care should ensure the Care Plan is completed for the	Fidelis Care has addressed the deficiencies noted in the Core Medicaid - 2023 CM Review in the following areas for GP: Identification, Preventive Services, and all CM element specific deficiencies noted in the review. **CM3:** To ensure that New and Existing Enrollees with potential CM needs are appropriately identified, Fidelis Care CM Team: 1. Has restructured CM staffing to meet member needs within the different LOBs. The plan hired 3 FTEs for the Tele Team CM Team. 2. Continues to monitor the CM Case Loads daily for progress towards goals to ensure capacity to accept members with pending CM outreach. (caseload threshold is 75 members with a metric goal of 90 days to address and achieve member goals). 2A. CM Manager continues to review the weekly NON MLTSS Report to identify cases approaching a 90 day threshold. Supervisor sends weekly emails to the team to provide updates on the cases to ensure timeliness. 3. Uses a daily metrics productivity CM Report (a weekly report that is completed for each CM to identify total number of new assessments completed). The CMs are encouraged to onboard 6 new cases per week. 3A. The CM manager sends weekly emails to the team identifying how many new assessments were completed on a weekly basis. 4. Coordinates with BH Team to transfer BH cases with minor medical education needs. This will ensure that the medical CMs open more medical pending cases. 4A. CM sends an email to the BH team to transfer cases with minor medical education needs and act as a SME as needed. **CM6**: To ensure that for New Enrollees, an IHS is completed within 45 days of enrollment, and aggressive outreach is attempted and documented when initial outreach is unsuccessful, within 45 days of the Enrollee's enrollment, Fidelis Care: 1. Revised its process; once members are identified as UTC for NJIHS by the vendor (Eliza), the members will receive	Addressed

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Enrollee and includes all required components. • **CM14:** Fidelis Care should ensure the Enrollee's (aged 0 through 20) EPSDT exam is up to date per periodicity exam schedule, and status is confirmed by a reliable source. • **CM14:** Fidelis Care should ensure immunizations are up to date for Enrollees (aged 0 through 18), immunization status is confirmed by a reliable source, and aggressive outreach attempts are documented to confirm immunization status. • **CM14:** Fidelis Care should ensure for Enrollees (aged 19 and above), appropriate vaccines have been administered and aggressive outreach attempts are documented to confirm immunization status. • **CM14:** For Enrollees (aged 1	an Unable to Contact Letter to call the market CM directly for completion of the IHS. UTC Letters will require state approval. Eliza will send a lead file that will have the wrong #s, disconnected and scrubbed information from the original lead file. This will go to the CTO Operations team. 2. Implemented additional call backs. The process that was in place is not to call members back once the member disconnects the call. The process now includes 2 additional calls for the purpose of engaging the members. The hang up logic went into effect February 2023. Hang-up call results will be treated as Busy/No Answer so we can continue to attempt to contact the member if calling logic is not finished yet. 3. Met with the vendor to begin discussion on the rebranding of the name WellCare to Fidelis began in June 2023. All Eliza communication will need the name change including the caller ID. 3A. (New) Mobile branding added to the Eliza calls. Caller ID will now show Fidelis Care Welcome to Plan and will also have the Fidelis Care logo. 4. CM Outreach Team continues to provide daily outreach status to supervisor with the count of outreaches per member, count of member refusals, count of unable to reach members and the count of members referred to Field Outreach Coordinators. The outreach coordinators are responsible for completing the NJIHS upon successful outreach. 5. Revised a monthly audit tool to track Aggressive outreach. 3 calls on 3 different days at 3 different times. - If the initial outreach attempt is unsuccessful the Care Coordinator proceeds to review service authorizations, medical claims and pharmacy claims for additional member information and the Care Coordinator then completes a 2nd attempt on the 3rd business day. -If the 2nd outreach attempt remains unsuccessful the Care Coordinator will complete the 3rd attempt on the next business day. - If the Care Coordinator locates an additional contact number for the Member, the 3 outreach attempts within 7 business days restarts. - A minimum of 3 outreach attempts are made within 7 business days of the referral to contact the member. **CM8:** Fidelis Care will ensure the Care Plan is completed for the Enrollee and includes all required components, Fidelis Care:	

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through 20), Fidelis Care should ensure a dental visit occurs during the review period.	1. Currently hired a supervisor for the DDD DCPP team 1A. 3 FTE CMs hired for the general population team 2. Supervisors monitors the JMD-DDD-DCPP enrollment report to ensure that all non-mandated DCPP cases have converted to mandated status monthly. Currently the market has resumed communicating with the Medicaid liaison via telephone and via email as a secondary form of communication to improve collaboration and response rate. 3. Supervisors continue to monitor the NON MLTSS Report for timeliness of the NJCNA completion within 30 days of referral to the care manager. Supervisor/manager continues to review the DDD-DCPP CM Scorecard to monitor and manage timeliness. Supervisors continue to monitor the monthly quality CM audit. **CM14:** Fidelis Care ensures the Enrollee's (aged 0 through 20) EPSDT exam is up to date per periodicity exam schedule, and status is confirmed by a reliable source. 1. Fidelis Care ensures immunizations are up to date for Enrollees (aged 0 through 18), immunization status is confirmed by a reliable source, and aggressive outreach attempts are documented to confirm immunization status. 2. Fidelis Care ensures for Enrollees (aged 19 and above), appropriate vaccines have been administered and aggressive outreach attempts are documented to confirm immunization status. For Enrollees (aged 1 through 20), Fidelis Care should ensure a dental visit occurs during the review period. Fidelis Care CM: Will ensure EPSDT exam are up to date per periodicity exam schedule and status is confirmed by a reliable source, that aggressive outreach attempts were documented to confirm EPSDT status. EPSDT Reminders are sent to all members by the QI Team via text messages and letters. 2. Care Managers will ensure that immunizations are up to date for all Enrollees in care management and immunization status is confirmed by a reliable source with aggressive outreach attempts documented. 2A. QI Team requests all medical records for members found to be non-compliant with EPSDT Services. Those medical records will be requested to determine compliance of EPSDT if the member are found to have secondary insurance. Medical Records will be uploaded to the CM documentation system.	

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	2B. Care Managers continue to include an EPSDT Care Plan Problem in the member's care plan to ensure EPSDT is reviewed and addressed. 2C. EPSDT element added to the monthly care manager's quality audit tool. Supervisor to continue to review the CM monthly quality results to ensure compliance. 3. QI Team will address immunizations for members not in CM by continuing to send reminder text messages. All members are referred to CM as necessary for immediate outreach and education. Parent/Guardians that decline EPSDT coordination will be sent to a pediatric CM for immediate follow-up and education. The primary care provider will be made aware of all outreach attempts and education via care plan and call. All QI Team touchpoints will be added to a database that can be easily retrieved as added to the CM file. QI database is scheduled to Go Live January 2023. 3A. (NEW) Current intervention is to meet with Data Analytics Team in Q1 2024 to discuss new opportunities to capture QI activities moving forward. 4. Immunization reminders to enrollees 0-18 are sent additional reminders via the Pfizer Vaccine Adherence in Kids (VAKs) Program. Reminders via post cards will begin to be sent out Q3 2023 that have been identified for immunization gaps. Program Description: The Pfizer/Intrados VAKs Program consists of 2 options: Missed Dose & Well Visit. • The Missed Dose Program sends postcards and/or IVR messages to parents of children at ages 5 months, 7 months and 16 months to remind them they may have missed a vaccine shot. Non-compliant members are pulled using CPT Code 90670. • The Well Visit Program sends postcards and/or IVR phone messages to parents of children who are 10 months old to remind them of the importance of their upcoming 1 year checkup. 5. Fidelis Care shall ensure that dental needs are addressed for Enrollees aged 21 and above, that a dental visit occurred during the review period for Enrollees aged 1 to 21 and that dental reminders were sent to Enrollees aged 1 to 21. Liberty Dental continue to have targeted outreach for DDD and DCPP Members. Liberty Dental will continue to make targeted outreach calls to all GP members found not to have a preventive dental claim for all age groups. 6. Fidelis Care shall ensure that Enrollees aged 9 months to 26 months were tested twice for lead. Fidelis Care shall ensure that an Enrollee who had never previously been	

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	tested for lead before 24 months of age received a blood lead test. A monitoring report will be created to identify members of this age range that have 1 lead test by the QI Team. Those identified members will be referred to CM for member education. Pediatricians will be outreached by the QI Team and CM Team for education and monitoring. 7. Fidelis Care shall ensure that a Care Manager sends lead screening reminders for Enrollees aged 9 months to 72 months. Fidelis Care shall ensure that the Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source. QI continues to perform the bi-annual mailing to members that are non-compliant with lead testing. UTC letters will be updated by February 2023 to include the need for 2 lead tests due to the need for state approval of the letter. Plan is to expedite state approval of the change to this letter. Quarterly telephonic outreach to the 3 lowest performing counties continues annually. QI Staff visits pediatric providers monthly to close EPDST Care Gaps on their panels. 7A. (NEW) Quality is seeking to improve this process so will be meeting internally with CM to identify opportunities to reach UTC members in a more efficient manner. 8. Additional audit criteria added to the CM Quality Audit for preventative services based on non-compliant areas identified in the IPRO Audit. Added 2 lead tests for member 9 months to 24 months.	
FC/WCHP should address the deficiencies noted in the Core Medicaid - 2023 CM Review in the following areas: DDD: Outreach, Preventive Services, Coordination of Services, and all CM element specific deficiencies noted in the review. • **CM7:** Fidelis Care should ensure that initial outreach to complete CNA is timely, within 45	**CM7:** Fidelis Care ensures that initial outreach to complete CNA is timely, within 45 days of Enrollee's enrollment. Fidelis Care ensures a level of Care Management is determined for the Enrollee. In response to IPRO's recommendation to address the deficiencies noted in the Core Medicaid - 2023 CM Review in the for DDD: Outreach, Preventive Services, Coordination of Services, and all CM element specific deficiencies noted in the review, Fidelis has implemented the following: 1. Supervisor will continue to monitor the weekly NON MLTSS Report to ensure timeliness of completion of assessments (NJCNA) and ensure that all CM cases have an acuity level assigned. 2. Care managers document the acuity level in the episode description in the Care Central CM system and have been instructed to enter the acuity level in the care plan. This is monitored by the NON MLTSS Report. The CM supervisors review this report weekly to ensure that all managed cases have an assigned acuity level.	Addressed

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days of Enrollee's enrollment. • **CM7:** Fidelis Care should ensure a level of Care Management is determined for the Enrollee. • **CM8:** Fidelis Care should ensure a Care Plan is completed for the Enrollee and includes all required components. • **CM14:** Fidelis Care should ensure the Enrollee's (aged 0 through 20) EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source. • **CM14:** Fidelis Care should ensure that for Enrollees (aged 0 through 18), immunizations are up to date, status is confirmed by a reliable source, and aggressive outreach attempts are documented to confirm immunization status. • **CM14:** Fidelis Care should ensure that for Enrollees (aged 19 and above),	3. The supervisors monitor the JMD-DDD-DCPP enrollment report to ensure that all non-mandated DCPP cases that have converted from a non-mandated status to a mandated status are assigned to a CM accordingly. During COVID, there was a delay with the Medicaid liaison to confirm the members mandated status and resource parent contact information. Once the information was received the members were assigned to a DCPP CM and the CNA was completed. 3A. The CM team has resumed outreach calls directly to the Medicaid liaison in addition to continuing to communicate via email. This process has improved collaboration and response rate. 4. Supervisors will continue to monitor the NON MLTSS Report for compliance with timeliness of CNA completion within 30 days of referrals to the CM. If the CNA is not completed within the 30 days of referrals, the supervisor/manager will be responsible for meeting with the case managers to provide an update regarding the completion status of the CNA and discuss any barriers identified. The goal is to complete the CNA within 45 days of enrollment for DDD/DCPP membership. Supervisor continues to monitor of the monthly quality CM audit. 4A. Supervisors will complete the DDD DCPP CM Scorecard for newly enrolled cases per CM to ensure timeliness of the NJCNA completion. 5. (New) Supervisor will utilize the NON MLTSS report to identify the NJCNAs at 21 days and send an individual email to each CM as a reminder that NJCNA is approaching the 30 day timeframe to ensure completion within the 30 day timeframe. **CM8:** Fidelis Care will ensure the Care Plan is completed for the Enrollee and includes all required components, Fidelis Care: 1. Currently hired a supervisor for the DDD DCPP team 1A. 3 FTE CMs hired for the general population team 2. Supervisors monitor the JMD-DDD-DCPP enrollment report to ensure that all non-mandated DCPP cases have converted to mandated status monthly. Currently the market has resumed communicating with the Medicaid liaison via telephone and via email as a secondary form of communication to improve collaboration and response rate. 3. Supervisors continue to monitor the NON MLTSS Report for timeliness of the NJCNA completion within 30 days of referral to the care manager. Supervisor/manager continues to review the DDD-DCPP CM Scorecard to	

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appropriate vaccines have been administered, and aggressive outreach attempts are documented to confirm immunization status. • **CM14:** Fidelis Care should ensure that for Enrollees (aged 21 and above), dental needs are addressed. • **CM14**: Fidelis Care should ensure that a dental visit occurs for Enrollees (aged 1 through 20) during the review period. • **CM15:** Fidelis Care should ensure for Enrollees demonstrating needs requiring a treatment plan, the Enrollee is given a comprehensive treatment plan to address the Enrollee's specific needs. • **CM17:** For Enrollees who are given a treatment plan**,** Fidelis Care should ensure that the treatment plan progresses in a	monitor and manage timeliness. Supervisors continue to monitor the monthly quality CM audit. **CM14**: Fidelis Care ensures the Enrollee's (aged 0 through 20) EPSDT exam is up to date per periodicity exam schedule, and status is confirmed by a reliable source. Fidelis Care ensures immunizations are up to date for Enrollees (aged 0 through 18), immunization status is confirmed by a reliable source, and aggressive outreach attempts are documented to confirm immunization status. Fidelis Care ensures for Enrollees (aged 19 and above), appropriate vaccines have been administered and aggressive outreach attempts are documented to confirm immunization status. For Enrollees (aged 1 through 20), Fidelis Care should ensure a dental visit occurs during the review period. Fidelis Care CM: 1. Will ensure EPSDT exam are up to date per periodicity exam schedule and status is confirmed by a reliable source, that aggressive outreach attempts were documented to confirm EPSDT status. EPSDT Reminders are sent to all members by the QI Team via text messages and letters. 2. Care Managers will ensure that immunizations are up to date for all Enrollees in care management and immunization status is confirmed by a reliable source with aggressive outreach attempts documented. QI Team will begin to request all medical records for members found to be non-compliant with EPSDT Services. Those medical records will be requested to determine compliance of EPSDT if the member are found to have secondary insurance. Medical Records will be uploaded to the CM documentation system. 2A. Care Managers to continue to include an EPSDT Care Plan Problem in the member's care plan to ensure EPSDT is reviewed and addressed. 2B. EPSDT element added to the monthly care manager's quality audit tool. Supervisor to continue to review the CM monthly quality results to ensure compliance. 3. QI Team will address immunizations for members not in CM by continuing to send reminder text messages. All members are referred to CM as necessary for immediate outreach and education. Parent/Guardians that decline EPSDT coordination will be sent to a pediatric CM for immediate follow-up and education. The primary care provider will be made aware of all outreach attempts and education via care plan and call. All QI Team touchpoints will be added to a database that can be easily retrieved as	

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timely manner without unreasonable interruption. • **CM19:** When appropriate for the applicable Enrollees, Fidelis Care should ensure that the Care Manager contacts Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD), and that documentation of all contacts and linkages, to medical and other services, is in the Enrollee's case files.	added to the CM file. QI database is scheduled to Go Live January 2023. 3A. (NEW) Current intervention is to meet with Data Analytics Team in Q1 2024 to discuss new opportunities to capture QI activities moving forward. 4. Immunization reminders to enrollees 0-18 are sent additional reminders via the Pfizer Vaccine Adherence in Kids (VAKs) Program. Reminders via post cards will begin to be sent out Q3 2023 that have been identified for immunization gaps. Program Description: The Pfizer/Intrados VAKs Program consists of 2 options: Missed Dose & Well Visit. • The Missed Dose Program sends postcards and/or IVR messages to parents of children at ages 5 months, 7 months and 16 months to remind them they may have missed a vaccine shot. Non-compliant members are pulled using CPT Code 90670. • The Well Visit Program sends postcards and/or IVR phone messages to parents of children who are 10 months old to remind them of the importance of their upcoming 1 year checkup. 5. Fidelis Care shall ensure that dental needs are addressed for Enrollees aged 21 and above, that a dental visit occurred during the review period for Enrollees aged 1 to 21 and that dental reminders were sent to Enrollees aged 1 to 21. Liberty Dental continue to have targeted outreach for DDD and DCPP Members. Liberty Dental will continue to make targeted outreach calls to all GP members found not to have a preventive dental claim for all age groups. 6. Fidelis Care shall ensure that Enrollees aged 9 months to 26 months were tested twice for lead. Fidelis Care shall ensure that an Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test. A monitoring report will be created to identify members of this age range that have 1 lead test by the QI Team. Those identified members will be referred to CM for member education. Pediatricians will be outreached by the QI Team and CM Team for education and monitoring. 7. Fidelis Care shall ensure that a Care Manager sent lead screening reminders for Enrollees aged 9 months to 72 months. Fidelis Care shall ensure that the Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source. QI continues to perform the bi-annual mailing to members that are non-compliant with lead testing. UTC letters will be updated by February 2023 to include the need for 2 lead tests due to the need for state approval of the letter. Plan is to expedite	

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	state approval of the change to this letter. Quarterly telephonic outreach to the 3 lowest performing counties continues annually. QI Staff visits pediatric providers on a monthly basis to close EPDST Care Gaps on their panels. 7A. (NEW) Quality is seeking to improve this process so will be meeting internally with CM to identify opportunities to reach UTC members in a more efficient manner. 8. Additional audit criteria added to the CM Quality Audit for preventative services based on non-compliant areas identified in the IPRO Audit. Added 2 lead tests for member 9 months to 24 months. **CM17:** For Enrollees who are given a treatment plan, Fidelis Care ensures that the treatment plan progresses in a timely manner without unreasonable interruption through the following: 1. CM Refresher training to include re-education on continuity of care-review of policy and CM assignment. 2. Supervisors to continue to monitor/review the NON MLTSS Report on a weekly basis to ensure timeliness for the NJCNA completion and care plan. 3. Supervisors to utilize/review the monthly dental preventative report to address any gaps in dental treatment. 4. Dental department to refer any member requiring continuity of care to the care management team. A care coordinator will be appointed to assign any members referred. 5. Monthly meetings held with vendor Liberty Dental to discuss number of members referred and number of noncompliant members with orthodontic needs 6. Members with 2 more ER visits within 6 months with a non-traumatic dental event will be referred to care management. Care Coordinator will be appointed to assign the members to a care manager. 7. The Utilization Management team to refer members for care management services if there is an identified need during the authorization process to the appointed care coordinator for care management assignment. **CM19:** When appropriate for the applicable Enrollees, Fidelis Care ensures that the Care Manager contacts Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD), and that documentation of all contacts and linkages, to medical and other services, is in the Enrollee's case files. Fidelis Care does the following:	

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	1. Monthly quality audit tool for all CM Teams was updated on 11-4-2022 to include referrals for all community outreaches to ensure CM documentation compliance. 2. Implement an annual training on the Navigator (community referral tracking system) and monthly opportunities for training with a new hire. The CMs are responsible for reviewing the Navigator to identity all community partners including Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD)documentation of all contacts and linkages to medical and other services in are in the member's case files-will now be conducted by the senior care managers/supervisors (see 2A). completed by the Community navigator team in 2023.	
FC/WCHP should address the deficiencies noted in the Core Medicaid - 2023 CM Review in the following areas: • DCP&P: Outreach, Preventive Services, and all CM element specific deficiencies noted in the review. • **CM7:** Fidelis Care should ensure that the outreach to complete a CNA and the completion of the CNA occurs timely, within 45 days of Enrollee's enrollment. • **CM14:** Fidelis Care should ensure that aggressive outreach attempts are documented to confirm EPSDT status and EPSDT reminders are	In response to IPRO's recommendation, Fidelis Care has addressed the deficiencies noted in the Core Medicaid - 2023 CM Review in the following areas: DCP&P: Outreach, Preventive Services, and all CM element specific deficiencies noted in the review: **CM7**: Fidelis Care ensures that the outreach to complete a CNA and the completion of the CNA occurs timely, within 45 days of Enrollee's enrollment. In response to IPRO's recommendation to address the deficiencies noted in the Core Medicaid - 2023 CM Review for DDD: Outreach, Preventive Services, Coordination of Services, and all CM element specific deficiencies noted in the review, Fidelis has implemented the following: 1. Supervisor will continue to monitor the weekly NON MLTSS Report to ensure timeliness of completion of assessments (NJCNA) and ensure that all CM cases have an acuity level assigned. 2. Care managers currently document the acuity level in the episode description in the Care Central CM system and have been instructed to enter the acuity level in the care plan. This is monitored by the NON MLTSS Report. The CM supervisors review this report weekly to ensure that all managed cases have an assigned acuity level. 3. The supervisors monitor the JMD-DDD-DCPP enrollment report to ensure that all non-mandated DCPP cases that have converted from a non-mandated status to a mandated status are assigned to a CM accordingly. During COVID, there was a delay with the Medicaid liaison to confirm the members mandated status and resource parent contact information. Once the	Addressed

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
sent for Enrollees (aged 0 through 20). • **CM14:** Fidelis Care should ensure that for Enrollees (aged 0 through 18), immunizations are up to date, immunization status is confirmed by a reliable source, and aggressive outreach attempts are documented to confirm immunization status. • **CM14:** For Enrollees (aged 1 through 20), Fidelis Care should ensure a dental visit occurs during the review period, the Care Manager makes attempts to obtain dental status, and dental reminders are sent.	information was received the members were assigned to a DCPP CM and the CNA was completed. 3A. The CM team has resumed outreach calls directly to the Medicaid liaison in addition to continuing to communicate via email. This process has improved collaboration and response rate. 4. Supervisors will continue to monitor the NON MLTSS Report for compliance with timeliness of CNA completion within 30 days of referrals to the CM. If the CNA is not completed within the 30 days of referrals, the supervisor/manager will be responsible for meeting with the case managers to provide an update regarding the completion status of the CNA and discuss any barriers identified. The goal is to complete the CNA within 45 days of enrollment for DDD/DCPP membership. Supervisor continues to monitor of the monthly quality CM audit. 4A. Supervisors will complete the DDD DCPP CM Scorecard for newly enrolled cases per CM to ensure timeliness of the NJCNA completion. 5. (New) Supervisor will utilize the NON MLTSS report to identify the NJCNAs at 21 days and send an individual email to each CM as a reminder that NJCNA is approaching the 30 day timeframe to ensure completion within the 30 day timeframe. **CM14:** Fidelis Care ensures the Enrollee's (aged 0 through 20) EPSDT exam is up to date per periodicity exam schedule, and status is confirmed by a reliable source. Fidelis Care ensures immunizations are up to date for Enrollees (aged 0 through 18), immunization status is confirmed by a reliable source, and aggressive outreach attempts are documented to confirm immunization status. Fidelis Care ensures for Enrollees (aged 19 and above), appropriate vaccines have been administered and aggressive outreach attempts are documented to confirm immunization status. For Enrollees (aged 1 through 20), Fidelis Care should ensure a dental visit occurs during the review period. Fidelis Care CM: 1. Will ensure EPSDT exam are up to date per periodicity exam schedule and status is confirmed by a reliable source, that aggressive outreach attempts were documented to confirm EPSDT status. EPSDT Reminders are sent to all members by the QI Team via text messages and letters. 2. Care Managers will ensure that immunizations are up to date for all Enrollees in care management and	

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	immunization status is confirmed by a reliable source with aggressive outreach attempts documented. QI Team will begin to request all medical records for members found to be non-compliant with EPSDT Services. Those medical records will be requested to determine compliance of EPSDT if the member are found to have a secondary insurance. Medical Records will be uploaded to the CM documentation system. 2A. Care Managers to continue to include an EPSDT Care Plan Problem in the member's care plan to ensure EPSDT is reviewed and addressed. 2B. EPSDT element added to the monthly care manager's quality audit tool. Supervisor to continue to review the CM monthly quality results to ensure compliance. 3. QI Team will address immunizations for members not in CM by continuing to send reminder text messages. All members are referred to CM as necessary for immediate outreach and education. Parent/Guardians that decline EPSDT coordination will be sent to a pediatric CM for immediate follow-up and education. The primary care provider will be made aware of all outreach attempts and education via care plan and call. All QI Team touchpoints will be added to a database that can be easily retrieved as added to the CM file. QI database is scheduled to Go Live January 2023. 3A. (NEW) Current intervention is to meet with Data Analytics Team in Q1 2024 to discuss new opportunities to capture QI activities moving forward. 4. Immunization reminders to enrollees 0-18 are sent additional reminders via the Pfizer Vaccine Adherence in Kids (VAKs) Program. Reminders via post cards will begin to be sent out Q3 2023 that have been identified for immunization gaps. Program Description: The Pfizer/Intrados VAKs Program consists of 2 options: Missed Dose & Well Visit. • The Missed Dose Program sends postcards and/or IVR messages to parents of children at ages 5 months, 7 months and 16 months to remind them they may have missed a vaccine shot. Non-compliant members are pulled using CPT Code 90670. • The Well Visit Program sends postcards and/or IVR phone messages to parents of children who are 10 months old to remind them of the importance of their upcoming 1-year checkup. 5. Fidelis Care shall ensure that dental needs are addressed for Enrollees aged 21 and above, that a dental visit occurred during the review period for Enrollees aged 1 to	

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	21 and that dental reminders were sent to Enrollees aged 1 to 21. Liberty Dental continue to have targeted outreach for DDD and DCPP Members. Liberty Dental will continue to make targeted outreach calls to all GP members found not to have a preventive dental claim for all age groups. 6. Fidelis Care shall ensure that Enrollees aged 9 months to 26 months were tested twice for lead. Fidelis Care shall ensure that an Enrollee who had never previously been tested for lead before 24 months of age received a blood lead test. A monitoring report will be created to identify members of this age range that have 1 lead test by the QI Team. Those identified members will be referred to CM for member education. Pediatricians will be outreached by the QI Team and CM Team for education and monitoring. 7. Fidelis Care shall ensure that a Care Manager sent lead screening reminders for Enrollees aged 9 months to 72 months. Fidelis Care shall ensure that the Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source. QI continues to perform the bi-annual mailing to members that are non-compliant with lead testing. UTC letters will be updated by February 2023 to include the need for 2 lead tests due to the need for state approval of the letter. Plan is to expedite state approval of the change to this letter. Quarterly telephonic outreach to the 3 lowest performing counties continues annually. QI Staff visits pediatric providers on a monthly basis to close EPDST Care Gaps on their panels. 7A. (NEW) Quality is seeking to improve this process so will be meeting internally with CM to identify opportunities to reach UTC members in a more efficient manner. 8. Additional audit criteria added to the CM Quality Audit for preventative services based on non-compliant areas identified in the IPRO Audit. Added 2 lead tests for member 9 months to 24 months.	
FC/WCHP should address all deficiencies noted in the MLTSS – HCBS 2023 CM Review for elements within groups that scored below 86%.	**Group C:** It was recommended that Fidelis Care should ensure that initial outreach to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) is completed within five (5) business days from the effective date of MLTSS enrollment. **Group E:** Recommendation that Fidelis Care should ensure that the Member has a documented face-to-face/telephonic visit to review Member placement and services during the review period, that is held within the	Addressed

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	appropriate timeframes (An ongoing face-to-face/telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit). In addition to continuing successful strategies implemented last year, Fidelis Care will implement the following new interventions, in support of the increase of the plan score from 30% previous year to 80% this year: 1. Fidelis Care will implement a mobile application for all MLTSS care management to monitor and alert care managers for all upcoming member visits to ensure timeliness. 2. Fidelis Care will utilize additional MLTSS staff members to assist assigned care managers with face-to-face visits to ensure timeliness of quarterly/annual visits. 3. Care Managers will be provided training on the implementation of mobile application reinforcing contractual requirements regarding HCBS face-to-face visit timeframes.	
FC/WCHP should address all deficiencies noted in the MLTSS – NF/SCNF 2023 CM Review for elements that scored below 86%.	Fidelis Care's MLTSS Care Managers should ensure the Member's individualized Plan of Care was developed in collaboration with the Member and a copy is mailed to the Member within 45 calendar days of enrollment into the MLTSS program, ensure that the Plan of Care is updated for a significant change, identify Members for transfer to HCBS and offer Members options including transfer to the community, participate in at least one IDT meeting during the review period, and ensure telephonic or onsite visits are timely and occur within at least 180 calendar days for non-pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members. It was recommended for Performance measures 8 & 9A Fidelis Care's MLTSS Care Managers should ensure that the Initial Plan of Care is established within 45 days of enrollment into MLTSS program and amend the Member's Plan of Care based on change of the Member's condition. In response to IPRO's recommendation, Fidelis Care addressed all deficiencies noted in the MLTSS – NF/SCNF 2023 CM Review for elements that scored below 86%: 1. Fidelis Care has implemented a Care Management Onboarding Team that works solely with new members to Fidelis Care and the MLTSS program. This team initiates contact with member/facility upon enrollment and meets with member face to face to complete all the initial	Addressed

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	documentation: MRR, POC, and NJHC assessment as well as complete all necessary authorizations for services. 2. Fidelis Care has implemented a new member scorecard that is completed by managers/supervisors with care managers monthly to ensure all new members have timely visits, required documentation is completed in its entirety and authorizations are completed within timeframes. 3. Fidelis Care has implemented a member scorecard that is completed by managers/supervisors with care managers monthly to ensure ongoing visits are completed within required timeframes, required documentation is completed in its entirety and services are reviewed with member during each visit for new and/or continued authorization of services selected by member. 4. Daily monitoring of Inpatient Census Report to identify potential change of conditions and refer to Care Manager for outreach/visit as needed. 5. Fidelis Care Quality Assessment Review Team will monitor for change in condition NJHC's. 6. Monthly reconciliation of change in condition NJHC against the visits report that also monitors the plan of care completion. 7. Care Managers were provided training on the member scorecards during their team meetings to reinforce timelines, completing documentation in a timely manner, participation in IDT meetings with facility staff all to ensure member receives services appropriately and are part of the care planning process. 8. Care Managers were re-educated during team meetings on visit timelines for face-to-face visits to ensure members receive visits from Care Managers and there is no disruption in services, visits occur at least every 180 days for Members residing in the NF and 90 for PED SCNF members, and visit is documented in its entirely in the member's electronic record. 9. Fidelis Care's MLTSS Review Specialists will monitor NJ Choice Assessments for options counseling including alternative living arrangements during review prior to submission to OCCO. 10. Fidelis Care's Internal Audit tool contains an audit element to ensure that there is documentation of an ICT note which indicates that the Care Manager is participating in a minimum of one IDT meeting per year for Nursing Facility members. Record audits are performed monthly by Fidelis Care's shared services Audit Team and results sent to MLTSS Managers/Supervisors.	

Recommendation for FC/WCHP	FC/WCHP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	11. Documentation of CM participation in a minimum of one IDT meeting per year for NF members will be reviewed and discussed during 1:1 case conference between Manager/Supervisor and Care Manager to ensure there is documentation of same in member's electronic health record.	

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

HNJH Response to Previous EQR Recommendations

Table 58 displays HNJH's progress related to the *State of New Jersey DMAHS, Horizon New Jersey Health Annual External Quality Review Technical Report FINAL REPORT: April 2024,* as well as IPRO's assessment of HNJH's response.

Table 59: HNJH Response to Previous EQR Recommendations

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
The MCO should continue to focus its efforts on provider recruitment in order to improve access to care for Pediatric Specialists in Pediatric Sleep Medicine in all counties, as well as other Pediatric Specialist deficiencies in Atlantic, Burlington, Camden, Cape May, Cumberland, Mercer, Monmouth, Ocean, Sussex, and Warren Counties.	Throughout 2023 and YTD 2024, we continue to focus on the gaps and have been successful in recruiting providers with pediatric specialties such as Pediatric Infectious Disease, Pediatric Rheumatology, Pediatric Pulmonology & Pediatric Sleep Medicine. We are finalizing negotiations with Children's Hospital of Philadelphia (CHOP) that will add approximately 2,000 practitioners with pediatric subspecialties to the network. We continue to partner with professional groups on recruitment efforts. The recruitment team is also focused on closing other such gaps as Pediatric Gastroenterology, Pediatric Psychiatry, Adolescent Medicine, Pediatric Nephrology & Pediatric Emergency Medicine.	Addressed
The MCO should continue to expand the Dental network in Hunterdon and Warren Counties.	Horizon Dental Operations partnered with SKYGEN USA, the delegated dental vendor, to identify prospective providers, as well as acceptable fee schedule parameters for negotiation. Horizon continued the following interventions in collaboration with SKYGEN: 1. Continued Intervention: Reached out to large provider groups to see if they are willing to add additional providers.	Addressed

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
	2. Continued Intervention: Reviewed "4 Plus County" network roster to confirm if any providers can be moved to the main, counted network, or if any providers can switch primary status with another county that is currently meeting dental network requirements. This is in regard to the NJ three county rule, which states that dental providers may not have more than three main locations in the provider directory. This ensures there is alignment with the Contract that states *"A Primary Care Dentist must provide a minimum of 20 hours per week per county".* However, providers can add additional locations to their profile in other counties that will be listed on a "4 Plus County" roster, but these locations are not counted toward the dental network requirements. 3. Continued Intervention: Identify additional providers that may fill network deficiencies. 4. Continued Intervention: Utilize zip code demographics to assist with closing network deficiencies. 5. Continued Intervention: Utilize New Jersey's Yellow Pages to search for offices in zip codes that are deficient. 6. Continued Intervention: Follow-up weekly with offices that are in fee negotiations. 7. Continued Intervention: Do weekly follow-up with each office with a max of (7) outreach attempts for offices not responding 8. Continued Intervention: Dental Director outreaches to interested providers to have a discussion directly. 9. Continued Intervention: Review out of network claim utilization reports for prospective providers. 10. Continued Intervention: Review of SKYGEN's monthly recruitment and contracting reports. Ensuring providers that are in the counties needed are credentialed timely. 11. New intervention: Collaborate with commercial line of business to recruit providers for the Medicaid line of business. Interventions 1-10 were ongoing throughout 2023. These interventions will continue through 2024. Intervention 11 was new in Q4, 2023. To monitor, the Dental Director receives and reviews a bi-weekly status report and monthly meetings are held with SKYGEN (vendor) review recruiting status.	

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]

The MCO should focus on improving appointment availability for adult PCPs, Specialists, OB/GYNs, Dental providers, and Behavioral Health providers, as well as improve PCP after-hours availability.	Behavioral Health Providers who failed one or more questions on the Appointment Availability Survey were sent a letter to submit a Corrective Action Plan within 30 days. The letter included a link to the website on Horizon's Appointment and Availability standards and suggestions on how to meet standards.
	
	Continued Interventions:
	• The Network Team continues to provide education to all behavioral health providers on appointment availability standards through the following measures:
	  ○ New Provider Orientations
	  ○ Bi-Annual Webinars
	  ○ Continue expansion of network of providers including telehealth services
	
	New Interventions:
	• Horizon sent an email blast to participating providers, advising them of the Appointment Availability standards.
	• Articles were published in the Provider Pulse Newsletter educating on the standards
	• Reviews of the Appointment Availability Standards were completed with high volume groups
	
	All professional practitioners who failed the 24-Hour Access Survey (including PCPs, and specialists) were asked to create an Action Plan to submit within 30 days to ensure future compliance. Re-audits were completed for those that submitted an Action Plan to ensure compliance. Practitioners that received Level 1 Sanctions received telephone outreach by the Network Specialist team to assist with compliance. Practitioners who failed one or more questions on the Appointment Availability Survey were sent a request to submit a Corrective Action Plan within 30 days. Follow up re-audits were completed to ensure compliance.
	
	Articles were posted in the March 2024 Provider Pulse with education for both the 24-Hour Access Standard and the Appointment Availability standard. In Q2, 2024 an alert was posted on Availity site to remind practitioners of the annual 24-Hour Access audit. Individual follow up education was provided for practitioners that failed the re-audit in 2023 and they also submitted a CAP. A review of Appointment Availability Survey calls was completed to
		Addressed

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
	improve our survey process, as well as a full review of all questions that are asked during those calls to ensure the questions are clear. Horizon completed a review of the survey scripting for 2025 for possible enhancements to ensure all questions are clear and relatable to the practices.	
The MCO should ensure that their policy or Member Handbook is updated to list specific good cause reasons as outlined in the Contract language.	Horizon NJ Health Handbook has been updated as of 5/5/24 under state approval number: 086-23-112 to reflect the good cause reasons. Good Cause reasons are in the "Ending your Membership" section of the handbook.	Addressed
The MCO should update the Disenrollment policy to address the required Contract language.	HNJH updated its Disenrollment policy on 1/17/24 to reflect the required Contract language. The revised text is located in policy 31C_102 on page 4 & 5.	Addressed
The MCO should ensure timeliness adherence regarding MLTSS Provider Grievances Resolution letters.	The Grievances Department continues to strive toward the timely resolution of all grievances utilizing multiple reports and inventory calls with various stake holders. There is also a monthly collaboration call with internal departments to address any trends or issues identified that affect the timely routing and resolution of complaints. Currently we have the following processes in place to monitor inventory: • Daily reports of open inventory are shared with the analysts and department leaders to monitor open cases. • Daily inventory touchpoints are held with the grievances analysts to discuss cases where they need guidance to facilitate closure • Daily grievance touchpoints are done with cross-functional team (appeals, UM, Provider Services) to discuss escalated/regulatory complaints • Pre-closure quality audit of each case is completed to ensure all elements of complaints are addressed in the resolution letter • A daily closed report of closed cases is generated to ensure cases are closed timely Provider Services intervention: • Monitor grievances to ensure that all grievances are routed within 3 days to the Grievances	Addressed

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
	Department. All cases that exceed the 3-day routing timeline are reviewed for additional process improvements to prevent recurrence.	
The MCO should focus on the HEDIS quality-related measures which fell below the NCQA National 50th percentile. HNJH should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.	Horizon NJ Health monitors HEDIS measure performance on an ongoing basis in an effort to improve health outcomes for our members. Several member and provider interventions were launched to help improve HEDIS measure performance and close member care gaps. New Interventions were developed, and existing interventions were enhanced based on barriers identified and impact analysis completed. HEDIS measure performance is reviewed during the HEDIS workgroup with a report out to Quality Improvement Committee on a quarterly basis. In 2024, several new and continuing initiatives are underway to improve performance for measures that fell below 50th percentile. The initiatives include: • Ongoing Member education via mailers and member newsletter on Annual Well visit, Preventive screenings, and Immunization (including for pregnant women) • Live outreach to members for Prenatal/Postpartum care (Target members - African American with lower compliance rates) • Live outreach calls for well child visits to parent/guardians with children that have care gaps • Member Rewards program 2024 - Increased incentive for completing Prenatal and Postpartum visit measures; Addition of well child visit measure and continuation of Lead Screening in Children, Diabetes A1C testing and Eye exam measure. • Member awareness and education on needed screenings via Email and Social Media campaign • Development of Texting campaigns for several measures such as Lead Screening, Immunization, Prenatal -postpartum care measure to be launched in Q4 • Providers participating in the Results and Recognition (R&R) program are assigned a Clinical Quality Improvement Liaison (CQIL). The CQIL conducts regularly scheduled meetings with the providers (cadence is different for each provider and dependent on their availability). During these meetings, the provider gap reports	Addressed

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
	are reviewed, barriers are discussed, and a strategy to improve performance is set. Additionally, live webinars are held quarterly educating providers on various measures. The R&R program provides several resources to the provider through the Quality Resource Center including billing tip sheets, HEDIS Guidelines, and the Provider Manual. Additionally, recorded webinars are posted on the Quality Resource center and available to all providers. • The Behavioral Health (BH) team continues to launch member and provider facing interventions focused on BH measures. Monthly Provider webinars continue in 2024 to educate providers on HEDIS Measures and best practices. These webinars are also published on the website for convenient provider access. In 2024, the BH team launched a CEU webinar to incentivize provider BH HEDIS education. The BH team continues to outreach members via mailers for select measures. The BH HEDIS team includes each BH HEDIS measure in member and provider newsletters throughout the year. Individual touchpoints continue with engaged facilities to review HEDIS scorecard and encourage best practices.	
The MCO should ensure to submit performance measures timely, or as directed by DMAHS and the EQRO.	All response requests are reviewed by the Director of Performance Reporting and the Manager of QI Data analysis. The request specifications are disseminated to the project team and cataloged for tracking purposes by the project manager. Horizon utilizes various methods to ensure compliance with timely HEDIS and MLTSS performance measure submissions. The HNJH Regulatory Affairs Team maintains a shared platform that is accessible to staff, which allows real-time tracking and status reporting of all performance measure deliverables. This platform tracks the performance measure title, status, reporting reference periods and both internal/external due dates, which are automatically sent via email as reminders to the appropriate business / data owners and approvers / submitters well in advance of reporting due dates. HNJH utilizes this platform to	Addressed

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
	confirm compliance with timely performance measure preparations and submissions. Additionally, Horizon utilizes the MLTSS PM slide deck, and MLTSS PM document submission guidelines as provided by DMAHS to communicate anticipated reporting timeframes and report guidance to all internal stakeholders. This information is also promptly shared with Horizon's Regulatory Affairs team to ensure the shared platform (as described above) maintains the most current performance measure guidance as per DMAHS and the ERQO. The MLTSS Quality Improvement Team meets monthly with the internal data analytics team to review approaching performance measure deliverables. This monthly meeting allows collaborative efforts between stakeholders, which is necessary to ensure both data integrity and readiness for timely performance measure submissions. Further, the Quality Improvement Team has begun meeting routinely with the data analysis team prior to preparation of any HEDIS related performance measures to review and validate externally prepared data (Inovalon), which is imperative to ensuring validation of data and timely preparation as per DMAHS and ERQO performance measure specifications.	
The MCO should ensure that the HEDIS team follows the guidance provided annually by DMAHS at the beginning of the HEDIS/Performance Measure season.	Each communication is reviewed by the manager and director of reporting. All requirements are detailed, and changes are noted for the team to review. The guidance is distributed to the appropriate staff and updates are made if required. In addition, we have ensured the certified software vendor receives all requirements and meetings are conducted to discuss the annual guidance.	Addressed
The MCO should continue to work to improve Adult and Child CAHPS scores that performed below the 50th percentile.	CAHPS Survey improvement was a focus in 2023 and continues to be a focus in 2024 across the organization. An annual workplan is created for all measures that fall below the 50th percentile. Member and provider facing initiatives were developed and implemented with the goal of improving the member experience and satisfaction as well as improving a member's overall health. The Quality Management Team works closely with Case Management, Member Experience, Network, Health Equity, Community Outreach and Member Services teams to address all CAHPS measures with a targeted focus on measures not meeting the 50th percentile.	Addressed

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
	Providers are educated through multiple channels on CAHPS measures, including newsletters, webinars, and a CAHPS coaching program. Webinar topics in Q1, 2024 included “Getting Needed Care, Getting Care Quickly, and Getting Needed Prescriptions” and in Q2 “Understanding "Rating of Healthcare CAHPS Survey Question: Insights into How Patient Perceptions Shape Healthcare Ratings". In Q3 a webinar session will include a collaboration with Inspira Health System and Summit Medical Group to review best practices at a Peer-to-Peer level. The topics will include expanded access to care and patient communication and the issues impact member experience and CAHPS. Newsletter topics for 2024 include “CAHPS survey: Facts on how to impact patient’s experience”, “Health Outcome Survey (HOS) tip sheet, Care Coordination; Behavioral Health” and “Getting Needed Care, Getting Care Quickly, Urgent Care/Telehealth, Care Coordination, Follow-up after ED visit, Flu vaccine”. Self-Guided Implicit Bias training is being offered to all Horizon Network Providers via email with over 400 providers registered to date. Additional providers will be added to the Medicaid VB network in 2025 with a focus on member engagement with a PCP and completing an annual visit. Providers will be notified on the percentage of their patients completing the visit. There will also be a targeted focus on reducing ED visits and readmission rates by improving PCP engagement. Member education is provided through multiple channels. 2024 Member Newsletter articles include in Q1“Appointments with Specialists, Timely Test Results & Using the Patient Portal; Fall prevention; Coordination of Care, Annual Wellness Visit, and Flu vaccine”, Q2 “Annual Wellness Visit, Finding an in-network doctor: when to use urgent care; contact PCP after ER/hospital discharge; bladder control; care coordination; improving/maintaining mental/physical health; flu vaccine; Health Equity” and Q3 “ Flu Shot, pneumonia vaccine, callout for Annual Wellness Visit, Care Management, Managing Diabetes, Breast Cancer Screening, Behavioral Health.” There is an enterprise Asthma initiative which aims to actively engage members with asthma and ensure appropriate care and treatment is being provided proactively, with a focus on children. An Expanded Well Child Program will be launched which focuses on engaging community partners to address the gaps in screenings/immunizations, lead testing, well child visits.	

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
HNJH should address the deficiencies noted in the Core Medicaid - 2023 CM Review in the following areas: General Population - Identification, Outreach, Preventive Services, and all CM element specific deficiencies noted in the review.	Horizon continues to monitor the below identified as opportunities for improvement for the General Population (GP) (scoring below 85%): •Identification (General Population) •Outreach (General Population) •Preventive Services (General Population) Efforts to increase timely identification of members with potential CM needs, the following interventions have been implemented: • Additional modifications were implemented to the existing parameters (to include a more robust list diagnosis and treatment codes) to identify enrollees with potential CM needs, thus the I.H.S. would be completed more timely. (Continued Intervention). • Horizon developed a new workflow to streamline interdepartmental referrals for enrollees with potential CM needs. (New Intervention). • The Care Management Initial Outreach and Enrollment workflow was enhanced to include an aggressive outreach process for members in an acute inpatient setting at the time of identification. (New Intervention). • In an effort to increase appropriate care plan updates and confirmation immunization and preventive care status, the following interventions were implemented: • A Care Management Ongoing Monitoring workflow was developed and implemented. This workflow better defines the expected care management activities designed to assist members achieve their treatment goals including care plan updates, assessment and outreach related to preventative health status, and parameters for appropriate termination of CM services. (New Intervention). • Horizon developed enhanced visualization for individual CM/Supervisor monitoring of compliance. This will include new daily reporting via a Tableau dashboard to be used in conjunction with the medical management system. (New Intervention). If a Care Manager is identified to be non-compliant with timeliness, remediation will be implemented.	Addressed

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
	• A comprehensive training series was created on a variety of care management related topics including (but not limited to) regulatory compliance, care planning, care coordination, and the role of the care manager. (New Intervention). The Aggressive Outreach process to complete the I.H.S. was expanded to include a 2nd round of outreach for members who remain inaccessible after initial outreach has been exhausted.	
HNJH should address the deficiencies noted in the Core Medicaid - 2023 CM Review in the following areas: • DDD: Preventive Services and all CM element specific deficiencies noted in the review.	Horizon continues to monitor the below identified as opportunities for improvement for the DDD Population (scoring below 85%): Preventive Services (DDD Population) • The Care Management Initial Outreach and Enrollment workflow was enhanced to include an aggressive outreach process for members in an acute inpatient setting at the time of identification. (New Intervention). In an effort to increase appropriate care plan updates and confirmation of immunization and preventive care status, the following interventions were implemented: • A Care Management Ongoing Monitoring workflow was created and implemented. This workflow better defines the expected care management activities designed to assist members achieve their treatment goals including care plan updates, assessment and outreach related to preventative health status, and parameters for appropriate termination of CM services. (New Intervention). • The new workflow also increases monitoring by the CM Supervisors and Managers to ensure timeliness in met per below bullet. • Horizon developed enhanced report and visualization for individual CM/Supervisor monitoring of compliance. This will include new daily reporting via a Tableau dashboard to be used in conjunction with the medical management system. (New Intervention) • A comprehensive training series was created on a variety of care management related topics including (but not limited to) regulatory compliance, care planning, care coordination,	Addressed

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
	and the role of the care manager. (New Intervention). In Q3 2024 the revised Aggressive Outreach workflow results in completion of a CNA and care plan development for all members in the absence of established contact with the member/guardian (based on a utilization review and any data gathered from collateral contacts). If a Care Manager is identified to be non-compliant with timeliness, remediation will be implemented.	
HNJH should address the deficiencies noted in the Core Medicaid - 2023 CM Review in the following areas: • DCP&P: Preventive Services and all CM element specific deficiencies noted in the review.	Horizon continues to monitor the below identified as opportunities for improvement in the DCP&P Population (scoring below 85%): Preventive Services (DCP&P Population) • The Care Management Initial Outreach and Enrollment workflow was enhanced to include an aggressive outreach process for members in an acute inpatient setting at the time of identification. (New Intervention). • In Q3 2024 the revised the Aggressive Outreach workflow results in completion of a CNA and care plan development for all members in the absence of established contact with the member/guardian (based on a utilization review and any data gathered from collateral contacts). If a Care Manager is identified to be non-compliant with timeliness, remediation will be implemented. • In an effort to increase appropriate care plan updates and confirmation immunization and preventive care status, the following interventions were implemented: • A Care Management Ongoing Monitoring workflow was created. This workflow better defines the expected care management activities designed to assist members achieve their treatment goals including care plan updates, assessment and outreach related to preventative health status, and parameters for appropriate termination of CM services. (New Intervention). • Horizon developed enhanced visualization for individual CM/Supervisor monitoring of compliance. This will include new daily reporting via a Tableau dashboard to be used in conjunction with the medical management system. (New Intervention)	Addressed

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
	A comprehensive training series was created on a variety of care management related topics including (but not limited to) regulatory compliance, care planning, care coordination, and the role of the care manager. (New Intervention).	
HNJH should address all deficiencies noted in the MLTSS – HCBS 2023 CM Review for elements within groups that scored below 86%.	Horizon submitted its MLTSS – HCBS 2023 CM Audit Corrective Action Plan (CAP) on 4/16/24. Horizon continues to monitor these areas identified as opportunities for improvement (scoring below 86%): • Ensuring that initial outreach to schedule a face-to-face visit to create an individualized and comprehensive Plan of Care occurs within five (5) business days from the effective date of MLTSS enrollment. • Ensuring that the Member has services in place within 45 calendar days of enrollment into MLTSS. • Ensuring that Member Plans of Care are reviewed and updated to reflect changes, and a copy is provided to the Member and/or authorized representative. • Ensuring that the Member has a documented face-to-face/ telephonic visit to review Member placement and services, held within the appropriate timeframes. • Ensuring that Care Managers conduct an onsite review within ten days of a Member's discharge from a facility to an HCBS setting and ensure that in home services are in place in a timely manner. • Ensuring that a copy of the completed initial Plan of Care is provided to the Member and/or authorized representative within 45 days of MLTSS enrollment (PM#08). As outlined in the approved Corrective Action Plan, to address those areas, HNJH took the following steps: • Updated and redistributed several MLTSS Care Manager Operational Workflows and standard operating procedures for staff; • Re-educated Care Manager Staff at team meetings; • Refined reporting specifications as needed to improve implementation and oversight; • Created a new report to support the monitoring of service plans of care aligning with service authorizations;	Addressed

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
	• Reviewed Tableau Dashboard oversight expectations with MLTSS Managers and increased reporting frequency from quarterly to monthly; and • Reviewed the Medicaid Care Management Quality Improvement team's processes for monitoring inpatient admissions and discharge reports used to communicate updates to Care Managers for advisement and timely follow-up with members as needed. Additionally, a segment was written for inclusion in the MLTSS Provider Newsletter to remind contracted providers on how and when to use the MLTSS Provider Alert Forms to communicate with HNJH MLTSS care management for improved care coordination, and timely notice of events such as facility discharge planning.	
HNJH should address all deficiencies noted in the MLTSS – NF/SCNF 2023 CM Review for elements that scored below 86%.	Horizon submitted its MLTSS – NF/SCNF 2023 CM Audit Corrective Action Plan (CAP) on 12/19/2023. Horizon continues to monitor the areas identified as opportunities for improvement (scoring below 86%): • Ensuring that Members' Plans of Care are updated, reviewed, and signed by the Member and/or representative, and a copy is provided to the Member and/or representative, when there is a significant change in condition. • Ensuring that facility-based Members are identified for transfer to HCBS and are offered options, including • transitioning to the community. • Ensuring that HNJH's MLTSS Care Managers participate in at least one facility-based Interdisciplinary Team (IDT) • meetings annually. As outlined in the approved Corrective Action Plan to address those areas, HNJH took the following steps: • Updated and reissued applicable MLTSS Care Manager Operational Workflows; • Held MLTSS care management staff meetings to discuss the identification and proper documentation of significant changes in member condition and subsequent updates to the plan of care; • Reissued the 'MLTSS Facility Alert Form' with a cover letter to all contracted NF/SCNF providers directing	Addressed

Recommendation for HNJH	HNJH Response/Actions Taken	IPRO Assessment of MCO Response[1]
	them on how and when to send in Alert Forms to MLTSS Care Management; and Enhanced NF IDT Monitoring Report specifications to improve data analysis opportunities to identify trends in NF Provider IDT Round participation by care management staff.	

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

UHCCP Response to Previous EQR Recommendations

Table 59 displays UHCCP's progress related to the *State of New Jersey DMAHS, UnitedHealthcare Community Plan of New Jersey Annual External Quality Review Technical Report FINAL REPORT: April 2024,* as well as IPRO's assessment of UHCCP's response.

Table 60: UHCCP Response to Previous EQR Recommendations

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
The MCO should ensure that the Barrier Analysis, Table 1a is in alignment with Table 1b, Quarterly Reporting Rates for Intervention Tracking Measures (ITMs). Changes made to an ITM can change the impact of a measure, even by adding a few words. The MCO should ensure alignment between tables for an accurate and comprehensive evaluation of Interventions/ITMs over the life of the PIP.	The MCO ensured that all Barriers, Interventions, and Intervention Tracking Measures were in alignment, with proper numbering, correct ITM numerators, denominators, and rates. The MCO ensured that the correct PIP template was used for the report. Old interventions were terminated as needed, and new interventions were added, with correct start dates. New Interventions to address the deficiency: The MCO ensured that all of the interventions were implemented as described in the PIP. The MCO ensured that all Barriers, Interventions, and Intervention Tracking Measures were in alignment, with proper numbering, correct ITM numerators, denominators, and rates.	Addressed
The MCO should continue to focus its efforts on provider	UHCCPNJ focuses efforts on all network deficiencies for all counties, including pediatric specialties. Network Operations analyzes, takes action on, and reports	Remains an opportunity for improvement

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
recruitment in order to improve Pediatric Specialist access in all counties, except Essex, Hudson, Hunterdon, Middlesex, Morris, Passaic, Somerset, and Union.	network deficiency findings at quarterly MCO committee meetings. Network Operations also meets at least twice a month with the contracting team to work collaboratively on contracting and negotiation efforts. UHCCPNJ also submits quarterly S3000 reporting and outreach effort updates to DMAHS.	
The MCO should continue to focus its efforts on provider recruitment in order to improve access to care for General Dentists in Hunterdon and Warren Counties.	UHC Dental identifies non-participating dental provider targets for outreach. They provide the health plan with updates on their outreach efforts quarterly. For general dentists in Hunterdon county, as of current there were 6 prospective providers identified – 3 were non-viable (location closed, left practice, phone number not in service), 1 only sees PPO patients, 1 only sees FFS patients, and 1 was previously par and had termed. For general dentists in Warren county, as of current there were 10 prospective providers identified – 3 were non-viable (location closed, phone number not in service), 2 were not interested, 1 was unable to reach, and 4 have been sent fee schedules and information on Medicaid. No responses have been received, as of current, from the providers who have been sent contracting fee schedules and information.	Remains an opportunity for improvement
The MCO should continue to expand the MLTSS network to include at least two providers in every County for Assisted Living Program.	The MLTSS network contracting team provides an update on contracting and negotiation efforts for all specialty/counties with deficiencies. As of current, there are 17 county deficiencies for ALP. For 5 of the counties, the MLTSS network contracting team is in active conversations with and is either waiting on a response, waiting on the completion and return of contracting paperwork, or is in process of credentialing. For the remaining 12 counties, all known possible providers have been outreached to and contracted with, exhausting efforts for any possible additional contracts in these counties at this time.	Addressed
The MCO should focus on improving appointment availability for OB-GYN providers, Dental providers, and Behavioral Health providers, as well as	UHCCPNJ Quarterly Appointment Availability reporting demonstrates that there are providers who are available for appointment scheduling within DMAHS requirements timeframes. The UHCCPNJ member services team can schedule an appointment on behalf of the member, with the provider for the specialty being requested, within those timeframes. UHCCPNJ continues to work with providers who are identified as deficiency in after-hours access. These	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
PCP after-hours compliance.	providers will continue to receive up to 3 letters after each of up to 3 survey calls from our third-party vendor, which educates the provider on the appointment availability standards for their specialty set forth by DMAHS.	
Focusing on the UHCCP quality-related measures which fell below the NCQA national 50th percentile, UHCCP should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.	UHCCP NJ reviews HEDIS results to identify measures that did not demonstrate improvement. An analysis of programs and initiatives that supported the measures is undertaken to determine effectiveness. Based on the analysis, decisions are made to continue or modify programs for providers and members. Prospective measure rates are also reviewed monthly with key stakeholders including Pharmacy, Maternity, Behavioral Health and Care Management and include a YOY comparison which allows for timely interventions as needed.	Addressed
The MCO should continue to work to improve Adult and Child CAHPS scores that perform below the 50th percentile.	The MCO acknowledges that additional focus is required regarding the 2023 results. The 2023 CAHPS workplan was reviewed and noted that additional interventions were needed for the 2023 results. The 2023 results were compared to the 2024 results and noted areas that continue to need more focus and improvement. A CAHPS workplan was developed for 2024 and submitted to DMAHS. The Workplan includes interventions for improving the following survey rates that did not meet the 50th percentile: Health Plan, Health Care, Getting needed care, Getting Care Quickly, Customer Service, Doctor Communication and Specialists. This workplan includes the Adult, Children and Children with Chronic Conditions populations. It includes intervention activities that focused both on our members and our providers. Interventions were developed to include multiple divisions e.g. Member Call Center, Quality, Provider Relations, MLTSS, and Care Management. The MCO has a CAHPS Task force which was developed to address the CAHPS scores. This Task Force discusses the progress of the CAHPS Workplan. Input from	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	member interaction staff will be one of the focuses in 2024. Examples are complaints, Care Management issues and requests, provider feedback, and community feedback events. This Workplan is monitored on a regular basis and reported quarterly to the Quality Management Committee (QMC).	
UHCCP should address the deficiencies noted in the Core Medicaid - 2023 CM Review in the following areas: • GP: Identification, Preventive Services, and all CM element specific deficiencies noted in the review.	In response to the identification of deficiencies in preventive services and CM elements, UHCCP has conducted a thorough analysis of the areas of opportunity highlighted in our 2023 CM review. We have incorporated additional training, performed root cause analysis, and revamped job aids to address these gaps. The team has been educated on these improvements, and we are actively monitoring the implementation to ensure compliance. We remain committed to identifying and addressing additional opportunities as we progress. **Revised Summary:** In response to the identified deficiencies within preventive services and various CM elements, UHCCP has developed a comprehensive improvement plan based on a detailed review of the 2023 CM findings. To effectively address these issues, UHCCP has implemented the following corrective actions: 1. **Targeted Training Initiatives:** UHCCP conducted targeted training sessions to address gaps identified in enrollee immunizations, confirmed dental visits during the review period, and discharge planning processes. Training emphasized the critical role of updated immunization records, documentation of dental visits from reliable sources, and comprehensive discharge planning. Care Management staff were trained in best practices for supporting enrollees through transitions of care, reinforcing adherence to protocols that ensure continuity and quality in discharge planning. Post-training assessments verified staff readiness to implement these standards in practice. 2. **Enhanced Identification of Enrollees with Potential CM Needs:** UHCCP has prioritized a proactive approach to identifying enrollees with potential Care Management needs by leveraging diverse data sources, such as claims data, hospital discharge records, and utilization trends. This multi-faceted data strategy supports the early identification of high-risk enrollees who may benefit from Care	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	Management interventions, helping UHCCP better meet their preventive and ongoing care needs. 3. **Root Cause Analysis (RCA):** A detailed RCA was conducted to uncover root causes behind deficiencies in enrollee immunizations, dental visit documentation, and discharge planning. Findings indicated barriers in data collection, discharge planning protocols, and the efficient use of data sources for identifying high-risk enrollees. To address these, UHCCP introduced simplified documentation processes and enhanced data tracking to capture preventive care metrics and discharge planning more accurately. 4. **Enhanced Job Aids and Documentation:** UHCCP updated job aids and procedural documentation to reflect findings from the RCA, including step-by-step guidance on tracking immunizations, confirming dental visits, and conducting effective discharge planning. These resources are readily available to staff, helping to ensure compliance with preventive care requirements and robust discharge planning. 5. **Auditing and Ongoing Monitoring:** UHCCP has implemented an audit process that reviews discharge planning activities, preventive care documentation, and the timely identification of enrollees with CM needs. Ongoing monitoring and quality assurance checkpoints provide real-time feedback on compliance, enabling prompt interventions as needed to maintain adherence. By following these steps, UHCCP is committed to fully addressing the deficiencies noted in the Core Medicaid - 2023 CM Review, enhancing the quality of preventive services, discharge planning, and Care Management services for high-risk enrollees. This approach reflects UHCCP's dedication to providing high-quality, continuous care management across its programs. **CM 6 Applied Interventions:** UHCCP provided training and communication to all outreach staff, emphasizing the importance of timely documentation and compliance with the 45-day requirement. Aggressive outreach criteria and standards were revised and provided to staff. Compliance is monitored through sample auditing to ensure adherence to these requirements. **CM 7 Applied Interventions:** UHCCP offered a refresher training for all staff in the general population, focusing in the assignment of care levels. To ensure compliance,	

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	UHCCP monitors monthly reports and conducts monthly sample audits. Additional interventions include evaluating and revising outreach practices for new enrollees, emphasizing aggressive outreach efforts to enhance member engagement and meet the 45-day Comprehensive Needs Assessment requirement. UHCCP also ensured clear documentation of outreach attempts for individuals who were not reachable. **CM 8 Applied Interventions:** A re-evaluation of Care Plan documentation was conducted to verify the inclusion of essential components, establishing a crosswalk aligned with the NJ Care Management Workbook and documentation systems. A Plan of Care refresher training was coordinated for both current and new staff, integrating the established crosswalks to align with the NJ Care Management Workbook guidelines and documentation systems. UHCCP monitors compliance through monthly reporting and sample auditing.	
UHCCP should address the deficiencies noted in the Core Medicaid - 2023 CM Review in the following areas: • DDD: Preventive Services and all CM element specific deficiencies noted in the review.	Following the identification of deficiencies in preventive services and CM elements, UHCCP has conducted a comprehensive review of the opportunities highlighted in our 2023 CM review. To address these issues, we've implemented targeted training, performed root cause analysis, and updated job aids accordingly. Staff have been trained on these enhancements, and we are actively monitoring their implementation to ensure compliance. **Revised Summary:** In response to the identified gaps in DDD preventive care services, particularly concerning the documentation of immunizations and dental visits, UHCCP has established a targeted improvement plan aligned with the findings from the 2023 CM review. To effectively address these deficiencies, UHCCP has implemented the following actions: 1. **Focused Training Initiatives:** Specialized training was provided to address the specific requirements for accurately documenting immunizations and dental visits for DDD enrollees. This training emphasizes the importance of obtaining reliable source confirmations, such as verified provider records, to ensure preventive care services meet regulatory standards. All Care Management staff have completed this training, with follow-up assessments conducted to confirm comprehensive understanding and readiness to implement these enhanced documentation practices.	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	2. **Root Cause Analysis (RCA):** A thorough RCA identified key factors contributing to documentation deficiencies in DDD preventive services. Findings highlighted the need for refined processes in confirming immunizations and dental visits. Based on these insights, UHCCP developed targeted solutions, including process modifications and clear guidelines to facilitate accurate, source-verified documentation of immunization and dental care. 3. **Enhanced Job Aids and Documentation Protocols:** UHCCP revised its job aids and documentation protocols to provide detailed instructions on verifying DDD enrollee immunizations and dental visits through reliable sources. Updated resources, such as checklists and verification templates, support staff in consistently meeting documentation standards and reducing gaps in preventive care records. 4. **Ongoing Monitoring and Auditing:** UHCCP has established a robust audit process to regularly assess compliance with documentation requirements for DDD enrollees. Audits and quality reviews specifically focus on confirming immunization and dental visit records, providing timely feedback to address any discrepancies and ensure continued adherence to preventive care standards. Through these actions, UHCCP is committed to addressing the preventive service deficiencies outlined in the Core Medicaid - 2023 CM Review. By strengthening the verification and documentation processes for immunizations and dental visits, UHCCP aims to enhance the quality and reliability of preventive care provided to DDD enrollees across its Care Management programs. A dedicated support team was assigned to address challenges and bottlenecks in the assessment process, facilitating a smoother workflow. UHCCP revised the outreach approach for new enrollees, including aggressive outreach attempts, to improve member engagement and ensure compliance with the 45 day- Comprehensive Needs Assessment requirement. Compliance is monitored via reports and sample auditing.	
UHCCP should address the deficiencies noted in	UHCCP in response to the deficiencies identified in preventive services and CM elements from the 2023 CM review, has implemented several corrective measures.	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
the Core Medicaid - 2023 CM Review in the following areas: • DCP&P: Preventive Services, and all CM element specific deficiencies noted in the review.	These include enhanced training, root cause analysis, and the revamping of job aids. Staff have been thoroughly educated on these updates, and ongoing monitoring is in place to ensure compliance and address any further areas of opportunity. **Revised Summary**: In response to identified deficiencies related to immunizations and dental visit documentation, UHCCP has undertaken a targeted improvement strategy based on the findings from the 2023 CM review. To address these issues comprehensively, UHCCP has implemented the following corrective actions: 1. **Targeted Training Initiatives:** Training was specifically designed to address gaps in documenting immunizations and dental visits for DCP&P enrollees. Emphasis was placed on ensuring that immunization records are current and dental visits are confirmed by reliable sources, such as medical records or verified provider communications. All Care Management staff have completed this training, with assessments conducted to ensure a clear understanding of the documentation requirements for these critical preventive services. 2. **Root Cause Analysis (RCA):** A detailed RCA was performed to identify underlying factors contributing to deficiencies in immunization and dental visit tracking for DCP&P enrollees. Findings indicated a need for improved data capture processes and clearer protocols for confirming visits through reliable sources. Based on these insights, UHCCP developed corrective strategies, including procedural adjustments that facilitate thorough, accurate documentation of immunization and dental records. 3. **Enhanced Job Aids and Documentation:** Job aids and procedural documentation have been updated to provide clear, step-by-step guidance on verifying immunizations and dental visits through reliable sources. These updated resources include checklists and sample verification methods, ensuring that staff have the tools needed to confirm preventive care compliance and document it consistently. 4. **Ongoing Monitoring and Auditing:** To ensure sustained improvement, UHCCP has implemented an auditing process that focuses on verifying immunization and dental visit documentation for DCP&P enrollees. Regular audits and quality	

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	assurance reviews assess compliance with documentation standards, providing feedback to address any issues promptly. These actions reflect UHCCP's commitment to addressing the specific deficiencies noted in the Core Medicaid - 2023 CM Review. By focusing on reliable documentation of immunizations and dental visits, UHCCP aims to improve preventive care quality and ensure compliance with DCP&P standards across its Care Management programs. For DCP&P Comprehensive Needs Assessment – UHCCP has developed tracking mechanisms to assist with the 45 days turn around as well as identification of individuals with non-mandated DCP&P exclusion codes to ensure they are identified and excluded accordingly. Sample audits are completed to ensure compliance.	
UHCCP should address all deficiencies noted in the MLTSS – HCBS 2023 CM Review for elements within groups that scored below 86%.	**Assessment** **Recommendation: Group D:** UHCCP should ensure that the NJCA is completed within 30 days of a referral to MLTSS **Response:** 1. Retraining to managers completed by the AHSD 2. Managers to train process to the teams in Huddles 3. PM-4 results will be reviewed with teams monthly **Member Outreach:** **Recommendation: Group C**: UHCCP should ensure that Initial outreach was completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment. **Response:** **Group C Remediation** UHC will ensure that the Care Manager contacts the Member within five (5) business days of MLTSS enrollment to schedule a telephonic visit to develop the Member's Plan of Care. Member Welcome Call – the assignment of the new members will be assigned to the CM teams one (1) week. prior to the first of the month to allow the CM the ability to contact the member timely after the first day of the month. The end-to-end process for HCBS was revised to include the documentation of the Welcome Call and date of the visit to complete the POC and other required documentation. CMs were trained on the process and completed the mandatory post-training quiz. Quarterly clinical audit tool reviews 5% (per contract) of each CM's caseload.	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	Recommendation: Group D: UHCCP should ensure that Initial outreach was completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment **Response:** **Group D Remediation:** United Healthcare will ensure the Care Manager contacts the Member telephonically to conduct a Screening for Community Services Assessment and complete the Plan of Care within forty-five (45) calendar days of enrollment notification. The HCBS end-to-end process job aid was revised, and all staff required to complete the training and the post quiz. The Combo report was developed to include the MLTSS Eligibility date, the date of the NJ Choice, the date of the POC completion and the date of the Welcome Call completion. A report was developed to monitor the enrollment date and the date the SCS, and Plan of Care are due. This report is monitored daily by the managers and weekly by the executive team. **Telephonic Monitoring (formerly Face-to-Face) Visits** **Recommendation:** 1. **Group C & Group D:** UHCCP should ensure that Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion. 2. **Group C and Group D:** UHCCP should ensure that Member has a completed and signed Interim Plan of Care (IPOC). 3. **Group C:** UHCCP should ensure that Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes. Group D: UHCCP should ensure that Options Counseling was provided to the Member. **Response:** **Group C Remediation:** United Healthcare will make certain and confirm that the Member (or Member's Representative) are present for, and included in, all telephonic meetings or face-to-face visits with the Care Manager. United Healthcare should ensure Options Counseling is provided to all MLTSS Members, and the Care Manager should discuss and offer Participant Direction as applicable during Options Counseling, for Members who	

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	select the option of Participant Direction, application packages are submitted within thirty (30) business days of completion. The Plan will safeguard a Cost Neutrality Analysis is completed during the review period and the Annual Cost Threshold be documented as a numeric percentage. POC was revised to include a place for the Member Representative to sign if the Member is cognitively impaired or otherwise not able to participate in the POC development. The POC has a place to document who was present during the call or visit. 1. SCS Template job aid was revised to include documentation regarding PPP option. 2. The POC was revised to include documentation regarding the option of PPP to the member. 3. The documentation of PPP is included in IPOC which was re-implemented with the return to field. 1. Revised the POC to include a place for CEA documentation. 2. The POC was later revised to make the documentation mandatory within the POC as opposed to other locations. 1. Managers have the CMs document the CEA in their weekly tracker. 2. Managers review the weekly tracker with the CM during their weekly 1:1 meeting. **Response:** **Group D Remediation:** United Healthcare will track and confirm that Options Counseling is provided to all MLTSS Members, and the Care Manager should discuss and offer Participant Direction as applicable during Options Counseling, for Members who select the option of Participant Direction, application packages are submitted within thirty (30) business days of completion. 1. IPOC was re-implemented upon return to field instructions by the state. 2. Options Counseling training was completed for all CMs. 3. 100% SCS tools were moved to the Assessment team for completion as the CMs returned to field. 4. The Assessment team was trained on the SCS Template job aid which included the type of options counseling completed for the member. 1. SCS Template job aid was revised to include documentation regarding PPP option. 2. The POC was revised to include documentation regarding the option of PPP to the member. 3. The documentation of PPP is included in IPOC which was re-implemented with the return to field. 1. Revised the POC to include a place for CEA documentation. 2. The POC was later revised to make the documentation mandatory within the POC as opposed to other locations. 1. Managers have the CMs document the CEA in their weekly tracker. 2. Managers review the weekly tracker with the CM during their weekly 1:1 meeting.	

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	Initial/Ongoing POC and Back-up Plan: 1. **Recommendation: Group C and Group D:** UHCCP should ensure that Member had a completed, signed/verbally acknowledged, initial Plan of Care on file that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program. 2. **Group C, Group D, and Group E:** UHCCP should ensure that Members who required a Back-up Plan, had a completed and signed Back-up Plan using the State mandated form. 3. **Group C, Group D, and Group E:** UHCCP should ensure that Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Backup Plan reviewed with the Member at least on a quarterly basis. 4. **Group C, Group D, and Group E**: UHCCP should ensure that there is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period. 5. **Group C, Group D, and Group E:** UHCCP should ensure that Member file included a member rights and responsibilities statement signed/verbally acknowledged by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them. 6. **Group C, Group D, and Group E:** UHCCP should ensure that the Care Manager educates the Member on how to file a grievance and/or an appeal. 7. **Group C, Group D, and Group E**: UHCCP should ensure that Members who were identified as having a positive risk, have a signed/verbally acknowledged Risk Management Agreement with all components. 8. **Group D: UHCCP** should ensure that Member was assessed for PCA services within 45 days of enrollment into MLTSS. 9. **Group D and Group E:** UHCCP should ensure that Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and	

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	that these needs or preferences were acknowledged and addressed in the Plan of Care. **Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans)** **Recommendation: Group C and Group D:** UHCCP should ensure that Member had a completed, signed/verbally acknowledged, initial Plan of Care on file that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program. **Response:** 1. New Options counseling Summary form was implemented by state. Training provided to CMs 2. Audits completed by designated team 3. Ongoing training as needed as results of audits **Recommendation: Group C, Group D, and Group E**: UHCCP should ensure that Members who required a Back-up Plan, had a completed and signed Back-up Plan using the State mandated form. **Response:** 1. Back-up plan retraining to managers completed by the AHSD to re-train CM staff during huddle 2. CMs will be audited monthly to ensure compliance 3. Mandatory POC training completed for all CM staff and educated on back up plan process **Recommendation: Group C, Group D, and Group E:** UHCCP should ensure that Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Backup Plan reviewed with the Member at least on a quarterly basis. **Response:** 1. Back-up plan retraining to managers completed by the AHSD to re-train CM staff during huddle 2. CMs will be audited monthly to ensure compliance 3. Mandatory POC training completed for all CM staff and educated on back up plan process **Recommendation: Group C, Group D, and Group E:** UHCCP should ensure that there is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period. **Response:** 1. Back-up plan retraining to managers completed by the AHSD to re-train staff during huddle 2. CMs will be audited monthly to ensure compliance 3. Mandatory POC training completed for all CM staff and educated on emergency/disaster planning **Recommendation: Group C, Group D, and Group E:** UHCCP should ensure that Member file included a member rights	

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	and responsibilities statement signed/verbally acknowledged by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them. **Response:** 1. Retraining to managers completed by the AHSD and Managers to train process to the teams in Huddles 2. CMs will be audited monthly to ensure compliance 3. Mandatory POC training completed and POC is in process of revision to provide clarity for signatures of POA/Representative when the member is cognitively impaired **Recommendation: Group C, Group D, and Group E:** UHCCP should ensure that the Care Manager educates the Member on how to file a grievance and/or an appeal. **Response:** 1. Retraining to managers completed by the AHSD and Managers to train process to the teams in Huddles 2. CMs will be audited monthly to ensure compliance 3. POC is in process of revision in case management system to provide specific documentation for Grievance and appeal process. **Recommendation: Group C, Group D, and Group E:** UHCCP should ensure that Members who were identified as having a positive risk, have a signed/verbally acknowledged Risk Management Agreement with all components. **Response:** 1. Retraining to managers completed by the AHSD and Managers to train process to the teams in Huddles of assessing and/or reviewing current or potential risk factors identified during each POC visit, consequences of risk, interventions to mitigate risk, documenting the risk in risk management agreement in member record, and obtaining signatures on the risk management agreement form. 2. CMs charts will be audited monthly to ensure compliance of risk management agreement in member record **Recommendation: Group D:** UHCCP should ensure that Member was assessed for PCA services within 45 days of enrollment into MLTSS. **Response:** 1. PCA retraining timeframes and process to be completed during team huddles 2. Attestations to be completed by staff	

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	3. Managers review PCA report monthly **Recommendation:** **Group D and Group E:** UHCCP should ensure that Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care. **Response:** 1. Retraining to managers completed by the AHSD and Managers to train process to the teams in Huddles 2. CMs will be audited monthly to ensure compliance 3. Mandatory POC training completed and person centric goals, SMART goals and interventions education provided to all CM staff. **Response:** **Group C Remediation:** United Healthcare will ensure that the Initial Plan of Care is completed, signed/verbally acknowledged by the Member/Member representative, and a copy of the Plan of Care will be provided to the Member within 45 days of enrollment in the MLTSS program. During the training, timeframes for completion of the POC were reinforced additional training via Resource Hours monthly to reinforce SMART goal and intervention development. 1. Completed a staffing analysis which showed a deficit in staffing levels. Human Resources began an intense campaign to hire CMs to bring staffing levels to contractual requirements. 2. The end-to-end process for HCBS was reviewed with the CMs with an emphasis on completing the POC within 45 days and the importance of having the member complete the documentation of understanding of the POC. 3. Quarterly clinical audit tool reviews 5% (per contract) of each CM's caseload. POC was revised to include a statement that the POC will be mailed to the PCP and member signed agreement. The end-to-end process for HCBS was reviewed with the CMs with an emphasis on completing the Options Counseling, PCA tool, and POC within 45 days. Quarterly clinical audit tool reviews 5% (per contract) of each CM's caseload. Training for member-centric documentation to include SMART goals with the participation of the Member were completed. Audit of POC put into place with corrections	

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

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	up Plan and the date it was reviewed. Computers that allow for onscreen signatures were provided to each of the CMs to allow for signature completion at the time of the visit instead of mailing the document and requesting a signed copy. All CMS completed Risk Management Agreement Training. Presentation developed for Managers to complete Risk Assessment training in their team Huddles. The Clinical Audit includes a metric for the statement that the member received the Member Rights and Responsibilities and is aware of their rights and responsibilities per the documentation in the POC. The Member Rights and Responsibilities are provided to the member either during the face-to-face touchpoint or through the mail. Computers that allow for onscreen signatures were provided to each of the CMs to allow for signature completion at the time of the visit instead of mailing the document and requesting a signed copy. **Group E Remediation:** United Healthcare will certify that the Plan of Care reflects a Member-centric approach, and the Member/Member Representative will be both present and involved in the development and modification of agreed upon goals. A Combo report has been developed to monitor the enrollment date and the date the Plan of Care is due to ensure the POC is completed by day 45. This report is monitored daily by the managers and weekly by the executive team. The POC was completely revised, trained, and implemented. Emphasis on Person-centered approach to all aspect of the POC as well as the development of SMART goals and interventions. During the training, timeframes for completion of the POC were reinforced additional training via Resource Hours monthly to reinforce SMART goal and intervention development. Audits are completed quarterly to review the POC to ensure person-centered approach. Reporting for adherence to required timeframes is run daily and provided to the management team. Risk Assessment and Risk Management Agreement are completed initially, annually, and change in condition. All required documentation of the Back-Up Plan was put in the revised Plan of Care that was rolled-out in March 2022. Member Rights and Responsibilities: Includes the process for grievance/appeals and how to report a Critical Incident. The Member Rights and Responsibilities is signed by the member initially and annually. Additional documentation is in the Plan of Care. Training for member-centric documentation to include SMART goals with the	

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	participation of the Member was completed. Audit of POC put into place with corrections requested as needed. POC was revised to include the documentation of the completion of the Back-up Plan and the date it was reviewed. Computers that allow for onscreen signatures were provided to each of the CMs to allow for signature completion at the time of the visit instead of mailing the document and requesting a signed copy. All CMS completed Risk Management Agreement Training. Presentation developed for Managers to complete Risk Assessment training in their team Huddles. The Clinical Audit includes a metric for the statement that the member received the Member Rights and Responsibilities and is aware of their rights and responsibilities per the documentation in the POC. The Member Rights and Responsibilities are provided to the member either during the face-to-face touchpoint or through the mail. Computers that allow for onscreen signatures were provided to each of the CMs to allow for signature completion at the time of the visit instead of mailing the document and requesting a signed copy. **Ongoing Care Management** **Recommendation:** 1. **Group C, Group D, and Group E:** UHCCP should ensure that Member had a documented face-to-face/telephonic visit to review Member placement and services during the review period that was held within the appropriate timeframes (An ongoing face-to-face/telephonic visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit). 2. **Group C and Group D:** UHCCP should ensure Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed/verbally acknowledged and was provided with a copy of the Plan of Care. 3. **Group D and Group E:** UHCCP should ensure that For Members who were discharged to a HCBS setting the onsite review occurred within ten (10) days of discharge. 4. **Group D:** UHCCP should ensure that Member was discharged to his/her own home and in home services were in place in a timely manner	

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

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	documentation in the POC. The Member Rights and Responsibilities are provided to the member either during the face-to-face touchpoint or through the mail. Computers that allow for onscreen signatures were provided to each of the CMs to allow for signature completion at the time of the visit instead of mailing the document and requesting a signed copy. There is a designated team that reviews discharges from facilities via the Blended Census Reporting Tool to notify CM of recent Discharge from an institution. CM calls the member within 10 days of discharge to confirm services have resumed and no other services are needed. Will schedule a face-to-face visit for any change in condition due to the hospitalization. **Group D Remediation**: The Clinical Coordinator will outreach to all MLTSS Community members at a minimum of every 90 days (or 180 days for CARS) to confirm placement and review the Plan of Care and the member's back up plan to ensure accuracy. United Healthcare will certify that the Plan of Care reflects a Member-centric approach, and the Member/Member Representative will be both present and involved in the development and modification of agreed upon goals. Audit of POC put into place with corrections requested as needed. POC was revised to include the documentation of the completion of the Back-up Plan and the date it was reviewed. Computers that allow for onscreen signatures were provided to each of the CMs to allow for signature completion at the time of the visit instead of mailing the document and requesting a signed copy. The Plan of Care was revised to capture the update the changes made to the Member's POC and is reviewed, updated, and signed by the CM at all touch points. Documentation at the end of the POC provides statement the member participated in the development of the POC, this includes updated training provisions around change in condition Plan of Care development and the secure of the amended, reviewed and verbally acknowledged POC by the member and/or authorized representative. Member will receive a copy of the POC. **Group E Remediation:** The Clinical Coordinator will outreach to all MLTSS Community members at a minimum of every 90 days (or 180 days for CARS) to confirm placement and review the Plan of Care and the member's back up plan to ensure accuracy. United Healthcare will certify that the Plan of Care reflects a Member-centric approach, and the Member/Member Representative will be both present and involved in the development and	

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

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	Manager follow-up to complete a telephonic visit within ten (10) business days of the Member's discharge from an institutional facility to a HCBS setting. Critical Incident training is completed during on boarding and then annually with a required post-test. Critical Incidents are initiated for members requiring immediate support loss or gaps of service for expedient resolve. **Group E Remediation:** Care Managers identifying a gap in care for members receiving MLTSS and not residing in community alternative settings will follow the documented escalation process. Plan of Care training to reinforce obtaining the member's acknowledgement. Managers provided reminders to their CM teams during huddles. Reinforcement of the Gap in Care job aid which includes documentation in an activity the notification of the gap in care, the reason for the gap in care and the steps taken to resolve the gap in care. Plan of Care contains an agreement statement where the member acknowledges they received the Member Rights and Responsibilities and is aware. Members displaying disagreement with the with the Assessment and/or authorization of placement/service (including the amount and/or frequency of a service) will be counseled by the Care Manager related to a written notice of action that will explain the member's rights to file an appeal. United Healthcare will certify that the Care Manager follow-up to complete a telephonic visit within ten (10) business days of the Member's discharge from an institutional facility to a HCBS setting. Critical Incident training is completed during on boarding and then annually with a required post-test. Critical Incidents are initiated for members requiring immediate support loss or gaps of service for expedient resolve. **Performance Measure #8. Plans of Care established within 45 days of MLTSS enrollment was missed for Group C (14.3%, Group D 9.2%, Ancillary Group C 0.0%, and Ancillary Group D 26.1%)** **Recommendation: Group C and Group D:** UHCCP should ensure that a copy of the initial Plan of Care is provided to the Member and/or authorized representative within 45 days of MLTSS enrollment. Response: 1. Managers will review initial POC expectations and POC completion report during team huddles and 1:1 with CMs during monthly supervision meetings.	

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	2. HCBS Face-to-face process review open to all CM staff for training provided monthly 3. Annual training for MLTSS CM HCBS face to face visit process was completed 10/2023 and ongoing monthly 1:1 monitoring of CM compliance. Performance Measure #9a: Member's Plan of Care is amended based on change of Member condition Group D 25.0%Recommendation: **Group D:** UHCCP should ensure that Member's Plan of Care is amended based on change in Member condition. **Response:** 1. Retraining to managers completed by the AHSD 2. Managers to train process to the teams in Huddles 3. CMs will be audited monthly to ensure compliance 4. Mandatory POC training completed which included revision to POC for Change in Condition. **Performance Measure #11: Plans of Care developed using "Person-Centered principles" Group D 58.7%, and Group E 62.5%** **Recommendation:** **Group D and Group E**: UHCCP should ensure that the Plans of Care developed are using "Person-Centered Principles." Plans of Care should contain evidence all options were reviewed with the Member and/or authorized representative and is signed by the Member and/or authorized representative. Response: 1. Retraining to managers completed by the AHSD and Managers to train process to the teams in Huddles 2. CMs will be audited monthly to ensure compliance 3. Mandatory POC training completed and person centric goals, SMART goals and interventions education provided to all CM staff. **Performance Measure #12: MLTSS Home and Community-Based Services (HCBS) Plans of Care that contain a Back-up Plan Group C 50.0%, Group D 68.8%, and Group E 65.2%** **Recommendation:** **Group C, Group D, and Group E**: UHCCP should ensure that MLTSS Home and Community Based Services (HCBS) Plans of Care contain a Back-up Plan signed by the Member and/or authorized representative. Response: 1. Back-up plan retraining to managers completed by the AHSD to train CM staff 2. CMs will be audited monthly to ensure compliance	

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	3. Mandatory POC training completed for all CM staff and educated on back up plan process. **Performance Measure #16: Member training on identifying/reporting critical incidents Group C 71.4%, Group D 80.0% and Group E 78.4%** **Recommendation:** **Group C, Group D, and Group E:** UHCCP should ensure that the Care Manager educates the Member on identifying/reporting Critical Incidents. Response: 1. Retraining to managers completed by the AHSD 2. Managers to train process to the teams in Huddles 3. CMs will be audited monthly to ensure compliance 4. Mandatory POC training completed which included revision to POC for Critical Incident Reporting	
UHCCP should address all deficiencies noted in the MLTSS – NF/SCNF 2023 CM Review for elements that scored below 86%.	**Facility and MCO Plan of Care:** **Recommendation:** UHCCP's MLTSS Care Managers should ensure that the Member's care management record contains a copy of the Facility Plan of Care during the review period. **Member's care management record contained copies of any Facility Plans of Care on file during the review period.** **Response:** 1. Updated the Plan of Care to document receipt of Facility Plan of Care to include date and storage location. 2. Monthly NF Face-to-face process review open to all CM staff for training 3. Continue to monitor Metric to the Nursing Facility documentation audit for managerial review **MLTSS Initial Plan of Care and Ongoing Plans of Care:** **Recommendation:** The Member's individualized Plan of Care was developed in collaboration with the Member and a copy is mailed to the Member within forty five (45) calendar days of enrollment notification into the MLTSS program. **The Member's individualized Plan of Care (including obtaining Member's signature) was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program (for Members newly enrolled in MLTSS).**	Addressed

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	Response: 1. Managers are required to review weekly POC and New Enrollee reports for compliance 2. Managers will review expectations 1:1 with CMs during supervision meetings. 3. Nursing Facility process was updated to reinforce policies 4. NF Face-to-face process review open to all CM staff for training provided monthly 5. Annual training for MLTSS CM NF face to face visit process 6. UHC shared an updated email inbox to NF providers to promote collaboration and improve communication between CM Team and NF Contacts. **Transition Planning:** **Recommendation:** Identify Members for transfer to HCBS and offer Members options including transfer to the community. **Member was identified for transfer to HCBS and was offered options, including transfer to the community.** Response: 1. Training scheduled for new Options Counseling Summary which included discussion of community options 2. Training provided on the Nursing Home Transition process provided to CMs monthly 3. Managers to provide Inservice to team during huddle to include Options Counseling and IDT attendance. **Transition Planning:** **Recommendation:** Participate in at least one Interdisciplinary Team meeting during the review period **Evidence of the Care Manager's participation in at least one Telephonic Interdisciplinary Team (IDT) meeting during the review period. (Participation in an IDT meeting may be substituted for one Member visit.)** **Response:** 1. Scheduling of IDT will be reinforced during huddles and 1:1 supervisory meetings. 2. Managers to provide Inservice to team during huddle to include Options Counseling and IDT attendance. **Transitioning Planning:** Recommendation: Ensure telephonic or onsite visits are timely and occurred within at least 180 calendar days for non-pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members	

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	Timely onsite/telephonic review of Member placement and services. Onsite/Telephonic visits were timely and occurred within at least 180 calendar days for non-pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability). **Response:** 1. Review reports for compliance 2 Review compliance expectations with CMs during 1:1 meetings. 3. Nursing Facility process was updated to reinforce setting assignments as a reminder 4. Monthly NF Face-to-face process review open to all CM staff for training 5. Managers will meet with staff who are non-compliant to review reporting and audit scores to create a plan to get membership assigned in compliance. Care management staff will be re-trained as needed to ensure understanding of contractual requirements. Recommendation: Care Managers should explain and discuss any payment liability with Members relating to their NF/SCNF admission. Care Manager explained and discussed any payment liability with the Member if a Member had any payment liability for the NF/SCNF admission. (72.0%) Response: 1. The CM documents in POC confirmation that education regarding Patient Payment Liability is provided. 2. Statement on the POC was revised to be required. 3. Annual training for MLTSS CM NF face to face visit process **Reassessment of the POC and Critical Incident Reporting:** **Recommendation:** Care Managers should ensure the NJCA is completed to assess the Member upon any of the following conditions: significant changes in Member condition, prior to a discharge from NF/SCNF, permanent change in living arrangement, or annual re-assessment. **NJCA was completed to assess the Member upon any of the following conditions: significant changes in Member condition, prior to a discharge from NF/SCNF, permanent change in living arrangement, or annual re-assessment.** **Response:** 1. Annual training for MLTSS CM NF face to face visit process was completed and included review of assessment	

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	completion for significant changes in Member condition, prior to a discharge from NF/SCNF, permanent change in living arrangement, or annual re-assessment. **Reassessment of the POC and Critical Incident Reporting:** Recommendation: Care Managers should also ensure the Plan of Care is updated, reviewed, and signed by the Member and/or representative and a copy is provided to the Member and/or representative. **Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative.** **Response:** 1. Annual training for MLTSS CM NF face to face visit process to include requirement for the signature and mailing of the Plan of Care after updating. **Reassessment of the POC and Critical Incident Reporting:** Care Manager educated the Member on how to file a grievance and/or an appeal (55.0%) Recommendation: Educate the Member on how to file a grievance and/or an appeal annually. Member and/or representative had training on how to report a critical incident, specifically including how to identify abuse, neglect, and exploitation (54.0%) Recommendation: Train on identifying/reporting critical incidents to specifically include how to identify abuse, neglect, and exploitation. Recommendation: Review the Member's Rights and Responsibilities under the MLTSS program annually. **Care Manager reviewed the Member's Rights and Responsibilities.** **Response:** 1. Annual training for MLTSS CM NF face to face visit process to include requirement for the signature and mailing of the Plan of Care after updating. **Performance Measure #8. Initial Plan of Care established within 45 days of enrollment into MLTSS (8.3%)** **Recommendation:** UHCCP's MLTSS Care Managers should ensure that the Initial Plan of Care is established within 45 days of enrollment. **Response:** 1. Managers are required to review weekly POC and New Enrollee reports for compliance	

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	2. Managers will review expectations 1;1 with CMs during supervision meetings. 3. Nursing Facility process was updated to reinforce policies 4. NF Face-to-face process review open to all CM staff for training provided monthly 5. Annual training for MLTSS CM NF face to face visit process. **Performance Measure #9. Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary** **Recommendation:** Review Member's Plan of Care annually within 30 days of the Member's anniversary and as necessary. Response: 1. Managers review weekly the POC report to determine compliance. 2. Manager review outcomes of audit reviews with the CM 1:1 as needed for compliance concerns. **Performance Measure #16. Member training on identifying/reporting critical incidents** **Recommendation:** MLTSS Care Managers should provide Member training on identifying/reporting critical incidents. Response: 1. Annual training for MLTSS CM NF face to face visit process to include requirement for how to submit a Critical Incident Report 2. CMs attend annual Learn Source training on the Critical Incident Reporting 3. Critical Incident Reporting process review open to all CM staff for training provided monthly	
UHCCP should address all deficiencies noted in the MLTSS – NF/SCNF 2023 CM Review for elements that scored below 86%. (Cont'd.)	**Facility and MCO Plan of Care** Member's care management record contained copies of any Facility Plans of Care on file during the review period. 1. NF process was updated to reinforce documentation upload of Facility POC 2. Reminder/re-education was provided during weekly huddle 3. Reinforced element of Facility POC that is in the HP POC and added to orientation materials 4. Added Metric to NF documentation audit for managerial review	

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	MLTSS Initial Plan of Care and Ongoing Plans of Care 1. HCBS CM to attend, either in person or telephonically, in order to provide a safe transitions for the NF to the community. 2. UHC shared and updated email inbox to NF providers to promote collaboration and improve communication between CM team and NF contacts. **Transition Planning** 1. The CM confirms with the facility personnel that they have discussed payment liability with the member 2. Added to Revised POC 3. Added to the End-to-End process 4. Timely review of placement and services are metrics on the Manager Audit tool **Reassessment of the Plan of Care and Critical Incident Reporting** 1. NJCA was completed to assess the Member upon any of the following conditions: significant changes in Member condition, prior to a discharge from NF/SCNF, permanent change in living arrangement, or annual re-assessment 2. Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative 3. Care Manager reviewed the Members's rights and responsibilities 4. Care Manager educated the Member on how to file a grievance and/or and appeal 5. Member and/or representative had training on how to report a critical incident, specifically including how to identify abuse, neglect and exploitation **MLTSS Performance Measures Results** 1. Review was added to the Manager Audit tool 2. POC section of the NF process updated to provide clarity for the required elements of the POC	

Recommendation for UHCCP	UHCCP Response/Actions Taken	IPRO Assessment of MCO Response[1]
	3. There is a box on the POC to allow for documentation of actions taken. The metric was added to the Manager Quality Audit tool 4. The metric is in the Manager Audit tool for quarterly review. The CM documents member education/agreement in the space provided on the POC 5. Annual training for Critical Incidents Reporting for CMs with the reviewed CI Reporting form included. During the POC review with the member, the CM reviews the situations where the CM should be contacted immediately. The member initials their understanding on the POC	

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

WPNJ Response to Previous EQR Recommendations

Table 60 displays WPNJ's progress related to the *State of New Jersey DMAHS, Wellpoint New Jersey, Inc. Annual External Quality Review Technical Report FINAL REPORT: April 2024,* as well as IPRO's assessment of WPNJ's response.

Table 61: WPNJ Response to Previous EQR Recommendations

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
For Improving Well Child Visits and Immunization Rates for members 0-30 months, the MCO should have used MY 2021 for the Baseline Rates inclusive of numerator and denominator. The MCO should have updated the information for the Baseline and corresponding Tables/ Sections that were impacted by not using the 2021 Baseline as guided. This discrepancy led to the	Established corrective measures defined in prior CAP response from prior review period (7/1/2021- 6/30/22). Demonstrated compliance and effectiveness of corrective measures as demonstrated in improved and exceeding PIP scores for review period during 7/1/2023-6/30/2024 review cycle.. No additional remediation steps will be implemented	Addressed

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
misalignment with the Objective, Aim, and Goals of the PIP which may have delayed progress toward the outcomes.		
For the MLTSS PIP Reduction in Falls among Home and Community Based members in MLTSS, there were miscalculations when updating data that remained in the Final Report. A correction was made to the HCBS value, however the total number of unique members remained unchanged. This one miscalculation also impacted the FRA Unique member percentage value and could be carried through the PIP. The MCO should have reviewed each section for all metrics, ensuring that all data were represented in a clear and concise manner, identifying the rational for changes and updates in the tables and in the discussion sections to ensure the accuracy of the information that carries through each measurement year through the life of the PIP.	Established corrective measures defined in prior CAP response from prior review period (7/1/2021- 6/30/22). Demonstrated compliance and effectiveness of corrective measures as demonstrated in improved and exceeding PIP scores for review period during 7/1/2023-6/30/2024 review cycle. No additional remediation steps will be implemented	Addressed

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
For the MLTSS PIP Decreasing Gaps in Care in Managed Long Term Services and Supports, there were inconsistencies in numeric formats and values and insufficient data presented to evaluate year-over-year progress. Data challenges were noted, but no solutions were identified. In addition, the MCO did not exhibit an understanding of progress made in performance indicators and its sustainability over time. The MCO should have reviewed each PIP section for all metrics, ensuring that all data were represented in a clear and concise manner, identifying the rational for changes and updates in the tables and in the discussion sections to ensure the accuracy of the information that carries through each measurement year through the life of the PIP.		
The MCO should ensure to provide DMAHS with a certified provider network file on a quarterly basis.	Wellpoint has a process in place to submit the quarterly Provider Network File (PNF) to DMAHS along with the Quarterly Provider Network Certification Form which is signed by Wellpoint's Health Plan President. Wellpoint has submitted its PNF reporting to the State timely however during submission of evidence in the 2023 Annual	Addressed

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	Assessment we submitted two quarters instead of all four quarters as an example of evidence. DMAHS accepted Wellpoint's Corrective Action Plan response for this finding for Element A4 of the 2023 Annual Assessment. Wellpoint will ensure future audit evidence will include all four quarters of the PNF for the audit contract year.	
The MCO should continue to focus its efforts on provider recruitment in order to improve access to care for adult PCPs in Hunterdon County.	Hunterdon Healthcare and its affiliated IPA directly employ the majority of the physicians in this county. Hunterdon Healthcare requested to enter into delegated credentialing with Wellpoint. The pre-delegation audit, and delegated credentialing agreement was approved by DMAHS and Department of Banking and Insurance on June 27, 2024. Wellpoint is actively working with Hunterdon Healthcare to load their entire provider roster. Once completed, the deficiency in Hunterdon will be resolved.	Addressed
The MCO should continue to focus its efforts on provider recruitment in order to improve access to care for Pediatric Specialists in Pediatric Sleep Medicine in all counties, as well as other Pediatric Specialist deficiencies in Atlantic, Burlington, Cape May, Mercer, Monmouth, Ocean, and Warren Counties.	Wellpoint conducted a comprehensive study of New Jersey providers to identify recruitment opportunities by geo-location and provider specialty. This analysis entailed review of the entire NJ Medicaid Certified Providers (21st century registered) as produced by DMAHS, National Plan & Provider Enumeration System (NPPES) for all Medicaid registered providers and nonregistered providers, NJMMIS, and internal claim processing databases. Wellpoint's competitive analysis of Pediatric network deficiencies was submitted to the State the week of June 24, 2024. Wellpoint has cured the Pediatric Sleep Medicine deficiencies in Ocean and Warren counties. Wellpoint continues to actively recruit, and search for additional available new providers.	Remains an opportunity for improvement
The MCO should continue to focus its efforts on provider recruitment in order to improve access to care for General Dentists in Cape May, Hunterdon, Middlesex, Monmouth, Salem, Somerset, Sussex and Warren Counties.	Wellpoint is focused on continued provider recruitment efforts to improve access to all its members, including those seeking care by general dentist in Cape May, Hunterdon, Middlesex, Monmouth, Salem, Somerset, Sussex and Warren Counties. Should there be any access related issues in securing a network provider, Wellpoint, in collaboration with our dental vendor partnerships, would establish an out-of-network agreement with an appropriate provider to guarantee that all dental requirements of all our members are fully accommodated. As part of our proactive approach to minimize any issues regarding access to dental services, we continue to enhance our service network via strategic recruitment. This includes a comprehensive review of geographical access reports, an ongoing analysis of competitor provider directories, and a thorough investigation of all provider	Addressed

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	leads. Suggestions from our members and providers are considered to broaden the scope of our service network. Precisely within the vicinity of FIDE SNP members, the provider relations team is leading strategic recruitment efforts. Recruitment information is now gathered and analyzed with increased detail which aids in the formulation of targeted strategies and intensifies the effectiveness of our recruitment drive. At regular monthly intervals, these procedures and strategies are reviewed for optimization. Constant communication is maintained between call centers, the provider relations team, and case management teams, fostering a collective effort to identify and resolve any potential issues relating to access to care. This collected information also aids in crafting strategies to prevent any future deficiencies. Our general dentistry deficiencies have decreased, but Wellpoint will sustain the intensity of our recruitment operations while maintaining a stringent overview of the network and associated recruitment tactics. Additional attention will also be placed on provider retention. Any potential provider terminations will be evaluated and addressed to not just retain the member and avert access issues, but also to gather key data that could help us inhibit similar issues in the future.	
The MCO should continue to focus its efforts on provider recruitment in order to improve access to care for Pedodontists in Atlantic, Cape May, Mercer, Monmouth, Somerset and Sussex Counties.	Wellpoint is focused on continued provider recruitment efforts to improve access to all its members, including those seeking care by pediatric dentist in Atlantic, Cape May, Mercer, Monmouth, Somerset and Sussex Counties. Should there be any access related issues in securing a network provider, Wellpoint, in collaboration with our dental vendor partnerships, would establish an out-of-network agreement with an appropriate provider to guarantee that all dental requirements of all our members are fully accommodated. As part of our proactive approach to minimize any issues regarding access to dental services, we continue to enhance our service network via strategic recruitment. This includes a comprehensive review of geographical access reports, an ongoing analysis of competitor provider directories, and a thorough investigation of all provider leads. Suggestions from our members and providers are considered to broaden the scope of our service network. Precisely, within the vicinity of FIDE SNP members, the provider relations team is leading strategic recruitment efforts. Recruitment information is now gathered and	Addressed

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	analyzed with increased detail which aids in the formulation of targeted strategies and intensifies the effectiveness of our recruitment drive. At regular monthly intervals, these procedures and strategies are reviewed for optimization. Constant communication is maintained between call centers, the provider relations team, and case management teams, fostering a collective effort to identify and resolve any potential issues relating to access to care. This collected information also aids in crafting strategies to prevent any future deficiencies. Currently there a no geo-access deficiencies regarding pediatric dentists, but Wellpoint will continue the intensity of our recruitment operations while maintaining a stringent overview of the network and associated recruitment tactics. Additional attention will also be placed on provider retention. Any potential provider terminations will be evaluated and addressed to not just retain the member and avert access issues, but also to gather key data that could help us prevent access deficiencies in the future.	
The MCO should continue to address hospital deficiencies in Hunterdon County.	MCO has contracted with Hunterdon Hospitals as of August 1, 2023 and there is no longer a hospital deficiency in the county.	Addressed
The MCO should focus on improving appointment availability for OB-GYNs, Other Specialists, Urgent Specialty care, Behavioral Health Prescribers, Behavioral Health Non-Prescribers as well as PCP after-hours non-compliance.	Appointment Availability is reviewed on a quarterly basis. We also send two survey waves per contractual year to ensure availability standards are being met. We will continue to assess and monitor any new deficiencies that may develop.	Addressed
The MCO should ensure to perform random quarterly surveys to members to verify the enrollees understanding of procedures and services available to new members.	In response to the IPRO recommendation, Wellpoint began to conduct quarterly, in-person member orientations. These orientations are designed to familiarize new members with available procedures and services. Furthermore, a survey is conducted at the end of each session to gauge members' understanding. In 2024, Wellpoint organized two such orientations on March 28th in Lakewood, NJ, and June 26th in Paterson, NJ. New members were identified and informed via a text campaign.	Addressed

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	At these orientations information was shared about NJ FamilyCare benefits along with other value-added benefits that Wellpoint offers. We also took the opportunity to review the onboarding process, demonstrate how to reach Member Services when needed, and discuss member ID cards and handbooks. One measure of success we used was a survey conducted during the orientation to ensure the new members understood the procedures and services. However, limited participation at these in-person orientations led us to add virtual orientations to our roster, starting in September. This change aims to reach and engage a larger pool of new members. In addition, Wellpoint regularly solicits feedback from members through quarterly Health Education Advisory meetings. We identify and invite members residing in the surrounding area of the meeting location via a text campaign. These meetings serve multiple purposes: they help us evaluate our services, benefits, and access to care, they get us up to speed on members' cultural and linguistic needs, and they help us discover preferred health education topics. The information collected enables us to identify any barriers to care that members might face, and answer any questions they may have regarding Wellpoint, our onboarding process, and their benefits. Our staff is always available to assist members facing difficulties. Finally, member feedback informs and enables us to improve our programs and processes continually.	
The MCO should establish a method for tracking and scoring the quarterly calls to new members and have available for review by DMAHS and/or the EQRO upon request at regularly scheduled site visits.	Survey results, up until February 2024, were submitted to DMAHS on March 1, 2024. Additionally, we also recorded and submitted survey responses from the two orientations as part of our annual audit materials in August 2024. Our health plan also includes a monthly welcome call for new members, which is conducted anywhere between 1 and 30 days following a member's enrollment. We strive to connect with each new household, making up to three call attempts if necessary. During this call, members are surveyed to gauge their understanding of the information they've received as new enrollees. If a member isn't fully aware of procedures or available benefits, they are informed and educated during the call itself. Responses to these survey questions are carefully noted and stored in a database. Monthly reports, summarizing these survey responses, are prepared for the health plan's review. This data is then scrutinized and put to use,	Addressed

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	helping us enhance and refine our programs and services on a continual basis.	
The MCO should ensure that their policy or Member Handbook should be updated to list specific good cause reasons as outlined in the Contract language.	To address IPRO's recommendation, Wellpoint updated its Member Handbook and Disenrollment policy (page 80) to list specific good cause reasons as outlined in the Managed Care Contract language.	Addressed
The MCO should ensure that their policy or Member Handbook should be updated to list specific out of state exceptions as outlined in the Contract language.	To address IPRO's recommendation, Wellpoint updated its Member Handbook and Disenrollment policy (page 83) to list specific out of state exceptions as outlined in the Managed Care Contract language.	Addressed
The MCO should ensure that appropriate staff with knowledge of the systems are available to demonstrate MCO compliance with the standard. Additionally, MLTSS staff who have a daily working knowledge of how the systems are used should be available to participate in the review.	Wellpoint will ensure both front end and engineering staff shall be available for future care management system demonstrations. Upon the release of the HIP 2.0 system, Wellpoint will also ensure the product development team will be available to provide a review of updates made to our care management user interface as well as how these systems interconnect.	Addressed
Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, WPNJ should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their	Wellpoint will continue to execute on the HEDIS work plan that identifies measures that fell below the NCQA 50th percentile benchmarks. Each identified measure has a barrier analysis completed with specific interventions designed to address both member and provider barriers, to help drive improved compliance across HEDIS measures. Wellpoint continues to see marked improvement across several measures and will continue to implement interventions that support improved compliance, such as leveraging digital solutions that get information to members and providers quickly and easily, expanding provider quality incentive offerings, re-evaluating and enhancing member incentives and value-based benefits that reward members for completing well-care and	Addressed

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
respective benchmarks for more than one reporting period.	preventive services, and designing educational materials to help further expand knowledge and awareness around the importance of continued engagement and completing timely preventive and well-care services, and medication adherence. Wellpoint will continue to use data trends and member and provider feedback as important resources to refine interventions and /or develop new interventions that the plan is confident will continue to mark improved performance in HEDIS measures in the future.	
The MCO should continue to work to improve Adult and Child CAHPS scores that perform below the 50th percentile.	Wellpoint will continue to re-evaluate prior years' CAHPS scores and defined workplan intervention results to identify additional areas of opportunity to focus on improving survey results across CAHPS categories. Health plan will implement expanded CAHPS survey for children with chronic conditions in 2024 and will continue to build upon established interventions and new areas for improvement based on upcoming survey.	Remains an opportunity for improvement
WPNJ should address the deficiencies noted in the Core Medicaid - 2023 CM Review in the following areas: GP: Identification, Outreach, Preventive Services, Continuity of Care, Coordination of Services, and all CM element specific deficiencies noted in the review.	**CM2:** Deficiency Noted - 72.7% - For Enrollees who were hospitalized, adequate discharge planning was performed. Interventions - Two additional care managers hired and dedicated to discharge planning via the DCMP (Discharge Management Program). Manager and senior care managers to attend daily rounds with the UM nurses and Medical Directors. CM Process Improvement Series to continue into 2024 with modifications to increase focus on discharge planning and other IPRO audit deficiencies. Review of PDM (post discharge management) protocols and expectations for documentation with clinical and non-clinical staff during team meetings and CM Process Improvement Series meetings. **CM3:** Deficiency Noted - 27.3% - The MCO appropriately identified Enrollees with potential CM needs during the review period (applies to New Enrollees enrolled prior to 11/16/2021). 69.8% - The MCO appropriately identified Enrollees with potential CM needs during the review period (applies to Existing Enrollees enrolled prior to 11/16/2021). Interventions - New CM protocols and expectations for documentation with clinical and non-clinical staff to be reviewed during the modified 2024 CM Process Improvement Series meetings using case studies. UM rounds process enhanced to include a more focused discussion on multiple members with CM needs. CM audit tool to be revised to include continued follow-up of members post discharge. Audit tool updates include clearer language regarding requirements for aggressive outreach, proper referrals and care coordination with	Addressed

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	members, providers, UM and CM teams. Manager to round with CMs on cases where members were unable to be contacted to ensure all methods of outreach are conducted. **CM5:** Deficiency Noted - 78.6% - For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee. Interventions - New CM protocols and documentation expectations to be discussed during the upcoming 2024 CM Process Improvement Series meetings with clinical and non-clinical staff. Topics to include use a multi-disciplinary team to manage the care of members needing care management services and other IPRO audit deficiencies. DCMP-specific audit tool to be developed to include an element on documentation of work with a multi-disciplinary team using the process of involving coordination with different types of health services provided by multiple providers in all care settings, including the home, clinic, and hospital. **CM7:** Deficiency Noted - 69.2% - For Enrollees with no CNA on file, initial outreach to complete a CNA was done. Interventions - General Population Manager will review cases without CNAs for evidence of appropriate aggressive outreach and timeliness of completion. Care managers who are non-compliant with this element will be coached and re-educated. **CM8:** Deficiency Noted - 53.3% - A Care Plan was completed for the Enrollee that included all the required components. 55.6% - The Care Plan was developed within 30 days of CNA completion. Interventions - Bi-monthly CM Process Improvement meetings to continue into 2024 to review CM required documentation for member Care Plans and process for CNA completion within 30 days of member identification and other IPRO audit deficiencies. Manager will begin utilizing the NJ Tracker Report to monitor CNA and Care Plan completion. Manager to continue monitoring team's adherence to this element. **CM14:** Deficiency Noted - 66.7% - The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source (aged 0 through 20). 16.7% - The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18) and immunization status is confirmed by a reliable source. 20.0% - Aggressive	

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	outreach attempts were documented to confirm immunization status (aged 0 through 18). 22.2% - Appropriate vaccines have been administered for Enrollees (aged 19 and above). 14.3% - Aggressive outreach attempts were documented to confirm immunization status for Enrollees (aged 19 and above). 33.3% - Dental needs are addressed for Enrollees (aged 21 and above). 66.7% - A dental visit occurred during the review period for Enrollees (aged 1 through 20). Interventions - Preventive services collaboration meetings scheduled between Quality Management and Managers to create a combined approach to addressing preventive services gaps. Implement collaborative efforts discussed in meetings above. Monitor CM Activity Report specifically for evidence of documentation related to preventive services. Peer-to-peer CM audits to be added to General Population CM audit process. Implement new EPSDT Report process which is to be discussed during CM Process Improvement Series meetings. Reinforce documentation of preventive services during team meetings and CM Process Improvement Series meetings. **CM15:** Deficiency Noted - 28.6% - For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs. Interventions - CM Process Improvement Series to continue into 2024 with meetings dedicated to documentation of a comprehensive treatment plan and other IPRO audit deficiencies. CMs to be educated on review of monthly predictive modeling report (Chronic Illness Intensity Index or CI3 report) to identify members with co-morbid conditions who may potentially require comprehensive treatment planning. Develop a CI3 Report documentation template to ensure CMs are reviewing predictive modeling data for co-morbid conditions potentially requiring comprehensive treatment planning on newly referred members.	
WPNJ should address the deficiencies noted in the Core Medicaid - 2023 CM Review in the following areas: DDD: Preventive Services and all CM element specific	**CM11:** Deficiency Noted – 83.3% - The Care Plan was updated upon a change in the Enrollee's care needs or circumstances. Interventions - The topic of modifying care plans to be included in the 2024 CM Process Improvement Series meetings. A demonstration to be provided utilizing the care management system. Care plan modification element to be added to CM audit tool. **CM14:** Deficiency Noted - 75.0% - The Enrollee's EPSDT exam is up to date per periodicity exam schedule and status is confirmed by a reliable source (0 through 20).	Addressed

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
deficiencies noted in the review.	50.0% - The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18) and immunization status is confirmed by a reliable source. 0.0% - Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18). 53.8% - Appropriate vaccines have been administered for Enrollees (aged 19 and above). 45.5% - Dental needs are addressed for Enrollees (aged 21 and above). 75.0% - A dental visit occurred during the review period for Enrollees (aged 1 through 20). 0.0% - Dental reminders were sent to Enrollees (aged 1 through 20). Interventions - Preventive services collaboration meetings scheduled between Quality Management and Managers to create a combined approach to addressing preventive services gaps. Implement collaborative efforts discussed in meetings above. Monitor CM Activity Report specifically for evidence of documentation related to preventive services. Peer-to-peer CM audits to be added to General Population CM audit process. Implement new EPSDT Report process which is to be discussed during CM Process Improvement Series meetings. Reinforce documentation of preventive services during team meetings and CM Process Improvement Series meetings. **CM15:** Deficiency Noted - 0.0% - For Enrollees demonstrating needs requiring a treatment plan, the Enrollee was given a comprehensive treatment plan to address the Enrollee's specific needs. Interventions - CM Process Improvement Series to continue into 2024 with meetings dedicated to documentation of a comprehensive treatment plan and other IPRO audit deficiencies. CMs to be educated on review of monthly predictive modeling report (Chronic Illness Intensity Index or CI3 report) to identify members with co-morbid conditions who may potentially require comprehensive treatment planning. Develop a CI3 Report documentation template to ensure CMs are reviewing predictive modeling data for co-morbid conditions potentially requiring comprehensive treatment planning on newly referred members.	
WPNJ should address the deficiencies noted in the Core Medicaid - 2023 CM Review in the following areas: DCP&P: Preventive Services and all CM element specific	**CM7:** Deficiency Noted – 66.7% - The outreach for CNA was timely within 45 days of enrollment. Interventions - DCP&P Manager will review the number of completed CNAs by reviewing 45-Day CNA Completion Report. **CM11:** Deficiency Noted – 69.2% - The Care Plan was updated upon a change in the Enrollee's care needs or circumstances. Interventions - The topic of modifying care plans to be included in the 2024 CM Process Improvement Series meetings. A demonstration to be provided utilizing	Addressed

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
deficiencies noted in the review.	the care management system. Care plan modification element to be added to CM audit tool. **CM14:** Deficiency Noted – 69.2% - The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18) and immunization status is confirmed by a reliable source. 50.0% - A dental visit occurred during the review period for Enrollees (aged 1 through 20). Interventions - Preventive services collaboration meetings scheduled between Quality Management and Managers to create a combined approach to addressing preventive services gaps. Implement collaborative efforts discussed in meetings above. Monitor CM Activity Report specifically for evidence of documentation related to preventive services. Peer-to-peer CM audits to be added to General Population CM audit process. Implement new EPSDT Report process which is to be discussed during CM Process Improvement Series meetings. Reinforce documentation of preventive services during team meetings and CM Process Improvement Series meetings.	
WPNJ should address all deficiencies noted in the MLTSS – HCBS 2023 CM Review for elements within groups that scored below 86%.	**Member Outreach** **Contract Cite: 9.6.2.A/9.6.2.B: Care Manager initiated contact with the Member to establish a time for completion an individualized Plan of Care within 5 business days of the effective date of a new Member's enrollment into the MLTSS program.** Historically, the initial outreach tracking grid uploaded to a shared site was a manual tracking process, identified as an area of opportunity. Subsequently, an automated report has been developed that is refreshed and sent to the Medical Management Specialist team daily. This allows for real time tracking of initial outreaches to ensure timely completion. In addition, a designated associate along with a clinical manager was selected to oversee this automated initial outreach report to ensure that a thorough review is completed daily and follow up with applicable staff on any areas of risk is completed timely. MLTSS has also updated its initial outreach process to reflect required language regarding plan of care completion and will be included in initial outreach documentation. **Ongoing Care Management** **Contract Cite: 9.6.5.B (1,2)-Group C, D, E: Member had a documented face-to-face/telephonic visit to review Member placement and services during the review period that was held within the appropriate timeframes (An ongoing face-to-face/telephonic visit**	Addressed

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit). Daily oversight of the daily snapshot by the clinical management team is conducted to ensure that visits are addressed timely. Overdue plan of care reports is reviewed by the Clinical Director and weekly meetings are held with the clinical management team to discuss risks and trends. All concerns are escalated to the care managers in real time for follow up. In addition, the internal audit was updated to include additional data points around plan of care timeliness. Internal audit findings related to timely visits per care manager is disseminated to the clinical managers on a quarterly basis. The staffing model was reviewed and updated to reflect the current care management needs of the MLTSS department. Additional positions have been approved to address the staffing need. A staffing report is run monthly and provided to the Clinical Director for ongoing oversight of staffing needs per county. **Group D & E: For Members who were discharged to a HCBS setting the onsite review occurred within ten (10) days of discharge** A designated associate reviews the daily census and ER report daily and sends an organized, detailed list to the Medical Management Specialist team, who then is responsible to notify care management staff thru tasking in our electronic documentation system (HIP). Hospitalization and ER tasking were added to a newly developed MMS internal audit tool, which will allow Wellpoint to stratify data quarterly and identify areas of opportunity. Daily Director level oversight is completed to ensure that risks for non-compliance are mitigated and weekly meetings are held with the clinical management team to ensure ongoing compliance. In addition, care management re-education regarding the timeliness of post hospitalization visits and all required assessments was recently completed in May. **Performance Measure #8 Contract Cite: 9.6.2.D: Plans of Care established within 45 days of MLTSS enrollment.** Wellpoint has set an internal deadline for 30 calendar days from the date of enrollment for plan of care completion. The daily snapshot report was updated to	

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	include upcoming plan of care due dates and will flag visits as overdue once they reach the 31st day (the day after 30 calendar days). Oversight is provided by the clinical managers thru the Daily Snapshot report, which identifies upcoming visits that are due as well as visits at risk for becoming non-compliant. In addition, a designated compliance manager will identify new member enrollees that are flagged as overdue (on Day 31) and will follow up with the assigned care manager & clinical manager to ensure that the visit/POC is completed timely. Care management re-education on timeliness of initial visit completion and plan of care mailing has been completed during our MLTSS dept meeting.	
WPNJ should address all deficiencies noted in the MLTSS – NF/SCNF 2023 CM Review for elements that scored below 86%.	**MLTSS Initial Plan of Care and Ongoing Plans of Care Contract Cite: 9.6.2.D/ Performance Measure #8: The Member's individualized Plan of Care (including obtaining Member's signature) was developed in collaboration with the Member and a copy mailed to the Member within forty five (45) calendar days of enrollment notification into the MLTSS program** Wellpoint has set an internal deadline for 30 calendar days from the date of enrollment for plan of care completion. The daily snapshot report was updated to include upcoming plan of care due dates and will flag visits as overdue once they reach the 31st day (the day after 30 calendar days). Daily oversight is provided by the Clinical Managers & Clinical Director thru the Daily Snapshot report, which identifies visits at risk for becoming non-compliant. In addition, a designated Nursing facility clinical manager will identify new member enrollees that are flagged as overdue (on Day 31) and will follow up with the assigned care manager to ensure that the visit is completed timely. Also, care manager re-education on timeliness of initial visit completion and plan of care mailing has been completed during our MLTSS dept meeting. The internal audit tool was updated to require the care mailing plan within 5 business days of the visit date. Internal audits are completed monthly and data is analyzed quarterly, shared with clinical managers and utilized to develop additional interventions as applicable. Care managers that fall below threshold on this element are educated 1:1 by their clinical manager and are placed on a monitoring plan to ensure compliance moving forward. In addition, the	Remains an opportunity for improvement

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	compliance team has provided guidance for how to address signatures when members are unable to sign. Care managers complete tasking in HIP when the plan of care is mailed. Wellpoint will have the capability to generate reporting related to task completion after implementation of our clinical system (HIP 2.0). **Contract Cite: 9.6.1.E/9.7.2.D/Performance Measure #9a: For any significant change in Member condition, Member's Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative** Internal auditing has been implemented for each MMS (Medical management specialist), which includes a review of the accuracy and timeliness of hospitalization tasking to the care manager. This will assist the care manager with monitoring members after discharge for a significant change in condition. The compliance manager will disseminate quarterly reports demonstrating trends per MMS for further follow up. In addition, internal auditing is completed on a monthly basis for each of the care managers, which includes a review of the care manager updating the plan of care for a significant change with the member. The compliance manager disseminates quarterly reports demonstrating trends per care manager for further follow up by the Clinical Manager. Clinical managers attend inpatient rounds daily to ensure that MLTSS members experiencing a change in condition are assessed appropriately. Wellpoint will have the capability to generate reporting related to significant change tasking after implementation of our new clinical system (HIP 2.0). **Transition Planning** **Contract Cite: 9.6.4.B/9.7.2.D (1)/9.7.2.G/9.3.1.B (1)/9.6.4.P: Member was identified for transfer to HCBS and was offered options, including transfer to the community** All nursing facility members are screened for desire to transition to a home and community based setting on the initial, biannual and annual visit. These screenings are conducted as needed as well if the member expresses interest in transitioning to the community in the interim. Each nursing facility transition referral indicating a desire to transition is tracked on a Master spreadsheet, monitored daily by the Nursing Facility Clinical	

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	Manager. The spreadsheet includes member's preferred county, community services needed, and various other details necessary for a successful transition. The transition coordinators will outreach members identified for transfer (as evidenced by a positive nursing facility transition screening tool) within 3 business days of receiving the positive screening tool task and document options counseling and next steps required for the transition. Wellpoint will monitor outreach & options counseling completion within 3 business days for members with a positive nursing facility transition screening tool, with the internal audit tool. Internal audits are completed monthly and data will be analyzed quarterly, shared with clinical managers, and utilized to develop additional interventions when needed. Education has been provided to the care management staff regarding options counseling for potential nursing facility referrals at the MTLSS department team meeting. **Contract Cite: 9.6.5.B.1 Evidence of the Care Manager's participation in at least one Interdisciplinary Team (IDT) meeting during the review period** Wellpoint has updated the tasking naming logic to ensure that IDT Documentation is being captured consistently. The IDT meeting narrative documentation was updated, standardized and disseminated to staff on November 30, 2023 as well. Education was provided to the care management staff regarding completion of an annual IDT and documentation guidelines in the MLTSS department meeting held on November 30, 2023. The MMS (medical management specialists) schedules 6 month and 12 month IDT reminder tasks for the care management staff in our electronic documentation system *(i.e. HIP).* Annual IDT meeting completion is included in the internal audit for all nursing facility members. Internal auditing is completed monthly for each care manager, which includes a review of CM attendance to at least 1 IDT annually. The compliance manager will disseminate quarterly reports demonstrating compliance trends per care manager for further follow up. Wellpoint will have the capability to pull reporting to show due/overdue tasks related to IDT meeting	

Recommendation for WPNJ	WPNJ Response/Actions Taken	IPRO Assessment of MCO Response[1]
	attendance with the new clinical system (HIP 2.0) implementation. **Contract Cite: 9.6.5.B: Timely onsite/telephonic Review of Member Placement and Services. Onsite/Telephonic visits were timely and occurred within at least 180 calendar days for non-pediatric SCNF/NF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability)** Wellpoint utilizes the Due/Overdue Plan of Care reports that are distributed to clinical managers to monitor care manager metrics, including compliance with contractual time frames for visit timeliness. The Daily Snapshot report has been updated to identify upcoming visits that are due per care manager. Clinical managers will be monitoring visit compliance daily and following up in real time with those care managers at risk for non-compliance. Daily director level oversight of the overdue plan of care reports will be completed and weekly meetings with the compliance team and clinical management team are held to discuss risks and trends. Internal audit findings related to timely visits per care manager is completed on a monthly basis for each care manager. Data is analyzed, results are tracked and trended quarterly, shared with clinical managers and used to develop additional interventions when needed. Care managers receive ongoing education regarding the contractual visit timeframe requirements.	

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

MCO Strengths and Opportunities for Improvement, and EQR Recommendations

Tables 61–65 highlight each MCO's performance strengths and opportunities for improvement, follow-up on prior EQRO recommendations, and this year's recommendations based on the aggregated results of the EQR activities conducted in 2024 as they relate to **quality**, **timeliness**, and **access**.

ABHNJ – Strengths and Opportunities for Improvement, and EQR Recommendations

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

ABHNJ – Strengths, Opportunities for Improvement, and EQR Recommendations		
EQR Activity	**Strengths**	**Opportunities for Improvement**
2024 PIPs	Of the 4 PIPs scored, 1 performed at or above the 85% threshold for Core Medicaid, indicating high performance; 1 PIP scored above the 86% threshold for MLTSS, indicating high performance.	Overall, ABHNJ was compliant in presentation of data and analysis of results. Opportunities for improvement include re-evaluation of barrier analyses to inform enhanced or new interventions. Two (2) Core Medicaid PIPs scored below the 85% threshold.
HEDIS MY 2023 Performance Measures	ABHNJ reported significant improvements (a more than five percentage point change is considered a significant change) in performance for fourteen (14) HEDIS measures.	ABHNJ reported significant declines (a more than five percentage point change is considered a significant change) in rates for seven (7) HEDIS measures.
2024 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2023, to June 30, 2024*)*	Of the 14 quality-related Subpart D and QAPI standard areas reviewed in 2024, twelve (12) standards received 100% compliance.	Two (2) standards, ranging from 67% to 73% did not meet compliance. Those standards were: Availability of services (67%) Coordination and continuity of Care (73%)
Network Adequacy – 2024 Provider Directory Validation	No strengths were identified.	ABHNJ should consider including detailed accessibility filters in their online directories. This enhancement will ensure that members can easily find providers who meet their individual needs, such as those who require accessible examination tables and scales.
Quality-of-Care Surveys – Member (CAHPS 2024)	Two (2) of eight (8) Adult CAHPS measure fell between the 50th and 75th percentiles.	Six (6) of eight (8) Adult CAHPS measures fell below the 50th percentile. Eight (8) of eight (8) Child CAHPS measures fell below the 50th percentile. Ten (10) of the eleven (11) Child CCC CAHPS measures fell below the 50th percentile. One (1) of the eleven (11) Child CCC CAHPS measures (Family Centered Care) does not have benchmark available.

ABHNJ – Strengths, Opportunities for Improvement, and EQR Recommendations		
Core Medicaid - 2024 CM Review	Of the 13 categories reviewed for GP, DDD and DCP&P populations, ABHNJ scored 85% or above in nine (9) categories ranging from 85.0% to 100%.	Of the 13 categories reviewed for GP, DDD, and DCP&P populations, ABHNJ scored below the 85% threshold in four (4) categories ranging from 72.1% to 82.8%.
MLTSS – 2024 HCBS CM Review	Of the 6 categories at the sub-population level, ABHNJ scored at or above 86% for 14 of the 17 sub-populations scores.	Of the 6 categories at the sub-population level, ABHNJ scored below 86% for three (3) of the 17 sub-populations scores.
MLTSS – 2024 NF CM Review	Of the 25 compliance review and performance measure elements, 21 elements had sufficient denominators and scored at or above 86%. Note: One (1) element was N/A*.	Of the 25 elements, three (3) elements had sufficient denominators and scored below 86%.
Recommendations		
2024 PIPs	ABHNJ should address the PIP validation elements that were determined to be partially met.	
HEDIS MY 2023 Performance Measures	Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, ABHNJ should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.	
2024 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2023, to June 30, 2024*)*	The following recommendations will require a Corrective Action Plan (CAP) from the MCO: **Access** 1. A4c. ABHNJ should continue to focus its efforts on provider recruitment in order to improve access to care for Pediatric Specialists across all counties except Essex, Hudson, Morris, Passaic, Somerset, and Union. 2. A4e. ABHNJ should continue to address hospital deficiencies in Salem County. 3. A4f. ABHNJ should continue to expand the MLTSS network to include at least two providers in every County for Private Duty Nursing. 4. A7. ABHNJ should focus on improving appointment availability for Specialists, and Behavioral Health Providers, as well as after-hours non-compliance.	
Network Adequacy – 2024 Provider Directory Validation	1. ABHNJ should conduct routine assessments of their provider directories to ensure provider data is accurate and updated timely, as most failure reasons resulted from the provider not being at the listed site. 2. ABHNJ should conduct reviews and verification processes to ensure the accuracy of board certification status for all providers listed in the online provider directory. 3. ABHNJ should ensure its provider network includes providers with disability accommodations. This will enable members to easily find providers who can meet their specific needs, such as those offering accessible facilities and specialized equipment.	
Quality-of-Care Surveys – Member (CAHPS 2024)	The MCO should continue to work to improve Adult, Child and Child CCC CAHPS scores that perform below the 50th percentile.	
Core Medicaid - 2024 CM Review	**For the General Population:** ABHNJ should address the deficiencies noted in the following areas:	

ABHNJ – Strengths, Opportunities for Improvement, and EQR Recommendations	
	1. CM6: ABHNJ should ensure that the IHS is completed for the Enrollee within 45 days of MCO enrollment date (applies to new Enrollees). 2. CM37: ABHNJ should establish an audit process to ensure compliance and accuracy with audit preparation and submissions to the EQRO. **For the DDD Population:** 1. CM2: ABHNJ should ensure for Enrollees who are hospitalized, adequate discharge planning is performed (applies to existing Enrollees). 2. CM7: ABHNJ should ensure that initial outreach to complete the CNA is done timely, within 45 days from the Enrollee's enrollment date (applies to new Enrollees). 3. CM7: ABHNJ should ensure that a level of Care Management is documented for the Enrollee during the review period (applies to existing Enrollees). 4. CM8 *File Audit*: ABHNJ should ensure that the Enrollee has a Care Plan on file during the review period (applies to new and existing Enrollees). 5. CM8 *File Audit*: ABHNJ should ensure that the Enrollees Care Plan is reviewed/monitored during the review period (applies to new Enrollees). 6. CM14: For Enrollees aged 0 through 20, ABHNJ should ensure EPSDT reminders are sent when the Enrollees EPSDT exam is not up to date (applies to new and existing Enrollees). 7. CM14: For Enrollees aged 21 and above, ABHNJ should ensure that the Care Manager addresses/discusses dental needs with the Enrollee (applies to new and existing Enrollees). 8. CM14: For Enrollees aged 1 through 20 without a confirmed dental status, ABHNJ should ensure that dental reminders are sent (applies to new and existing Enrollees). 9. CM16: For Enrollees who were hospitalized with a mental/behavioral health diagnosis, ABHNJ should ensure that for Enrollees discharged prior to 12/1/2023, the Care Manager documents evidence of follow up with the mental/behavioral health provider within 30 days of discharge (applies to new and existing Enrollees). 10. CM16 *File Audit*: ABHNJ should ensure the Care Manager makes aggressive attempts to determine follow up status with a mental/behavioral health provider for Enrollees hospitalized with a mental/behavioral health diagnosis (applies to existing Enrollees). 11. CM19: When appropriate for the applicable Enrollees, ABHNJ should ensure the Care Manager contacts Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD) (applies to existing Enrollees). **For the DCP&P Population:** 1. CM2: ABHNJ should ensure for Enrollees who are hospitalized, adequate discharge planning is performed (applies to existing Enrollees). 2. CM7: For new Enrollees, ABHNJ should ensure the Comprehensive Needs Assessment (CNA) is completed within 45 days of the Enrollees enrollment.

ABHNJ – Strengths, Opportunities for Improvement, and EQR Recommendations	
	3. CM7: For existing Enrollees, ABHNJ should ensure the Care Manager documents a level of Care Management for the Enrollee during the review period. 4. CM8 *File Audit*: ABHNJ should ensure that the Enrollee has a Care Plan on file during the review period (applies to new and existing Enrollees). 5. CM14: For Enrollees aged 0 through 20, where the EPSDT exam is not up to date, ABHNJ should ensure that the Care Manager makes aggressive outreach attempts to confirm EPSDT status (applies to existing Enrollees). 6. CM14: For Enrollees aged 0 through 20 where the EPSDT exam is not up to date, ABHNJ should ensure EPSDT reminders are sent (applies to new and existing Enrollees). 7. CM14: For Enrollees aged 0 through 18, ABHNJ should ensure aggressive outreach attempts are documented to confirm immunization status (applies to existing Enrollees). 8. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, ABHNJ should make attempts to obtain dental status (applies to existing Enrollees). 9. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, ABHNJ should ensure dental reminders are sent (applies to new and existing Enrollees). 10. CM19: When appropriate for the applicable Enrollees, ABHNJ should ensure the Care Manager contacts Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD) (applies to existing Enrollees). 11. CM19: For Enrollees demonstrating needs requiring coordination of services, ABHNJ should ensure that the Care Manager documents coordination of needed care/services and linkages to providers, medical services, residential, social, community, and other support services (applies to existing Enrollees).
MLTSS – 2024 HCBS CM Review	ABHNJ was provided with recommendations for each opportunity for improvement. These can be found in **Appendix B.**
MLTSS – 2024 NF CM Review	ABHNJ was provided with recommendations for each opportunity for improvement. These can be found in **Appendix B**.

*N/A: ABHNJ had no members who met criteria for evaluation for the element reviewed.

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

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

FC/WCHP – Strengths, Opportunities for Improvement, and EQR Recommendations		
Quality of Care	**Strengths**	**Opportunities for Improvement**
2024 PIPs	Of the 4 PIPs scored, 2 performed at or above the 85% threshold for Core Medicaid, indicating high performance; 1 PIP scored above the 86% threshold for MLTSS, indicating high performance.	Overall, FC/WCHP was compliant in presentation of data and analysis of results. Opportunities for improvement include ensuring barrier analyses are comprehensive and drive appropriate interventions and sufficiently addressing factors that impact external validity of performance indicator results.

FC/WCHP – Strengths, Opportunities for Improvement, and EQR Recommendations		
		One (1) Core Medicaid PIP scored below the 85% threshold.
HEDIS MY 2023 Performance Measures	FC/WCHP reported significant improvements (a more than five percentage point change is considered a significant change) in rates for twenty (20) HEDIS measures.	FC/WCHP reported significant declines (a more than five percentage point change is considered a significant change) in rates for nine (9) HEDIS measures.
2024 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2023, to June 30, 2024*)*	Of the 14 quality-related Subpart D and QAPI standard areas reviewed in 2024, eleven (11) standards received 100% compliance.	Three (3) standards, ranging from 67% to 78% did not meet compliance. Those standards were: Disenrollment (78%) Availability of services (67%) Coordination and continuity of Care (73%)
Network Adequacy – 2024 Provider Directory Validation	No strengths were identified.	Fidelis Care should consider including detailed accessibility filters in their online directories. This enhancement will ensure that members can easily find providers who meet their specific needs, such as those who require accessible examination tables and scales.
Quality-of-Care Surveys – Member (CAHPS 2024)	One (1) of the eight (8) Adult CAHPS measure scored greater than or equal to 90th percentile. One (1) scored between the 75th and 90th percentiles. Two (2) scored between the 50th and 75th percentiles. One (1) of the eleven (11) Child CCC CAHPS measures fell between the 50th and 75th percentiles. One (1) of the eleven (11) Child CCC CAHPS measures (Family Centered Care) does not have benchmark available.	Four (4) of eight (8) Adult CAHPS measures fell below the 50th percentile. All of the eight (8) Child CAHPS measures fell below the 50th percentile. Nine (9) of the eleven (11) Child CCC CAHPS measures fell below the 50th percentile.
Core Medicaid - 2024 CM Review	Of the 13 categories reviewed for GP, DDD and DCP&P populations, FC/WCHP scored over the 85% threshold in eleven(11) categories ranging from 90.0% to 100.0%.	Of the 13 categories reviewed for GP, DDD, and DCP&P populations, FC/WCHP scored below the 85% threshold in one (1) category at 83.1% One (1) category (Outreach) was N/A as no DCP&P enrollees met criteria for this measure as all CNAs were completed timely.
MLTSS – 2024 HCBS CM Review	Of the 6 categories at the sub-population level, FC/WCHP scored at or above 86% for 17 of the 17 sub-populations scores.	Of the 6 categories at the sub-population level, FC/WCHP scored below 86% for none of the 17 sub-populations scores.
MLTSS – 2024 NF CM Review	Of the 25 compliance review and Performance Measure elements, 19 elements had sufficient denominators and scored at or above 86%.	Of the 25 elements, one (1) element with a sufficient denominator scored below 86%.

FC/WCHP – Strengths, Opportunities for Improvement, and EQR Recommendations		
	Note: Five (5) elements were N/A*.	
Recommendations		
2024 PIPs	FC/WCHP should address the PIP validation elements that were determined to be partially met.	
HEDIS MY 2023Performance Measures	1. Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, FC/WCHP should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period. 2. The MCO should ensure that the HEDIS team follows the guidance provided annually by DMAHS at the beginning of the HEDIS/Performance Measure season.	
2024 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2023, to June 30, 2024*)*	The following recommendations will require a Corrective Action Plan (CAP) from the MCO: **Access** 1. A4b. Fidelis Care should continue to focus its efforts on provider recruitment in order to improve access to care for Pediatric PCPs in Sussex County. 2. A4c. Fidelis Care should continue to focus its efforts on provider recruitment in order to improve access to care for Pediatric Specialists across all Counties. 3. A4d. Fidelis Care should continue to focus its efforts on provider recruitment in order to improve access to care for General Dentists in Hudson County. 4. A7. Fidelis Care should focus on improving appointment availability for Adult PCPs, Pediatric PCPs, OB-GYNs, Specialists, Behavioral Health Prescribers, Behavioral Health Non-Prescribers, as well as after-hours non-compliance. **Quality Management** 1. QM11a. For the Core Medicaid Improving Early and Periodic Screening Diagnostic and Diagnosis (EPSDT) Well Child Visits and Childhood Immunizations PIP, as this PIP has moved into the final phase, Fidelis Care should continue to develop more robust interventions to improve performance indicators for this and future PIPs. 2. QM11b. For the MLTSS Improving Coordination of Care and Ambulatory Follow-up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations PIP, as this PIP has moved into the final phase, Fidelis Care should continue to develop more robust interventions to address the barriers identified for this and future PIPs. 3. QM19. Fidelis Care should adhere to Waiver Year End (WYE) timeline and submit the Care of Older Adults (COA) MLTSS performance measure timely. **Member Disenrollment** 1. MD2. Fidelis Care should update the Member Handbook to reflect all Contract requirements. 2. MD2. Fidelis Care should ensure that policy updates should be applicable during the review period and provided to the EQR for review. 3. MD4. Fidelis Care should ensure that the Disenrollment Policy incorporates the specific language regarding "Clients of DCP&P who are temporarily residing in a state adjacent to New Jersey but remain in the custody of DCP&P", and policy updates should be applicable during the review period and provided to the EQR	

FC/WCHP – Strengths, Opportunities for Improvement, and EQR Recommendations	
	for review. 4. MD20. Fidelis Care should ensure the MLTSS Disenrollment Request Step Action explicitly outlines the written notification requirements for members who refuse consent for clinical eligibility reassessment or face-to-face visits, despite having received counseling and a minimum of two attempts to obtain consent, and policy updates should be applicable during the review period and provided to the EQR for review. 5. MD24. Fidelis Care should ensure MLTSS Disenrollment Request Step Action clearly specifies that the Care Manager must initiate a face-to-face visit within 10 business days, and policy updates should be applicable during the review period and provided to the EQR for review. **Credentialing and Re-Credentialing** 1. CR9. Fidelis Care should have a process in place to appropriately pull the correct Credentialing and Re-Credentialing files for MLTSS providers. Fidelis Care should also ensure the provider files will be QA'd before submitting them to the EQRO for review. Fidelis Care should ensure all MLTSS providers (including Skilled Nursing Facilities) submit an attestation as evidence for conducting criminal background checks per Contract requirements.
Network Adequacy – 2024 Provider Directory Validation	1. Fidelis Care should conduct routine assessments of their provider directories to ensure provider data is accurate and updated timely, as many failures resulted from the provider not being at the listed site and surveyors reaching an answering machine on all call attempts. 2. Fidelis Care should conduct reviews and verification processes to ensure the accuracy of board certification status for all providers listed in the online provider directory. 3. Fidelis Care should ensure its provider network includes providers with disability accommodations. This will enable members to easily find providers who can meet their specific needs, such as those offering accessible facilities and specialized equipment.
Quality-of-Care Surveys – Member (CAHPS 2024)	The MCO should continue to work to improve Adult, Child and Child CCC CAHPS scores that performed below the 50th percentile.
Core Medicaid - 2024 CM Review	FC/WCHP should address the deficiencies noted in the following areas: **For the General Population:** 1. CM6: Fidelis Care should ensure that for Enrollees where no Initial Health Screen (IHS) is on file, aggressive outreach attempts are documented and are done within 45 days of the Enrollee's enrollment (applies to new Enrollees). 2. CM7: Fidelis Care should ensure that Initial outreach to complete the Comprehensive Needs Assessment is done timely, within 30 days of identification of CM needs (applies to new Enrollees). 3. CM7: Fidelis Care should ensure that the Comprehensive Needs Assessment is completed timely (within 30 days of identification of CM needs) (applies to new and existing Enrollees).

FC/WCHP – Strengths, Opportunities for Improvement, and EQR Recommendations	
	For the DDD Population: 1. CM14: For Enrollees aged 21 and above, Fidelis Care should ensure that the Care Manager addresses/discusses dental needs with the Enrollee (applies to new Enrollees). **For the DCP&P Population:** 1. CM2: Fidelis Care should ensure for Enrollees who are hospitalized, adequate discharge planning is performed (applies to existing Enrollees). 2. CM14: For Enrollees aged 0 through 20 where the EPSDT exam is not up to date, Fidelis Care should ensure EPSDT reminders are sent (applies to new Enrollees). 3. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, Fidelis Care should ensure dental reminders are sent (applies to new Enrollees).
MLTSS – 2024 HCBS CM Review	No opportunities for improvement were noted for this review period.
MLTSS – 2024 NF CM Review	FC/WCHP was provided with recommendations for each opportunity for improvement. These can be found in **Appendix C**.

*N/A: FC/WCHP had no members who met criteria for evaluation for the element reviewed.

HNJH – Strengths and Opportunities for Improvement, and EQR Recommendations

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

HNJH – Strengths, Opportunities for Improvement, and EQR Recommendations		
Quality of Care	**Strengths**	**Opportunities for Improvement**
2024 PIPs	Of the 4 PIPs scored, 3 performed at or above the 85% threshold for Core Medicaid, indicating high performance; 1 PIP scored above the 86% threshold for MLTSS, indicating high performance.	Overall, HNJH was compliant in presentation of data and analysis of results. Opportunities for improvement include more detailed analysis of performance indicator results and disparities presented.
HEDIS MY 2023 Performance Measures	HNJH reported significant improvements (a more than five percentage point change is considered a significant change) in rates for twelve (12) HEDIS measures.	HNJH reported significant declines (a more than five percentage point change is considered a significant change) in performance for six (6) HEDIS measures.
2024 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2023, to June 30, 2024*)*	Of the 14 quality-related Subpart D and QAPI standard areas reviewed in 2024, twelve (12) standards received 100% compliance.	Two (2) standards, ranging from 64% to 75%, did not meet compliance. Those standards were: Availability of services (75%) Coordination and continuity of Care (64%)
Network Adequacy – 2024 Provider Directory Validation	No strengths were identified.	HNJH should consider including additional accessibility filters in their online directories. This enhancement will ensure that members can easily find providers who meet their individual needs, such as

HNJH – Strengths, Opportunities for Improvement, and EQR Recommendations		
		those who require accessible examination tables and scales.
Quality-of-Care Surveys – Member (CAHPS 2024)	Three (3) of eight (8) Adult CAHPS measures were at or above the 75th percentile. One (1) of eight (8) Adult CAHPS measures fell between the 50th and 75th percentiles. Two (2) of the Child CAHPS measures were at or above the 75th percentile. Three (3) of eight (8) Child CAHPS measures fell between the 50th and 75th percentiles. Two (2) of the eleven (11) Child CCC CAHPS measures were at or above the 75th percentile. One (1) measure fell between the 50th and 75th percentiles. One (1) of the eleven (11) Child CCC CAHPS measures (Family Centered Care) does not have benchmark available.	Four (4) of eight (8) Adult CAHPS measures fell below the 50th percentile. Three (3) of the eight (8) Child CAHPS measures fell below the 50th percentile. Seven (7) of the eleven (11) Child CCC CAHPS measures fell below the 50th percentile.
Core Medicaid - 2024 CM Review	Of the 13 categories reviewed for GP, DDD and DCP&P populations, HNJH scored over the 85% threshold nine (9) categories ranging from 86.4% to 100%.	Of the 13 categories reviewed for GP, DDD, and DCP&P populations, HNJH scored below the 85% threshold in four (4) categories ranging from 58.8% to 82.6%.
MLTSS – 2024 HCBS CM Review	Of the 6 categories at the sub-population level, HNJH scored at or above 86% for 14 of the 17 sub-populations scores.	Of the 6 categories at the sub-population level, HNJH scored below 86% for 3 of the 17 sub-populations scores.
MLTSS – 2024 NF CM Review	Of the 25 compliance review and performance measure elements, 19 elements had sufficient denominators and scored at or above 86%. Note: Three (3) elements were N/A*.	Of the 25 elements, three (3) elements with sufficient denominators scored below 86%.
Recommendations		
2024 PIPs	HNJH should address the PIP validation elements that were determined to be partially met.	
HEDIS MY 2023 Performance Measures	1. The MCO should focus on the HEDIS quality-related measures which fell below the NCQA National 50th percentile. HNJH should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.	
2024 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2023, to June 30, 2024*)*	The following recommendations will require a Corrective Action Plan (CAP) from the MCO: **Access** 1. A4c. HNJH should continue to focus its efforts on provider recruitment in order to improve access to care for Pediatric Specialists Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester, Hunterdon, Mercer, Middlesex, Monmouth, Ocean, Salem, Sussex, Union and Warren counties. 2. A4d. HNJH should continue to expand Dental network in Hunterdon, Ocean and Warren counties. 3. A7. HNJH should focus on improving appointment availability for adult PCPs,	

HNJH – Strengths, Opportunities for Improvement, and EQR Recommendations	
	Specialists, OB/GYNs, and Behavioral Health providers, as well as improve PCP after-hours availability.
Network Adequacy – 2024 Provider Directory Validation	1. HNJH should conduct routine assessments of their provider directories to ensure provider data is accurate and updated timely, as many failures resulted from the provider not being at the listed site and surveyors reaching an answering machine on all call attempts. 2. HNJH should conduct reviews and verification processes to ensure the accuracy of board certification status for all providers listed in the online provider directory. 3. HNJH should ensure its provider network includes providers with disability accommodations. This will enable members to easily find providers who can meet their specific needs, such as those offering accessible facilities and specialized equipment.
Quality-of-Care Surveys – Member (CAHPS 2024)	The MCO should continue to work to improve Adult, Child and Child CCC CAHPS scores that performed below the 50th percentile.
Core Medicaid - 2024 CM Review	HNJH should address the deficiencies noted in the following areas: **For the General Population:** 1. CM6: HNJH should ensure that the IHS is completed for the Enrollee within 45 days of MCO enrollment date (applies to new Enrollees). 2. CM6: HNJH should ensure for Enrollees where no IHS are on file, aggressive outreach attempts are documented and are done within 45 days of the Enrollee's enrollment (applies to new Enrollees). 3. CM7: HNJH should ensure initial outreach to complete the CNA is done timely, within 30 days of identification of CM needs. (30 days from IHS score 5 or greater; or IHS less than 5, no IHS, identification of CM needs through other sources) (applies to new Enrollees). 4. CM18c: HNJH should ensure that supporting policy documentation is dated during the review period and shows evidence of contractual compliance with the element in review (applies to new Enrollees). **For the DDD Population:** 1. CM2: HNJH should ensure for Enrollees who are hospitalized, adequate discharge planning is performed (applies to existing Enrollees). 2. CM4: HNJH should ensure a process to refer Enrollees with complex medical and social needs to Community Based Care Management (CBCM) that includes aggressive outreach within the community to locate and engage members in high need (applies to existing Enrollees). 3. CM5: HNJH should ensure that for Enrollees demonstrating needs requiring coordination of services within the MCO, the Care Manager demonstrates follow up with coordination of services (including, but not limited to Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee (applies to new and existing Enrollees). 4. CM7: HNJH should ensure the CNA is done timely, within 45 days from the Enrollee's enrollment date (applies to new Enrollees).

5. CM8 *File Audit:* HNJHJ should ensure that the Enrollee's Care Plan is reviewed/monitored during the review period (applies to existing Enrollees).
6. CM8: HNJH should ensure Care Plans completed contain all required components (applies to existing Enrollees).
7. CM9: HNJH should ensure Care Managers implement Care Plans (applies to existing Enrollees).
8. CM10: HNJH should ensure that each Enrollee has a Care Plan to address his/her individual health related needs, that Care Managers are regularly reviewing and analyzing the effectiveness of Care Plans, and Care Managers are providing feedback of the analysis to Enrollee/caregiver, primary care physician, and other healthcare professionals involved in the Enrollee's care (applies to existing Enrollees).
9. CM11: HNJH should ensure Care Plans are updated upon a change in the Enrollee's care needs or circumstances (applies to existing Enrollees).
10. CM14: For Enrollees aged 0 through 20, HNJH should ensure aggressive attempts are made to confirm EPSDT status when EPSDT status is not up to date (applies to existing Enrollees).
11. CM14: For Enrollees aged 0 through 20, HNJH should ensure EPSDT reminders are sent when the Enrollee's EPSDT exam is not up to date (applies to existing Enrollees).
12. CM14: For Enrollees aged 0 through 18, HNJH should ensure aggressive outreach attempts are made to confirm immunization status (applies to existing Enrollees).
13. CM14: For Enrollees aged 19 and above, HNJH should ensure aggressive outreach attempts are made to confirm immunization status (applies to existing Enrollees).
14. CM14: For Enrollees aged 21 and above, HNJH should ensure that the Care Manager addresses/discusses dental needs with the Enrollee (applies to existing Enrollees).
15. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, HNJH should make attempts to obtain dental status (applies to existing Enrollees).
16. CM14: For Enrollees aged 0 through 20 without a confirmed dental status, HNJH should ensure that dental reminders are sent (applies to existing Enrollees).
17. CM18c: HNJH should ensure that supporting policy documentation is dated during the review period and shows evidence of contractual compliance with the Element in review (applies to new Enrollees).
18. CM19: When appropriate for the applicable Enrollees, HNJH should ensure the Care Manager contacts Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD) (applies to existing Enrollees).
19. CM19: For Enrollees demonstrating needs requiring coordination of services, HNJH should ensure the Care Manager coordinates needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services (applies to new and existing Enrollees).
20. CM23: HNJH should ensure compliance with changing levels of Care Management as Enrollees' needs change (applies to existing Enrollees).

HNJH – Strengths, Opportunities for Improvement, and EQR Recommendations	
	For the DCP&P Population: 1. CM5: HNJH should ensure that for Enrollees demonstrating needs requiring coordination of services within the MCO, the Care Manager demonstrates follow up with coordination of services (including, but not limited to Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee (applies to existing Enrollees). 2. CM8 *File Audit*: HNJHJ should ensure that the Enrollee has a Care Plan on file during the review period (applies to existing Enrollees). 3. CM14: For Enrollees aged 0 through 18, HNJH should ensure aggressive outreach attempts are made to confirm immunization status (applies to existing Enrollees). 4. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, HNJH should make attempts to obtain dental status (applies to existing Enrollees). 5. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, HNJH should ensure dental reminders are sent (applies to existing Enrollees). 6. CM18c: HNJH should ensure that supporting policy documentation is dated during the review period and shows evidence of contractual compliance with the Element in review (applies to new Enrollees). 7. CM19: When appropriate for the applicable Enrollees, HNJH should ensure the Care Manager contacts Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD) (applies to existing Enrollees). 8. CM19: For Enrollees demonstrating needs requiring coordination of services, HNJH should ensure the Care Manager coordinates needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services (applies to existing Enrollees).
MLTSS – 2024 HCBS CM Review	HNJH was provided with recommendations for each opportunity for improvement. These can be found in **Appendix D.**
MLTSS – 2024 NF CM Review	HNJH was provided with recommendations for each opportunity for improvement. These can be found in **Appendix D**.

*N/A: HNJH had no members who met criteria for evaluation for the element reviewed.

UHCCP – Strengths and Opportunities for Improvement, and EQR Recommendations

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

UHCCP – Strengths, Opportunities for Improvement, and EQR Recommendations		
Quality of Care	**Strengths**	**Opportunities for Improvement**
2024 PIPs	Of the 4 PIPs scored, 2 performed at or above the 85% threshold for Core Medicaid, indicating high performance; 1 PIP scored above the 86% threshold for MLTSS, indicating high performance.	Overall, UHCCP was compliant in presentation of data and analysis of results. Opportunities for improvement include re-evaluation of barrier analyses to inform enhanced or new interventions. One (1) Core Medicaid PIP scored below the 85% threshold.

UHCCP – Strengths, Opportunities for Improvement, and EQR Recommendations		
HEDIS MY 2023 Performance Measures	UHCCP reported significant improvements (a more than five percentage point change is considered a significant change) in rates for six (6) HEDIS measures.	UHCCP reported significant declines (a more than five percentage point change is considered a significant change) in rates for eight (8) HEDIS measures.
2024 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2023, to June 30, 2024*)*	Of the 14 quality-related Subpart D and QAPI standard areas reviewed in 2024, twelve (12) standards received 100% compliance.	Two (2) standards, ranging from 67% to 82% did not meet compliance. Those standards were: Availability of services (67%) Coordination and continuity of Care (82%)
Network Adequacy – 2024 Provider Directory Validation	No strengths were identified.	While UHCCP's online provider directory contains detailed accessibility information, UHCCP should consider adding a filter option for members to easily find this information. This enhancement will ensure that members can easily find providers who meet their individual needs, such as those who require accessible examination tables and scales.
Quality-of-Care Surveys – Member (CAHPS 2024)	Two (2) Child CAHPS measure fell between the 50th and 75th percentiles. One (1) of the Child CCC CAHPS measures scored at or above the 90th percentile. One (1) of the Child CCC CAHPS measures scored at or above the 75th percentile. One (1) of the Child CCC CAHPS measures fell between the 50th and 75th percentiles. One (1) of the eleven (11) Child CCC CAHPS measures (Family Centered Care) does not have benchmark available.	All of the eight (8) Adult CAHPS measures fell below the 50th percentile. Six (6) of the eight (8) Child CAHPS measures fell below the 50th percentile. Seven (7) of the eleven (11) Child CCC CAHPS measures fell below the 50th percentile.
Core Medicaid - 2024 CM Review	Of the 13 categories reviewed for GP, DDD and DCP&P populations, UHCCP scored over the 85% threshold in eleven (11) categories ranging from 93.6% to 100%.	Of the 13 categories reviewed for GP, DDD, and DCP&P populations, UHCCP scored below the 85% threshold in one (1) category at 77.4% One (1) category (Outreach) was N/A as no DCP&P enrollees met criteria for this measure as all CNAs were completed timely.
MLTSS – 2024 HCBS CM Review	Of the 6 categories at the sub-population level, UHCCP scored at or above 86% for 12 of the 17 sub-populations scores.	Of the 6 categories at the sub-population level, UHCCP scored below 86% for five (5) of the 17 sub-populations scores.
MLTSS – 2024 NF CM Rev	Of the 25 compliance review and performance measure elements, 16 elements had sufficient denominators and scored at or above 86%. Note: One (1) element was N/A*.	Of the 25 elements, eight (8) elements with sufficient denominators scored below 86%.

UHCCP – Strengths, Opportunities for Improvement, and EQR Recommendations	
Recommendations	
2024 PIPs	UHCCP should address the PIP validation elements that were determined to be partially met.
HEDIS MY 2023 Performance Measures	Focusing on the UHCCP quality-related measures which fell below the NCQA national 50th percentile, UHCCP should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.
2024 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2023, to June 30, 2024*)*	The following recommendations will require a Corrective Action Plan (CAP) from the MCO: **Access** 1. A4c. UHCCP should continue to focus its efforts on provider recruitment in order to improve access to care for Pediatric Specialists in multiple Counties. 2. A4d. UHCCP should continue to focus its efforts on provider recruitment in order to improve access to care for General Dentists in Burlington, Hunterdon, Salem, Sussex and Warren Counties. 3. A4f. UHCCP should continue to expand the MLTSS network to include at least two providers in every County for Adult Medical Day Care in Hunterdon and Sussex Counties, and Assisted Living in Atlantic, Bergen, Camden, Essex, Gloucester, Hudson, Morris, Passaic, Somerset and Union Counties. 4. A7. UHCCP should focus on improving appointment availability for OB-GYNs, High Volume Specialists and Behavioral Health providers, as well as PCP after-hours and wait time non-compliance.
Network Adequacy – 2024 Provider Directory Validation	1. UHCCP should conduct routine assessments of their provider directories to ensure provider data is accurate and updated timely, as many failures resulted from the provider not being at the listed site and surveyors reaching an answering machine on all call attempts. 2. UHCCP should ensure the online provider directory accurately lists all board-certified providers and routinely conduct reviews and verification processes to maintain the accuracy of this information. 3. UHCCP should regularly review the accessibility options listed under providers' profiles to ensure their accuracy.
Quality-of-Care Surveys – Member (CAHPS 2024)	The MCO should continue to work to improve Adult, Child and Child CCC CAHPS scores that performed below the 50th percentile.
Core Medicaid - 2024 CM Review	UHCCP should address the deficiencies noted in the following areas: **For the General Population:** 1. CM6: UHCCP should ensure that the IHS is completed for the Enrollee within 45 days of MCO enrollment date (applies to new Enrollees). **For the DDD Population:** 1. CM7: UHCCP should ensure that the Comprehensive Needs Assessment is completed timely, within 45 days of Enrollee's MCO enrollment date (applies to new Enrollees). 2. CM7: UHCCP should ensure that a level of Care Management is documented for the Enrollee during the review period (applies to existing Enrollees).

UHCCP – Strengths, Opportunities for Improvement, and EQR Recommendations	
	3. CM14: For Enrollees aged 21 and above, UHCCP should ensure that the Care Manager addresses/discusses dental needs with the Enrollee (applies to new and existing Enrollees).
MLTSS – 2024 HCBS CM Review	UHCCP was provided with recommendations for each opportunity for improvement. These can be found in **Appendix E.**
MLTSS – 2024 NF CM Review	UHCCP was provided with recommendations for each opportunity for improvement. These can be found in **Appendix E**.

*N/A: UHCCP had no members who met criteria for evaluation for the element reviewed.

WPNJ – Strengths and Opportunities for Improvement, and EQR Recommendations

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

WPNJ – Strengths, Opportunities for Improvement, and EQR Recommendations		
Quality of Care	**Strengths**	**Opportunities for Improvement**
2024 PIPs	Of the 4 PIPs scored, 3 PIPs performed at or above the 85% threshold for Core Medicaid, indicating high performance; 1 PIP scored above the 86% threshold for MLTSS, indicating high performance.	Overall, WPNJ was compliant in presentation of data and analysis of results. Opportunities for improvement include re-evaluation of barrier analyses to inform enhanced or new interventions.
HEDIS MY 2023 Performance Measures	WPNJ reported significant improvements (a more than five percentage point change is considered a significant change) for fifteen (15) HEDIS measures.	WPNJ reported significant declines (a more than five percentage point change is considered a significant change) in rates for nine (9) HEDIS measures.
2024 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2023, to June 30, 2024*)*	Of the 14 quality-related Subpart D and QAPI standard areas reviewed in 2024, twelve (12) standards received 100% compliance.	Two (2) standards, ranging from 50% to 64%, did not meet compliance. Those standards were: Availability of services (50%) Coordination and continuity of Care (64%)
Network Adequacy – 2024 Provider Directory Validation	No strengths were identified.	WPNJ should consider adding signs in braille to the accessibility information provided in the online provider directory.
Quality-of-Care Surveys – Member (CAHPS 2024)	Two (2) of eight (8) Adult CAHPS measures fell between the 50th and 75th percentiles. Three (3) of eight (8) Child CAHPS measures fell between the 50th and 75th percentiles. Three (3) of the eleven (11) Child CCC CAHPS measures fell between the 50th and 75th percentiles. One (1) of the eleven (11) Child CCC CAHPS measures (Family Centered Care) does not have benchmark available.	Six (6) of eight (8) Adult CAHPS measures fell below the 50th percentile. Five (5) of the eight (8) Child CAHPS measures fell below the 50th percentile. Seven (7) of the eleven (11) Child CCC CAHPS measures fell below the 50th percentile.
Core Medicaid - 2024 CM Review	Of the 13 categories reviewed for GP, DDD and DCP&P populations, WPNJ scored	Of the 13 categories reviewed for GP, DDD, and DCP&P populations, WPNJ

WPNJ – Strengths, Opportunities for Improvement, and EQR Recommendations		
	over the 85% threshold in eleven (11) categories ranging from 85.7% to 100%.	scored below the 85% threshold in two (2) categories ranging from 68.4% to 82.6%.
MLTSS – 2024 HCBS CM Review	Of the 6 categories at the sub-population level, WPNJ scored at or above 86% for 13 of the 17 sub-populations scores.	Of the 6 categories at the sub-population level, WPNJ scored below 86% for 4 of the 17 sub-populations scores
MLTSS – 2024 NF CM Review	Of the 25 compliance review and performance measure elements, 16 elements had sufficient denominators and scored at or above 86%. Note: Five (5) elements were N/A*.	Of the 25 elements, 4 elements with sufficient denominators scored below 86%.
Recommendations		
2024 PIPs	WPNJ should address the PIP validation elements that were determined to be partially met.	
HEDIS MY 2023 Performance Measures	Focusing on the HEDIS quality-related measures which fell below the NCQA national 50th percentile, WPNJ should continue to identify barriers and consider interventions to improve performance, particularly for those measures that have ranked below their respective benchmarks for more than one reporting period.	
2024 Compliance with Medicaid and CHIP Managed Care Regulations *(*July 1, 2023, to June 30, 2024*)*	The following recommendations will require a Corrective Action Plan (CAP) from the MCO: **Access** 1. A4a. WPNJ should continue to focus its efforts on provider recruitment in order to improve access to care for adult PCPs in Hunterdon and Warren Counties. 2. A4b. WPNJ should continue to focus its efforts on provider recruitment in order to improve access to care for pediatric PCPs in Hunterdon, Sussex and Warren Counties. 3. A4c. WPNJ should continue to focus its efforts on provider recruitment in order to improve access to care for Pediatric Specialists in Pediatric Sleep Medicine in all counties, as well as other Pediatric Specialist deficiencies in Atlantic, Burlington, Cape May, Mercer, Monmouth, Ocean, and Warren counties. 4. A4d. WPNJ should continue to focus its efforts on provider recruitment in order to improve access to care for General Dentists in Burlington, Cape May, Hunterdon, and Warren Counties. 5. A4e. WPNJ should continue to address hospital deficiencies in Salem County. 6. A7. WPNJ should focus on improving appointment availability for Adult PCP, OB-GYNs, Other Specialists, and Behavioral Health Providers (Prescribers and Non-Prescribers). **Satisfaction** 1. S5. WPNJ should ensure that they have evidence of the new enrollee quarterly surveys, as well as the results of these surveys available for review by DMAHS and/or the EQRO upon request at regularly scheduled site visits.	
Network Adequacy – 2024 Provider Directory Validation	1. WPNJ should conduct routine assessments of their provider directories to ensure provider data is accurate and updated timely, as many failures resulted from the provider not being at the listed site and wrong addresses. 2. WPNJ should conduct reviews and verification processes to ensure the accuracy of board certification status for all providers listed in the online provider directory.	

WPNJ – Strengths, Opportunities for Improvement, and EQR Recommendations	
	3. WPNJ should conduct reviews and verification processes to ensure the accuracy of providers with disability accommodations. This will enable members to easily find providers who can meet their specific needs, such as those offering accessible facilities and specialized equipment.
Quality-of-Care Surveys – Member (CAHPS 2024)	The MCO should continue to work to improve Adult, Child and Child CCC CAHPS scores that performed below the 50th percentile.
Core Medicaid - 2024 CM Review	WPNJ should address the deficiencies noted in the following areas: **For the General Population:** 1. CM6: WPNJ should ensure that the IHS is completed for the Enrollee within 45 days of MCO enrollment date (applies to New Enrollees). 2. CM6: WPNJ should ensure that for Enrollees where no IHS is on file, aggressive outreach attempts are documented and were done within 45 days of the Enrollee's enrollment (applies to new Enrollees). 3. CM7: WPNJ should ensure that initial outreach to complete the CNA is done timely, within 30 days of identification of CM needs. (30 days from IHS score 5 or greater; or IHS less than 5, no IHS, identification of CM needs through other sources) (applies to new Enrollees). 4. CM7: WPNJ should ensure that the Comprehensive Needs Assessment is completed timely (within 30 days of identification of CM needs) (applies to new Enrollees). 5. CM7 *File Audit:* WPNJ should perform initial outreach to complete the CNA (applies to new Enrollees). 6. CM8 *File Audit*: WPNJ should ensure that the Enrollee has a Care Plan on file during the review period (applies to new Enrollees). 7. CM14: For Enrollees aged 0 through 20, where the EPSDT exam is not up to date, WPNJ should ensure that the Care Manager makes aggressive outreach attempts to confirm EPSDT status (applies to existing Enrollees). 8. CM14: For Enrollees aged 0 through 20 where the EPSDT exam is not up to date, WPNJ should ensure EPSDT reminders are sent (applies to existing Enrollees). 9. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, WPNJ should ensure dental reminders are sent (applies to existing Enrollees). 10. CM37: WPNJ should establish an audit process to ensure compliance and accuracy with audit preparation and submissions to the EQRO. **For the DDD Population:** 1. CM5: WPNJ should ensure that for Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee (applies to new and existing Enrollees). 2. CM7: WPNJ should ensure that a level of Care Management is documented for the Enrollee during the review period (applies to existing Enrollees). 3. CM11: WPNJ should ensure that the Care Plan is updated upon a change in the Enrollee's care needs or circumstances (applies to existing Enrollees).

WPNJ – Strengths, Opportunities for Improvement, and EQR Recommendations	
	4. CM14: For Enrollees aged 0 through 20, WPNJ should ensure EPSDT reminders are sent when the Enrollees EPSDT exam is not up to date (applies to existing Enrollees). 5. CM19: When appropriate for the applicable Enrollees, WPNJ should ensure the Care Manager contacts Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD) (applies to existing Enrollees). **6.** CM19: For Enrollees demonstrating needs requiring coordination of services, WPNJ should ensure that the Care Manager documents coordination of needed care/services and linkages to providers, medical services, residential, social, community, and other support services (applies to new and existing Enrollees). **For the DCP&P Population:** 1. CM2: WPNJ should ensure for Enrollees who are hospitalized, adequate discharge planning is performed (applies to new Enrollees only). 2. CM7 *File Audit:* WPNJ should perform initial outreach to complete the CNA (applies new Enrollees). 3. CM8 *File Audit*: WPNJ should ensure that the Enrollee has a Care Plan on file during the review period (applies to existing Enrollees). 4. CM8 *File Audit*: WPNJ should ensure that the Enrollee's Care Plan is reviewed/monitored during the review period (applies to new Enrollees). 5. CM14: For Enrollees aged 0 through 20, WPNJ should ensure EPSDT reminders are sent when the Enrollees EPSDT exam is not up to date (applies to new Enrollees). 6. CM19: When appropriate for the applicable Enrollees, WPNJ should ensure the Care Manager contacts Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD) (applies to existing Enrollees). 7. CM19: For Enrollees demonstrating needs requiring coordination of services, WPNJ should ensure that the Care Manager documents coordination of needed care/services and linkages to providers, medical services, residential, social, community, and other support services (applies to new Enrollees).
MLTSS – 2024 HCBS CM Review	WPNJ was provided with recommendations for each opportunity for improvement. These can be found in **Appendix F**.
MLTSS – 2024 NF CM Review	WPNJ was provided with recommendations for each opportunity for improvement. These can be found in **Appendix F**.

*N/A: WPNJ had no members who met criteria for evaluation for the element reviewed.

Appendix A: January 2024 – December 2024 NJ MCO-Specific Review Finding

Note: This is a separate document.

Appendix B: ABHNJ 2024 Core Medicaid and MLTSS Care Management Audits

Note: This is a separate document.

Appendix C: FC/WCHP 2024 Core Medicaid and MLTSS Care Management Audits

Note: This is a separate document.

Appendix D: HNJH 2024 Core Medicaid and MLTSS Care Management Audits

Note: This is a separate document.

Appendix E: UHCCP 2024 Core Medicaid and MLTSS Care Management Audits

Note: This is a separate document.

Appendix F: WPNJ 2024 Core Medicaid and MLTSS Care Management Audits

Note: This is a separate document.

Appendix G: 2024 Network Adequacy Provider Directory Validation Surveys

Note: This is a separate document.

Appendix H: Supplemental Documents for all MCOs: Submission Guide for 2024 Annual Assessment Enhanced, 2024 Care Management Audits (Core Medicaid and MLTSS), and 2024 ISCA Template

Note: This is a separate document.

APPENDIX A: January 2024–December 2024 MCO-Specific Review Findings (2024 – 2025 Reporting Cycle)

APPENDIX A: January 2024–December 2024 MCO-Specific Review Findings (2024 – 2025 Reporting Cycle)

Appendix Table of Contents

ABHNJ Core Medicaid/MLTSS Annual Assessment of MCO Operations

ABHNJ 2024 Annual Assessment of MCO Operations

Review Category	Total Elements[1]	Deemed Met from the Prior Year	Subject to Review[2]	Subject to Review and Met[3]	Subject to review and Not Met	Subject to Review and N/A	Total Met	% Met[4]
Care Management and Continuity of Care – Core Medicaid*	30	0	30	23	7	0	23	77%
Care Management and Continuity of Care - MLTSS*	10	0	10	10	0	0	10	100%
Access**	12	2	10	6	4	0	8	67%
Emergency and Post-Stabilization Services[5]	6	-	6	6	0	0	6	100%
Quality Assessment and Performance Improvement	10	0	10	10	0	0	10	100%
Quality Management	21	9	12	12	0	0	21	100%
Efforts to Reduce Healthcare Disparities	5	0	5	5	0	0	5	100%
Committee Structure	9	6	3	3	0	0	9	100%
Programs for the Elderly and Disabled	44	33	11	11	0	0	44	100%
Provider Training and Performance	11	7	4	4	0	0	11	100%
Satisfaction	5	2	3	3	0	0	5	100%
Enrollee Rights and Responsibilities	8	4	4	4	0	0	8	100%
Member Disenrollment	29	24	5	5	0	0	29	100%
Credentialing and Re-credentialing	10	7	3	3	0	0	10	100%
Utilization Management	30	16	14	14	0	0	30	100%
Administration and Operations	14	10	4	4	0	0	14	100%
Management Information Systems	18	15	3	3	0	0	18	100%
TOTAL	**232**	**135**	**97**	**93**	**4**	**0**	**228**	**98%**

[1] A total of 116 elements were reviewed in the previous review period; of these 116, 107 were Met, 9 were Not Met; 0 were N/A. Remaining existing elements that were Met Prior Year were deemed Met in the previous review period.

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

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

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

[5] Emergency and Post-Stabilization Services was a new standard reviewed in 2024.

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

** Access had 14 elements in 2023. In 2024, two elements (A1 and A2) were moved to a new category Emergency and Post-Stabilization Services. Although not an annual element, A3 was reviewed in the partial audits this year due to enhancements in the Access category.

ABHNJ Performance Improvement Projects

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

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

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

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

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

Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M	M	M	
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M	M	M	
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M	M	M	
7d. Lessons learned & follow-up activities planned as a result	N/A	M	M	PM	
Element 7 Overall Review Determination	**N/A**	**M**	**M**	**PM**	
Element 7 Overall Score	**N/A**	**100**	**100**	**50**	**0**
Element 7 Weighted Score	**N/A**	**20.0**	**20.0**	**10.0**	**0.0**
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There were ongoing, additional, or modified interventions documented	N/A	N/A	N/A	M	
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	PM	
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**PM**	
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**50**	**0**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**10.0**	**0.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated, and addressed (**Y**=Yes **N**=No)	**N/A**	**N**	**N**	**N**	

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

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

IPRO Reviewers: Lois Heffernan (lheffernan@ipro.org); Deb Chambers (dchambers@ipro.org)
Date (report submission) reviewed: September 2, 2024
Reporting Period: Year 3

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

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

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

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

Element 5 Overall Review Determination was that the MCO is partially compliant. For elements 5a and 5c, given the results on PCP utilization seen to date, the MCO has not updated the barrier analysis to include drivers related to members not seeing their PCP or implemented new or enhanced interventions to address barriers.

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

Element 7 Overall Review Determination was that the MCO is partially compliant. For element 7d, the MCO has not specifically planned follow-up activities to address barriers related to PCP utilization.

Element 8 Overall Review Determination that the MCO is partially compliant. For element 8b, while the MCO showed progress in reducing ED utilization for the targeted PCPs and the Medicaid network, PCP utilization for the all PCPs in the network has declined from baseline to MY1 and MY2. PCP utilization for the targeted PCPs declined from baseline to MY1, but did subsequently increase to slightly over baseline in MY2.

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

Overall, the MCO is partially compliant with this PIP; out of a maximum possible weighted score of 100.0 points, the MCO scored 72.5 points, which results in a rating of 72.5% (which is below 85% [≥ 85% being the threshold for meeting compliance]). The MCO has implemented a number of member- and provider-focused interventions aimed at increasing PCP utilization and decreasing ED utilization (for LANE diagnoses). However, while ED utilization has seen a decline year over year, PCP utilization continues to fall well below the goal rate. The MCO should re-evaluate barriers impacting PCP utilization and explore reasons for the significant variation in PCP utilization for the targeted practices versus the entire PCP network. Given what appears to be limited impact of current interventions on PCP utilization, the MCO should consider revisions/updates to interventions based on expanded barrier analysis.

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

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

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

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

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

Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M	M	M	
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M	M	M	
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M	M	M	
7d. Lessons learned & follow-up activities planned as a result	N/A	M	M	M	
Element 7 Overall Review Determination	**N/A**	**M**	**M**	**M**	
Element 7 Overall Score	**N/A**	**100**	**100**	**100**	**0**
Element 7 Weighted Score	**N/A**	**20.0**	**20.0**	**20.0**	**0.0**
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	PM	
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	PM	
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**PM**	
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**50**	**0**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**10.0**	**0.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)	**N/A**	**Y**	**Y**	**Y**	

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**72.5**	**72.5**	**75.0**	**0.0**
Overall Rating	**N/A**	**90.6%**	**90.6%**	**75.0%**	**0.0%**

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

IPRO Reviewers: Carolyn Gallagher (cgallagher@ipro.org); Deb Chambers (dchambers@ipro.org)
Date (report submission) reviewed: November 4, 2024
Reporting Period: Year 3

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

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

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

Element 4 Overall Review Determination was that the MCO is partially compliant with element 4b. The declining performance indicator rates and the lack of ITM progress highlight an opportunity to obtain direct member feedback on barriers, with findings from the barrier analysis used to inform modifications to interventions. For continued sustainability, consider obtaining member feedback on SDOH barriers, such as housing insecurity, as this may have been experienced by patients with failed outreach contacts. Another question the MCO might consider is whether appointment times are insufficient to meet parents' work and child care needs.

Element 5 Overall Review Determination was that the MCO is partially compliant with element 5a. As stated in the above review comment for Element 4, direct member feedback might be helpful to inform more effective interventions. It is commendable that the MCO noted the greater effectiveness of member outreach that combines IVR with SMS, and is spreading this success.

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

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

Element 8 Overall Review Determination was partially compliant with element 8a. There is an opportunity for additional interventions modified to address direct member feedback on barriers, as recommended in the above review Elements 4 and 5. This also applies to element 8b, as the data do not support sustained improvement.

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

Overall, the MCO is partially compliant with this PIP; out of a maximum possible weighted score of 100.0 points, the MCO scored 75.0 points, which results in a rating of 75.0% (which is below 85% [≥ 85% being the threshold for meeting compliance]). The MCO addressed healthcare disparities in this PIP, identifying disparities in utilization in the African-American membership and focused on provider practices with a significant African-American panel. There is an opportunity to improve performance by obtaining direct member feedback on the barriers they face, with findings from this barrier analysis used to inform modifications to interventions.

ABHNJ PIP 3: Decreasing Member Grievances Related to Balance Billing

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

PIP Topic 3: Decreasing Member Grievances Related to Balance Billing

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

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

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

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

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

IPRO Reviewers: Deb Chambers (dchambers@ipro.org) Rob Accetta (raccetta@ipro.org)
Date (report submission) reviewed: October 15, 2024
Reporting Period: Year 1

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

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

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

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

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

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

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

Element 8 Overall Review Determination was N/A. Sustainability is not evaluated at the Year 1 phase.

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

Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 80.0 points, the MCO scored 80.0 points, which results in a rating of 100.0% (which is above 85% [≥ 85% being the threshold for meeting compliance]). The MCO has made significant changes over this first year, taking time to review every aspect of the PIP, using the QI process to make appropriate changes in each area when needed. All comments/recommendations from IPRO have been appropriately addressed.

ABHNJ PIP 4: Increasing IMA Combination 2 Vaccinations and Well Child Visits

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

PIP Topic 4: Increasing IMA Combination 2 Vaccinations and Well Child Visits

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

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

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

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

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

IPRO Reviewers: Sopan Mohnot, MD, MPH (smohnot@ipro.org), Teresa Lubowski (TLubowski@ipro.org)
Date reviewed: October 21, 2024
Reporting Period: Proposal Findings

IPRO Comments:

Elements 1 through 8 were not scored for the Overall Review Determination, as a numerical score was not ascertained for this PIP proposal.

Element 1 Overall Review Determination was N/A.

Element 2 Overall Review Determination was N/A.

Element 3 Overall Review Determination was N/A.

Element 4 Overall Review Determination was N/A.

Element 5 Overall Review Determination was N/A. Although not scored, concerns were identified in the interventions listed in Table 1a. 1) It is unclear how intervention 1a differs from intervention 2a, please provide clarification. Additionally, information regarding the frequency of educational contacts should be provided for interventions 1a and 2a. 2) It is unclear what ITM2a1 is tracking with regards to intervention 2a. The ITM 2a1 denominator pertains to age appropriate well child visits. Please describe if the educational material in intervention 2a will also focus on the importance of well visits or how this ITM will help inform intervention 2a. Additionally, the description of the intervention states IVR AND SMS, but the description of tracking measures uses “or”; please clarify the mode of communication. Similar issues were noted for ITM2b. 3) The description in Table 1a for barrier #3 is unclear. Based on the fishbone diagram, it should be specific to providers not educating members on the vaccine, please add that to Table 1. 4) ITM 6a1 may be difficult to interpret as the numerator and denominator do not align. Consider changing the denominator to 'Number of nonadherent members assigned to the targeted practices who received Gaps in Care reports within the quarter.' 5) The fishbone diagram does not identify Plan-level barriers. Throughout the PIP, continue to conduct the barrier analysis and add interventions according to new barriers identified.

Element 6 Overall Review Determination is N/A.

Element 7 Overall Review Determination is N/A.

Element 8 Overall Review Determination is N/A.

Element 9 Overall Review Determination is N/A.

For this PIP proposal, the submission was not scored. Therefore, a rating of the PIP for determination of overall compliance was N/A. Although not scored, concerns were identified with aspects of Interventions and Barriers. The MCO should address the above concerns with clarifications or adjustments for a sufficiently developed PIP proposal that is ultimately demonstrative of the intended impact on performance outcomes. The MCO should ensure that all changes are noted and documented in the April and August 2025 submissions. In subsequent submissions in the reporting schedule, the MCO will be evaluated accordingly on the reporting of results and discussion/validity of improvement, and later, on reporting of sustainability.

ABHNJ PIP 5: Improving Coordination of Care and Ambulatory Follow up After Mental Hospitalization in the MLTSS Home and Community Based (HCBS) Populations

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

PIP Topic 5: Improving Coordination of Care and Ambulatory Follow up After Mental Hospitalization in the MLTSS Home and Community Based (HCBS) Populations

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

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

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

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**80.0**	**72.5**	**100.0**	**0.0**
Overall Rating	**N/A**	**100.0%**	**90.6%**	**100.0%**	**0.0%**

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

IPRO Reviewers: Carolyn Gallagher (cgallagher@ipro.org) Rob Accetta (raccetta@ipro.org)
Date (report submission) reviewed: October 23, 2024
Reporting Period: Year 3

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

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

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

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

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

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

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

Element 8 Overall Review Determination was that the MCO is compliant.

Element 9 Overall Review Determination was that healthcare disparities are being identified and reviewed.

Overall, the MCO was compliant with this PIP; out of a maximum possible weighted score of 100 points the MCO scored 100 points, which results in a rating of 100% (Which is above 86% [≥ 86% being the threshold for meeting compliance]). As the MCO noted, the denominator for this population remains small. The MCO has provided detailed explanatory notes and plans through each update.

ABHNJ PIP 6: Increasing the number of 10 day post-discharge visits with assessment for the MLTSS population

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

PIP Topic 6: Increasing the number of 10 day post-discharge visits with assessment for the MLTSS population

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

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

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

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

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

IPRO Reviewers: Teresa Lubowski (tlubowski@ipro.org), Deb Chambers (dchambers@ipro.org)
Date (report submission) reviewed: 11/11/2024
Reporting Period: Proposal Findings

IPRO Comments:

Elements 1 through 8 were not scored for the Overall Review Determination, as a numerical score was not ascertained for this PIP proposal.

Element 1 Overall Review Determination was N/A.

Element 2 Overall Review Determination was N/A. Although not scored, please review the calculation for the baseline rate for Performance Indicator #1. Should be 18.67%, not 18.61%, please confirm.

Element 3 Overall Review Determination was N/A.

Element 4 Overall Review Determination was N/A.

Element 5 Overall Review Determination was N/A. Although not scored, concerns were identified in the interventions. Table 1a., Barrier 1 indicates that members feel overwhelmed post-discharge. Please indicate how members declining an assessment within 10 days are going to be addressed in the interventions. Also, please correct the numbering of the ITMs. There are 3 barriers identified, but the interventions for Barrier 2 are labeled as 2a and 3a, while the interventions for Barrier 3 are labeled as 4a1-4a5.

Element 6 Overall Review Determination was N/A. The Results Table is not evaluated at the Proposal phase.

Element 7 Overall Review Determination was N/A. Discussion of Validity and Reported Improvement is not evaluated at the Proposal phase.

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

Element 9 Overall Review Determination was N/A. Although not scored, the MCO has not planned to identify, evaluate, and address healthcare disparities.

For this PIP Proposal, the submission was not scored. Therefore, the rating for the PIP for overall compliance was N/A. Although not scored, the MCO should address any concerns above with clarifications or revisions for a sufficiently developed PIP proposal that demonstrates the intended impact on the performance indicators.

ABHNJ HEDIS Audit Review Table MY 2023

Audit Review Table					
Aetna Better Health of New Jersey (Org ID: 236303, Sub ID: 15442, Medicaid, Spec Area: None, Spec Proj: None, Contract Number: None)					
Measurement Year - 2023; Date & Timestamp - 6/14/2024 11:43:29 AM					
This submission is on the stage: Submission Finalized					
Measure/Data Element	**Benefit Offered**	**Rate**	**Status**	**Audit Designation**	**Comment**
Effectiveness of Care					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
BMI percentile (Total)		87.83%	R	R	Reported
Counseling for Nutrition (Total)		79.81%	R	R	Reported
Counseling for Physical Activity (Total)		78.35%	R	R	Reported
Childhood Immunization Status (CIS)					
DTaP		68.13%	R	R	Reported
IPV		84.43%	R	R	Reported
MMR		82.73%	R	R	Reported
HiB		84.91%	R	R	Reported
Hepatitis B		79.56%	R	R	Reported
VZV		82.73%	R	R	Reported
Pneumococcal Conjugate		65.69%	R	R	Reported
Hepatitis A		67.64%	R	R	Reported
Rotavirus		64.72%	R	R	Reported
Influenza		42.58%	R	R	Reported
Combo 3		55.72%	R	R	Reported
Combo 7		43.31%	R	R	Reported
Combo 10		27.01%	R	R	Reported
Immunizations for Adolescents (IMA)					
Meningococcal		81.02%	R	R	Reported
Tdap		83.70%	R	R	Reported
HPV		25.55%	R	R	Reported
Combination 1		79.56%	R	R	Reported
Combination 2		23.84%	R	R	Reported
Lead Screening in Children (LSC)					
Lead Screening in Children		72.51%	R	R	Reported
Cervical Cancer Screening (CCS)					
Cervical Cancer Screening		48.91%	R	R	Reported
Colorectal Cancer Screening (COL)					
(Total)		28.24%	R	R	Reported
Chlamydia Screening in Women (CHL)					
(Total)		64.27%	R	R	Reported
Oral Evaluation, Dental Services (OED)	Y				
(0-2)		15.71%	R	R	Reported
(3-5)		41.02%	R	R	Reported
(6-14)		46.86%	R	R	Reported
(15-20)		31.42%	R	R	Reported
(Total)		37.02%	R	R	Reported

Topical Fluoride for Children (TFC)					
(1-2)		9.45%	R	R	Reported
(3-4)		12.20%	R	R	Reported
(Total)		10.80%	R	R	Reported
Appropriate Testing for Pharyngitis (CWP)	Y				
(Total)		77.42%	R	R	Reported
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)					
Use of Spirometry Testing in the Assessment and Diagnosis of COPD		28.24%	R	R	Reported
Pharmacotherapy Management of COPD Exacerbation (PCE)	Y				
Systemic Corticosteroid		75.39%	R	R	Reported
Bronchodilator		79.69%	R	R	Reported
Asthma Medication Ratio (AMR)	Y				
(Total)		70.92%	R	R	Reported
Controlling High Blood Pressure (CBP)					
Controlling High Blood Pressure		69.83%	R	R	Reported
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	Y				
Persistence of Beta-Blocker Treatment After a Heart Attack		54.05%	R	R	Reported
Statin Therapy for Patients With Cardiovascular Disease (SPC)	Y				
Received Statin Therapy (Total)		63.56%	R	R	Reported
Statin Adherence 80% (Total)		69.64%	R	R	Reported
Cardiac Rehabilitation (CRE)					
Initiation (Total)		1.08%	R	R	Reported
Engagement1 (Total)		4.84%	R	R	Reported
Engagement2 (Total)		5.38%	R	R	Reported
Achievement (Total)		3.23%	R	R	Reported
Hemoglobin A1c Control for Patients With Diabetes (HBD)					
HbA1c Control (<8%)		61.31%	R	R	Reported
Poor HbA1c Control		28.47%	R	R	Reported
Blood Pressure Control for Patients With Diabetes (BPD)					
Blood Pressure Control for Patients With Diabetes		70.80%	R	R	Reported
Eye Exam for Patients With Diabetes (EED)					
Eye Exam for Patients With Diabetes		54.26%	R	R	Reported
Kidney Health Evaluation for Patients With Diabetes (KED)					
(Total)		39.66%	R	R	Reported
Statin Therapy for Patients With Diabetes (SPD)	Y				
Received Statin Therapy		59.79%	R	R	Reported
Statin Adherence 80%		58.66%	R	R	Reported
Diagnosed Mental Health Disorders (DMH)					
(Total)		22.91%	R	R	Reported
Antidepressant Medication Management (AMM)	Y				

Effective Acute Phase Treatment		61.29%	R	R	Reported
Effective Continuation Phase Treatment		46.77%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Y				
Initiation Phase		34.62%	R	R	Reported
Continuation and Maintenance Phase		37.04%	R	R	Reported
Follow-Up After Hospitalization for Mental Illness (FUH)	Y				
30 days (Total)		36.04%	R	R	Reported
7 days (Total)		18.93%	R	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Y				
30 days (Total)		58.38%	R	R	Reported
7 days (Total)		48.30%	R	R	Reported
Diagnosed Substance Use Disorders (DSU)					
Alcohol (Total)		3.29%	R	R	Reported
Opioid (Total)		3.76%	R	R	Reported
Other (Total)		4.12%	R	R	Reported
Any (Total)		7.82%	R	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	Y				
30 days (Total)		40.79%	R	R	Reported
7 Days (Total)		22.38%	R	R	Reported
Follow-Up After Emergency Department Visit for Substance Use (FUA)	Y				
30 days (Total)		34.18%	R	R	Reported
7 days (Total)		24.10%	R	R	Reported
Pharmacotherapy for Opioid Use Disorder (POD)	Y				
(Total)		21.08%	R	R	Reported
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Y				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		87.21%	R	R	Reported
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)					
Diabetes Monitoring for People With Diabetes and Schizophrenia		68.95%	R	R	Reported
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		60.00%	NA	R	Reported
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	Y				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		55.98%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	Y				
Blood Glucose Testing (Total)		53.80%	R	R	Reported
Cholesterol Testing (Total)		39.87%	R	R	Reported
Blood Glucose and Cholesterol Testing (Total)		39.24%	R	R	Reported

Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)					
Non-Recommended Cervical Cancer Screening in Adolescent Females		0.38%	R	R	Reported
Appropriate Treatment for Upper Respiratory Infection (URI)	Y				
(Total)		86.72%	R	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	Y				
(Total)		59.11%	R	R	Reported
Use of Imaging Studies for Low Back Pain (LBP)					
(Total)		68.93%	R	R	Reported
Use of Opioids at High Dosage (HDO)	Y				
Use of Opioids at High Dosage		12.54%	R	R	Reported
Use of Opioids From Multiple Providers (UOP)	Y				
Multiple Prescribers		22.91%	R	R	Reported
Multiple Pharmacies		2.50%	R	R	Reported
Multiple Prescribers and Multiple Pharmacies		1.55%	R	R	Reported
Risk of Continued Opioid Use (COU)	Y				
>=15 Days (Total)		6.47%	R	R	Reported
>=31 Days (Total)		3.91%	R	R	Reported
Access/Availability of Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
(Total)		68.45%	R	R	Reported
Initiation and Engagement of Substance Use Disorder Treatment (IET)	Y				
Initiation of SUD Treatment - Total (Total)		49.60%	R	R	Reported
Engagement of SUD Treatment - Total (Total)		14.79%	R	R	Reported
Prenatal and Postpartum Care (PPC)					
Timeliness of Prenatal Care		87.10%	R	R	Reported
Postpartum Care		83.21%	R	R	Reported
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Y				
(Total)		59.72%	R	R	Reported
Utilization and Risk Adjusted Utilization					
Well-Child Visits in the First 30 Months of Life (W30)					
(First 15 Months)		53.71%	R	R	Reported
(15 Months-30 Months)		71.93%	R	R	Reported
Child and Adolescent Well-Care Visits (WCV)					
(Total)		56.40%	R	R	Reported
Ambulatory Care (AMB)			R	R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPU)			R	R	Reported
Antibiotic Utilization for Respiratory Conditions (AXR)	Y				
(Total)		22.63%	R	R	Reported
Plan All-Cause Readmissions (PCR)			R	R	Reported
Health Plan Descriptive Information					

Enrollment by Product Line (ENP)			R	R	Reported
Language Diversity of Membership (LDM)			R	R	Reported
Race/Ethnicity Diversity of Membership (RDM)			R	R	Reported
Measures Reported Using Electronic Clinical Data Systems					
Childhood Immunization Status (CIS-E)					
DTaP		59.30%	R	R	Reported
IPV		74.29%	R	R	Reported
MMR		80.69%	R	R	Reported
HiB		76.73%	R	R	Reported
Hepatitis B		44.15%	R	R	Reported
VZV		79.79%	R	R	Reported
Pneumococcal Conjugate		56.48%	R	R	Reported
Hepatitis A		68.49%	R	R	Reported
Rotavirus		56.04%	R	R	Reported
Influenza		36.07%	R	R	Reported
Combo 3		31.24%	R	R	Reported
Combo 7		23.74%	R	R	Reported
Combo 10		13.58%	R	R	Reported
Immunizations for Adolescents (IMA-E)					
Meningococcal		79.65%	R	R	Reported
Tdap		81.41%	R	R	Reported
HPV		23.74%	R	R	Reported
Combination 1		77.88%	R	R	Reported
Combination 2		22.59%	R	R	Reported
Breast Cancer Screening (BCS-E)					
Breast Cancer Screening		45.86%	R	R	Reported
Cervical Cancer Screening (CCS-E)					
Cervical Cancer Screening		47.38%	R	R	Reported
Colorectal Cancer Screening (COL-E)					
(Total)		28.24%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)	Y				
Initiation Phase		34.62%	R	R	Reported
Continuation and Maintenance Phase		37.04%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	Y				
Blood Glucose Testing (Total)		53.80%	R	R	Reported
Cholesterol Testing (Total)		39.87%	R	R	Reported
Blood Glucose and Cholesterol Testing (Total)		39.24%	R	R	Reported
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)					
Depression Screening (Total)		0.99%	R	R	Reported
Follow-Up on Positive Screen (Total)		86.49%	R	R	Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)					
Utilization of PHQ-9-Total (Total)		8.15%	R	R	Reported
Depression Remission or Response for Adolescents and Adults (DRR-E)					

Follow-Up PHQ-9 (Total)		0.00%	NA	R	Reported
Depression Remission (Total)		0.00%	NA	R	Reported
Depression Response (Total)		0.00%	NA	R	Reported
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)					
Unhealthy Alcohol Use Screening (Total)		4.57%	R	R	Reported
Alcohol Counseling or Other Follow-Up Care (Total)		2.42%	R	R	Reported
Adult Immunization Status (AIS-E)					
Influenza (19-65)		12.31%	R	R	Reported
Influenza (66+)		28.47%	R	R	Reported
Influenza (Total)		13.73%	R	R	Reported
Td/Tdap (19-65)		19.95%	R	R	Reported
Td/Tdap (66+)		10.94%	R	R	Reported
Td/Tdap (Total)		19.16%	R	R	Reported
Zoster (50-65)		6.38%	R	R	Reported
Zoster (66+)		7.03%	R	R	Reported
Zoster (Total)		6.55%	R	R	Reported
Pneumococcal (66+)		27.46%	R	R	Reported
Prenatal Immunization Status (PRS-E)					
Influenza		18.13%	R	R	Reported
Tdap		38.71%	R	R	Reported
Combination		13.68%	R	R	Reported
Prenatal Depression Screening and Follow-Up (PND-E)					
Depression Screening		9.36%	R	R	Reported
Follow-Up on Positive Screen		66.67%	NA	R	Reported
Postpartum Depression Screening and Follow-Up (PDS-E)					
Depression Screening		0.06%	R	R	Reported
Follow-Up on Positive Screen		0.00%	NA	R	Reported
Social Need Screening and Intervention (SNS-E)					
Food Screening (Total)		0.00%	R	R	Reported
Food Intervention (Total)			NA	R	Reported
Housing Screening (Total)		0.00%	R	R	Reported
Housing Intervention (Total)			NA	R	Reported
Transportation Screening (Total)		0.00%	R	R	Reported
Transportation Intervention (Total)			NA	R	Reported

ABHNJ 2024 ISCA Summary of Findings

Assessment Topic	ABHNJ Assessment Finding	Review Note
Completeness and accuracy of encounter data collected and submitted to the State	Met	ABHNJ has adequate checks and audit processes in place to monitor the submission of encounter data. ABHNJ's timeliness and State acceptance rates for all encounter types are all above 97.00%. No issues were noted in the ABHNJ's encounter data submission and reconciliation processes.
Validation and/or calculation of performance measures	Met	ABHNJ uses Converged Analytics for HEDIS, CMS Adult and Child Core Set, and NJ State-specific performance measures, ECDS, and race and ethnicity reporting. ABHNJ loads all data elements in the input files needed for calculation of performance measures into Inovalon's robust software, Converged Analytics. Regarding HEDIS ECDS performance measures, ABHNJ follows the prescribed NCQA hierarchy order for the inclusion of supplemental data sources. No issues were noted in validation and calculation processes for the required performance measures.
Completeness and accuracy of tracking of member grievances	Met	ABHNJ has created a daily dashboard for Table 3B, a report of all non-Utilization Management (UM) member grievance requests and dispositions; Table 3C, a report of all non-UM provider grievance and appeal requests and dispositions; and Table H2A, a report of UM and appeals for FIDE SNP. No issues were noted in ABHNJ's systems used for handling grievances and reporting Tables 3B, 3C, and H2A to the State.
NJ Appointment Assistance Form	Met	ABHNJ demonstrated the NJ Appointment Assistance Form on their member portal and confirmed that the member portal had an option for the member to select whether a grievance should be filed. No issues were noted.
Utility of the information system to conduct MCO quality assessment and improvement initiatives	Met	ABHNJ's information systems support various data reporting requests, both internally and externally.
Ability of the information system to conduct MCO quality assessment and improvement initiatives	Met	ABHNJ's information systems can conduct quality assessments and conduct improvement initiatives.
Ability of the information system to oversee and manage the delivery of health care to the MCO's enrollees	Met	ABHNJ receives and processes the daily 834 eligibility files. The 834 daily eligibility files are loaded into QNXT®. ABHNJ uniquely identifies members by their health plan ID and enrollee ID. All enrollment history data are stored in a single

Assessment Topic	ABHNJ Assessment Finding	Review Note
		record identified by a unique record ID. ABHNJ can track members who switch product lines, track the member's initial enrollment date, and track and link previous claims/encounter data across product lines for the purposes of performance measure reporting. No issues were noted in ABHNJ's systems or enrollment processes.
Validation and/or calculation of network adequacy reports	Met	ABHNJ utilizes Quest Analytics software for assessing, monitoring and reporting network adequacy across geographic areas based on NJ's distance and time standards. ABHNJ submits monthly reports to NJ as per DMAHS's regulatory requirements. ABHNJ submitted multiple waiver requests to DMAHS for pediatric sub-specialties for network gaps with providers' availability, time, and distance.
Identification and reporting of NCQA's and CMS' race and ethnicity categories	Met	ABHNJ uses race and ethnicity/language codes received on the State 834 file(s) for direct race and ethnicity/language values utilized for HEDIS, CMS, and NJ-specific performance measure reporting. ABHNJ's vendor, Inovalon, crosswalks race and ethnicity values for HEDIS rate reporting. ABHNJ utilizes NCQA's direct methodology for reporting NCQA race and ethnicity values. ABHNJ advised that they will be incorporating NCQA's approved indirect methodology for MY 2024 reporting of race and ethnicity values. No issues were identified.

Assessment Level Definitions

Assessment Levels	Definition
Met	MCO met or exceeded standards.
Partially Met	MCO met some of the standards and demonstrates opportunities for improvement.
Not Met	MCO did not meet the standards and a corrective action plan is required.
Not Applicable	Standard does not apply.

FC/WCHP Core Medicaid/MLTSS Annual Assessment of MCO Operations

FC/WCHP 2024 Annual Assessment of MCO Operations

Review Category	Total Elements[1]	Deemed Met from the Prior Year	Subject to Review[2]	Subject to Review and Met[3]	Subject to review and Not Met	Subject to Review and N/A	Total Met	% Met[4]
Care Management and Continuity of Care – Core Medicaid*	30	0	30	26	4	0	26	87%
Care Management and Continuity of Care - MLTSS*	10	0	10	10	0	0	10	100%
Access**	12	0	12	8	4	0	8	67%
Emergency and Post-Stabilization Services[5]	6	0	6	6	0	0	6	100%
Quality Assessment and Performance Improvement	10	0	10	10	0	0	10	100%
Quality Management	21	0	21	18	3	0	18	86%
Efforts to Reduce Healthcare Disparities	5	0	5	5	0	0	5	100%
Committee Structure	9	0	9	9	0	0	9	100%
Programs for the Elderly and Disabled	44	0	44	44	0	0	44	100%
Provider Training and Performance	11	0	11	11	0	0	11	100%
Satisfaction	5	0	5	5	0	0	5	100%
Enrollee Rights and Responsibilities	8	0	8	8	0	0	8	100%
Member Disenrollment	29	0	29	25	4	0	25	86%
Credentialing and Re-credentialing	10	0	10	9	1	0	9	90%
Utilization Management	30	0	30	30	0	0	30	100%
Administration and Operations	14	0	14	14	0	0	14	100%
Management Information Systems	18	0	18	18	0	0	18	100%
TOTAL	**232**	**0**	**232**	**220**	**12**	**0**	**220**	**95%**

[1] A total of 115 elements were reviewed in the previous review period; of these 115, 100 were *Met,* 15 were *Not Met*; 0 were *N/A.* Remaining existing elements that were Met Prior Year were deemed Met in the previous review period.

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

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

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

[5] Emergency and Post-Stabilization Services was a new standard reviewed in 2024.

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

** Access had 14 elements in 2023. In 2024, two elements (A1 and A2) were moved to a new category Emergency and Post-Stabilization Services. Although not an annual element, A3 was reviewed in the partial audits this year due to enhancements in the Access category.

FC/WCHP Performance Improvement Projects

FC/WCHP PIP 1: Medicaid Primary Care Physician Access and Availability

MCO Name: WellCare Health Plans of New Jersey, Inc., d/b/a Fidelis Care (FC/WCHP)
PIP Topic 1: Medicaid Primary Care Physician Access and Availability

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

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

Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M	M	M	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M	M	M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M	M	M	M
7d. Lessons learned & follow-up activities planned as a result	N/A	M	M	M	M
Element 7 Overall Review Determination	**N/A**	**M**	**M**	**M**	**M**
Element 7 Overall Score	**N/A**	**100**	**100**	**100**	**100**
Element 7 Weighted Score	**N/A**	**20.0**	**20.0**	**20.0**	**20.0**
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There were ongoing, additional, or modified interventions documented	N/A	N/A	N/A	M	M
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	**PM**	PM
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**PM**	**PM**
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**50**	**50**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**10.0**	**10.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated, and addressed	**N/A**	**N**	**N**	**N**	**N**

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**65.0**	**72.5**	**90.0**	**90.0**
Overall Rating	**N/A**	**81.3%**	**90.6%**	**90.0%**	**90.0%**

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

IPRO Reviewers: Lois Heffernan (lheffernan@ipro.org); Deb Chambers (dchambers@ipro.org)
Date (report submission) reviewed: September 3, 2024
Reporting Period: Final Report

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

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

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

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

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

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

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

Element 8 Overall Review Determination was that the MCO is partially compliant regarding element 8b. The MCO demonstrated sustained improvement in PI1 and PI2, which are provider survey response measures, from baseline to MY1 and MY2. Significant declines were seen in these PIs in the Sustainability Year, which the MCO attributed to removing a question on telehealth services from the survey. PI3 and PI4, which are the true outcome indicators, did not show sustained improvement.

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

Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 100.0 points, the MCO scored 90.0 points, which results in a rating of 90.0% (which is above 85% [≥ 85% being the threshold for meeting compliance]). The MCO used member outreach to solicit information on members choosing the ED or Urgent Care over the PCP office, revealing that transportation and timely PCP appointments were barriers to PCP utilization. The MCO followed up with the PCPs for which timely appointments were an issue and also provided transportation information to members for whom this was an issue. The MCO noted that after analysis of ED and Urgent Care utilization, there was not a substantial number of visits that would have been better addressed in the PCP office. The MCO updated interventions based on barrier analysis year over year.

FC/WCHP PIP 2: Improving Early and Periodic Screening Diagnostic and Diagnosis (EPSDT) Well Child Visits and Childhood Immunizations

MCO Name: WellCare Health Plans of New Jersey, Inc., d/b/a Fidelis Care (FC/WCHP)
PIP Topic 2: Improving Early and Periodic Screening Diagnostic and Diagnosis (EPSDT) Well Child Visits and Childhood Immunizations

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

3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	M	N/A	M	
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	PM	M	M	
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M	M	
Element 3 Overall Review Determination	**N/A**	**PM**	**M**	**M**	
Element 3 Overall Score	**N/A**	**50**	**100**	**100**	0
Element 3 Weighted Score	**N/A**	**7.5**	**15.0**	**15.0**	**0.0**
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M	M	M	
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M	M	
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	M	M	
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	M	M	M	
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M	M	M	
4f. Literature review	**N/A**	M	M	M	
Element 4 Overall Review Determination	**N/A**	**M**	**M**	**M**	
Element 4 Overall Score	**N/A**	**100**	**100**	**100**	0
Element 4 Weighted Score	**N/A**	**15.0**	**15.0**	**15.0**	**0.0**
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	N/A	M	PM	PM	
5b. Actions that target member, provider and MCO	N/A	M	M	PM	
5c. New or enhanced, starting after baseline year	N/A	M	M	M	
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	PM	M	M	
Element 5 Overall Review Determination	**N/A**	**PM**	**PM**	**PM**	
Element 5 Overall Score	**N/A**	**50**	**50**	**50**	**0**
Element 5 Weighted Score	**N/A**	**7.5**	**7.5**	**7.5**	**0.0**
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	PM	M	M	
Element 6 Overall Review Determination	**N/A**	**PM**	**M**	**M**	
Element 6 Overall Score	**N/A**	**50**	**100**	**100**	**0**
Element 6 Weighted Score	**N/A**	**2.5**	**5.0**	**5.0**	**0.0**

Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M	M	M	
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M	M	M	
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M	PM	M	
7d. Lessons learned & follow-up activities planned as a result	N/A	M	M	M	
Element 7 Overall Review Determination	**N/A**	**M**	**PM**	**M**	
Element 7 Overall Score	**N/A**	**100**	**50**	**100**	**0**
Element 7 Weighted Score	**N/A**	**20.0**	**10.0**	**20.0**	**0.0**
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	M	
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	PM	
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**PM**	
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**50**	**0**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**10.0**	**0.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)	**N/A**	**Y**	**Y**	**Y**	

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**60.0**	**62.5**	**82.5**	**0.0**
Overall Rating	**N/A**	**75.0%**	**78.1%**	**82.5%**	**0.0%**

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

IPRO Reviewers: Carolyn Gallagher (cgallagher@ipro.org); Deb Chambers (dchambers@ipro.org)
Date (report submission) reviewed: November 4, 2024
Report Status: Year 3

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

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

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

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

Element 5 Overall Review Determination was that the MCO is partially compliant with element 5a. Interventions 2 and 6 to provide referrals for parent/guardian to FQHCs to provide alternate night and weekend hours was discontinued despite data to support robustness, i.e., 48 of 48 parents with scheduling conflicts were referred to FQHC. The MCO's rationale was that this intervention "does not promote the relationship between the patient and the provider"; however, this is a subjective rationale that is not supported by the data. Nor was a replacement intervention added to address the barrier of parents who have difficulty taking time off from work (e.g., expansion of PCP practice hours). Also, for element 5b, the MCO limited the impact of many interventions by targeting only those members who agreed to participate in Care Management. Broader public educational campaign interventions might be conducted in partnership with community organizations. For continued sustainability, a broad intervention would be an on-line newsletter for all parents of young children that provides immunization information to counter vaccine hesitance. Also, please remove the duplicate section "2023 Barriers" that follows "2024 Barriers" on page 64.

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

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

Element 8 Overall Review Determination was partially compliant for element 8b. Indicator #1 (well-child visits gaps in care) showed some improvement from 2021 to 2023, but Indicator #2 (CIS care gaps) did not show improvement from 2021 to 2023.

Element 9 Overall Review Determination was that Healthcare disparities have been reviewed and are being addressed.

Overall, the MCO was partially compliant with this PIP; out of a maximum possible weighted score of 100 points the MCO scored 82.5 points, which results in a rating of 82.5% (which is below 85% [≥ 85% being the threshold for meeting compliance]). There is an opportunity to clarify and expand the population of members who are eligible for interventions, as well as an opportunity to address the scheduling barriers faced by working parents.

FC/WCHP PIP 3: Addressing Medicaid Member's Complaints and Grievances

MCO Name: WellCare Health Plans of New Jersey, Inc., d/b/a Fidelis Care (FC/WCHP)
PIP Topic 3: Addressing Medicaid Member's Complaints and Grievances

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

3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M			
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M			
Element 3 Overall Review Determination	**N/A**	**M**			
Element 3 Overall Score	**N/A**	**100**	0	0	0
Element 3 Weighted Score	**N/A**	**15.0**	**0.0**	**0.0**	**0.0**
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M			
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M			
4c. Provider input at focus groups and/or Quality Meetings	N/A	M			
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	M			
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M			
4f. Literature review	N/A	M			
Element 4 Overall Review Determination	**N/A**	**M**			
Element 4 Overall Score	**N/A**	**100**	0	0	0
Element 4 Weighted Score	**N/A**	**15.0**	**0.0**	**0.0**	**0.0**
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	N/A	M			
5b. Actions that target member, provider and MCO	N/A	M			
5c. New or enhanced, starting after baseline year	N/A	N/A			
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	M			
Element 5 Overall Review Determination	**N/A**	**M**			
Element 5 Overall Score	**N/A**	**100**	**0**	**0**	**0**
Element 5 Weighted Score	**N/A**	**15.0**	**0.0**	**0.0**	**0.0**
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	PM			
Element 6 Overall Review Determination	**N/A**	**PM**			
Element 6 Overall Score	**N/A**	**50**	**0**	**0**	**0**
Element 6 Weighted Score	**N/A**	**2.5**	**0.0**	**0.0**	**0.0**
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of					

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

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**77.5**	**0.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**96.9%**	**0%**	**0%**	**0%**

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

IPRO Reviewers: Deb Chambers (dchambers@ipro.org) Rob Accetta (raccetta@ipro.org)
Date (report submission) reviewed: October 11, 2024
Reporting Period: Year 1

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

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

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

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

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

Element 6 Overall Review Determination was that the MCO is partially compliant. Element 6a, Table 2, the calculation for Year 1 is incorrect and should be .7082, not 70.82. (The 2024 preliminary data (1/1/2024 – 6/30/2024 was 59 balance billing grievances filed/83,305 unique Medicaid members X 1000 = .7082 balance billing grievances per 1000 Medicaid members during the measurement year); please correct in future reports.

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

Element 8 Overall Review Determination was N/A. Sustainability is not evaluated at the Year 1 phase.

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

Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 80.0 points, the MCO scored 77.5 points, which results in a rating of 96.9% (which is above 85% [≥ 85% being the threshold for meeting compliance]). Please review comment above for future reporting. All other comments/recommendations made from IPRO have been appropriately addressed.

FC/WCHP PIP 4: Improving Compliance with Adolescent Immunizations specifically targeting the completion of meningococcal vaccine, Tdap vaccine, and full HPV vaccine series

MCO Name: WellCare Health Plans of New Jersey, Inc., d/b/a Fidelis Care (FC/WCHP)

PIP Topic 4: Improving Compliance with Adolescent Immunizations specifically targeting the completion of meningococcal vaccine, Tdap vaccine, and full HPV vaccine series

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

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

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

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

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

IPRO Reviewers: Sopan Mohnot, MD, MPH (smohnot@ipro.org); Teresa Lubowski (TLubowski@ipro.org)
Date (report submission) reviewed: October 21, 2024
Reporting Period: Proposal Findings

IPRO Comments:

Elements 1 through 8 were not scored for the Overall Review Determination, as a numerical score was not ascertained for this PIP proposal.

Element 1 Overall Review Determination was N/A. Although not scored, it is recommended to label the baseline year in Table 1a in columns for Health Plan Average and Statewide Weighted Average for clarity. This was done for 2022, but not 2023.

Element 2 Overall Review Determination was N/A.

Element 3 Overall Review Determination was N/A. Although not scored, concerns were identified with aspects of the Methodology section. The MCO has not described data collection, analysis, and reporting for intervention tracking measures that will be used during the PIP. This should be included in the Methodology section. Also, please include the age group of the members that will be the focus of the interventions.

Element 4 Overall Review Determination was N/A. Although not scored, concerns were identified with aspects of the Barrier Analysis, Interventions, Monitoring and Table 1a. The MCO has not provided the method of identification or sources of the listed barriers in Table 1a. Overall, the barriers are poorly described and it is therefore difficult to assess how the associated intervention addresses the specific barrier. The MCO should continue to develop the barrier analysis and provide further description in Table 1a.

Element 5 Overall Review Determination was N/A. Although not scored, concerns were identified with aspects of Interventions. Table 1a: 1) ITM#1 should be clarified. The description indicates providers, however, the N and D reference members. Based on the intervention, providers, not members, would receive the toolkit. The description of intervention #1 is lacking sufficient detail and should state what the expectations of the providers in the pilot program. 2) Intervention #2 requires more detail including mode of communication for the outreach. The report states: "Focused Outreach and Support: Care Management will focus on adolescent members who lack WCV visits and immunization claims." Please identify which members will be called. The description of ITM #2b does not match the N and D. Also, the look back period for ITM 2b should be described (i.e. 90 days after outreach). This information should be added to Table 1a. 3) Intervention 3 and ITM 3a lack detail. How the MCO plans to address vaccine hesitancy with intervention #3 should be described. Also, how many school-based educational events will be held each quarter and what the MCO's role is during these events should be included. 4) The section on **Focused Outreach and Support** provides a more thorough description of interventions, however, it is not clear based on what is described in Table 1a if the MCO is planning to conduct all interventions described in that section. For example, the current intervention descriptions do not have information regarding assessing and addressing SDOH or utilizing mobile vans (assumption is that this would be for a mobile immunization clinic). 5) While it is understandable that most of the efforts are directed toward improving HPV vaccination, please describe what, if any, are the interventions that address all adolescent immunizations and well child visits.
Please make any changes to interventions and ITMs in Table 1a and Table 1b.

Element 6 Overall Review Determination was N/A. Results are not evaluated at the proposal phase.

Element 7 Overall Review Determination was N/A. Discussion and validity of reported improvement are not evaluated at the proposal phase.

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

Element 9 Overall Review Determination was N/A.

For this PIP proposal, the submission was not scored. Therefore, a rating of the PIP for determination of overall compliance was N/A. Although not scored, concerns were identified with several aspects of the proposal. The MCO should address the above concerns with clarifications or adjustments for a sufficiently developed PIP proposal that is ultimately demonstrative of the intended impact on performance outcomes. The MCO should ensure that all changes are noted and documented in the April and August 2025 submissions. In subsequent submissions in the reporting schedule, the MCO will be evaluated accordingly on the reporting of results and discussion/validity of improvement, and later, on reporting of sustainability.

FC/WCHP PIP 5: Improving Coordination of Care and Ambulatory Follow-Up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations

MCO Name: WellCare Health Plans of New Jersey, Inc., d/b/a Fidelis Care (FC/WCHP)

PIP Topic 5: Improving Coordination of Care and Ambulatory Follow-Up After Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations

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

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

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

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**70.0**	**65.0**	**100.0**	**0.0**
Overall Rating	**N/A**	**87.5%**	**81.3%**	**100.0%**	**0.0%**

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

IPRO Reviewers: Carolyn Gallagher (cgallagher@ipro.org) Rob Accetta (raccetta@ipro.org)
Date (report submission) reviewed: October 24, 2024
Reporting Period: Year 3

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

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

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

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

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

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

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

Element 8 Overall Review Determination was that the MCO is compliant. 8a. There was ongoing, additional or modified interventions documented; however, assessment of sustained improvement is pending submission of the Final Report with a full 2024 year of sustainability data.

Element 9 Overall Review Determination was that Healthcare disparities have been assessed and are being addressed through identification of SDOH and appropriate referrals.

Overall, the MCO was compliant with this PIP; out of a maximum possible weighted score of 100 points the MCO scored 100 points, which results in a rating of 100% (Which is above 86% [≥ 86% being the threshold for meeting compliance]).

FC/WCHP PIP 6: Improving timely 10-day post discharge visits from the acute care setting with assessment by the care manager in the MLTSS(HCBS) /Core Medicaid and DSNP population

MCO Name: WellCare Health Plans of New Jersey, Inc., d/b/a Fidelis Care (FC/WCHP)

PIP Topic 6: Improving timely 10-day post discharge visits from the acute care setting with assessment by the care manager in the MLTSS(HCBS) /Core Medicaid and DSNP population

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

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

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

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

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

IPRO Reviewers: Teresa Lubowski (tlubowski@ipro.org), Deb Chambers (dchambers@ipro.org)
Date (report submission) reviewed: 11/13/2024
Reporting Period: Proposal Findings

IPRO Comments:

Elements 1 through 8 were not scored for the Overall Review Determination, as a numerical score is not calculated at the Proposal stage of a PIP.

Element 1 Overall Review Determination was N/A. Although not scored, concerns were identified in Section 3. Please describe how this PIP addresses member needs; the PIP does not indicate why the 10 day post

discharge visit is important to the members selected for inclusion. Please include MCO data to highlight how the PIP addresses high volume or high risk conditions.

Element 2 Overall Review Determination was N/A.

Element 3 Overall Review Determination was N/A.

Element 4 Overall Review Determination was N/A. Although not scored, the following concerns were identified in the Barrier Analysis. In Table 1a, please include what internal and external sources were used to determine the identified barriers. Please clarify in Table 1a if FIDE SNP members are also included as described in the Aim Statement. The fishbone diagram does not include input from the MCO or Provider.

Element 5 Overall Review Determination was N/A. Although not scored, the following concerns were identified. The descriptions for ITMs 1b and 2a or identical, however the numerator and denominator definitions differ. For Barrier #2 consider adding an additional ITM that looks at the members that screen positive for additional MLTSS services/SDOH needs and what percent of those members' needs were subsequently addressed by the care manager.

Element 6 Overall Review Determination was N/A. The Results Table is not evaluated at the Proposal phase.

Element 7 Overall Review Determination was N/A. Discussion of Validity and Reported Improvement is not evaluated at the Proposal phase.

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

Element 9 Overall Review Determination was N/A. Although not scored, the MCO has not planned to identify, evaluate, and address healthcare disparities.

For this PIP Proposal, the submission was not scored. Therefore, the rating for the PIP for overall compliance was N/A. Although not scored, the MCO should address any concerns above with clarifications or revisions for a sufficiently developed PIP proposal that demonstrates the intended impact on the performance indicators.

FC/WCHP HEDIS Audit Review Table MY 2023

Audit Review Table					
WellCare Health Plans of New Jersey, Inc. (Org ID: 10793, Sub ID: 11953, Medicaid, Spec Area: None, Spec Proj: None, Contract Number: None)					
Measurement Year - 2023; Date & Timestamp - 6/13/2024 2:44:04 PM					
This submission is on the stage: Submission Finalized					
Measure/Data Element	**Benefit Offered**	**Rate**	**Status**	**Audit Designation**	**Comment**
Effectiveness of Care					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
BMI percentile (Total)		86.62%	R	R	Reported
Counseling for Nutrition (Total)		81.27%	R	R	Reported
Counseling for Physical Activity (Total)		78.59%	R	R	Reported
Childhood Immunization Status (CIS)					
DTaP		71.53%	R	R	Reported
IPV		82.48%	R	R	Reported
MMR		82.97%	R	R	Reported
HiB		85.40%	R	R	Reported
Hepatitis B		80.54%	R	R	Reported
VZV		81.75%	R	R	Reported
Pneumococcal Conjugate		66.91%	R	R	Reported
Hepatitis A		71.29%	R	R	Reported
Rotavirus		65.21%	R	R	Reported
Influenza		43.80%	R	R	Reported
Combo 3		57.18%	R	R	Reported
Combo 7		44.04%	R	R	Reported
Combo 10		27.49%	R	R	Reported
Immunizations for Adolescents (IMA)					
Meningococcal		85.40%	R	R	Reported
Tdap		90.27%	R	R	Reported
HPV		31.87%	R	R	Reported
Combination 1		84.18%	R	R	Reported
Combination 2		29.68%	R	R	Reported
Lead Screening in Children (LSC)					
Lead Screening in Children		78.59%	R	R	Reported
Cervical Cancer Screening (CCS)					
Cervical Cancer Screening		51.34%	R	R	Reported
Colorectal Cancer Screening (COL)					
(Total)		39.25%	R	R	Reported
Chlamydia Screening in Women (CHL)					
(Total)		64.35%	R	R	Reported
Oral Evaluation, Dental Services (OED)	Y				
(0-2)		23.42%	R	R	Reported
(3-5)		55.60%	R	R	Reported
(6-14)		61.40%	R	R	Reported
(15-20)		43.04%	R	R	Reported
(Total)		50.54%	R	R	Reported

Topical Fluoride for Children (TFC)					
(1-2)		15.15%	R	R	Reported
(3-4)		18.56%	R	R	Reported
(Total)		16.88%	R	R	Reported
Appropriate Testing for Pharyngitis (CWP)	Y				
(Total)		64.48%	R	R	Reported
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)					
Use of Spirometry Testing in the Assessment and Diagnosis of COPD		32.39%	R	R	Reported
Pharmacotherapy Management of COPD Exacerbation (PCE)	Y				
Systemic Corticosteroid		58.87%	R	R	Reported
Bronchodilator		74.03%	R	R	Reported
Asthma Medication Ratio (AMR)	Y				
(Total)		61.45%	R	R	Reported
Controlling High Blood Pressure (CBP)					
Controlling High Blood Pressure		73.72%	R	R	Reported
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	Y				
Persistence of Beta-Blocker Treatment After a Heart Attack		45.45%	NA	R	Reported
Statin Therapy for Patients With Cardiovascular Disease (SPC)	Y				
Received Statin Therapy (Total)		71.98%	R	R	Reported
Statin Adherence 80% (Total)		77.69%	R	R	Reported
Cardiac Rehabilitation (CRE)					
Initiation (Total)		1.87%	R	R	Reported
Engagement1 (Total)		3.73%	R	R	Reported
Engagement2 (Total)		3.73%	R	R	Reported
Achievement (Total)		1.49%	R	R	Reported
Hemoglobin A1c Control for Patients With Diabetes (HBD)					
HbA1c Control (<8%)		61.07%	R	R	Reported
Poor HbA1c Control		29.68%	R	R	Reported
Blood Pressure Control for Patients With Diabetes (BPD)					
Blood Pressure Control for Patients With Diabetes		66.18%	R	R	Reported
Eye Exam for Patients With Diabetes (EED)					
Eye Exam for Patients With Diabetes		52.80%	R	R	Reported
Kidney Health Evaluation for Patients With Diabetes (KED)					
(Total)		39.91%	R	R	Reported
Statin Therapy for Patients With Diabetes (SPD)	Y				
Received Statin Therapy		66.43%	R	R	Reported
Statin Adherence 80%		70.76%	R	R	Reported
Diagnosed Mental Health Disorders (DMH)					
(Total)		25.17%	R	R	Reported
Antidepressant Medication Management (AMM)	Y				

Effective Acute Phase Treatment		64.63%	R	R	Reported
Effective Continuation Phase Treatment		51.53%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Y				
Initiation Phase		45.64%	R	R	Reported
Continuation and Maintenance Phase		51.52%	R	R	Reported
Follow-Up After Hospitalization for Mental Illness (FUH)	Y				
30 days (Total)		56.77%	R	R	Reported
7 days (Total)		32.90%	R	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Y				
30 days (Total)		59.48%	R	R	Reported
7 days (Total)		49.59%	R	R	Reported
Diagnosed Substance Use Disorders (DSU)					
Alcohol (Total)		2.18%	R	R	Reported
Opioid (Total)		2.93%	R	R	Reported
Other (Total)		2.82%	R	R	Reported
Any (Total)		5.95%	R	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	Y				
30 days (Total)		52.98%	R	R	Reported
7 Days (Total)		33.63%	R	R	Reported
Follow-Up After Emergency Department Visit for Substance Use (FUA)	Y				
30 days (Total)		28.42%	R	R	Reported
7 days (Total)		20.54%	R	R	Reported
Pharmacotherapy for Opioid Use Disorder (POD)	Y				
(Total)		26.58%	R	R	Reported
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Y				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		77.69%	R	R	Reported
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)					
Diabetes Monitoring for People With Diabetes and Schizophrenia		69.49%	R	R	Reported
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		83.93%	R	R	Reported
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	Y				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		69.79%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	Y				
Blood Glucose Testing (Total)		64.23%	R	R	Reported
Cholesterol Testing (Total)		56.93%	R	R	Reported
Blood Glucose and Cholesterol Testing (Total)		51.82%	R	R	Reported

Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)					
Non-Recommended Cervical Cancer Screening in Adolescent Females		1.05%	R	R	Reported
Appropriate Treatment for Upper Respiratory Infection (URI)	Y				
(Total)		82.55%	R	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	Y				
(Total)		52.40%	R	R	Reported
Use of Imaging Studies for Low Back Pain (LBP)					
(Total)		76.37%	R	R	Reported
Use of Opioids at High Dosage (HDO)	Y				
Use of Opioids at High Dosage		10.61%	R	R	Reported
Use of Opioids From Multiple Providers (UOP)	Y				
Multiple Prescribers		12.85%	R	R	Reported
Multiple Pharmacies		1.80%	R	R	Reported
Multiple Prescribers and Multiple Pharmacies		1.01%	R	R	Reported
Risk of Continued Opioid Use (COU)	Y				
>=15 Days (Total)		11.13%	R	R	Reported
>=31 Days (Total)		6.76%	R	R	Reported
Access/Availability of Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
(Total)		77.22%	R	R	Reported
Initiation and Engagement of Substance Use Disorder Treatment (IET)	Y				
Initiation of SUD Treatment - Total (Total)		34.75%	R	R	Reported
Engagement of SUD Treatment - Total (Total)		4.51%	R	R	Reported
Prenatal and Postpartum Care (PPC)					
Timeliness of Prenatal Care		74.70%	R	R	Reported
Postpartum Care		82.24%	R	R	Reported
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Y				
(Total)		60.71%	R	R	Reported
Utilization and Risk Adjusted Utilization					
Well-Child Visits in the First 30 Months of Life (W30)					
(First 15 Months)		52.98%	R	R	Reported
(15 Months-30 Months)		73.77%	R	R	Reported
Child and Adolescent Well-Care Visits (WCV)					
(Total)		62.17%	R	R	Reported
Ambulatory Care (AMB)			R	R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPU)			R	R	Reported
Antibiotic Utilization for Respiratory Conditions (AXR)	Y				
(Total)		21.99%	R	R	Reported
Plan All-Cause Readmissions (PCR)			R	R	Reported
Health Plan Descriptive Information					

Enrollment by Product Line (ENP)			R	R	Reported
Language Diversity of Membership (LDM)			R	R	Reported
Race/Ethnicity Diversity of Membership (RDM)			R	R	Reported
Measures Reported Using Electronic Clinical Data Systems					
Childhood Immunization Status (CIS-E)					
DTaP		59.55%	R	R	Reported
IPV		73.40%	R	R	Reported
MMR		81.39%	R	R	Reported
HiB		76.71%	R	R	Reported
Hepatitis B		62.58%	R	R	Reported
VZV		81.12%	R	R	Reported
Pneumococcal Conjugate		57.00%	R	R	Reported
Hepatitis A		71.74%	R	R	Reported
Rotavirus		53.82%	R	R	Reported
Influenza		42.11%	R	R	Reported
Combo 3		43.35%	R	R	Reported
Combo 7		33.15%	R	R	Reported
Combo 10		20.61%	R	R	Reported
Immunizations for Adolescents (IMA-E)					
Meningococcal		82.28%	R	R	Reported
Tdap		86.71%	R	R	Reported
HPV		30.94%	R	R	Reported
Combination 1		81.13%	R	R	Reported
Combination 2		28.57%	R	R	Reported
Breast Cancer Screening (BCS-E)					
Breast Cancer Screening		54.08%	R	R	Reported
Cervical Cancer Screening (CCS-E)					
Cervical Cancer Screening		50.28%	R	R	Reported
Colorectal Cancer Screening (COL-E)					
(Total)		39.24%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)	Y				
Initiation Phase		45.64%	R	R	Reported
Continuation and Maintenance Phase		51.52%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	Y				
Blood Glucose Testing (Total)		64.23%	R	R	Reported
Cholesterol Testing (Total)		56.93%	R	R	Reported
Blood Glucose and Cholesterol Testing (Total)		51.82%	R	R	Reported
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)					
Depression Screening (Total)		0.04%	R	R	Reported
Follow-Up on Positive Screen (Total)		100.00%	NA	R	Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)					
Utilization of PHQ-9-Total (Total)		0.54%	R	R	Reported
Depression Remission or Response for Adolescents and Adults (DRR-E)					

Follow-Up PHQ-9 (Total)			NA	R	Reported
Depression Remission (Total)			NA	R	Reported
Depression Response (Total)			NA	R	Reported
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)					
Unhealthy Alcohol Use Screening (Total)		0.22%	R	R	Reported
Alcohol Counseling or Other Follow-Up Care (Total)		0.00%	NA	R	Reported
Adult Immunization Status (AIS-E)					
Influenza (19-65)		16.66%	R	R	Reported
Influenza (66+)		28.69%	R	R	Reported
Influenza (Total)		20.31%	R	R	Reported
Td/Tdap (19-65)		20.89%	R	R	Reported
Td/Tdap (66+)		11.43%	R	R	Reported
Td/Tdap (Total)		18.02%	R	R	Reported
Zoster (50-65)		8.77%	R	R	Reported
Zoster (66+)		8.78%	R	R	Reported
Zoster (Total)		8.78%	R	R	Reported
Pneumococcal (66+)		30.32%	R	R	Reported
Prenatal Immunization Status (PRS-E)					
Influenza		16.46%	R	R	Reported
Tdap		31.36%	R	R	Reported
Combination		10.77%	R	R	Reported
Prenatal Depression Screening and Follow-Up (PND-E)					
Depression Screening		0.00%	R	R	Reported
Follow-Up on Positive Screen			NA	R	Reported
Postpartum Depression Screening and Follow-Up (PDS-E)					
Depression Screening		0.00%	R	R	Reported
Follow-Up on Positive Screen			NA	R	Reported
Social Need Screening and Intervention (SNS-E)					
Food Screening (Total)		0.00%	R	R	Reported
Food Intervention (Total)			NA	R	Reported
Housing Screening (Total)		0.00%	R	R	Reported
Housing Intervention (Total)			NA	R	Reported
Transportation Screening (Total)		0.00%	R	R	Reported
Transportation Intervention (Total)			NA	R	Reported

FC/WCHP 2024 ISCA Summary of Findings

Assessment Topic	FC/WCHP Assessment Finding	Review Note
Completeness and accuracy of encounter data collected and submitted to the State	Met	FC/WCHP has adequate checks and audit processes in place to monitor the submission of encounter data. FC/WCHP's timeliness and State acceptance rates for all encounter types are all above 98.00%. No issues were noted in FC/WCHP's encounter data submission and reconciliation processes.
Validation and/or calculation of performance measures	Met	FC/WCHP uses Inovalon for HEDIS, CMS Adult and Child Core Set, and NJ State-specific performance measures, ECDS, and race and ethnicity reporting. FC/WCHP loads all data elements in the input files needed for calculation of performance measures into Inovalon's QSI-XL application and Converged Analytics software. Regarding HEDIS ECDS performance measures, FC/WCHP follows the prescribed NCQA hierarchy order for the inclusion of supplemental data sources. No issues were noted in validation and calculation processes for the required performance measures.
Completeness and accuracy of tracking of member grievances	Met	FC/WCHP submits quarterly reports to DMAHS for Table 3B, a report of all non-Utilization Management (UM) member grievance requests and dispositions, and for Table 3C, a report of all non- Utilization Management (UM) provider grievance and appeal requests and dispositions. FC/WCHP submits quarterly reports to DMAHS for Table H2A, a report of UM and appeals for FIDE SNP. FC/WCHP utilizes a customer service application, CAREConnects. FC/WCHP utilizes a specification document with business rules for member grievances. FC/WCHP indicated they utilize WCTOOLBOX for Medicaid and FIDE SNP member grievances, ICarePath for MLTSS member grievances, and COMPASS for pharmacy appeals. No issues were noted in FC/WCHP's systems used for handling grievances and appeals and reporting Tables 3B, 3C, and H2A to the State.
NJ Appointment Assistance Form	Met	FC/WCHP demonstrated the NJ Appointment Assistance Form on their member portal and confirmed that the member portal had an option for the member to select whether a grievance should be filed. No issues were noted.

Assessment Topic	FC/WCHP Assessment Finding	Review Note
Utility of the information system to conduct MCO quality assessment and improvement initiatives	Met	FC/WCHP's information systems support various data reporting requests, both internally and externally.
Ability of the information system to conduct MCO quality assessment and improvement initiatives	Met	FC/WCHP's information systems can conduct quality assessments and conduct improvement initiatives.
Ability of the information system to oversee and manage the delivery of health care to the MCO's enrollees	Met	FC/WCHP receives and processes the daily 834 eligibility file. The 834 daily eligibility files are loaded into FC/WCHP's CPS Xcelys system. FC/WCHP loads and stores both NJ OIDs and NJ CIDs into CPS. No issues were noted in FC/WCHP's systems or enrollment processes.
Validation and/or calculation of network adequacy reports	Met	FC/WCHP utilizes Quest Analytics software for assessing, monitoring, and reporting network adequacy across geographic areas based on NJ's distance and time standards. FC/WCHP submits monthly reports to NJ as per DMAHS's regulatory requirements. FC/WCHP's network adequacy reports show some gaps and there are multiple waivers submitted for Medicaid line of business. FC/WCHP indicated that they have waivers submitted and for adult living services in counties where recruiting efforts have been exhausted. FC/WCHP submitted multiple waiver requests to DMAHS for pediatric sub-specialties for network gaps with providers availability, time, and distance.
Identification and reporting of NCQA's and CMS' race and ethnicity categories	Met	FC/WCHP uses race and ethnicity/language codes received on the State 834 file(s) for direct race and ethnicity/language values utilized for HEDIS, CMS, and NJ-specific performance measure reporting. FC/WCHP's vendor, Inovalon, crosswalks race and ethnicity values for HEDIS rate reporting. FC/WCHP can capture the race and ethnicity values based on the 2024 OMB Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity, which includes the new Middle Eastern and Northern African race category. No issues were identified.

Assessment Level Definitions

Assessment Levels	Definition
Met	MCO met or exceeded standards.
Partially Met	MCO met some of the standards and demonstrates opportunities for improvement.
Not Met	MCO did not meet the standards and a corrective action plan is required.
Not Applicable	Standard does not apply.

HNJH Core Medicaid/MLTSS Annual Assessment of MCO Operations

HNJH 2024 Annual Assessment of MCO Operations

Review Category	Total Elements[1]	Deemed Met from the Prior Year	Subject to Review[2]	Subject to Review and Met[3]	Subject to review and Not Met	Subject to Review and N/A	Total Met	% Met[4]
Care Management and Continuity of Care – Core Medicaid*	30	0	30	17	13	0	17	57%
Care Management and Continuity of Care - MLTSS*	10	0	10	10	0	0	10	100%
Access**	12	2	10	7	3	0	9	75%
Emergency and Post-Stabilization Services[5]	6	0	6	6	0	0	6	100%
Quality Assessment and Performance Improvement	10	0	10	10	0	0	10	100%
Quality Management	21	9	12	12	0	0	21	100%
Efforts to Reduce Healthcare Disparities	5	0	5	5	0	0	5	100%
Committee Structure	9	6	3	3	0	0	9	100%
Programs for the Elderly and Disabled	44	33	11	11	0	0	44	100%
Provider Training and Performance	11	7	4	4	0	0	11	100%
Satisfaction	5	2	3	3	0	0	5	100%
Enrollee Rights and Responsibilities	8	4	4	4	0	0	8	100%
Member Disenrollment	29	26	3	3	0	0	29	100%
Credentialing and Re-credentialing	10	8	2	2	0	0	10	100%
Utilization Management	30	16	14	14	0	0	30	100%
Administration and Operations	14	10	4	4	0	0	14	100%
Management Information Systems	18	15	3	3	0	0	18	100%
TOTAL	**232**	**138**	**94**	**91**	**3**	**0**	**229**	**99%**

1 A total of 115 elements were reviewed in the previous review period; of these 115, 108 were *Met*, 7were *Not Met*; 0 were *N/A*. Remaining existing elements that were Met Prior Year were deemed Met in the previous review period.

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

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

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

[5] Emergency and Post-Stabilization Services was a new standard reviewed in 2024.

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

** Access had 14 elements in 2023. In 2024, two elements (A1 and A2) were moved to a new category Emergency and Post-Stabilization Services. Although not an annual element, A3 was reviewed in the partial audits this year due to enhancements in the Access category.

HNJH Performance Improvement Projects

HNJH PIP 1: Increasing PCP Access and Availability for members with low acuity, non-emergent ED visits

MCO Name: Horizon New Jersey Health (HNJH)

PIP Topic 1: Increasing PCP Access and Availability for members with low acuity, non-emergent ED visits

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

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

6a. Table shows Performance Indicator rates, numerators, and denominators, with corresponding goals	N/A	M	M	M	M
Element 6 Overall Review Determination	**N/A**	**M**	**M**	**M**	**M**
Element 6 Overall Score	**N/A**	**100**	**100**	**100**	**100**
Element 6 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**5.0**
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M	M	M	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M	PM	M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M	M	M	M
7d. Lessons learned & follow-up activities planned as a result	N/A	M	M	M	M
Element 7 Overall Review Determination	**N/A**	**M**	**PM**	**M**	**M**
Element 7 Overall Score	**N/A**	**100**	**50**	**100**	**100**
Element 7 Weighted Score	**N/A**	**20.0**	**10.0**	**20.0**	**20.0**
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There were ongoing, additional, or modified interventions documented	N/A	N/A	N/A	M	M
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	M	M
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**M**	**M**
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**100**	**100**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**20.0**	**20.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated, and addressed (Y=Yes N=No)	**N/A**	**N**	**N**	**N**	**Y**

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**65.0**	**70.0**	**92.5**	**100.0**
Overall Rating	**N/A**	**81.3%**	**87.5%**	**92.5%**	**100.0%**

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

IPRO Reviewers: Deb Chambers(dchambers@ipro.org) Rob Accetta (raccetta@ipro.org)
Date (report submission) reviewed: October 8, 2024
Reporting Period: Final Report

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

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

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

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

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

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

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

Element 8 Overall Review Determination was that the MCO is compliant.

Element 9 Overall Review Determination was that the MCO identified, evaluated and addressed Healthcare Disparities.

Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 100 points, the MCO scored 100 points, which results in a rating of 100% (which is above 85% [≥ 85% being the threshold for meeting compliance]). The MCO addressed prior calculation and rounding issues and no further calculation issues were identified. The MCO presented an in-depth analysis of interventions by provider practice and their potential impact on results. The MCO also identified, evaluated and addressed health disparities. The MCO might consider expanding the distribution of gaps reports to a broader group of practices given the positive response from the participating provider groups.

HNJH PIP 2: Improving Childhood Immunization and Well-Child Visit Rates While Strengthening the Relationship to a Pediatric Medical Home in the HNJH Population

MCO Name: Horizon NJ Health (HNJH)

PIP Topic 2: Improving Childhood Immunization and Well-Child Visit Rates While Strengthening the Relationship to a Pediatric Medical Home in the HNJH Population

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

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

Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M	PM	M	
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M	M	M	
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M	M	M	
7d. Lessons learned & follow-up activities planned as a result	N/A	M	M	M	
Element 7 Overall Review Determination	**N/A**	**M**	**PM**	**M**	
Element 7 Overall Score	**N/A**	**100**	**50**	**100**	**0**
Element 7 Weighted Score	**N/A**	**20.0**	**10.0**	**20.0**	**0.0**
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	PM	
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	M	
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**PM**	
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**50**	**0**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**10.0**	**0.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)	**N/A**	**Y**	**Y**	**Y**	

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**80.0**	**70.0**	**90.0**	**0.0**
Overall Rating	**N/A**	**100%**	**87.5%**	**90.0%**	**0.0%**

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

IPRO Reviewers: Carolyn Gallagher (cgallagher@ipro.org); Deb Chambers (dchambers@ipro.org)
Date (report submission) reviewed: November 4, 2024
Reporting Period: Year 3

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

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

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

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

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

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

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

Element 8 Overall Review Determination was the MCO is partially compliant with elements 8a and 8b. It is recommended that the MCO continue to revisit barrier analysis and use those findings to inform new interventions to drive performance improvement for the entire eligible population for the CIS Combination performance indicator.

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

Overall, the MCO was compliant with this PIP; out of a maximum possible weighted score of 100 points the MCO scored 90.0 points, which results in a rating of 90.0%. The above comments are intended to provide guidance for performance improvement, including improved measurement of performance improvement, deeper barrier analysis, and modification of interventions to enhance robustness, relevance, and drive performance improvement.

HNJH PIP 3: Complaints and Grievances - Core Medicaid Membership

MCO Name: Horizon New Jersey Health (HNJH)
PIP Topic 3: Complaints and Grievances - Core Medicaid Membership

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

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

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

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**72.5**	**0.0**	**0.0**	**0.0**
Overall Rating	**N/A**	**90.6%**	**0%**	**0%**	**0%**

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

IPRO Reviewers: Deb Chambers (dchambers@ipro.org) , Rob Accetta (raccetta@ipro.org)
Date (report submission) reviewed: October 10, 2024
Reporting Period: Year 1

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

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

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

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

Element 5 Overall Review Determination was that the MCO is partially compliant. For element 5b, the current interventions directed at providers only are passive in nature. For element 5d, the MCO should consider modifying or adding interventions related to how many Medicaid Network representatives meet with and/or discuss complaint information with providers/provider groups.

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

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

Element 8 Overall Review Determination was N/A. Sustainability is not evaluated at the Year 1 phase.

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

Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 80.0 points, the MCO scored 72.5 points, which results in a rating of 90.6% (which is above 85% [≥ 85% being the threshold for meeting compliance]). The MCO has made significant changes over this first year, taking time to review every aspect of the PIP, using the QI process to make appropriate changes in each area when needed. Please review comment above for consideration in future reports.

HNJH PIP 4: IMA Combo-2 PIP - Core Medicaid Membership

MCO Name: Horizon NJ Health (HNJH)
PIP Topic 4: IMA Combo-2 PIP - Core Medicaid Membership

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

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

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

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

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

IPRO Reviewers: Sopan Mohnot, MD, MPH (smohnot@ipro.org); Teresa Lubowski (TLubowski@ipro.org**)**
Date reviewed: October 21, 2024
Reporting Period: Proposal Findings

IPRO Comments:

Elements 1 through 8 were not scored for the Overall Review Determination, as a numerical score was not ascertained for this PIP proposal.

Element 1 Overall Review Determination was N/A. Although not scored, concerns were identified in the background section. Table 3.2 Tdap rates are not calculated correctly. Please review rate calculations.

Element 2 Overall Review Determination was N/A. Although not scored, recommend MCO consider setting a higher goal for Indicator 1.

Element 3 Overall Review Determination was N/A.

Element 4 Overall Review Determination was N/A. Although not scored, concerns were identified in the barriers listed in Table 1a. The barriers are primarily identified through interdepartmental discussions, and the corresponding interventions are general and passive. Recommend the MCO continue the barrier analysis throughout the PIP and attempt to gather direct member/provider feedback about barriers that can help inform new interventions. Consider adding content related to the rural setting given the selection of the 3 counties to potentially expand interventions.

Element 5 Overall Review Determination was N/A. Although not scored, concerns were identified in the interventions listed in Table 1a. Several of the interventions are passive and seem limited in how engaging the interventions will be for providers and members. Recommend the MCO consider more ways to actively engage members and providers through the interventions. The ITMs measure initial aspects of the intervention implementation; however, the analysis of the ITM data may be limited, and may not be sufficient to make appropriate changes to interventions based on the ITM data. For example, ITMs 2a-2d are tracking mailings. IPRO suggests the MCO use/provide methods to measure the short term impact of these mailings (e.g., using claims data to measure completed appointments/ vaccination after mailings are sent/utilization of transportation services). Similarly, for ITM #4a, #4b, #4c, consider measuring the IMA-Combo 2 vaccines completed following the distribution of the care gap report, quarterly FAX blast and outreach on initiating office "standing orders" to providers. Please clarify if the outreach in intervention 4c is direct outreach with providers. This would is be an opportunity to ask providers about barriers they are facing.

Element 6 Overall Review Determination is N/A.

Element 7 Overall Review Determination is N/A.

Element 8 Overall Review Determination is N/A.

Element 9 Overall Review Determination is N/A.

For this PIP proposal, the submission was not scored. Therefore, a rating of the PIP for determination of overall compliance was N/A. Although not scored, concerns were identified with several aspects of the PIP. The MCO should address the above concerns with clarifications or adjustments for a sufficiently developed PIP proposal that is ultimately demonstrative of the intended impact on performance outcomes. The MCO should ensure that all changes are noted and documented in the April and August 2025 submissions. In subsequent submissions in the reporting schedule, the MCO will be evaluated accordingly on the reporting of results and discussion/validity of improvement, and later, on reporting of sustainability.

HNJH PIP 5: Improving Coordination of Care and Follow-up After Mental Health Hospitalization in the MLTSS Home and Community (HCBS) Populations

MCO Name: Horizon NJ Health (HNJH)

PIP Topic 5: Improving Coordination of Care and Follow-up After Mental Health Hospitalization in the MLTSS Home and Community (HCBS) Populations

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

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

Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M	M	M	
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M	M	M	
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M	M	M	
7d. Lessons learned & follow-up activities planned as a result	N/A	M	M	M	
Element 7 Overall Review Determination	**N/A**	**M**	**M**	**M**	
Element 7 Overall Score	**N/A**	**100**	**100**	**100**	**0**
Element 7 Weighted Score	**N/A**	**20.0**	**20**	**20.0**	**0.0**
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	M	
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	N/A	
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**M**	
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**100**	**0**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**20**	**0.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes, N=No)	**N/A**	**Y**	**Y**	**Y**	

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**72.5**	**80.0**	**100.0**	**0.0**
Overall Rating	**N/A**	**90.6%**	**100.0%**	**100.0%**	**0.0%**

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

IPRO Reviewers: Carolyn Gallagher (cgallagher@ipro.org), Rob Accetta (raccetta@ipro.org)
Date (report submission) reviewed: October 24, 2024
Reporting Period: Year 3

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

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

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

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

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

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

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

Element 8 Overall Review Determination was that the MCO is compliant. Sustainability is not evaluated at the Year 3 phase.

Element 9 Overall Review Determination was that healthcare disparities relative to performance indicator results have been assessed based on race/ethnicity.

Overall, the MCO was compliant with this PIP; out of a maximum possible weighted score of 100.0 points the MCO scored 100.0 points, which results in a rating of 100% (Which is above 86% [≥ 86% being the threshold for meeting compliance]). The MCO has implemented a number of care management-related interventions, which have appeared to positively impact follow-up visit within 30-day rates (PI3), but not IP readmission rates; however, the plan attributed higher readmission rates to the COVID emergency, and there was no updated full year data available for the 2024, so interpretation is limited. The disparity analysis evaluated rate differences for each race/ethnic group from 2019 to 2022, but did not evaluate disparities by race/ethnicity. The 2022 PI rates were worse for Black enrollees compared to White enrollees for all indicators. Therefore, the plan could consider eliciting direct member feedback from Black enrollees about what their barriers are to well visits and follow-up with PCPs, and develop and implement interventions tailored to address those specific barriers. Feedback from care managers to identify barriers to outreaching Black enrollees is merited, with corresponding interventions to prevent readmissions, as well.

HNJH PIP 6: Improving the Rate of Timely 10 Day Post-Discharge Visit with Assessment for MLTSS Members

MCO Name: Horizon NJ Health (HNJH)

PIP Topic 6: Improving the Rate of Timely 10 Day Post-Discharge Visit with Assessment for MLTSS Members

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

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

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

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

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

IPRO Reviewers: Teresa Lubowski (tlubowski@ipro.org), Deb Chambers (dchambers@ipro.org)
Date (report submission) reviewed: 11-08-24
Reporting Period: Proposal Findings

IPRO Comments:

Elements 1 through 8 were not scored for the Overall Review Determination, as a numerical score is not assigned for the PIP proposal.

Element 1 Overall Review Determination was N/A.

Element 2 Overall Review Determination was N/A. Although not scored, the following concerns were identified. In Section 3, page 9, please correct HBCS to HCBS in the first sentence. Also, in Table 4.2, the members identifying as "other" should be 96.82% (not 96.02%), please correct in subsequent reports.

Element 3 Overall Review Determination was N/A.

Element 4 Overall Review Determination was N/A

Element 5 Overall Review Determination was N/A. Although not scored, the following concerns were identified. Barriers do not capture any provider (i.e. PCP) input. For Intervention #1a, explain how the education will be provided (i.e. mailed or provided as part of telephone outreach or visit). SDOH barriers were noted (transportation, cultural) but not fully addressed within the interventions. In Table 1A, Barrier 4 is missing a description.

Element 6 Overall Review Determination was N/A. The Results Table is not evaluated at the Proposal phase.

Element 7 Overall Review Determination was N/A. Discussion of Validity and Reported Improvement is not evaluated at the Proposal phase.

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

Element 9 Overall Review Determination was N/A. Although not scored, the MCO has not planned to identify, evaluate, and address healthcare disparities.

For this PIP Proposal, the submission was not scored. Therefore, the rating for the PIP for overall compliance was N/A. Although not scored, the MCO should address any concerns above with clarifications or revisions for a sufficiently developed PIP proposal that demonstrates the intended impact on the performance indicators.

HNJH HEDIS Audit Review Table MY 2023

Audit Review Table					
Horizon Healthcare of New Jersey, Inc. d/b/a Horizon NJ Health (Org ID: 6610, Sub ID: 7459, Medicaid, Spec Area: None, Spec Proj: None, Contract Number: None)					
Measurement Year - 2023; Date & Timestamp - 6/12/2024 12:35:08 PM					
This submission is on the stage: Submission Finalized					
Measure/Data Element	**Benefit Offered**	**Rate**	**Status**	**Audit Designation**	**Comment**
Effectiveness of Care					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
BMI percentile (Total)		87.21%	R	R	Reported
Counseling for Nutrition (Total)		86.23%	R	R	Reported
Counseling for Physical Activity (Total)		83.28%	R	R	Reported
Childhood Immunization Status (CIS)					
DTaP		75.43%	R	R	Reported
IPV		89.29%	R	R	Reported
MMR		86.13%	R	R	Reported
HiB		88.56%	R	R	Reported
Hepatitis B		88.32%	R	R	Reported
VZV		85.40%	R	R	Reported
Pneumococcal Conjugate		70.32%	R	R	Reported
Hepatitis A		77.13%	R	R	Reported
Rotavirus		71.53%	R	R	Reported
Influenza		48.42%	R	R	Reported
Combo 3		63.99%	R	R	Reported
Combo 7		54.01%	R	R	Reported
Combo 10		34.55%	R	R	Reported
Immunizations for Adolescents (IMA)					
Meningococcal		89.05%	R	R	Reported
Tdap		93.19%	R	R	Reported
HPV		36.74%	R	R	Reported
Combination 1		88.56%	R	R	Reported
Combination 2		35.04%	R	R	Reported
Lead Screening in Children (LSC)					
Lead Screening in Children		74.70%	R	R	Reported
Cervical Cancer Screening (CCS)					
Cervical Cancer Screening		59.05%	R	R	Reported
Colorectal Cancer Screening (COL)					
(Total)		42.62%	R	R	Reported
Chlamydia Screening in Women (CHL)					
(Total)		61.37%	R	R	Reported
Oral Evaluation, Dental Services (OED)	Y				
(0-2)		23.39%	R	R	Reported
(3-5)		56.35%	R	R	Reported
(6-14)		63.20%	R	R	Reported
(15-20)		46.73%	R	R	Reported
(Total)		52.96%	R	R	Reported

Topical Fluoride for Children (TFC)					
(1-2)		12.24%	R	R	Reported
(3-4)		20.01%	R	R	Reported
(Total)		16.22%	R	R	Reported
Appropriate Testing for Pharyngitis (CWP)	Y				
(Total)		61.38%	R	R	Reported
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)					
Use of Spirometry Testing in the Assessment and Diagnosis of COPD		32.94%	R	R	Reported
Pharmacotherapy Management of COPD Exacerbation (PCE)	Y				
Systemic Corticosteroid		72.39%	R	R	Reported
Bronchodilator		90.19%	R	R	Reported
Asthma Medication Ratio (AMR)	Y				
(Total)		72.89%	R	R	Reported
Controlling High Blood Pressure (CBP)					
Controlling High Blood Pressure		72.61%	R	R	Reported
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	Y				
Persistence of Beta-Blocker Treatment After a Heart Attack		67.84%	R	R	Reported
Statin Therapy for Patients With Cardiovascular Disease (SPC)	Y				
Received Statin Therapy (Total)		83.68%	R	R	Reported
Statin Adherence 80% (Total)		76.92%	R	R	Reported
Cardiac Rehabilitation (CRE)					
Initiation (Total)		1.16%	R	R	Reported
Engagement1 (Total)		2.99%	R	R	Reported
Engagement2 (Total)		3.60%	R	R	Reported
Achievement (Total)		1.10%	R	R	Reported
Hemoglobin A1c Control for Patients With Diabetes (HBD)					
HbA1c Control (<8%)		60.93%	R	R	Reported
Poor HbA1c Control		32.19%	R	R	Reported
Blood Pressure Control for Patients With Diabetes (BPD)					
Blood Pressure Control for Patients With Diabetes		71.99%	R	R	Reported
Eye Exam for Patients With Diabetes (EED)					
Eye Exam for Patients With Diabetes		59.21%	R	R	Reported
Kidney Health Evaluation for Patients With Diabetes (KED)					
(Total)		38.40%	R	R	Reported
Statin Therapy for Patients With Diabetes (SPD)	Y				
Received Statin Therapy		69.91%	R	R	Reported
Statin Adherence 80%		68.03%	R	R	Reported
Diagnosed Mental Health Disorders (DMH)					
(Total)		25.12%	R	R	Reported
Antidepressant Medication Management (AMM)	Y				

Effective Acute Phase Treatment		58.85%	R	R	Reported
Effective Continuation Phase Treatment		44.37%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Y				
Initiation Phase		35.39%	R	R	Reported
Continuation and Maintenance Phase		37.40%	R	R	Reported
Follow-Up After Hospitalization for Mental Illness (FUH)	Y				
30 days (Total)		51.95%	R	R	Reported
7 days (Total)		31.25%	R	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Y				
30 days (Total)		66.79%	R	R	Reported
7 days (Total)		56.93%	R	R	Reported
Diagnosed Substance Use Disorders (DSU)					
Alcohol (Total)		2.60%	R	R	Reported
Opioid (Total)		3.40%	R	R	Reported
Other (Total)		3.37%	R	R	Reported
Any (Total)		6.95%	R	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	Y				
30 days (Total)		52.97%	R	R	Reported
7 Days (Total)		32.77%	R	R	Reported
Follow-Up After Emergency Department Visit for Substance Use (FUA)	Y				
30 days (Total)		39.63%	R	R	Reported
7 days (Total)		28.43%	R	R	Reported
Pharmacotherapy for Opioid Use Disorder (POD)	Y				
(Total)		27.68%	R	R	Reported
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Y				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		87.05%	R	R	Reported
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)					
Diabetes Monitoring for People With Diabetes and Schizophrenia		73.05%	R	R	Reported
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		75.50%	R	R	Reported
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	Y				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		68.72%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	Y				
Blood Glucose Testing (Total)		57.08%	R	R	Reported
Cholesterol Testing (Total)		38.33%	R	R	Reported
Blood Glucose and Cholesterol Testing (Total)		37.39%	R	R	Reported

Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)					
Non-Recommended Cervical Cancer Screening in Adolescent Females		0.17%	R	R	Reported
Appropriate Treatment for Upper Respiratory Infection (URI)	Y				
(Total)		84.63%	R	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	Y				
(Total)		52.92%	R	R	Reported
Use of Imaging Studies for Low Back Pain (LBP)					
(Total)		72.64%	R	R	Reported
Use of Opioids at High Dosage (HDO)	Y				
Use of Opioids at High Dosage		10.74%	R	R	Reported
Use of Opioids From Multiple Providers (UOP)	Y				
Multiple Prescribers		16.97%	R	R	Reported
Multiple Pharmacies		2.54%	R	R	Reported
Multiple Prescribers and Multiple Pharmacies		1.02%	R	R	Reported
Risk of Continued Opioid Use (COU)	Y				
>=15 Days (Total)		5.67%	R	R	Reported
>=31 Days (Total)		3.54%	R	R	Reported
Access/Availability of Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
(Total)		78.83%	R	R	Reported
Initiation and Engagement of Substance Use Disorder Treatment (IET)	Y				
Initiation of SUD Treatment - Total (Total)		36.86%	R	R	Reported
Engagement of SUD Treatment - Total (Total)		7.85%	R	R	Reported
Prenatal and Postpartum Care (PPC)					
Timeliness of Prenatal Care		84.03%	R	R	Reported
Postpartum Care		84.72%	R	R	Reported
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Y				
(Total)		65.87%	R	R	Reported
Utilization and Risk Adjusted Utilization					
Well-Child Visits in the First 30 Months of Life (W30)					
(First 15 Months)		57.04%	R	R	Reported
(15 Months-30 Months)		73.09%	R	R	Reported
Child and Adolescent Well-Care Visits (WCV)					
(Total)		61.95%	R	R	Reported
Ambulatory Care (AMB)			R	R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPU)			R	R	Reported
Antibiotic Utilization for Respiratory Conditions (AXR)	Y				
(Total)		24.96%	R	R	Reported
Plan All-Cause Readmissions (PCR)			R	R	Reported
Health Plan Descriptive Information					

Enrollment by Product Line (ENP)			R	R	Reported
Language Diversity of Membership (LDM)			R	R	Reported
Race/Ethnicity Diversity of Membership (RDM)			R	R	Reported
Measures Reported Using Electronic Clinical Data Systems					
Childhood Immunization Status (CIS-E)					
DTaP		64.22%	R	R	Reported
IPV		78.93%	R	R	Reported
MMR		83.01%	R	R	Reported
HiB		81.11%	R	R	Reported
Hepatitis B		72.05%	R	R	Reported
VZV		82.35%	R	R	Reported
Pneumococcal Conjugate		61.46%	R	R	Reported
Hepatitis A		74.10%	R	R	Reported
Rotavirus		62.07%	R	R	Reported
Influenza		43.86%	R	R	Reported
Combo 3		49.52%	R	R	Reported
Combo 7		40.54%	R	R	Reported
Combo 10		25.06%	R	R	Reported
Immunizations for Adolescents (IMA-E)					
Meningococcal		88.43%	R	R	Reported
Tdap		91.17%	R	R	Reported
HPV		33.73%	R	R	Reported
Combination 1		87.70%	R	R	Reported
Combination 2		32.43%	R	R	Reported
Breast Cancer Screening (BCS-E)					
Breast Cancer Screening		58.61%	R	R	Reported
Cervical Cancer Screening (CCS-E)					
Cervical Cancer Screening		55.57%	R	R	Reported
Colorectal Cancer Screening (COL-E)					
(Total)		42.62%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)	Y				
Initiation Phase		35.41%	R	R	Reported
Continuation and Maintenance Phase		37.40%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	Y				
Blood Glucose Testing (Total)		57.08%	R	R	Reported
Cholesterol Testing (Total)		38.33%	R	R	Reported
Blood Glucose and Cholesterol Testing (Total)		37.39%	R	R	Reported
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)					
Depression Screening (Total)		0.17%	R	R	Reported
Follow-Up on Positive Screen (Total)		43.71%	R	R	Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)					
Utilization of PHQ-9-Total (Total)		0.25%	R	R	Reported
Depression Remission or Response for Adolescents and Adults (DRR-E)					

Follow-Up PHQ-9 (Total)		0.00%	NA	R	Reported
Depression Remission (Total)		0.00%	NA	R	Reported
Depression Response (Total)		0.00%	NA	R	Reported
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)					
Unhealthy Alcohol Use Screening (Total)		0.00%	R	R	Reported
Alcohol Counseling or Other Follow-Up Care (Total)			NA	R	Reported
Adult Immunization Status (AIS-E)					
Influenza (19-65)		15.22%	R	R	Reported
Influenza (66+)		44.77%	R	R	Reported
Influenza (Total)		16.34%	R	R	Reported
Td/Tdap (19-65)		28.28%	R	R	Reported
Td/Tdap (66+)		17.84%	R	R	Reported
Td/Tdap (Total)		27.89%	R	R	Reported
Zoster (50-65)		10.00%	R	R	Reported
Zoster (66+)		16.97%	R	R	Reported
Zoster (Total)		10.96%	R	R	Reported
Pneumococcal (66+)		43.38%	R	R	Reported
Prenatal Immunization Status (PRS-E)					
Influenza		18.02%	R	R	Reported
Tdap		40.13%	R	R	Reported
Combination		12.80%	R	R	Reported
Prenatal Depression Screening and Follow-Up (PND-E)					
Depression Screening		0.02%	R	R	Reported
Follow-Up on Positive Screen			NA	R	Reported
Postpartum Depression Screening and Follow-Up (PDS-E)					
Depression Screening		3.49%	R	R	Reported
Follow-Up on Positive Screen		41.67%	NA	R	Reported
Social Need Screening and Intervention (SNS-E)					
Food Screening (Total)		0.00%	R	R	Reported
Food Intervention (Total)			NA	R	Reported
Housing Screening (Total)		0.00%	R	R	Reported
Housing Intervention (Total)			NA	R	Reported
Transportation Screening (Total)		0.00%	R	R	Reported
Transportation Intervention (Total)			NA	R	Reported

HNJH 2024 ISCA Summary of Findings

Assessment Topic	HNJH Assessment Finding	Review Note
Completeness and accuracy of encounter data collected and submitted to the State	Met	HNJH has adequate checks and audit processes in place to monitor the submission of encounter data. HNJH's timeliness and State acceptance rates for all encounter types are all above 98.00%. No issues were noted in HNJH's encounter data submission and reconciliation processes.
Validation and/or calculation of performance measures	Met	HNJH uses Inovalon for HEDIS, CMS Adult and Child Core Set, and NJ State-specific performance measures, ECDS, and race and ethnicity reporting. HNJH loads all data elements in the input files needed for calculation of performance measures into Inovalon's robust software, Converged Analytics. Regarding HEDIS ECDS performance measures, HNJH follows the prescribed NCQA hierarchy order for the inclusion of supplemental data sources. No issues were noted in validation and calculation processes for the required performance measures.
Completeness and accuracy of tracking of member grievances	Met	HNJH submits quarterly reports to DMAHS for Table 3B, a report of all non-utilization management (UM) member grievance requests and dispositions, and for Table 3C, a report of all non-utilization management (UM) provider grievance and appeal requests and dispositions. HNJH submits quarterly reports to DMAHS for Table H2A, a report of UM and appeals for FIDE SNP. HNJH also conducts pre-closure audits to review grievances. HNJH indicated on the virtual meeting that they currently face challenges with identifying BH grievances. No issues were noted in HNJH's systems used for handling grievances and reporting Tables 3B, 3C, and H2A to the State.
NJ Appointment Assistance Form	Met	HNJH demonstrated the NJ Appointment Assistance Form on their member portal and confirmed that the member portal had an option for the member to select whether a grievance should be filed. No issues were noted.
Utility of the information system to conduct MCO quality assessment and improvement initiatives	Met	HNJH's information systems support various data reporting requests, both internally and externally.
Ability of the information system to conduct MCO quality	Met	HNJH's information systems can conduct quality assessments and conduct improvement initiatives.

Assessment Topic	HNJH Assessment Finding	Review Note
assessment and improvement initiatives		
Ability of the information system to oversee and manage the delivery of health care to the MCO's enrollees	Met	HNJH receives and processes the daily 834 eligibility file. The 834 daily eligibility files are loaded into HNJH's TriZetto Enrollment Application Manager (EAM) and Facets application. HNJH loads and stores both NJ OIDs and NJ CIDs into Facets. No issues were noted in HNJH's systems or enrollment processes.
Validation and/or calculation of network adequacy reports	Met	HNJH utilizes Quest Analytics software for assessing, monitoring, and reporting network adequacy across geographic areas based on NJ's distance and time standards. HNJH submits monthly reports to NJ as per DMAHS's regulatory requirements. At the time of this report, HNJH has active CAPs for pediatric specialties including dental, and they have submitted waiver requests to the State where they are unable to identify providers. HNJH submitted multiple waiver requests to DMAHS for pediatric sub-specialties for network gaps with providers availability, time, and distance.
Identification and reporting of NCQA's and CMS' race and ethnicity categories	Met	HNJH uses race and ethnicity/language codes received on the State 834 file(s) for direct race and ethnicity/language values utilized for HEDIS, CMS, and NJ-specific performance measure reporting. HNJH's vendor, Inovalon, crosswalks race and ethnicity values for HEDIS rate reporting. HNJH can capture the race and ethnicity values, based on the 2024 OMB Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity, which includes the new Middle Eastern and Northern African race category. No issues were identified.

Assessment Level Definitions

Assessment Levels	Definition
Met	MCO met or exceeded standards.
Partially Met	MCO met some of the standards and demonstrates opportunities for improvement.
Not Met	MCO did not meet the standards and a corrective action plan is required.
Not Applicable	Standard does not apply.

UHCCP Core Medicaid/MLTSS Annual Assessment of MCO Operations

UHCCP 2024 Annual Assessment of MCO Operations

Review Category	Total Elements[1]	Deemed Met from the Prior Year	Subject to Review[2]	Subject to Review and Met[3]	Subject to review and Not Met	Subject to Review and N/A	Total Met	% Met[4]
Care Management and Continuity of Care – Core Medicaid*	30	0	30	27	3	0	27	90%
Care Management and Continuity of Care - MLTSS*	10	0	10	10	0	0	10	100%
Access**	12	2	10	6	4	0	8	67%
Emergency and Post-Stabilization Services[5]	6	0	6	6	0	0	6	100%
Quality Assessment and Performance Improvement	10	0	10	10	0	0	10	100%
Quality Management	21	9	12	12	0	0	21	100%
Efforts to Reduce Healthcare Disparities	5	0	5	5	0	0	5	100%
Committee Structure	9	6	3	3	0	0	9	100%
Programs for the Elderly and Disabled	44	33	11	11	0	0	44	100%
Provider Training and Performance	11	7	4	4	0	0	11	100%
Satisfaction	5	2	3	3	0	0	5	100%
Enrollee Rights and Responsibilities	8	4	4	4	0	0	8	100%
Member Disenrollment	29	29	0	0	0	0	29	100%
Credentialing and Re-credentialing	10	8	2	2	0	0	10	100%
Utilization Management	30	16	14	12	0	2	28	100%
Administration and Operations	14	10	4	4	0	0	14	100%
Management Information Systems	18	15	3	3	0	0	18	100%
TOTAL	**232**	**141**	**91**	**85**	**4**	**2**	**226**	**98%**

[1] A total of 116 elements were reviewed in the previous review period; of these 116, 109 were Met, 5 were Not Met; 2 were N/A. Remaining existing elements that were Met Prior Year were deemed Met in the previous review period.

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

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

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

[5] Emergency and Post-Stabilization Services was a new standard reviewed in 2024.

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

** Access had 14 elements in 2023. In 2024, two elements (A1 and A2) were moved to a new category Emergency and Post-Stabilization Services. Although not an annual element, A3 was reviewed in the partial audits this year due to enhancements in the Access category.

UHCCP Performance Improvement Projects

UHCCP PIP 1: Decreasing Emergency Room Utilization for Low Acuity Primary Care Conditions and Improving Access to Primary Care for Adult Medicaid Members

MCO Name: UnitedHealthcare Community Plan (UHCCP)

PIP Topic 1: Decreasing Emergency Room Utilization for Low Acuity Primary Care Conditions and Improving Access to Primary Care for Adult Medicaid Members

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

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

Element 6 Overall Score	**N/A**	**100**	**100**	**100**	**100**
Element 6 Weighted Score	**N/A**	**5.0**	**5.0**	**5.0**	**5.0**
Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M	M	M	M
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M	M	M	M
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M	M	PM	M
7d. Lessons learned & follow-up activities planned as a result	N/A	M	M	M	M
Element 7 Overall Review Determination	**N/A**	**M**	**M**	**PM**	**M**
Element 7 Overall Score	**N/A**	**100**	**100**	**50**	**100**
Element 7 Weighted Score	**N/A**	**20.0**	**20.0**	**10.0**	**20.0**
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There were ongoing, additional, or modified interventions documented	N/A	N/A	N/A	M	M
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	M	M
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**M**	**M**
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**100**	**100**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**20.0**	**20.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated, and addressed (**Y**=Yes **N**=No)	**N**	**N**	**N**	**N**	**N**

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**0**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**0.0**	**77.5**	**80.0**	**90.0**	**100.0**
Overall Rating	**0%**	**96.9%**	**100%**	**90.0%**	**100%**

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

IPRO Reviewers: Deb Chambers (dchambers@ipro.org), Rob Accetta (raccetta@ipro.org)
Date (report submission) reviewed: October 8, 2024
Reporting Period: Final Report

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

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

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

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

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

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

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

Element 8 Overall Review Determination was that the MCO is compliant**.**

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

Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 100 points, the MCO scored 100 points, which results in a rating of 100.0% (which is above 85% [≥ 85% being the threshold for meeting compliance]). The MCO presented an in-depth analysis of interventions by provider practice and their potential impact on results. The Final Report submission addressed the issues that had been identified during the Year 3 report. Also, the plans that the MCO has to continue the provider and member interventions across the network will help to keep awareness raised on the importance of increasing PCP utilization and decreasing avoidable ER events long term and on a broader scale.

UHCCP PIP 2: Improving Frequency of Well Visits in the First 30 Months of Life and Compliance with Childhood Immunizations

MCO Name: UnitedHealthcare Community Plan (UHCCP)

PIP Topic 2: Improving Frequency of Well Visits in the First 30 Months of Life and Compliance with Childhood Immunizations

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

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

Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M	M	M	
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M	M	M	
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M	M	M	
7d. Lessons learned & follow-up activities planned as a result	N/A	M	M	M	
Element 7 Overall Review Determination	**N/A**	**M**	**M**	**M**	
Element 7 Overall Score	**N/A**	**100**	**100**	**100**	**0**
Element 7 Weighted Score	**N/A**	**20.0**	**20.0**	**20.0**	**0.0**
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	M	
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	PM	
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**PM**	
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**50**	**0**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**10.0**	**0.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y= Yes N= No)	**N/A**	**Y**	**Y**	**Y**	

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**80.0**	**80.0**	**82.5**	**0.0**
Overall Rating	**N/A**	**100.0%**	**100.0%**	**82.5%**	**0.0%**

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

IPRO Reviewers: Carolyn Gallagher (cgallagher@ipro.org), Deb Chambers (dchambers@ipro.org)
Date (report submission) reviewed: December 6, 2024
Reporting Period: Year 3

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

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

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

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

Element 5 Overall Review Determination was that the MCO is partially compliant with Element 5a. The MCO identified barriers faced by Practice 1 providers, e.g., high staff turnover, challenges of engaging new staff, late submission of monthly schedules and, consequently, outreach was not able to be performed. However, barrier analysis findings were not used to inform modifications to interventions. For continued sustainability, the MCO might want to consider how enrollees served by Practice 1 providers, as well as enrollees served by Practice 2 providers, could be referred by the MCO to immunization appointments at other sites, such as public health departments (Kempe et al., 2013: Population-Based Versus Practice-Based Recall for Childhood Immunizations: A Randomized Controlled Comparative Effectiveness Trial) and university centers (Crowe et al., 2024: Social determinant of health-based strategies to address vaccination disparities through a university-public health partnership).

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

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

Element 8 Overall Review Determination was that the MCO is partially compliant with Element 8b. The ITMs did show progress in implementation of interventions; however, the performance indicators did not show any improvement. Of note, the slight increase for Indicator 1-Practice 3 did not represent a statistically significant difference.

Element 9 Overall Review Determination was that the MCO identified health care disparities and is prioritizing interventions based on the analysis.

Overall, the MCO was partially compliant with this PIP; out of a maximum possible weighted score of 100 points the MCO scored 82.5 points, which results in a rating of 82.5% (which is below 85% [≥ 85% being the threshold for meeting compliance]). It is recommended that the plan explore new interventions, such as MCO referrals to alternative vaccination sites in the community as an option to give enrollees' parents a choice.

UHCCP PIP 3: Reducing Member Grievances for Medicaid Members

MCO Name: UnitedHealthcare Community Plan (UHCCP)

PIP Topic 3: Reducing Member Grievances for Medicaid Members

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

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

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

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

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

IPRO Reviewers: Deb Chambers (dchambers@ipro.org) Rob Accetta (raccetta@ipro.org)
Date (report submission) Reviewed: October 15, 2024
Reporting Period: Year 1

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

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

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

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

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

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

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

Element 8 Overall Review Determination was N/A. Sustainability is not evaluated at the Year 1 phase.

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

Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 80.0 points, the MCO scored 80.0 points, which results in a rating of 100.0% (which is above 85% [≥ 85% being the threshold for meeting compliance]). The MCO has made significant changes over this first year, taking time to review every aspect of the PIP, using the QI process to make appropriate changes in each area when needed. All comments/recommendations from IPRO have been appropriately addressed.

UHCCP PIP 4: Immunizations for Adolescents (IMA)

MCO Name: UnitedHealthcare Community Plan (UHCCP)

PIP Topic 4: Immunizations for Adolescents (IMA)

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

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

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

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

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

IPRO Reviewers: Sopan Mohnot, MD, MPH (smohnot@ipro.org); Teresa Lubowski (TLubowski@ipro.org)
Date reviewed: October 21, 2024
Reporting Period: Proposal Findings

IPRO Comments:
Elements 1 through 8 were not scored for the Overall Review Determination, as a numerical score was not ascertained for this PIP proposal.

Element 1 Overall Review Determination was N/A.

Element 2 Overall Review Determination was N/A. Although not scored, concerns were identified in the goals. The proposed goals are not bold and represent a small, proposed change in improvement. Recommend re-evaluating the goals and aiming for at least a 10% increase in vaccination rates by the end of the PIP.

Element 3 Overall Review Determination was N/A. Although not scored, concerns were identified in methodology section. Although the selection of the practices is well described in the Topic section, the rationale should also be described in the sampling since the PIP will selectively focus on specific practices. Additionally, please provide the total number of practices and how many members would be eligible for the PIP from the 3 practices included in the PIP and the total number of eligible members from all practices. Page 12, Target Providers: One of the criteria include providers that have a strong relationship and willingness to work with a Clinical Practice Consultant. Include how many practices in the MCO meet this criteria and whether this a potential source of bias. Please add more information and consider including additional practices outside of this requirement. For intervention 4a, consider the sustainability of interventions that involve incentives and whether these will continue beyond the PIP if proven effective. Additionally, data collection and analysis for the intervention tracking measures is not described in the PIP report. Please add this information in the methodology section.

Element 4 Overall Review Determination is N/A.

Element 5 Overall Review Determination is N/A.

Element 6 Overall Review Determination is N/A.

Element 7 Overall Review Determination is N/A.

Element 8 Overall Review Determination is N/A.

Element 9 Overall Review Determination is N/A.

For this PIP proposal, the submission was not scored. Therefore, a rating of the PIP for determination of overall compliance was N/A. Although not scored, concerns were identified with aspects of the goals and methodology. The MCO should address the above concerns with clarifications or adjustments for a sufficiently developed PIP proposal that is ultimately demonstrative of the intended impact on performance outcomes. The MCO should ensure that all changes are noted and documented in the April and August 2025 submissions. In subsequent submissions in the reporting schedule, the MCO will be evaluated accordingly on the reporting of results and discussion/validity of improvement, and later, on reporting of sustainability.

UHCCP PIP 5: Improving Coordination of Care and Ambulatory Follow-Up After Mental health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations

MCO Name: UnitedHealthcare Community Plan (UHCCP)

PIP Topic 5: Improving Coordination of Care and Ambulatory Follow-Up After Mental health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations

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

3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	N/A	N/A	N/A	
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M	M	M	
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M	M	
Element 3 Overall Review Determination	**N/A**	**M**	**M**	**M**	
Element 3 Overall Score	**N/A**	**100**	**100**	**100**	0
Element 3 Weighted Score	**N/A**	**15.0**	**15.0**	**15.0**	**0.0**
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M	M	M	
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M	M	
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	M	M	
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	PM	M	M	
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M	M	M	
4f. Literature review	N/A	M	M	M	
Element 4 Overall Review Determination	**N/A**	**PM**	**M**	**M**	
Element 4 Overall Score	**N/A**	**50**	**100**	**100**	0
Element 4 Weighted Score	**N/A**	**7.5**	**15.0**	**15.0**	**0.0**
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	N/A	M	M	M	
5b. Actions that target member, provider and MCO	N/A	M	M	M	
5c. New or enhanced, starting after baseline year	N/A	M	M	M	
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	PM	M	M	
Element 5 Overall Review Determination	**N/A**	**PM**	**M**	**M**	
Element 5 Overall Score	**N/A**	**50**	**100**	**100**	**0**
Element 5 Weighted Score	**N/A**	**7.5**	**15.0**	**15.0**	**0.0**
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	M	PM	M	
Element 6 Overall Review Determination	**N/A**	M	**PM**	**M**	
Element 6 Overall Score	**N/A**	**100**	**50**	**100**	**0**
Element 6 Weighted Score	**N/A**	**5.0**	**2.5**	**5.0**	**0.0**

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

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**65.0**	**77.5**	**100.0**	**0.0**
Overall Rating	**N/A**	**81.3%**	**96.9%**	**100.0%**	**0.0%**

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

IPRO Reviewers: Carolyn Gallagher (cgallagher@ipro.org) Rob Accetta (raccetta@ipro.org)
Date (report submission) reviewed: October 24, 2024
Reporting Period: Year 3

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

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

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

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

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

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

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

Element 8 Overall Review Determination was N/A. Sustainability is not evaluated at the Year 3 phase due to nonavailability of full CY data for 2024.

Element 9 Overall Review Determination was that healthcare disparities relative to performance indicator results have been assessed based on social determinants of health.

Overall, the MCO was compliant with this PIP; out of a maximum possible weighted score of 100 points the MCO scored 100 points, which results in a rating of 100% (Which is above 86% [≥ 86% being the threshold for meeting compliance]). The MCO updated the barrier analysis and implemented additional interventions to address barriers encountered.

UHCCP PIP 6: Improving the Rate of Timely 10 Day Post-Discharge Visit with Assessment for MLTSS Members

MCO Name: UnitedHealthcare Community Plan (UHCCP)

PIP Topic 6: Improving the Rate of Timely 10 Day Post-Discharge Visit with Assessment for MLTSS Members

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

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

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

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

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

IPRO Reviewers: Teresa Lubowski (tlubowski@ipro.org), Deb Chambers (dchambers@ipro.org)
Date (report submission) reviewed: 11/11/2024
Reporting Period: Proposal Findings

IPRO Comments:

Elements 1 through 8 were not scored for the Overall Review Determination, as a numerical score was not ascertained for this PIP proposal.

Element 1 Overall Review Determination was N/A.
Element 2 Overall Review Determination was N/A. Although not scored, Performance Indicator (PI)3 is simply a combined rate of PI1 and PI2.

The MCO should consider including an objective involving members and/or providers (hospitals).

Element 3 Overall Review Determination was N/A. Although not scored, for PI2, the MCO should consider removing the members from the denominator that refused a post discharge face-to-face assessment.

Element 4 Overall Review Determination was N/A. Although not scored, regarding ITM #1a, it is not clear how the denominator will be determined with the description of "intended to be mailed". ITM #2a, the MCO should consider including an additional ITM showing that the documented visit was scheduled.

Element 5 Overall Review Determination was N/A.

Element 6 Overall Review Determination was N/A. The Results Table is not evaluated at the Proposal phase.

Element 7 Overall Review Determination was N/A. Discussion of Validity and Reported Improvement is not evaluated at the Proposal phase.

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

Element 9 Overall Review Determination was N/A. Although not scored, the MCO has not planned to identify, evaluate, and address healthcare disparities.

For this PIP Proposal, the submission was not scored. Therefore, the rating for the PIP for overall compliance was N/A. Although not scored, the MCO should address any concerns above with clarifications or revisions for a sufficiently developed PIP proposal that demonstrates the intended impact on the performance indicators.

UHCCP HEDIS Audit Review Table MY 2023

Audit Review Table					
AmeriChoice of New Jersey, Inc. (UnitedHealthcare Community Plan (NJ)) (Org ID: 1995, Sub ID: 8004, Medicaid, Spec Area: None, Spec Proj: None, Contract Number: None)					
Measurement Year - 2023; Date & Timestamp - 6/10/2024 10:09:22 AM					
This submission is on the stage: Submission Finalized					
Measure/Data Element	**Benefit Offered**	**Rate**	**Status**	**Audit Designation**	**Comment**
Effectiveness of Care					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
BMI percentile (Total)		84.67%	R	R	Reported
Counseling for Nutrition (Total)		70.32%	R	R	Reported
Counseling for Physical Activity (Total)		65.21%	R	R	Reported
Childhood Immunization Status (CIS)					
DTaP		65.45%	R	R	Reported
IPV		77.86%	R	R	Reported
MMR		81.27%	R	R	Reported
HiB		78.35%	R	R	Reported
Hepatitis B		73.97%	R	R	Reported
VZV		79.81%	R	R	Reported
Pneumococcal Conjugate		63.26%	R	R	Reported
Hepatitis A		72.26%	R	R	Reported
Rotavirus		58.88%	R	R	Reported
Influenza		41.36%	R	R	Reported
Combo 3		53.53%	R	R	Reported
Combo 7		43.07%	R	R	Reported
Combo 10		26.76%	R	R	Reported
Immunizations for Adolescents (IMA)					
Meningococcal		85.16%	R	R	Reported
Tdap		89.78%	R	R	Reported
HPV		29.93%	R	R	Reported
Combination 1		84.43%	R	R	Reported
Combination 2		28.22%	R	R	Reported
Lead Screening in Children (LSC)					
Lead Screening in Children		76.40%	R	R	Reported
Cervical Cancer Screening (CCS)					
Cervical Cancer Screening		58.64%	R	R	Reported
Colorectal Cancer Screening (COL)					
(Total)		49.35%	R	R	Reported
Chlamydia Screening in Women (CHL)					
(Total)		62.46%	R	R	Reported
Oral Evaluation, Dental Services (OED)	Y				
(0-2)		22.92%	R	R	Reported
(3-5)		59.98%	R	R	Reported
(6-14)		66.17%	R	R	Reported
(15-20)		50.82%	R	R	Reported
(Total)		56.62%	R	R	Reported

Topical Fluoride for Children (TFC)					
(1-2)		16.16%	R	R	Reported
(3-4)		26.40%	R	R	Reported
(Total)		21.41%	R	R	Reported
Appropriate Testing for Pharyngitis (CWP)	Y				
(Total)		71.61%	R	R	Reported
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)					
Use of Spirometry Testing in the Assessment and Diagnosis of COPD		34.09%	R	R	Reported
Pharmacotherapy Management of COPD Exacerbation (PCE)	Y				
Systemic Corticosteroid		64.55%	R	R	Reported
Bronchodilator		86.00%	R	R	Reported
Asthma Medication Ratio (AMR)	Y				
(Total)		57.77%	R	R	Reported
Controlling High Blood Pressure (CBP)					
Controlling High Blood Pressure		64.48%	R	R	Reported
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	Y				
Persistence of Beta-Blocker Treatment After a Heart Attack		57.35%	R	R	Reported
Statin Therapy for Patients With Cardiovascular Disease (SPC)	Y				
Received Statin Therapy (Total)		81.36%	R	R	Reported
Statin Adherence 80% (Total)		78.58%	R	R	Reported
Cardiac Rehabilitation (CRE)					
Initiation (Total)		1.98%	R	R	Reported
Engagement1 (Total)		5.79%	R	R	Reported
Engagement2 (Total)		5.37%	R	R	Reported
Achievement (Total)		2.54%	R	R	Reported
Hemoglobin A1c Control for Patients With Diabetes (HBD)					
HbA1c Control (<8%)		64.48%	R	R	Reported
Poor HbA1c Control		25.79%	R	R	Reported
Blood Pressure Control for Patients With Diabetes (BPD)					
Blood Pressure Control for Patients With Diabetes		69.34%	R	R	Reported
Eye Exam for Patients With Diabetes (EED)					
Eye Exam for Patients With Diabetes		62.53%	R	R	Reported
Kidney Health Evaluation for Patients With Diabetes (KED)					
(Total)		45.98%	R	R	Reported
Statin Therapy for Patients With Diabetes (SPD)	Y				
Received Statin Therapy		73.30%	R	R	Reported
Statin Adherence 80%		74.18%	R	R	Reported
Diagnosed Mental Health Disorders (DMH)					
(Total)		25.07%	R	R	Reported
Antidepressant Medication Management (AMM)	Y				

Effective Acute Phase Treatment		65.56%	R	R	Reported
Effective Continuation Phase Treatment		48.00%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Y				
Initiation Phase		39.46%	R	R	Reported
Continuation and Maintenance Phase		44.40%	R	R	Reported
Follow-Up After Hospitalization for Mental Illness (FUH)	Y				
30 days (Total)		53.77%	R	R	Reported
7 days (Total)		32.66%	R	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Y				
30 days (Total)		61.67%	R	R	Reported
7 days (Total)		49.58%	R	R	Reported
Diagnosed Substance Use Disorders (DSU)					
Alcohol (Total)		2.14%	R	R	Reported
Opioid (Total)		2.80%	R	R	Reported
Other (Total)		2.99%	R	R	Reported
Any (Total)		5.80%	R	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	Y				
30 days (Total)		43.52%	R	R	Reported
7 Days (Total)		23.92%	R	R	Reported
Follow-Up After Emergency Department Visit for Substance Use (FUA)	Y				
30 days (Total)		33.75%	R	R	Reported
7 days (Total)		23.98%	R	R	Reported
Pharmacotherapy for Opioid Use Disorder (POD)	Y				
(Total)		25.87%	R	R	Reported
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Y				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		87.74%	R	R	Reported
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)					
Diabetes Monitoring for People With Diabetes and Schizophrenia		80.34%	R	R	Reported
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		88.50%	R	R	Reported
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	Y				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		70.80%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	Y				
Blood Glucose Testing (Total)		61.21%	R	R	Reported
Cholesterol Testing (Total)		45.65%	R	R	Reported
Blood Glucose and Cholesterol Testing (Total)		44.56%	R	R	Reported

Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)					
Non-Recommended Cervical Cancer Screening in Adolescent Females		0.69%	R	R	Reported
Appropriate Treatment for Upper Respiratory Infection (URI)	Y				
(Total)		82.84%	R	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	Y				
(Total)		52.28%	R	R	Reported
Use of Imaging Studies for Low Back Pain (LBP)					
(Total)		75.58%	R	R	Reported
Use of Opioids at High Dosage (HDO)	Y				
Use of Opioids at High Dosage		9.48%	R	R	Reported
Use of Opioids From Multiple Providers (UOP)	Y				
Multiple Prescribers		11.28%	R	R	Reported
Multiple Pharmacies		1.77%	R	R	Reported
Multiple Prescribers and Multiple Pharmacies		0.81%	R	R	Reported
Risk of Continued Opioid Use (COU)	Y				
>=15 Days (Total)		7.66%	R	R	Reported
>=31 Days (Total)		4.47%	R	R	Reported
Access/Availability of Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
(Total)		82.47%	R	R	Reported
Initiation and Engagement of Substance Use Disorder Treatment (IET)	Y				
Initiation of SUD Treatment - Total (Total)		41.45%	R	R	Reported
Engagement of SUD Treatment - Total (Total)		7.08%	R	R	Reported
Prenatal and Postpartum Care (PPC)					
Timeliness of Prenatal Care		82.00%	R	R	Reported
Postpartum Care		83.21%	R	R	Reported
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Y				
(Total)		62.91%	R	R	Reported
Utilization and Risk Adjusted Utilization					
Well-Child Visits in the First 30 Months of Life (W30)					
(First 15 Months)		54.62%	R	R	Reported
(15 Months-30 Months)		69.16%	R	R	Reported
Child and Adolescent Well-Care Visits (WCV)					
(Total)		61.16%	R	R	Reported
Ambulatory Care (AMB)			R	R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPU)			R	R	Reported
Antibiotic Utilization for Respiratory Conditions (AXR)	Y				
(Total)		25.25%	R	R	Reported
Plan All-Cause Readmissions (PCR)			R	R	Reported
Health Plan Descriptive Information					

Enrollment by Product Line (ENP)			R	R	Reported
Language Diversity of Membership (LDM)			R	R	Reported
Race/Ethnicity Diversity of Membership (RDM)			R	R	Reported
Measures Reported Using Electronic Clinical Data Systems					
Childhood Immunization Status (CIS-E)					
DTaP		57.70%	R	R	Reported
IPV		71.56%	R	R	Reported
MMR		78.85%	R	R	Reported
HiB		74.05%	R	R	Reported
Hepatitis B		51.13%	R	R	Reported
VZV		77.72%	R	R	Reported
Pneumococcal Conjugate		55.58%	R	R	Reported
Hepatitis A		68.82%	R	R	Reported
Rotavirus		53.37%	R	R	Reported
Influenza		37.75%	R	R	Reported
Combo 3		36.72%	R	R	Reported
Combo 7		29.91%	R	R	Reported
Combo 10		19.82%	R	R	Reported
Immunizations for Adolescents (IMA-E)					
Meningococcal		84.67%	R	R	Reported
Tdap		87.94%	R	R	Reported
HPV		28.54%	R	R	Reported
Combination 1		83.43%	R	R	Reported
Combination 2		27.07%	R	R	Reported
Breast Cancer Screening (BCS-E)					
Breast Cancer Screening		62.66%	R	R	Reported
Cervical Cancer Screening (CCS-E)					
Cervical Cancer Screening		57.80%	R	R	Reported
Colorectal Cancer Screening (COL-E)					
(Total)		49.35%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)	Y				
Initiation Phase		39.51%	R	R	Reported
Continuation and Maintenance Phase		44.40%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	Y				
Blood Glucose Testing (Total)		61.21%	R	R	Reported
Cholesterol Testing (Total)		45.65%	R	R	Reported
Blood Glucose and Cholesterol Testing (Total)		44.56%	R	R	Reported
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)					
Depression Screening (Total)		0.48%	R	R	Reported
Follow-Up on Positive Screen (Total)		57.58%	R	R	Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)					
Utilization of PHQ-9-Total (Total)		0.34%	R	R	Reported
Depression Remission or Response for Adolescents and Adults (DRR-E)					

Follow-Up PHQ-9 (Total)		0.00%	NA	R	Reported
Depression Remission (Total)		0.00%	NA	R	Reported
Depression Response (Total)		0.00%	NA	R	Reported
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)					
Unhealthy Alcohol Use Screening (Total)		0.00%	R	R	Reported
Alcohol Counseling or Other Follow-Up Care (Total)		0.00%	NA	R	Reported
Adult Immunization Status (AIS-E)					
Influenza (19-65)		10.87%	R	R	Reported
Influenza (66+)		27.09%	R	R	Reported
Influenza (Total)		13.65%	R	R	Reported
Td/Tdap (19-65)		29.60%	R	R	Reported
Td/Tdap (66+)		19.16%	R	R	Reported
Td/Tdap (Total)		27.81%	R	R	Reported
Zoster (50-65)		9.85%	R	R	Reported
Zoster (66+)		11.21%	R	R	Reported
Zoster (Total)		10.40%	R	R	Reported
Pneumococcal (66+)		29.96%	R	R	Reported
Prenatal Immunization Status (PRS-E)					
Influenza		16.31%	R	R	Reported
Tdap		31.91%	R	R	Reported
Combination		11.05%	R	R	Reported
Prenatal Depression Screening and Follow-Up (PND-E)					
Depression Screening		4.03%	R	R	Reported
Follow-Up on Positive Screen		80.00%	NA	R	Reported
Postpartum Depression Screening and Follow-Up (PDS-E)					
Depression Screening		0.31%	R	R	Reported
Follow-Up on Positive Screen			NA	R	Reported
Social Need Screening and Intervention (SNS-E)					
Food Screening (Total)		0.00%	R	R	Reported
Food Intervention (Total)		0.00%	NA	R	Reported
Housing Screening (Total)		0.00%	R	R	Reported
Housing Intervention (Total)		0.00%	NA	R	Reported
Transportation Screening (Total)		0.00%	R	R	Reported
Transportation Intervention (Total)		0.00%	NA	R	Reported

UHCCP 2024 ISCA Summary of Findings

Assessment Topic	UHCCP Assessment Finding	Review Note
Completeness and accuracy of encounter data collected and submitted to the State	Met	UHCCP has adequate checks and audit processes in place to monitor the submission of encounter data. UHCCP's timeliness and State acceptance rates for all encounter types are all above 98.00%. No issues were noted in UHCCP's encounter data submission and reconciliation processes.
Validation and/or calculation of performance measures	Met	UHCCP uses Inovalon for HEDIS, CMS Adult and Child Core Set, and NJ State-specific performance measures, ECDS, and race and ethnicity reporting. UHCCP loads all data elements in the input files needed for calculation of performance measures into Inovalon's robust software, Converged Analytics. Regarding HEDIS ECDS performance measures, UHCCP follows the prescribed NCQA hierarchy order for the inclusion of supplemental data sources. No issues were noted in validation and calculation processes for the required performance measures.
Completeness and accuracy of tracking of member grievances	Met	UHCCP submits quarterly reports to DMAHS for Table 3B, a report of all non-utilization management (UM) member grievance requests and dispositions, and for Table 3C, a report of all non-utilization management (UM) provider grievance and appeal requests and dispositions. UHCCP submits quarterly reports to DMAHS for Table H2A, a report of UM and appeals for FIDE SNP. UHCCP conducts resolution audits on a bi-weekly and monthly basis to review grievances. No issues were noted in UHCCP's systems used for handling grievances and reporting Tables 3B, 3C, and H2A to the State.
NJ Appointment Assistance Form	Met	UHCCP demonstrated the NJ Appointment Assistance Form on their member portal and confirmed that the member portal had an option for the member to select whether a grievance should be filed. No issues were noted.
Utility of the information system to conduct MCO quality assessment and improvement initiatives	Met	UHCCP's information systems support various data reporting requests, both internally and externally.
Ability of the information system to conduct MCO quality	Met	UHCCP's information systems can conduct quality assessments and conduct improvement initiatives.

Assessment Topic	UHCCP Assessment Finding	Review Note
assessment and improvement initiatives		
Ability of the information system to oversee and manage the delivery of health care to the MCO's enrollees	Met	UHCCP receives and processes the daily 834 eligibility files. The 834 daily eligibility files are loaded into UHCCP's CSP Facets system. UHCCP loads and stores both NJ OIDs and NJ CIDs into CSP Facets. No issues were noted in UHCCP's systems or enrollment processes.
Validation and/or calculation of network adequacy reports	Met	UHCCP utilizes Quest Analytics software for assessing, monitoring, and reporting network adequacy across geographic areas based on NJ's distance and time standards. UHCCP submits monthly reports to NJ as per DMAHS's regulatory requirements. At the time of this report, UHCCP has active CAPs for dental provider standards and network gaps for acute care distance standards. UHCCP submitted multiple waiver requests to DMAHS for pediatric sub-specialties for network gaps with providers availability, time, and distance.
Identification and reporting of NCQA's and CMS' race and ethnicity categories	Met	UHCCP uses race and ethnicity/language codes received on the State 834 file(s) for direct race and ethnicity/language values utilized for HEDIS, CMS, and NJ-specific performance measure reporting. UHCCP's vendor, Inovalon, crosswalks race and ethnicity values for HEDIS rate reporting. UHCCP can capture the race and ethnicity values, based on the 2024 OMB Statistical Policy Directive No. 15: Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity, which includes the new Middle Eastern and Northern African race category. No issues were identified.

Assessment Level Definitions

Assessment Levels	Definition
Met	MCO met or exceeded standards.
Partially Met	MCO met some of the standards and demonstrates opportunities for improvement.
Not Met	MCO did not meet the standards and a corrective action plan is required.
Not Applicable	Standard does not apply.

WPNJ Core Medicaid/MLTSS Annual Assessment of MCO Operations

WPNJ 2024 Annual Assessment of MCO Operations

Review Category	Total Elements[1]	Deemed Met from the Prior Year	Subject to Review[2]	Subject to Review and Met[3]	Subject to review and Not Met	Subject to Review and N/A	Total Met	% Met[4]
Care Management and Continuity of Care – Core Medicaid*	30	0	30	22	8	0	22	73%
Care Management and Continuity of Care - MLTSS*	10	0	10	10	0	0	10	100%
Access**	12	2	10	4	6	0	6	50%
Emergency and Post-Stabilization Services[5]	6	0	6	6	0	0	6	100%
Quality Assessment and Performance Improvement	10	0	10	10	0	0	10	100%
Quality Management	21	9	12	12	0	0	21	100%
Efforts to Reduce Healthcare Disparities	5	0	5	5	0	0	5	100%
Committee Structure	9	6	3	3	0	0	9	100%
Programs for the Elderly and Disabled	44	33	11	11	0	0	44	100%
Provider Training and Performance	11	7	4	4	0	0	11	100%
Satisfaction	5	2	3	2	1	0	4	80%
Enrollee Rights and Responsibilities	8	4	4	4	0	0	8	100%
Member Disenrollment	29	26	3	3	0	0	29	100%
Credentialing and Re-credentialing	10	8	2	2	0	0	10	100%
Utilization Management	30	16	14	14	0	0	30	100%
Administration and Operations	14	10	4	4	0	0	14	100%
Management Information Systems	18	15	3	3	0	0	18	100%
TOTAL	**232**	**138**	**94**	**87**	**7**	**0**	**225**	**97%**

[1] A total of 117 elements were reviewed in the previous review period; of these 117, 105 were *Met*, 12 were *Not Met*; 0 were *N/A*. Remaining existing elements that were Met Prior Year were deemed Met in the previous review period.

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

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

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

[5] Emergency and Post-Stabilization Services was a new standard reviewed in 2024.

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

** Access had 14 elements in 2023. In 2024, two elements (A1 and A2) were moved to a new category Emergency and Post-Stabilization Services. Although not an annual element, A3 was reviewed in the partial audits this year due to enhancements in the Access category.

WPNJ Performance Improvement Projects

WPNJ PIP 1: Increasing Primary Care Physician (PCP) Access and Availability for Wellpoint Members

MCO Name: Wellpoint New Jersey Inc. (WPNJ) formerly known as Amerigroup New Jersey Inc. (AGNJ)
PIP Topic 1: Increasing Primary Care Physician (PCP) Access and Availability for Wellpoint Members

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

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

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

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**0**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**0.0**	**62.5**	**70.0**	**90.0**	**100.0**
Overall Rating	**0%**	**78.1%**	**87.5%**	**90.0%**	**100.0%**

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

IPRO Reviewers: Deb Chambers(dchambers@ipro.org), Rob Accetta (raccetta@ipro.org)
Date (report submission) reviewed: October 9, 2024
Reporting Period: Final Report

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

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

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

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

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

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

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

Element 8 Overall Review Determination was that the MCO is compliant.

Element 9 Overall Review Determination was that the MCO conducted a data review and was not able to identify any healthcare disparities.

Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 100.0 points, the MCO scored 100.0 points, which results in a rating of 100.0% which is above 85% ([≥ 85% being the threshold for meeting compliance]). The MCO focused on interventions for three provider practices to increase PCP visits and reduce inpatient admissions. Provider Group #1 showed a slight increase for PI#1 although the goal was not met. For PI#2, Provider Group 1 exceeded the goal. Provider Group #2 has shown improvement and is on a good trajectory, but the goal has not been met. The goal for PI#2 was also not met. Provider Group #3 has shown steady improvements in PI#1 and exceeded the goal, while PI#2 has improved since baseline, the goal was not met. The MCO has indicated that the member incentive intervention used for this project will be expanded to the entire membership. Also, the provider education interventions are planned to be incorporated into the MCO's regular material discussed during provider meetings. The MCO should consider evaluating the interventions around decreasing inpatient utilization which appear to be having a positive impact for the 3 targeted provider groups and potentially expanding them to a wider group of practices.

WPNJ PIP 2: Improving Well-Child Visits and Immunization Rates for Members Ages 0-30 Months

MCO Name: Wellpoint New Jersey Inc. (WPNJ) formerly known as Amerigroup New Jersey Inc. (AGNJ)
PIP Topic 2: Improving Well-Child Visits and Immunization Rates for Members Ages 0-30 Months

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

3f. If sampling was used, the MCO identified a representative sample, utilizing statistically sound methodology to limit bias. The sampling technique specifies estimated/true frequency, margin of error, and confidence interval.	N/A	N/A	N/A	N/A	
3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline	N/A	M	M	M	
3h. Study design specifies data analysis procedures with a corresponding timeline	N/A	M	M	M	
Element 3 Overall Review Determination	**N/A**	**PM**	**M**	**M**	
Element 3 Overall Score	**N/A**	**50**	**100**	**100**	0
Element 3 Weighted Score	**N/A**	**7.5**	**15.0**	**15.0**	**0.0**
Element 4. Barrier Analysis Items 4a-4f located in PIP Report Section 5, Table 1a.					
Barrier analysis is comprehensive, identifying obstacles faced by members and/or providers and/or MCO. MCO uses one or more of the following methodologies:					
4a. Susceptible subpopulations identified using claims data on performance measures stratified by demographic and clinical characteristics	N/A	M	M	M	
4b. Member input at focus groups and/or Quality Meetings, and/or from CM outreach	N/A	M	M	PM	
4c. Provider input at focus groups and/or Quality Meetings	N/A	M	M	PM	
4d. QI Process data ("5 Why's", fishbone diagram)	N/A	M	M	M	
4e. HEDIS® rates (or other performance metric; e.g., CAHPS)	N/A	M	M	M	
4f. Literature review	N/A	M	M	M	
Element 4 Overall Review Determination	**N/A**	**M**	**M**	**PM**	
Element 4 Overall Score	**N/A**	**100**	**100**	**50**	0
Element 4 Weighted Score	**N/A**	**15.0**	**15.0**	**7.5**	**0.0**
Element 5. Robust Interventions Items 5a-5c located in PIP Report Section 5, Table 1a. Item 5d located in PIP Report Section 5, Table 1b.					
5a. Informed by barrier analysis	N/A	M	M	M	
5b. Actions that target member, provider and MCO	N/A	M	M	M	
5c. New or enhanced, starting after baseline year	N/A	M	M	M	
5d. With corresponding monthly or quarterly intervention tracking measures (aka process measures), with numerator/denominator (specified in proposal and baseline PIP reports, with actual data reported in Interim and Final PIP Reports)	N/A	M	M	M	
Element 5 Overall Review Determination	**N/A**	**M**	**M**	**M**	
Element 5 Overall Score	**N/A**	**100**	**100**	**100**	**0**
Element 5 Weighted Score	**N/A**	**15.0**	**15.0**	**15.0**	**0.0**
Element 6. Results Table Item 6a located in PIP Report Section 6, Table 2.					
6a. Table shows Performance Indicator rates, numerators and denominators, with corresponding goals	N/A	**PM**	M	M	
Element 6 Overall Review Determination	**N/A**	**PM**	**M**	**M**	
Element 6 Overall Score	**N/A**	**50**	**100**	**100**	**0**
Element 6 Weighted Score	**N/A**	**2.5**	**5.0**	**5.0**	**0.0**

Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M	M	M	
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M	PM	M	
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M	M	M	
7d. Lessons learned & follow-up activities planned as a result	N/A	M	M	M	
Element 7 Overall Review Determination	**N/A**	**M**	**PM**	**M**	
Element 7 Overall Score	**N/A**	**100**	**50**	**100**	**0**
Element 7 Weighted Score	**N/A**	**20.0**	**10.0**	**20.0**	**0.0**
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	M	
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	M	
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**M**	
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**100**	**0**
Element 8 Weighted Score	**N/A**	**N/A**	**N/A**	**20.0**	**0.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes N=No)	**N/A**	**N**	**Y**	**Y**	

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**67.5**	**70.0**	**92.5**	**0.0**
Overall Rating	**N/A**	**84.4%**	**87.5%**	**92.5%**	**0.0%**

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

IPRO Reviewers: Carolyn Gallagher (cgallagher@ipro.org), Deb Chambers (dchambers@ipro.org)
Date (report submission) reviewed: November 4, 2024
Reporting Period: Year 3

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

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

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

Element 4 Overall Review Determination was that the MCO is partially compliant with elements 4b and 4c. Indicator 2 (well-child visits, 15-30 months) did not show improvement from 2021 to 2023; therefore, updated member and provider barrier analyses are merited, with findings used to inform modifications to interventions. Indicator 3 showed improvement from 2021 to 2023 using administrative data, but did not show improvement using the more robust hybrid data; again, updated member and provider barrier analyses are merited, with findings used to inform modifications to interventions.

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

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

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

Element 8 Overall Review Determination was that the MCO is compliant.

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

Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 100 points the MCO scored 92.5 points, which results in a rating of 92.5%. Updated barrier analysis is merited, with findings used to inform modifications to interventions.

WPNJ PIP 3: Decreasing Member Grievances Related to Balance Billing Issues

MCO Name: Wellpoint New Jersey Inc. (WPNJ) formerly known as Amerigroup New Jersey Inc. (AGNJ)
PIP Topic 3: Decreasing Member Grievances Related to Balance Billing Issues

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

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

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

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

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

IPRO Reviewers: Deb Chambers (dchambers@ipro.org)
Date (report submission) reviewed: October 9, 2024
Reporting Period: Year 1

IPRO Comments:

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

Element 2 Overall Review Determination was that the MCO is partially compliant. For Element 2b, the MCO should look at PI #1 and consider changing this to a rate/1,000 rather than an actual number of grievances.

Element 3 Overall Review Determination was that the MCO is partially compliant. The same comment as above also applies for Element 3a. This outcome measure would be helpful in evaluating the success of the

PIP. The MCO should review and adjust accordingly for consistent data flow and validity over the life of the PIP.

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

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

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

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

Element 8 Overall Review Determination was N/A. Sustainability is not evaluated at the Year 1 phase.

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

Overall, the MCO is compliant with this PIP; out of a maximum possible weighted score of 80.0 points, the MCO scored 70.0 points, which results in a rating of 87.5% (which is above 85% [≥ 85% being the threshold for meeting compliance]). Please review comments above for future reporting.

WPNJ PIP 4: Increasing Immunization for Adolescents (IMA-E Combo 2) Compliance

MCO Name: Wellpoint New Jersey Inc. (WPNJ) formerly known as Amerigroup New Jersey Inc. (AGNJ)
PIP Topic 4: Increasing Immunization for Adolescents (IMA-E Combo 2) Compliance

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

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

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

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

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

IPRO Reviewers: Sopan Mohnot, MD, MPH (smohnot@ipro.org); Teresa Lubowski (TLubowski@ipro.org)
Date reviewed: October 21, 2024
Reporting Period: Proposal Findings

IPRO Comments:

Elements 1 through 8 were not scored for the Overall Review Determination, as a numerical score was not ascertained for this PIP proposal.

Element 1 Overall Review Determination was N/A.

Element 2 Overall Review Determination was N/A.

Element 3 Overall Review Determination was N/A. Although not scored, concerns with the methodology were identified. The MCO should describe how data collection and analysis will be done for the intervention tracking measures.

Element 4 Overall Review Determination is N/A.

Element 5 Overall Review Determination is N/A. Although not scored, concerns with the intervention tracking measures were identified. Recommend the MCO consider additional ways to measure the effectiveness of the intervention. Consider adding a third ITM to measure the completed immunizations after intervention; this suggestion can be applied to all of the ITMs. For example, ITM 3a measures how many members were sent the educational material, however, it would be helpful to know how many members completed the HPV vaccine series after the mailing was sent. Similarly, intervention 4a- if data are available, recommend adding an ITM to measure how many appointments were made through the online portal after the mailing- this can help assess the utility of the online feature. Additionally, please describe for ITM 5a the process for selection of the top provider groups with the highest gaps in care.

Element 6 Overall Review Determination is N/A.

Element 7 Overall Review Determination is N/A.

Element 8 Overall Review Determination is N/A.

Element 9 Overall Review Determination is N/A.

For this PIP proposal, the submission was not scored. Therefore, a rating of the PIP for determination of overall compliance was N/A. Although not scored, concerns were identified with aspects of intervention tracking measures. The MCO should address the above concerns with clarifications or adjustments for a sufficiently developed PIP proposal that is ultimately demonstrative of the intended impact on performance outcomes. The MCO should ensure that all changes are noted and documented in the April and August 2025 submissions. In subsequent submissions in the reporting schedule, the MCO will be evaluated accordingly on the reporting of results and discussion/validity of improvement, and later, on reporting of sustainability.

WPNJ PIP 5: Improving the Coordination of Care and Ambulatory Follow-Up for Mental Health Hospitalization in the MLTSS Home and Community Based Population

MCO Name: Wellpoint New Jersey Inc. (WPNJ) formerly known as Amerigroup New Jersey Inc. (AGNJ)
PIP Topic 5: Improving the Coordination of Care and Ambulatory Follow-Up for Mental Health Hospitalization in the MLTSS Home and Community Based Population

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

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

Element 7. Discussion and Validity of Reported Improvement Items 7a-7b located in PIP Report Section 7, bullet 1 (Discussion of Results). Item 7c located in PIP Report Section 7, bullet 2 (Limitations). Item 7d located in PIP Report Section 8.					
7a. Interpretation of extent to which PIP is successful, and the factors associated with success (e.g., interventions)	N/A	M	M	M	
7b. Data presented adhere to the statistical techniques outlined in the MCO's data analysis plan	N/A	M	PM	M	
7c. Analysis identifies changes in indicator performance, factors that influence comparability, and that threaten internal/external validity.	N/A	M	M	M	
7d. Lessons learned & follow-up activities planned as a result	N/A	M	M	M	
Element 7 Overall Review Determination	**N/A**	**M**	**PM**	**M**	
Element 7 Overall Score	**N/A**	**100**	**50**	**100**	**0**
Element 7 Weighted Score	**N/A**	**20.0**	**10.0**	**20.0**	**0.0**
Element 8. Sustainability Item 8a located in PIP Report Section 8, bullet 1 (Lessons Learned). Item 8b located in the PIP Report Section 6, Table 2.					
8a. There was ongoing, additional or modified interventions documented	N/A	N/A	N/A	M	
8b. Sustained improvement was demonstrated through repeated measurements over comparable time periods	N/A	N/A	N/A	N/A	
Element 8 Overall Review Determination	**N/A**	**N/A**	**N/A**	**M**	
Element 8 Overall Score	**N/A**	**N/A**	**N/A**	**100**	**0**
Element 8 Weighted Score (Y=Yes, N=No)	**N/A**	**N/A**	**N/A**	**20.0**	**0.0**
Non-Scored Element: **Element 9. Healthcare Disparities**					
9a. Healthcare disparities are identified, evaluated and addressed (Y=Yes, N=No)	**N/A**	**Y**	**Y**	**Y**	

	Proposal Findings	Year 1 Findings	Year 2 Findings	Sustainability Findings	Final Report Findings
Maximum Possible Weighted Score	**N/A**	**80**	**80**	**100**	**100**
Actual Weighted Total Score	**N/A**	**72.5**	**70.0**	**92.5**	**0.0**
Overall Rating	**N/A**	**90.6%**	**87.5%**	**92.5%**	**0.0%**

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

IPRO Reviewers: Carolyn Gallagher (cgallagher@ipro.org) Rob Accetta (raccetta@ipro.org)
Date (report submission) reviewed: October 24, 2024
Reporting Period: Year 3

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

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

Element 3 Overall Review Determination was that the MCO is partially compliant. 3g. Study design specifies data collection methodologies that are valid and reliable, and representative of the entire eligible population, with a corresponding timeline. The Plans indicated that denominator changes were made to ITMs 5a and 5b

("from # all FUH claims submitted"); however, the "Validity and Reliability" section does not address this change in reliability of measurement over time, nor does the Data Analysis section explain how data analysis will address this change in measurement. ITMs 5a and 5b do show a notable increase in the denominator from Y1, Q3 2022 to Y1, Q4 2022--is this when the change in measurement occurred? An explanatory footnote is merited, with corresponding explanations to the Validity and Reliability and Data Analysis sections.

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

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

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

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

Element 8 Overall Review Determination was compliant in terms of modification of interventions; however, sustainability as measured by performance indicator rates cannot be measured at this time due to incomplete data for 2024.

Element 9 Overall Review Determination was that the MCO is implementing processes to evaluate healthcare disparities.

Overall, the MCO was compliant with this PIP; out of a maximum possible weighted score of 100 points the MCO scored 92.5 points, which results in a rating of 92.5% (Which is ≥ the 86% threshold for meeting compliance). The MCO has implemented an array of member and provider interventions to improve performance on the indicators. The MCO should continue to analyze the effectiveness of the various interventions and modify as needed to maximize overall improvement toward the Goals.

WPNJ PIP 6: Improving 10-Day Post-Discharge Visit with Assessment for Wellpoint MLTSS HCBS Members

MCO Name: Wellpoint New Jersey Inc. (WPNJ) formerly known as Amerigroup New Jersey Inc. (AGNJ)
PIP Topic 6: Improving 10-Day Post-Discharge Visit with Assessment for Wellpoint MLTSS HCBS Members

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

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

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

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

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

IPRO Reviewers: Teresa Lubowski (tlubowski@ipro.org), Deb Chambers (dchambers@ipro.org)
Date (report submission) reviewed: 11/13/2024
Reporting Period: Proposal Findings

IPRO Comments:

Elements 1 through 8 were not scored for the Overall Review Determination, as a numerical score is not ascertained at the PIP Proposal stage.

Element 1 Overall Review Determination was N/A., Although not scored, the Assessment tool does not appear to address member specific needs Post Discharge including whether the follow-up post discharge is Face-to

Face or Telephonic, member needs following discharge (i.e. DME, transportation, scheduling), actual or potential barriers to members post discharge, and does not appear to be person centered.

Element 2 Overall Review Determination was N/A. Although not scored, in the Aim Statement, please indicate the population that will be included in the PIP. In Section 3, Item 2. Aim Statement, Objectives and Goals, in the table, Indicators 1 and 2 state "increase timeliness" in the text for each indicator, but the year 1 and year 2 goals are both lower than the baseline rates (also repeated in Section 6, Table 2). Also, please be consistent with the language "within 10 business days" and "within 10 days" throughout the PIP.

Element 3 Overall Review Determination was N/A. Although not scored, in the Methodology section, Performance Indicators 1-3 state the eligible population as MLTSS HCBS and FIDE SNP/MLTSS HCBS members, but the numerator and denominator state MLTSS HCBS only. Please update for consistency.

Element 4 Overall Review Determination was N/A. Although not scored, the following areas were noted in the Barrier Analysis section. In Table 1a, please confirm if the eligible population is MLTSS HCBS as stated or if it also includes FIDE SNP/MLTSS HCBS members. Also, please consider identifying barriers from external sources (provider discussions, member survey, etc.)

Element 5 Overall Review Determination was N/A. Although not scored, the following areas were noted in the Robust Interventions section. For ITM#1a, please define the benchmark for what the appropriate ratio of membership to care managers should be. For ITM #2a Table 1a, confirm the post hospitalization visit that the member is refusing is the face to face visit, and whether the timeframe that the telephonic outreach needs to be completed by (i.e. 10 business days post discharge). For ITM #4a, the numerator and denominator do not match the description of the intervention, please refine. Also, the Performance Indicators are aimed at increasing face-to-face visits, as opposed to telephonic outreach; the MCO should consider adding an ITM that addresses and measures this specifically.

Element 6 Overall Review Determination was N/A. The Results Table is not evaluated at the Proposal phase.

Element 7 Overall Review Determination was N/A. Discussion of Validity and Reported Improvement is not evaluated at the Proposal phase.

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

Element 9 Overall Review Determination was N/A.

For this PIP Proposal, the submission was not scored. Therefore, the rating for the PIP for overall compliance was N/A. Although not scored, the MCO should address any concerns above with clarifications or revisions for a sufficiently developed PIP proposal that demonstrates the intended impact on the performance indicators.

WPNJ HEDIS Audit Review Table MY 2023

Audit Review Table					
Wellpoint New Jersey, Inc. (Org ID: 1791, Sub ID: 4308, Medicaid, Spec Area: None, Spec Proj: None, Contract Number: None)					
Measurement Year - 2023; Date & Timestamp - 6/14/2024 5:12:30 PM					
This submission is on the stage: Submission Finalized					
Measure/Data Element	**Benefit Offered**	**Rate**	**Status**	**Audit Designation**	**Comment**
Effectiveness of Care					
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)					
BMI percentile (Total)		86.62%	R	R	Reported
Counseling for Nutrition (Total)		82.73%	R	R	Reported
Counseling for Physical Activity (Total)		80.54%	R	R	Reported
Childhood Immunization Status (CIS)					
DTaP		71.53%	R	R	Reported
IPV		85.40%	R	R	Reported
MMR		84.18%	R	R	Reported
HiB		84.91%	R	R	Reported
Hepatitis B		85.64%	R	R	Reported
VZV		83.94%	R	R	Reported
Pneumococcal Conjugate		68.13%	R	R	Reported
Hepatitis A		72.99%	R	R	Reported
Rotavirus		62.77%	R	R	Reported
Influenza		37.71%	R	R	Reported
Combo 3		61.07%	R	R	Reported
Combo 7		47.69%	R	R	Reported
Combo 10		26.03%	R	R	Reported
Immunizations for Adolescents (IMA)					
Meningococcal		88.56%	R	R	Reported
Tdap		91.97%	R	R	Reported
HPV		28.22%	R	R	Reported
Combination 1		88.32%	R	R	Reported
Combination 2		27.01%	R	R	Reported
Lead Screening in Children (LSC)					
Lead Screening in Children		75.31%	R	R	Reported
Cervical Cancer Screening (CCS)					
Cervical Cancer Screening		63.26%	R	R	Reported
Colorectal Cancer Screening (COL)					
(Total)		38.98%	R	R	Reported
Chlamydia Screening in Women (CHL)					
(Total)		61.32%	R	R	Reported
Oral Evaluation, Dental Services (OED)	Y				
(0-2)		17.10%	R	R	Reported
(3-5)		54.48%	R	R	Reported
(6-14)		61.91%	R	R	Reported
(15-20)		43.38%	R	R	Reported
(Total)		49.80%	R	R	Reported

Topical Fluoride for Children (TFC)					
(1-2)		14.31%	R	R	Reported
(3-4)		19.00%	R	R	Reported
(Total)		16.68%	R	R	Reported
Appropriate Testing for Pharyngitis (CWP)	Y				
(Total)		80.76%	R	R	Reported
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)					
Use of Spirometry Testing in the Assessment and Diagnosis of COPD		30.48%	R	R	Reported
Pharmacotherapy Management of COPD Exacerbation (PCE)	Y				
Systemic Corticosteroid		66.52%	R	R	Reported
Bronchodilator		84.24%	R	R	Reported
Asthma Medication Ratio (AMR)	Y				
(Total)		57.67%	R	R	Reported
Controlling High Blood Pressure (CBP)					
Controlling High Blood Pressure		69.59%	R	R	Reported
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)	Y				
Persistence of Beta-Blocker Treatment After a Heart Attack		74.07%	R	R	Reported
Statin Therapy for Patients With Cardiovascular Disease (SPC)	Y				
Received Statin Therapy (Total)		82.39%	R	R	Reported
Statin Adherence 80% (Total)		70.75%	R	R	Reported
Cardiac Rehabilitation (CRE)					
Initiation (Total)		3.21%	R	R	Reported
Engagement1 (Total)		6.95%	R	R	Reported
Engagement2 (Total)		6.68%	R	R	Reported
Achievement (Total)		2.41%	R	R	Reported
Hemoglobin A1c Control for Patients With Diabetes (HBD)					
HbA1c Control (<8%)		66.42%	R	R	Reported
Poor HbA1c Control		26.76%	R	R	Reported
Blood Pressure Control for Patients With Diabetes (BPD)					
Blood Pressure Control for Patients With Diabetes		69.59%	R	R	Reported
Eye Exam for Patients With Diabetes (EED)					
Eye Exam for Patients With Diabetes		51.09%	R	R	Reported
Kidney Health Evaluation for Patients With Diabetes (KED)					
(Total)		42.65%	R	R	Reported
Statin Therapy for Patients With Diabetes (SPD)	Y				
Received Statin Therapy		72.98%	R	R	Reported
Statin Adherence 80%		66.24%	R	R	Reported
Diagnosed Mental Health Disorders (DMH)					
(Total)		21.10%	R	R	Reported
Antidepressant Medication Management (AMM)	Y				

Effective Acute Phase Treatment		64.23%	R	R	Reported
Effective Continuation Phase Treatment		46.48%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD)	Y				
Initiation Phase		35.13%	R	R	Reported
Continuation and Maintenance Phase		39.33%	R	R	Reported
Follow-Up After Hospitalization for Mental Illness (FUH)	Y				
30 days (Total)		43.03%	R	R	Reported
7 days (Total)		24.94%	R	R	Reported
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	Y				
30 days (Total)		58.19%	R	R	Reported
7 days (Total)		47.78%	R	R	Reported
Diagnosed Substance Use Disorders (DSU)					
Alcohol (Total)		2.14%	R	R	Reported
Opioid (Total)		2.63%	R	R	Reported
Other (Total)		2.97%	R	R	Reported
Any (Total)		5.62%	R	R	Reported
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	Y				
30 days (Total)		48.55%	R	R	Reported
7 Days (Total)		26.27%	R	R	Reported
Follow-Up After Emergency Department Visit for Substance Use (FUA)	Y				
30 days (Total)		32.28%	R	R	Reported
7 days (Total)		21.52%	R	R	Reported
Pharmacotherapy for Opioid Use Disorder (POD)	Y				
(Total)		21.96%	R	R	Reported
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	Y				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		85.01%	R	R	Reported
Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD)					
Diabetes Monitoring for People With Diabetes and Schizophrenia		79.95%	R	R	Reported
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)					
Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia		88.89%	R	R	Reported
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	Y				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		68.87%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)	Y				
Blood Glucose Testing (Total)		57.90%	R	R	Reported
Cholesterol Testing (Total)		43.30%	R	R	Reported
Blood Glucose and Cholesterol Testing (Total)		41.92%	R	R	Reported

Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)					
Non-Recommended Cervical Cancer Screening in Adolescent Females		0.69%	R	R	Reported
Appropriate Treatment for Upper Respiratory Infection (URI)	Y				
(Total)		87.12%	R	R	Reported
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	Y				
(Total)		57.84%	R	R	Reported
Use of Imaging Studies for Low Back Pain (LBP)					
(Total)		73.32%	R	R	Reported
Use of Opioids at High Dosage (HDO)	Y				
Use of Opioids at High Dosage		8.73%	R	R	Reported
Use of Opioids From Multiple Providers (UOP)	Y				
Multiple Prescribers		15.29%	R	R	Reported
Multiple Pharmacies		1.83%	R	R	Reported
Multiple Prescribers and Multiple Pharmacies		0.88%	R	R	Reported
Risk of Continued Opioid Use (COU)	Y				
>=15 Days (Total)		5.29%	R	R	Reported
>=31 Days (Total)		3.38%	R	R	Reported
Access/Availability of Care					
Adults' Access to Preventive/Ambulatory Health Services (AAP)					
(Total)		75.68%	R	R	Reported
Initiation and Engagement of Substance Use Disorder Treatment (IET)	Y				
Initiation of SUD Treatment - Total (Total)		44.80%	R	R	Reported
Engagement of SUD Treatment - Total (Total)		12.74%	R	R	Reported
Prenatal and Postpartum Care (PPC)					
Timeliness of Prenatal Care		89.29%	R	R	Reported
Postpartum Care		82.24%	R	R	Reported
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)	Y				
(Total)		52.11%	R	R	Reported
Utilization and Risk Adjusted Utilization					
Well-Child Visits in the First 30 Months of Life (W30)					
(First 15 Months)		58.20%	R	R	Reported
(15 Months-30 Months)		75.13%	R	R	Reported
Child and Adolescent Well-Care Visits (WCV)					
(Total)		63.65%	R	R	Reported
Ambulatory Care (AMB)			R	R	Reported
Inpatient Utilization - General Hospital/Acute Care (IPU)			R	R	Reported
Antibiotic Utilization for Respiratory Conditions (AXR)	Y				
(Total)		25.74%	R	R	Reported
Plan All-Cause Readmissions (PCR)			R	R	Reported
Health Plan Descriptive Information					

Enrollment by Product Line (ENP)			R	R	Reported
Language Diversity of Membership (LDM)			R	R	Reported
Race/Ethnicity Diversity of Membership (RDM)			R	R	Reported
Measures Reported Using Electronic Clinical Data Systems					
Childhood Immunization Status (CIS-E)					
DTaP		64.29%	R	R	Reported
IPV		78.71%	R	R	Reported
MMR		83.39%	R	R	Reported
HiB		80.93%	R	R	Reported
Hepatitis B		72.30%	R	R	Reported
VZV		82.50%	R	R	Reported
Pneumococcal Conjugate		61.55%	R	R	Reported
Hepatitis A		71.21%	R	R	Reported
Rotavirus		55.08%	R	R	Reported
Influenza		34.76%	R	R	Reported
Combo 3		50.05%	R	R	Reported
Combo 7		36.68%	R	R	Reported
Combo 10		19.32%	R	R	Reported
Immunizations for Adolescents (IMA-E)					
Meningococcal		85.07%	R	R	Reported
Tdap		88.73%	R	R	Reported
HPV		27.18%	R	R	Reported
Combination 1		83.87%	R	R	Reported
Combination 2		25.64%	R	R	Reported
Breast Cancer Screening (BCS-E)					
Breast Cancer Screening		56.95%	R	R	Reported
Cervical Cancer Screening (CCS-E)					
Cervical Cancer Screening		57.50%	R	R	Reported
Colorectal Cancer Screening (COL-E)					
(Total)		38.97%	R	R	Reported
Follow-Up Care for Children Prescribed ADHD Medication (ADD-E)	Y				
Initiation Phase		35.13%	R	R	Reported
Continuation and Maintenance Phase		39.33%	R	R	Reported
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	Y				
Blood Glucose Testing (Total)		57.90%	R	R	Reported
Cholesterol Testing (Total)		43.30%	R	R	Reported
Blood Glucose and Cholesterol Testing (Total)		41.92%	R	R	Reported
Depression Screening and Follow-Up for Adolescents and Adults (DSF-E)					
Depression Screening (Total)		0.02%	R	R	Reported
Follow-Up on Positive Screen (Total)		66.67%	NA	R	Reported
Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults (DMS-E)					
Utilization of PHQ-9-Total (Total)		0.06%	R	R	Reported
Depression Remission or Response for Adolescents and Adults (DRR-E)					

Follow-Up PHQ-9 (Total)			NA	R	Reported
Depression Remission (Total)			NA	R	Reported
Depression Response (Total)			NA	R	Reported
Unhealthy Alcohol Use Screening and Follow-Up (ASF-E)					
Unhealthy Alcohol Use Screening (Total)		0.00%	R	R	Reported
Alcohol Counseling or Other Follow-Up Care (Total)			NA	R	Reported
Adult Immunization Status (AIS-E)					
Influenza (19-65)		13.06%	R	R	Reported
Influenza (66+)		36.99%	R	R	Reported
Influenza (Total)		15.31%	R	R	Reported
Td/Tdap (19-65)		26.75%	R	R	Reported
Td/Tdap (66+)		15.34%	R	R	Reported
Td/Tdap (Total)		25.68%	R	R	Reported
Zoster (50-65)		5.56%	R	R	Reported
Zoster (66+)		7.77%	R	R	Reported
Zoster (Total)		6.23%	R	R	Reported
Pneumococcal (66+)		37.65%	R	R	Reported
Prenatal Immunization Status (PRS-E)					
Influenza		13.71%	R	R	Reported
Tdap		30.06%	R	R	Reported
Combination		9.11%	R	R	Reported
Prenatal Depression Screening and Follow-Up (PND-E)					
Depression Screening		0.00%	R	R	Reported
Follow-Up on Positive Screen			NA	R	Reported
Postpartum Depression Screening and Follow-Up (PDS-E)					
Depression Screening		0.00%	R	R	Reported
Follow-Up on Positive Screen			NA	R	Reported
Social Need Screening and Intervention (SNS-E)					
Food Screening (Total)		4.95%	R	R	Reported
Food Intervention (Total)		5.17%	R	R	Reported
Housing Screening (Total)		3.67%	R	R	Reported
Housing Intervention (Total)		0.00%	R	R	Reported
Transportation Screening (Total)		3.71%	R	R	Reported
Transportation Intervention (Total)		0.25%	R	R	Reported

WPNJ 2024 ISCA Summary of Findings

Assessment Topic	WPNJ Assessment Finding	Review Note
Completeness and accuracy of encounter data collected and submitted to the State	Met	WPNJ has adequate checks and audit processes in place to monitor the submission of encounter data. WPNJ's timeliness and State acceptance rates for all encounter types are all above 98.00%. No issues were noted in the WPNJ's encounter data submission and reconciliation processes.
Validation and/or calculation of performance measures	Met	WPNJ uses Quality Engine® for HEDIS, CMS Adult and Child Core Set and NJ State-specific performance measures, ECDS, and race and ethnicity reporting. WPNJ's loads all data elements in the input files needed for calculation of performance measures into Quality Engine. Regarding HEDIS ECDS performance measures, WPNJ follows the prescribed NCQA hierarchy order for the inclusion of supplemental data sources. No issues were noted in validation and calculation processes for the required performance measures.
Completeness and accuracy of tracking of member grievances	Met	No issues were noted in WPNJ's systems used for handling grievances and for reporting Table 3B, a report of all non-Utilization Management (UM) member grievance requests and dispositions; Table 3C, a report of all non-UM provider grievance and appeal requests and dispositions; and Table H2A, a report of UM and appeals for FIDE SNP. WPNJ indicated that all grievances make it to the reports sent to DMAHS and no challenges transferring information from a call center to the report or producing the report otherwise were reported.
NJ Appointment Assistance Form	Met	WPNJ demonstrated the NJ Appointment Assistance Form on their member portal, available in English and Spanish and confirmed that the member portal had an option for the member to select whether a grievance should be filed. No issues were noted.
Utility of the information system to conduct MCO quality assessment and improvement initiatives	Met	WPNJ's information systems support various data reporting requests, both internally and externally.
Ability of the information system to conduct MCO quality assessment and improvement initiatives	Met	WPNJ's information systems can conduct quality assessments and conduct improvement initiatives.
Ability of the information system to oversee and manage the	Met	WPNJ receives and processes the daily 834 eligibility files. The 834 daily eligibility files are loaded into Facets®.

Assessment Topic	WPNJ Assessment Finding	Review Note
delivery of health care to the MCO's enrollees		WPNJ uniquely identifies members. WPNJ can track members who switch product lines, track the member's initial enrollment date, and can track and link previous claims/encounter data across product lines for the purposes of performance measure reporting. No issues were noted in WPNJ's systems or enrollment processes.
Validation and/or calculation of network adequacy reports	Met	WPNJ utilizes Quest Analytics® and Facets® software for assessing, monitoring and reporting network adequacy across geographic areas based on NJ's distance and time standards. ABHNJ submits quarterly reports to NJ. WPNJ submitted multiple waiver requests to DMAHS for pediatric sub-specialties for network gaps with providers' availability, time, and distance.
Identification and reporting of NCQA's and CMS' race and ethnicity categories	Partially Met	In addition to using the 834 as a direct source, E-tech is used as an indirect source. For FIDE SNP members, the MCO also receives race data from CMS. WPNJ began using a Social Determinants of Health (SDoH) system that contains data from various resources. During the virtual meeting, WPNJ advised that for MY 2023, Cotiviti's Quality Engine® could not capture more than one race for a member. Cotiviti's Quality Engine®'s ability to capture race data has been expanded and should be able to capture multiple race values for a member for MY 2024.

Assessment Level Definitions

Assessment Levels	Definition
Met	MCO met or exceeded standards.
Partially Met	MCO met some of the standards and demonstrates opportunities for improvement.
Not Met	MCO did not meet the standards and a corrective action plan is required.
Not Applicable	Standard does not apply.

Appendix B – ABHNJ 2024 Core Medicaid and MLTSS Care Management Audit Reports

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
Office of Quality Assurance

MCO Care Management Audit and Annual Assessment
Aetna Better Health of New Jersey

Review Period: January 1, 2023 to December 31, 2023

September 2024

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MCO Care Management Audit and Annual Assessment

Introduction

The purpose of the Care Management Audit and Annual Assessment was to evaluate the effectiveness of the contractually required Care Management program. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) established Care Management requirements to ensure that the services provided to Enrollees with special health care needs are consistent with professionally recognized standards of care. The populations included in this audit include General Population (GP) Enrollees, Enrollees under the Division of Developmental Disabilities (DDD), and Enrollees under the Division of Child Protection and Permanency (DCP&P).

Annually, DMAHS evaluates Managed Care Organization (MCO) performance against these requirements through its External Quality Review Organization (EQRO) Contractor. The results of these audits are used to improve MCO performance.

MCO Care Management Chart Audit

Methodology

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

Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the prior year's report, NJ FamilyCare contract references, NJ Care Management Workbook, and CDC Immunization Schedules. For 2024, at the direction of DMAHS, the MCO Care Management audit evaluation process changed for GP, DDD, and DCP&P Enrollees. For the GP population, IPRO evaluated Enrollees new to the MCO and new to Care Management between 1/1/2023 and 11/16/2023 and existing Enrollees enrolled in Care Management between 3/1/2023 and 11/16/2023. For the DDD and DCP&P populations, IPRO evaluated newly eligible Enrollees new to Care Management during the 2023 review period and existing eligible Enrollees enrolled in Care Management prior to 1/1/2023. Audit questions are limited exclusively to 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool, where appropriate, to determine whether an Enrollee met the criteria for a subsequent section or question. Therefore, for some audit questions, Enrollees represented in the numerator and denominator represent only those who met the specific applicable criteria.

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

Population Selection

The sample was determined by excluding Enrollees with Third Party Liability (TPL) from the three populations, all pregnant members from the General Population, and applying the sampling methodology described below. The sampling methodology, as shown in **Table 1**, resulted in the selection of 253 cases for Aetna Better Health of New Jersey (ABHNJ).

Using a conservative assumption of a 65% proportion, a sample size of 100 was selected to yield sufficient statistical power to produce a 95% confidence interval, with a 10% margin of error. The confidence interval provides the range within which there is a 95% probability that the true rate falls between the lower rate and the upper rate of the confidence interval. Higher rates lead to smaller ranges in confidence intervals.

A random sample of 107 Enrollees for the General Population (including a 7% oversample required for substitutions or exclusions) was selected, as the total eligible population submitted was less than 130. A random sample of 130 Enrollees for the DDD Population and 130 Enrollees for the DCP&P Population (including a 30% oversample required for substitutions or exclusions) was selected.

Table 1: Sampling Methodology

Population Criteria	General Population (GP)	DDD	DCP&P
Criteria	Using the criteria below, the MCO will provide two (2) listings of ALL eligible New and Existing Enrollees (exclude DDD, DCP&P, all pregnant Enrollees, and TPL). IPRO will pull a random sample of 65 Enrollees new to the MCO and Care Management anytime between 1/1/2023 through 11/16/2023 and 65 existing Enrollees new to Care Management between 3/1/2023 through 11/16/2023 from the universes provided.** **Random sample size modified by IPRO.	Using the appropriate Capitation Codes and the criteria below, the MCO will provide two (2) listings (exclude TPL) for: 1 - ALL New eligible DDD Enrollees in Care Management and; 2 - ALL Existing eligible DDD Enrollees in Care Management IPRO will select a random sample of 130 new and existing DDD Enrollees in Care Management per MCO from the universes provided.** **Random sample size modified by IPRO.	Using the appropriate Capitation Codes and the criteria below, the MCO will provide two (2) listings (exclude TPL) for: 1 - ALL New eligible DCP&P Enrollees in Care Management and; 2 - ALL Existing eligible DCP&P Enrollees in Care Management IPRO will select a random sample of 130 new and existing DCP&P Enrollees in Care Management per MCO from the universes provided.** **Random sample size modified by IPRO.
Age	>=6 months as of 12/31/2023	>= 6 months as of 12/31/2023	>= 6 months and < 18 years as of 12/31/2023
Sex	Both	Both	Both
Enrollment in MCO • New Enrollees	Initial enrollment between 1/1/2023 to 6/30/2023	Initial enrollment between 1/1/2023 and 6/30/2023	Initial enrollment between 1/1/2023 and 6/30/2023
• Existing Enrollees	Enrolled prior to 1/1/2023	Enrolled prior to 1/1/2023	Enrolled prior to 1/1/2023
Current Enrollment	Enrolled as of 12/31/2023 and with the same MCO for 6 months during the review period.	Enrolled as of 12/31/23 and with the same MCO for 6 months during the review period.	Enrolled as of 12/31/23 and with the same MCO for 6 months during the review period.
Continuous Enrollment Criteria	Enrolled in same population and same MCO through 12/31/2023 allowing no more than a one-month gap.	Enrolled in same population and same MCO at least 6 months in 2023 allowing one gap <= 45 days. Gap is not permissible at the beginning or the end of the enrollment time period. Where Enrollee meets enrollment criteria for 2 MCOs in 2023, the later MCO enrollment is selected.	Enrolled in same population and same MCO at least 6 months in 2023 allowing one gap <= 45 days. Gap is not permissible at the beginning or the end of the enrollment time period. Where Enrollee meets enrollment criteria for 2 MCOs in 2023 the later MCO enrollment is selected.

Introductory E-Mail

For this year's audit, the evaluation included an audit review for three (3) sampled populations. IPRO sent an Introductory E-Mail to the MCO prior to the offsite desk audit including:

- A description of the current year audit process and specifications for each population.
- File listings identifying the files that needed to be submitted to IPRO, along with instructions for preparing the files and uploading the files to IPRO's S.E.N.D. FTP site.

Audit Activities

IPRO reviewers conducted the file reviews over a five-week period. Reviewer inter-rater reliability was maintained through use of the standardized Audit Tool, and ongoing communication and coordination among the review team.

Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report. MCOs were not permitted to submit additional information after the offsite audit.

Audit Results

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in Table 2, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

ABHNJ's 2024 CM Audit results for the review period 1/1/2023 to 12/31/2023 ranged from 72.1% to 100% across all populations for the five audit categories.

Table 2: Aggregate Results by Category

Determination by Category	GP (n=98)	DDD (n=100)	DCP&P (n=55)
Identification[1]	72.1%		
Outreach[2,3]	100.0%	88.2%	100.0%
Preventive Services[3]	100.0%	85.0%	82.8%
Continuity of Care[3]	98.1%	78.5%	86.8%
Coordination of Services[3]	98.5%	81.0%	91.3%

[1]The Identification category is not evaluated for New and Existing DDD and DCP&P Enrollees, or Existing GP Enrollees.
[2]The Outreach category is evaluated for Enrollee files with no CNA or untimely completion of the CNA.
[3]Aggregate scores represent a combination of New and Existing population specific rates.

GP Population Findings

Identification

The Identification category applies to GP Enrollees new to the MCO and new to Care Management between 1/1/2023 and 11/16/2023. There are 33 Enrollees new to the MCO and new to Care Management during the review period.

Table 3: Identification – GP Population- Enrollees New to the MCO and New to Care Management

Identification	General Population		
	Numerator	Denominator	Rate
Enrollee has an Initial Health Screen (IHS) on file and/or an IHS score documented in the file that was completed during the review period (1/1/2023 to 12/31/2023).*	33	33	100.0%
For IHS on file, IHS was completed for the Enrollee within 45 days of MCO enrollment date.	21	33	63.6%
For no IHS on file, the MCO made outreach attempts to complete the IHS.*	0	0	N/A
For Enrollees where no IHS was on file, initial outreach to complete the IHS was successful (even if Enrollee declined to complete the IHS).*	0	0	N/A
For Enrollees where no IHS was on file, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment.	0	0	N/A
Enrollees who scored less than 5 on the IHS or no IHS on file.*	10	33	30.3%
Enrollees identified by the Plan as having Care Management needs through additional sources (applies to Enrollees new to the MCO and new to CM where the IHS score is less than 5 or no IHS on file).	10	10	100.0%

**Not Included in aggregate score calculation*
N/A: Not Applicable

Outreach

The Outreach category applies to new GP Enrollees (33) enrolled in Care Management between 1/1/2023 and 11/16/2023 and existing GP Enrollees (65) enrolled in Care Management between 3/1/2023 and 11/16/2023.

Table 4: Outreach – General Population – New and Existing Enrollees enrolled in Care Management

Outreach	General Population – New Enrollees			General Population – Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The MCO completed a Comprehensive Needs Assessment (CNA) during the review period.*	33	33	100.0%	65	65	100.0%
The Enrollee was unable to reach to complete the CNA.*	0	0	N/A	0	0	N/A
The MCO completed the CNA timely.*	30	33	90.9%	61	65	93.8%
Initial outreach to complete a CNA was performed.[1]	3	3	100.0%	4	4	100.0%
Initial outreach to complete the CNA was done timely, within 30 days of identification of CM needs. (30 days from IHS score 5 or greater; or IHS less than 5, no IHS, identification of CM needs through other sources).	3	3	100.0%	4	4	100.0%

Outreach	General Population – New Enrollees			General Population – Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Initial outreach to complete a CNA was successful (even if the Enrollee declined to complete the CNA).*	1	3	33.3%	1	4	25.0%
The MCO performed and documented aggressive outreach attempts to complete a CNA.*	2	2	100.0%	2	3	66.7%
For CNAs not completed timely or no CNA, aggressive outreach attempts were made timely (30 days from IHS score 5 or greater or identification of CM needs through other sources).	2	2	100.0%	2	2	100.0%
Upon any successful outreach to the Enrollee, the Enrollee opted out of Care Management.*	3	33	9.1%	0	65	0.0%
Enrollee became lost to contact during the review period.*	0	33	0.0%	1	65	1.5%
For Enrollees who were lost to contact, aggressive outreach attempts were made and documented by the Care Manager.	0	0	N/A	1	1	100.0%

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollee files with no CNA or a CNA completed untimely. All CNAs were completed for the entire sample for new (33) and existing (65) GP Enrollees. The denominator in this measure represents the 3 untimely CNAs for new GP Enrollees and 4 untimely CNAs for existing GP Enrollees.

N/A: Not Applicable

Preventive Services

The Preventive Services category applies to new GP Enrollees (33) enrolled in Care Management between 1/1/2023 and 11/16/2023 and existing GP Enrollees (65) enrolled in Care Management between 3/1/2023 and 11/16/2023.

Table 5: Preventive Services – General Population- New and Existing Enrollees enrolled in Care Management

Preventive Services	General Population - New Enrollees			General Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The Enrollee's EPSDT[1] exam is up to date per periodicity exam schedule (aged 0 through 20).*	7	10	70.0%	20	20	100.0%
The Enrollee's EPSDT status is confirmed by a reliable source (aged 0 through 20).	7	7	100.0%	20	20	100.0%
Aggressive outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	3	3	100.0%	0	0	N/A
The Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	3	3	100.0%	0	0	N/A
The Enrollee or legal guardian refused immunizations (aged 0 to 18).*	1	8	12.5%	2	20	10.0%
The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18).*	3	7	42.9%	15	18	83.3%
The Enrollee's immunization status is confirmed by a reliable source (aged 0 through 18).	3	3	100.0%	15	15	100.0%
Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18).	4	4	100.0%	3	3	100.0%
The Enrollee or legal guardian refused immunizations (aged 19 and above).*	8	25	32.0%	12	45	26.7%
Appropriate vaccines have been administered for Enrollees (aged 19 and above).*	4	17	23.5%	8	33	24.2%
Aggressive outreach attempts were documented to confirm immunization status for Enrollees (aged 19 and above).	13	13	100.0%	25	25	100.0%

Preventive Services	General Population - New Enrollees			General Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The Care Manager addressed and/or discussed dental needs with Enrollees (aged 21 and above).	23	23	100.0%	45	45	100.0%
A dental visit occurred during the review period for Enrollees (aged 1 through 20).*	4	9	44.4%	13	19	68.4%
Care Manager made attempts to obtain dental status for Enrollees without a confirmed dental visit (aged 1 through 20).	5	5	100.0%	6	6	100.0%
Dental reminders were sent to Enrollees without a confirmed dental visit (aged 1 through 20).	5	5	100.0%	6	6	100.0%

**Not Included in aggregate score calculation*
[1]EPSDT: Early and Periodic Screening, Diagnostic and Treatment
N/A: Not Applicable

Continuity of Care

The Continuity of Care category applies to new GP Enrollees (33) enrolled in Care Management between 1/1/2023 and 11/16/2023 and existing GP Enrollees (65) enrolled in Care Management between 3/1/2023 and 11/16/2023.

Table 6: Continuity of Care – General Population - New and Existing Enrollees enrolled in Care Management

Continuity of Care	General Population - New Enrollees			General Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The MCO completed a CNA during the review period.*	33	33	100.0%	65	65	100.0%
The CNA contained all elements of the State approved CNA tool.	33	33	100.0%	65	65	100.0%
The Comprehensive Needs Assessment was completed timely (within 30 days of identification of CM needs).	30	33	90.9%	61	65	93.8%
The Care Manager documented a level of Care Management for the Enrollee during the review period.	33	33	100.0%	65	65	100.0%
The Enrollee is in Community Based Care Management (CBCM).[1]*	0	33	0.0%	0	65	0.0%
The Enrollee has a Care Plan on file during the review period.	33	33	100.0%	64	65	98.5%
A Care Plan was completed for the Enrollee that included all required components.	33	33	100.0%	64	64	100.0%
The Care Plan was developed within 30 days of CNA completion.[2]	31	33	93.9%	64	64	100.0%
The Enrollee's Care Plan was reviewed/monitored during the review period.	31	33	93.9%	63	64	98.4%
The Enrollee had a change in care needs or circumstances during the review period.*	2	33	6.1%	1	64	1.6%
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances.	2	2	100.0%	1	1	100.0%
Enrollee demonstrated needs requiring a comprehensive treatment plan.*	0	33	0.0%	0	65	0.0%
The Enrollee had a comprehensive treatment plan documented to address the Enrollee's specific care needs.	0	0	N/A	0	0	N/A
The comprehensive treatment plan progressed in a timely manner without unreasonable interruption.	0	0	N/A	0	0	N/A

**Not Included in aggregate score calculation*
[1] Community Based Care Management (CBCM) resumed in October 2023 following the end of the Public Health Emergency.

[2]This measure is evaluated for Enrollee's with a Care Plan and a CNA on file during the review period.
N/A: Not Applicable

Coordination of Services

The Coordination of Services category applies to new GP Enrollees (33) enrolled in Care Management between 1/1/2023 and 11/16/2023 and existing GP Enrollees (65) enrolled in Care Management between 3/1/2023 and 11/16/2023.

Table 7: Coordination of Services – General Population - New and Existing Enrollees enrolled in Care Management

Coordination of Services	General Population- New Enrollees			General Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF[1], CSOC[2], CMOs[3], Special Child Health Services (under DOH[4]) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD).	3	3	100.0%	7	7	100.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services.	27	27	100.0%	37	37	100.0%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee.	13	13	100.0%	13	13	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed.	9	10	90.0%	26	27	96.3%

[1]DCF: Department of Children and Families
[2]CSOC: Children's System of Care
[3]CMOs: Care Management Organizations
[4]DOH: Department of Health

DDD Population Findings

Outreach

The Outreach category applies to new DDD Enrollees (50) in Care Management during the 2023 review period. The Outreach category is not evaluated for the existing DDD Enrollees in Care Management.

Table 8: Outreach – DDD Population - Enrollees New to the MCO and New to Care Management

Outreach	DDD Population		
	Numerator	Denominator	Rate
The MCO completed a Comprehensive Needs Assessment (CNA) during the review period.*	24	50	48.0%
The Enrollee was unable to reach to complete the CNA.*	14	26	53.8%
The MCO completed the CNA timely (within 45 days of MCO enrollment date).*	23	24	95.8%
Initial outreach to complete a CNA was performed.[1]	24	27	88.9%
Initial outreach to complete the CNA was done timely, within 45 days from the Enrollee's enrollment date.	20	24	83.3%
Initial outreach to complete the CNA was successful (even if the Enrollee declines to complete the CNA).*	7	24	29.2%
The MCO performed aggressive outreach to complete a CNA.*	17	17	100.0%
Aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment.	16	17	94.1%
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA.*	9	12	75.0%
Upon any successful outreach to the Enrollee, the Enrollee declined Care Management.*	9	12	75.0%

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollee files with no CNA or a CNA completed untimely. The denominator for this measure includes 26 files with no CNA and 1 file with a CNA completed untimely.

Preventive Services

The Preventive Services category applies to new DDD Enrollees (50) and existing DDD Enrollees (50) in Care Management during the 2023 review period.

Table 9: Preventive Services – DDD Population - New and Existing Enrollees enrolled in Care Management

Preventive Services	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The Enrollee's EPSDT[1] exam is up to date per periodicity exam schedule (aged 0 through 20).*	15	22	68.2%	7	13	53.8%
The Enrollee's EPSDT status is confirmed by a reliable source (aged 0 through 20).	15	15	100.0%	7	7	100.0%
Aggressive outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	7	7	100.0%	6	6	100.0%
The Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	4	7	57.1%	4	6	66.7%

Preventive Services	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The Enrollee or legal guardian refused immunizations (aged 0 to 18).*	1	17	5.9%	1	11	9.1%
The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18).*	8	16	50.0%	4	10	40.0%
The Enrollee's immunization status is confirmed by a reliable source (aged 0 through 18).	8	8	100.0%	4	4	100.0%
Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18).	8	8	100.0%	6	6	100.0%
The Enrollee or legal guardian refused immunizations (aged 19 and above).*	4	33	12.1%	3	39	7.7%
Appropriate vaccines have been administered for Enrollees (aged 19 and above).*	11	29	37.9%	9	36	25.0%
Aggressive outreach attempts were documented to confirm immunization status for Enrollees (aged 19 and above).	17	18	94.4%	24	27	88.9%
The Care Manager addressed and/or discussed dental needs with Enrollees (aged 21 and above).	22	28	78.6%	27	37	73.0%
A dental visit occurred during the review period for Enrollees (aged 1 through 20).*	11	22	50.0%	3	13	23.1%
Care Manager made attempts to obtain dental status for Enrollees without a confirmed dental visit (aged 1 through 20).	10	11	90.9%	9	10	90.0%
Dental reminders were sent to Enrollees without a confirmed dental visit (aged 1 through 20).	6	11	54.5%	8	10	80.0%

**Not Included in aggregate score calculation*

[1]EPSDT: Early and Periodic Screening, Diagnostic and Treatment

Continuity of Care

The Continuity of Care category applies to new DDD Enrollees (50) and existing DDD Enrollees (50) in Care Management during the 2023 review period. Gray shading represents elements that are not evaluated for existing DDD Enrollees in Care Management.

Table 10: Continuity of Care – DDD Population - New and Existing Enrollees enrolled in Care Management

Continuity of Care	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The MCO completed a CNA during the review period.*	24	50	48.0%			
The CNA contained all elements of the State approved CNA tool.	24	24	100.0%			
The Comprehensive Needs Assessment was completed timely, within 45 days of Enrollee's MCO enrollment date.	23	24	95.8%			
The Care Manager documented a level of Care Management for the Enrollee during the review period.	24	24	100.0%	34	50	68.0%
The Enrollee is in Community Based Care Management (CBCM).[1]*	2	50	4.0%	1	50	2.0%
The Enrollee has a Care Plan on file during the review period.	36	50	72.0%	20	50	40.0%
A Care Plan was completed for the Enrollee that included all required components.	36	36	100.0%	20	20	100.0%

Continuity of Care	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The Care Plan was developed within 30 days of CNA completion.[2]	22	24	91.7%			
The Enrollee's Care Plan was reviewed/monitored during the review period.	24	36	66.7%	18	20	90.0%
The Enrollee had a change in care needs or circumstances during the review period.*	0	36	0.0%	0	20	0.0%
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances.	0	0	N/A	0	0	N/A
Enrollee demonstrated needs requiring a comprehensive treatment plan.*	0	50	0.0%	0	50	0.0%
The Enrollee had a comprehensive treatment plan documented to address the Enrollee's specific care needs.	0	0	N/A	0	0	N/A
The comprehensive treatment plan progressed in a timely manner without unreasonable interruption.	0	0	N/A	0	0	N/A

**Not Included in aggregate score calculation*

[1] Community Based Care Management (CBCM) resumed in October 2023 following the end of the Public Health Emergency.

[2]This measure is evaluated for Enrollee's with a Care Plan and a CNA on file during the review period.

N/A: Not Applicable

Coordination of Services

The Coordination of Services category applies to new DDD Enrollees (50) and existing DDD Enrollees (50) in Care Management during the 2023 review period.

Table 11: Coordination of Services – DDD Population- New and Existing Enrollees enrolled in Care Management

Coordination of Services	DDD Population - New Enrollees			DDD Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF[1], CSOC[2], CMOs[3], Special Child Health Services (under DOH[4]) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD).	43	50	86.0%	30	50	60.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services.	20	20	100.0%	12	12	100.0%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee.	17	17	100.0%	6	6	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed.	2	2	100.0%	1	2	50.0%
For Enrollees who were hospitalized with a mental/behavioral health diagnosis and discharged prior to 12/1/2023 the Care Manager documented	0	1	0.0%	0	1	0.0%

Coordination of Services	DDD Population - New Enrollees			DDD Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
evidence of follow up with the mental/behavioral health provider within 30 days of discharge.						
The Care Manager made aggressive attempts to determine follow up status with a mental/ behavioral health provider for Enrollees hospitalized with a mental/behavioral health diagnosis.	1	1	100.0%	0	1	0.0%

[1]DCF: Department of Children and Families
[2]CSOC: Children's System of Care
[3]CMOs: Care Management Organizations
[4]DOH: Department of Health

DCP&P Population Findings

Outreach

The Outreach category applies to new DCP&P Enrollees (31) in Care Management during the 2023 review period. The Outreach category is not evaluated for the existing DCP&P Enrollees in Care Management.

Table 12: Outreach – DCP&P Population – Enrollees New to the MCO and New to Care Management

Outreach	DCP&P Population		
	Numerator	Denominator	Rate
The MCO completed a Comprehensive Needs Assessment (CNA) during the review period.*	26	31	83.9%
The Enrollee was unable to reach to complete the CNA.*	5	5	100.0%
The MCO completed the CNA timely, within 45 days of MCO enrollment date.*	19	26	73.1%
Initial outreach to complete a CNA was performed.[1]	12	12	100.0%
Initial outreach to complete the CNA was timely, within 45 days from the Enrollee's enrollment date.	12	12	100.0%
Initial outreach was successful (even if the Enrollee declines to complete the CNA).*	1	12	8.3%
The MCO performed aggressive outreach to complete a CNA.*	11	11	100.0%
Aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment.	11	11	100.0%
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA.*	0	0	N/A

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollee files with no CNA or a CNA completed untimely. The denominator includes 5 files with no CNA and 7 files with a CNA completed untimely.

N/A: Not Applicable

Preventive Services

The Preventive Services category applies to new DCP&P Enrollees (31) and existing DCP&P Enrollees (24) in Care Management during the 2023 review period.

Table 13: Preventive Services – DCP&P Population – New and Existing Enrollees enrolled in Care Management

Preventive Services	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The Enrollee's EPSDT[1] exam is up to date per periodicity exam schedule (aged 0 through 20).*	24	31	77.4%	18	24	75.0%
The Enrollee's EPSDT status is confirmed by a reliable source (aged 0 through 20).	24	24	100.0%	18	18	100.0%
Aggressive outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	7	7	100.0%	3	6	50.0%
The Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	5	7	71.4%	0	6	0.0%
The Enrollee or legal guardian refused immunizations (aged 0 to 18).*	0	31	0.0%	0	24	0.0%
The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18).*	12	31	38.7%	12	24	50.0%

Preventive Services	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The Enrollee's immunization status is confirmed by a reliable source (aged 0 through 18).	12	12	100.0%	12	12	100.0%
Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18).	19	19	100.0%	9	12	75.0%
A dental visit occurred during the review period for Enrollees (aged 1 through 20).*	19	28	67.9%	18	23	78.3%
Care Manager made attempts to obtain dental status for Enrollees without a confirmed dental visit (aged 1 through 20).	9	9	100.0%	2	5	40.0%
Dental reminders were sent to Enrollees without a confirmed dental visit (aged 1 through 20).	4	9	44.4%	1	5	20.0%

**Not Included in aggregate score calculation*

[1]EPSDT: Early and Periodic Screening, Diagnostic and Treatment

Continuity of Care

The Continuity of Care category applies to new DCP&P Enrollees (31) and existing DCP&P Enrollees (24) in Care Management during the 2023 review period. Gray shading represents elements that are not evaluated for existing DCP&P Enrollees in Care Management.

Table 14: Continuity of Care – DCP&P Population – New and Existing Enrollees enrolled in Care Management

Continuity of Care	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The MCO completed a CNA during the review period.*	26	31	83.9%			
The completed CNA contained all elements of the State approved CNA tool.	26	26	100.0%			
The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment).	19	26	73.1%			
The Care Manager documented a level of Care Management for the Enrollee during the review period.	26	26	100.0%	16	24	66.7%
The Enrollee has a Care Plan on file during the review period.	26	31	83.9%	14	24	58.3%
A Care Plan was completed for the Enrollee that included all required components.	26	26	100.0%	14	14	100.0%
The Care Plan was developed within 30 days of CNA completion.[1]	26	26	100.0%			
The Enrollee's Care Plan was reviewed/monitored during the review period.	23	26	88.5%	12	14	85.7%
The Enrollee had a change in care needs or circumstances during the review period.*	1	26	3.8%	1	14	7.1%
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances.	1	1	100.0%	1	1	100.0%
Enrollee demonstrated needs requiring a comprehensive treatment plan.*	0	31	0.0%	0	24	0.0%
The Enrollee had a comprehensive treatment plan documented to address the Enrollee's specific care needs.	0	0	N/A	0	0	N/A
The comprehensive treatment plan progressed in a timely manner without unreasonable interruption.	0	0	N/A	0	0	N/A

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollee's with a Care Plan and a CNA on file during the review period.
N/A: Not Applicable

Coordination of Services

The Coordination of Services category applies to new DCP&P Enrollees (31) and existing DCP&P Enrollees (24) in Care Management during the 2023 review period.

Table 15: Coordination of Services – DCP&P Population - New and Existing Enrollees enrolled in Care Management

Coordination of Services	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF[1], CSOC[2], CMOs[3], Special Child Health Services (under DOH[4]) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD).	31	31	100.0%	20	24	83.3%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services.	7	7	100.0%	3	5	60.0%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee.	12	12	100.0%	6	7	85.7%
For Enrollees who were hospitalized, adequate discharge planning was performed.	3	3	100.0%	2	3	66.7%

[1]DCF: Department of Children and Families
[2]CSOC: Children's System of Care
[3]CMOs: Care Management Organizations
[4]DOH: Department of Health

Limitations

ABHNJ had a combined total of 75 file exclusions for the DCP&P Population new and existing Enrollees. As a result, the total files reviewed are 31 (new Enrollees) and 24 (existing Enrollees). Audit results should be considered cautiously due to the low sample sizes.

Conclusions

Overall, the MCO scored 85% or above in the following review categories (**Table 2**):

- Outreach (General Population) (100.0%)
- Outreach (DDD Population) (88.2%)
- Outreach (DCP&P Population) (100.0%)

- Preventive Services (General Population) (100.0%)
- Preventive Services (DDD Population) (85.0%)

- Continuity of Care (General Population) (98.1%)
- Continuity of Care (DCP&P Population) (86.8%)

- Coordination of Services (General Population) (98.5%)
- Coordination of Services (DCP&P Population) (91.3%)

Overall, the MCO scored below 85% in the following categories (**Table 2**):

- Identification (General Population) (72.1%)

- Preventive Services (DCP&P Population) (82.8%)

- Continuity of Care (DDD Population) (78.5%)

- Coordination of Services (DDD Population) (81.0%)

MCO Care Management Annual Assessment

Assessment Methodology

The Care Management Annual Assessment consisted of pre-audit review of documentation provided by Aetna Better Health of New Jersey, as evidence of compliance of the standard under review; audit review of random file samples for the GP, DDD, and DCP&P Populations; interviews with key ABHNJ staff via TEAMS held on May 29, 2024; and post audit evaluation of documentation and audit activities.

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

The documentation for the audit review was requested by IPRO on March 8, 2024, and documentation was received from the MCO on March 29, 2024. The documentation review occurred offsite at IPRO beginning on April 1, 2024. The audit review team was made up of Carla Zuccarello, Sue Williams, and Cynthia Santangelo. The Care Management assessment covered the period from January 1, 2023 to December 31, 2023.

During the audit review, the Plan had the opportunity to provide supplemental documentation as requested by IPRO.

Table 16 shows the rating scale used to determine compliance.

Table 16: Rating Scale for the Annual Care Management Assessment

Rating	Rating Methodology
Met	All parts within this element were met.
Not Met	Not all the required parts within the element were met.
N/A	This element is not applicable and will not be considered as part of the score.
Met Prior Review	This element was met in the previous review cycle.
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.

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

There are 30 elements in this review based on Contractual provisions, which are subject to review annually. ABHNJ received an overall compliance score of 77% in 2024. In 2023, the MCO received a score of 70%. Review of the elements CM2, CM4, CM5, CM6, CM7, CM8, CM11, CM14, CM15, CM16, CM17, and CM19 was based on results from the Core Medicaid CM Audit conducted in 2024. Where appropriate, assessment of other elements was informed by both documents submitted for review and the file review. This audit evaluated Core Medicaid CM files for calendar year 2023 for three populations, namely the Enrollees under the General Population (GP), Division of Developmental Disabilities (DDD), and the Division of Child Protection and Permanency (DCP&P).

Care Management Assessment Results

Table 17 presents an overview of ABHNJ's Care Management Annual Assessment results; **Table 18** presents Contract language and reviewer comments for deficient element(s); and **Table 19** presents Contract language for resolved deficiencies.

Table 17: Summary of Findings for Care Management Annual Assessment

Element	Met Prior Review	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM1	X	X	-	-	-	-	-
CM2	-	-	X	-	X	-	-
CM3	-	X	-	-	-	X	-
CM4	X	X	-	-	-	-	-
CM5	X	X	-	-	-	-	-
CM6	-	-	X	-	X	-	-
CM7	-	-	X	-	X	-	-
CM8	-	X	-	-	-	X	-
CM9	X	X	-	-	-	-	-
CM10	X	X	-	-	-	-	-
CM11	-	X	-	-	-	X	-
CM12	X	X	-	-	-	-	-
CM13	X	X	-	-	-	-	-
CM14	-	-	X	-	X	-	-
CM15	-	X	-	-	-	X	-
CM16	X	-	X	-	-	-	X
CM17	-	X	-	-	-	X	-
CM18a	X	X	-	-	-	-	-
CM18c	X	X	-	-	-	-	-

Element	Met Prior Review	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM18d	X	X	-	-	-	-	-
CM19	X	-	X	-	-	-	X
CM20	X	X	-	-	-	-	-
CM21	X	X	-	-	-	-	-
CM22	X	X	-	-	-	-	-
CM23	X	X	-	-	-	-	-
CM24	X	X	-	-	-	-	-
CM25	X	X	-	-	-	-	-
CM26	X	X	-	-	-	-	-
CM27	X	X	-	-	-	-	-
CM37[1]	X	-	X	-	-	-	X
TOTAL	**21**	**23**	**7**	**0**	**4**	**5**	**3**
Compliance Percentage		**77%**					

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

Table 18: Findings for Deficient Care Management Elements

Element	Contract Language	Reviewer Comments
CM2	**4.6.2.J** **Discharge Planning** The Contractor shall have procedures to ensure adequate and appropriate discharge planning, and to include Coordination of Services for Enrollees with special needs.	**In the 2024 CM file audit the MCO scored for the DDD Population Enrollees:** 50.0%- For Enrollees who were hospitalized, adequate discharge planning was performed (applies to existing Enrollees). **In the 2024 CM file audit the MCO scored for the DCP&P Population Enrollees:** 66.7%- For Enrollees who were hospitalized, adequate discharge planning was performed (applies to existing Enrollees).
CM6	**4.6.5.B.1** **Identification of Enrollees Who Need Care Management** The MCO must have effective systems, policies, procedures, and practices in place to identify any Enrollee in need of Care Management services. All New Enrollees, including Enrollees who were disenrolled from the MCO for at least six (6) months, (except for DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD) will be screened using an approved Initial Health Screen tool (IHS) to quickly identify their immediate physical and/or behavioral health care needs, as well as the need for more extensive screening. Any Enrollee identified as having potential Care Management needs will receive a detailed	**In the 2024 CM file audit the MCO scored for the General Population Enrollees:** 63.6%- IHS was completed for the Enrollee within 45 days of MCO enrollment date (applies to new Enrollees).

Element	Contract Language	Reviewer Comments
	Comprehensive Needs Assessment (if deemed necessary by a healthcare professional), and ongoing care coordination and management as appropriate. All elements of the State approved IHS tool that appear in the Care Management Workbook must be included in the MCO's screening tool.	
CM7	**4.6.5. B.2** **Comprehensive Needs Assessment (CNA)** The MCO will conduct an approved CNA on New Enrollees following the evaluation by a healthcare professional of their Initial Health Screen results; any Enrollee identified as having potential Care Management needs; as well as DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD. The goal of the CNA is to identify an Enrollee's Care Management needs to determine an Enrollee's level of care and develop a Care Plan. The CNA will be conducted by a healthcare professional, either telephonically or face-to-face, depending on the Enrollee's needs. All elements of the State approved CNA tool that appears in the Care Management Workbook must be included in the MCO assessment tool. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	**In the 2024 CM file audit the MCO scored for the DDD Population Enrollees:** 83.3%- Initial outreach to complete the CNA was done timely, within 45 days from the Enrollee's enrollment date (applies to new Enrollees). 68.0%- The Care Manager documented a level of Care Management for the Enrollee during the review period (applies to existing Enrollees). **In the 2024 CM file audit the MCO scored for the DCP&P Population Enrollees:** 73.1%- The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment) (applies to new Enrollees). 66.7%- The Care Manager documented a level of Care Management for the Enrollee during the review period (applies to existing Enrollees).
CM14	**4.6.2.O** **Continuity of Care** The Contractor's Quality Management Plan shall include a continuity of care system including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as preventive services and maintenance of function for Enrollees with special needs.	**In the 2024 CM file audit the MCO scored for the DDD Population Enrollees:** 57.1%- The Care Manager sent EPSDT reminders (applies to new Enrollees aged 0 through 20 where EPSDT exam is not up to date). 66.7%- The Care Manager sent EPSDT reminders (applies to existing Enrollees aged 0 through 20 where EPSDT exam is not up to date). 78.6%- The Care Manager addressed and/or discussed dental needs with the Enrollee (applies to new Enrollees aged 21 and above).

Element	Contract Language	Reviewer Comments
		73.0%- The Care Manager addressed and/or discussed dental needs with the Enrollee (applies to existing Enrollees aged 21 and above). 54.5%- Dental reminders were sent to Enrollees (applies to new Enrollees aged 1 through 20). 80.0%- Dental reminders were sent to Enrollees (applies to existing Enrollees aged 1 through 20). **In the 2024 CM file audit the MCO scored for the DCP&P Population Enrollees:** 50.0%- Aggressive outreach attempts were documented to confirm EPSDT status (applies to existing Enrollees where EPSDT exam is not up to date aged 0 through 20). 71.4%- The Care Manager sent EPSDT reminders (applies to new Enrollees where EPSDT exam is not up to date aged 0 through 20). 0.0%- The Care Manager sent EPSDT reminders (applies to existing Enrollees where EPSDT exam is not up to date aged 0 through 20). 75%- Aggressive outreach attempts were documented to confirm immunization status (applies to existing Enrollees aged 0 through 18). 40.0%- Care Manager made attempts to obtain dental status for Enrollees without a confirmed dental visit (aged 1 through 20) (applies to existing Enrollees). 44.4%- Dental reminders were sent to Enrollees without a confirmed dental visit (aged 1 through 20) (applies to new Enrollees). 20.0%- Dental reminders were sent to Enrollees without a confirmed dental visit (aged 1 through 20) (applies to existing Enrollees).

Element	Contract Language	Reviewer Comments
CM16	**4.6.5.D.2** The Contractor shall construct and maintain policies and procedures to ensure Continuity of Care by each provider in its network.	**In the 2024 CM file audit the MCO scored for the DDD Population Enrollees:** 0.0%- For Enrollees who were hospitalized with an MH/BH diagnosis and discharged prior to 12/1/2023 the Care Manager documented evidence of follow up with the MH/BH provider within 30 days of discharge (applies to new and existing Enrollees).
CM19	**4.6.5.E** **Documentation** The Contractor shall document all contacts and linkages to medical and other services in the Enrollee's case files.	**In the 2024 CM file audit the MCO scored for the DDD Population Enrollees:** 60%- When appropriate for the applicable Enrollees, the Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD) (applies to existing Enrollees). **In the 2024 CM file audit the MCO scored for the DCP&P Population Enrollees:** 83.3%- When appropriate for the applicable Enrollees, the Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD) (applies to existing Enrollees). 60.0%- For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services (applies to existing Enrollees).
CM37	**4.7.4.A** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	**In the 2024 CM file audit the MCO received a Not Met for the General Population file universe submission.** The GP Enrollee file universe did not meet compliance with the MCO file instructions and audit specifications.

Table 19: Findings for Resolved Deficiencies for Care Management Elements

Element	Contract Language
CM3	**4.6.5.A** Apply systems, science, and information to identify Enrollees with potential Care Management needs and assist Enrollees in managing their health care more effectively with the goal of improving, maintaining, or slowing the deterioration of their health status.
CM8	**4.6.5.B.3** **Plan of Care to Address Needs Identified** Care Plan: Based on the CNA, the Care Manager will assign Enrollees to a care level, develop a Care Plan and facilitate and coordinate the care of each Enrollee according to his/her needs or circumstances. With input from the Enrollee and/or caregiver and PCP, the Care Manager must jointly create a Care Plan with short/long-term Care Management goals, specific actionable objectives, and measurable quality outcomes. The Care Plan should be culturally appropriate and consistent with the abilities and desires of the Enrollee and/or caregiver. Understanding that Enrollees' care needs and circumstances change, the Care Manager must continually evaluate the Care Plan to update and/or change it to accurately reflect the Enrollee's needs and level of care.
CM11	**4.6.5.B.6** **Modify Care Plan Based on Analysis** Following analysis, the Care Manager will modify the strategies outlined in the Care Plan to achieve its stated goals and desired outcomes. The strategies must reflect any new information received, the Enrollee's current circumstances and healthcare status, and remain consistent with the abilities, desires and level of self-direction of the Enrollee and/or caregiver.
CM15	**4.6.5.D.1** The Contractor shall establish and operate a system to assure that a comprehensive treatment plan for every Enrollee will progress to completion in a timely manner without unreasonable interruption.
CM17	**4.6.5.D.3** An Enrollee shall not suffer unreasonable interruption of his/her active treatment plan. Any interruptions beyond the control of the provider will not be deemed a violation of this requirement.

Comprehensive Recommendations

The following recommendations are for deficiencies identified in the Care Management Audit and Annual Assessment.

For the General Population:

1. CM6: ABHNJ should ensure that the IHS is completed for the Enrollee within 45 days of MCO enrollment date (applies to new Enrollees).
2. CM37: ABHNJ should establish an audit process to ensure compliance and accuracy with audit preparation and submissions to the EQRO.

For the DDD Population:

1. CM2: ABHNJ should ensure for Enrollees who are hospitalized, adequate discharge planning is performed (applies to existing Enrollees).
2. CM7: ABHNJ should ensure that initial outreach to complete the CNA is done timely, within 45 days from the Enrollee's enrollment date (applies to new Enrollees).
3. CM7: ABHNJ should ensure that a level of Care Management is documented for the Enrollee during the review period (applies to existing Enrollees).
4. CM8 *File Audit*: ABHNJ should ensure that the Enrollee has a Care Plan on file during the review period (applies to new and existing Enrollees).
5. CM8 *File Audit*: ABHNJ should ensure that the Enrollees Care Plan is reviewed/monitored during the review period (applies to new Enrollees).
6. CM14: For Enrollees aged 0 through 20, ABHNJ should ensure EPSDT reminders are sent when the Enrollees EPSDT exam is not up to date (applies to new and existing Enrollees).
7. CM14: For Enrollees aged 21 and above, ABHNJ should ensure that the Care Manager addresses/discusses dental needs with the Enrollee (applies to new and existing Enrollees).
8. CM14: For Enrollees aged 1 through 20 without a confirmed dental status, ABHNJ should ensure that dental reminders are sent (applies to new and existing Enrollees).
9. CM16: For Enrollees who were hospitalized with a mental/behavioral health diagnosis, ABHNJ should ensure that for Enrollees discharged prior to 12/1/2023, the Care Manager documents evidence of follow up with the mental/behavioral health provider within 30 days of discharge (applies to new and existing Enrollees).
10. CM16 *File Audit*: ABHNJ should ensure the Care Manager makes aggressive attempts to determine follow up status with a mental/behavioral health provider for Enrollees hospitalized with a mental/behavioral health diagnosis (applies to existing Enrollees).
11. CM19: When appropriate for the applicable Enrollees, ABHNJ should ensure the Care Manager contacts Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD) (applies to existing Enrollees).

For the DCP&P Population:

1. CM2: ABHNJ should ensure for Enrollees who are hospitalized, adequate discharge planning is performed (applies to existing Enrollees).
2. CM7: For new Enrollees, ABHNJ should ensure the Comprehensive Needs Assessment (CNA) is completed within 45 days of the Enrollees enrollment.
3. CM7: For existing Enrollees, ABHNJ should ensure the Care Manager documents a level of Care Management for the Enrollee during the review period.
4. CM8 *File Audit*: ABHNJ should ensure that the Enrollee has a Care Plan on file during the review period (applies to new and existing Enrollees).
5. CM14: For Enrollees aged 0 through 20, where the EPSDT exam is not up to date, ABHNJ should ensure that the Care Manager makes aggressive outreach attempts to confirm EPSDT status (applies to existing Enrollees).
6. CM14: For Enrollees aged 0 through 20 where the EPSDT exam is not up to date, ABHNJ should ensure EPSDT reminders are sent (applies to new and existing Enrollees).
7. CM14: For Enrollees aged 0 through 18, ABHNJ should ensure aggressive outreach attempts are documented to confirm immunization status (applies to existing Enrollees).

8. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, ABHNJ should make attempts to obtain dental status (applies to existing Enrollees).
9. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, ABHNJ should ensure dental reminders are sent (applies to new and existing Enrollees).
10. CM19: When appropriate for the applicable Enrollees, ABHNJ should ensure the Care Manager contacts Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD) (applies to existing Enrollees).
11. CM19: For Enrollees demonstrating needs requiring coordination of services, ABHNJ should ensure that the Care Manager documents coordination of needed care/services and linkages to providers, medical services, residential, social, community, and other support services (applies to existing Enrollees).

IPRO
Better healthcare, realized.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office of MLTSS Quality Monitoring

MCO MLTSS HCBS Care Management Audit
Aetna Better Health of New Jersey

Review Period July 1, 2023 – June 30, 2024

January 2025

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Introduction

The purpose of the Managed Long-Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community Based Services (HCBS) and Institutionalization for Long-Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. The U.S. Department of Health and Human Services (HHS) declared an end to the Public Health Emergency (PHE) for COVID-19 on May 11, 2023. The State issued Covid-19 flexibilities related to specific MLTSS Care Management activities ended prior to this review period (July 1, 2023 to June 30, 2024), except for the NJ DHS, Division of Aging Services (DoAS), *Temporary Waiver of Clinical Eligibility Requirements for MLTSS Enrollment for MCO Members in a Community Setting.* Effective July 5, 2023 the use of the Screen for Community Services (SCS) as presumptive eligibility was discontinued.

The populations included in this audit were Members who met eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or Community Alternative Residential Setting (CARS), for at least six consecutive months within the review period July 1, 2023 to June 30, 2024.

Annually, DMAHS evaluates the MCO performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the NJ FamilyCare Contracts (Article 9), dated July 2023 and January 2024. A representative sample of files were selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities, and post-audit activities.

1. Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology, necessary source documents, contract references, and the Division of Aging Services (DoAS), Office of Community Choice Options (OCCO) new contract requirements for MLTSS Care Management. Effective November 15, 2023, as part of the NJ Choice Assessment system, MCOs are required to complete a NJ specific Options Counseling Summary (OCS) form, whereas the Interim Plan of Care (IPOC) was no longer contractually required.

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

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

Population Selection

The sample was determined by using the following capitation codes to identify MLTSS HCBS enrollment presented in **Table 1** and applying the sampling methodology described in **Table 2**.

Table 1. Capitation Codes

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

The sampling methodology as shown in **Table 2** resulted in the selection of 156 cases for Aetna Better Health of New Jersey (ABHNJ), including an oversample.

Table 2. Sampling Methodology

Subpopulations	Criteria
Group C: Members New to Managed care and Newly Eligible for MLTSS between 7/1/2023 and 6/30/2024.	• The Member must have been initially enrolled in MLTSS HCBS between 7/1/2023 and 1/1/2024. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2024 in the *same* MCO with no gaps in enrollment.
Group D: Current Medicaid Managed care Members enrolled in MLTSS between 7/1/2023 and 6/30/2024.	• The Member must have been initially enrolled in MLTSS HCBS between 7/1/2023 and 1/1/2024. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2024 in the *same* MCO with no gaps in enrollment. • On the first day of the month prior to the initial MLTSS HCBS enrollment, the Member was enrolled in the *same* Medicaid MCO as the MLTSS HCBS MCO.
Group E: Current Medicaid Managed care Members enrolled in MLTSS prior to 7/1/2023 and continuously enrolled in MLTSS through 6/30/2024.	• The Member must have been initially enrolled in MLTSS HCBS prior to 7/1/2023. • The Member must have remained enrolled in MLTSS HCBS through 6/30/2024 in the *same* MCO with no gaps in enrollment.
Performance Measure #9a Enhancement	• A sample of 30 MLTSS HCBS Members across subgroups C, D, and E, identified on the NJ Choice Assessment Data list with assessment code 3, 4, and 5 will be included in the base sample abstracted from the universe. All MLTSS HCBS Members were included if the MCO has less than 30 Members who meet eligibility criteria.

MLTSS HCBS subpopulations were identified depending on different enrollment criteria. A stratified methodology was used to randomly select 100 MLTSS HCBS Members across subgroups C and D, and 30 MLTSS HCBS Members in subgroup E as a base sample. A 20% oversample across subgroups C and D, and subgroup E was drawn for substitution of exclusions.

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

All MLTSS HCBS Members were included if there were less than 100 Members across subgroups C and D, or less than 30 Members in subgroup E. Members could only be excluded by the MCO if they could provide evidence that the Member did not meet eligibility requirements. An oversample was selected for the MCO to replace any excluded files, as well as ensure an adequate denominator to evaluate Performance Measures.

Introductory E-Mail

IPRO sent an Introductory E-Mail to the MCO prior to the scheduled offsite audit including:

- Confirmation of the dates for the audit.
- Description of the sample.
- File listings identifying the files that needed to be available at the time of the offsite audit.

2. Audit Activities

IPRO reviewers conducted the file reviews over a five-week period. Reviewer inter-rater reliability was maintained using the standardized audit tool, and ongoing communication and coordination among the review team. Electronic files were prepared by the MCO for review.

3. Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the 156 cases selected for ABHNJ, 136 Member files were reviewed and 130 were included in the results.

Description	Group C	Group D	Group E	Subtotal
Total Number of Files Reviewed	50	51	35	136
Exclusions	0	1	5	6
Number of Files included in Results	50	50	30	130

Population-specific findings are presented in **Table 3**, which contains aggregate scores based on the results of selected review questions within each review category: Assessment, Member Outreach, Face-to-Face Visits, Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans), Ongoing Care Management, and Gaps in Care/Critical Incidents. Rates for each subpopulation and a combined score calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 3**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

ABHNJ's audit results for the combined MLTSS sample ranged from 83.0% to 100.0% across all three (3) populations for the six (6) audit categories.

Table 3. Results by Category

Determination by Category	July 1, 2023 – June 30, 2024			
	Group C	Group D	Group E[2]	Combined[3]
Assessment	100.0%	97.9%	100.0%	99.0%
Member Outreach	100.0%	90.0%	--	95.0%
Face-to-Face Visits	84.7%	90.2%	86.2%	87.2%
Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans)[1]	98.8%	97.8%	97.1%	97.9%
Ongoing Care Management	83.8%	86.8%	83.0%	84.8%
Gaps in Care/Critical Incidents	98.8%	100.0%	93.2%	97.9%

[1]Initial Plan of Care is assessed for Group C and Group D Members. Ongoing Plans of Care are assessed for Group E Members as they are not new to MLTSS. Back-up Plans are assessed for Group C, D, and E Members.
[2]Member Outreach is not evaluated for Members in Group E as they are not new to the MLTSS.
[3]Calculated as an aggregate score by combining elements applicable to each category.

Members New to Managed Care and Newly Eligible for MLTSS (Group C)

A total of 50 files were reviewed for new Members enrolled in Managed Care and newly eligible for MLTSS (Group C). There were no files excluded. All 50 files were further reviewed for compliance in 6 categories. There were 23 Members residing in CARS.

Assessment	N	D	Rate
The MCO requested a NJ Choice Assessment (NJCA) for the Member from OCCO.*	41	50	82.0%
MCO requested an NJCA for the Member from OCCO within fifteen (15) business days of the effective date of the Member's enrollment (for this population, MCOs have the option of requesting the NJCA from the Office of Community Choice Options (OCCO).*	41	41	100.0%
OCCO response was received within 5 business days of the MCO request.*	41	41	100.0%
The MCO received an NJCA from OCCO within 5 business days of OCCO's notification that is considered valid and current.*	0	41	0.0%
OCCO completed the NJCA which is valid during the review period.*	0	50	0.0%
The MCO completed the NJCA with the Member.	50	50	100.0%

*Not included in aggregate score calculation.

Member Outreach	N	D	Rate
Initial outreach was completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.	50	50	100.0%

Face-to-Face Visits	N	D	Rate
Member participated in all face-to-face visits.*	50	50	100.0%
Member was unable to participate in the face-to-face visit due to cognitive impairment, a minor child, and/or the Member has a legal guardian.*	0	0	N/A
Member or authorized representative participated in the onsite visit with the Care Manager.*	0	0	N/A
Options Counseling was provided to the Member.[1]	33	50	66.0%
Member was offered the participant direction option.[3]	26	27	96.3%
Member chose to participate in participant direction (excludes Members residing in CARS).*	11	26	42.3%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.[3]	11	11	100.0%
Member had a completed and signed Interim Plan of Care (IPOC) or Options Counseling Summary (OCS) form on file.[1,2]	45	50	90.0%
A cost effective analysis was completed during the review period.	44	50	88.0%
Member reached or exceeded 85% of the annual cost thresholds (ACT).*	1	44	2.3%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period, had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	1	1	100.0%

*Not included in aggregate score calculation
[1] Denominator excludes Members where OCCO completed the New Jersey Choice Assessment
[2]Compliance was evaluated for IPOCs completed before November 15, 2023 or OCS form completed on or after November 15, 2023
[3]Denominator excludes Members residing in CARS
N/A: Not Applicable

Initial Plan of Care (Including Back-up Plans)	N	D	Rate
Member had a completed and signed Initial Plan of Care on file, that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	48	50	96.0%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	50	50	100.0%
Member refused to be assessed for PCA services (excludes Members residing in CARS).*	1	27	3.7%
Member was assessed for PCA services (excludes Members residing in CARS).*	20	26	76.9%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.[1]	19	20	95.0%
Member required another PCA assessment due to changes in condition (excludes Members in CARS).*	5	20	25.0%
Member was re-assessed for PCA due to changes in condition.[1]	5	5	100.0%

Member had a Plan of Care and NJCA on file during the review period.*	50	50	100.0%
Plans of Care for MLTSS Members are aligned with Member needs as identified during the NJCA.	50	50	100.0%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	50	50	100.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	50	50	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	50	50	100.0%
Members who required a Back-up Plan, had a completed and signed Back-up Plan using the State mandated form.[1]	27	27	100.0%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	27	27	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	27	27	100.0%
Member service preference levels were documented in the Back-up Plan.[1]	27	27	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	25	27	92.6%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	24	27	88.9%
Member file included a Member Rights and Responsibilities statement signed by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	50	50	100.0%
Care Manager educated the Member on how to file a grievance and/or an appeal.	50	50	100.0%
Members residing in their community home had a risk assessment completed that included documentation of whether a positive risk was identified or not.[1]	27	27	100.0%
Member required a Risk Management Agreement (excludes Members residing in CARS).*	27	27	100.0%
Members who were identified as having a positive risk, had a signed Risk Management Agreement with all components.[1]	27	27	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS

Ongoing Care Management	N	D	Rate
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).[1]	25	27	92.6%
Member experienced issues that impeded access to care.*	9	50	18.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	9	9	100.0%
Member had a documented face-to-face visit to review Member placement and services during the review period.	50	50	100.0%
Review of Member's placement and services occurred timely (an ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	27	50	54.0%
Member required a change in Plan of Care based on an increase or reduction of services.*	9	50	18.0%
Member files that indicated a change from the Initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed and was provided with a copy of the Plan of Care.	9	9	100.0%
Member file indicates disagreement with the Plan of Care.*	0	0	N/A
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	50	0.0%
A face-to-face visit was conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition, or well-being.	0	0	N/A
Member was discharged to an HCBS setting during the review period.*	7	50	14.0%
Member refused the 10 day post discharge onsite visit.*	0	7	0.0%
Care Manager completed a 10 day post discharge telephonic visit.*	0	0	N/A
For Members who were discharged to an HCBS setting the onsite review occurred within ten (10) days of discharge.	5	7	71.4%
Member was discharged to his/her own home and in home services were in place in a timely manner.	7	7	100.0%
Member experienced a significant change in condition requiring the Plan of Care to be amended.*	8	50	16.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed by the Member and/or authorized representative.	8	8	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS

N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation the Care Manager reviewed the process for immediately reporting gaps in service delivery with the Member.	27	27	100.0%
Member reported a gap in service delivery (excludes Members residing in CARS).*	4	27	14.8%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	4	4	100.0%
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	49	50	98.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS

Members Currently Enrolled in Managed Care and Newly Eligible for MLTSS (Group D)

A total of 51 files were reviewed for Members currently enrolled in Managed Care and newly eligible for MLTSS (Group D). There was 1 file excluded. All 50 files were further reviewed for compliance in all 6 categories. There was 1 Member residing in CARS.

Assessment	*N*	*D*	*Rate*
Member had a Screen for Community Services (SCS) tool completed.*	45	50	90.0%
Member enrolled in MLTSS on an SCS Waiver.*	0	45	0.0%
The NJ Choice Assessment (NJCA) was completed within 30 days of a referral to MLTSS.	43	45	95.6%
The MCO completed the NJCA with the Member.	50	50	100.0%

*Not included in aggregate score calculation

Member Outreach	N	D	Rate
Initial outreach was completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.	45	50	90.0%

Face-to-Face Visits	N	D	Rate
Member participated in all face-to-face visits.*	50	50	100.0%
Member was unable to participate in face-to-face visit due to cognitive impairment, a minor child, and/or the Member had a legal guardian.*	0	0	N/A

Member or authorized representative participated in the onsite meeting with the Care Manager.*	0	0	N/A
Options Counseling was provided to the Member.	34	50	68.0%
Member had PPP prior to MLTSS enrollment.*	13	49	26.5%
Member had PPP pending prior to MLTSS enrollment.*	2	49	4.1%
Member was offered the participant direction option.[1]	34	34	100.0%
Member chose to participate in participant direction (excludes Members residing in CARS).*	10	34	29.4%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.[1]	10	10	100.0%
Member had a completed and signed Interim Plan of Care (IPOC) or Options Counseling Summary (OCS) form on file.[2]	48	50	96.0%
A cost effective analysis was completed during the review period.	49	50	98.0%
Member reached or exceeded 85% of the annual cost threshold (ACT).*	0	49	0.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period, had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

*Not included in aggregate score calculation

[1] Denominator excludes Members residing in CARS

[2]Compliance was evaluated for IPOCs completed before November 15, 2023 or OCS form completed on or after November 15, 2023

N/A: Not Applicable

Initial Plan of Care (Including Back-up Plans)	N	D	Rate
Member had a completed and signed Initial Plan of Care on file, that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	47	50	94.0%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	50	50	100.0%
Member had PCA services prior to MLTSS enrollment.*	9	49	18.4%
Member refused to be assessed for PCA services (excludes Members residing in CARS).*	1	40	2.5%
Member was assessed for PCA services (excludes Members residing in CARS).*	30	39	76.9%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.[1]	28	30	93.3%
Member required another PCA assessment due to changes in condition (excludes Members residing in CARS).*	5	30	16.7%
Member was re-assessed for PCA due to changes in condition.[1]	5	5	100.0%
Member had a Plan of Care and NJCA on file during the review period.*	50	50	100.0%
Plans of Care for MLTSS Members are aligned with Member's need as identified during the NJCA.	50	50	100.0%

There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	50	50	100.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	50	50	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	50	50	100.0%
Members who required a Back-up Plan, had a completed and signed Back-up Plan using the State mandated form.[1]	49	49	100.0%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	49	49	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	49	49	100.0%
Member service preference levels were documented in the Back-up Plan.[1]	49	49	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	46	49	93.9%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	44	49	89.8%
Member file included a Member Rights and Responsibilities statement signed by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	47	50	94.0%
Care Manager educated the Member on how to file a grievance and/or an appeal.	50	50	100.0%
Members residing in their community home had a risk assessment completed that included documentation of whether a positive risk was identified or not.[1]	47	49	95.9%
Member required a Risk Management Agreement (excludes Members residing in CARS).*	47	47	100.0%
Members who were identified as having a positive risk, had a signed Risk Management Agreement with all components.[1]	47	47	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS

Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).[1]	47	49	95.9%
Member experienced issues that impeded access to care.*	3	50	6.0%

Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	3	3	100.0%
Member had a documented face-to-face visit to review Member placement and services during the review period.	50	50	100.0%
Review of Member's placement and services occurred timely (an ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	30	50	60.0%
Member required a change in Plan of Care based on an increase or reduction of services.*	11	50	22.0%
Member files that indicated a change from the Initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed and was provided with a copy of the Plan of Care.	11	11	100.0%
Member file indicates disagreement with the Plan of Care.*	0	0	N/A
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	50	0.0%
Face-to-face visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition, or well-being.	0	0	N/A
Member was discharged to an HCBS setting during the review period.*	10	50	20.0%
Member refused the 10 day post discharge onsite visit.*	1	10	10.0%
The Care Manager completed a 10 day post discharge telephonic visit.*	1	1	100.0%
For Members who were discharged to an HCBS setting the onsite review occurred within ten (10) days of discharge.	7	9	77.8%
Member was discharged to his/her own home and in home services were in place in a timely manner.	9	10	90.0%
Member experienced a significant change in condition requiring the Plan of Care to be amended.*	7	50	14.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed by the Member and/or authorized representative.	7	7	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS

N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	49	49	100.0%

Member reported a gap in service delivery (excludes Members residing in CARS).*	0	49	0.0%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	0	0	N/A
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	50	50	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS

Members Enrolled in Managed Care and MLTSS Prior to the Review Period (Group E)

A total of 35 files were reviewed for the Members enrolled in Managed Care and MLTSS prior to the review period (Group E). There were 5 files excluded. The Member Outreach category is not assessed for Members in Group E. All 30 files were reviewed for compliance in 5 categories. There were 3 Members residing in CARS.

Assessment	*N*	*D*	*Rate*
The NJ Choice Assessment (NJCA) was due during the review period.*	28	30	93.3%
The MCO completed the NJ Choice Assessment with the Member.	28	28	100.0%
Member had an NJCA completed to reassess clinical eligibility for MLTSS within 11 to 13 months from the last NJCA authorized by OCCO.	28	28	100.0%

*Not included in aggregate score calculation

Face-to-Face Visits	N	D	Rate
Member participated in all face-to-face visits.*	29	30	96.7%
Member was unable to participate in the face-to-face visit due to cognitive impairment, a minor child, and/or the Member had a legal guardian.*	1	1	100.0%
Member or authorized representative participated in the onsite visit with the Care Manager.*	1	1	100.0%
Options Counseling was provided to the Member.	20	28	71.4%
Member had PPP prior to review period (excludes Members residing in CARS).*	8	27	29.6%
Member had PPP pending prior to review period (excludes Members residing in CARS).*	0	27	0.0%
Member was offered the participant direct option.[1]	18	19	94.7%
Member chose to participate in participant direction (excludes Members residing in CARS).*	4	18	22.2%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.[1]	2	4	50.0%
Member had a completed and signed Interim Plan of Care (IPOC) or Options Counseling Summary (OCS) form on file.[2]	27	28	96.4%

A cost effective analysis was completed during the review period.	27	30	90.0%
Member reached or exceeded 85% of the annual cost thresholds (ACT).*	0	27	0.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period, had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

*Not included in aggregate score calculation

[1] Denominator excludes Members residing in CARS

[2]Compliance was evaluated for IPOCs completed before November 15, 2023 or OCS form completed on or after November 15, 2023

N/A: Not Applicable

Ongoing Plans of Care (Including Back-up Plans)	N	D	Rate
Plan of Care reassessment for MLTSS Members was conducted within 30 days of annual LOC re-determination.	28	28	100.0%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	30	30	100.0%
Member file had documentation to demonstrate contact with the Member's HCBS providers at least annually to discuss the providers' reviews of the Member's needs and status and quarterly for Members receiving skilled nursing care, treatment for traumatic brain injury or behavioral health services.	30	30	100.0%
Member had PCA services prior to the review period (excludes Members residing in CARS).*	15	27	55.6%
Member refused to be assessed for PCA services (excludes Members residing in CARS).*	3	12	25.0%
Member was assessed for PCA services (excludes Members residing in CARS).*	9	9	100.0%
Member required another PCA assessment due to changes in condition (excludes Members in CARS).*	4	9	44.4%
Member was re-assessed for PCA due to changes in condition.[1]	4	4	100.0%
Member had a Plan of Care and NJCA on file during the review period.*	28	30	93.3%
Plans of Care for MLTSS Members are aligned with the Member's need as identified during the NJCA.	28	28	100.0%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	30	30	100.0%
Member's Plan of Care contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	30	30	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	30	30	100.0%

Members who required a Back-up Plan, had a completed and signed Back-up Plan using the State mandated form.[1]	25	27	92.6%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	25	25	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	25	25	100.0%
Member service preference levels were documented in the Back-up Plan.[1]	25	25	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	20	25	80.0%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	25	27	92.6%
Member file included a Member Rights and Responsibilities statement signed by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	26	30	86.7%
Care Manager educated the Member on how to file a grievance and/or an appeal.	30	30	100.0%
Care Manager completed an Annual Risk Assessment for the Member.[1]	26	27	96.3%
Members who were identified as having a positive risk (excludes Members residing in CARS).*	26	26	100.0%
IPRO identified the Member as having a potential risk during the review period that the Care Manager failed to identify. [1,2]	0	0	N/A[2]
Members who were identified as having a positive risk, had a signed Risk Management Agreement with all components.[1]	26	26	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members in CARS
[2]Percentage rate is indicative of compliant cases
N/A: Not Applicable

Ongoing Care Management	**N**	**D**	**Rate**
Member experienced issues that impeded access to care.*	2	30	6.7%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	2	2	100.0%
Member had a documented face-to-face visit to review Member placement and services during the review period.	30	30	100.0%
Review of Member's placement and services occurred timely (an ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	14	30	46.7%
Member required a change in Plan of Care based on an increase or reduction of services.*	11	30	36.7%
Member files that indicated a change from the Initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed and was provided with a copy of the Plan of Care.	11	11	100.0%

Member file indicated a disagreement with the Plan of Care.*	0	0	N/A
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service), were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	30	0.0%
Face-to-face visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition, or well-being.	0	0	N/A
Member was discharged to an HCBS setting during the review period.*	11	30	36.7%
Member refused the 10 day post discharge onsite visit.*	0	11	0.0%
Care Manager completed a 10 day post discharge telephonic visit.*	0	0	N/A
For Members who were discharged to an HCBS setting the onsite review occurred within ten (10) days of discharge.	10	11	90.9%
Member was discharged to his/her own home and in home services were in place in a timely manner.	10	11	90.9%
Member experienced a significant change in condition requiring the Plan of Care to be amended.*	11	30	36.7%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed by the Member and/or authorized representative.	11	11	100.0%
Member had a change in placement occur during the review period.*	0	30	0.0%
Member had a change in placement indicated and there was documentation of discussion with the Member before the change was made.	0	0	N/A

*Not included in aggregate score calculation
N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	25	27	92.6%
Member reported a gap in service delivery (excludes Members in CARS).*	2	27	7.4%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	2	2	100.0%
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	28	30	93.3%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS

Performance Measures

Population-Specific findings are presented in **Table 4**, which present results on the following MLTSS Performance Measures: #8 (Plans of Care established within 45 days of MLTSS enrollment), #9 (Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination), #9a (Plan of Care for MLTSS Members amended based on change of Member condition), #10 (Plans of Care for MLTSS Members are aligned with Member needs identified during the NJ Choice Assessment), #11 (Plans of Care for MLTSS Members are developed using "Person-Centered Principles"), #12 (MLTSS Home and Community Based Services (HCBS) Plans of Care that include a Back-up Plan), and #16 (MCO provided training to MLTSS Member on identifying/reporting Critical Incidents).

Population results, as shown in **Table 4**, are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. **Table 4** shows the results of the 2023-2024 audit findings. Overall, ABHNJ's audit results ranged from 95.0% to 100.0% across all groups for seven (7) Performance Measures for the current review period.

Table 4. Results of MLTSS Performance Measures

Performance Measure	Group[1]	Numerator	Denominator	Rate
#8. Plans of Care established within 45 days of MLTSS enrollment.	Group C	48	50	96.0%
	Group D	47	50	94.0%
	Group E[4]			
	Total	95	100	95.0%
#9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination.	Group C[5]			
	Group D[5]			
	Group E	28	28	100.0%
	Total	28	28	100.0%
#9a. Plan of Care for MLTSS Members amended based on change of Member condition.[2]	Group C	8	8	100.0%
	Group D	7	7	100.0%
	Group E	11	11	100.0%
	Total	26	26	100.0%
#10. Plans of Care for MLTSS Members are aligned with Member needs identified during the NJ Choice Assessment.	Group C	50	50	100.0%
	Group D	50	50	100.0%
	Group E	28	28	100.0%
	Total	128	128	100.0%

#11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles."	Group C	50	50	100.0%
	Group D	50	50	100.0%
	Group E	30	30	100.0%
	Total	130	130	100.0%
#12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that include a Back-up Plan.[3]	Group C	27	27	100.0%
	Group D	49	49	100.0%
	Group E	25	27	92.6%
	Total	101	103	98.1%
#16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents.	Group C	49	50	98.0%
	Group D	50	50	100.0%
	Group E	28	30	93.3%
	Total	127	130	97.7%

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

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

[3]Members in Community Alternative Residential Settings (CARS) are excluded from this measure

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

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

Discussion

Limitations

None

Conclusions and Recommendations

Population-Specific conclusions and recommendations are presented by category below.

Assessment

Across all three groups, the MCO had a combined score of 99.0% in the Assessment category.

Group	7/1/23 to 6/30/24
Group C	100.0%
Group D	97.9%
Group E	100.0%
Combined	99.0%

Member Outreach

Across groups, the MCO had a combined score of 95.0% in the Member Outreach category.

Group	7/1/23 to 6/30/24
Group C	100.0%
Group D	90.0%
Group E[1]	--
Combined	95.0%

[1]Member Outreach is not assessed for Members in Group E because Group E Members are not new to MLTSS

Face-to-Face Visits

Across all three groups, the MCO had a combined score of 87.2% in the Face-to-Face Visits category.

Group	7/1/23 to 6/30/24
Group C	84.7%
Group D	90.2%
Group E	86.2%
Combined	87.2%

Opportunities for Improvement for elements at the group level in the *Face-to-Face Visits* category include the following:

- **Group C**: ABHNJ should ensure that PACE is discussed with the Member during Options Counseling.

Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans)

Across all three groups, the MCO had a combined score of 97.9% in the Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans) category.

Group	7/1/23 to 6/30/24
Group C	98.8%
Group D	97.8%
Group E	97.1%
Combined	97.9%

Ongoing Care Management

Across all three groups, the MCO had a combined score of 84.8% in the Ongoing Care Management category.

Group	7/1/23 to 6/30/24
Group C	83.8%
Group D	86.8%
Group E	83.0%
Combined	84.8%

Opportunities for Improvement for elements at the group level in the *Ongoing Care Management* category include the following:

- **Group C and Group E:** ABHNJ should ensure that review of Member's placement and services occurs timely (an ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).

- **Group C:** For Members who are discharged to an HCBS setting, ABHNJ should ensure the onsite review occurs within ten (10) days of discharge.

Gaps in Care/Critical Incidents

Across all three groups, the MCO had a combined score of 97.9% in the Gaps in Care/Critical Incidents category.

Group	7/1/23 to 6/30/24
Group C	98.8%
Group D	100.0%
Group E	93.2%
Combined	97.9%

Performance Measures

Overall, the MCO scored above 86% in all seven (7) Performance Measures.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
Managed Long Term Services and Supports (MLTSS)

2024 Annual Assessment Review of Care Management
Aetna Better Health of New Jersey

Review Period - July 1, 2023 to June 30, 2024
December 2024

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Introduction

The NJ Family Care Managed Care Program, administered by the NJ Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), provides healthcare benefits for certain groups of children and adults with low-to-moderate incomes. The program provides health coverage to children, pregnant women, single adults, childless couples, aged, blind, and disabled individuals, and individuals qualified for long-term care services.

Background

The purpose of the Managed Long-Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure "That services were provided" to special needs members who met MLTSS eligibility requirements as specified in Article 9.

Annually, DMAHS evaluates Managed Care Organization (MCO) performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Assessment Methodology

The review consisted of pre-offsite review of documentation provided by Aetna Better Health of New Jersey (ABHNJ) as evidence of compliance of the standards under review; interviews with key ABHNJ staff (held via Teams meeting on December 3, 2024) and post-offsite evaluation of documentation and offsite activities.

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

The offsite review of documentation was requested by IPRO on July 26, 2024, and received from the MCOs on August 9, 2024. The documentation review occurred offsite at IPRO beginning on August 12, 2024. The IPRO review team consisted of Carla Zuccarello, Karen Halley, and Cynthia Santangelo. The Care Management assessment covered the period from July 1, 2023 to June 30, 2024. The MCOs were advised to provide both MLTSS and FIDE SNP/MLTSS documents if their Care Management documentation differed between MLTSS and FIDE SNP/MLTSS.

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

Table 1: All MLTSS CM elements are subject to be reviewed annually regardless of a prior year Met, and therefore be considered full reviews every year.

Table 1: Rating Scale for the MCO (MLTSS) Annual Assessment Review of Care Management

Rating	Rating Methodology	Review Type
Met in Prior Review	This element was met in the previous review cycle.	Full, Partial
Met	All parts within this element were met.	Full, Partial
Not Met	Not all required parts within the element were met.	Full, Partial
N/A	This element is not applicable and will not be considered as part of the score.	Full, Partial
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.	Full, Partial
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.	Full, Partial
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.	Full, Partial

Report Organization

This report provides findings for the MLTSS Care Management and Continuity of Care document submission portion of the 2024 MLTSS Care Management review.

A table is presented which provides the number of elements under review, the number *Met*, *Not Applicable* (*N/A*), and the number *Not Met* for this review. Percentages are based on the total number of applicable elements in the standard. Credit is given for receiving a *Met* finding in the current review. Contract language and reviewer comments are provided for *Not Met* elements. Contract language is provided for *N/A* elements and resolved deficiencies.

Following this summary, Strengths, Recommendations, and Findings for Improvement are reported where applicable. Recommendations relate to those elements that are deficient and must be addressed by the Plan. Findings for Improvement are suggestions by the IPRO review team to strengthen current processes.

Care Management and Continuity of Care

The Care Management and Continuity of Care review category examines if the MCO has an effective care and case management service structure. This structure includes written policies, procedures, processes, and systems to identify, assess and manage its member population in care and case management program(s). This review category also examines whether the MCO has developed and implemented MLTSS Care Management Programs for enrollees who may benefit from these services in accordance with State requirements.

There are 10 contractual provisions in this category. ABHNJ received an overall compliance score of 100% in 2024. In 2023, the MCO received a score of 100% for this category. **Table 1a** presents an overview of the results.

Table 1a: Summary of Findings for MLTSS Care Management and Continuity of Care

Element	Met Prior Year	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM18b	X	X	-	-	-	-	-
CM28	X	X	-	-	-	-	-
CM29	X	X	-	-	-	-	-
CM30	X	X	-	-	-	-	-
CM31	X	X	-	-	-	-	-
CM32	X	X	-	-	-	-	-
CM34	X	X	-	-	-	-	-
CM36	X	X	-	-	-	-	-
CM37	X	X	-	-	-	-	-
CM38	X	X	-	-	-	-	-
TOTAL	**10**	**10**	**0**	**0**	**0**	**0**	**0**
Compliance Percentage		**100%**					

Strengths

None

Recommendations

None

Findings for Improvement

None

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
Office of MLTSS Quality Monitoring

MCO MLTSS Nursing Facility/Special Care Nursing Facility Ancillary Review
Compliance Evaluation of MLTSS Performance Measures

Aetna Better Health of New Jersey

July 2024

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Introduction

The purpose of the Managed Long Term Services and Supports (MLTSS) Nursing Facility (NF)/Special Care Nursing Facility (SCNF) Ancillary Review is to evaluate Managed Care Organizations (MCOs) compliance with the Division of Medical Assistance and Health Services (DMAHS) NJ FamilyCare Contract Article 9.11.G, MLTSS Performance Measures. IPRO conducted a review of the following MLTSS Performance Measures: PM #8, PM #9, PM #9a, PM #11, and PM #16 for the review period September 1, 2022 through June 30, 2023.

Sampling Methodology

Population Selection

Population Criteria	September 1, 2022 to June 30, 2023
Codes	Capitation Codes **MLTSS NF Codes:** 88199, 88399, 88499, 78199, 78399 and 78499 **MLTSS HCBS Codes:** 89399 and 79399 *Needs to include **both** Core Medicaid and FIDE SNP Plan codes. Moving from one Plan Code to another does not constitute a change in MCO.
Age	No age requirements
Sex	Both
Nursing Facility Placement	Enrolled in a NF/SCNF for at least six (6) consecutive months, between 9/1/2022 and up to and including 6/30/2023.
Anchor Date	Enrolled in NF on 6/30/2023.
Continuous Enrollment Criteria	Enrolled in the same MCO for the entire period, from the initial six (6) consecutive months of residence in a NF/SCNF and remains in MLTSS through 6/30/2023 with no gaps in MLTSS enrollment.

Methodology

A random sample of 35 NF/SCNF Members new to MLTSS and/or new to the MCO during the review period and 25 NF/SCNF Members enrolled in MLTSS and the MCO prior to 9/1/2022 was selected to meet a minimum of 60 files (including a 20% oversample required for substitutions or exclusions) for each MCO. IPRO reviewed a total of 51 Member files for Aetna Better Health of New Jersey (ABHNJ). One (1) file was excluded, resulting in 50 files evaluated for compliance with MLTSS Performance Measures #8, #9, #9a, #11, and #16.

Evaluation of MLTSS Performance Measures

The following MLTSS Performance Measures were evaluated to determine MCO compliance; PM #8: Plans of Care established within 45 days of MLTSS enrollment; PM #9: Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination; PM #9a: Plan of Care for MLTSS Members amended based on change of Member condition; PM #11: Plans of Care for MLTSS Members are developed using "Person-Centered Principles;" and PM #16: MCO provided training to MLTSS Member on identifying/reporting Critical Incidents. ABHNJ's results for each MLTSS Performance Measure are shown below in **Table 1**.

Table 1: MLTSS Performance Measures Results

Performance Measure	Numerator	Denominator	Rate
#8. Plans of Care established within 45 days of MLTSS enrollment.[1]	28	30	93.3%
#9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination.[2]	16	16	100.0%
#9a. Plan of Care for MLTSS Members amended based on change of Member condition.[3]	2	3	66.7%
#11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles."[4]	50	50	100.0%
#16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents.	50	50	100.0%

[1] Compliance with this measure includes completion of the Initial Plan of Care and timeliness of completion. The denominator includes all NF/SCNF Members new to MLTSS and/or new to the MCO during the review period.

[2] Members included in this measure (denominator) have an annual LOC re-determination that was due and completed during the review period and a Plan of Care on file.

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

[4] For compliance with this measure Members must have a Plan of Care on file during the review period that contains documentation 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 be addressed in the Plan of Care.

Limitations

None.

Conclusions

As directed by DMAHS, no Corrective Action Plans (CAPs) will be required for MLTSS Performance Measures that score below the MLTSS compliance threshold of 86%.

Overall, the MCO scored 86% or above for the following MLTSS Performance Measures (**Table 1**):

- PM #8: Plans of Care established within 45 days of MLTSS enrollment.
- PM #9: Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination.
- PM #11: Plans of Care for MLTSS Members are developed using "Person-Centered Principles."
- PM #16: MCO provided training to MLTSS Member on identifying/reporting Critical Incidents.

Overall, the MCO scored below 86% for the following MLTSS Performance Measure (**Table 1**):

- PM #9a: Plan of Care for MLTSS Members amended based on change of Member condition.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services,
Office of MLTSS Quality Monitoring

MCO MLTSS Nursing Facility/Special Care Nursing Facility Care Management Audit

Aetna Better Health of New Jersey

February 2025

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Introduction

The purpose of the Managed Long-Term Services and Supports (MLTSS) Nursing Facility/Special Care Nursing Facility (NF/SCNF) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS Care Management program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Specifically, the populations included in this audit were Members who met the eligibility requirements for MLTSS and were receiving services in a Nursing Facility/Special Care Nursing Facility for at least six consecutive months within the review period from July 1, 2023 through June 30, 2024.

The U.S. Department of Health and Human Services (HHS) declared an end to the Public Health Emergency (PHE) for COVID-19 on May 11, 2023. State issued COVID-19 flexibilities related to specific Care Management activities and Nursing Facilities with visitation protocols (restricting Care Manager access) discontinued prior to this review period.

In addition to the CM audit, MLTSS Performance Measures #8 (Plans of Care established within 45 days of MLTSS enrollment), #9 (Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination), #9a (Plan of Care for MLTSS Members amended based on change of Member condition), #11 (Plans of Care for MLTSS Members are developed using “Person-Centered Principles”), and #16 (MCO provided training to MLTSS Member on identifying/reporting Critical Incidents) were calculated. Annually, DMAHS will evaluate the Managed Care Organization (MCO) performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the NJ FamilyCare Contracts (Article 9), dated July 2023 and January 2024. A representative sample of files were selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities, and post-audit activities.

1. Pre-audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the NJ Choice Assessment System, Plan of Care, contract references, and revision of elements for review. Audit questions are limited exclusively to ”Yes” or ”No” answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool in 2024, where appropriate, to determine whether a Member met the criteria for a subsequent section or question. Therefore, for some audit questions, Members represented in the numerator and denominator represent only those who met the specific applicable criteria. IPRO prepared an audit tool structured to collect requirement-specific information related to Facility and MCO Plan of Care, MLTSS Initial Plan of Care and Ongoing Plans of Care, Ongoing Care Management, Reassessment of the Plan of Care and Critical Incident Reporting, and Preadmission Screening and Resident Review (PASRR) Communications for Transitions to NF/SCNF. In addition, MLTSS Performance Measures #8, #9, #9a, #11, and #16 were calculated for the applicable NF/SCNF population. Rates calculated from these audit tool sections are utilized to determine MCO performance.

Separate rates were calculated on requirement-specific questions related to MLTSS Members who transitioned between HCBS and NF/SCNF settings during the review period. These rates are utilized solely for informational purposes.

Population Selection

Capitation and Plan codes were used to identify MLTSS HCBS and MLTSS NF/SCNF enrollment. The study sample was selected by using the capitation codes to identify MLTSS HCBS and NF/SCNF enrollment listed in **Table 1** and **Table 2**, and applying the sampling methodology described below.

Table 1: Capitation Codes for MLTSS HCBS Enrollment

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

Table 2: Capitation Codes for MLTSS NF Enrollment

Capitation Code	Description
88199	MLTSS Eligible Without Medicare – NF
88399	MLTSS Eligible Without Medicare – SCNF (Vents and Pediatrics)
88499	MLTSS Eligible Without Medicare – SCNF
78199	MLTSS Eligible With Medicare - NF
78399	MLTSS Eligible With Medicare – SCNF (Vents and Pediatrics)
78499	MLTSS Eligible With Medicare - SCNF

A random sampling method was used to meet a minimum of records needed to reach 100 files for each MCO. If the MCO did not have 100 files, the entire universe was selected for review. IPRO selected 110 cases for Aetna Better Health of New Jersey (ABHNJ), inclusive of an oversample of 10 cases to replace any excluded files as necessary.

Sampling Methodology

The criteria used to select the MLTSS NF/SCNF population were as follows:

- The Member must have been enrolled in MLTSS on June 30, 2024.
- The Member must have been enrolled as a NF/SCNF Member for 6 consecutive months during the review period and still enrolled with the MCO of record on June 30, 2024.
- The Member cannot be enrolled with another MCO at any time between the beginning of the minimum 6-month NF/SCNF enrollment and the end of the review period (June 30, 2024).

In order to collect additional information for MLTSS Members who transitioned between HCBS and NF/SCNF settings during the review period, the selected MLTSS NF/SCNF population was further identified as one of the four subgroups listed in **Table 3**.

Table 3: MLTSS NF/SCNF Population Subgroups

Group	Description
Group 1	Members permanently residing in a NF/SCNF at least 6 consecutive months from July 1, 2023 to June 30, 2024, with the MCO of record on June 30, 2024.
Group 2	Members residing in a NF/SCNF for at least 6 consecutive months from July 1, 2023 to June 30, 2024, and transitioned to HCBS during the review period with no transition from HCBS to another NF.
Group 3	Members residing in HCBS for at least 1 month between July 1, 2023 to June 30, 2024, and transitioned to a NF/SCNF for at least 6 consecutive months during the review period (and still residing in the NF/SCNF as of June 30, 2024).
Group 4	Members residing in HCBS for at least 1 month between July 1, 2023 and June 30, 2024, transitioned to a NF/SCNF for at least 6 consecutive months, and transitioned back to HCBS for at least 1 month during the review period.

Introductory E-mail

IPRO sent an introductory e-mail to the MCO prior to the scheduled offsite audit including:

- Formal notification of the audit with a file due date,
- Description of the sample,
- File listing identifying the files that needed to be submitted to IPRO, and
- Instructions for preparing files and uploading the files to IPRO's SEND File Transfer Protocol (FTP) site.

2. Offsite Audit Activities

Electronic files were prepared by the MCO for review and posted to IPRO's SEND FTP site. IPRO reviewers conducted the offsite file reviews over a five (5) week period. Reviewer inter-rater reliability (IRR) was maintained using the standardized audit tool with ongoing communication and coordination among the review team. Electronic files were prepared by the MCO for review.

3. Post-audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the 110 files selected for ABHNJ, 102 Member files were reviewed. There were 2 files excluded. A total of 100 files were further reviewed for compliance in the following five (5) categories; Facility and MCO Plan of Care, MLTSS Initial Plan of Care and Ongoing Plans of Care, Ongoing Care Management, Reassessment of the Plan of Care and Critical Incident Reporting, and PASRR Communications for Transitions to NF/SCNF. Based on sample selection criteria, this included all four subpopulations (Groups 1, 2, 3 and 4). Rates for individual elements were calculated as the number of "Yes" determinations divided by the sum of "Yes" plus "No" determinations. Abbreviated review elements appear in bold in the table sections of this report (**Tables 4–8**). Rates should be considered cautiously for review elements with a denominator of less than 30.

Table 4: Facility and MCO Plan of Care

Facility and MCO Plan of Care	N	D	Rate
Member's Care Management record contained **copies of any Facility Plans of Care on file** during the review period.	86	100	86.0%
Documented review of the Facility Plan of Care by the Care Manager.	84	86	97.7%
MLTSS Plan of Care on file includes information from the Facility Plan of Care.	96	100	96.0%

Table 5: MLTSS Initial Plan of Care and Ongoing Plans of Care

MLTSS Initial Plan of Care and Ongoing Plans of Care	N	D	Rate
The Member's individualized Plan of Care (including obtaining Member's signature) **was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program.**[1]	4	5	80.0%
Care Managers used a Person-Centered approach regarding the Member's assessment and needs; taking into account not only covered services, but also formal and informal support services.	96	96	100.0%
Plan of Care reassessment for MLTSS Members conducted within 30 days of annual level of care (LOC) re-determination.[2]	86	87	98.9%
Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems, and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process.	96	96	100.0%
Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	96	96	100.0%
Member's agreement/disagreement with the Plan of Care statements were documented on the Member's Plan of Care and maintained in the Member's electronic CM record.	96	96	100.0%
Member experienced a significant change in condition requiring the Plan of Care to be amended.	2	96	2.1%

MLTSS Initial Plan of Care and Ongoing Plans of Care	N	D	Rate
Updated Plan of Care for a significant change. For any significant change in Member condition, Member's Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative.	2	2	100.0%

[1]Compliance with this measure includes completion of the Initial Plan of Care, Member signature, and a copy provided to the Member within 45 calendar days of the MLTSS enrollment date. The denominator includes all NF/SCNF Members new to MLTSS and/or new to the MCO during the review period.

[2]Members included in this measure (denominator) have an annual LOC re-determination that was due and completed during the review period and a Plan of Care on file.

Table 6: Ongoing Care Management

Ongoing Care Management	N	D	Rate
There was evidence in the file that the Member had the ability and/or desire to transition from the NF/SCNF.	3	100	3.0%
Member was identified for transfer to HCBS and was offered options, including transfer to the community.	3	3	100.0%
Evidence of the **Care Manager's participation in at least one interdisciplinary team (IDT) meeting** during the review period.	93	100	93.0%
Member was present at each onsite visit or had involvement from the Member's authorized representative regarding the Plan of Care. (If the Member was not able to participate in an onsite visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable).	97	100	97.0%
The Care Manager reviewed Member placement and services onsite with the Member present.	97	100	97.0%
Timely onsite review of Member placement and services. Onsite visits were timely and occurred within at least 180 calendar days for non-pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability).	44	97	45.4%
Member required coordination of care (physical health and/or behavioral health services) not covered by NF/SCNF.	2	100	2.0%
Members requiring coordination of care had coordination of care by the Care Manager.	2	2	100.0%

Table 7: Reassessment of the Plan of Care and Critical Incident Reporting

Reassessment of the Plan of Care and Critical Incident Reporting	N	D	Rate
The NJ Choice Assessment (NJCA) was due during the review period (initial or annual redetermination NJCA).	97	100	97.0%
Member had a NJCA completed during the review period.	94	97	96.9%
Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative.	96	96	100.0%
Care Manager reviewed the Member's rights and responsibilities.	97	100	97.0%
Care Manager educated the Member on how to file a grievance and/or an appeal.	96	100	96.0%
Member and/or representative had **training on how to report a critical incident**, specifically including how to identify abuse, neglect and exploitation.	94	100	94.0%

Table 8: PASRR Communications for Transitions to NF/SCNF

PASRR Communications for Transitions to NF/SCNF	N	D	Rate
Member transitioned to the NF/SCNF during the review period.	10	100	10.0%
Care Manager completed or confirmed PASRR Level I prior to Member transition to NF/SCNF.	10	10	100.0%
Communication of PASRR Level I to OCCO documented by the Care Manager in the NJCA.	10	10	100.0%
Member required a PASRR Level II prior to admission to the NF/SCNF.	2	10	20.0%
Care Manager completed or confirmed PASRR Level II, prior to Member transition to NF/SCNF.	2	2	100.0%
Communication of PASRR Level II to OCCO documented by the Care Manager (within 1 business day of receipt of determination).	1	2	50.0%
Member demonstrated a need for MCO coordination with DDD/DMHAS.	0	2	0.0%
Members who had a PASRR Level II indicating a need for Specialized Services setting had coordination with DDD/DMHAS.	0	0	N/A

OCCO: Office of Community Choice Options; DDD: Division of Developmental Disabilities; DMHAS: Division of Mental Health and Addiction Services
N/A: Not Applicable

MLTSS Members Transitioning Between HCBS and NF/SCNF Settings

Of the cases selected for ABHNJ, 100 Member files were reviewed and included in the results. Rates were calculated for Members who transitioned from one MLTSS setting to another during the review period (Groups 2, 3, and 4; **Table 9**). Review elements are abbreviated in bold. Evaluation of MCO performance is for information purposes only.

Table 9: Member Transition Groups

Group	Member Transition	Number of Members
Group 1	Permanently residing in NF/SCNF for at least 6 months without a transition during the review period.	97
Group 2	Transitioned from NF/SCNF to HCBS with no other facility transition during the review period.	0
Group 3	Transitioned from HCBS to NF/SCNF and remained in a facility at the end of the review period.	3
Group 4	Transitioned from HCBS to NF/SCNF and back to HCBS during the review period.	0

MLTSS Members Transitioning from NF/SCNF to HCBS

A total of 0 files were reviewed for Members permanently residing in a NF/SCNF and subsequently transitioned to a home or community-based setting. Rates were calculated to profile NF/SCNF Members that transitioned to HCBS (Groups 2 and 4; **Table 9**).

Table 10: NF/SCNF Members Transitioned to HCBS

Transitions to HCBS	N	D	Rate
Member transitioned from NF/SCNF to HCBS during the review period.	0	100	0.0%
Member had a **Person-Centered transition plan on file.**	0	0	N/A
Cost effectiveness evaluation was completed for the Member prior to discharge from a NF/SCNF.	0	0	N/A
Plan of Care updated prior to discharge from a facility. Plan of Care was developed and agreed upon by the Member and/or representative prior to the effective date of transfer to the community.	0	0	N/A
Participation in an interdisciplinary team (IDT) meeting related to transition. Care Manager participated in the coordination of an IDT meeting related to transition planning.	0	0	N/A
Authorizations and procurement of transitional services for the Member were completed prior to NF/SCNF transfer.	0	0	N/A
Care Manager conducted a **face-to-face visit within 10 business days following a NF/SCNF discharge to the community.**	0	0	N/A
Services initiated upon NF/SCNF discharge were according to the Member's Plan of Care.	0	0	N/A

N/A: Not Applicable

MLTSS Members Transitioning from HCBS to NF/SCNF

A total of 3 files were reviewed for Members receiving HCBS and subsequently transitioned to an NF/SCNF for long-term placement. Rates were calculated to profile HCBS Members that transitioned to an NF/SCNF (Groups 3 and 4; **Table 9**).

Table 11: HCBS Members Transitioned to a NF/SCNF

Transitions to NF/SCNF	N	D	Rate
Member transitioned from HCBS to NF/SCNF during the review period.	3	100	3.0%
Member was admitted to NF/SCNF directly from an acute care facility.	0	3	0.0%
Care Manager determined during the reassessment process that changes in placement or services were indicated, and a **discussion with the Member occurred prior to the change in service/placement.**	3	3	100.0%

The expansion of the NF/SCNF audit components included evaluation of MLTSS Performance Measures. Population-specific findings are presented in **Table 12**, which include results on the following MLTSS Performance Measures: #8 (Plans of Care established within 45 days of MLTSS enrollment), #9 (Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination), #9a (Plan of Care for MLTSS Members amended based on change of Member condition), #11 (Plans of Care for MLTSS Members are developed using Person-Centered Principles), and #16 (MCO provided training to MLTSS Member on identifying/reporting Critical Incidents). Population results are rates calculated as the number of "Yes" determinations divided by the sum of "Yes" plus "No" determinations.

Table 12: MLTSS Performance Measures Results

Performance Measure	N	D	Rate
#8. Plans of Care established within 45 days of MLTSS enrollment.[1]	4	5	80.0%
#9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination.[2]	86	87	98.9%
#9a. Plan of Care for MLTSS Members amended based on change of Member condition.[3]	2	2	100.0%
#11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles."[4]	96	96	100.0%
#16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents.	94	100	94.0%

[1]Compliance with this measure includes completion of the Initial Plan of Care, Member signature, and a copy provided to the Member within 45 calendar days of the MLTSS enrollment date. The denominator includes all NF/SCNF Members new to MLTSS and/or new to the MCO during the review period.

[2] Members included in this measure (denominator) have an annual LOC re-determination that was due and completed during the review period and a Plan of Care on file.

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

[4] For compliance with this measure Members must have a Plan of Care on file during the review period that contains documentation 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 be addressed in the Plan of Care.

Discussion

Limitations

Results are limited due to the absence of Members in Group 2 (Members who transitioned from NF/SCNF to HCBS with no other facility transition during the review period) and Group 4 (Members who transitioned from HCBS to the NF/SCNF and returned to HCBS) during the review period.

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Conclusions

Overall, the MCO scored 86% or above in the following review elements (**Tables 4–8**). Review elements evaluated for calculation of Performance Measures are resulted in the MLTSS Performance Measures section of this report.

Facility and MCO Plan of Care

- Member's Care Management record contained copies of any Facility Plans of Care on file during the review period. (86.0%)
- Documented review of the Facility Plan of Care by the Care Manager. (97.7%)
- MLTSS Plan of Care on file includes information from the Facility Plan of Care. (96.0%)

MLTSS Initial Plan of Care and Ongoing Plans of Care

- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems, and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process. (100.0%)
- Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this). (100.0%)
- Member's agreement/disagreement with the Plan of Care statements were documented on the Member's Plan of Care and maintained in the Member's electronic CM record. (100.0%)

Ongoing Care Management

- Member was identified for transfer to HCBS and was offered options, including transfer to the community. (100.0%)
- Evidence of the Care Manager's participation in at least one interdisciplinary team (IDT) meeting during the review period. (93.0%)

- Member was present at each onsite visit or had involvement from the Member's authorized representative regarding the Plan of Care. (If the Member was not able to participate in an onsite visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable). (97.0%)
- Members requiring coordination of care had coordination of care by the Care Manager. (100.0%)

Reassessment of the Plan of Care and Critical Incident Reporting

- Member had a NJCA completed during the review period. (96.9%)
- Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative. (100.0%)
- Care Manager reviewed the Member's rights and responsibilities. (97.0%)
- Care Manager educated the Member on how to file a grievance and/or an appeal. (96.0%)

PASRR Communications for Transitions to NF/SCNF

- Care Manager completed or confirmed PASRR Level I prior to Member transition to NF/SCNF. (100.0%)
- Communication of PASRR Level I to OCCO documented by the Care Manager in the NJCA. (100.0%)
- Care Manager completed or confirmed PASRR Level II, prior to Member transition to NF/SCNF. (100.0%)

Opportunities for Improvement for Review Elements

Opportunities for improvement for MCO scores below 86% exist in the following review elements (**Tables 4–8).**

- Timely onsite review of Member placement and services. Onsite visits were timely and occurred within at least 180 calendar days for non-pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability). (45.4 %)
- Communication of PASRR Level II to OCCO documented by the Care Manager (within 1 business day of receipt of determination). (50.0%)

Recommendations for Review Elements

- ABHNJ MLTSS Care Managers should ensure review of the Member's placement and services occurs timely (at least 180 days for non-pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members).

- ABHNJ MLTSS Care Managers should ensure communication of PASRR Level II to OCCO is documented by the Care Manager (within 1 business day of receipt of determination).

MLTSS Performance Measures

Overall, the MCO scored 86% or above in the following Performance Measures (PMs) (**Table 12**).

- PM #9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination. (98.9%)
- PM #9a. Plan of Care for MLTSS Members amended based on change of Member condition. (100.0%)
- PM #11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles." (100.0%)
- PM #16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents. (94.0%)

Opportunities for Improvement for MLTSS Performance Measures

Opportunities for improvement for MCO scores below 86% exist for the following MLTSS Performance Measures (**Table 12**).

- PM #8. Plan of Care established within 45 days of MLTSS enrollment. (80.0%)

Recommendations for MLTSS Performance Measures

- PM #8. ABHNJ MLTSS Care Managers should ensure that a copy of the Member's Plan of Care is provided to the Member within 45 days of MLTSS enrollment.

Appendix C – FC/WCHP 2024 Core Medicaid and MLTSS Care Management Audit Reports

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
Office of Quality Assurance

MCO Care Management Audit and Annual Assessment
Fidelis Care

Review Period: January 1, 2023 to December 31, 2023

September 2024

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ISO 9001:2015 CERTIFIED

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MCO Care Management Audit and Annual Assessment

Introduction

The purpose of the Care Management Audit and Annual Assessment was to evaluate the effectiveness of the contractually required Care Management program. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) established Care Management requirements to ensure that the services provided to Enrollees with special health care needs are consistent with professionally recognized standards of care. The populations included in this audit include General Population (GP) Enrollees, Enrollees under the Division of Developmental Disabilities (DDD), and Enrollees under the Division of Child Protection and Permanency (DCP&P).

Annually, DMAHS evaluates Managed Care Organization (MCO) performance against these requirements through its External Quality Review Organization (EQRO) Contractor. The results of these audits are used to improve MCO performance.

MCO Care Management Chart Audit

Methodology

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

Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the prior year's report, NJ FamilyCare contract references, NJ Care Management Workbook, and CDC Immunization Schedules. For 2024, at the direction of DMAHS, the MCO Care Management audit evaluation process changed for GP, DDD, and DCP&P Enrollees. For the GP population, IPRO evaluated Enrollees new to the MCO and new to Care Management between 1/1/2023 and 11/16/2023 and existing Enrollees enrolled in Care Management between 3/1/2023 and 11/16/2023. For the DDD and DCP&P populations, IPRO evaluated newly eligible Enrollees new to Care Management during the 2023 review period and existing eligible Enrollees enrolled in Care Management prior to 1/1/2023. Audit questions are limited exclusively to 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool, where appropriate, to determine whether an Enrollee met the criteria for a subsequent section or question. Therefore, for some audit questions, Enrollees represented in the numerator and denominator represent only those who met the specific applicable criteria.

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

Population Selection

The sample was determined by excluding Enrollees with Third Party Liability (TPL) from the three populations, all pregnant members from the General Population, and applying the sampling methodology described below. The sampling methodology, as shown in **Table 1**, resulted in the selection of 237 cases for Fidelis Care.

Using a conservative assumption of a 65% proportion, a sample size of 100 was selected to yield sufficient statistical power to produce a 95% confidence interval, with a 10% margin of error. The confidence interval provides the range within which there is a 95% probability that the true rate falls between the lower rate and the upper rate of the confidence interval. Higher rates lead to smaller ranges in confidence intervals.

A random sample of 130 Enrollees for the General Population, DDD Population, and DCP&P Population (including a 30% oversample required for substitutions or exclusions), was selected.

Table 1: Sampling Methodology

Population Criteria	General Population (GP)	DDD	DCP&P
Criteria	Using the criteria below, the MCO will provide two (2) listings of ALL eligible New and Existing Enrollees (exclude DDD, DCP&P, all pregnant Enrollees, and TPL). IPRO will pull a random sample of 65 Enrollees new to the MCO and Care Management anytime between 1/1/2023 through 11/16/2023 and 65 existing Enrollees new to Care Management between 3/1/2023 through 11/16/2023 from the universes provided.** **Random sample size modified by IPRO.	Using the appropriate Capitation Codes and the criteria below, the MCO will provide two (2) listings (exclude TPL) for: 1 - ALL New eligible DDD Enrollees in Care Management and; 2 - ALL Existing eligible DDD Enrollees in Care Management IPRO will select a random sample of 130 new and existing DDD Enrollees in Care Management per MCO from the universes provided.** **Random sample size modified by IPRO.	Using the appropriate Capitation Codes and the criteria below, the MCO will provide two (2) listings (exclude TPL) for: 1 - ALL New eligible DCP&P Enrollees in Care Management and; 2 - ALL Existing eligible DCP&P Enrollees in Care Management IPRO will select a random sample of 130 new and existing DCP&P Enrollees in Care Management per MCO from the universes provided.** **Random sample size modified by IPRO.
Age	>=6 months as of 12/31/2023	>= 6 months as of 12/31/2023	>= 6 months and < 18 years as of 12/31/2023
Sex	Both	Both	Both
Enrollment in MCO • New Enrollees	Initial enrollment between 1/1/2023 to 6/30/2023	Initial enrollment between 1/1/2023 and 6/30/2023	Initial enrollment between 1/1/2023 and 6/30/2023
• Existing Enrollees	Enrolled prior to 1/1/2023	Enrolled prior to 1/1/2023	Enrolled prior to 1/1/2023
Current Enrollment	Enrolled as of 12/31/2023 and with the same MCO for 6 months during the review period.	Enrolled as of 12/31/23 and with the same MCO for 6 months during the review period.	Enrolled as of 12/31/23 and with the same MCO for 6 months during the review period.
Continuous Enrollment Criteria	Enrolled in same population and same MCO through 12/31/2023 allowing no more than a one-month gap.	Enrolled in same population and same MCO at least 6 months in 2023 allowing one gap <= 45 days. Gap is not permissible at the beginning or the end of the enrollment time period. Where Enrollee meets enrollment criteria for 2 MCOs in 2023, the later MCO enrollment is selected.	Enrolled in same population and same MCO at least 6 months in 2023 allowing one gap <= 45 days. Gap is not permissible at the beginning or the end of the enrollment time period. Where Enrollee meets enrollment criteria for 2 MCOs in 2023 the later MCO enrollment is selected.

Introductory E-Mail

For this year's audit, the evaluation included an audit review for three (3) sampled populations. IPRO sent an Introductory E-Mail to the MCO prior to the offsite desk audit including:

- A description of the current year audit process and specifications for each population.
- File listings identifying the files that needed to be submitted to IPRO, along with instructions for preparing the files and uploading the files to IPRO's S.E.N.D. FTP site.

Audit Activities

IPRO reviewers conducted the file reviews over a five-week period. Reviewer inter-rater reliability was maintained through use of the standardized Audit Tool, and ongoing communication and coordination among the review team.

Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report. MCOs were not permitted to submit additional information after the offsite audit.

Audit Results

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in Table 2, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

Fidelis Care's 2024 CM Audit results for the review period 1/1/2023 to 12/31/2023 ranged from 83.1% to 100% across all populations for the five audit categories.

Table 2: Aggregate Results by Category

Determination by Category	GP (n=100)	DDD (n=100)	DCP&P (n=37)
Identification[1]	83.1%		
Outreach[2,3]	90.0%	97.0%	N/A[4]
Preventive Services[3]	100.0%	96.8%	96.4%
Continuity of Care[3]	94.8%	99.4%	99.5%
Coordination of Services[3]	97.2%	96.9%	94.6%

[1]The Identification category is not evaluated for New and Existing DDD and DCP&P Enrollees, or Existing GP Enrollees.
[2]The Outreach category is evaluated for Enrollee files with no CNA or untimely completion of the CNA.
[3]Aggregate scores represent a combination of New and Existing population specific rates.
[4]N/A: Not Applicable. No DCP&P Enrollees met criteria for this measure as all CNAs were completed timely.

GP Population Findings

Identification

The Identification category applies to GP Enrollees (50) new to the MCO and new to Care Management between 1/1/2023 and 11/16/2023.

Table 3: Identification – GP Population- Enrollees New to the MCO and New to Care Management

Identification	General Population		
	Numerator	Denominator	Rate
Enrollee has an Initial Health Screen (IHS) on file and/or an IHS score documented in the file that was completed during the review period (1/1/2023 to 12/31/2023).*	38	50	76.0%
For IHS on file, IHS was completed for the Enrollee within 45 days of MCO enrollment date.	33	38	86.8%
For no IHS on file, the MCO made outreach attempts to complete the IHS.*	12	12	100.0%
For Enrollees where no IHS was on file, initial outreach to complete the IHS was successful (even if Enrollee declined to complete the IHS).*	2	12	16.7%
For Enrollees where no IHS was on file, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment.	0	10	0.0%
Enrollees who scored less than 5 on the IHS or no IHS on file.*	41	50	82.0%
Enrollees identified by the Plan as having Care Management needs through additional sources (applies to Enrollees new to the MCO and new to CM where the IHS score is less than 5 or no IHS on file).	41	41	100.0%

**Not Included in aggregate score calculation*

Outreach

The Outreach category applies to new GP Enrollees (50) enrolled in Care Management between 1/1/2023 and 11/16/2023 and existing GP Enrollees (50) enrolled in Care Management between 3/1/2023 and 11/16/2023.

Table 4: Outreach – General Population – New and Existing Enrollees enrolled in Care Management

Outreach	General Population – New Enrollees			General Population – Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The MCO completed a Comprehensive Needs Assessment (CNA) during the review period.*	50	50	100.0%	49	50	98.0%
The Enrollee was unable to reach to complete the CNA.*	0	0	N/A	0	1	0.0%
The MCO completed the CNA timely.*	36	50	72.0%	36	49	73.5%
Initial outreach to complete a CNA was performed.[1]	14	14	100.0%	14	14	100.0%
Initial outreach to complete the CNA was done timely, within 30 days of identification of CM needs. (30 days from IHS score 5 or greater; or IHS less than 5, no IHS, identification of CM needs through other sources).	7	14	50.0%	13	14	92.9%
Initial outreach to complete a CNA was successful (even if the Enrollee declined to complete the CNA).*	12	14	85.7%	13	14	92.9%

Outreach	General Population – New Enrollees			General Population – Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The MCO performed and documented aggressive outreach attempts to complete a CNA.*	2	2	100.0%	1	1	100.0%
For CNAs not completed timely or no CNA, aggressive outreach attempts were made timely (30 days from IHS score 5 or greater or identification of CM needs through other sources).	2	2	100.0%	1	1	100.0%
Upon any successful outreach to the Enrollee, the Enrollee opted out of Care Management.*	20	50	40.0%	14	50	28.0%
Enrollee became lost to contact during the review period.*	9	50	18.0%	12	50	24.0%
For Enrollees who were lost to contact, aggressive outreach attempts were made and documented by the Care Manager.	9	9	100.0%	12	12	100.0%

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollee files with no CNA or a CNA completed untimely. The denominator in this measure represents the 14 untimely CNAs for new GP Enrollees. The denominator in this measure represents 1 file with no CNA and 13 untimely CNAs for existing GP.

N/A: Not Applicable

Preventive Services

The Preventive Services category applies to new GP Enrollees (50) enrolled in Care Management between 1/1/2023 and 11/16/2023 and existing GP Enrollees (50) enrolled in Care Management between 3/1/2023 and 11/16/2023.

Table 5: Preventive Services – General Population- New and Existing Enrollees enrolled in Care Management

Preventive Services	General Population - New Enrollees			General Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The Enrollee's EPSDT[1] exam is up to date per periodicity exam schedule (aged 0 through 20).*	8	14	57.1%	11	12	91.7%
The Enrollee's EPSDT status is confirmed by a reliable source (aged 0 through 20).	8	8	100.0%	11	11	100.0%
Aggressive outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	6	6	100.0%	1	1	100.0%
The Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	6	6	100.0%	1	1	100.0%
The Enrollee or legal guardian refused immunizations (aged 0 to 18).*	2	14	14.3%	4	12	33.3%
The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18).*	4	12	33.3%	5	8	62.5%
The Enrollee's immunization status is confirmed by a reliable source (aged 0 through 18).	4	4	100.0%	5	5	100.0%
Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18).	8	8	100.0%	3	3	100.0%
The Enrollee or legal guardian refused immunizations (aged 19 and above).*	11	36	30.6%	9	38	23.7%
Appropriate vaccines have been administered for Enrollees (aged 19 and above).*	20	25	80.0%	25	29	86.2%
Aggressive outreach attempts were documented to confirm immunization status for Enrollees (aged 19 and above).	5	5	100.0%	4	4	100.0%
The Care Manager addressed and/or discussed dental needs with Enrollees (aged 21 and above).	36	36	100.0%	38	38	100.0%

Preventive Services	General Population - New Enrollees			General Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
A dental visit occurred during the review period for Enrollees (aged 1 through 20).*	2	13	15.4%	5	12	41.7%
Care Manager made attempts to obtain dental status for Enrollees without a confirmed dental visit (aged 1 through 20).	11	11	100.0%	7	7	100.0%
Dental reminders were sent to Enrollees without a confirmed dental visit (aged 1 through 20).	11	11	100.0%	7	7	100.0%

**Not Included in aggregate score calculation*

[1]EPSDT: Early and Periodic Screening, Diagnostic and Treatment

Continuity of Care

The Continuity of Care category applies to new GP Enrollees (50) enrolled in Care Management between 1/1/2023 and 11/16/2023 and existing GP Enrollees (50) enrolled in Care Management between 3/1/2023 and 11/16/2023.

Table 6: Continuity of Care – General Population - New and Existing Enrollees enrolled in Care Management

Continuity of Care	General Population - New Enrollees			General Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The MCO completed a CNA during the review period.*	50	50	100.0%	49	50	98.0%
The CNA contained all elements of the State approved CNA tool.	49	50	98.0%	49	49	100.0%
The Comprehensive Needs Assessment was completed timely (within 30 days of identification of CM needs).	36	50	72.0%	36	49	73.5%
The Care Manager documented a level of Care Management for the Enrollee during the review period.	46	50	92.0%	45	49	91.8%
The Enrollee is in Community Based Care Management (CBCM).[1]*	3	50	6.0%	1	50	2.0%
The Enrollee has a Care Plan on file during the review period.	49	50	98.0%	50	50	100.0%
A Care Plan was completed for the Enrollee that included all required components.	49	49	100.0%	50	50	100.0%
The Care Plan was developed within 30 days of CNA completion.[2]	49	49	100.0%	49	49	100.0%
The Enrollee's Care Plan was reviewed/monitored during the review period.	49	49	100.0%	50	50	100.0%
The Enrollee had a change in care needs or circumstances during the review period.*	7	49	14.3%	6	50	12.0%
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances.	7	7	100.0%	6	6	100.0%
Enrollee demonstrated needs requiring a comprehensive treatment plan.*	0	50	0.0%	0	50	0.0%
The Enrollee had a comprehensive treatment plan documented to address the Enrollee's specific care needs.	0	0	N/A	0	0	N/A
The comprehensive treatment plan progressed in a timely manner without unreasonable interruption.	0	0	N/A	0	0	N/A

**Not Included in aggregate score calculation*

[1]Community Based Care Management (CBCM) resumed in October 2023 following the end of the Public Health Emergency.

[2]This measure is evaluated for Enrollee's with a Care Plan and a CNA on file during the review period.

N/A: Not Applicable

Coordination of Services

The Coordination of Services category applies to new GP Enrollees (50) enrolled in Care Management between 1/1/2023 and 11/16/2023 and existing GP Enrollees (50) enrolled in Care Management between 3/1/2023 and 11/16/2023.

Table 7: Coordination of Services – General Population - New and Existing Enrollees enrolled in Care Management

Coordination of Services	General Population- New Enrollees			General Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF[1], CSOC[2], CMOs[3], Special Child Health Services (under DOH[4]) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD).	1	1	100.0%	0	0	N/A
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services.	30	30	100.0%	24	26	92.3%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee.	12	12	100.0%	14	14	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed.	12	12	100.0%	13	14	92.9%

[1]DCF: Department of Children and Families
[2]CSOC: Children's System of Care
[3]CMOs: Care Management Organizations
[4]DOH: Department of Health
N/A: Not Applicable

DDD Population Findings

Outreach

The Outreach category applies to new DDD Enrollees (39) in Care Management during the 2023 review period. The Outreach category is not evaluated for the existing DDD Enrollees in Care Management.

Table 8: Outreach – DDD Population - Enrollees New to the MCO and New to Care Management

Outreach	DDD Population		
	Numerator	Denominator	Rate
The MCO completed a Comprehensive Needs Assessment (CNA) during the review period.*	29	39	74.4%
The Enrollee was unable to reach to complete the CNA.*	7	10	70.0%
The MCO completed the CNA timely (within 45 days of MCO enrollment date).*	26	29	89.7%
Initial outreach to complete a CNA was performed.[1]	13	13	100.0%
Initial outreach to complete the CNA was done timely, within 45 days from the Enrollee's enrollment date.	12	13	92.3%
Initial outreach to complete the CNA was successful (even if the Enrollee declines to complete the CNA).*	4	13	30.8%
The MCO performed aggressive outreach to complete a CNA.*	7	9	77.8%
Aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment.	7	7	100.0%
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA.*	3	3	100.0%
Upon any successful outreach to the Enrollee, the Enrollee declined Care Management.*	3	3	100.0%

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollee files with no CNA or a CNA completed untimely. The denominator for this measure includes 10 files with no CNA and 3 files with a CNA completed untimely.

Preventive Services

The Preventive Services category applies to new DDD Enrollees (39) and existing DDD Enrollees (61) in Care Management during the 2023 review period.

Table 9: Preventive Services – DDD Population - New and Existing Enrollees enrolled in Care Management

Preventive Services	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The Enrollee's EPSDT[1] exam is up to date per periodicity exam schedule (aged 0 through 20).*	5	23	21.7%	3	6	50.0%
The Enrollee's EPSDT status is confirmed by a reliable source (aged 0 through 20).	5	5	100.0%	3	3	100.0%
Aggressive outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	18	18	100.0%	3	3	100.0%
The Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	17	18	94.4%	3	3	100.0%
The Enrollee or legal guardian refused immunizations (aged 0 to 18).*	1	12	8.3%	2	4	50.0%
The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18).*	2	11	18.2%	1	2	50.0%

Preventive Services	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The Enrollee's immunization status is confirmed by a reliable source (aged 0 through 18).	2	2	100.0%	1	1	100.0%
Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18).	9	9	100.0%	1	1	100.0%
The Enrollee or legal guardian refused immunizations (aged 19 and above).*	6	27	22.2%	15	57	26.3%
Appropriate vaccines have been administered for Enrollees (aged 19 and above).*	9	21	42.9%	10	42	23.8%
Aggressive outreach attempts were documented to confirm immunization status for Enrollees (aged 19 and above).	11	12	91.7%	32	32	100.0%
The Care Manager addressed and/or discussed dental needs with Enrollees (aged 21 and above).	13	16	81.2%	53	55	96.4%
A dental visit occurred during the review period for Enrollees (aged 1 through 20).*	5	23	21.7%	2	6	33.3%
Care Manager made attempts to obtain dental status for Enrollees without a confirmed dental visit (aged 1 through 20).	18	18	100.0%	4	4	100.0%
Dental reminders were sent to Enrollees without a confirmed dental visit (aged 1 through 20).	18	18	100.0%	4	4	100.0%

**Not Included in aggregate score calculation*

[1]EPSDT: Early and Periodic Screening, Diagnostic and Treatment

Continuity of Care

The Continuity of Care category applies to new DDD Enrollees (39) and existing DDD Enrollees (61) in Care Management during the 2023 review period. Gray shading represents elements that are not evaluated for existing DDD Enrollees in Care Management.

Table 10: Continuity of Care – DDD Population - New and Existing Enrollees enrolled in Care Management

Continuity of Care	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The MCO completed a CNA during the review period.*	29	39	74.4%			
The CNA contained all elements of the State approved CNA tool.	29	29	100.0%			
The Comprehensive Needs Assessment was completed timely, within 45 days of Enrollee's MCO enrollment date.	26	29	89.7%			
The Care Manager documented a level of Care Management for the Enrollee during the review period.	29	29	100.0%	61	61	100.0%
The Enrollee is in Community Based Care Management (CBCM).[1]*	1	39	2.6%	0	61	0.0%
The Enrollee has a Care Plan on file during the review period.	39	39	100.0%	61	61	100.0%
A Care Plan was completed for the Enrollee that included all required components.	39	39	100.0%	61	61	100.0%
The Care Plan was developed within 30 days of CNA completion.[2]	29	29	100.0%			
The Enrollee's Care Plan was reviewed/monitored during the review period.	39	39	100.0%	61	61	100.0%

Continuity of Care	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The Enrollee had a change in care needs or circumstances during the review period.*	1	39	2.6%	0	61	0.0%
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances.	1	1	100.0%	0	0	N/A
Enrollee demonstrated needs requiring a comprehensive treatment plan.*	0	39	0.0%	0	61	0.0%
The Enrollee had a comprehensive treatment plan documented to address the Enrollee's specific care needs.	0	0	N/A	0	0	N/A
The comprehensive treatment plan progressed in a timely manner without unreasonable interruption.	0	0	N/A	0	0	N/A

**Not Included in aggregate score calculation*

[1] Community Based Care Management (CBCM) resumed in October 2023 following the end of the Public Health Emergency.

[2]This measure is evaluated for Enrollee's with a Care Plan and a CNA on file during the review period.

N/A: Not Applicable

Coordination of Services

The Coordination of Services category applies to new DDD Enrollees (39) and existing DDD Enrollees (61) in Care Management during the 2023 review period.

Table 11: Coordination of Services – DDD Population- New and Existing Enrollees enrolled in Care Management

Coordination of Services	DDD Population - New Enrollees			DDD Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF[1], CSOC[2], CMOs[3], Special Child Health Services (under DOH[4]) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD).	37	39	94.9%	59	61	96.7%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services.	3	3	100.0%	18	18	100.0%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee.	3	3	100.0%	2	2	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed.	1	1	100.0%	2	2	100.0%
For Enrollees who were hospitalized with a mental/behavior health diagnosis and discharged prior to 12/1/2023 the Care Manager documented evidence of follow up with the mental/behavioral health provider within 30 days of discharge.	0	0	N/A	0	0	N/A

Coordination of Services	DDD Population - New Enrollees			DDD Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The Care Manager made aggressive attempts to determine follow up status with a mental/behavioral health provider for Enrollees hospitalized with a mental/behavioral health diagnosis.	0	0	N/A	0	0	N/A

[1]DCF: Department of Children and Families
[2]CSOC: Children's System of Care
[3]CMOs: Care Management Organizations
[4]DOH: Department of Health
N/A: Not Applicable

DCP&P Population Findings

Outreach

The Outreach category applies to new DCP&P Enrollees (17) in Care Management during the 2023 review period. The Outreach category is not evaluated for the existing DCP&P Enrollees in Care Management.

Table 12: Outreach – DCP&P Population- Enrollees New to the MCO and New to Care Management

Outreach	DCP&P Population		
	Numerator	Denominator	Rate
The MCO completed a Comprehensive Needs Assessment (CNA) during the review period.*	17	17	100.0%
The Enrollee was unable to reach to complete the CNA.*	0	0	N/A
The MCO completed the CNA timely, within 45 days of MCO enrollment date.*	17	17	100.0%
Initial outreach to complete a CNA was performed.[1]	0	0	N/A
Initial outreach to complete the CNA was timely, within 45 days from the Enrollee's enrollment date.	0	0	N/A
Initial outreach was successful (even if the Enrollee declines to complete the CNA).*	0	0	N/A
The MCO performed aggressive outreach to complete a CNA.*	0	0	N/A
Aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment.	0	0	N/A
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA.*	0	0	N/A

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollee files with no CNA or a CNA completed untimely. All 17 CNAs were completed timely.

N/A: Not Applicable

Preventive Services

The Preventive Services category applies to new DCP&P Enrollees (17) and existing DCP&P Enrollees (20) in Care Management during the 2023 review period.

Table 13: Preventive Services – DCP&P Population – New and Existing Enrollees enrolled in Care Management

Preventive Services	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The Enrollee's EPSDT[1] exam is up to date per periodicity exam schedule (aged 0 through 20).*	13	17	76.5%	15	20	75.0%
The Enrollee's EPSDT status is confirmed by a reliable source (aged 0 through 20).	13	13	100.0%	15	15	100.0%
Aggressive outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	4	4	100.0%	5	5	100.0%
The Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	2	4	50.0%	5	5	100.0%
The Enrollee or legal guardian refused immunizations (aged 0 to 18).*	0	17	0.0%	3	20	15.0%
The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18).*	13	17	76.5%	12	17	70.6%

Preventive Services	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The Enrollee's immunization status is confirmed by a reliable source (aged 0 through 18).	13	13	100.0%	12	12	100.0%
Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18).	4	4	100.0%	5	5	100.0%
A dental visit occurred during the review period for Enrollees (aged 1 through 20).*	12	13	92.3%	17	18	94.4%
Care Manager made attempts to obtain dental status for Enrollees without a confirmed dental visit (aged 1 through 20).	1	1	100.0%	1	1	100.0%
Dental reminders were sent to Enrollees without a confirmed dental visit (aged 1 through 20).	0	1	0.0%	1	1	100.0%

**Not Included in aggregate score calculation*

[1]EPSDT: Early and Periodic Screening, Diagnostic and Treatment

Continuity of Care

The Continuity of Care category applies to new DCP&P Enrollees (17) and existing DCP&P Enrollees (20) in Care Management during the 2023 review period. Gray shading represents elements that are not evaluated for existing DCP&P Enrollees in Care Management.

Table 14: Continuity of Care – DCP&P Population – New and Existing Enrollees enrolled in Care Management

Continuity of Care	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The MCO completed a CNA during the review period.*	17	17	100.0%			
The completed CNA contained all elements of the State approved CNA tool.	17	17	100.0%			
The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment).	17	17	100.0%			
The Care Manager documented a level of Care Management for the Enrollee during the review period.	17	17	100.0%	20	20	100.0%
The Enrollee has a Care Plan on file during the review period.	16	17	94.1%	20	20	100.0%
A Care Plan was completed for the Enrollee that included all required components.	16	16	100.0%	20	20	100.0%
The Care Plan was developed within 30 days of CNA completion.[1]	16	16	100.0%			
The Enrollee's Care Plan was reviewed/monitored during the review period.	16	16	100.0%	20	20	100.0%
The Enrollee had a change in care needs or circumstances during the review period.*	1	16	6.2%	6	20	30.0%
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances.	1	1	100.0%	6	6	100.0%
Enrollee demonstrated needs requiring a comprehensive treatment plan.*	0	17	0.0%	0	20	0.0%
The Enrollee had a comprehensive treatment plan documented to address the Enrollee's specific care needs.	0	0	N/A	0	0	N/A

Continuity of Care	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The comprehensive treatment plan progressed in a timely manner without unreasonable interruption.	0	0	N/A	0	0	N/A

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollee's with a Care Plan and a CNA on file during the review period.

N/A: Not Applicable

Coordination of Services

The Coordination of Services category applies to new DCP&P Enrollees (17) and existing DCP&P Enrollees (20) in Care Management during the 2023 review period.

Table 15: Coordination of Services – DCP&P Population - New and Existing Enrollees enrolled in Care Management

Coordination of Services	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF[1], CSOC[2], CMOs[3], Special Child Health Services (under DOH[4]) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD).	17	17	100.0%	19	20	95.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services.	2	2	100.0%	7	7	100.0%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee.	1	1	100.0%	4	4	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed.	1	1	100.0%	2	4	50.0%

[1]DCF: Department of Children and Families

[2]CSOC: Children's System of Care

[3]CMOs: Care Management Organizations

[4]DOH: Department of Health

Limitations

Fidelis Care had a combined total of 93 file exclusions for the DCP&P Population new and existing Enrollees. As a result, the total files reviewed are 17 (new Enrollees) and 20 (existing Enrollees). Audit results should be considered cautiously due to the low sample sizes.

Conclusions

Overall, the MCO scored 85% or above in the following review categories (**Table 2**):

- Outreach (General Population) (90.0%)
- Outreach (DDD Population) (97.0%)

- Preventive Services (General Population) (100%)
- Preventive Services (DDD Population) (96.8%)
- Preventive Services (DCP&P Population) (96.4%)

- Continuity of Care (General Population) (94.8%)
- Continuity of Care (DDD Population) (99.4%)
- Continuity of Care (DCP&P Population) (99.5%)

- Coordination of Services (General Population) (97.2%)
- Coordination of Services (DDD Population) (96.9%)
- Coordination of Services (DCP&P Population) (94.6%)

Overall, the MCO scored below 85% in the following categories (**Table 2**):

- Identification (General Population) (83.1%)

MCO Care Management Annual Assessment

Assessment Methodology

The Care Management Annual Assessment consisted of pre-audit review of documentation provided by Fidelis Care, as evidence of compliance of the standard under review; audit review of random file samples for the GP, DDD, and DCP&P Populations; interviews with key Fidelis Care staff via TEAMS held on May 30, 2024; and post audit evaluation of documentation and audit activities.

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

The documentation for the audit review was requested by IPRO on March 8, 2024, and documentation was received from the MCO on March 30, 2024. The documentation review occurred offsite at IPRO beginning on April 1, 2024. The audit review team was made up of Carla Zuccarello, Cynthia Steffe, and Cynthia Santangelo. The Care Management assessment covered the period from January 1, 2023 to December 31, 2023.

During the audit review, the Plan had the opportunity to provide supplemental documentation as requested by IPRO.

Table 16 shows the rating scale used to determine compliance.

Table 16: Rating Scale for the Annual Care Management Assessment

Rating	Rating Methodology
Met	All parts within this element were met.
Not Met	Not all the required parts within the element were met.
N/A	This element is not applicable and will not be considered as part of the score.
Met Prior Review	This element was met in the previous review cycle.
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.

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

There are 30 elements in this review based on Contractual provisions, which are subject to review annually. Fidelis Care received an overall compliance score of 87% in 2024. In 2023, the MCO received a score of 73%. Review of the elements CM2, CM4, CM5, CM6, CM7, CM8, CM11, CM14, CM15, CM16, CM17, and CM19 was based on results from the Core Medicaid CM Audit conducted in 2024. Where appropriate, assessment of other elements was informed by both documents submitted for review and the file review. This audit evaluated Core Medicaid CM files for calendar year 2023 for three populations, namely the Enrollees under the General Population (GP), Division of Developmental Disabilities (DDD), and the Division of Child Protection and Permanency (DCP&P).

Care Management Assessment Results

Table 17 presents an overview of Fidelis Care's Care Management Annual Assessment results; **Table 18** presents Contract language and reviewer comments for deficient element(s); and **Table 19** presents Contract language for resolved deficiencies.

Table 17: Summary of Findings for Care Management Annual Assessment

Element	Met Prior Review	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM1	X	X	-	-	-	-	-
CM2	X	-	X	-	-	-	X
CM3	-	X	-	-	-	X	-
CM4	X	X	-	-	-	-	-
CM5	X	X	-	-	-	-	-
CM6	-	-	X	-	X	-	-
CM7	-	-	X	-	X	-	-
CM8	-	X	-	-	-	X	-
CM9	X	X	-	-	-	-	-
CM10	X	X	-	-	-	-	-
CM11	X	X	-	-	-	-	-
CM12	X	X	-	-	-	-	-
CM13	X	X	-	-	-	-	-
CM14	-	-	X	-	X	-	-
CM15	-	X	-	-	-	X	-
CM16	X	X	-	-	-	-	-
CM17	-	X	-	-	-	X	-
CM18a	X	X	-	-	-	-	-
CM18c	X	X	-	-	-	-	-

Element	Met Prior Review	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM18d	X	X	-	-	-	-	-
CM19	-	X	-	-	-	X	-
CM20	X	X	-	-	-	-	-
CM21	X	X	-	-	-	-	-
CM22	X	X	-	-	-	-	-
CM23	X	X	-	-	-	-	-
CM24	X	X	-	-	-	-	-
CM25	X	X	-	-	-	-	-
CM26	X	X	-	-	-	-	-
CM27	X	X	-	-	-	-	-
CM37[1]	X	X	-	-	-	-	-
TOTAL	**22**	**26**	**4**	**0**	**3**	**5**	**1**
Compliance Percentage		**87%**					

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

Table 18: Findings for Deficient Care Management Elements

Element	Contract Language	Reviewer Comments
CM2	**4.6.2.J** **Discharge Planning** The Contractor shall have procedures to ensure adequate and appropriate discharge planning, and to include Coordination of Services for Enrollees with special needs.	**In the 2024 CM file audit the MCO scored for the DCP&P Population Enrollees:** 50.0%- For Enrollees who were hospitalized, adequate discharge planning was performed (applies to existing Enrollees).
CM6	**4.6.5.B.1** **Identification of Enrollees Who Need Care Management** The MCO must have effective systems, policies, procedures, and practices in place to identify any Enrollee in need of Care Management services. All New Enrollees, including Enrollees who were disenrolled from the MCO for at least six (6) months, (except for DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD) will be screened using an approved Initial Health Screen tool (IHS) to quickly identify their immediate physical and/or behavioral health care needs, as well as the need for more extensive screening. Any Enrollee identified as having potential Care Management needs will receive a detailed Comprehensive Needs Assessment (if deemed necessary by a healthcare professional), and ongoing care coordination and management as appropriate. All elements of the State approved IHS tool that appear in the Care Management Workbook must be included in the MCO's screening tool.	**In the 2024 CM file audit the MCO scored for the General Population Enrollees:** 0.0%- For Enrollees where no IHS was on file, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment (applies to new Enrollees).

Element	Contract Language	Reviewer Comments
CM7	**4.6.5. B.2** **Comprehensive Needs Assessment (CNA)** The MCO will conduct an approved CNA on New Enrollees following the evaluation by a healthcare professional of their Initial Health Screen results; any Enrollee identified as having potential Care Management needs; as well as DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD. The goal of the CNA is to identify an Enrollee's Care Management needs to determine an Enrollee's level of care and develop a Care Plan. The CNA will be conducted by a healthcare professional, either telephonically or face-to-face, depending on the Enrollee's needs. All elements of the State approved CNA tool that appears in the Care Management Workbook must be included in the MCO assessment tool. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	**In the 2024 CM file audit the MCO scored for the General Population Enrollees:** 50.0%- Initial outreach to complete the CNA was done timely, within 30 days of identification of CM needs. (30 days from IHS score 5 or greater; or IHS less than 5, no IHS, identification of CM needs through other sources) (applies to new Enrollees). 72.0%- The Comprehensive Needs Assessment was completed timely (within 30 days of identification of CM needs (applies to new Enrollees). 73.5%- The Comprehensive Needs Assessment was completed timely (within 30 days of identification of CM needs) (applies to existing Enrollees).
CM14	**4.6.2.O** **Continuity of Care** The Contractor's Quality Management Plan shall include a continuity of care system including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as preventive services and maintenance of function for Enrollees with special needs.	**In the 2024 CM file audit the MCO scored for the DDD Population Enrollees:** 81.2%- The Care Manager addressed and/or discussed dental needs with Enrollees (aged 21 and above) (applies to new Enrollees). **In the 2024 CM file audit the MCO scored for the DCP&P Population Enrollees:** 50.0%- The Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20) (applies to new Enrollees). 0.0%- Dental reminders were sent to Enrollees without a confirmed dental visit (aged 1 through 20) (applies to new Enrollees).

Table 19: Findings for Resolved Deficiencies for Care Management Elements

Element	Contract Language
CM3	**4.6.5.A** Apply systems, science, and information to identify Enrollees with potential Care Management needs and assist Enrollees in managing their health care more effectively with the goal of improving, maintaining, or slowing the deterioration of their health status.

Element	Contract Language
CM8	**4.6.5.B.3** **Plan of Care to Address Needs Identified** Care Plan: Based on the CNA, the Care Manager will assign Enrollees to a care level, develop a Care Plan and facilitate and coordinate the care of each Enrollee according to his/her needs or circumstances. With input from the Enrollee and/or caregiver and PCP, the Care Manager must jointly create a Care Plan with short/long-term Care Management goals, specific actionable objectives, and measurable quality outcomes. The Care Plan should be culturally appropriate and consistent with the abilities and desires of the Enrollee and/or caregiver. Understanding that Enrollees' care needs and circumstances change, the Care Manager must continually evaluate the Care Plan to update and/or change it to accurately reflect the Enrollee's needs and level of care.
CM15	**4.6.5.D.1** The Contractor shall establish and operate a system to assure that a comprehensive treatment plan for every Enrollee will progress to completion in a timely manner without unreasonable interruption.
CM17	**4.6.5.D.3** An Enrollee shall not suffer unreasonable interruption of his/her active treatment plan. Any interruptions beyond the control of the provider will not be deemed a violation of this requirement.
CM19	**4.6.5.E** **Documentation** The Contractor shall document all contacts and linkages to medical and other services in the Enrollee's case files.

Comprehensive Recommendations

The following recommendations are for deficiencies identified in the Care Management Audit and Annual Assessment.

For the General Population:

1. CM6: Fidelis Care should ensure that for Enrollees where no Initial Health Screen (IHS) is on file, aggressive outreach attempts are documented and are done within 45 days of the Enrollee's enrollment (applies to new Enrollees).
2. CM7: Fidelis Care should ensure that Initial outreach to complete the Comprehensive Needs Assessment is done timely, within 30 days of identification of CM needs (applies to new Enrollees).
3. CM7: Fidelis Care should ensure that the Comprehensive Needs Assessment is completed timely (within 30 days of identification of CM needs) (applies to new and existing Enrollees).

For the DDD Population:

1. CM14: For Enrollees aged 21 and above, Fidelis Care should ensure that the Care Manager addresses/discusses dental needs with the Enrollee (applies to new Enrollees).

For the DCP&P Population:

1. CM2: Fidelis Care should ensure for Enrollees who are hospitalized, adequate discharge planning is performed (applies to existing Enrollees).
2. CM14: For Enrollees aged 0 through 20 where the EPSDT exam is not up to date, Fidelis Care should ensure EPSDT reminders are sent (applies to new Enrollees).
3. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, Fidelis Care should ensure dental reminders are sent (applies to new Enrollees).

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office of MLTSS Quality Monitoring

MCO MLTSS HCBS Care Management Audit
Fidelis Care

Review Period July 1, 2023 – June 30, 2024

January 2025

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Introduction

The purpose of the Managed Long-Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community Based Services (HCBS) and Institutionalization for Long-Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. The U.S. Department of Health and Human Services (HHS) declared an end to the Public Health Emergency (PHE) for COVID-19 on May 11, 2023. The State issued Covid-19 flexibilities related to specific MLTSS Care Management activities ended prior to this review period (July 1, 2023 to June 30, 2024), except for the NJ DHS, Division of Aging Services (DoAS), *Temporary Waiver of Clinical Eligibility Requirements for MLTSS Enrollment for MCO Members in a Community Setting.* Effective July 5, 2023 the use of the Screen for Community Services (SCS) as presumptive eligibility was discontinued.

The populations included in this audit were Members who met eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or Community Alternative Residential Setting (CARS), for at least six consecutive months within the review period July 1, 2023 to June 30, 2024.

Annually, DMAHS evaluates the MCO performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the NJ FamilyCare Contracts (Article 9), dated July 2023 and January 2024. A representative sample of files were selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities, and post-audit activities.

1. Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology, necessary source documents, contract references, and the Division of Aging Services (DoAS), Office of Community Choice Options (OCCO) new contract requirements for MLTSS Care Management. Effective November 15, 2023, as part of the NJ Choice Assessment system, MCOs are required to complete a NJ specific Options Counseling Summary (OCS) form, whereas the Interim Plan of Care (IPOC) was no longer contractually required.

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

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

Population Selection

The sample was determined by using the following capitation codes to identify MLTSS HCBS enrollment presented in **Table 1** and applying the sampling methodology described in **Table 2**.

Table 1. Capitation Codes

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

The sampling methodology as shown in **Table 2** resulted in the selection of 156 cases for Fidelis Care, including an oversample.

Table 2. Sampling Methodology

Subpopulations	Criteria
Group C: Members New to Managed care and Newly Eligible for MLTSS between 7/1/2023 and 6/30/2024.	• The Member must have been initially enrolled in MLTSS HCBS between 7/1/2023 and 1/1/2024. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2024 in the ***same*** MCO with no gaps in enrollment.
Group D: Current Medicaid Managed care Members enrolled in MLTSS between 7/1/2023 and 6/30/2024.	• The Member must have been initially enrolled in MLTSS HCBS between 7/1/2023 and 1/1/2024. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2024 in the ***same*** MCO with no gaps in enrollment. • On the first day of the month prior to the initial MLTSS HCBS enrollment, the Member was enrolled in the ***same*** Medicaid MCO as the MLTSS HCBS MCO.
Group E: Current Medicaid Managed care Members enrolled in MLTSS prior to 7/1/2023 and continuously enrolled in MLTSS through 6/30/2024.	• The Member must have been initially enrolled in MLTSS HCBS prior to 7/1/2023. • The Member must have remained enrolled in MLTSS HCBS through 6/30/2024 in the ***same*** MCO with no gaps in enrollment.
Performance Measure #9a Enhancement	• A sample of 30 MLTSS HCBS Members across subgroups C, D, and E, identified on the NJ Choice Assessment Data list with assessment code 3, 4, and 5 will be included in the base sample abstracted from the universe. All MLTSS HCBS Members were included if the MCO has less than 30 Members who meet eligibility criteria.

MLTSS HCBS subpopulations were identified depending on different enrollment criteria. A stratified methodology was used to randomly select 100 MLTSS HCBS Members across subgroups C and D, and 30 MLTSS HCBS Members in subgroup E as a base sample. A 20% oversample across subgroups C and D, and subgroup E was drawn for substitution of exclusions.

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

All MLTSS HCBS Members were included if there were less than 100 Members across subgroups C and D, or less than 30 Members in subgroup E. Members could only be excluded by the MCO if they could provide evidence that the Member did not meet eligibility requirements. An oversample was selected for the MCO to replace any excluded files, as well as ensure an adequate denominator to evaluate Performance Measures.

Introductory E-Mail

IPRO sent an Introductory E-Mail to the MCO prior to the scheduled offsite audit including:

- Confirmation of the dates for the audit.
- Description of the sample.
- File listings identifying the files that needed to be available at the time of the offsite audit.

2. Audit Activities

IPRO reviewers conducted the file reviews over a five-week period. Reviewer inter-rater reliability was maintained using the standardized audit tool, and ongoing communication and coordination among the review team. Electronic files were prepared by the MCO for review.

3. Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the 156 cases selected for Fidelis Care, 142 Member files were reviewed and 130 were included in the results.

Description	Group C	Group D	Group E	Subtotal
Total Number of Files Reviewed	47	56	39	142
Exclusions	3	0	9	12
Number of Files included in Results	44	56	30	130

Population-specific findings are presented in **Table 3**, which contains aggregate scores based on the results of selected review questions within each review category: Assessment, Member Outreach, Face-to-Face Visits, Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans), Ongoing Care Management, and Gaps in Care/Critical Incidents. Rates for each subpopulation and a combined score calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 3**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

Fidelis Care's audit results for the combined MLTSS sample ranged from 89.9% to 100.0% across all three (3) populations for the six (6) audit categories.

Table 3. Results by Category

Determination by Category	July 1, 2023 – June 30, 2024			
	Group C	Group D	Group E[2]	Combined[3]
Assessment	100.0%	99.0%	96.4%	98.5%
Member Outreach	90.9%	96.4%	--	94.0%
Face-to-Face Visits	98.9%	100.0%	96.2%	98.8%
Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans)[1]	99.8%	99.4%	98.0%	99.2%
Ongoing Care Management	95.4%	99.0%	89.9%	96.0%
Gaps in Care/Critical Incidents	100.0%	100.0%	100.0%	100.0%

[1]Initial Plan of Care is assessed for Group C and Group D Members. Ongoing Plans of Care are assessed for Group E Members as they are not new to MLTSS. Back-up Plans are assessed for Group C, D, and E Members.
[2]Member Outreach is not evaluated for Members in Group E as they are not new to the MLTSS.
[3]Calculated as an aggregate score by combining elements applicable to each category.

Members New to Managed Care and Newly Eligible for MLTSS (Group C)

A total of 47 files were reviewed for new Members enrolled in Managed Care and newly eligible for MLTSS (Group C). There were 3 files excluded. All 44 files were further reviewed for compliance in 6 categories. There were 12 Members residing in CARS.

Assessment	N	D	Rate
The MCO requested an NJ Choice Assessment (NJCA) for the Member from OCCO.*	17	44	38.6%
MCO requested an NJCA for the Member from OCCO within fifteen (15) business days of the effective date of the Member's enrollment (for this population, MCOs have the option of requesting a New Jersey Choice Assessment (NJCA) from the Office of Community Choice Options (OCCO).*	17	17	100.0%
OCCO response was received within 5 business days of the MCO request.*	1	17	5.9%
The MCO received an NJCA from OCCO within 5 business days of OCCO's notification that is considered valid and current.*	0	17	0.0%
OCCO completed the NJCA which is valid during the review period.*	2	44	4.5%
The MCO completed the NJCA with the Member.	42	42	100.0%

*Not included in aggregate score calculation

Member Outreach	N	D	Rate
Initial outreach was completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.	40	44	90.9%

Face-to-Face Visits	N	D	Rate
Member participated in all face-to-face visits.*	44	44	100.0%
Member was unable to participate in the face-to-face visit due to cognitive impairment, a minor child, and/or the Member has a legal guardian.*	0	0	N/A
Member or authorized representative participated in the onsite visit with the Care Manager.*	0	0	N/A
Options Counseling was provided to the Member.[1]	42	42	100.0%
Member was offered the participant direction option.[3]	32	32	100.0%
Member chose to participate in participant direction (excludes Members residing in CARS).*	15	32	46.9%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.[3]	14	15	93.3%
Member had a completed and signed Interim Plan of Care (IPOC) or Options Counseling Summary (OCS) form on file.[1,2]	42	42	100.0%
A cost effective analysis was completed during the review period.	43	44	97.7%
Member reached or exceeded 85% of the annual cost thresholds (ACT).*	0	43	0.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period, had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

*Not included in aggregate score calculation

[1] Denominator excludes Members where OCCO completed the New Jersey Choice Assessment

[2]Compliance was evaluated for IPOCs completed before November 15, 2023 or OCS form completed on or after November 15, 2023

[3]Denominator excludes Members residing in CARS

N/A: Not Applicable

Initial Plan of Care (Including Back-up Plans)	N	D	Rate
Member had a completed and signed Initial Plan of Care on file, that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	44	44	100.0%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	44	44	100.0%
Member refused to be assessed for PCA services (excludes Members residing in CARS).*	19	32	59.4%
Member was assessed for PCA services (excludes Members residing in CARS).*	13	13	100.0%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.[1]	13	13	100.0%
Member required another PCA assessment due to changes in condition (excludes Members in CARS).*	1	13	7.7%
Member was re-assessed for PCA due to changes in condition.[1]	1	1	100.0%

Member had a Plan of Care and NJCA on file during the review period.*	44	44	100.0%
Plans of Care for MLTSS Members are aligned with Member needs as identified during the NJCA.	44	44	100.0%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	44	44	100.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	44	44	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	44	44	100.0%
Members who required a Back-up Plan, had a completed and signed Back-up Plan using the State mandated form.[1]	32	32	100.0%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	32	32	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	32	32	100.0%
Member service preference levels were documented in the Back-up Plan.[1]	32	32	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	32	32	100.0%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	32	32	100.0%
Member file included a Member Rights and Responsibilities statement signed by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	43	44	97.7%
The Care Manager educated the Member on how to file a grievance and/or an appeal.	44	44	100.0%
Members residing in their community home had a risk assessment completed that included documentation of whether a positive risk was identified or not.[1]	32	32	100.0%
Member required a Risk Management Agreement (excludes Members residing in CARS).*	0	32	0.0%
Members who were identified as having a positive risk, had a signed Risk Management Agreement with all components.[1]	0	0	N/A

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS

N/A: Not Applicable

Ongoing Care Management	N	D	Rate
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).[1]	32	32	100.0%
Member experienced issues that impeded access to care.*	0	44	0.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	0	0	N/A
Member had a documented face-to-face visit to review Member placement and services during the review period.	44	44	100.0%
Review of Member's placement and services occurred timely (an ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	40	44	90.9%
Member required a change in Plan of Care based on an increase or reduction of services.*	3	44	6.8%
Member files that indicated a change from the Initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed and was provided with a copy of the Plan of Care.	3	3	100.0%
Member file indicates disagreement with the Plan of Care.*	0	0	N/A
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	44	0.0%
A face-to-face visit was conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition or well-being.	0	0	N/A
Member was discharged to an HCBS setting during the review period.*	2	44	4.5%
Member refused the 10 day post discharge onsite visit.*	0	2	0.0%
The Care Manager completed a 10 day post discharge telephonic visit.*	0	0	N/A
For Members who were discharged to an HCBS setting the onsite review occurred within ten (10) days of discharge.	0	2	0.0%
Member was discharged to his/her own home and in home services were in place in a timely manner.	2	2	100.0%
Member experienced a significant change in condition requiring the Plan of Care to be amended.*	3	44	6.8%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed by the Member and/or authorized representative.	3	3	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS

N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation the Care Manager reviewed the process for immediately reporting gaps in service delivery with the Member.	32	32	100.0%
Member reported a gap in service delivery (excludes Members residing in CARS).*	0	32	0.0%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	0	0	N/A
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	44	44	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS
N/A: Not Applicable

Members Currently Enrolled in Managed Care and Newly Eligible for MLTSS (Group D)

A total of 56 files were reviewed for Members currently enrolled in Managed Care and newly eligible for MLTSS (Group D). No files were excluded. All 56 files were further reviewed for compliance in all 6 categories. There were no Members residing in CARS.

Assessment	*N*	*D*	*Rate*
Member had a Screening for Community Services (SCS) tool completed.*	42	56	75.0%
Member enrolled in MLTSS on an SCS Waiver.*	1	42	2.4%
The NJ Choice Assessment (NJCA) was completed within 30 days of a referral to MLTSS.	40	41	97.6%
The MCO completed the NJCA with the Member.	56	56	100.0%

*Not included in aggregate score calculation

Member Outreach	N	D	Rate
Initial outreach was completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.	54	56	96.4%

Face-to-Face Visits	N	D	Rate
Member participated in all face-to-face visits.*	56	56	100.0%

Member was unable to participate in face-to-face visit due to cognitive impairment, a minor child, and/or the Member had a legal guardian.*	0	0	N/A
Member or authorized representative participated in the onsite meeting with the Care Manager.*	0	0	N/A
Options Counseling was provided to the Member.	56	56	100.0%
Member had PPP prior to MLTSS enrollment.*	5	56	8.9%
Member had PPP pending prior to MLTSS enrollment.*	1	56	1.8%
Member was offered the participant direction option.[1]	50	50	100.0%
Member chose to participate in participant direction (excludes Members residing in CARS).*	15	50	30.0%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.[1]	15	15	100.0%
Member had a completed and signed Interim Plan of Care (IPOC) or Options Counseling Summary (OCS) form on file. [2]	56	56	100.0%
A cost effective analysis was completed during the review period.	56	56	100.0%
Member reached or exceeded 85% of the annual cost threshold (ACT).*	0	56	0.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period, had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

*Not included in aggregate score calculation

[1] Denominator excludes Members residing in CARS

[2]Compliance was evaluated for IPOCs completed before November 15, 2023 or OCS form completed on or after November 15, 2023

N/A: Not Applicable

Initial Plan of Care (Including Back-up Plans)	N	D	Rate
Member had a completed and signed Initial Plan of Care on file, that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	55	56	98.2%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	56	56	100.0%
Member had PCA services prior to MLTSS enrollment.*	11	56	19.6%
Member refused to be assessed for PCA services (excludes Members residing in CARS).*	25	45	55.6%
Member was assessed for PCA services (excludes Members residing in CARS).*	20	20	100.0%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.[1]	20	20	100.0%
Member required another PCA assessment due to changes in condition (excludes Members residing in CARS).*	3	20	15.0%
Member was re-assessed for PCA due to changes in condition.[1]	3	3	100.0%
Member had a Plan of Care and NJCA on file during the review period.*	56	56	100.0%
Plans of Care for MLTSS Members are aligned with Member's needs as identified during the NJCA.	56	56	100.0%

There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	56	56	100.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	56	56	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	56	56	100.0%
Members who required a Back-up Plan, had a completed and signed Back-up Plan using the State mandated form.[1]	56	56	100.0%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	56	56	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	56	56	100.0%
Member service preference levels were documented in the Back-up Plan.[1]	56	56	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	55	56	98.2%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	56	56	100.0%
Member file included a Member Rights and Responsibilities statement signed by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	56	56	100.0%
Care Manager educated the Member on how to file a grievance and/or an appeal.	56	56	100.0%
Members residing in their community home had a risk assessment completed that included documentation of whether a positive risk was identified or not.[1]	56	56	100.0%
Member required a Risk Management Agreement (excludes Members residing in CARS).*	4	56	7.1%
Members who were identified as having a positive risk, had a signed Risk Management Agreement with all components.[1]	1	4	25.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS

Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).[1]	56	56	100.0%
Member experienced issues that impeded access to care.*	0	56	0.0%

Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	0	0	N/A
Member had a documented face-to-face visit to review Member placement and services during the review period.	56	56	100.0%
Review of Member's placement and services occurred timely (an ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	54	56	96.4%
Member required a change in Plan of Care based on an increase or reduction of services.*	13	56	23.2%
Member files that indicated a change from the Initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed and was provided with a copy of the Plan of Care.	13	13	100.0%
Member file indicates disagreement with the Plan of Care.*	0	0	N/A
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	56	0.0%
Face-to-face visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition, or well-being.	0	0	N/A
Member was discharged to an HCBS setting during the review period.*	2	56	3.6%
Member refused the 10 day post discharge onsite visit.*	1	2	50.0%
Care Manager completed a 10 day post discharge telephonic visit.*	1	1	100.0%
For Members who were discharged to an HCBS setting the onsite review occurred within ten (10) days of discharge.	1	1	100.0%
Member was discharged to his/her own home and in home services were in place in a timely manner.	2	2	100.0%
Member experienced a significant change in condition requiring the Plan of Care to be amended.*	8	56	14.3%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed by the Member and/or authorized representative.	8	8	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS

N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	56	56	100.0%

Member reported a gap in service delivery (excludes Members residing in CARS).*	0	56	0.0%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	0	0	N/A
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	56	56	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS
N/A: Not Applicable

Members Enrolled in Managed Care and MLTSS Prior to the Review Period (Group E)

A total of 39 files were reviewed for the Members enrolled in Managed Care and MLTSS prior to the review period (Group E). There were 9 files excluded. The Member Outreach category is not assessed for Members in Group E. All 30 files were reviewed for compliance in 5 categories. There were no Members residing in CARS.

Assessment	*N*	*D*	*Rate*
The NJ Choice Assessment (NJCA) was due during the review period.*	28	30	93.3%
The MCO completed the NJ Choice Assessment with the Member.	27	28	96.4%
Member had an NJCA completed to reassess clinical eligibility for MLTSS within 11 to 13 months from the last NJCA authorized by OCCO.	27	28	96.4%

*Not included in aggregate score calculation

Face-to-Face Visits	N	D	Rate
Member participated in all face-to-face visits.*	30	30	100.0%
Member was unable to participate in the face-to-face visit due to cognitive impairment, a minor child, and/or the Member had a legal guardian.*	0	0	N/A
Member or authorized representative participated in the onsite visit with the Care Manager.*	0	0	N/A
Options Counseling was provided to the Member.	27	27	100.0%
Member had PPP prior to review period (excludes Members residing in CARS).*	9	30	30.0%
Member had PPP pending prior to review period (excludes Members residing in CARS).*	0	30	0.0%
Member was offered the participant direction option.[1]	21	21	100.0%
Member chose to participate in participant direction (excludes Members residing in CARS).*	1	21	4.8%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.[1]	1	1	100.0%
Member had a completed and signed Interim Plan of Care (IPOC) or Options Counseling Summary (OCS) form on file.[2]	27	27	100.0%

A cost effective analysis was completed during the review period.	26	30	86.7%
Member reached or exceeded 85% of the annual cost thresholds (ACT).*	0	26	0.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period, had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

*Not included in aggregate score calculation
[1]Denominator excludes Members in CARS
[2]Compliance was evaluated for IPOCs completed before November 15, 2023 or OCS form completed on or after November 15, 2023
N/A: Not Applicable

Ongoing Plans of Care (Including Back-up Plans)	N	D	Rate
Plan of Care reassessment for MLTSS Members was conducted within 30 days of annual LOC re-determination.	26	27	96.3%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	30	30	100.0%
Member file had documentation to demonstrate contact with the Member's HCBS providers at least annually to discuss the providers' reviews of the Member's needs and status and quarterly for Members receiving skilled nursing care, treatment for traumatic brain injury or behavioral health services.	30	30	100.0%
Member had PCA services prior to the review period (excludes Members residing in CARS).*	18	30	60.0%
Member refused to be assessed for PCA services (excludes Members residing in CARS).*	9	12	75.0%
Member was assessed for PCA services (excludes Members residing in CARS).*	3	3	100.0%
Member required another PCA assessment due to changes in condition (excludes Members in CARS).*	1	3	33.3%
Member was re-assessed for PCA due to changes in condition.[1]	1	1	100.0%
Member had a Plan of Care and NJCA on file during the review period.*	27	30	90.0%
Plans of Care for MLTSS Members are aligned with Member's need as identified during the NJCA.	27	27	100.0%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	30	30	100.0%
Member's Plan of Care contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	30	30	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	30	30	100.0%

Members who required a Back-up Plan, had a completed and signed Back-up Plan using the State mandated form.[1]	30	30	100.0%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	30	30	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	30	30	100.0%
Member service preference levels were documented in the Back-up Plan.[1]	30	30	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	29	30	96.7%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	30	30	100.0%
Member file included a Member Rights and Responsibilities statement signed by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	27	30	90.0%
Care Manager educated the Member on how to file a grievance and/or an appeal.	30	30	100.0%
Care Manager completed an Annual Risk Assessment for the Member.[1]	28	30	93.3%
Members who were identified as having a positive risk (excludes Members residing in CARS).*	1	28	3.6%
IPRO identified the Member as having a potential risk during the review period that the Care Manager failed to identify. [1,2]	3	27	88.9%[2]
Members who were identified as having a positive risk, had a signed Risk Management Agreement with all components.[1]	1	1	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members in CARS
[2]Percentage rate is indicative of compliant cases

Ongoing Care Management	**N**	**D**	**Rate**
Member experienced issues that impeded access to care.*	0	30	0.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	0	0	N/A
Member had a documented face-to-face visit to review Member placement and services during the review period.	30	30	100.0%
Review of Member's placement and services occurred timely (an ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	24	30	80.0%
Member required a change in Plan of Care based on an increase or reduction of services.*	7	30	23.3%
Member files that indicated a change from the Initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed and was provided with a copy of the Plan of Care.	7	7	100.0%

Member file indicated a disagreement with the Plan of Care.*	0	0	N/A
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service), were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	30	0.0%
Face-to-face visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition, or well-being.	0	0	N/A
Member was discharged to an HCBS setting during the review period.*	3	30	10.0%
Member refused the 10 day post discharge onsite visit.*	0	3	0.0%
The Care Manager completed a 10 day post discharge telephonic visit.*	0	0	N/A
For Members who were discharged to an HCBS setting the onsite review occurred within ten (10) days of discharge.	1	3	33.3%
Member was discharged to his/her own home and in home services were in place in a timely manner.	3	3	100.0%
Member experienced a significant change in condition requiring the Plan of Care to be amended.*	4	30	13.3%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed by the Member and/or authorized representative.	4	4	100.0%
Member had a change in placement occur during the review period.*	2	30	6.7%
Member had a change in placement indicated and there was documentation of discussion with the Member before the change was made.	2	2	100.0%

*Not included in aggregate score calculation
N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	30	30	100.0%
Member reported a gap in service delivery (excludes Members in CARS).*	0	30	0.0%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	0	0	N/A
Member file had documentation that the Care Manager explained the Member's Rights and Responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	30	30	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS
N/A: Not Applicable

Performance Measures

Population-Specific findings are presented in **Table 4**, which present results on the following MLTSS Performance Measures: #8 (Plans of Care established within 45 days of MLTSS enrollment), #9 (Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination), #9a (Plan of Care for MLTSS Members amended based on change of Member condition), #10 (Plans of Care for MLTSS Members are aligned with Member needs identified during the NJ Choice Assessment), #11 (Plans of Care for MLTSS Members are developed using "Person-Centered Principles"), #12 (MLTSS Home and Community Based Services (HCBS) Plans of Care that include a Back-up Plan), and #16 (MCO provided training to MLTSS Member on identifying/reporting Critical Incidents).

Population results, as shown in **Table 4**, are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. **Table 4** shows the results of the 2023-2024 audit findings. Overall, Fidelis Care's audit results ranged from 96.3% to 100.0% across all groups for seven (7) Performance Measures for the current review period.

Table 4. Results of MLTSS Performance Measures

Performance Measure	Group[1]	Numerator	Denominator	Rate
#8. Plans of Care established within 45 days of MLTSS enrollment.	Group C	44	44	100.0%
	Group D	55	56	98.2%
	Group E[4]			
	Total	99	100	99.0%
#9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination.	Group C[5]			
	Group D[5]			
	Group E	26	27	96.3%
	Total	26	27	96.3%
#9a. Plan of Care for MLTSS Members amended based on change of Member condition.[2]	Group C	3	3	100.0%
	Group D	8	8	100.0%
	Group E	4	4	100.0%
	Total	15	15	100.0%
#10. Plans of Care for MLTSS Members are aligned with Member needs identified during the NJ Choice Assessment.	Group C	44	44	100.0%
	Group D	56	56	100.0%
	Group E	27	27	100.0%
	Total	127	127	100.0%

#11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles."	Group C	44	44	100.0%
	Group D	56	56	100.0%
	Group E	30	30	100.0%
	Total	130	130	100.0%
#12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that include a Back-up Plan.[3]	Group C	32	32	100.0%
	Group D	56	56	100.0%
	Group E	30	30	100.0%
	Total	118	118	100.0%
#16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents.	Group C	44	44	100.0%
	Group D	56	56	100.0%
	Group E	30	30	100.0%
	Total	130	130	100.0%

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

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

[3]Members in Community Alternative Residential Settings (CARS) are excluded from this measure

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

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

Discussion

Limitations

The NJ Department of Human Services, Division of Aging Services, *Temporary Waiver of Clinical Eligibility Requirements for MLTSS Enrollment for MCO Members in a Community Setting,* discontinued on July 5, 2023. For Group D Members, the MCO utilized the Screening for Community Services (SCS) tool for MLTSS enrollment if the Member met criteria (i.e. scores of 3, 4, or 5) up until July 5, 2023. Therefore, completion of the NJ Choice Assessment within 30 days of a referral to MLTSS could not be evaluated for those Members enrolled in MLTSS through an SCS waiver.

Conclusions and Recommendations

Population-Specific conclusions and recommendations are presented by category below.

Assessment

Across all three groups, the MCO had a combined score of 98.5% in the Assessment category.

Group	7/1/23 to 6/30/24
Group C	100.0%
Group D	99.0%
Group E	96.4%
Combined	98.5%

Member Outreach

Across groups, the MCO had a combined score of 94.0% in the Member Outreach category.

Group	7/1/23 to 6/30/24
Group C	90.9%
Group D	96.4%
Group E[1]	--
Combined	94.0%

[1]Member Outreach is not assessed for Members in Group E because Group E Members are not new to MLTSS

Face-to-Face Visits

Across all three groups, the MCO had a combined score of 98.8% in the Face-to-Face Visits category.

Group	7/1/23 to 6/30/24
Group C	98.9%
Group D	100.0%
Group E	96.2%
Combined	98.8%

Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans)

Across all three groups, the MCO had a combined score of 99.2% in the Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans) category.

Group	7/1/23 to 6/30/24
Group C	99.8%
Group D	99.4%
Group E	98.0%
Combined	99.2%

Ongoing Care Management

Across all three groups, the MCO had a combined score of 96.0% in the Ongoing Care Management category.

Group	7/1/23 to 6/30/24
Group C	95.4%
Group D	99.0%
Group E	89.9%
Combined	96.0%

Gaps in Care/Critical Incidents

Across all three groups, the MCO had a combined score of 100.0% in the Gaps in Care/Critical Incidents category.

Group	7/1/23 to 6/30/24
Group C	100.0%
Group D	100.0%
Group E	100.0%
Combined	100.0%

Performance Measures

Overall, the MCO scored above 86% in all seven (7) Performance Measures.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
Managed Long Term Services and Supports (MLTSS)

2024 Annual Assessment Review of Care Management
Fidelis Care

Review Period - July 1, 2023 to June 30, 2024
December 2024

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Introduction

The NJ Family Care Managed Care Program, administered by the NJ Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), provides healthcare benefits for certain groups of children and adults with low-to-moderate incomes. The program provides health coverage to children, pregnant women, single adults, childless couples, aged, blind, and disabled individuals, and individuals qualified for long-term care services.

Background

The purpose of the Managed Long-Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure "That services were provided" to special needs members who met MLTSS eligibility requirements as specified in Article 9.

Annually, DMAHS evaluates Managed Care Organization (MCO) performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Assessment Methodology

The review consisted of pre-offsite review of documentation provided by Fidelis Care (FC) as evidence of compliance of the standards under review; interviews with key Fidelis Care staff (held via Teams meeting on December 4, 2024) and post-offsite evaluation of documentation and offsite activities.

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

The offsite review of documentation was requested by IPRO on July 26, 2024, and received from the MCOs on August 9, 2024. The documentation review occurred offsite at IPRO beginning on August 12, 2024. The IPRO review team consisted of Carla Zuccarello, Karen Halley, and Cynthia Santangelo. The Care Management assessment covered the period from July 1, 2023 to June 30, 2024. The MCOs were advised to provide both MLTSS and FIDE SNP/MLTSS documents if their Care Management documentation differed between MLTSS and FIDE SNP/MLTSS.

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

Table 1: All MLTSS CM elements are subject to be reviewed annually regardless of a prior year Met, and therefore be considered full reviews every year.

Table 1: Rating Scale for the MCO (MLTSS) Annual Assessment Review of Care Management

Rating	Rating Methodology	Review Type
Met in Prior Review	This element was met in the previous review cycle.	Full, Partial
Met	All parts within this element were met.	Full, Partial
Not Met	Not all required parts within the element were met.	Full, Partial
N/A	This element is not applicable and will not be considered as part of the score.	Full, Partial
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.	Full, Partial
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.	Full, Partial
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.	Full, Partial

Report Organization

This report provides findings for the MLTSS Care Management and Continuity of Care document submission portion of the 2024 MLTSS Care Management review.

A table is presented which provides the number of elements under review, the number *Met*, *Not Applicable* (*N/A*), and the number *Not Met* for this review. Percentages are based on the total number of applicable elements in the standard. Credit is given for receiving a *Met* finding in the current review. Contract language and reviewer comments are provided for *Not Met* elements. Contract language is provided for *N/A* elements and resolved deficiencies.

Following this summary, Strengths, Recommendations and Findings for Improvement are reported where applicable. Recommendations relate to those elements that are deficient and must be addressed by the Plan. Findings for Improvement relate to suggestions by the IPRO review team to strengthen current processes.

Care Management and Continuity of Care

The Care Management and Continuity of Care review category examines if the MCO has an effective care and case management service structure. This structure includes written policies, procedures, processes, and systems to identify, assess and manage its member population in care and case management program(s). This review category also examines whether the MCO has developed and implemented MLTSS Care Management Programs for enrollees who may benefit from these services in accordance with State requirements.

There are 10 contractual provisions in this category. Fidelis Care received an overall compliance score of 100% in 2024. In 2023, the MCO received a score of 100% for this category. **Table 1a** presents an overview of the results.

Table 1a: Summary of Findings for MLTSS Care Management and Continuity of Care

Element	Met Prior Year	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM18b	X	X	-	-	-	-	-
CM28	X	X	-	-	-	-	-
CM29	X	X	-	-	-	-	-
CM30	X	X	-	-	-	-	-
CM31	X	X	-	-	-	-	-
CM32	X	X	-	-	-	-	-
CM34	X	X	-	-	-	-	-
CM36	X	X	-	-	-	-	-
CM37	X	X	-	-	-	-	-
CM38	X	X	-	-	-	-	-
TOTAL	**10**	**10**	**0**	**0**	**0**	**0**	**0**
Compliance Percentage		**100%**					

Strengths

None

Recommendations

None

Findings for Improvement

None

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
Office of MLTSS Quality Monitoring

MCO MLTSS Nursing Facility/Special Care Nursing Facility Ancillary Review
Compliance Evaluation of MLTSS Performance Measures

Fidelis Care

July 2024

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Introduction

The purpose of the Managed Long Term Services and Supports (MLTSS) Nursing Facility (NF)/Special Care Nursing Facility (SCNF) Ancillary Review is to evaluate Managed Care Organizations (MCOs) compliance with the Division of Medical Assistance and Health Services (DMAHS) NJ FamilyCare Contract Article 9.11.G, MLTSS Performance Measures. IPRO conducted a review of the following MLTSS Performance Measures: PM #8, PM #9, PM #9a, PM #11, and PM #16 for the review period September 1, 2022 through June 30, 2023.

Sampling Methodology

Population Selection

Population Criteria	September 1, 2022 to June 30, 2023
Codes	Capitation Codes **MLTSS NF Codes:** 88199, 88399, 88499, 78199, 78399 and 78499 **MLTSS HCBS Codes:** 89399 and 79399 *Needs to include **both** Core Medicaid and FIDE SNP Plan codes. Moving from one Plan Code to another does not constitute a change in MCO.
Age	No age requirements
Sex	Both
Nursing Facility Placement	Enrolled in a NF/SCNF for at least six (6) consecutive months, between 9/1/2022 and up to and including 6/30/2023.
Anchor Date	Enrolled in NF on 6/30/2023.
Continuous Enrollment Criteria	Enrolled in the same MCO for the entire period, from the initial six (6) consecutive months of residence in a NF/SCNF and remains in MLTSS through 6/30/2023 with no gaps in MLTSS enrollment.

Methodology

A random sample of 35 NF/SCNF Members new to MLTSS and/or new to the MCO during the review period and 25 NF/SCNF Members enrolled in MLTSS and the MCO prior to 9/1/2022 was selected to meet a minimum of 60 files (including a 20% oversample required for substitutions or exclusions) for each MCO. IPRO reviewed a total of 50 files for Fidelis Care. There were no exlusions, resulting in 50 files evaluated for compliance with MLTSS Performance Measures #8, #9, #9a, #11, and #16.

Evaluation of MLTSS Performance Measures

The following Performance Measures were evaluated to determine MCO compliance; PM #8: Plans of Care established within 45 days of MLTSS enrollment; PM #9: Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination; PM #9a: Plan of Care for MLTSS Members amended based on change of Member condition; PM #11: Plans of Care for MLTSS Members are developed using "Person-Centered Principles;" and PM #16: MCO provided training to MLTSS Member on identifying/reporting Critical Incidents. Fidelis Care's results for each MLTSS Performance Measure are shown below in **Table 1**.

Table 1: MLTSS Performance Measures Results

Performance Measure	Numerator	Denominator	Rate
#8. Plans of Care established within 45 days of MLTSS enrollment.[1]	25	30	83.3%
#9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination.[2]	8	8	100.0%
#9a. Plan of Care for MLTSS Members amended based on change of Member condition.[3]	0	0	N/A
#11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles."[4]	50	50	100.0%
#16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents.	50	50	100.0%

[1] Compliance with this measure includes completion of the Initial Plan of Care and timeliness of completion. The denominator includes all NF/SCNF Members new to MLTSS and/or new to the MCO during the review period.
[2] Members included in this measure (denominator) have an annual LOC re-determination that was due and completed during the review period and a Plan of Care on file.
[3] Members who did not have a documented change in condition during the study period are excluded from this measure.
[4] For compliance with this measure Members must have a Plan of Care on file during the review period that contains documentation 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 be addressed in the Plan of Care.
N/A: Not Applicable. There were no Members who met the criteria for this measure.

Limitations

None.

Conclusions

As directed by DMAHS, no Corrective Action Plans (CAPs) will be required for MLTSS Performance Measures that score below the MLTSS compliance threshold of 86%.

Overall, the MCO scored 86% or above for the following MLTSS Performance Measures (**Table 1**):

- PM #9: Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination.
- PM #11: Plans of Care for MLTSS Members are developed using "Person-Centered Principles."
- PM #16: MCO provided training to MLTSS Member on identifying/reporting Critical Incidents.

Overall, the MCO scored below 86% for the following MLTSS Performance Measure (**Table 1**):

- PM #8: Plans of Care established within 45 days of MLTSS enrollment.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office of MLTSS Quality Monitoring

MCO MLTSS Nursing Facility/Special Care Nursing Facility Care Management Audit

Fidelis Care

February 2025

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Introduction

The purpose of the Managed Long-Term Services and Supports (MLTSS) Nursing Facility/Special Care Nursing Facility (NF/SCNF) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS Care Management program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Specifically, the populations included in this audit were Members who met the eligibility requirements for MLTSS and were receiving services in a Nursing Facility/Special Care Nursing Facility for at least six consecutive months within the review period from July 1, 2023 through June 30, 2024.

The U.S. Department of Health and Human Services (HHS) declared an end to the Public Health Emergency (PHE) for COVID-19 on May 11, 2023. State issued COVID-19 flexibilities related to specific Care Management activities and Nursing Facilities with visitation protocols (restricting Care Manager access) discontinued prior to this review period.

In addition to the CM audit, MLTSS Performance Measures #8 (Plans of Care established within 45 days of MLTSS enrollment), #9 (Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination), #9a (Plan of Care for MLTSS Members amended based on change of Member condition), #11 (Plans of Care for MLTSS Members are developed using “Person-Centered Principles”), and #16 (MCO provided training to MLTSS Member on identifying/reporting Critical Incidents) were calculated. Annually, DMAHS will evaluate the Managed Care Organization (MCO) performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the NJ FamilyCare Contracts (Article 9), dated July 2023 and January 2024. A representative sample of files were selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities, and post-audit activities.

1. Pre-audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the NJ Choice Assessment System, Plan of Care, contract references, and revision of elements for review. Audit questions are limited exclusively to ”Yes” or ”No” answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool in 2024, where appropriate, to determine whether a Member met the criteria for a subsequent section or question. Therefore, for some audit questions, Members represented in the numerator and denominator represent only those who met the specific applicable criteria. IPRO prepared an audit tool structured to collect requirement-specific information related to Facility and MCO Plan of Care, MLTSS Initial Plan of Care and Ongoing Plans of Care, Ongoing Care Management, Reassessment of the Plan of Care and Critical Incident Reporting, and Preadmission Screening and Resident Review (PASRR) Communications for Transitions to NF/SCNF. In addition, MLTSS Performance Measures #8, #9, #9a, #11, and #16 were calculated for the applicable NF/SCNF population. Rates calculated from these audit tool sections are utilized to determine MCO performance.

Separate rates were calculated on requirement-specific questions related to MLTSS Members who transitioned between HCBS and NF/SCNF settings during the review period. These rates are utilized solely for informational purposes.

Population Selection

Capitation and Plan codes were used to identify MLTSS HCBS and MLTSS NF/SCNF enrollment. The study sample was selected by using the capitation codes to identify MLTSS HCBS and NF/SCNF enrollment listed in **Table 1** and **Table 2**, and applying the sampling methodology described below.

Table 1: Capitation Codes for MLTSS HCBS Enrollment

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

Table 2: Capitation Codes for MLTSS NF Enrollment

Capitation Code	Description
88199	MLTSS Eligible Without Medicare – NF
88399	MLTSS Eligible Without Medicare – SCNF (Vents and Pediatrics)
88499	MLTSS Eligible Without Medicare – SCNF
78199	MLTSS Eligible With Medicare - NF
78399	MLTSS Eligible With Medicare – SCNF (Vents and Pediatrics)
78499	MLTSS Eligible With Medicare - SCNF

A random sampling method was used to meet a minimum of records needed to reach 100 files for each MCO. If the MCO did not have 100 files, the entire universe was selected for review. IPRO selected 110 cases for Fidelis Care, inclusive of an oversample of 10 cases to replace any excluded files as necessary.

Sampling Methodology

The criteria used to select the MLTSS NF/SCNF population were as follows:

- The Member must have been enrolled in MLTSS on June 30, 2024.
- The Member must have been enrolled as a NF/SCNF Member for 6 consecutive months during the review period and still enrolled with the MCO of record on June 30, 2024.
- The Member cannot be enrolled with another MCO at any time between the beginning of the minimum 6-month NF/SCNF enrollment and the end of the review period (June 30, 2024).

In order to collect additional information for MLTSS Members who transitioned between HCBS and NF/SCNF settings during the review period, the selected MLTSS NF/SCNF population was further identified as one of the four subgroups listed in **Table 3**.

Table 3: MLTSS NF/SCNF Population Subgroups

Group	Description
Group 1	Members permanently residing in an NF/SCNF at least 6 consecutive months from July 1, 2023 to June 30, 2024, with the MCO of record on June 30, 2024.
Group 2	Members residing in an NF/SCNF for at least 6 consecutive months from July 1, 2023 to June 30, 2024, and transitioned to HCBS during the review period with no transition from HCBS to another NF.
Group 3	Members residing in HCBS for at least 1 month between July 1, 2023 and June 30, 2024, and transitioned to an NF/SCNF for at least 6 consecutive months during the review period (and still residing in the NF/SCNF as of June 30, 2024).
Group 4	Members residing in HCBS for at least 1 month between July 1, 2023 and June 30, 2024, transitioned to an NF/SCNF for at least 6 consecutive months, and transitioned back to HCBS for at least 1 month during the review period.

Introductory E-mail

IPRO sent an introductory e-mail to the MCO prior to the scheduled offsite audit including:

- Formal notification of the audit with a file due date,
- Description of the sample,
- File listing identifying the files that needed to be submitted to IPRO, and
- Instructions for preparing files and uploading the files to IPRO's SEND File Transfer Protocol (FTP) site.

2. Offsite Audit Activities

Electronic files were prepared by the MCO for review and posted to IPRO's SEND FTP site. IPRO reviewers conducted the offsite file reviews over a five (5) week period. Reviewer inter-rater reliability (IRR) was maintained using the standardized audit tool with ongoing communication and coordination among the review team. Electronic files were prepared by the MCO for review.

3. Post-audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the 110 files selected for Fidelis Care, 104 Member files were reviewed. There were 4 files excluded. A total of 100 files were further reviewed for compliance in the following five (5) categories; Facility and MCO Plan of Care, MLTSS Initial Plan of Care and Ongoing Plans of Care, Ongoing Care Management, Reassessment of the Plan of Care and Critical Incident Reporting, and PASRR Communications for Transitions to NF/SCNF. Based on sample selection criteria, this included all four subpopulations (Groups 1, 2, 3 and 4). Rates for individual elements were calculated as the number of "Yes" determinations divided by the sum of "Yes" plus "No" determinations. Abbreviated review elements appear in bold in the table sections of this report (**Tables 4–8**). Rates should be considered cautiously for review elements with a denominator of less than 30.

Table 4: Facility and MCO Plan of Care

Facility and MCO Plan of Care	N	D	Rate
Member's Care Management record contained **copies of any Facility Plans of Care on file** during the review period.	89	100	89.0%
Documented review of the Facility Plan of Care by the Care Manager.	89	89	100.0%
MLTSS Plan of Care on file includes information from the Facility Plan of Care.	100	100	100.0%

Table 5: MLTSS Initial Plan of Care and Ongoing Plans of Care

MLTSS Initial Plan of Care and Ongoing Plans of Care	N	D	Rate
The Member's individualized Plan of Care (including obtaining Member's signature) **was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program.**[1]	6	6	100.0%
Care Managers used a Person-Centered approach regarding the Member's assessment and needs; taking into account not only covered services, but also formal and informal support services.	100	100	100.0%
Plan of Care reassessment for MLTSS Members conducted within 30 days of annual level of care (LOC) re-determination.[2]	87	90	96.7%
Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems, and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process.	100	100	100.0%
Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	100	100	100.0%
Member's agreement/disagreement with the Plan of Care statements were documented on the Member's Plan of Care and maintained in the Member's electronic CM record.	98	100	98.0%
Member experienced a significant change in condition requiring the Plan of Care to be amended.	0	100	0.0%

MLTSS Initial Plan of Care and Ongoing Plans of Care	N	D	Rate
Updated Plan of Care for a significant change. For any significant change in Member condition, Member's Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative.	0	0	N/A

[1]Compliance with this measure includes completion of the Initial Plan of Care, Member signature, and a copy provided to the Member within 45 calendar days of the MLTSS enrollment date. The denominator includes all NF/SCNF Members new to MLTSS and/or new to the MCO during the review period.
[2]Members included in this measure (denominator) have an annual LOC re-determination that was due and completed during the review period and a Plan of Care on file.
N/A: Not Applicable

Table 6: Ongoing Care Management

Ongoing Care Management	N	D	Rate
There was evidence in the file that the Member had the ability and/or desire to transition from the NF/SCNF.	3	100	3.0%
Member was identified for transfer to HCBS and was offered options, including transfer to the community.	3	3	100.0%
Evidence of the **Care Manager's participation in at least one interdisciplinary team (IDT) meeting** during the review period.	36	100	36.0%
Member was present at each onsite visit or had involvement from the Member's authorized representative regarding the Plan of Care. (If the Member was not able to participate in an onsite visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable).	100	100	100.0%
The Care Manager reviewed Member placement and services onsite with the Member present.	99	100	99.0%
Timely onsite review of Member placement and services. Onsite visits were timely and occurred within at least 180 calendar days for non-pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability).	86	99	86.9%
Member required coordination of care (physical health and/or behavioral health services) not covered by NF/SCNF.	0	100	0.0%
Members requiring coordination of care had coordination of care by the Care Manager.	0	0	N/A

N/A: Not Applicable

Table 7: Reassessment of the Plan of Care and Critical Incident Reporting

Reassessment of the Plan of Care and Critical Incident Reporting	N	D	Rate
The NJ Choice Assessment (NJCA) was due during the review period (initial or annual redetermination NJCA).	98	100	98.0%
Member had a NJCA completed during the review period.	95	98	96.9%
Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative.	95	100	95.0%
Care Manager reviewed the Member's rights and responsibilities.	100	100	100.0%

Reassessment of the Plan of Care and Critical Incident Reporting	N	D	Rate
Care Manager educated the Member on how to file a grievance and/or an appeal.	99	100	99.0%
Member and/or representative had **training on how to report a critical incident**, specifically including how to identify abuse, neglect and exploitation.	99	100	99.0%

Table 8: PASRR Communications for Transitions to NF/SCNF

PASRR Communications for Transitions to NF/SCNF	N	D	Rate
Member transitioned to the NF/SCNF during the review period.	1	100	1.0%
Care Manager completed or confirmed PASRR Level I prior to Member transition to NF/SCNF.	1	1	100.0%
Communication of PASRR Level I to OCCO documented by the Care Manager in the NJCA.	1	1	100.0%
Member required a PASRR Level II prior to admission to the NF/SCNF.	0	1	0.0%
Care Manager completed or confirmed PASRR Level II, prior to Member transition to NF/SCNF.	0	0	N/A
Communication of PASRR Level II to OCCO documented by the Care Manager (within 1 business day of receipt of determination).	0	0	N/A
Member demonstrated a need for MCO coordination with DDD/DMHAS.	0	0	N/A
Members who had a PASRR Level II indicating a need for Specialized Services setting had coordination with DDD/DMHAS.	0	0	N/A

OCCO: Office of Community Choice Options; DDD: Division of Developmental Disabilities; DMHAS: Division of Mental Health and Addiction Services
N/A: Not Applicable

MLTSS Members Transitioning Between HCBS and NF/SCNF Settings

Of the cases selected for Fidelis Care, 100 Member files were reviewed and included in the results. Rates were calculated for Members who transitioned from one MLTSS setting to another during the review period (Groups 2, 3, and 4; **Table 9**). Review elements are abbreviated in bold. Evaluation of MCO performance is for information purposes only.

Table 9: Member Transition Groups

Group	Member Transition	Number of Members
Group 1	Permanently residing in NF/SCNF for at least 6 months without a transition during the review period.	99
Group 2	Transitioned from NF/SCNF to HCBS with no other facility transition during the review period.	1
Group 3	Transitioned from HCBS to NF/SCNF and remained in a facility at the end of the review period.	0
Group 4	Transitioned from HCBS to NF/SCNF and back to HCBS during the review period.	0

MLTSS Members Transitioning from NF/SCNF to HCBS

A total of 1 file was reviewed for Members permanently residing in a NF/SCNF and subsequently transitioned to a home or community-based setting. Rates were calculated to profile NF/SCNF Members that transitioned to HCBS (Groups 2 and 4; **Table 9**).

Table 10: NF/SCNF Members Transitioned to HCBS

Transitions to HCBS	N	D	Rate
Member transitioned from NF/SCNF to HCBS during the review period.	1	100	1.0%
Member had a **Person-Centered transition plan on file.**	1	1	100.0%
Cost effectiveness evaluation was completed for the Member prior to discharge from a NF/SCNF.	0	1	0.0%
Plan of Care updated prior to discharge from a facility. Plan of Care was developed and agreed upon by the Member and/or representative prior to the effective date of transfer to the community.	0	1	0.0%
Participation in an interdisciplinary team (IDT) meeting related to transition. Care Manager participated in the coordination of an IDT meeting related to transition planning.	1	1	100.0%
Authorizations and procurement of transitional services for the Member were completed prior to NF/SCNF transfer.	1	1	100.0%
Care Manager conducted a **face-to-face visit within 10 business days following a NF/SCNF discharge to the community.**	1	1	100.0%
Services initiated upon NF/SCNF discharge were according to the Member's Plan of Care.	1	1	100.0%

MLTSS Members Transitioning from HCBS to NF/SCNF

A total of 0 files were reviewed for Members receiving HCBS and subsequently transitioned to an NF/SCNF for long-term placement. Rates were calculated to profile HCBS Members that transitioned to an NF/SCNF (Groups 3 and 4; **Table 9**).

Table 11: HCBS Members Transitioned to a NF/SCNF

Transitions to NF/SCNF	N	D	Rate
Member transitioned from HCBS to NF/SCNF during the review period.	0	100	0.0%
Member was admitted to NF/SCNF directly from an acute care facility.	0	0	N/A
Care Manager determined during the reassessment process that changes in placement or services were indicated, and a **discussion with the Member occurred prior to the change in service/placement.**	0	0	N/A

N/A: Not Applicable

The expansion of the NF/SCNF audit components included evaluation of MLTSS Performance Measures. Population-specific findings are presented in **Table 12**, which include results on the following MLTSS Performance Measures: #8 (Plans of Care established within 45 days of MLTSS enrollment), #9 (Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination), #9a (Plan of Care for MLTSS Members amended based on change of Member condition), #11 (Plans of Care for MLTSS Members are developed using Person-Centered Principles), and #16 (MCO provided training to MLTSS Member on identifying/reporting Critical Incidents). Population results are rates calculated as the number of "Yes" determinations divided by the sum of "Yes" plus "No" determinations.

Table 12: MLTSS Performance Measures Results

Performance Measure	N	D	Rate
#8. Plans of Care established within 45 days of MLTSS enrollment.[1]	6	6	100.0%
#9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination.[2]	87	90	96.7%
#9a. Plan of Care for MLTSS Members amended based on change of Member condition.[3]	0	0	N/A
#11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles."[4]	100	100	100.0%
#16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents.	99	100	99.0%

[1]Compliance with this measure includes completion of the Initial Plan of Care, Member signature, and a copy provided to the Member within 45 calendar days of the MLTSS enrollment date. The denominator includes all NF/SCNF Members new to MLTSS and/or new to the MCO during the review period.
[2] Members included in this measure (denominator) have an annual LOC re-determination that was due and completed during the review period and a Plan of Care on file.
[3] Members who did not have a documented change in condition during the study period are excluded from this measure.
[4] For compliance with this measure Members must have a Plan of Care on file during the review period that contains documentation 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 be addressed in the Plan of Care.
N/A: Not Applicable

Discussion

Limitations

Results are limited due to the absence of Members in Group 3 (Members who transitioned from HCBS to the NF/SCNF) and Group 4 (Members who transitioned from HCBS to the NF/SCNF and returned to HCBS) during the review period. Additionally, there were no Members with a documented change in condition during the review period, therefore compliance with PM #9a could not be evaluated.

Conclusions

Overall, the MCO scored 86% or above in the following review elements **(Tables 4-8)**. Review elements evaluated for calculation of Performance Measures are resulted in the MLTSS Performance Measures section of this report.

Facility and MCO Plan of Care

- Member's Care Management record contained copies of any Facility Plans of Care on file during the review period. (89.0%)
- Documented review of the Facility Plan of Care by the Care Manager. (100.0%)
- MLTSS Plan of Care on file includes information from the Facility Plan of Care. (100.0%)

MLTSS Initial Plan of Care and Ongoing Plans of Care

- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems, and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process. (100.0%)
- Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this). (100.0%)
- Member's agreement/disagreement with the Plan of Care statements were documented on the Member's Plan of Care and maintained in the Member's electronic CM record. (98.0%)

Ongoing Care Management

- Member was identified for transfer to HCBS and was offered options, including transfer to the community. (100.0%)
- Member was present at each onsite visit or had involvement from the Member's authorized representative regarding the Plan of Care. (If the Member was not able to participate in an onsite visit for reasons such as

cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable). (100.0%)
- Timely onsite review of Member placement and services. Onsite visits were timely and occurred within at least 180 calendar days for non-pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability). (86.9%)

Reassessment of the Plan of Care and Critical Incident Reporting

- Member had a NJCA completed during the review period. (96.9%)
- Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative. (95.0%)
- Care Manager reviewed the Member's rights and responsibilities. (100.0%)
- Care Manager educated the Member on how to file a grievance and/or an appeal. (99.0%)

PASRR Communications for Transitions to NF/SCNF

- Care Manager completed or confirmed PASRR Level I prior to Member transition to NF/SCNF. (100.0%)
- Communication of PASRR Level I to OCCO documented by the Care Manager in the NJCA. (100.0%)

Opportunities for Improvement for Review Elements

Opportunities for improvement for MCO scores below 86% exist in the following review elements (**Tables 4–8**).

- Evidence of the Care Manager's participation in at least one interdisciplinary team (IDT) meeting during the review period. (36.0%)

Recommendations for Review Elements

- Fidelis Care MLTSS Care Managers should ensure the Care Manager participates in a minimum of one interdisciplinary team (IDT) meeting per year.

MLTSS Performance Measures

Overall, the MCO scored 86% or above in the following Performance Measures (PMs) (**Table 12**).

- PM #8. Plans of Care established within 45 days of MLTSS enrollment. (100.0%)
- PM #9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination. (96.7%)
- PM #11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles." (100.0%)
- PM #16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents. (99.0%)

Opportunities for Improvement for MLTSS Performance Measures

None.

Recommendations for MLTSS Performance Measures

None.

Appendix D – HNJH 2024 Core Medicaid and MLTSS Care Management Audit Reports

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
Office of Quality Assurance

MCO Care Management Audit and Annual Assessment
Horizon New Jersey Health

Review Period: January 1, 2023 to December 31, 2023

September 2024

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MCO Care Management Audit and Annual Assessment

Introduction

The purpose of the Care Management Audit and Annual Assessment was to evaluate the effectiveness of the contractually required Care Management program. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) established Care Management requirements to ensure that the services provided to Enrollees with special health care needs are consistent with professionally recognized standards of care. The populations included in this audit include General Population (GP) Enrollees, Enrollees under the Division of Developmental Disabilities (DDD), and Enrollees under the Division of Child Protection and Permanency (DCP&P).

Annually, DMAHS evaluates Managed Care Organization (MCO) performance against these requirements through its External Quality Review Organization (EQRO) Contractor. The results of these audits are used to improve MCO performance.

MCO Care Management Chart Audit

Methodology

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

Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the prior year's report, NJ FamilyCare contract references, NJ Care Management Workbook, and CDC Immunization Schedules. For 2024, at the direction of DMAHS, the MCO Care Management audit evaluation process changed for GP, DDD, and DCP&P Enrollees. For the GP population, IPRO evaluated Enrollees new to the MCO and new to Care Management between 1/1/2023 and 11/16/2023 and existing Enrollees enrolled in Care Management between 3/1/2023 and 11/16/2023. For the DDD and DCP&P populations, IPRO evaluated newly eligible Enrollees new to Care Management during the 2023 review period and existing eligible Enrollees enrolled in Care Management prior to 1/1/2023. Audit questions are limited exclusively to 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool, where appropriate, to determine whether an Enrollee met the criteria for a subsequent section or question. Therefore, for some audit questions, Enrollees represented in the numerator and denominator represent only those who met the specific applicable criteria.

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

Population Selection

The sample was determined by excluding Enrollees with Third Party Liability (TPL) from the three populations, all pregnant members from the General Population, and applying the sampling methodology described below. The sampling methodology, as shown in **Table 1**, resulted in the selection of 290 cases for Horizon New Jersey Health (HNJH).

Using a conservative assumption of a 65% proportion, a sample size of 100 was selected to yield sufficient statistical power to produce a 95% confidence interval, with a 10% margin of error. The confidence interval provides the range within which there is a 95% probability that the true rate falls between the lower rate and the upper rate of the confidence interval. Higher rates lead to smaller ranges in confidence intervals.

A random sample of 130 Enrollees for the General Population, DDD Population, and DCP&P Population (including a 30% oversample required for substitutions or exclusions), was selected.

Table 1: Sampling Methodology

Population Criteria	General Population (GP)	DDD	DCP&P
Criteria	Using the criteria below, the MCO will provide two (2) listings of ALL eligible New and Existing Enrollees (exclude DDD, DCP&P, all pregnant Enrollees, and TPL). IPRO will pull a random sample of 65 Enrollees new to the MCO and Care Management anytime between 1/1/2023 through 11/16/2023 and 65 existing Enrollees new to Care Management between 3/1/2023 through 11/16/2023 from the universes provided.** **Random sample size modified by IPRO.	Using the appropriate Capitation Codes and the criteria below, the MCO will provide two (2) listings (exclude TPL) for: 1 - ALL New eligible DDD Enrollees in Care Management and; 2 - ALL Existing eligible DDD Enrollees in Care Management IPRO will select a random sample of 130 new and existing DDD Enrollees in Care Management per MCO from the universes provided.** **Random sample size modified by IPRO.	Using the appropriate Capitation Codes and the criteria below, the MCO will provide two (2) listings (exclude TPL) for: 1 - ALL New eligible DCP&P Enrollees in Care Management and; 2 - ALL Existing eligible DCP&P Enrollees in Care Management IPRO will select a random sample of 130 new and existing DCP&P Enrollees in Care Management per MCO from the universes provided.** **Random sample size modified by IPRO.
Age	>=6 months as of 12/31/2023	>= 6 months as of 12/31/2023	>= 6 months and < 18 years as of 12/31/2023
Sex	Both	Both	Both
Enrollment in MCO • New Enrollees	Initial enrollment between 1/1/2023 to 6/30/2023	Initial enrollment between 1/1/2023 and 6/30/2023	Initial enrollment between 1/1/2023 and 6/30/2023
• Existing Enrollees	Enrolled prior to 1/1/2023	Enrolled prior to 1/1/2023	Enrolled prior to 1/1/2023
Current Enrollment	Enrolled as of 12/31/2023 and with the same MCO for 6 months during the review period.	Enrolled as of 12/31/23 and with the same MCO for 6 months during the review period.	Enrolled as of 12/31/23 and with the same MCO for 6 months during the review period.
Continuous Enrollment Criteria	Enrolled in same population and same MCO through 12/31/2023 allowing no more than a one-month gap.	Enrolled in same population and same MCO at least 6 months in 2023 allowing one gap <= 45 days. Gap is not permissible at the beginning or the end of the enrollment time period. Where Enrollee meets enrollment criteria for 2 MCOs in 2023, the later MCO enrollment is selected.	Enrolled in same population and same MCO at least 6 months in 2023 allowing one gap <= 45 days. Gap is not permissible at the beginning or the end of the enrollment time period. Where Enrollee meets enrollment criteria for 2 MCOs in 2023 the later MCO enrollment is selected.

Introductory E-Mail

For this year's audit, the evaluation included an audit review for three (3) sampled populations. IPRO sent an Introductory E-Mail to the MCO prior to the offsite desk audit including:

- A description of the current year audit process and specifications for each population.
- File listings identifying the files that needed to be submitted to IPRO, along with instructions for preparing the files and uploading the files to IPRO's S.E.N.D. FTP site.

Audit Activities

IPRO reviewers conducted the file reviews over a five-week period. Reviewer inter-rater reliability was maintained through use of the standardized Audit Tool, and ongoing communication and coordination among the review team.

Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report. MCOs were not permitted to submit additional information after the offsite audit.

Audit Results

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in Table 2, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

HNJH's 2024 CM Audit results for the review period 1/1/2023 to 12/31/2023 ranged from 58.8% to 100% across all populations for the five audit categories.

Table 2: Aggregate Results by Category

Determination by Category	GP (n=100)	DDD (n=100)	DCP&P (n=90)
Identification[1]	77.9%		
Outreach[2,3]	82.6%	100.0%	95.0%
Preventive Services[3]	99.0%	74.1%	96.9%
Continuity of Care[3]	98.2%	86.4%	97.0%
Coordination of Services[3]	96.6%	58.8%	89.5%

[1]The Identification category is not evaluated for New and Existing DDD and DCP&P Enrollees, or Existing GP Enrollees.
[2]The Outreach category is evaluated for Enrollee files with no CNA or untimely completion of the CNA.
[3]Aggregate scores represent a combination of New and Existing population specific rates.

GP Population Findings

Identification

The Identification category applies to GP Enrollees (50) new to the MCO and new to Care Management between 1/1/2023 and 11/16/2023.

Table 3: Identification – GP Population- Enrollees New to the MCO and New to Care Management

Identification	General Population		
	Numerator	Denominator	Rate
Enrollee has an Initial Health Screen (IHS) on file and/or an IHS score documented in the file that was completed during the review period (1/1/2023 to 12/31/2023).*	44	50	88.0%
For IHS on file, IHS was completed for the Enrollee within 45 days of MCO enrollment date.	32	44	72.7%
For no IHS on file, the MCO made outreach attempts to complete the IHS.*	3	6	50.0%
For Enrollees where no IHS was on file, initial outreach to complete the IHS was successful (even if Enrollee declined to complete the IHS).*	0	6	0.0%
For Enrollees where no IHS was on file, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment.	3	6	50.0%
Enrollees who scored less than 5 on the IHS or no IHS on file.*	18	50	36.0%
Enrollees identified by the Plan as having Care Management needs through additional sources (applies to Enrollees new to the MCO and new to CM where the IHS score is less than 5 or no IHS on file).	18	18	100.0%

**Not Included in aggregate score calculation*

Outreach

The Outreach category applies to new GP Enrollees (50) enrolled in Care Management between 1/1/2023 and 11/16/2023 and existing GP Enrollees (50) enrolled in Care Management between 3/1/2023 and 11/16/2023.

Table 4: Outreach – General Population – New and Existing Enrollees enrolled in Care Management

Outreach	General Population – New Enrollees			General Population – Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The MCO completed a Comprehensive Needs Assessment (CNA) during the review period.*	50	50	100.0%	50	50	100.0%
The Enrollee was unable to reach to complete the CNA.*	0	0	N/A	0	0	N/A
The MCO completed the CNA timely.*	43	50	86.0%	48	50	96.0%
Initial outreach to complete a CNA was performed.[1]	6	7	85.7%	2	2	100.0%
Initial outreach to complete the CNA was done timely, within 30 days of identification of CM needs. (30 days from IHS score 5 or greater; or IHS less than 5, no IHS, identification of CM needs through other sources).	3	6	50.0%	2	2	100.0%
Initial outreach to complete a CNA was successful (even if the Enrollee declined to complete the CNA).*	2	6	33.3%	0	2	0.0%
The MCO performed and documented aggressive outreach attempts to complete a CNA.*	4	4	100.0%	2	2	100.0%

Outreach	General Population – New Enrollees			General Population – Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
For CNAs not completed timely or no CNA, aggressive outreach attempts were made timely (30 days from IHS score 5 or greater or identification of CM needs through other sources).	4	4	100.0%	2	2	100.0%
Upon any successful outreach to the Enrollee, the Enrollee opted out of Care Management.*	1	50	2.0%	0	50	0.0%
Enrollee became lost to contact during the review period.*	0	50	0.0%	0	50	0.0%
For Enrollees who were lost to contact, aggressive outreach attempts were made and documented by the Care Manager.	0	0	N/A	0	0	N/A

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollee files with no CNA or a CNA completed untimely. All CNAs were completed for the entire sample for new (50) and existing (50) GP Enrollees. The denominator in this measure represents 7 untimely CNAs for new GP Enrollees and 2 untimely CNAs for existing GP Enrollees.

N/A: Not Applicable

Preventive Services

The Preventive Services category applies to new GP Enrollees (50) enrolled in Care Management between 1/1/2023 and 11/16/2023 and existing GP Enrollees (50) enrolled in Care Management between 3/1/2023 and 11/16/2023.

Table 5: Preventive Services – General Population- New and Existing Enrollees enrolled in Care Management

Preventive Services	General Population - New Enrollees			General Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The Enrollee's EPSDT[1] exam is up to date per periodicity exam schedule (aged 0 through 20).*	27	29	93.1%	16	16	100.0%
The Enrollee's EPSDT status is confirmed by a reliable source (aged 0 through 20).	27	27	100.0%	16	16	100.0%
Aggressive outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	2	2	100.0%	0	0	N/A
The Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	2	2	100.0%	0	0	N/A
The Enrollee or legal guardian refused immunizations (aged 0 to 18).*	3	29	10.3%	2	16	12.5%
The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18).*	24	26	92.3%	9	14	64.3%
The Enrollee's immunization status is confirmed by a reliable source (aged 0 through 18).	24	24	100.0%	9	9	100.0%
Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18).	2	2	100.0%	5	5	100.0%
The Enrollee or legal guardian refused immunizations (aged 19 and above).*	4	21	19.0%	9	34	26.5%
Appropriate vaccines have been administered for Enrollees (aged 19 and above).*	10	17	58.8%	11	25	44.0%
Aggressive outreach attempts were documented to confirm immunization status for Enrollees (aged 19 and above).	6	7	85.7%	14	14	100.0%
The Care Manager addressed and/or discussed dental needs with Enrollees (aged 21 and above).	21	21	100.0%	34	34	100.0%
A dental visit occurred during the review period for Enrollees (aged 1 through 20).*	9	23	39.1%	9	16	56.2%

Preventive Services	General Population - New Enrollees			General Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Care Manager made attempts to obtain dental status for Enrollees without a confirmed dental visit (aged 1 through 20).	13	14	92.9%	7	7	100.0%
Dental reminders were sent to Enrollees without a confirmed dental visit (aged 1 through 20).	14	14	100.0%	7	7	100.0%

**Not Included in aggregate score calculation*

[1]EPSDT: Early and Periodic Screening, Diagnostic and Treatment

N/A: Not Applicable

Continuity of Care

The Continuity of Care category applies to new GP Enrollees (50) enrolled in Care Management between 1/1/2023 and 11/16/2023 and existing GP Enrollees (50) enrolled in Care Management between 3/1/2023 and 11/16/2023.

Table 6: Continuity of Care – General Population - New and Existing Enrollees enrolled in Care Management

Continuity of Care	General Population - New Enrollees			General Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The MCO completed a CNA during the review period.*	50	50	100.0%	50	50	100.0%
The CNA contained all elements of the State approved CNA tool.	50	50	100.0%	50	50	100.0%
The Comprehensive Needs Assessment was completed timely (within 30 days of identification of CM needs).	43	50	86.0%	48	50	96.0%
The Care Manager documented a level of Care Management for the Enrollee during the review period.	50	50	100.0%	50	50	100.0%
The Enrollee is in Community Based Care Management (CBCM).[1]*	19	50	38.0%	4	50	8.0%
The Enrollee has a Care Plan on file during the review period.	50	50	100.0%	49	50	98.0%
A Care Plan was completed for the Enrollee that included all required components.	50	50	100.0%	49	49	100.0%
The Care Plan was developed within 30 days of CNA completion.[2]	48	50	96.0%	48	49	98.0%
The Enrollee's Care Plan was reviewed/monitored during the review period.	50	50	100.0%	48	49	98.0%
The Enrollee had a change in care needs or circumstances during the review period.*	40	50	80.0%	39	49	79.6%
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances.	40	40	100.0%	39	39	100.0%
Enrollee demonstrated needs requiring a comprehensive treatment plan.*	4	50	8.0%	1	50	2.0%
The Enrollee had a comprehensive treatment plan documented to address the Enrollee's specific care needs.	4	4	100.0%	1	1	100.0%
The comprehensive treatment plan progressed in a timely manner without unreasonable interruption.	4	4	100.0%	1	1	100.0%

**Not Included in aggregate score calculation*

[1] Community Based Care Management (CBCM) resumed in October 2023 following the end of the Public Health Emergency.

[2]This measure is evaluated for Enrollee's with a Care Plan and a CNA on file during the review period.

Coordination of Services

The Coordination of Services category applies to new GP Enrollees (50) enrolled in Care Management between 1/1/2023 and 11/16/2023 and existing GP Enrollees (50) enrolled in Care Management between 3/1/2023 and 11/16/2023.

Table 7: Coordination of Services – General Population - New and Existing Enrollees enrolled in Care Management

Coordination of Services	General Population- New Enrollees			General Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF[1], CSOC[2], CMOs[3], Special Child Health Services (under DOH[4]) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD).	36	36	100.0%	28	28	100.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services.	43	50	86.0%	43	44	97.7%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee.	34	35	97.1%	39	40	97.5%
For Enrollees who were hospitalized, adequate discharge planning was performed.	25	25	100.0%	32	32	100.0%

[1]DCF: Department of Children and Families
[2]CSOC: Children's System of Care
[3]CMOs: Care Management Organizations
[4]DOH: Department of Health

DDD Population Findings

Outreach

The Outreach category applies to new DDD Enrollees (50) in Care Management during the 2023 review period. The Outreach category is not evaluated for the existing DDD Enrollees in Care Management.

Table 8: Outreach – DDD Population - Enrollees New to the MCO and New to Care Management

Outreach	DDD Population		
	Numerator	Denominator	Rate
The MCO completed a Comprehensive Needs Assessment (CNA) during the review period.*	42	50	84.0%
The Enrollee was unable to reach to complete the CNA.*	0	8	0.0%
The MCO completed the CNA timely (within 45 days of MCO enrollment date).*	35	42	83.3%
Initial outreach to complete a CNA was performed.[1]	15	15	100.0%
Initial outreach to complete the CNA was done timely, within 45 days from the Enrollee's enrollment date.	15	15	100.0%
Initial outreach to complete the CNA was successful (even if the Enrollee declines to complete the CNA).*	15	15	100.0%
The MCO performed aggressive outreach to complete a CNA.*	0	0	N/A
Aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment.	0	0	N/A
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA.*	7	8	87.5%
Upon any successful outreach to the Enrollee, the Enrollee declined Care Management.*	7	8	87.5%

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollee files with no CNA or a CNA completed untimely. The denominator for this measure includes 8 files with no CNA and 7 files with a CNA completed untimely.

N/A: Not Applicable

Preventive Services

The Preventive Services category applies to new DDD Enrollees (50) and existing DDD Enrollees (50) in Care Management during the 2023 review period.

Table 9: Preventive Services – DDD Population - New and Existing Enrollees enrolled in Care Management

Preventive Services	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The Enrollee's EPSDT[1] exam is up to date per periodicity exam schedule (aged 0 through 20).*	25	30	83.3%	11	13	84.6%
The Enrollee's EPSDT status is confirmed by a reliable source (aged 0 through 20).	25	25	100.0%	11	11	100.0%
Aggressive outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	5	5	100.0%	0	2	0.0%
The Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	5	5	100.0%	0	2	0.0%
The Enrollee or legal guardian refused immunizations (aged 0 to 18).*	3	24	12.5%	0	11	0.0%

Preventive Services	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18).*	18	21	85.7%	6	11	54.5%
The Enrollee's immunization status is confirmed by a reliable source (aged 0 through 18).	18	18	100.0%	6	6	100.0%
Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18).	3	3	100.0%	0	5	0.0%
The Enrollee or legal guardian refused immunizations (aged 19 and above).*	8	26	30.8%	2	39	5.1%
Appropriate vaccines have been administered for Enrollees (aged 19 and above).*	13	18	72.2%	16	37	43.2%
Aggressive outreach attempts were documented to confirm immunization status for Enrollees (aged 19 and above).	5	5	100.0%	1	21	4.8%
The Care Manager addressed and/or discussed dental needs with Enrollees (aged 21 and above).	20	20	100.0%	24	37	64.9%
A dental visit occurred during the review period for Enrollees (aged 1 through 20).*	23	30	76.7%	10	13	76.9%
Care Manager made attempts to obtain dental status for Enrollees without a confirmed dental visit (aged 1 through 20).	7	7	100.0%	0	3	0.0%
Dental reminders were sent to Enrollees without a confirmed dental visit (aged 1 through 20).	7	7	100.0%	0	3	0.0%

**Not Included in aggregate score calculation*

[1]EPSDT: Early and Periodic Screening, Diagnostic and Treatment

Continuity of Care

The Continuity of Care category applies to new DDD Enrollees (50) and existing DDD Enrollees (50) in Care Management during the 2023 review period. Gray shading represents elements that are not evaluated for existing DDD Enrollees in Care Management.

Table 10: Continuity of Care – DDD Population - New and Existing Enrollees enrolled in Care Management

Continuity of Care	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The MCO completed a CNA during the review period.*	42	50	84.0%			
The CNA contained all elements of the State approved CNA tool.	42	42	100.0%			
The Comprehensive Needs Assessment was completed timely, within 45 days of Enrollee's MCO enrollment date.	35	42	83.3%			
The Care Manager documented a level of Care Management for the Enrollee during the review period.	42	42	100.0%	49	50	98.0%
The Enrollee is in Community Based Care Management (CBCM).[1]*	1	50	2.0%	0	50	0.0%
The Enrollee has a Care Plan on file during the review period.	50	50	100.0%	3	50	6.0%
A Care Plan was completed for the Enrollee that included all required components.	50	50	100.0%	1	3	33.3%
The Care Plan was developed within 30 days of CNA completion.[2]	42	42	100.0%			
The Enrollee's Care Plan was reviewed/monitored during the review period.	49	50	98.0%	1	3	33.3%

Continuity of Care	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The Enrollee had a change in care needs or circumstances during the review period.*	21	50	42.0%	2	3	66.7%
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances.	21	21	100.0%	1	2	50.0%
Enrollee demonstrated needs requiring a comprehensive treatment plan.*	1	50	2.0%	0	50	0.0%
The Enrollee had a comprehensive treatment plan documented to address the Enrollee's specific care needs.	1	1	100.0%	0	0	N/A
The comprehensive treatment plan progressed in a timely manner without unreasonable interruption.	1	1	100.0%	0	0	N/A

**Not Included in aggregate score calculation*

[1]Community Based Care Management (CBCM) resumed in October 2023 following the end of the Public Health Emergency.

[2]This measure is evaluated for Enrollee's with a Care Plan and a CNA on file during the review period.

N/A: Not Applicable

Coordination of Services

The Coordination of Services category applies to new DDD Enrollees (50) and existing DDD Enrollees (50) in Care Management during the 2023 review period.

Table 11: Coordination of Services – DDD Population- New and Existing Enrollees enrolled in Care Management

Coordination of Services	DDD Population - New Enrollees			DDD Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF[1], CSOC[2], CMOs[3], Special Child Health Services (under DOH[4]) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD).	50	50	100.0%	3	50	6.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services.	35	48	72.9%	2	4	50.0%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee.	20	38	52.6%	4	6	66.7%
For Enrollees who were hospitalized, adequate discharge planning was performed.	3	3	100.0%	3	5	60.0%
For Enrollees who were hospitalized with a mental/behavioral health diagnosis and discharged prior to 12/1/2023 the Care Manager documented evidence of follow up with the mental/behavioral health provider within 30 days of discharge.	0	0	N/A	0	0	N/A

Coordination of Services	DDD Population - New Enrollees			DDD Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The Care Manager made aggressive attempts to determine follow up status with a mental/behavioral health provider for Enrollees hospitalized with a mental/behavioral health diagnosis.	0	0	N/A	0	0	N/A

[1]DCF: Department of Children and Families
[2]CSOC: Children's System of Care
[3]CMOs: Care Management Organizations
[4]DOH: Department of Health
N/A: Not Applicable

DCP&P Population Findings

Outreach

The Outreach category applies to new DCP&P Enrollees (64) in Care Management during the 2023 review period. The Outreach category is not evaluated for the existing DCP&P Enrollees in Care Management.

Table 12: Outreach – DCP&P Population- Enrollees New to the MCO and New to Care Management

Outreach	DCP&P Population		
	Numerator	Denominator	Rate
The MCO completed a Comprehensive Needs Assessment (CNA) during the review period.*	63	64	98.4%
The Enrollee was unable to reach to complete the CNA.*	1	1	100.0%
The MCO completed the CNA timely, within 45 days of MCO enrollment date.*	56	63	88.9%
Initial outreach to complete a CNA was performed.[1]	8	8	100.0%
Initial outreach to complete the CNA was timely, within 45 days from the Enrollee's enrollment date.	7	8	87.5%
Initial outreach was successful (even if the Enrollee declines to complete the CNA).*	4	8	50.0%
The MCO performed aggressive outreach to complete a CNA.*	4	4	100.0%
Aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment.	4	4	100.0%
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA.*	0	0	N/A

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollee files with no CNA or a CNA completed untimely. The denominator includes 1 file with no CNA and 7 files with a CNA completed untimely.

N/A: Not Applicable

Preventive Services

The Preventive Services category applies to new DCP&P Enrollees (64) and existing DCP&P Enrollees (26) in Care Management during the 2023 review period.

Table 13: Preventive Services – DCP&P Population – New and Existing Enrollees enrolled in Care Management

Preventive Services	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The Enrollee's EPSDT[1] exam is up to date per periodicity exam schedule (aged 0 through 20).*	63	64	98.4%	26	26	100.0%
The Enrollee's EPSDT status is confirmed by a reliable source (aged 0 through 20).	63	63	100.0%	26	26	100.0%
Aggressive outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	1	1	100.0%	0	0	N/A
The Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	1	1	100.0%	0	0	N/A
The Enrollee or legal guardian refused immunizations (aged 0 to 18).*	0	64	0.0%	0	26	0.0%

Preventive Services	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18).*	62	64	96.9%	20	26	76.9%
The Enrollee's immunization status is confirmed by a reliable source (aged 0 through 18).	62	62	100.0%	20	20	100.0%
Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18).	2	2	100.0%	2	6	33.3%
A dental visit occurred during the review period for Enrollees (aged 1 through 20).*	31	34	91.2%	20	22	90.9%
Care Manager made attempts to obtain dental status for Enrollees without a confirmed dental visit (aged 1 through 20).	3	3	100.0%	1	2	50.0%
Dental reminders were sent to Enrollees without a confirmed dental visit (aged 1 through 20).	3	3	100.0%	1	2	50.0%

**Not Included in aggregate score calculation*
[1]EPSDT: Early and Periodic Screening, Diagnostic and Treatment

Continuity of Care

The Continuity of Care category applies to new DCP&P Enrollees (64) and existing DCP&P Enrollees (26) in Care Management during the 2023 review period. Gray shading represents elements that are not evaluated for existing DCP&P Enrollees in Care Management.

Table 14: Continuity of Care – DCP&P Population – New and Existing Enrollees enrolled in Care Management

Continuity of Care	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The MCO completed a CNA during the review period.*	63	64	98.4%			
The completed CNA contained all elements of the State approved CNA tool.	63	63	100.0%			
The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment).	56	63	88.9%			
The Care Manager documented a level of Care Management for the Enrollee during the review period.	63	63	100.0%	26	26	100.0%
The Enrollee has a Care Plan on file during the review period.	64	64	100.0%	17	26	65.4%
A Care Plan was completed for the Enrollee that included all required components.	64	64	100.0%	17	17	100.0%
The Care Plan was developed within 30 days of CNA completion.[1]	63	63	100.0%			
The Enrollee's Care Plan was reviewed/monitored during the review period.	64	64	100.0%	16	17	94.1%
The Enrollee had a change in care needs or circumstances during the review period.*	28	64	43.8%	14	17	82.4%
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances.	28	28	100.0%	14	14	100.0%
Enrollee demonstrated needs requiring a comprehensive treatment plan.*	1	64	1.6%	0	26	0.0%

Continuity of Care	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The Enrollee had a comprehensive treatment plan documented to address the Enrollee's specific care needs.	1	1	100.0%	0	0	N/A
The comprehensive treatment plan progressed in a timely manner without unreasonable interruption.	1	1	100.0%	0	0	N/A

**Not Included in aggregate score calculation*
[1]This measure is evaluated for Enrollee's with a Care Plan and a CNA on file during the review period.
N/A: Not Applicable

Coordination of Services

The Coordination of Services category applies to new DCP&P Enrollees (64) and existing DCP&P Enrollees (26) in Care Management during the 2023 review period.

Table 15: Coordination of Services – DCP&P Population - New and Existing Enrollees enrolled in Care Management

Coordination of Services	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF[1], CSOC[2], CMOs[3], Special Child Health Services (under DOH[4]) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD).	64	64	100.0%	21	26	80.8%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services.	44	51	86.3%	13	17	76.5%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee.	17	20	85.0%	7	9	77.8%
For Enrollees who were hospitalized, adequate discharge planning was performed.	9	9	100.0%	4	4	100.0%

[1]DCF: Department of Children and Families
[2]CSOC: Children's System of Care
[3]CMOs: Care Management Organizations
[4]DOH: Department of Health

Limitations

HNJH had a combined total of 40 file exclusions for the DCP&P Population new and existing Enrollees.

Conclusions

Overall, the MCO scored 85% or above in the following review categories (**Table 2**):

- Outreach (DDD Population) (100%)
- Outreach (DCP&P Population) (95.0%)

- Preventive Services (General Population) (99.0%)
- Preventive Services (DCP&P Population) (96.9%)

- Continuity of Care (General Population) (98.2%)
- Continuity of Care (DDD Population) (86.4%)
- Continuity of Care (DCP&P Population) (97.0%)

- Coordination of Services (General Population) (96.6%)
- Coordination of Services (DCP&P Population) (89.5%)

Overall, the MCO scored below 85% in the following categories (**Table 2**):

- Identification (General Population) (77.9%)

- Outreach (General Population) (82.6%)

- Preventive Services (DDD Population) (74.1%)

- Coordination of Services (DDD Population) (58.8%)

MCO Care Management Annual Assessment

Assessment Methodology

The Care Management Annual Assessment consisted of pre-audit review of documentation provided by Horizon NJ Health (HNJH), as evidence of compliance of the standard under review; audit review of random file samples for the GP, DDD, and DCP&P Populations; interviews with key HNJH staff via TEAMS held on May 31, 2024; and post audit evaluation of documentation and audit activities.

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

The documentation for the audit review was requested by IPRO on March 8, 2024, and documentation was received from the MCO on March 29, 2024. The documentation review occurred offsite at IPRO beginning on April 1, 2024. The audit review team was made up of Carla Zuccarello, Cynthia Steffe, and Cynthia Santangelo. The Care Management assessment covered the period from January 1, 2023 to December 31, 2023.

During the audit review, the Plan had the opportunity to provide supplemental documentation as requested by IPRO.

Table 16 shows the rating scale used to determine compliance.

Table 16: Rating Scale for the Annual Care Management Assessment

Rating	Rating Methodology
Met	All parts within this element were met.
Not Met	Not all the required parts within the element were met.
N/A	This element is not applicable and will not be considered as part of the score.
Met Prior Review	This element was met in the previous review cycle.
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.

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

There are 30 elements in this review based on Contractual provisions, which are subject to review annually. HNJH received an overall compliance score of 57% in 2024. In 2023, the MCO received a score of 77%. Review of the elements CM2, CM4, CM5, CM6, CM7, CM8, CM11, CM14, CM15, CM16, CM17, and CM19 was based on results from the Core Medicaid CM Audit conducted in 2024. Where appropriate, assessment of other elements was informed by both documents submitted for review and the file review. This audit evaluated Core Medicaid CM files for calendar year 2023 for three populations, namely the Enrollees under the General Population (GP), Division of Developmental Disabilities (DDD), and the Division of Child Protection and Permanency (DCP&P).

Care Management Assessment Results

Table 17 presents an overview of HNJH's Care Management Annual Assessment results; **Table 18** presents Contract language and reviewer comments for deficient element(s); and **Table 19** presents Contract language for resolved deficiencies.

Table 17: Summary of Findings for Care Management Annual Assessment

Element	Met Prior Review	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM1	X	X	-	-	-	-	-
CM2	X	-	X	-	-	-	X
CM3	-	X	-	-	-	X	-
CM4	X	-	X	-	-	-	X
CM5	X	-	X	-	-	-	X
CM6	-	-	X	-	X	-	-
CM7	-	-	X	-	X	-	-
CM8	-	-	X	-	X	-	-
CM9	X	-	X	-	-	-	X
CM10	X	-	X	-	-	-	X
CM11	-	-	X	-	X	-	-
CM12	X	X	-	-	-	-	-
CM13	X	X	-	-	-	-	-
CM14	-	-	X	-	X	-	-
CM15	-	X	-	-	-	X	-
CM16	X	X	-	-	-	-	-
CM17	X	X	-	-	-	-	-
CM18a	X	X	-	-	-	-	-
CM18c	X	-	X	-	-	-	X

Element	Met Prior Review	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM18d	X	X	-	-	-	-	-
CM19	X	-	X	-	-	-	X
CM20	X	X	-	-	-	-	-
CM21	X	X	-	-	-	-	-
CM22	X	X	-	-	-	-	-
CM23	X	-	X	-	-	-	X
CM24	X	X	-	-	-	-	-
CM25	X	X	-	-	-	-	-
CM26	X	X	-	-	-	-	-
CM27	X	X	-	-	-	-	-
CM37[1]	X	X	-	-	-	-	-
TOTAL	**23**	**17**	**13**	**0**	**5**	**2**	**8**
Compliance Percentage		**57%**					

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

Table 18: Findings for Deficient Care Management Elements

Element	Contract Language	Reviewer Comments
CM2	**4.6.2.J** **Discharge Planning** The Contractor shall have procedures to ensure adequate and appropriate discharge planning, and to include Coordination of Services for Enrollees with special needs.	**In the 2024 CM file audit the MCO scored for the DDD Population Enrollees:** 60%- For Enrollees who were hospitalized, adequate discharge planning was performed (applies to existing Enrollees).
CM4	**4.6.5.A** Design and implement Care Management programs and services that are dynamic and change as Enrollees' needs or circumstances change.	**In the 2024 CM file audit/AA the MCO received a Not Met for the Existing DDD Population Enrollees:** The MCO did not meet compliance with Element CM4 contract requirement. There was no evidence documented in the Enrollee files to support MCO implementation of Care Management programs and services that are dynamic and change as Enrollees' needs or circumstances change.
CM5	**4.6.5.A** Use a multi-disciplinary team to manage the care of Enrollees needing Care Management. While Care Management may be performed by one qualified health professional (a nurse, social worker, physician, or other professional), the process will involve coordinating with different types of health services provided by multiple	**In the 2024 CM file audit the MCO scored for the DDD Population Enrollees:** 52.6%- For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee

Element	Contract Language	Reviewer Comments
	providers in all care settings, including the home, clinic and hospital. Refer to Care Management Workbook at NJMMIS.com https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management Workbook.pdf for Care Management Framework, Standards, Definitions and Tools.	services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee (applies to new Enrollees). 66.7%- For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee (applies to existing Enrollees). **In the 2024 CM file audit the MCO scored for the DCP&P Population Enrollees:** 77.8%- For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee (applies to existing Enrollees).
CM6	**4.6.5.B.1** **Identification of Enrollees Who Need Care Management** The MCO must have effective systems, policies, procedures, and practices in place to identify any Enrollee in need of Care Management services. All New Enrollees, including Enrollees who were disenrolled from the MCO for at least six (6) months, (except for DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD) will be screened using an approved Initial Health Screen tool (IHS) to quickly identify their immediate physical and/or behavioral health care needs, as well as the need for more extensive screening. Any Enrollee identified as having potential Care Management needs will receive a detailed Comprehensive Needs Assessment (if deemed necessary by a healthcare professional), and ongoing care coordination and management as appropriate. All elements of the State approved IHS tool that appear in the Care Management Workbook must be included in the MCO's screening tool.	**In the 2024 CM file audit the MCO scored for the General Population Enrollees:** 72.7%- IHS was completed for the Enrollee within 45 days of MCO enrollment date (applies to new Enrollees). 50.0%- For Enrollees where no IHS was on file, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment (applies to new Enrollees).

Element	Contract Language	Reviewer Comments
CM7	**4.6.5.B.2** **Comprehensive Needs Assessment (CNA)** The MCO will conduct an approved CNA on New Enrollees following the evaluation by a healthcare professional of their Initial Health Screen results; any Enrollee identified as having potential Care Management needs; as well as DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD. The goal of the CNA is to identify an Enrollee's Care Management needs to determine an Enrollee's level of care and develop a Care Plan. The CNA will be conducted by a healthcare professional, either telephonically or face-to-face, depending on the Enrollee's needs. All elements of the State approved CNA tool that appears in the Care Management Workbook must be included in the MCO assessment tool. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	**In the 2024 CM file audit the MCO scored for the General Population Enrollees:** 50.0%- Initial outreach to complete the CNA was done timely, within 30 days of identification of CM needs. (30 days from IHS score 5 or greater; or IHS less than 5, no IHS, identification of CM needs through other source (applies to new Enrollees). **In the 2024 CM file audit the MCO scored for the DDD Population Enrollees:** 83.3%- The Comprehensive Needs Assessment was completed timely within 45 days of the Member's MCO enrollment date (applies to new Enrollees).
CM8	**4.6.5.B.3** **Plan of Care to Address Needs Identified** Care Plan: Based on the CNA, the Care Manager will assign Enrollees to a care level, develop a Care Plan and facilitate and coordinate the care of each Enrollee according to his/her needs or circumstances. With input from the Enrollee and/or caregiver and PCP, the Care Manager must jointly create a Care Plan with short/long-term Care Management goals, specific actionable objectives, and measurable quality outcomes. The Care Plan should be culturally appropriate and consistent with the abilities and desires of the Enrollee and/or caregiver. Understanding that Enrollees' care needs and circumstances change, the Care Manager must continually evaluate the Care Plan to update and/or change it to accurately reflect the Enrollee's needs and level of care.	**In the 2024 CM file audit the MCO scored for the DDD Population Enrollees:** 33.3%- A Care Plan was completed for the Enrollee that included all required components (applies to existing Enrollees).
CM9	**4.6.5.B.4** **Implementation of Care Plan** The Care Manager shall be responsible for executing the linkages and monitoring the provision of needed services identified in the Care Plan. This includes making referrals, coordinating care, promoting communication, ensuring Continuity of Care, and conducting follow-up. Care Management activities may be conducted telephonically, electronically or face-to-face, depending on the Enrollee's identified needs and level of care. Implementation of the Enrollee's Care Plan should enhance his/her health literacy while being considerate of the Enrollee's overall capacity to	**In the 2024 CM file audit/AA the MCO received a Not Met for the Existing DDD Population Enrollees:** The MCO did not meet compliance with Element CM9 contract requirement. There was no evidence documented in the Enrollee files to support the Care Manager executing linkages and monitoring provision of needed services identified in the Care Plan.

Element	Contract Language	Reviewer Comments
	learn and (to the extent possible) assist the Enrollee to become self-directed and compliant with his/her healthcare regimen.	
CM10	**4.6.5.B.5** **Analysis of Care Plan Effectiveness and Appropriateness** Each Enrollee with Care Management needs must have a Care Plan to address his/her individual health related needs that when successfully implemented, assists him/her to reach their optimal level of wellness and self-direction. The MCO will develop a process that is reflected in its policies and procedures to regularly review the Care Plan to analyze its effectiveness in reaching the stated goals and desired outcomes. The Care Manager will provide feedback of the analysis to the Enrollee/caregiver, primary care physician, and other healthcare professionals involved in the Enrollee's care.	**In the 2024 CM file audit/AA the MCO received a Not Met for the Existing DDD Population Enrollees:** The MCO did not meet compliance with Element CM10 contract requirement. There was no evidence in the file review that each Enrollee with Care Management needs had a Care Plan to address his/her individual health related needs, Care Plans were regularly reviewed and analyzed for effectiveness, or that the MCO provided feedback of analysis to the Enrollee/ caregiver, primary care physician, or other healthcare professionals involved in the Enrollee's care.
CM11	**4.6.5.B.6** **Modify Care Plan Based on Analysis** Following analysis, the Care Manager will modify the strategies outlined in the Care Plan to achieve its stated goals and desired outcomes. The strategies must reflect any new information received, the Enrollee's current circumstances and healthcare status, and remain consistent with the abilities, desires and level of self-direction of the Enrollee and/or caregiver.	**In the 2024 CM file audit the MCO received a Not Met for the DDD Population Enrollees:** 50%- The Care Plan was updated upon a change in the Enrollee's care needs or circumstances (applies to existing Enrollees).
CM14	**4.6.2.O** **Continuity of Care** The Contractor's Quality Management Plan shall include a continuity of care system including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as preventive services and maintenance of function for Enrollees with special needs.	**In the 2024 CM file audit the MCO scored for the DDD Population Enrollees:** 0.0%- Aggressive outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date (aged 0 through 20) (applies to existing Enrollees). 0.0%- The Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20) (applies to existing Enrollees). 0.0%- Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18) (applies to existing Enrollees).

Element	Contract Language	Reviewer Comments
		4.8%- Aggressive outreach attempts were documented to confirm immunization status for Enrollees (aged 19 and above) (applies to existing Enrollees). 64.9%- The Care Manager addressed and/or discussed dental needs with Enrollees (aged 21 and above) (applies to existing Enrollees). 0.0%- Care Manager made attempts to obtain dental status for Enrollees (aged 1 through 20) (applies to existing Enrollees). 0.0%- Dental reminders were sent to Enrollees without a confirmed dental visit (aged 1 through 20) (applies to existing Enrollees). **In the 2024 CM file audit the MCO scored for the DCP&P Population Enrollees:** 33.3%- Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18) (applies to existing Enrollees). 50.0%- Care Manager made attempts to obtain dental status for Enrollees (aged 1 through 20) (applies to existing Enrollees). 50.0%- Dental reminders were sent to Enrollees without a confirmed dental visit (aged 1 through 20) (applies to existing Enrollees).
CM18c	**4.6.5.D.7** If a change in Contractor or Fee-for-Service enrollment occurs, approved Behavioral Health services with an active authorization shall be honored for sixty (60) days unless there is a change in treatment plan.	**In the 2024 CM Compliance review, the MCO received a Not Met for evidence of compliance with CM Element 18c.** The MCO did not submit a policy for the 2023 review period as evidence of compliance with the contract requirement for Element CM18c for new General Population Enrollees, new DDD Enrollees, and new DCP&P Enrollees.

Element	Contract Language	Reviewer Comments
CM19	**4.6.5.E** **Documentation** The Contractor shall document all contacts and linkages to medical and other services in the Enrollee's case files.	**In the 2024 CM file audit the MCO scored for the DDD Population Enrollees:** 6.0%- When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD) (applies to existing Enrollees). 72.9%- For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services (applies to new Enrollees). 50.0%- For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services (applies to existing Enrollees). **In the 2024 CM file audit the MCO scored for the DCP&P Population Enrollees:** 80.8%- When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, PCPs, specialists, and the local health department (LHD) (applies to existing Enrollees). 76.5%- For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services (applies to existing Enrollees).

Element	Contract Language	Reviewer Comments
CM23	**4.6.5.I.2** The Contractor shall have a mechanism to allow for changing levels of Care Management as needs change.	**In the 2024 CM file audit/AA the MCO received a Not Met for the Existing DDD Population Enrollees:** The MCO did not meet compliance with Element CM23 contract requirement. There was no evidence of a process for changing levels of Care Management for Enrollees with identified changes in care needs documented in the Enrollee files.

Table 19: Findings for Resolved Deficiencies for Care Management Elements

Element	Contract Language
CM3	**4.6.5.A** Apply systems, science, and information to identify Enrollees with potential Care Management needs and assist Enrollees in managing their health care more effectively with the goal of improving, maintaining, or slowing the deterioration of their health status.
CM15	**4.6.5.D.1** The Contractor shall establish and operate a system to assure that a comprehensive treatment plan for every Enrollee will progress to completion in a timely manner without unreasonable interruption.

Comprehensive Recommendations

The following recommendations are for deficiencies identified in the Care Management Audit and Annual Assessment.

For the General Population:

1. CM6: HNJH should ensure that the IHS is completed for the Enrollee within 45 days of MCO enrollment date (applies to new Enrollees).
2. CM6: HNJH should ensure for Enrollees where no IHS are on file, aggressive outreach attempts are documented and are done within 45 days of the Enrollee's enrollment (applies to new Enrollees).
3. CM7: HNJH should ensure initial outreach to complete the CNA is done timely, within 30 days of identification of CM needs. (30 days from IHS score 5 or greater; or IHS less than 5, no IHS, identification of CM needs through other sources) (applies to new Enrollees).
4. CM18c: HNJH should ensure that supporting policy documentation is dated during the review period and shows evidence of contractual compliance with the element in review (applies to new Enrollees).

For the DDD Population:

1. CM2: HNJH should ensure for Enrollees who are hospitalized, adequate discharge planning is performed (applies to existing Enrollees).
2. CM4: HNJH should ensure a process to refer Enrollees with complex medical and social needs to Community Based Care Management (CBCM) that includes aggressive outreach within the community to locate and engage members in high need (applies to existing Enrollees).

3. CM5: HNJH should ensure that for Enrollees demonstrating needs requiring coordination of services within the MCO, the Care Manager demonstrates follow up with coordination of services (including, but not limited to Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee (applies to new and existing Enrollees).
4. CM7: HNJH should ensure the CNA is done timely, within 45 days from the Enrollee's enrollment date (applies to new Enrollees).
5. CM8 *File Audit:* HNJHJ should ensure that the Enrollee's Care Plan is reviewed/monitored during the review period (applies to existing Enrollees).
6. CM8: HNJH should ensure Care Plans completed contain all required components (applies to existing Enrollees).
7. CM9: HNJH should ensure Care Managers implement Care Plans (applies to existing Enrollees).
8. CM10: HNJH should ensure that each Enrollee has a Care Plan to address his/her individual health related needs, that Care Managers are regularly reviewing and analyzing the effectiveness of Care Plans, and Care Managers are providing feedback of the analysis to Enrollee/caregiver, primary care physician, and other healthcare professionals involved in the Enrollee's care (applies to existing Enrollees).
9. CM11: HNJH should ensure Care Plans are updated upon a change in the Enrollee's care needs or circumstances (applies to existing Enrollees).
10. CM14: For Enrollees aged 0 through 20, HNJH should ensure aggressive attempts are made to confirm EPSDT status when EPSDT status is not up to date (applies to existing Enrollees).
11. CM14: For Enrollees aged 0 through 20, HNJH should ensure EPSDT reminders are sent when the Enrollee's EPSDT exam is not up to date (applies to existing Enrollees).
12. CM14: For Enrollees aged 0 through 18, HNJH should ensure aggressive outreach attempts are made to confirm immunization status (applies to existing Enrollees).
13. CM14: For Enrollees aged 19 and above, HNJH should ensure aggressive outreach attempts are made to confirm immunization status (applies to existing Enrollees).
14. CM14: For Enrollees aged 21 and above, HNJH should ensure that the Care Manager addresses/discusses dental needs with the Enrollee (applies to existing Enrollees).
15. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, HNJH should make attempts to obtain dental status (applies to existing Enrollees).
16. CM14: For Enrollees aged 0 through 20 without a confirmed dental status, HNJH should ensure that dental reminders are sent (applies to existing Enrollees).
17. CM18c: HNJH should ensure that supporting policy documentation is dated during the review period and shows evidence of contractual compliance with the Element in review (applies to new Enrollees).
18. CM19: When appropriate for the applicable Enrollees, HNJH should ensure the Care Manager contacts Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD) (applies to existing Enrollees).
19. CM19: For Enrollees demonstrating needs requiring coordination of services, HNJH should ensure the Care Manager coordinates needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services (applies to new and existing Enrollees).
20. CM23: HNJH should ensure compliance with changing levels of Care Management as Enrollees' needs change (applies to existing Enrollees).

For the DCP&P Population:

1. CM5: HNJH should ensure that for Enrollees demonstrating needs requiring coordination of services within the MCO, the Care Manager demonstrates follow up with coordination of services (including, but not limited to Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee (applies to existing Enrollees).
2. CM8 *File Audit*: HNJHJ should ensure that the Enrollee has a Care Plan on file during the review period (applies to existing Enrollees).
3. CM14: For Enrollees aged 0 through 18, HNJH should ensure aggressive outreach attempts are made to confirm immunization status (applies to existing Enrollees).

4. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, HNJH should make attempts to obtain dental status (applies to existing Enrollees).
5. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, HNJH should ensure dental reminders are sent (applies to existing Enrollees).
6. CM18c: HNJH should ensure that supporting policy documentation is dated during the review period and shows evidence of contractual compliance with the Element in review (applies to new Enrollees).
7. CM19: When appropriate for the applicable Enrollees, HNJH should ensure the Care Manager contacts Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD) (applies to existing Enrollees).
8. CM19: For Enrollees demonstrating needs requiring coordination of services, HNJH should ensure the Care Manager coordinates needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services (applies to existing Enrollees).

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State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office of MLTSS Quality Monitoring

MCO MLTSS HCBS Care Management Audit
Horizon New Jersey Health

Review Period July 1, 2023 – June 30, 2024

January 2025

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Introduction

The purpose of the Managed Long-Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community Based Services (HCBS) and Institutionalization for Long-Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. The U.S. Department of Health and Human Services (HHS) declared an end to the Public Health Emergency (PHE) for COVID-19 on May 11, 2023. The State issued Covid-19 flexibilities related to specific MLTSS Care Management activities ended prior to this review period (July 1, 2023 to June 30, 2024), except for the NJ DHS, Division of Aging Services (DoAS), *Temporary Waiver of Clinical Eligibility Requirements for MLTSS Enrollment for MCO Members in a Community Setting.* Effective July 5, 2023 the use of the Screen for Community Services (SCS) as presumptive eligibility was discontinued.

The populations included in this audit were Members who met eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or Community Alternative Residential Setting (CARS), for at least six consecutive months within the review period July 1, 2023 to June 30, 2024.

Annually, DMAHS evaluates the MCO performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the NJ FamilyCare Contracts (Article 9), dated July 2023 and January 2024. A representative sample of files were selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities, and post-audit activities.

1. Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology, necessary source documents, contract references, and the Division of Aging Services (DoAS), Office of Community Choice Options (OCCO) new contract requirements for MLTSS Care Management. Effective November 15, 2023, as part of the NJ Choice Assessment system, MCOs are required to complete a NJ specific Options Counseling Summary (OCS) form, whereas the Interim Plan of Care (IPOC) was no longer contractually required.

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

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

Population Selection

The sample was determined by using the following capitation codes to identify MLTSS HCBS enrollment presented in **Table 1** and applying the sampling methodology described in **Table 2**.

Table 1. Capitation Codes

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

The sampling methodology as shown in **Table 2** resulted in the selection of 156 cases for Horizon New Jersey Health (HNJH), including an oversample.

Table 2. Sampling Methodology

Subpopulations	Criteria
Group C: Members New to Managed care and Newly Eligible for MLTSS between 7/1/2023 and 6/30/2024.	• The Member must have been initially enrolled in MLTSS HCBS between 7/1/2023 and 1/1/2024. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2024 in the *same* MCO with no gaps in enrollment.
Group D: Current Medicaid Managed care Members enrolled in MLTSS between 7/1/2023 and 6/30/2024.	• The Member must have been initially enrolled in MLTSS HCBS between 7/1/2023 and 1/1/2024. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2024 in the *same* MCO with no gaps in enrollment. • On the first day of the month prior to the initial MLTSS HCBS enrollment, the Member was enrolled in the *same* Medicaid MCO as the MLTSS HCBS MCO.
Group E: Current Medicaid Managed care Members enrolled in MLTSS prior to 7/1/2023 and continuously enrolled in MLTSS through 6/30/2024.	• The Member must have been initially enrolled in MLTSS HCBS prior to 7/1/2023. • The Member must have remained enrolled in MLTSS HCBS through 6/30/2024 in the *same* MCO with no gaps in enrollment.
Performance Measure #9a Enhancement	• A sample of 30 MLTSS HCBS Members across subgroups C, D, and E, identified on the NJ Choice Assessment Data list with assessment code 3, 4, and 5 will be included in the base sample abstracted from the universe. All MLTSS HCBS Members were included if the MCO has less than 30 Members who meet eligibility criteria.

MLTSS HCBS subpopulations were identified depending on different enrollment criteria. A stratified methodology was used to randomly select 100 MLTSS HCBS Members across subgroups C and D, and 30 MLTSS HCBS Members in subgroup E as a base sample. A 20% oversample across subgroups C and D, and subgroup E was drawn for substitution of exclusions.

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

All MLTSS HCBS Members were included if there were less than 100 Members across subgroups C and D, or less than 30 Members in subgroup E. Members could only be excluded by the MCO if they could provide evidence that the Member did not meet eligibility requirements. An oversample was selected for the MCO to replace any excluded files, as well as ensure an adequate denominator to evaluate Performance Measures.

Introductory E-Mail

IPRO sent an Introductory E-Mail to the MCO prior to the scheduled offsite audit including:

- Confirmation of the dates for the audit.
- Description of the sample.
- File listings identifying the files that needed to be available at the time of the offsite audit.

2. Audit Activities

IPRO reviewers conducted the file reviews over a five-week period. Reviewer inter-rater reliability was maintained using the standardized audit tool, and ongoing communication and coordination among the review team. Electronic files were prepared by the MCO for review.

3. Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the 156 cases selected for the HNJH, 137 Member files were reviewed and 130 were included in the results:

Description	Group C	Group D	Group E	Subtotal
Total Number of Files Reviewed	52	50	35	137
Exclusions	2	0	5	7
Number of Files included in Results	50	50	30	130

Population-specific findings are presented in **Table 3**, which contains aggregate scores based on the results of selected review questions within each review category: Assessment, Member Outreach, Face-to-Face Visits, Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans), Ongoing Care Management, and Gaps in Care/Critical Incidents. Rates for each subpopulation and a combined score calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 3**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

HNJH's audit results for the combined MLTSS sample ranged from 82.0% to 100.0% across all three (3) populations for the six (6) audit categories.

Table 3. Results by Category

Determination by Category	July 1, 2023 – June 30, 2024			
	Group C	Group D	Group E[2]	Combined[3]
Assessment	100.0%	97.6%	100.0%	99.0%
Member Outreach	82.0%	68.0%	--	75.0%
Face-to-Face Visits	96.4%	98.0%	93.5%	96.4%
Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans)[1]	96.4%	96.4%	95.6%	96.2%
Ongoing Care Management	86.9%	90.5%	82.2%	87.4%
Gaps in Care/Critical Incidents	100.0%	100.0%	100.0%	100.0%

[1]Initial Plan of Care is assessed for Group C and Group D Members. Ongoing Plans of Care are assessed for Group E Members as they are not new to MLTSS. Back-up Plans are assessed for Group C, D, and E Members.
[2]Member Outreach is not evaluated for Members in Group E as they are not new to the MLTSS.
[3]Calculated as an aggregate score by combining elements applicable to each category.

Members New to Managed Care and Newly Eligible for MLTSS (Group C)

A total of 52 files were reviewed for new Members enrolled in Managed Care and newly eligible for MLTSS (Group C). There were 2 files excluded. All 50 files were further reviewed for compliance in 6 categories. There were 21 Members residing in CARS.

Assessment	N	D	Rate
The MCO requested an NJ Choice Assessment (NJCA) for the Member from OCCO.*	0	50	0.0%
MCO requested a NJCA for the Member from OCCO within fifteen (15) business days of the effective date of the Member's enrollment (for this population, MCOs have the option of requesting a New Jersey Choice Assessment (NJCA) from the Office of Community Choice Options (OCCO).*	0	0	N/A
OCCO response was received within 5 business days of the MCO request.*	0	0	N/A
The MCO received an NJCA from OCCO within 5 business days of OCCO's notification that is considered valid and current.*	0	0	N/A
OCCO completed the NJCA which is valid during the review period.*	0	50	0.0%
The MCO completed the NJCA with the Member.	50	50	100.0%

*Not included in aggregate score calculation
N/A: Not Applicable

Member Outreach	N	D	Rate
Initial outreach was completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.	41	50	82.0%

Face-to-Face Visits	N	D	Rate
Member participated in all face-to-face visits.*	49	50	98.0%
Member was unable to participate in face-to-face visit due to cognitive impairment, a minor child, and/or the Member has a legal guardian.*	1	1	100.0%
Member or authorized representative participated in the onsite visit with the Care Manager.*	1	1	100.0%
Options Counseling was provided to the Member.[1]	50	50	100.0%
Member was offered the participant direction option.[3]	29	29	100.0%
Member chose to participate in participant direction (excludes Members residing in CARS).*	18	29	62.1%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.[3]	18	18	100.0%
Member had a completed and signed Interim Plan of Care (IPOC) or Options Counseling Summary (OCS) form on file.[1,2]	50	50	100.0%
A cost effective analysis was completed during the review period.	43	50	86.0%
Member reached or exceeded 85% of the annual cost thresholds (ACT).*	0	43	0.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period, had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

*Not included in aggregate score calculation

[1] Denominator excludes Members where OCCO completed the New Jersey Choice Assessment

[2]Compliance was evaluated for IPOCs completed before November 15, 2023 or OCS form completed on or after November 15, 2023

[3]Denominator excludes Members residing in CARS

N/A: Not Applicable

Initial Plan of Care (Including Back-up Plans)	N	D	Rate
Member had a completed and signed Initial Plan of Care on file, that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	46	50	92.0%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	50	50	100.0%
Member refused to be assessed for PCA services (excludes Members residing in CARS).*	4	29	13.8%
Member was assessed for PCA services (excludes Members residing in CARS).*	25	25	100.0%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.[1]	23	25	92.0%
Member required another PCA assessment due to changes in condition (excludes Members in CARS).*	5	25	20.0%
Member was re-assessed for PCA due to changes in condition.[1]	5	5	100.0%

Member had a Plan of Care and NJCA on file during the review period.*	50	50	100.0%
Plans of Care for MLTSS Members are aligned with Member needs as identified during the NJCA.	50	50	100.0%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	50	50	100.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	50	50	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	50	50	100.0%
Members who required a Back-up Plan, had a completed and signed Back-up Plan using the State mandated form.[1]	27	29	93.1%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	27	27	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	27	27	100.0%
Member service preference levels were documented in the Back-up Plan.[1]	27	27	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	27	27	100.0%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	29	29	100.0%
Member file included a Member Rights and Responsibilities statement signed by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	50	50	100.0%
Care Manager educated the Member on how to file a grievance and/or an appeal.	50	50	100.0%
Members residing in their community home had a risk assessment completed that included documentation of whether a positive risk was identified or not.[1]	29	29	100.0%
Member required a Risk Management Agreement (excludes Members residing in CARS).*	18	29	62.1%
Members who were identified as having a positive risk, had a signed Risk Management Agreement with all components.[1]	3	18	16.7%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS

Ongoing Care Management	N	D	Rate
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).[1]	29	29	100.0%
Member experienced issues that impeded access to care.*	0	50	0.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	0	0	N/A
Member had a documented face-to-face visit to review Member placement and services during the review period.	50	50	100.0%
Review of Member's placement and services occurred timely (an ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	34	50	68.0%
Member required a change in Plan of Care based on an increase or reduction of services.*	2	50	4.0%
Member files that indicated a change from the Initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed and was provided with a copy of the Plan of Care.	2	2	100.0%
Member file indicates disagreement with the Plan of Care.*	0	0	N/A
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	50	0.0%
A face-to-face visit was conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition, or well-being.	0	0	N/A
Member was discharged to an HCBS setting during the review period.*	5	50	10.0%
Member refused the 10 day post discharge onsite visit.*	0	5	0.0%
Care Manager completed a 10 day post discharge telephonic visit.*	0	0	N/A
For Members who were discharged to an HCBS setting the onsite review occurred within ten (10) days of discharge.	3	5	60.0%
Member was discharged to his/her own home and in home services were in place in a timely manner.	4	5	80.0%
Member experienced a significant change in condition requiring the Plan of Care to be amended.*	4	50	8.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed by the Member and/or authorized representative.	4	4	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS

N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation the Care Manager reviewed the process for immediately reporting gaps in service delivery with the Member.	29	29	100.0%
Member reported a gap in service delivery (excludes Members residing in CARS).*	0	29	0.0%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	0	0	N/A
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	50	50	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS
N/A: Not Applicable

Members Currently Enrolled in Managed Care and Newly Eligible for MLTSS (Group D)

A total of 50 files were reviewed for Members currently enrolled in Managed Care and newly eligible for MLTSS (Group D). No files were excluded. All 50 files were further reviewed for compliance in all 6 categories. There was 1 Member residing in CARS.

Assessment	*N*	*D*	*Rate*
Member had a Screen for Community Services (SCS) tool completed.*	46	50	92.0%
Member enrolled in MLTSS on an SCS Waiver.*	11	46	23.9%
The NJ Choice Assessment (NJCA) was completed within 30 days of a referral to MLTSS.	33	35	94.3%
The MCO completed the NJCA with the Member.	50	50	100.0%

*Not included in aggregate score calculation

Member Outreach	N	D	Rate
Initial outreach was completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.	34	50	68.0%

Face-to-Face Visits	N	D	Rate
Member participated in all face-to-face visits.*	47	50	94.0%
Member was unable to participate in face-to-face visit due to cognitive impairment, a minor child, and/or the Member had a legal guardian.*	3	3	100.0%
Member or authorized representative participated in the onsite meeting with the Care Manager.*	3	3	100.0%
Options Counseling was provided to the Member.	50	50	100.0%
Member has PPP prior to MLTSS enrollment.*	13	49	26.5%
Member has PPP pending prior to MLTSS enrollment.*	0	49	0.0%
Member was offered the participant direction option.[1]	36	36	100.0%
Member chose to participate in participant direction (excludes Members residing in CARS).*	10	36	27.8%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.[1]	10	10	100.0%
Member had a completed and signed Interim Plan of Care (IPOC) or Options Counseling Summary (OCS) form on file.[2]	50	50	100.0%
A cost effective analysis was completed during the review period.	47	50	94.0%
The Member reached or exceeded 85% of the annual cost threshold (ACT).*	1	47	2.1%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period, had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	1	0.0%

*Not included in aggregate score calculation

[1] Denominator excludes Members residing in CARS

[2]Compliance was evaluated for IPOCs completed before November 15, 2023 or OCS form completed on or after November 15, 2023

Initial Plan of Care (Including Back-up Plans)	N	D	Rate
Member had a completed and signed Initial Plan of Care on file, that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	48	50	96.0%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	50	50	100.0%
Member had PCA services prior to MLTSS enrollment.*	32	49	65.3%
Member refused to be assessed for PCA services (excludes Members residing in CARS).*	6	17	35.3%
Member was assessed for PCA services (excludes Members residing in CARS).*	11	11	100.0%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.[1]	10	11	90.9%
Member required another PCA assessment due to changes in condition (excludes Members residing in CARS).*	0	11	0.0%
Member was re-assessed for PCA due to changes in condition.[1]	0	0	N/A

Member had a Plan of Care and NJCA on file during the review period.*	50	50	100.0%
Plans of Care for MLTSS Members are aligned with Member needs as identified during the NJCA.	50	50	100.0%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	50	50	100.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	50	50	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	50	50	100.0%
Members who required a Back-up Plan, had a completed and signed Back-up Plan using the State mandated form.[1]	48	49	98.0%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	48	48	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	48	48	100.0%
Member service preference levels were documented in the Back-up Plan.[1]	48	48	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	47	48	97.9%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	49	49	100.0%
Member file included a Member Rights and Responsibilities statement signed by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	50	50	100.0%
Care Manager educated the Member on how to file a grievance and/or an appeal.	50	50	100.0%
Members residing in their community home had a risk assessment completed that included documentation of whether a positive risk was identified or not.[1]	49	49	100.0%
Member required a Risk Management Agreement (excludes Members residing in CARS).*	34	49	69.4%
Members who were identified as having a positive risk, had a signed Risk Management Agreement with all components.[1]	11	34	32.4%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS

N/A: Not Applicable

Ongoing Care Management	N	D	Rate
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).[1]	49	49	100.0%
Member experienced issues that impeded access to care.*	0	50	0.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	0	0	N/A
Member had a documented face-to-face visit to review Member placement and services during the review period.	50	50	100.0%
Review of Member's placement and services occurred timely (an ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	37	50	74.0%
Member required a change in Plan of Care based on an increase or reduction of services.*	8	50	16.0%
Member files that indicated a change from the Initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed and was provided with a copy of the Plan of Care.	8	8	100.0%
Member file indicates disagreement with the Plan of Care.*	0	0	N/A
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	50	0.0%
Face-to-face visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition, or well-being.	0	0	N/A
Member was discharged to an HCBS setting during the review period.*	8	50	16.0%
Member refused the 10 day post discharge onsite visit.*	0	8	0.0%
Care Manager completed a 10 day post discharge telephonic visit.*	0	0	N/A
For Members who were discharged to an HCBS setting the onsite review occurred within ten (10) days of discharge.	6	8	75.0%
Member was discharged to his/her own home and in home services were in place in a timely manner.	6	8	75.0%
Member experienced a significant change in condition requiring the Plan of Care to be amended.*	6	50	12.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed by the Member and/or authorized representative.	6	6	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS

N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	49	49	100.0%
Member reported a gap in service delivery (excludes Members residing in CARS).*	0	49	0.0%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	0	0	N/A
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	50	50	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS
N/A: Not Applicable

Members Enrolled in Managed Care and MLTSS Prior to the Review Period (Group E)

A total of 35 files were reviewed for the Members enrolled in Managed Care and MLTSS prior to the review period (Group E). There were 5 files excluded. The Member Outreach category is not assessed for Members in Group E. All 30 files were reviewed for compliance in 5 categories. There were 9 Members residing in CARS.

Assessment	*N*	*D*	*Rate*
The NJ Choice Assessment (NJCA) was due during the review period.*	30	30	100.0%
The MCO completed the NJCA with the Member.	30	30	100.0%
Member had an NJCA completed to reassess clinical eligibility for MLTSS within 11 to 13 months from the last NJCA authorized by OCCO.	30	30	100.0%

*Not included in aggregate score calculation

Face-to-Face Visits	N	D	Rate
Member participated in all face-to-face visits.*	29	30	96.7%
Member was unable to participate in the face-to-face visit due to cognitive impairment, a minor child, and/or the Member had a legal guardian.*	1	1	100.0%
Member or authorized representative participated in the onsite visit with the Care Manager.*	1	1	100.0%
Options Counseling was provided to the Member.	30	30	100.0%
Member had PPP prior to review period (excludes Members residing in CARS).*	6	21	28.6%
Member had PPP pending prior to review period (excludes Members residing in CARS).*	0	21	0.0%
Member was offered the participant direction option.[1]	15	15	100.0%

Member chose to participate in participant direction (excludes Members residing in CARS).*	0	15	0.0%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.[1]	0	0	N/A
Member had a completed and signed Interim Plan of Care (IPOC) or Options Counseling Summary (OCS) form on file.[2]	30	30	100.0%
A cost effective analysis was completed during the review period.	24	30	80.0%
Member reached or exceeded 85% of the annual cost thresholds (ACT).*	2	24	8.3%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period, had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	1	2	50.0%

*Not included in aggregate score calculation

[1] Denominator excludes Members residing in CARS

[2]Compliance was evaluated for IPOCs completed before November 15, 2023 or OCS form completed on or after November 15, 2023

N/A: Not Applicable

Ongoing Plans of Care (Including Back-up Plans)	N	D	Rate
Plan of Care reassessment for MLTSS Members was conducted within 30 days of annual LOC re-determination.	26	30	86.7%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	30	30	100.0%
Member file had documentation to demonstrate contact with the Member's HCBS providers at least annually to discuss the providers' reviews of the Member's needs and status and quarterly for Members receiving skilled nursing care, treatment for traumatic brain injury or behavioral health services.	30	30	100.0%
Member had PCA services prior to the review period (excludes Members residing in CARS).*	11	21	52.4%
Member refused to be assessed for PCA services (excludes Members residing in CARS).*	10	10	100.0%
Member was assessed for PCA services (excludes Members residing in CARS).*	0	0	N/A
Member required another PCA assessment due to changes in condition (excludes Members in CARS).*	0	0	N/A
Member was re-assessed for PCA due to changes in condition.[1]	0	0	N/A
Member had a Plan of Care and NJCA on file during the review period.*	30	30	100.0%
Plans of Care for MLTSS Members are aligned with Member needs as identified during the NJCA.	30	30	100.0%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	30	30	100.0%
Member's Plan of Care contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	30	30	100.0%

Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	30	30	100.0%
Members who required a Back-up Plan, had a completed and signed Back-up Plan using the State mandated form.[1]	20	21	95.2%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	20	20	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	20	20	100.0%
Member service preference levels were documented in the Back-up Plan.[1]	20	20	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	19	20	95.0%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	21	21	100.0%
Member file included a Member Rights and Responsibilities statement signed by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	30	30	100.0%
Care Manager educated the Member on how to file a grievance and/or an appeal.	30	30	100.0%
Care Manager completed an Annual Risk Assessment for the Member.[1]	21	21	100.0%
Members who were identified as having a positive risk (excludes Members residing in CARS).*	13	21	61.9%
IPRO identified the Member as having a potential risk during the review period that the Care Manager failed to identify. [1,2]	1	8	87.5%[2]
Members who were identified as having a positive risk, had a signed Risk Management Agreement with all components.[1]	1	13	7.7%

*Not included in aggregate score calculation
[1]Denominator excludes Members in CARS
[2]Percentage rate is indicative of compliant cases
N/A: Not Applicable

Ongoing Care Management	N	D	Rate
Member experienced issues that impeded access to care.*	0	30	0.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	0	0	N/A
Member had a documented face-to-face visit to review Member placement and services during the review period.	30	30	100.0%
Review of Member's placement and services occurred timely (an ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	15	30	50.0%

Member required a change in Plan of Care based on an increase or reduction of services.*	1	30	3.3%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed and was provided with a copy of the Plan of Care.	1	1	100.0%
Member file indicated a disagreement with the Plan of Care.*	0	0	N/A
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service), were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	30	0.0%
Face-to-face visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member needs, condition, or well-being.	0	0	N/A
Member was discharged to an HCBS setting during the review period.*	7	30	23.3%
Member refused the 10 day post discharge onsite visit.*	1	7	14.3%
Care Manager completed a 10 day post discharge telephonic visit.*	1	1	100.0%
For Members who were discharged to an HCBS setting the onsite review occurred within ten (10) days of discharge.	6	6	100.0%
Member was discharged to his/her own home and in home services were in place in a timely manner.	6	7	85.7%
Member experienced a significant change in condition requiring the Plan of Care to be amended.*	7	30	23.3%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed by the Member and/or authorized representative.	7	7	100.0%
Member had a change in placement occur during the review period.*	9	30	30.0%
Member had a change in placement indicated and there was documentation of discussion with the Member before the change was made.	9	9	100.0%

*Not included in aggregate score calculation
N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	21	21	100.0%
Member reported a gap in service delivery (excludes Members in CARS).*	0	21	0.0%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	0	0	N/A
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	30	30	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS
N/A: Not Applicable

Performance Measures

Population-Specific findings are presented in **Table 4**, which present results on the following MLTSS Performance Measures: #8 (Plans of Care established within 45 days of MLTSS enrollment), #9 (Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination), #9a (Plan of Care for MLTSS Members amended based on change of Member condition), #10 (Plans of Care for MLTSS Members are aligned with Member needs identified during the NJ Choice Assessment), #11 (Plans of Care for MLTSS Members are developed using "Person-Centered Principles"), #12 (MLTSS Home and Community Based Services (HCBS) Plans of Care that include a Back-up Plan), and #16 (MCO provided training to MLTSS Member on identifying/reporting Critical Incidents).

Population results, as shown in **Table 4**, are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. **Table 4** shows the results of the 2023-2024 audit findings. Overall, HNJH's audit results ranged from 86.7% to 100.0% across all groups for seven (7) Performance Measures for the current review period.

Table 4. Results of MLTSS Performance Measures

Performance Measure	Group[1]	Numerator	Denominator	Rate
#8. Plans of Care established within 45 days of MLTSS enrollment.	Group C	46	50	92.0%
	Group D	48	50	96.0%
	Group E[4]			
	Total	94	100	94.0%
#9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination.	Group C[5]			
	Group D[5]			
	Group E	26	30	86.7%
	Total	26	30	86.7%
#9a. Plan of Care for MLTSS Members amended based on change of Member condition.[2]	Group C	4	4	100.0%
	Group D	6	6	100.0%
	Group E	7	7	100.0%
	Total	17	17	100.0%
#10. Plans of Care for MLTSS Members are aligned with Member needs identified during the NJ Choice Assessment.	Group C	50	50	100.0%
	Group D	50	50	100.0%
	Group E	30	30	100.0%
	Total	130	130	100.0%

#11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles."	Group C	50	50	100.0%
	Group D	50	50	100.0%
	Group E	30	30	100.0%
	Total	130	130	100.0%
#12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that include a Back-up Plan.[3]	Group C	27	29	93.1%
	Group D	48	49	98.0%
	Group E	20	21	95.2%
	Total	95	99	96.0%
#16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents.	Group C	50	50	100.0%
	Group D	50	50	100.0%
	Group E	30	30	100.0%
	Total	130	130	100.0%

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

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

[3]Members in Community Alternative Residential Settings (CARS) are excluded from this measure

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

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

Discussion

Limitations

The NJ Department of Human Services, Division of Aging Services, *Temporary Waiver of Clinical Eligibility Requirements for MLTSS Enrollment for MCO Members in a Community Setting,* discontinued on July 5, 2023. For Group D Members, the MCO utilized the Screening for Community Services (SCS) tool for MLTSS enrollment if the Member met criteria (i.e. scores of 3, 4, or 5) up until July 5, 2023. Therefore, completion of the NJ Choice Assessment within 30 days of a referral to MLTSS could not be evaluated for those Members enrolled in MLTSS through an SCS waiver.

Conclusions and Recommendations

Population-Specific conclusions and recommendations are presented by category below.

Assessment

Across all three groups, the MCO had a combined score of 99.0% in the Assessment category.

Group	7/1/23 to 6/30/24
Group C	100.0%
Group D	97.6%
Group E	100.0%
Combined	99.0%

Member Outreach

Across groups, the MCO had a combined score of 75.0% in the Member Outreach category.

Group	7/1/23 to 6/30/24
Group C	82.0%
Group D	68.0%
Group E[1]	--
Combined	75.0%

[1]Member Outreach is not assessed for Members in Group E because Group E Members are not new to MLTSS

Opportunities for Improvement for elements at the group level in the *Member Outreach* category include the following:

- **Group C and Group D:** HNJH should ensure that Initial outreach is completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.

Face-to-Face Visits

Across all three groups, the MCO had a combined score of 96.4% in the face-to-face visits category.

Group	7/1/23 to 6/30/24
Group C	96.4%
Group D	98.0%
Group E	93.5%
Combined	96.4%

Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans)

Across all three groups, the MCO had a combined score of 96.2% in the Initial Plan of Care/Ongoing Plans of Care (including Back-up Plans) category.

Group	7/1/23 to 6/30/24
Group C	96.4%
Group D	96.4%
Group E	95.6%
Combined	96.2%

Ongoing Care Management

Across all three groups, the MCO had a combined score of 87.4% in the Ongoing Care Management category.

Group	7/1/23 to 6/30/24
Group C	86.9%
Group D	90.5%
Group E	82.2%
Combined	87.4%

Opportunities for Improvement for elements at the group level in the *Ongoing Care Management* category include the following:

- **Group E:** HNJH should ensure that review of Member's placement and services occurs timely (an ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).
  For Members discharged to his/her own home, HNJH should ensure that in home services are in place in a timely manner.

Gaps in Care/Critical Incidents

Across all three groups, the MCO had a combined score of 100.0% in the Gaps in Care/Critical Incidents category.

Group	7/1/23 to 6/30/24
Group C	100.0%
Group D	100.0%
Group E	100.0%
Combined	100.0%

Performance Measures

Overall, the MCO scored above 86% in all seven (7) Performance Measures.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
Managed Long Term Services and Supports (MLTSS)

2024 Annual Assessment Review of Care Management
Horizon New Jersey Health

Review Period - July 1, 2023 to June 30, 2024
December 2024

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Introduction

The NJ Family Care Managed Care Program, administered by the NJ Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), provides healthcare benefits for certain groups of children and adults with low-to-moderate incomes. The program provides health coverage to children, pregnant women, single adults, childless couples, aged, blind, and disabled individuals, and individuals qualified for long-term care services.

Background

The purpose of the Managed Long-Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure "That services were provided" to special needs members who met MLTSS eligibility requirements as specified in Article 9.

Annually, DMAHS evaluates Managed Care Organization (MCO) performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Assessment Methodology

The review consisted of pre-offsite review of documentation provided by Horizon New Jersey Health (HNJH) as evidence of compliance of the standards under review; interviews with key HNJH staff (held via Teams meeting on December 6, 2024) and post-offsite evaluation of documentation and offsite activities.

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

The offsite review of documentation was requested by IPRO on July 26, 2024, and received from the MCOs on August 9, 2024. The documentation review occurred offsite at IPRO beginning on August 12, 2024. The IPRO review team consisted of Carla Zuccarello, Karen Halley, and Cynthia Santangelo. The Care Management assessment covered the period from July 1, 2023 to June 30, 2024. The MCOs were advised to provide both MLTSS and FIDE SNP/MLTSS documents if their Care Management documentation differed between MLTSS and FIDE SNP/MLTSS.

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

Table 1: All MLTSS CM elements are subject to be reviewed annually regardless of a prior year Met, and therefore be considered full reviews every year.

Table 1: Rating Scale for the MCO (MLTSS) Annual Assessment Review of Care Management

Rating	Rating Methodology	Review Type
Met in Prior Review	This element was met in the previous review cycle.	Full, Partial
Met	All parts within this element were met.	Full, Partial
Not Met	Not all required parts within the element were met.	Full, Partial
N/A	This element is not applicable and will not be considered as part of the score.	Full, Partial
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.	Full, Partial
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.	Full, Partial
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.	Full, Partial

Report Organization

This report provides findings for the MLTSS Care Management and Continuity of Care document submission portion of the 2024 MLTSS Care Management review.

A table is presented which provides the number of elements under review, the number *Met*, *Not Applicable* (*N/A*), and the number *Not Met* for this review. Percentages are based on the total number of applicable elements in the standard. Credit is given for receiving a *Met* finding in the current review. Contract language and reviewer comments are provided for *Not Met* elements. Contract language is provided for *N/A* elements and resolved deficiencies.

Following this summary, Strengths, Recommendations and Findings for Improvement are reported where applicable. Recommendations relate to those elements that are deficient and must be addressed by the Plan. Findings for Improvement relate to suggestions by the IPRO review team to strengthen current processes.

Care Management and Continuity of Care

The Care Management and Continuity of Care review category examines if the MCO has an effective care and case management service structure. This structure includes written policies, procedures, processes, and systems to identify, assess and manage its member population in care and case management program(s). This review category also examines whether the MCO has developed and implemented MLTSS Care Management Programs for enrollees who may benefit from these services in accordance with State requirements.

There are 10 contractual provisions in this category. HNJH received an overall compliance score of 100% in 2024. In 2023, the MCO received a score of 100% for this category. **Table 1a** presents an overview of the results.

Table 1a: Summary of Findings for MLTSS Care Management and Continuity of Care

Element	Met Prior Year	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM18b	X	X	-	-	-	-	-
CM28	X	X	-	-	-	-	-
CM29	X	X	-	-	-	-	-
CM30	X	X	-	-	-	-	-
CM31	X	X	-	-	-	-	-
CM32	X	X	-	-	-	-	-
CM34	X	X	-	-	-	-	-
CM36	X	X	-	-	-	-	-
CM37	X	X	-	-	-	-	-
CM38	X	X	-	-	-	-	-
TOTAL	**10**	**10**	**0**	**0**	**0**	**0**	**0**
Compliance Percentage		**100%**					

Strengths

None

Recommendations

None

Findings for Improvement

None

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
Office of MLTSS Quality Monitoring

MCO MLTSS Nursing Facility/Special Care Nursing Facility Ancillary Review Compliance Evaluation of MLTSS Performance Measures

Horizon New Jersey Health

July 2024

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Introduction

The purpose of the Managed Long Term Services and Supports (MLTSS) Nursing Facility (NF)/Special Care Nursing Facility (SCNF) Ancillary Review is to evaluate Managed Care Organizations (MCOs) compliance with the Division of Medical Assistance and Health Services (DMAHS) NJ FamilyCare Contract Article 9.11.G, MLTSS Performance Measures. IPRO conducted a review of the following MLTSS Performance Measures: PM #8, PM #9, PM #9a, PM #11, and PM #16 for the review period September 1, 2022 through June 30, 2023.

Sampling Methodology

Population Selection

Population Criteria	September 1, 2022 to June 30, 2023
Codes	Capitation Codes **MLTSS NF Codes:** 88199, 88399, 88499, 78199, 78399 and 78499 **MLTSS HCBS Codes:** 89399 and 79399 *Needs to include **both** Core Medicaid and FIDE SNP Plan codes. Moving from one Plan Code to another does not constitute a change in MCO.
Age	No age requirements
Sex	Both
Nursing Facility Placement	Enrolled in a NF/SCNF for at least six (6) consecutive months, between 9/1/2022 and up to and including 6/30/2023.
Anchor Date	Enrolled in NF on 6/30/2023.
Continuous Enrollment Criteria	Enrolled in the same MCO for the entire period, from the initial six (6) consecutive months of residence in a NF/SCNF and remains in MLTSS through 6/30/2023 with no gaps in MLTSS enrollment.

Methodology

A random sample of 35 NF/SCNF Members new to MLTSS and/or new to the MCO during the review period and 25 NF/SCNF Members enrolled in MLTSS and the MCO prior to 9/1/2022 was selected to meet a minimum of 60 files (including a 20% oversample required for substitutions or exclusions) for each MCO. IPRO reviewed a total of 51 files for Horizon NJ Health (HNJH). One (1) file was excluded, resulting in 50 files evaluated for compliance with MLTSS Performance Measures #8, #9, #9a, #11, and #16.

Evaluation of MLTSS Performance Measures

The following Performance Measures were evaluated to determine MCO compliance; PM #8: Plans of Care established within 45 days of MLTSS enrollment; PM #9: Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination; PM #9a: Plan of Care for MLTSS Members amended based on change of Member condition; PM #11: Plans of Care for MLTSS Members are developed using Person-Centered Principles; and PM #16: MCO provided training to MLTSS Member on identifying/reporting Critical Incidents. HNJH's results for each MLTSS Performance Measure are shown below in **Table 1**.

Table 1: MLTSS Performance Measures Results

Performance Measure	Numerator	Denominator	Rate
#8. Plans of Care established within 45 days of MLTSS enrollment.[1]	26	30	86.7%
#9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination.[2]	16	16	100.0%
#9a. Plan of Care for MLTSS Members amended based on change of Member condition.[3]	2	2	100.0%
#11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles."[4]	50	50	100.0%
#16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents.	50	50	100.0%

[1] Compliance with this measure includes completion of the Initial Plan of Care and timeliness of completion. The denominator includes all NF/SCNF Members new to MLTSS and/or new to the MCO during the review period.

[2] Members included in this measure (denominator) have an annual LOC re-determination that was due and completed during the review period and a Plan of Care on file.

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

[4] For compliance with this measure Members must have a Plan of Care on file during the review period that contains documentation 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 be addressed in the Plan of Care.

Limitations

None.

Conclusions

As directed by DMAHS, no Corrective Action Plans (CAPs) will be required for MLTSS Performance Measures that score below the MLTSS compliance threshold of 86%.

Overall, the MCO scored 86% or above for all five (5) MLTSS Performance Measures (**Table 1**):

- PM #8: Plans of Care established within 45 days of MLTSS enrollment.
- PM #9: Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination.
- PM #9a: Plan of Care for MLTSS Members amended based on change of Member condition.
- PM #11: Plans of Care for MLTSS Members are developed using “Person-Centered Principles.”
- PM #16: MCO provided training to MLTSS Member on identifying/reporting Critical Incidents.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services,
Office of MLTSS Quality Monitoring

MCO MLTSS Nursing Facility/Special Care Nursing Facility Care Management Audit

Horizon New Jersey Health

February 2025

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Introduction

The purpose of the Managed Long-Term Services and Supports (MLTSS) Nursing Facility/Special Care Nursing Facility (NF/SCNF) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS Care Management program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Specifically, the populations included in this audit were Members who met the eligibility requirements for MLTSS and were receiving services in a Nursing Facility/Special Care Nursing Facility for at least six consecutive months within the review period from July 1, 2023 through June 30, 2024.

The U.S. Department of Health and Human Services (HHS) declared an end to the Public Health Emergency (PHE) for COVID-19 on May 11, 2023. State issued COVID-19 flexibilities related to specific Care Management activities and Nursing Facilities with visitation protocols (restricting Care Manager access) discontinued prior to this review period.

In addition to the CM audit, MLTSS Performance Measures #8 (Plans of Care established within 45 days of MLTSS enrollment), #9 (Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination), #9a (Plan of Care for MLTSS Members amended based on change of Member condition), #11 (Plans of Care for MLTSS Members are developed using “Person-Centered Principles”), and #16 (MCO provided training to MLTSS Member on identifying/reporting Critical Incidents) were calculated. Annually, DMAHS will evaluate the Managed Care Organization (MCO) performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the NJ FamilyCare Contracts (Article 9), dated July 2023 and January 2024. A representative sample of files were selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities, and post-audit activities.

1. Pre-audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the NJ Choice Assessment System, Plan of Care, contract references, and revision of elements for review. Audit questions are limited exclusively to ”Yes” or ”No” answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool in 2024, where appropriate, to determine whether a Member met the criteria for a subsequent section or question. Therefore, for some audit questions, Members represented in the numerator and denominator represent only those who met the specific applicable criteria. IPRO prepared an audit tool structured to collect requirement-specific information related to Facility and MCO Plan of Care, MLTSS Initial Plan of Care and Ongoing Plans of Care, Ongoing Care Management, Reassessment of the Plan of Care and Critical Incident Reporting, and Preadmission Screening and Resident Review (PASRR) Communications for Transitions to NF/SCNF. In addition, MLTSS Performance Measures #8, #9, #9a, #11, and #16 were calculated for the applicable NF/SCNF population. Rates calculated from these audit tool sections are utilized to determine MCO performance.

Separate rates were calculated on requirement-specific questions related to MLTSS Members who transitioned between HCBS and NF/SCNF settings during the review period. These rates are utilized solely for informational purposes.

Population Selection

Capitation and Plan codes were used to identify MLTSS HCBS and MLTSS NF/SCNF enrollment. The study sample was selected by using the capitation codes to identify MLTSS HCBS and NF/SCNF enrollment listed in **Table 1** and **Table 2**, and applying the sampling methodology described below.

Table 1: Capitation Codes for MLTSS HCBS Enrollment

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

Table 2: Capitation Codes for MLTSS NF Enrollment

Capitation Code	Description
88199	MLTSS Eligible Without Medicare – NF
88399	MLTSS Eligible Without Medicare – SCNF (Vents and Pediatrics)
88499	MLTSS Eligible Without Medicare – SCNF
78199	MLTSS Eligible With Medicare - NF
78399	MLTSS Eligible With Medicare – SCNF (Vents and Pediatrics)
78499	MLTSS Eligible With Medicare - SCNF

A random sampling method was used to meet a minimum of records needed to reach 100 files for each MCO. If the MCO did not have 100 files, the entire universe was selected for review. IPRO selected 110 cases for Horizon New Jersey Health (HNJH), inclusive of an oversample of 10 cases to replace any excluded files as necessary.

Sampling Methodology

The criteria used to select the MLTSS NF/SCNF population were as follows:

- The Member must have been enrolled in MLTSS on June 30, 2024.
- The Member must have been enrolled as a NF/SCNF Member for 6 consecutive months during the review period and still enrolled with the MCO of record on June 30, 2024.
- The Member cannot be enrolled with another MCO at any time between the beginning of the minimum 6-month NF/SCNF enrollment and the end of the review period (June 30, 2024).

In order to collect additional information for MLTSS Members who transitioned between HCBS and NF/SCNF settings during the review period, the selected MLTSS NF/SCNF population was further identified as one of the four subgroups listed in **Table 3**.

Table 3: MLTSS NF/SCNF Population Subgroups

Group	Description
Group 1	Members permanently residing in a NF/SCNF at least 6 consecutive months from July 1, 2023 to June 30, 2024, with the MCO of record on June 30, 2024.
Group 2	Members residing in a NF/SCNF for at least 6 consecutive months from July 1, 2023 to June 30, 2024, and transitioned to HCBS during the review period with no transition from HCBS to another NF.
Group 3	Members residing in HCBS for at least 1 month between July 1, 2023 to June 30, 2024, and transitioned to a NF/SCNF for at least 6 consecutive months during the review period (and still residing in the NF/SCNF as of June 30, 2024).
Group 4	Members residing in HCBS for at least 1 month between July 1, 2023 and June 30, 2024, transitioned to a NF/SCNF for at least 6 consecutive months, and transitioned back to HCBS for at least 1 month during the review period.

Introductory E-mail

IPRO sent an introductory e-mail to the MCO prior to the scheduled offsite audit including:

- Formal notification of the audit with a file due date,
- Description of the sample,
- File listing identifying the files that needed to be submitted to IPRO, and
- Instructions for preparing files and uploading the files to IPRO's SEND File Transfer Protocol (FTP) site.

2. Offsite Audit Activities

Electronic files were prepared by the MCO for review and posted to IPRO's SEND FTP site. IPRO reviewers conducted the offsite file reviews over a five (5) week period. Reviewer inter-rater reliability (IRR) was maintained using the standardized audit tool with ongoing communication and coordination among the review team. Electronic files were prepared by the MCO for review.

3. Post-audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the 110 files selected for HNJH, 101 Member files were reviewed. There was 1 file excluded. A total of 100 files were further reviewed for compliance in the following five (5) categories; Facility and MCO Plan of Care, MLTSS Initial Plan of Care and Ongoing Plans of Care, Ongoing Care Management, Reassessment of the Plan of Care and Critical Incident Reporting, and PASRR Communications for Transitions to NF/SCNF. Based on sample selection criteria, this included all four subpopulations (Groups 1, 2, 3 and 4). Rates for individual elements were calculated as the number of "Yes" determinations divided by the sum of "Yes" plus "No" determinations. Abbreviated review elements appear in bold in the table sections of this report (**Tables 4–8**). Rates should be considered cautiously for review elements with a denominator of less than 30.

Table 4: Facility and MCO Plan of Care

Facility and MCO Plan of Care	N	D	Rate
Member's Care Management record contained **copies of any Facility Plans of Care on file** during the review period.	82	100	82.0%
Documented review of the Facility Plan of Care by the Care Manager.	82	82	100.0%
MLTSS Plan of Care on file includes information from the Facility Plan of Care.	100	100	100.0%

Table 5: MLTSS Initial Plan of Care and Ongoing Plans of Care

MLTSS Initial Plan of Care and Ongoing Plans of Care	N	D	Rate
The Member's individualized Plan of Care (including obtaining Member's signature) **was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program.**[1]	1	1	100.0%
Care Managers used a Person-Centered approach regarding the Member's assessment and needs; taking into account not only covered services, but also formal and informal support services.	100	100	100.0%
Plan of Care reassessment for MLTSS Members conducted within 30 days of annual level of care (LOC) re-determination.[2]	97	99	98.0%
Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems, and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process.	100	100	100.0%
Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	100	100	100.0%
Member's agreement/disagreement with the Plan of Care statements were documented on the Member's Plan of Care and maintained in the Member's electronic CM record.	100	100	100.0%
Member experienced a significant change in condition requiring the Plan of Care to be amended.	3	100	3.0%

MLTSS Initial Plan of Care and Ongoing Plans of Care	N	D	Rate
Updated Plan of Care for a significant change. For any significant change in Member condition, Member's Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative.	2	3	66.7%

[1]Compliance with this measure includes completion of the Initial Plan of Care, Member signature, and a copy provided to the Member within 45 calendar days of the MLTSS enrollment date. The denominator includes all NF/SCNF Members new to MLTSS and/or new to the MCO during the review period.

[2]Members included in this measure (denominator) have an annual LOC re-determination that was due and completed during the review period and a Plan of Care on file.

Table 6: Ongoing Care Management

Ongoing Care Management	N	D	Rate
There was evidence in the file that the Member had the ability and/or desire to transition from the NF/SCNF.	12	100	12.0%
Member was identified for transfer to HCBS and was offered options, including transfer to the community.	12	12	100.0%
Evidence of the **Care Manager's participation in at least one interdisciplinary team (IDT) meeting** during the review period.	18	100	18.0%
Member was present at each onsite visit or had involvement from the Member's authorized representative regarding the Plan of Care. (If the Member was not able to participate in an onsite visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable).	97	100	97.0%
The Care Manager reviewed Member placement and services onsite with the Member present.	100	100	100.0%
Timely onsite review of Member placement and services. Onsite visits were timely and occurred within at least 180 calendar days for non-pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability).	89	100	89.0%
Member required coordination of care (physical health and/or behavioral health services) not covered by NF/SCNF.	1	100	1.0%
Members requiring coordination of care had coordination of care by the Care Manager.	1	1	100.0%

Table 7: Reassessment of the Plan of Care and Critical Incident Reporting

Reassessment of the Plan of Care and Critical Incident Reporting	N	D	Rate
The NJ Choice Assessment (NJCA) was due during the review period (initial or annual redetermination NJCA).	100	100	100.0%
Member had a NJCA completed during the review period.	100	100	100.0%
Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative.	99	100	99.0%
Care Manager reviewed the Member's rights and responsibilities.	100	100	100.0%
Care Manager educated the Member on how to file a grievance and/or an appeal.	100	100	100.0%
Member and/or representative had **training on how to report a critical incident**, specifically including how to identify abuse, neglect and exploitation.	100	100	100.0%

Table 8: PASRR Communications for Transitions to NF/SCNF

PASRR Communications for Transitions to NF/SCNF	N	D	Rate
Member transitioned to the NF/SCNF during the review period.	2	100	2.0%
Care Manager completed or confirmed PASRR Level I prior to Member transition to NF/SCNF.	2	2	100.0%
Communication of PASRR Level I to OCCO documented by the Care Manager in the NJCA.	2	2	100.0%
Member required a PASRR Level II prior to admission to the NF/SCNF.	0	2	0.0%
Care Manager completed or confirmed PASRR Level II, prior to Member transition to NF/SCNF.	0	0	N/A
Communication of PASRR Level II to OCCO documented by the Care Manager (within 1 business day of receipt of determination).	0	0	N/A
Member demonstrated a need for MCO coordination with DDD/DMHAS.	0	0	N/A
Members who had a PASRR Level II indicating a need for Specialized Services setting had coordination with DDD/DMHAS.	0	0	N/A

OCCO: Office of Community Choice Options; DDD: Division of Developmental Disabilities; DMHAS: Division of Mental Health and Addiction Services
N/A: Not Applicable

MLTSS Members Transitioning Between HCBS and NF/SCNF Settings

Of the cases selected for HNJH, 100 Member files were reviewed and included in the results. Rates were calculated for Members who transitioned from one MLTSS setting to another during the review period (Groups 2, 3, and 4; **Table 9**). Review elements are abbreviated in bold. Evaluation of MCO performance is for information purposes only.

Table 9: Member Transition Groups

Group	Member Transition	Number of Members
Group 1	Permanently residing in NF/SCNF for at least 6 months without a transition during the review period.	97
Group 2	Transitioned from NF/SCNF to HCBS with no other facility transition during the review period.	2
Group 3	Transitioned from HCBS to NF/SCNF and remained in a facility at the end of the review period.	1
Group 4	Transitioned from HCBS to NF/SCNF and back to HCBS during the review period.	0

MLTSS Members Transitioning from NF/SCNF to HCBS

A total of 2 files were reviewed for Members permanently residing in a NF/SCNF and subsequently transitioned to a home or community-based setting. Rates were calculated to profile NF/SCNF Members that transitioned to HCBS (Groups 2 and 4; **Table 9**).

Table 10: NF/SCNF Members Transitioned to HCBS

Transitions to HCBS	N	D	Rate
Member transitioned from NF/SCNF to HCBS during the review period.	2	100	2.0%
Member had a **Person-Centered transition plan on file.**	2	2	100.0%
Cost effectiveness evaluation was completed for the Member prior to discharge from a NF/SCNF.	1	2	50.0%
Plan of Care updated prior to discharge from a facility. Plan of Care was developed and agreed upon by the Member and/or representative prior to the effective date of transfer to the community.	1	2	50.0%
Participation in an interdisciplinary team (IDT) meeting related to transition. Care Manager participated in the coordination of an IDT meeting related to transition planning.	2	2	100.0%
Authorizations and procurement of transitional services for the Member were completed prior to NF/SCNF transfer.	2	2	100.0%
Care Manager conducted a **face-to-face visit within 10 business days following a NF/SCNF discharge to the community.**	2	2	100.0%
Services initiated upon NF/SCNF discharge were according to the Member's Plan of Care.	2	2	100.0%

MLTSS Members Transitioning from HCBS to NF/SCNF

A total of 1 file was reviewed for Members receiving HCBS and subsequently transitioned to an NF/SCNF for long-term placement. Rates were calculated to profile HCBS Members that transitioned to an NF/SCNF (Groups 3 and 4; **Table 9**).

Table 11: HCBS Members Transitioned to a NF/SCNF

Transitions to NF/SCNF	N	D	Rate
Member transitioned from HCBS to NF/SCNF during the review period.	1	100	1.0%
Member was admitted to NF/SCNF directly from an acute care facility.	1	1	100.0%
Care Manager determined during the reassessment process that changes in placement or services were indicated, and a **discussion with the Member occurred prior to the change in service/placement.**	1	1	100.0%

The expansion of the NF/SCNF audit components included evaluation of MLTSS Performance Measures. Population-specific findings are presented in **Table 12**, which include results on the following MLTSS Performance Measures: #8 (Plans of Care established within 45 days of MLTSS enrollment), #9 (Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination), #9a (Plan of Care for MLTSS Members amended based on change of Member condition), #11 (Plans of Care for MLTSS Members are developed using Person-Centered Principles), and #16 (MCO provided training to MLTSS Member on identifying/reporting Critical Incidents). Population results are rates calculated as the number of "Yes" determinations divided by the sum of "Yes" plus "No" determinations.

Table 12: MLTSS Performance Measures Results

Performance Measure	N	D	Rate
#8. Plans of Care established within 45 days of MLTSS enrollment.[1]	1	1	100.0%
#9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination.[2]	97	99	98.0%
#9a. Plan of Care for MLTSS Members amended based on change of Member condition.[3]	2	3	66.7%
#11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles."[4]	100	100	100.0%
#16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents.	100	100	100.0%

[1]Compliance with this measure includes completion of the Initial Plan of Care, Member signature, and a copy provided to the Member within 45 calendar days of the MLTSS enrollment date. The denominator includes all NF/SCNF Members new to MLTSS and/or new to the MCO during the review period.

[2] Members included in this measure (denominator) have an annual LOC re-determination that was due and completed during the review period and a Plan of Care on file.

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

[4] For compliance with this measure Members must have a Plan of Care on file during the review period that contains documentation 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 be addressed in the Plan of Care.

Discussion

Limitations

Results are limited due to the absence of Members in Group 4 (Members who transitioned from HCBS to the NF/SCNF and returned to HCBS) during the review period.

Conclusions

Overall, the MCO scored 86% or above in the following review elements (**Tables 4–8**). Review elements evaluated for calculation of Performance Measures are resulted in the MLTSS Performance Measures section of this report.

Facility and MCO Plan of Care

- Documented review of the Facility Plan of Care by the Care Manager. (100.0%)
- MLTSS Plan of Care on file includes information from the Facility Plan of Care. (100.0%)

MLTSS Initial Plan of Care and Ongoing Plans of Care

- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems, and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process. (100.0%)
- Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this). (100.0%)
- Member's agreement/disagreement with the Plan of Care statements were documented on the Member's Plan of Care and maintained in the Member's electronic CM record. (100.0%)

Ongoing Care Management

- Member was identified for transfer to HCBS and was offered options, including transfer to the community. (100.0%)
- Member was present at each onsite visit or had involvement from the Member's authorized representative regarding the Plan of Care. (If the Member was not able to participate in an onsite visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable). (97.0%)
- Timely onsite review of Member placement and services. Onsite visits were timely and occurred within at least 180 calendar days for non-pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability). (89.0%)
- Members requiring coordination of care had coordination of care by the Care Manager. (100.0%)

Reassessment of the Plan of Care and Critical Incident Reporting

- Member had a NJCA completed during the review period. (100.0%)
- Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative. (99.0%)
- Care Manager reviewed the Member's rights and responsibilities. (100.0%)
- Care Manager educated the Member on how to file a grievance and/or an appeal. (100.0%)

PASRR Communications for Transitions to NF/SCNF

- Care Manager completed or confirmed PASRR Level I prior to Member transition to NF/SCNF. (100.0%)
- Communication of PASRR Level I to OCCO documented by the Care Manager in the NJCA. (100.0%)

Opportunities for Improvement for Review Elements

Opportunities for improvement for MCO scores below 86% exist in the following review elements (**Tables 4–8**).

- Member's Care Management record contained copies of any Facility Plans of Care on file during the review period. (82.0%)
- Evidence of the Care Manager's participation in at least one interdisciplinary team (IDT) meeting during the review period. (18.0%)

Recommendations for Review Elements

- HNJH MLTSS Care Managers should ensure the Member's record contains copies of Facility Care Plans during the review period.
- HNJH MLTSS Care Managers should ensure the Care Manager participates in a minimum of one interdisciplinary team (IDT) meeting per year.

MLTSS Performance Measures

Overall, the MCO scored 86% or above in the following Performance Measures (PMs) (**Table 12**).

- PM #8. Plans of Care established within 45 days of MLTSS enrollment. (100.0%)
- PM #9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination. (98.0%)
- PM #11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles." (100.0%)
- PM #16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents. (100.0%)

Opportunities for Improvement for MLTSS Performance Measures

Opportunities for improvement for MCO scores below 86% exist for the following MLTSS Performance Measures (**Table 12**).

- PM #9a. Member's Plan of Care is amended based on change of Member condition. (66.7%)

Recommendations for MLTSS Performance Measures

- PM #9. HNJH MLTSS Care Managers should ensure the Member's Plan of Care is amended when a Member experiences a significant change in condition.

Appendix E – UHCCP 2024 Core Medicaid and MLTSS Care Management Audit Reports

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
Office of Quality Assurance

MCO Care Management Audit and Annual Assessment
UnitedHealthcare Community Plan

Review Period: January 1, 2023 to December 31, 2023

September 2024

IPRO
Better healthcare, realized.

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MCO Care Management Audit and Annual Assessment

Introduction

The purpose of the Care Management Audit and Annual Assessment was to evaluate the effectiveness of the contractually required Care Management program. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) established Care Management requirements to ensure that the services provided to Enrollees with special health care needs are consistent with professionally recognized standards of care. The populations included in this audit include General Population (GP) Enrollees, Enrollees under the Division of Developmental Disabilities (DDD), and Enrollees under the Division of Child Protection and Permanency (DCP&P).

Annually, DMAHS evaluates Managed Care Organization (MCO) performance against these requirements through its External Quality Review Organization (EQRO) Contractor. The results of these audits are used to improve MCO performance.

MCO Care Management Chart Audit

Methodology

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

Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the prior year's report, NJ FamilyCare contract references, NJ Care Management Workbook, and CDC Immunization Schedules. For 2024, at the direction of DMAHS, the MCO Care Management audit evaluation process changed for GP, DDD, and DCP&P Enrollees. For the GP population, IPRO evaluated Enrollees new to the MCO and new to Care Management between 1/1/2023 and 11/16/2023 and existing Enrollees enrolled in Care Management between 3/1/2023 and 11/16/2023. For the DDD and DCP&P populations, IPRO evaluated newly eligible Enrollees new to Care Management during the 2023 review period and existing eligible Enrollees enrolled in Care Management prior to 1/1/2023. Audit questions are limited exclusively to 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool, where appropriate, to determine whether an Enrollee met the criteria for a subsequent section or question. Therefore, for some audit questions, Enrollees represented in the numerator and denominator represent only those who met the specific applicable criteria.

IPRO prepared Audit Tools structured to collect requirement-specific information related to: Identification, Outreach, Preventive Services, Continuity of Care, and Coordination of Services. The tools included State-specific Contract

requirements, reviewer guidelines (noting specific elements that required review), reviewer determination (Yes or No), and reviewer comments (to document findings related to any requirements that were determined not fully compliant).

Population Selection

The sample was determined by excluding Enrollees with Third Party Liability (TPL) from the three populations, all pregnant members from the General Population, and applying the sampling methodology described below. The sampling methodology, as shown in **Table 1**, resulted in the selection of 300 cases for UnitedHealthcare Community Plan (UHCCP).

Using a conservative assumption of a 65% proportion, a sample size of 100 was selected to yield sufficient statistical power to produce a 95% confidence interval, with a 10% margin of error. The confidence interval provides the range within which there is a 95% probability that the true rate falls between the lower rate and the upper rate of the confidence interval. Higher rates lead to smaller ranges in confidence intervals.

A random sample of 130 Enrollees for the General Population, DDD Population, and DCP&P Population (including a 30% oversample required for substitutions or exclusions), was selected.

Table 1: Sampling Methodology

Population Criteria	General Population (GP)	DDD	DCP&P
Criteria	Using the criteria below, the MCO will provide two (2) listings of ALL eligible New and Existing Enrollees (exclude DDD, DCP&P, all pregnant Enrollees, and TPL). IPRO will pull a random sample of 65 Enrollees new to the MCO and Care Management anytime between 1/1/2023 through 11/16/2023 and 65 existing Enrollees new to Care Management between 3/1/2023 through 11/16/2023 from the universes provided.** **Random sample size modified by IPRO.	Using the appropriate Capitation Codes and the criteria below, the MCO will provide two (2) listings (exclude TPL) for: 1 - ALL New eligible DDD Enrollees in Care Management and; 2 - ALL Existing eligible DDD Enrollees in Care Management IPRO will select a random sample of 130 new and existing DDD Enrollees in Care Management per MCO from the universes provided.** **Random sample size modified by IPRO.	Using the appropriate Capitation Codes and the criteria below, the MCO will provide two (2) listings (exclude TPL) for: 1 - ALL New eligible DCP&P Enrollees in Care Management and; 2 - ALL Existing eligible DCP&P Enrollees in Care Management IPRO will select a random sample of 130 new and existing DCP&P Enrollees in Care Management per MCO from the universes provided.** **Random sample size modified by IPRO.
Age	>=6 months as of 12/31/2023	>= 6 months as of 12/31/2023	>= 6 months and < 18 years as of 12/31/2023
Sex	Both	Both	Both
Enrollment in MCO • New Enrollees	Initial enrollment between 1/1/2023 to 6/30/2023	Initial enrollment between 1/1/2023 and 6/30/2023	Initial enrollment between 1/1/2023 and 6/30/2023
• Existing Enrollees	Enrolled prior to 1/1/2023	Enrolled prior to 1/1/2023	Enrolled prior to 1/1/2023
Current Enrollment	Enrolled as of 12/31/2023 and with the same MCO for 6 months during the review period.	Enrolled as of 12/31/23 and with the same MCO for 6 months during the review period.	Enrolled as of 12/31/23 and with the same MCO for 6 months during the review period.
Continuous Enrollment Criteria	Enrolled in same population and same MCO through 12/31/2023 allowing no more than a one-month gap.	Enrolled in same population and same MCO at least 6 months in 2023 allowing one gap <= 45 days. Gap is not permissible at the beginning or the end of the enrollment time period.	Enrolled in same population and same MCO at least 6 months in 2023 allowing one gap <= 45 days. Gap is not permissible at the beginning or the end of the enrollment time period.

		Where Enrollee meets enrollment criteria for 2 MCOs in 2023, the later MCO enrollment is selected.	Where Enrollee meets enrollment criteria for 2 MCOs in 2023 the later MCO enrollment is selected.

Introductory E-Mail

For this year's audit, the evaluation included an audit review for three (3) sampled populations. IPRO sent an Introductory E-Mail to the MCO prior to the offsite desk audit including:

- A description of the current year audit process and specifications for each population.
- File listings identifying the files that needed to be submitted to IPRO, along with instructions for preparing the files and uploading the files to IPRO's S.E.N.D. FTP site.

Audit Activities

IPRO reviewers conducted the file reviews over a five-week period. Reviewer inter-rater reliability was maintained through use of the standardized Audit Tool, and ongoing communication and coordination among the review team.

Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report. MCOs were not permitted to submit additional information after the offsite audit.

Audit Results

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in Table 2, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

UHCCP's 2024 CM Audit results for the review period 1/1/2023 to 12/31/2023 ranged from 77.4% to 100% across all populations for the five audit categories.

Table 2: Aggregate Results by Category

Determination by Category	GP (n=100)	DDD (n=100)	DCP&P (n=100)
Identification[1]	77.4%		
Outreach[2,3]	100.0%	98.2%	N/A[4]
Preventive Services[3]	99.4%	93.6%	99.6%
Continuity of Care[3]	100.0%	95.6%	99.4%
Coordination of Services[3]	100.0%	95.1%	99.2%

[1]The Identification category is not evaluated for New and Existing DDD and DCP&P Enrollees, or Existing GP Enrollees.
[2]The Outreach category is evaluated for Enrollee files with no CNA or untimely completion of the CNA.
[3]Aggregate scores represent a combination of New and Existing population specific rates.
[4]N/A: Not Applicable. No DCP&P Enrollees met criteria for this measure as all CNAs were completed timely.

GP Population Findings

Identification

The Identification category applies to GP Enrollees (50) new to the MCO and new to Care Management between 1/1/2023 and 11/16/2023.

Table 3: Identification – GP Population- Enrollees New to the MCO and New to Care Management

Identification	General Population		
	Numerator	Denominator	Rate
Enrollee has an Initial Health Screen (IHS) on file and/or an IHS score documented in the file that was completed during the review period (1/1/2023 to 12/31/2023).*	50	50	100.0%
For IHS on file, IHS was completed for the Enrollee within 45 days of MCO enrollment date.	36	50	72.0%
For no IHS on file, the MCO made outreach attempts to complete the IHS.*	0	0	N/A
For Enrollees where no IHS was on file, initial outreach to complete the IHS was successful (even if Enrollee declined to complete the IHS).*	0	0	N/A
For Enrollees where no IHS was on file, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment.	0	0	N/A
Enrollees who scored less than 5 on the IHS or no IHS on file.*	12	50	24.0%
Enrollees identified by the Plan as having Care Management needs through additional sources (applies to Enrollees new to the MCO and new to CM where the IHS score is less than 5 or no IHS on file).	12	12	100.0%

**Not Included in aggregate score calculation*
N/A: Not Applicable

Outreach

The Outreach category applies to new GP Enrollees (50) enrolled in Care Management between 1/1/2023 and 11/16/2023 and existing GP Enrollees (50) enrolled in Care Management between 3/1/2023 and 11/16/2023.

Table 4: Outreach – General Population – New and Existing Enrollees enrolled in Care Management

Outreach	General Population – New Enrollees			General Population – Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The MCO completed a Comprehensive Needs Assessment (CNA) during the review period.*	50	50	100.0%	50	50	100.0%
The Enrollee was unable to reach to complete the CNA.*	0	0	N/A	0	0	N/A
The MCO completed the CNA timely.*	50	50	100.0%	50	50	100.0%
Initial outreach to complete a CNA was performed.[1]	0	0	N/A	0	0	N/A
Initial outreach to complete the CNA was done timely, within 30 days of identification of CM needs. (30 days from IHS score 5 or greater; or IHS	0	0	N/A	0	0	N/A

Outreach	General Population – New Enrollees			General Population – Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
less than 5, no IHS, identification of CM needs through other sources).						
Initial outreach to complete a CNA was successful (even if the Enrollee declined to complete the CNA).	0	0	N/A	0	0	N/A
The MCO performed and documented aggressive outreach attempts to complete a CNA.)*	0	0	N/A	0	0	N/A
For CNAs not completed timely or no CNA, aggressive outreach attempts were made timely (30 days from IHS score 5 or greater or identification of CM needs through other sources).	0	0	N/A	0	0	N/A
Upon any successful outreach to the Enrollee, the Enrollee opted out of Care Management.*	2	50	4.0%	0	50	0.0%
Enrollee became lost to contact during the review period.*	17	50	34.0%	6	50	12.0%
For Enrollees who were lost to contact, aggressive outreach attempts were made and documented by the Care Manager.	17	17	100.0%	6	6	100.0%

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollee files with no CNA or a CNA completed untimely.

N/A: Not Applicable

Preventive Services

The Preventive Services category applies to new GP Enrollees (50) enrolled in Care Management between 1/1/2023 and 11/16/2023 and existing GP Enrollees (50) enrolled in Care Management between 3/1/2023 and 11/16/2023.

Table 5: Preventive Services – General Population- New and Existing Enrollees enrolled in Care Management

Preventive Services	General Population - New Enrollees			General Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The Enrollee's EPSDT[1] exam is up to date per periodicity exam schedule (aged 0 through 20).*	5	8	62.5%	9	10	90.0%
The Enrollee's EPSDT status is confirmed by a reliable source (aged 0 through 20).	5	5	100.0%	9	9	100.0%
Aggressive outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	3	3	100.0%	1	1	100.0%
The Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	3	3	100.0%	1	1	100.0%
The Enrollee or legal guardian refused immunizations (aged 0 to 18).*	0	7	0.0%	2	8	25.0%
The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18).*	1	7	14.3%	4	6	66.7%
The Enrollee's immunization status is confirmed by a reliable source (aged 0 through 18).	1	1	100.0%	4	4	100.0%
Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18).	6	6	100.0%	2	2	100.0%
The Enrollee or legal guardian refused immunizations (aged 19 and above).*	10	43	23.3%	3	42	7.1%

Preventive Services	General Population - New Enrollees			General Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Appropriate vaccines have been administered for Enrollees (aged 19 and above).*	10	33	30.3%	25	39	64.1%
Aggressive outreach attempts were documented to confirm immunization status for Enrollees (aged 19 and above).	22	23	95.7%	14	14	100.0%
The Care Manager addressed and/or discussed dental needs with Enrollees (aged 21 and above).	42	42	100.0%	40	40	100.0%
A dental visit occurred during the review period for Enrollees (aged 1 through 20).*	6	7	85.7%	4	10	40.0%
Care Manager made attempts to obtain dental status for Enrollees without a confirmed dental visit (aged 1 through 20).	1	1	100.0%	6	6	100.0%
Dental reminders were sent to Enrollees without a confirmed dental visit (aged 1 through 20).	1	1	100.0%	6	6	100.0%

**Not Included in aggregate score calculation*

[1]EPSDT: Early and Periodic Screening, Diagnostic and Treatment

Continuity of Care

The Continuity of Care category applies to new GP Enrollees (50) in Care Management between 1/1/2023 and 11/16/2023 and existing GP Enrollees (50) enrolled in Care Management between 3/1/2023 and 11/16/2023.

Table 6: Continuity of Care – General Population - New and Existing Enrollees enrolled in Care Management

Continuity of Care	General Population - New Enrollees			General Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The MCO completed a CNA during the review period.*	50	50	100.0%	50	50	100.0%
The CNA contained all elements of the State approved CNA tool.	50	50	100.0%	50	50	100.0%
The Comprehensive Needs Assessment was completed timely (within 30 days of identification of CM needs).	50	50	100.0%	50	50	100.0%
The Care Manager documented a level of Care Management for the Enrollee during the review period.	50	50	100.0%	50	50	100.0%
The Enrollee is in Community Based Care Management (CBCM).[1]*	0	50	0.0%	6	50	12.0%
The Enrollee has a Care Plan on file during the review period.	50	50	100.0%	50	50	100.0%
A Care Plan was completed for the Enrollee that included all required components.	50	50	100.0%	50	50	100.0%
The Care Plan was developed within 30 days of CNA completion.[2]	50	50	100.0%	50	50	100.0%
The Enrollee's Care Plan was reviewed/monitored during the review period.	50	50	100.0%	50	50	100.0%
The Enrollee had a change in care needs or circumstances during the review period.*	6	50	12.0%	8	50	16.0%
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances.	6	6	100.0%	8	8	100.0%
Enrollee demonstrated needs requiring a comprehensive treatment plan.*	0	50	0.0%	0	50	0.0%
The Enrollee had a comprehensive treatment plan documented to address the Enrollee's specific care needs.	0	0	N/A	0	0	N/A

Continuity of Care	General Population - New Enrollees			General Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The comprehensive treatment plan progressed in a timely manner without unreasonable interruption.	0	0	N/A	0	0	N/A

**Not Included in aggregate score calculation*

[1] Community Based Care Management (CBCM) resumed in October 2023 following the end of the Public Health Emergency.

[2]This measure is evaluated for Enrollee's with a Care Plan and a CNA on file during the review period.

N/A: Not Applicable

Coordination of Services

The Coordination of Services category applies to new GP Enrollees (50) enrolled in Care Management between 1/1/2023 and 11/16/2023 and existing GP Enrollees (50) enrolled in Care Management between 3/1/2023 and 11/16/2023.

Table 7: Coordination of Services – General Population - New and Existing Enrollees enrolled in Care Management

Coordination of Services	General Population- New Enrollees			General Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF[1], CSOC[2], CMOs[3], Special Child Health Services (under DOH[4]) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD).	10	10	100.0%	5	5	100.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services.	16	16	100.0%	26	26	100.0%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee.	11	11	100.0%	22	22	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed.	9	9	100.0%	14	14	100.0%

[1]DCF: Department of Children and Families

[2]CSOC: Children's System of Care

[3]CMOs: Care Management Organizations

[4]DOH: Department of Health

DDD Population Findings

Outreach

The Outreach category applies to new DDD Enrollees (50) in Care Management during the 2023 review period. The Outreach category is not evaluated for the existing DDD Enrollees in Care Management.

Table 8: Outreach – DDD Population - Enrollees New to the MCO and New to Care Management

Outreach	DDD Population		
	Numerator	Denominator	Rate
The MCO completed a Comprehensive Needs Assessment (CNA) during the review period.*	39	50	78.0%
The Enrollee was unable to reach to complete the CNA.*	11	11	100.0%
The MCO completed the CNA timely (within 45 days of MCO enrollment date).*	31	39	79.5%
Initial outreach to complete a CNA was performed.[1]	19	19	100.0%
Initial outreach to complete the CNA was done timely, within 45 days from the Enrollee's enrollment date.	18	19	94.7%
Initial outreach to complete the CNA was successful (even if the Enrollee declines to complete the CNA.*	1	19	5.3%
The MCO performed aggressive outreach to complete a CNA.*	18	18	100.0%
Aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment.	18	18	100.0%
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA.*	0	0	N/A
Upon any successful outreach to the Enrollee, the Enrollee declined Care Management.*	0	0	N/A

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollee files with no CNA or a CNA completed untimely. The denominator for this measure includes 11 files with no CNA and 8 files with a CNA completed untimely.

N/A: Not Applicable

Preventive Services

The Preventive Services category applies to new DDD Enrollees (50) and existing DDD Enrollees (50) in Care Management during the 2023 review period.

Table 9: Preventive Services – DDD Population - New and Existing Enrollees enrolled in Care Management

Preventive Services	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The Enrollee's EPSDT[1] exam is up to date per periodicity exam schedule (aged 0 through 20).*	28	37	75.7%	8	14	57.1%
The Enrollee's EPSDT status is confirmed by a reliable source (aged 0 through 20).	28	28	100.0%	8	8	100.0%
Aggressive outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	9	9	100.0%	6	6	100.0%
The Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	9	9	100.0%	6	6	100.0%

Preventive Services	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The Enrollee or legal guardian refused immunizations (aged 0 to 18).*	2	25	8.0%	1	11	9.1%
The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18).*	11	23	47.8%	2	10	20.0%
The Enrollee's immunization status is confirmed by a reliable source (aged 0 through 18).	11	11	100.0%	2	2	100.0%
Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18).	12	12	100.0%	8	8	100.0%
The Enrollee or legal guardian refused immunizations (aged 19 and above).*	5	25	20.0%	7	39	17.9%
Appropriate vaccines have been administered for Enrollees (aged 19 and above).*	11	20	55.0%	19	32	59.4%
Aggressive outreach attempts were documented to confirm immunization status for Enrollees (aged 19 and above).	9	9	100.0%	13	13	100.0%
The Care Manager addressed and/or discussed dental needs with Enrollees (aged 21 and above).	11	13	84.6%	25	36	69.4%
A dental visit occurred during the review period for Enrollees (aged 1 through 20).*	25	37	67.6%	9	14	64.3%
Care Manager made attempts to obtain dental status for Enrollees without a confirmed dental visit (aged 1 through 20).	12	12	100.0%	5	5	100.0%
Dental reminders were sent to Enrollees without a confirmed dental visit (aged 1 through 20).	12	12	100.0%	5	5	100.0%

**Not Included in aggregate score calculation*

[1]EPSDT: Early and Periodic Screening, Diagnostic and Treatment

Continuity of Care

The Continuity of Care category applies to new DDD Enrollees (50) and existing DDD Enrollees (50) in Care Management during the 2023 review period. Gray shading represents elements that are not evaluated for existing DDD Enrollees in Care Management.

Table 10: Continuity of Care – DDD Population - New and Existing Enrollees enrolled in Care Management

Continuity of Care	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The MCO completed a CNA during the review period.*	39	50	78.0%			
The CNA contained all elements of the State approved CNA tool.	39	39	100.0%			
The Comprehensive Needs Assessment was completed timely, within 45 days of Enrollee's MCO enrollment date.	31	39	79.5%			
The Care Manager documented a level of Care Management for the Enrollee during the review period.	39	39	100.0%	42	50	84.0%
The Enrollee is in Community Based Care Management (CBCM).[1]*	1	50	2.0%	0	50	0.0%
The Enrollee has a Care Plan on file during the review period.	50	50	100.0%	46	50	92.0%
A Care Plan was completed for the Enrollee that included all required components.	50	50	100.0%	46	46	100.0%

Continuity of Care	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The Care Plan was developed within 30 days of CNA completion.[2]	38	39	97.4%			
The Enrollee's Care Plan was reviewed/monitored during the review period.	49	50	98.0%	46	46	100.0%
The Enrollee had a change in care needs or circumstances during the review period.*	0	50	0.0%	1	46	2.2%
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances.	0	0	N/A	1	1	100.0%
Enrollee demonstrated needs requiring a comprehensive treatment plan.*	0	50	0.0%	0	50	0.0%
The Enrollee had a comprehensive treatment plan documented to address the Enrollee's specific care needs.	0	0	N/A	0	0	N/A
The comprehensive treatment plan progressed in a timely manner without unreasonable interruption.	0	0	N/A	0	0	N/A

**Not Included in aggregate score calculation*

[1] Community Based Care Management (CBCM) resumed in October 2023 following the end of the Public Health Emergency.

[2] This measure is evaluated for Enrollee's with a Care Plan and a CNA on file during the review period.

N/A: Not Applicable

Coordination of Services

The Coordination of Services category applies to new DDD Enrollees (50) and existing DDD Enrollees (50) in Care Management during the 2023 review period.

Table 11: Coordination of Services – DDD Population- New and Existing Enrollees enrolled in Care Management

Coordination of Services	DDD Population - New Enrollees			DDD Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF[1], CSOC[2], CMOs[3], Special Child Health Services (under DOH[4]) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD).	49	50	98.0%	44	50	88.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services.	12	12	100.0%	8	8	100.0%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee.	19	19	100.0%	1	1	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed.	1	1	100.0%	3	3	100.0%
For Enrollees who were hospitalized with a mental/behavioral health diagnosis and	0	0	N/A	0	0	N/A

Coordination of Services	DDD Population - New Enrollees			DDD Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
discharged prior to 12/1/2023 the Care Manager documented evidence of follow up with the mental/behavioral health provider within 30 days of discharge.						
The Care Manager made aggressive attempts to determine follow up status with a mental/ behavioral health provider for Enrollees hospitalized with a mental/behavioral health diagnosis.	0	0	N/A	0	0	N/A

[1]DCF: Department of Children and Families
[2]CSOC: Children's System of Care
[3]CMOs: Care Management Organizations
[4]DOH: Department of Health
N/A: Not Applicable

DCP&P Population Findings

Outreach

The Outreach category applies to new DCP&P Enrollees (31) in Care Management during the 2023 review period. The Outreach category is not evaluated for the existing DCP&P Enrollees in Care Management.

Table 12: Outreach – DCP&P Population- Enrollees New to the MCO and New to Care Management

Outreach	DCP&P Population		
	Numerator	Denominator	Rate
The MCO completed a Comprehensive Needs Assessment (CNA) during the review period.*	31	31	100.0%
The Enrollee was unable to reach to complete the CNA .*	0	0	N/A
The MCO completed the CNA timely, within 45 days of MCO enrollment date.*	31	31	100.0%
Initial outreach to complete a CNA was performed.[1]	0	0	N/A
Initial outreach to complete the CNA was timely, within 45 days from the Enrollee's enrollment date.	0	0	N/A
Initial outreach was successful (even if the Enrollee declines to complete the CNA).*	0	0	N/A
The MCO performed aggressive outreach to complete a CNA.*	0	0	N/A
Aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment.	0	0	N/A
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA.*	0	0	N/A

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollee files with no CNA or a CNA completed untimely. All 31 CNAs were completed timely.

N/A: Not Applicable

Preventive Services

The Preventive Services category applies to new DCP&P Enrollees (31) and existing DCP&P Enrollees (69) in Care Management during the 2023 review period.

Table 13: Preventive Services – DCP&P Population – New and Existing Enrollees enrolled in Care Management

Preventive Services	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The Enrollee's EPSDT[1] exam is up to date per periodicity exam schedule (aged 0 through 20).*	30	31	96.8%	67	69	97.1%
The Enrollee's EPSDT status is confirmed by a reliable source (aged 0 through 20).	30	30	100.0%	67	67	100.0%
Aggressive outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	1	1	100.0%	2	2	100.0%
The Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	1	1	100.0%	2	2	100.0%
The Enrollee or legal guardian refused immunizations (aged 0 to 18).*	0	31	0.0%	2	69	2.9%

Preventive Services	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18).*	14	31	45.2%	34	67	50.7%
The Enrollee's immunization status is confirmed by a reliable source (aged 0 through 18).	14	14	100.0%	34	34	100.0%
Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18).	17	17	100.0%	32	33	97.0%
A dental visit occurred during the review period for Enrollees (aged 1 through 20).*	21	24	87.5%	58	67	86.6%
Care Manager made attempts to obtain dental status for Enrollees without a confirmed dental visit (aged 1 through 20).	3	3	100.0%	9	9	100.0%
Dental reminders were sent to Enrollees without a confirmed dental visit (aged 1 through 20).	3	3	100.0%	9	9	100.0%

**Not Included in aggregate score calculation*
[1]EPSDT: Early and Periodic Screening, Diagnostic and Treatment

Continuity of Care

The Continuity of Care category applies to new DCP&P Enrollees (31) and existing DCP&P Enrollees (69) in Care Management during the 2023 review period. Gray shading represents elements that are not evaluated for existing DCP&P Enrollees in Care Management.

Table 14: Continuity of Care – DCP&P Population – New and Existing Enrollees enrolled in Care Management

Continuity of Care	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The MCO completed a CNA during the review period.*	31	31	100.0%			
The completed CNA contained all elements of the State approved CNA tool.	31	31	100.0%			
The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment).	31	31	100.0%			
The Care Manager documented a level of Care Management for the Enrollee during the review period.	31	31	100.0%	69	69	100.0%
The Enrollee has a Care Plan on file during the review period.	28	31	90.3%	69	69	100.0%
A Care Plan was completed for the Enrollee that included all required components.	28	28	100.0%	69	69	100.0%
The Care Plan was developed within 30 days of CNA completion.[1]	28	28	100.0%			
The Enrollee's Care Plan was reviewed/monitored during the review period.	28	28	100.0%	69	69	100.0%
The Enrollee had a change in care needs or circumstances during the review period.*	0	28	0.0%	2	69	2.9%
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances.	0	0	N/A	2	2	100.0%
Enrollee demonstrated needs requiring a comprehensive treatment plan.*	0	31	0.0%	0	69	0.0%
The Enrollee had a comprehensive treatment plan documented to address the Enrollee's specific care needs.	0	0	N/A	0	0	N/A

Continuity of Care	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The comprehensive treatment plan progressed in a timely manner without unreasonable interruption.	0	0	N/A	0	0	N/A

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollee's with a Care Plan and a CNA on file during the review period.

N/A: Not Applicable

Coordination of Services

The Coordination of Services category applies to new DCP&P Enrollees (31) and existing DCP&P Enrollees (69) in Care Management during the 2023 review period.

Table 15: Coordination of Services – DCP&P Population - New and Existing Enrollees enrolled in Care Management

Coordination of Services	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF[1], CSOC[2], CMOs[3], Special Child Health Services (under DOH[4]) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD).	31	31	100.0%	69	69	100.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services.	4	4	100.0%	7	7	100.0%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee.	1	1	100.0%	9	10	90.0%
For Enrollees who were hospitalized, adequate discharge planning was performed.	1	1	100.0%	3	3	100.0%

[1]DCF: Department of Children and Families

[2]CSOC: Children's System of Care

[3]CMOs: Care Management Organizations

[4]DOH: Department of Health

Limitations

UHCCP had a combined total of 9 file exclusions for the DCP&P Population new and existing Enrollees. There was a total of 32 files submitted for the new DCP&P Population file universe.

Conclusions

Overall, the MCO scored 85% or above in the following review categories (**Table 2**):

- Outreach (General Population) (100%)
- Outreach (DDD Population) (98.2%)

- Preventive Services (General Population) (99.4%)
- Preventive Services (DDD Population) (93.6%)
- Preventive Services (DCP&P Population) (99.6%)

- Continuity of Care (General Population) (100%)
- Continuity of Care (DDD Population) (95.6%)
- Continuity of Care (DCP&P Population (99.4%)

- Coordination of Services (General Population) (100%)
- Coordination of Services (DDD Population) (95.1%)
- Coordination of Services (DCP&P Population) (99.2%)

Overall, the MCO scored below 85% in the following categories (**Table 2**):

- Identification (General Population) (77.4%)

MCO Care Management Annual Assessment

Assessment Methodology

The Care Management Annual Assessment consisted of pre-audit review of documentation provided by UnitedHealthcare Community Plan (UHCCP), as evidence of compliance of the standard under review; audit review of random file samples for the GP, DDD, and DCP&P Populations; interviews with key UHCCP staff via TEAMS held on May 30, 2024; and post audit evaluation of documentation and audit activities.

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

The documentation for the audit review was requested by IPRO on March 8, 2024, and documentation was received from the MCO on March 29, 2024. The documentation review occurred offsite at IPRO beginning on April 1, 2024. The audit review team was made up of Carla Zuccarello, Lois Heffernan, and Juana Torres. The Care Management assessment covered the period from January 1, 2023 to December 31, 2023.

During the audit review, the Plan had the opportunity to provide supplemental documentation as requested by IPRO.

Table 16 shows the rating scale used to determine compliance.

Table 16: Rating Scale for the Annual Care Management Assessment

Rating	Rating Methodology
Met	All parts within this element were met.
Not Met	Not all the required parts within the element were met.
N/A	This element is not applicable and will not be considered as part of the score.
Met Prior Review	This element was met in the previous review cycle.
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.

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

There are 30 elements in this review based on Contractual provisions, which are subject to review annually. UHCCP received an overall compliance score of 90% in 2024. In 2023, the MCO received a score of 80%. Review of the elements CM2, CM4, CM5, CM6, CM7, CM8, CM11, CM14, CM15, CM16, CM17, and CM19 was based on results from the Core Medicaid CM Audit conducted in 2024. Where appropriate, assessment of other elements was informed by both documents submitted for review and the file review. This audit evaluated Core Medicaid CM files for calendar year 2023 for three populations, namely the Enrollees under the General Population (GP), Division of Developmental Disabilities (DDD), and the Division of Child Protection and Permanency (DCP&P).

Care Management Assessment Results

Table 17 presents an overview of UHCCP's Care Management Annual Assessment results; **Table 18** presents Contract language and reviewer comments for deficient element(s); and **Table 19** presents Contract language for resolved deficiencies.

Table 17: Summary of Findings for Care Management Annual Assessment

Element	Met Prior Review	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM1	X	X	-	-	-	-	-
CM2	-	X	-	-	-	X	-
CM3	-	X	-	-	-	X	-
CM4	X	X	-	-	-	-	-
CM5	X	X	-	-	-	-	-
CM6	-	-	X	-	X	-	-
CM7	-	-	X	-	X	-	-
CM8	-	X	-	-	-	X	-
CM9	X	X	-	-	-	-	-
CM10	X	X	-	-	-	-	-
CM11	X	X	-	-	-	-	-
CM12	X	X	-	-	-	-	-
CM13	X	X	-	-	-	-	-
CM14	-	-	X	-	X	-	-
CM15	X	X	-	-	-	-	-
CM16	X	X	-	-	-	-	-
CM17	X	X	-	-	-	-	-
CM18a	X	X	-	-	-	-	-
CM18c	X	X	-	-	-	-	-

Element	Met Prior Review	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM18d	X	X	-	-	-	-	-
CM19	X	X	-	-	-	-	-
CM20	X	X	-	-	-	-	-
CM21	X	X	-	-	-	-	-
CM22	X	X	-	-	-	-	-
CM23	X	X	-	-	-	-	-
CM24	X	X	-	-	-	-	-
CM25	X	X	-	-	-	-	-
CM26	X	X	-	-	-	-	-
CM27	X	X	-	-	-	-	-
CM37[1]	X	X	-	-	-	-	-
TOTAL	**24**	**27**	**3**	**0**	**3**	**3**	**0**
Compliance Percentage		**90%**					

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

Table 18: Findings for Deficient Care Management Elements

Element	Contract Language	Reviewer Comments
CM6	**4.6.5.B.1** **Identification of Enrollees Who Need Care Management** The MCO must have effective systems, policies, procedures, and practices in place to identify any Enrollee in need of Care Management services. All New Enrollees, including Enrollees who were disenrolled from the MCO for at least six (6) months, (except for DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD) will be screened using an approved Initial Health Screen tool (IHS) to quickly identify their immediate physical and/or behavioral health care needs, as well as the need for more extensive screening. Any Enrollee identified as having potential Care Management needs will receive a detailed Comprehensive Needs Assessment (if deemed necessary by a healthcare professional), and ongoing care coordination and management as appropriate. All elements of the State approved IHS tool that appear in the Care Management Workbook must be included in the MCO's screening tool.	**In the 2024 CM file audit the MCO scored for the General Population Enrollees:** 72.0%- For IHS on file, IHS was completed for the Enrollee within 45 days of MCO enrollment date (applies to new Enrollees).
CM7	**4.6.5. B.2** **Comprehensive Needs Assessment (CNA)** The MCO will conduct an approved CNA on New Enrollees following the evaluation by a healthcare professional of their Initial Health Screen results; any Enrollee identified as having potential Care Management needs; as well as DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD. The goal of the CNA is to identify an	**In the 2024 CM file audit the MCO scored for the DDD Population Enrollees:** 79.5%- The Comprehensive Needs Assessment was completed timely, within 45 days of Enrollee's MCO enrollment date (applies to new Enrollees).

Element	Contract Language	Reviewer Comments
	Enrollee's Care Management needs to determine an Enrollee's level of care and develop a Care Plan. The CNA will be conducted by a healthcare professional, either telephonically or face-to-face, depending on the Enrollee's needs. All elements of the State approved CNA tool that appears in the Care Management Workbook must be included in the MCO assessment tool. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	84.0%- The Care Manager documented a level of Care Management for the Enrollee during the review period (applies to existing Enrollees).
CM14	**4.6.2.O** **Continuity of Care** The Contractor's Quality Management Plan shall include a continuity of care system including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as preventive services and maintenance of function for Enrollees with special needs.	**In the 2024 CM file audit the MCO scored for the DDD Population Enrollees:** 84.6%- The Care Manager addressed and/or discussed dental needs with the Enrollee (applies to new Enrollees aged 21 and above). 69.4%- The Care Manager addressed and/or discussed dental needs with the Enrollee (applies to existing Enrollees aged 21 and above).

Table 19: Findings for Resolved Deficiencies for Care Management Elements

Element	Contract Language
CM2	**4.6.2.J** **Discharge Planning** The Contractor shall have procedures to ensure adequate and appropriate discharge planning, and to include Coordination of Services for Enrollees with special needs.
CM3	**4.6.5.A** Apply systems, science, and information to identify Enrollees with potential Care Management needs and assist Enrollees in managing their health care more effectively with the goal of improving, maintaining, or slowing the deterioration of their health status.
CM8	**4.6.5.B.3** **Plan of Care to Address Needs Identified** Care Plan: Based on the CNA, the Care Manager will assign Enrollees to a care level, develop a Care Plan and facilitate and coordinate the care of each Enrollee according to his/her needs or circumstances. With input from the Enrollee and/or caregiver and PCP, the Care Manager must jointly create a Care Plan with short/long-term Care Management goals, specific actionable objectives, and measurable quality outcomes. The Care Plan should be culturally appropriate and consistent with the abilities and desires of the Enrollee and/or caregiver. Understanding that Enrollees' care needs and circumstances change, the Care Manager must continually evaluate the Care Plan to update and/or change it to accurately reflect the Enrollee's needs and level of care.

Comprehensive Recommendations

The following recommendations are for deficiencies identified in the Care Management Audit and Annual Assessment.

For the General Population:

1. CM6: UHCCP should ensure that the IHS is completed for the Enrollee within 45 days of MCO enrollment date (applies to new Enrollees).

For the DDD Population:

1. CM7: UHCCP should ensure that the Comprehensive Needs Assessment is completed timely, within 45 days of Enrollee's MCO enrollment date (applies to new Enrollees).
2. CM7: UHCCP should ensure that a level of Care Management is documented for the Enrollee during the review period (applies to existing Enrollees).
3. CM14: For Enrollees aged 21 and above, UHCCP should ensure that the Care Manager addresses/discusses dental needs with the Enrollee (applies to new and existing Enrollees).

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office of MLTSS Quality Monitoring

MCO MLTSS HCBS Care Management Audit
UnitedHealthcare Community Plan

Review Period July 1, 2023 – June 30, 2024

January 2025

Corporate Headquarters
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Introduction

The purpose of the Managed Long-Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community Based Services (HCBS) and Institutionalization for Long-Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. The U.S. Department of Health and Human Services (HHS) declared an end to the Public Health Emergency (PHE) for COVID-19 on May 11, 2023. The State issued Covid-19 flexibilities related to specific MLTSS Care Management activities ended prior to this review period (July 1, 2023 to June 30, 2024), except for the NJ DHS, Division of Aging Services (DoAS), *Temporary Waiver of Clinical Eligibility Requirements for MLTSS Enrollment for MCO Members in a Community Setting.* Effective July 5, 2023 the use of the Screen for Community Services (SCS) as presumptive eligibility was discontinued.

The populations included in this audit were Members who met eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or Community Alternative Residential Setting (CARS), for at least six consecutive months within the review period July 1, 2023 to June 30, 2024.

Annually, DMAHS evaluates the MCO performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the NJ FamilyCare Contracts (Article 9), dated July 2023 and January 2024. A representative sample of files were selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities, and post-audit activities.

1. Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology, necessary source documents, contract references, and the Division of Aging Services (DoAS), Office of Community Choice Options (OCCO) new contract requirements for MLTSS Care Management. Effective November 15, 2023, as part of the NJ Choice Assessment system, MCOs are required to complete a NJ specific Options Counseling Summary (OCS) form, whereas the Interim Plan of Care (IPOC) was no longer contractually required.

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

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

Population Selection

The sample was determined by using the following capitation codes to identify MLTSS HCBS enrollment presented in **Table 1** and applying the sampling methodology described in **Table 2**.

Table 1. Capitation Codes

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

The sampling methodology as shown in **Table 2** resulted in the selection of 156 cases for UnitedHealthcare Community Plan (UHCCP), including an oversample.

Table 2. Sampling Methodology

Subpopulations	Criteria
Group C: Members New to Managed care and Newly Eligible for MLTSS between 7/1/2023 and 6/30/2024.	• The Member must have been initially enrolled in MLTSS HCBS between 7/1/2023 and 1/1/2024. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2024 in the *same* MCO with no gaps in enrollment.
Group D: Current Medicaid Managed care Members enrolled in MLTSS between 7/1/2023 and 6/30/2024.	• The Member must have been initially enrolled in MLTSS HCBS between 7/1/2023 and 1/1/2024. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2024 in the *same* MCO with no gaps in enrollment. • On the first day of the month prior to the initial MLTSS HCBS enrollment, the Member was enrolled in the *same* Medicaid MCO as the MLTSS HCBS MCO.
Group E: Current Medicaid Managed care Members enrolled in MLTSS prior to 7/1/2023 and continuously enrolled in MLTSS through 6/30/2024.	• The Member must have been initially enrolled in MLTSS HCBS prior to 7/1/2023. • The Member must have remained enrolled in MLTSS HCBS through 6/30/2024 in the *same* MCO with no gaps in enrollment.
Performance Measure #9a Enhancement	• A sample of 30 MLTSS HCBS Members across subgroups C, D, and E, identified on the NJ Choice Assessment Data list with assessment code 3, 4, and 5 will be included in the base sample abstracted from the universe. All MLTSS HCBS Members were included if the MCO has less than 30 Members who meet eligibility criteria.

MLTSS HCBS subpopulations were identified depending on different enrollment criteria. A stratified methodology was used to randomly select 100 MLTSS HCBS Members across subgroups C and D, and 30 MLTSS HCBS Members in subgroup E as a base sample. A 20% oversample across subgroups C and D, and subgroup E was drawn for substitution of exclusions.

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

All MLTSS HCBS Members were included if there were less than 100 Members across subgroups C and D, or less than 30 Members in subgroup E. Members could only be excluded by the MCO if they could provide evidence that the Member did not meet eligibility requirements. An oversample was selected for the MCO to replace any excluded files, as well as ensure an adequate denominator to evaluate Performance Measures.

Introductory E-Mail

IPRO sent an Introductory E-Mail to the MCO prior to the scheduled offsite audit including:

- Confirmation of the dates for the audit.
- Description of the sample.
- File listings identifying the files that needed to be available at the time of the offsite audit.

2. Audit Activities

IPRO reviewers conducted the file reviews over a five-week period. Reviewer inter-rater reliability was maintained using the standardized audit tool, and ongoing communication and coordination among the review team. Electronic files were prepared by the MCO for review.

3. Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the 156 cases selected for UHCCP, 140 Member files were reviewed and 130 were included in the results.

Description	Group C	Group D	Group E	Subtotal
Total Number of Files Reviewed	54	53	33	140
Exclusions	4	3	3	10
Number of Files included in Results	50	50	30	130

Population-specific findings are presented in **Table 3**, which contains aggregate scores based on the results of selected review questions within each review category: Assessment, Member Outreach, Face-to-Face Visits, Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans), Ongoing Care Management, and Gaps in Care/Critical Incidents. Rates for each subpopulation and a combined score calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 3**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

UHCCP's audit results for the combined MLTSS sample ranged from 38.0% to 98.8% across all three (3) populations for the six (6) audit categories.

Table 3. Results by Category

Determination by Category	July 1, 2023 – June 30, 2024			
	Group C	Group D	Group E[2]	Combined[3]
Assessment	98.0%	90.4%	96.6%	94.2%
Member Outreach	46.0%	38.0%	--	42.0%
Face-to-Face Visits	95.8%	94.1%	98.2%	95.7%
Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans)[1]	92.9%	91.9%	95.5%	93.2%
Ongoing Care Management	73.3%	69.4%	55.6%	68.3%
Gaps in Care/Critical Incidents	98.8%	95.0%	91.4%	95.4%

[1]Initial Plan of Care is assessed for Group C and Group D Members. Ongoing Plans of Care are assessed for Group E Members as they are not new to MLTSS. Back-up Plans are assessed for Group C, D, and E Members.
[2]Member Outreach is not evaluated for Members in Group E as they are not new to the MLTSS.
[3]Calculated as an aggregate score by combining elements applicable to each category.

Members New to Managed Care and Newly Eligible for MLTSS (Group C)

A total of 54 files were reviewed for new Members enrolled in Managed Care and newly eligible for MLTSS (Group C). There were 4 files excluded. All 50 files were further reviewed for compliance in 6 categories. There were 19 Members residing in CARS.

Assessment	**N**	**D**	**Rate**
The MCO requested an NJ Choice Assessment (NJCA) for the Member from OCCO.*	0	50	0.0%
MCO requested an NJCA for the Member from OCCO within fifteen (15) business days of the effective date of the Member's enrollment (for this population, MCOs have the option of requesting a New Jersey Choice Assessment (NJCA) from the Office of Community Choice Options (OCCO).*	0	0	N/A
OCCO response was received within 5 business days of the MCO request.*	0	0	N/A
The MCO received an NJCA from OCCO within 5 business days of OCCO's notification that is considered valid and current.*	0	0	N/A
OCCO completed the NJCA which is valid during the review period.*	0	50	0.0%
The MCO completed the NJ Choice with the Member.	49	50	98.0%

*Not included in aggregate score calculation
N/A: Not Applicable

Member Outreach	**N**	**D**	**Rate**
Initial outreach was completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.	23	50	46.0%

Face-to-Face Visits	N	D	Rate
Member participated in all face-to-face visits.*	49	50	98.0%
Member is unable to participate in the face-to-face visit due to cognitive impairment, a minor child, and/or the member has a legal guardian.*	1	1	100.0%
Member or authorized representative participated in the onsite visit with the Care Manager.*	1	1	100.0%
Options Counseling was provided to the Member.[1]	49	49	100.0%
Member was offered the participant direction option.[3]	31	31	100.0%
Member chose to participate in participant direction (excludes Members residing in CARS).*	8	31	25.8%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.[3]	6	8	75.0%
Member had a completed and signed Interim Plan of Care (IPOC) or Options Counseling Summary (OCS) form on file.[1,2]	48	49	98.0%
A cost effective analysis was completed during the review period.	47	50	94.0%
Member reached or exceeded 85% of the annual cost thresholds (ACT).*	2	47	4.3%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period, had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	2	0.0%

*Not included in aggregate score calculation

[1] Denominator excludes Members where OCCO completed the New Jersey Choice Assessment

[2]Compliance was evaluated for IPOCs completed before November 15, 2023 or OCS form completed on or after November 15, 2023

[3]Denominator excludes Members residing in CARS

Initial Plan of Care (Including Back-up Plans)	N	D	Rate
Member had a completed and signed Initial Plan of Care on file, that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	25	50	50.0%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	49	50	98.0%
Member refused to be assessed for PCA services (excludes Members residing in CARS).*	9	31	29.0%
Member was assessed for PCA services (excludes Members residing in CARS).*	21	22	95.5%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.[1]	16	21	76.2%
Member required another PCA assessment due to changes in condition (excludes Members in CARS).*	1	21	4.8%
Member was re-assessed for PCA due to changes in condition.[1]	1	1	100.0%

Member had a Plan of Care and NJCA on file during the review period.*	49	50	98.0%
Plans of Care for MLTSS Members are aligned with Member needs as identified during the NJCA.	49	49	100.0%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	50	50	100.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	50	50	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	50	50	100.0%
Members who required a Back-up Plan, had a completed and signed Back-up Plan using the State mandated form.[1]	29	31	93.5%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	29	29	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	29	29	100.0%
Member service preference levels were documented in the Back-up Plan.[1]	29	29	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	24	29	82.8%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	31	31	100.0%
Member file included a Member Rights and Responsibilities statement signed by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	43	50	86.0%
Care Manager educated the Member on how to file a grievance and/or an appeal.	50	50	100.0%
Members residing in their community home had a risk assessment completed that included documentation of whether a positive risk was identified or not.[1]	31	31	100.0%
Member required a Risk Management Agreement (excludes Members residing in CARS).*	31	31	100.0%
Members who were identified as having a positive risk, had a signed Risk Management Agreement with all components.[1]	29	31	93.5%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS

Ongoing Care Management	N	D	Rate
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).[1]	31	31	100.0%
Member experienced issues that impeded access to care.*	0	50	0.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	0	0	N/A
Member had a documented face-to-face visit to review Member placement and services during the review period.	50	50	100.0%
Review of Member's placement and services occurred timely (an ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	16	50	32.0%
Member required a change in Plan of Care based on an increase or reduction of services.*	1	50	2.0%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed and was provided with a copy of the Plan of Care.	1	1	100.0%
Member file indicates disagreement with the Plan of Care.*	0	0	N/A
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	50	0.0%
A face-to-face visit was conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition or well-being.	0	0	N/A
Member was discharged to an HCBS setting during the review period.*	7	50	14.0%
Member refused the 10 day post discharge onsite visit.*	1	7	14.3%
Care Manager completed a 10 day post discharge telephonic visit.*	1	1	100.0%
For Members who were discharged to an HCBS setting the onsite review occurred within ten (10) days of discharge.	4	6	66.7%
Member was discharged to his/her own home and in home services were in place in a timely manner.	4	7	57.1%
Member experienced a significant change in condition requiring the Plan of Care to be amended.*	1	50	2.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed by the Member and/or authorized representative.	1	1	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS

N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation the Care Manager reviewed the process for immediately reporting gaps in service delivery with the Member.	31	31	100.0%
Member reported a gap in service delivery (excludes Members residing in CARS).*	0	31	0.0%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	0	0	N/A
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	49	50	98.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS
N/A: Not Applicable

Members Currently Enrolled in Managed Care and Newly Eligible for MLTSS (Group D)

A total of 53 files were reviewed for Members currently enrolled in Managed Care and newly eligible for MLTSS (Group D). There were 3 files excluded. All 50 files were further reviewed for compliance in all 6 categories. There were 3 Members residing in CARS.

Assessment	*N*	*D*	*Rate*
Member had a Screen for Community Services (SCS tool) completed.*	36	50	72.0%
Member enrolled into MLTSS on an SCS Waiver.*	3	36	8.3%
The NJ Choice Assessment (NJCA) was completed within 30 days of a referral to MLTSS.	25	33	75.8%
The MCO completed the NJCA with the Member.	50	50	100.0%

*Not included in aggregate score calculation

Member Outreach	N	D	Rate
Initial outreach was completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.	19	50	38.0%

Face-to-Face Visits	N	D	Rate
Member participated in all face-to-face visits.*	49	50	98.0%
Member was unable to participate in the face-to-face visit due to cognitive impairment, a minor child, and/or the Member had a legal guardian.*	1	1	100.0%

Member or authorized representative participated in the onsite meeting with the Care Manager.*	1	1	100.0%
Options Counseling was provided to the Member.	50	50	100.0%
Member had PPP prior to MLTSS enrollment.*	12	47	25.5%
Member had PPP pending prior to MLTSS enrollment.*	4	47	8.5%
Member was offered the participant direction option.[1]	31	31	100.0%
Member chose to participate in participant direction (excludes Members residing in CARS).*	2	31	6.5%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.[1]	0	2	0.0%
Member had a completed and signed Interim Plan of Care (IPOC) or Options Counseling Summary (OCS) form on file.[2]	46	50	92.0%
A cost effective analysis was completed during the review period.	48	50	96.0%
Member reached or exceeded 85% of the annual cost threshold (ACT).*	3	48	6.2%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period, had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	3	0.0%

*Not included in aggregate score calculation

[1] Denominator excludes Members residing in CARS

[2]Compliance was evaluated for IPOCs completed before November 15, 2023 or OCS form completed on or after November 15, 2023

Initial Plan of Care (Including Back-up Plans)	N	D	Rate
Member had a completed and signed Initial Plan of Care on file, that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	20	50	40.0%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	49	50	98.0%
Member had PCA services prior to MLTSS enrollment.*	25	47	53.2%
Member refused to be assessed for PCA services (excludes Members residing in CARS).*	15	22	68.2%
Member was assessed for PCA services (excludes Members residing in CARS).*	6	7	85.7%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.[1]	3	6	50.0%
Member required another PCA assessment due to changes in condition (excludes Members residing in CARS).*	0	6	0.0%
Member was re-assessed for PCA due to changes in condition.[1]	0	0	N/A
Member had a Plan of Care and NJCA on file during the review period.*	49	50	98.0%
Plans of Care for MLTSS Members are aligned with Member needs as identified during the NJCA.	49	49	100.0%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	49	49	100.0%

Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	49	49	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	49	49	100.0%
Members who required a Back-up Plan, had a completed and signed Back-up Plan using the State mandated form.[1]	45	47	95.7%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	45	45	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	44	45	97.8%
Member service preference levels were documented in the Back-up Plan.[1]	44	45	97.8%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	33	45	73.3%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	46	47	97.9%
Member file included a Member Rights and Responsibilities statement signed by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	45	50	90.0%
Care Manager educated the Member on how to file a grievance and/or an appeal.	49	50	98.0%
Members residing in their community home had a risk assessment completed that included documentation of whether a positive risk was identified or not.[1]	47	47	100.0%
Member required a Risk Management Agreement (excludes Members residing in CARS).*	44	47	93.6%
Members who were identified as having a positive risk, had a signed Risk Management Agreement with all components.[1]	39	44	88.6%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS
N/A: Not Applicable

Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).[1]	47	47	100.0%
Member experienced issues that impeded access to care.*	0	50	0.0%

Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	0	0	N/A
Member had a documented face-to-face visit to review Member placement and services during the review period.	49	50	98.0%
Review of Member's placement and services occurred timely (an ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	11	49	22.4%
Member required a change in Plan of Care based on an increase or reduction of services.*	8	50	16.0%
Member files that indicated a change from the Initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed and was provided with a copy of the Plan of Care.	5	8	62.5%
Member file indicates disagreement with the Plan of Care.*	0	3	0.0%
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	50	0.0%
Face-to-face visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition, or well-being.	0	0	N/A
Member was discharged to an HCBS setting during the review period.*	12	50	24.0%
Member refused the 10 day post discharge onsite visit.*	1	12	8.3%
Care Manager completed a 10 day post discharge telephonic visit.*	1	1	100.0%
For Members who were discharged to an HCBS setting the onsite review occurred within ten (10) days of discharge.	4	11	36.4%
Member was discharged to his/her own home and in home services were in place in a timely manner.	6	12	50.0%
The Member experienced a significant change in condition requiring the Plan of Care to be amended.*	6	50	12.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed by the Member and/or authorized representative.	5	6	83.3%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS

N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	45	47	95.7%
Member reported a gap in service delivery (excludes Members residing in CARS).*	3	47	6.4%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	3	3	100.0%
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	47	50	94.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS

Members Enrolled in Managed Care and MLTSS Prior to the Review Period (Group E)

A total of 33 files were reviewed for the Members enrolled in Managed Care and MLTSS prior to the review period (Group E). There were 3 files excluded. The Member Outreach category is not assessed for Members in Group E. All 30 files were reviewed for compliance in 5 categories. There were 2 Members residing in CARS.

Assessment	*N*	*D*	*Rate*
The NJ Choice Assessment (NJCA) was due during the review period.*	29	30	96.7%
The MCO completed the NJCA with the Member.	29	29	100.0%
Member had an NJCA completed to reassess clinical eligibility for MLTSS within 11 to 13 months from the last NJCA authorized by OCCO.	27	29	93.1%

*Not included in aggregate score calculation

Face-to-Face Visits	N	D	Rate
Member participated in all face-to-face visits.*	29	30	96.7%
Member was unable to participate in the face-to-face visit due to cognitive impairment, a minor child, and/or the Member had a legal guardian.*	1	1	100.0%
Member or authorized representative participated in the onsite visit with the Care Manager.*	1	1	100.0%
Options Counseling was provided to the Member.	29	29	100.0%
Member had PPP prior to review period (excludes Members residing in CARS).*	5	28	17.9%
Member had PPP pending prior to review period (excludes Members residing in CARS).*	1	28	3.6%
Member was offered the participant direction option.[1]	22	22	100.0%
Member chose to participate in participant direction (excludes Members residing in CARS).*	2	22	9.1%

Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.[1]	2	2	100.0%
Member had a completed and signed Interim Plan of Care (IPOC) or Options Counseling Summary (OCS) form on file.[2]	27	29	93.1%
A cost effective analysis was completed during the review period.	30	30	100.0%
Member reached or exceeded 85% of the annual cost thresholds (ACT).*	0	30	0.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period, had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

*Not included in aggregate score calculation

[1] Denominator excludes Members residing in CARS

[2]Compliance was evaluated for IPOCs completed before November 15, 2023 or OCS form completed on or after November 15, 2023

N/A: Not Applicable

Ongoing Plans of Care (Including Back-up Plans)	N	D	Rate
Plan of Care reassessment for MLTSS Members was conducted within 30 days of annual LOC re-determination.	24	29	82.8%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	30	30	100.0%
Member file had documentation to demonstrate contact with the Member's HCBS providers at least annually to discuss the providers' reviews of the Member's needs and status and quarterly for Members receiving skilled nursing care, treatment for traumatic brain injury or behavioral health services.	30	30	100.0%
Member had PCA services prior to the review period (excludes Members residing in CARS).*	19	28	67.9%
Member refused to be assessed for PCA services (excludes Members residing in CARS).*	5	9	55.6%
Member was assessed for PCA services (excludes Members residing in CARS).*	3	4	75.0%
Member required another PCA assessment due to changes in condition (excludes Members in CARS).*	1	3	33.3%
Member was re-assessed for PCA due to changes in condition.[1]	1	1	100.0%
Member had a Plan of Care and NJCA on file during the review period.*	29	30	96.7%
Plans of Care for MLTSS Members are aligned with Member needs as identified during the NJCA.	29	29	100.0%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	30	30	100.0%
Member's Plan of Care contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	30	30	100.0%

Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	30	30	100.0%
Members who required a Back-up Plan, had a completed and signed Back-up Plan using the State mandated form.[1]	26	28	92.9%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	26	26	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	26	26	100.0%
Member service preference levels were documented in the Back-up Plan.[1]	26	26	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	19	26	73.1%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	28	28	100.0%
Member file included a Member Rights and Responsibilities statement signed by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	29	30	96.7%
Care Manager educated the Member on how to file a grievance and/or an appeal.	29	30	96.7%
Care Manager completed an Annual Risk Assessment for the Member.[1]	28	28	100.0%
Members who were identified as having a positive risk (excludes Members residing in CARS).*	28	28	100.0%
IPRO identified the Member as having a potential risk during the review period that the Care Manager failed to identify. [1,2]	0	0	N/A[2]
Members who were identified as having a positive risk, had a signed Risk Management Agreement with all components.[1]	22	28	78.6%

*Not included in aggregate score calculation
[1]Denominator excludes Members in CARS
[2]Percentage rate is indicative of compliant cases
N/A: Not Applicable

Ongoing Care Management	**N**	**D**	**Rate**
Member experienced issues that impeded access to care.*	0	30	0.0%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	0	0	N/A
Member had a documented face-to-face visit to review Member placement and services during the review period.	29	30	96.7%
Review of Member's placement and services occurred timely (an ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	3	29	10.3%

Member required a change in Plan of Care based on an increase or reduction of services.*	5	30	16.7%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed and was provided with a copy of the Plan of Care.	5	5	100.0%
Member file indicated a disagreement with the Plan of Care.*	0	0	N/A
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service), were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	30	0.0%
Face-to-face visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition or well-being.	0	0	N/A
Member was discharged to an HCBS setting during the review period.*	1	30	3.3%
Member refused the 10 day post discharge onsite visit.*	0	1	0.0%
Care Manager completed a 10 day post discharge telephonic visit.*	0	0	N/A
For Members who were discharged to an HCBS setting the onsite review occurred within ten (10) days of discharge.	0	1	0.0%
Member was discharged to his/her own home and in home services were in place in a timely manner.	0	1	0.0%
Member experienced a significant change in condition requiring the Plan of Care to be amended.*	6	30	20.0%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed by the Member and/or authorized representative.	3	6	50.0%
Member had a change in placement occur during the review period.*	0	30	0.0%
Member had a change in placement indicated and there was documentation of discussion with the Member before the change was made.	0	0	N/A

*Not included in aggregate score calculation
N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	27	28	96.4%
Member reported a gap in service delivery (excludes Members in CARS).*	0	28	0.0%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	0	0	N/A
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	26	30	86.7%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS
N/A: Not Applicable

Performance Measures

Population-Specific findings are presented in **Table 4**, which present results on the following MLTSS Performance Measures: #8 (Plans of Care established within 45 days of MLTSS enrollment), #9 (Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination), #9a (Plan of Care for MLTSS Members amended based on change of Member condition), #10 (Plans of Care for MLTSS Members are aligned with Member needs identified during the NJ Choice Assessment), #11 (Plans of Care for MLTSS Members are developed using "Person-Centered Principles"), #12 (MLTSS Home and Community Based Services (HCBS) Plans of Care that include a Back-up Plan), and #16 (MCO provided training to MLTSS Member on identifying/reporting Critical Incidents).

Population results, as shown in **Table 4**, are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. **Table 4** shows the results of the 2023-2024 audit findings. Overall, UHCCP's audit results ranged from 45.0% to 100.0% across all groups for seven (7) Performance Measures for the current review period.

Table 4. Results of MLTSS Performance Measures

Performance Measure	Group[1]	Numerator	Denominator	Rate
#8. Plans of Care established within 45 days of MLTSS enrollment.	Group C	25	50	50.0%
	Group D	20	50	40.0%
	Group E[4]			
	Total	45	100	45.0%
#9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination.	Group C[5]			
	Group D[5]			
	Group E	24	29	82.8%
	Total	24	29	82.8%
#9a. Plan of Care for MLTSS Members amended based on change of Member condition.[2]	Group C	1	1	100.0%
	Group D	5	6	83.3%
	Group E	3	6	50.0%
	Total	9	13	69.2%
#10. Plans of Care for MLTSS Members are aligned with Member needs identified during the NJ Choice Assessment.	Group C	49	49	100.0%
	Group D	49	49	100.0%
	Group E	29	29	100.0%
	Total	127	127	100.0%

#11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles."	Group C	50	50	100.0%
	Group D	49	49	100.0%
	Group E	30	30	100.0%
	Total	129	129	100.0%
#12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that include a Back-up Plan[3]	Group C	29	31	93.5%
	Group D	45	47	95.7%
	Group E	26	28	92.9%
	Total	100	106	94.3%
#16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents.	Group C	49	50	98.0%
	Group D	47	50	94.0%
	Group E	26	30	86.7%
	Total	122	130	93.8%

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

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

[3]Members in Community Alternative Residential Settings (CARS) are excluded from this measure

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

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

Discussion

Limitations

The NJ Department of Human Services, Division of Aging Services, *Temporary Waiver of Clinical Eligibility Requirements for MLTSS Enrollment for MCO Members in a Community Setting,* discontinued on July 5, 2023. For Group D Members, the MCO utilized the Screening for Community Services (SCS) tool for MLTSS enrollment if the Member met criteria (i.e. scores of 3, 4, or 5) up until July 5, 2023. Therefore, completion of the NJ Choice Assessment within 30 days of a referral to MLTSS could not be evaluated for those Members enrolled in MLTSS through an SCS waiver.

Conclusions and Recommendations

Population-Specific conclusions and recommendations are presented by category below.

Assessment

Across all three groups, the MCO had a combined score of 94.2% in the Assessment category.

Group	7/1/23 to 6/30/24
Group C	98.0%
Group D	90.4%
Group E	96.6%
Combined	94.2%

Member Outreach

Across groups, the MCO had a combined score of 42.0% in the Member Outreach category.

Group	7/1/23 to 6/30/24
Group C	46.0%
Group D	38.0%
Group E[1]	--
Combined	42.0%

[1]Member Outreach is not assessed for Members in Group E because Group E Members are not new to MLTSS

Opportunities for Improvement for elements at the group level in the *Member Outreach* category include the following:

- **Group C and Group D:** UHCCP should ensure that Initial outreach is completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.

Face-to-Face Visits

Across all three groups, the MCO had a combined score of 95.7% in the Face-to-Face Visits category.

Group	7/1/23 to 6/30/24
Group C	95.8%
Group D	94.1%
Group E	98.2%
Combined	95.7%

Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans)

Across all three groups, the MCO had a combined score of 93.2% in the Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans) category.

Group	7/1/23 to 6/30/24
Group C	92.9%
Group D	91.9%
Group E	95.5%
Combined	93.2%

Ongoing Care Management

Across all three groups, the MCO had a combined score of 68.3% in the Ongoing Care Management category.

Group	7/1/23 to 6/30/24
Group C	73.3%
Group D	69.4%
Group E	55.6%
Combined	68.3%

Opportunities for Improvement for elements at the group level in the *Ongoing Care Management* category include the following:

- **Group C, Group D, and Group E:** UHCCP should ensure that review of Member's placement and services occurs timely (an ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).

- **Group D:** UHCCP should ensure that Member files that indicate a change from the Initial Plan of Care have documentation that the Member's Plan of Care is updated and/or reviewed, that the Member agrees with the Plan of Care, and that the Member signed and is provided with a copy of the Plan of Care.

- **Group C, Group D, and Group E:** For Members who were discharged to a HCBS setting, UHCCP should ensure the onsite review occurs within ten (10) days of discharge and should ensure that in home services are in place in a timely manner.

- **Group D and Group E:** UHCCP should ensure that Member files that indicate a significant change in Member condition have documentation that the Member's Plan of Care was amended, reviewed, and signed by the Member and/or authorized representative.

Gaps in Care/Critical Incidents

Across all three groups, the MCO had a combined score of 95.4% in the Gaps in Care/Critical Incidents category.

Group	7/1/23 to 6/30/24
Group C	98.8%
Group D	95.0%
Group E	91.4%
Combined	95.4%

Performance Measures

Overall, the MCO scored below 86% in three (3) of the seven (7) Performance Measures.

- **PM #8.** Plans of Care established within 45 days of MLTSS enrollment.
- **PM #9.** Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination.
- **PM #9a.** Plan of Care for MLTSS Members amended based on change of Member condition.

Opportunities for Improvement at the group level in MLTSS Performance Measures *for scores less than 86%* include the following:

PM #8: Plans of Care established within 45 days of MLTSS enrollment.

- **Group C and Group D:** UHCCP should ensure that the Initial Plan of Care is completed, signed, and mailed within 45 days of MLTSS enrollment.

PM #9: Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination.

- **Group E:** UHCCP should ensure that the Plan of Care reassessment for MLTSS Members is conducted within 30 days of annual LOC re-determination.

PM #9a: Plan of Care for MLTSS Members amended based on change of Member condition.

- **Group D and Group E:** For MLTSS Members with a change in condition, UHCCP should ensure that the Plan of Care is amended to reflect the changes in Member condition.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
Managed Long Term Services and Supports (MLTSS)

2024 Annual Assessment Review of Care Management
UnitedHealthcare Community Plan

Review Period - July 1, 2023 to June 30, 2024
December 2024

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Introduction

The NJ Family Care Managed Care Program, administered by the NJ Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), provides healthcare benefits for certain groups of children and adults with low-to-moderate incomes. The program provides health coverage to children, pregnant women, single adults, childless couples, aged, blind, and disabled individuals, and individuals qualified for long-term care services.

Background

The purpose of the Managed Long-Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure "That services were provided" to special needs members who met MLTSS eligibility requirements as specified in Article 9.

Annually, DMAHS evaluates Managed Care Organization (MCO) performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Assessment Methodology

The review consisted of pre-offsite review of documentation provided by UnitedHealthcare Community Plan (UHCCP) as evidence of compliance of the standards under review; interviews with key UHCCP staff (held via Teams meeting on December 3, 2024) and post-offsite evaluation of documentation and offsite activities.

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

The offsite review of documentation was requested by IPRO on July 26, 2024, and received from the MCOs on August 9, 2024. The documentation review occurred offsite at IPRO beginning on August 12, 2024. The IPRO review team consisted of Carla Zuccarello, Karen Halley, and Cynthia Santangelo. The Care Management assessment covered the period from July 1, 2023 to June 30, 2024. The MCOs were advised to provide both MLTSS and FIDE SNP/MLTSS documents if their Care Management documentation differed between MLTSS and FIDE SNP/MLTSS.

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

Table 1: All MLTSS CM elements are subject to be reviewed annually regardless of a prior year Met, and therefore be considered full reviews every year.

Table 1: Rating Scale for the MCO (MLTSS) Annual Assessment Review of Care Management

Rating	Rating Methodology	Review Type
Met in Prior Review	This element was met in the previous review cycle.	Full, Partial
Met	All parts within this element were met.	Full, Partial
Not Met	Not all required parts within the element were met.	Full, Partial
N/A	This element is not applicable and will not be considered as part of the score.	Full, Partial
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.	Full, Partial
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.	Full, Partial
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.	Full, Partial

Report Organization

This report provides findings for the MLTSS Care Management and Continuity of Care document submission portion of the 2024 MLTSS Care Management review.

A table is presented which provides the number of elements under review, the number *Met*, *Not Applicable* (*N/A*), and the number *Not Met* for this review. Percentages are based on the total number of applicable elements in the standard. Credit is given for receiving a *Met* finding in the current review. Contract language and reviewer comments are provided for *Not Met* elements. Contract language is provided for *N/A* elements and resolved deficiencies.

Following this summary, Strengths, Recommendations and Findings for Improvement are reported where applicable. Recommendations relate to those elements that are deficient and must be addressed by the Plan. Findings for Improvement relate to suggestions by the IPRO review team to strengthen current processes.

Care Management and Continuity of Care

The Care Management and Continuity of Care review category examines if the MCO has an effective care and case management service structure. This structure includes written policies, procedures, processes, and systems to identify, assess and manage its member population in care and case management program(s). This review category also examines whether the MCO has developed and implemented MLTSS Care Management Programs for enrollees who may benefit from these services in accordance with State requirements.

There are 10 contractual provisions in this category. UHCCP received an overall compliance score of 100% in 2024. In 2023, the MCO received a score of 100% for this category. **Table 1a** presents an overview of the results.

Table 1a: Summary of Findings for MLTSS Care Management and Continuity of Care

Element	Met Prior Year	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM18b	X	X	-	-	-	-	-
CM28	X	X	-	-	-	-	-
CM29	X	X	-	-	-	-	-
CM30	X	X	-	-	-	-	-
CM31	X	X	-	-	-	-	-
CM32	X	X	-	-	-	-	-
CM34	X	X	-	-	-	-	-
CM36	X	X	-	-	-	-	-
CM37	X	X	-	-	-	-	-
CM38	X	X	-	-	-	-	-
TOTAL	**10**	**10**	**0**	**0**	**0**	**0**	**0**
Compliance Percentage		**100%**					

Strengths

None

Recommendations

None

Findings for Improvement

None

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
Office of MLTSS Quality Monitoring

MCO MLTSS Nursing Facility/Special Care Nursing Facility Ancillary Review Compliance Evaluation of MLTSS Performance Measures

UnitedHealthcare Community Plan

July 2024

IPRO
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Introduction

The purpose of the Managed Long Term Services and Supports (MLTSS) Nursing Facility (NF)/Special Care Nursing Facility (SCNF) Ancillary Review is to evaluate Managed Care Organizations (MCOs) compliance with the Division of Medical Assistance and Health Services (DMAHS) NJ FamilyCare Contract Article 9.11.G, MLTSS Performance Measures. IPRO conducted a review of the following MLTSS Performance Measures: PM #8, PM #9, PM #9a, PM #11, and PM #16 for the review period September 1, 2022 through June 30, 2023.

Sampling Methodology

Population Selection

Population Criteria	September 1, 2022 to June 30, 2023
Codes	Capitation Codes **MLTSS NF Codes:** 88199, 88399, 88499, 78199, 78399 and 78499 **MLTSS HCBS Codes:** 89399 and 79399 *Needs to include **both** Core Medicaid and FIDE SNP Plan codes. Moving from one Plan Code to another does not constitute a change in MCO.
Age	No age requirements
Sex	Both
Nursing Facility Placement	Enrolled in a NF/SCNF for at least six (6) consecutive months, between 9/1/2022 and up to and including 6/30/2023.
Anchor Date	Enrolled in NF on 6/30/2023.
Continuous Enrollment Criteria	Enrolled in the same MCO for the entire period, from the initial six (6) consecutive months of residence in a NF/SCNF and remains in MLTSS through 6/30/2023 with no gaps in MLTSS enrollment.

Methodology

A random sample of 35 NF/SCNF Members new to MLTSS and/or new to the MCO during the review period and 25 NF/SCNF Members enrolled in MLTSS and the MCO prior to 9/1/2022 was selected to meet a minimum of 60 files (including a 20% oversample required for substitutions or exclusions) for each MCO. IPRO reviewed a total of 55 files for UnitedHealthcare Community Plan (UHCCP). Five (5) files were excluded, resulting in 50 files evaluated for compliance with MLTSS Performance Measures #8, #9, #9a, #11, and #16.

Evaluation of MLTSS Performance Measures

The following Performance Measures were evaluated to determine MCO compliance; PM #8: Plans of Care established within 45 days of MLTSS enrollment; PM #9: Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination; PM #9a: Plan of Care for MLTSS Members amended based on change of Member condition; PM #11: Plans of Care for MLTSS Members are developed using "Person-Centered Principles;" and PM #16: MCO provided training to MLTSS Member on identifying/reporting Critical Incidents. UHCCP's results for each MLTSS Performance Measure are shown below in **Table 1**.

Table 1: MLTSS Performance Measures Results

Performance Measure	Numerator	Denominator	Rate
#8. Plans of Care established within 45 days of MLTSS enrollment.[1]	6	30	20.0%
#9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination.[2]	13	15	86.7%
#9a. Plan of Care for MLTSS Members amended based on change of Member condition.[3]	0	0	N/A
#11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles."[4]	43	43	100.0%
#16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents.	30	50	60.0%

[1] Compliance with this measure includes completion of the Initial Plan of Care and timeliness of completion. The denominator includes all NF/SCNF Members new to MLTSS and/or new to the MCO during the review period.
[2] Members included in this measure (denominator) have an annual LOC re-determination that was due and completed during the review period and a Plan of Care on file.
[3] Members who did not have a documented change in condition during the study period are excluded from this measure.
[4] For compliance with this measure Members must have a Plan of Care on file during the review period that contains documentation 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 be addressed in the Plan of Care.
N/A: Not Applicable. There were no Members who met the criteria for this measure.

Limitations

None.

Conclusions

As directed by DMAHS, no Corrective Action Plans (CAPs) will be required for MLTSS Performance Measures that score below the MLTSS compliance threshold of 86%.

Overall, the MCO scored 86% or above for the following MLTSS Performance Measures (**Table 1**):

- PM #9: Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination.
- PM #11: Plans of Care for MLTSS Members are developed using "Person-Centered Principles."

Overall, the MCO scored below 86% for the following MLTSS Performance Measures (**Table 1**):

- PM #8. Plans of Care established within 45 days of MLTSS enrollment.
- PM #16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services,
Office of MLTSS Quality Monitoring

MCO MLTSS Nursing Facility/Special Care Nursing Facility Care Management Audit

UnitedHealthcare Community Plan

February 2025

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Introduction

The purpose of the Managed Long-Term Services and Supports (MLTSS) Nursing Facility/Special Care Nursing Facility (NF/SCNF) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS Care Management program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Specifically, the populations included in this audit were Members who met the eligibility requirements for MLTSS and were receiving services in a Nursing Facility/Special Care Nursing Facility for at least six consecutive months within the review period from July 1, 2023 through June 30, 2024.

The U.S. Department of Health and Human Services (HHS) declared an end to the Public Health Emergency (PHE) for COVID-19 on May 11, 2023. State issued COVID-19 flexibilities related to specific Care Management activities and Nursing Facilities with visitation protocols (restricting Care Manager access) discontinued prior to this review period.

In addition to the CM audit, MLTSS Performance Measures #8 (Plans of Care established within 45 days of MLTSS enrollment), #9 (Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination), #9a (Plan of Care for MLTSS Members amended based on change of Member condition), #11 (Plans of Care for MLTSS Members are developed using “Person-Centered Principles”), and #16 (MCO provided training to MLTSS Member on identifying/reporting Critical Incidents) were calculated. Annually, DMAHS will evaluate the Managed Care Organization (MCO) performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the NJ FamilyCare Contracts (Article 9), dated July 2023 and January 2024. A representative sample of files were selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities, and post-audit activities.

1. Pre-audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the NJ Choice Assessment System, Plan of Care, contract references, and revision of elements for review. Audit questions are limited exclusively to ”Yes” or ”No” answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool in 2024, where appropriate, to determine whether a Member met the criteria for a subsequent section or question. Therefore, for some audit questions, Members represented in the numerator and denominator represent only those who met the specific applicable criteria. IPRO prepared an audit tool structured to collect requirement-specific information related to Facility and MCO Plan of Care, MLTSS Initial Plan of Care and Ongoing Plans of Care, Ongoing Care Management, Reassessment of the Plan of Care and Critical Incident Reporting, and Preadmission Screening and Resident Review (PASRR) Communications for Transitions to NF/SCNF. In addition, MLTSS Performance Measures #8, #9, #9a, #11, and #16 were calculated for the applicable NF/SCNF population. Rates calculated from these audit tool sections are utilized to determine MCO performance.

Separate rates were calculated on requirement-specific questions related to MLTSS Members who transitioned between HCBS and NF/SCNF settings during the review period. These rates are utilized solely for informational purposes.

Population Selection

Capitation and Plan codes were used to identify MLTSS HCBS and MLTSS NF/SCNF enrollment. The study sample was selected by using the capitation codes to identify MLTSS HCBS and NF/SCNF enrollment listed in **Table 1** and **Table 2**, and applying the sampling methodology described below.

Table 1: Capitation Codes for MLTSS HCBS Enrollment

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

Table 2: Capitation Codes for MLTSS NF Enrollment

Capitation Code	Description
88199	MLTSS Eligible Without Medicare – NF
88399	MLTSS Eligible Without Medicare – SCNF (Vents and Pediatrics)
88499	MLTSS Eligible Without Medicare – SCNF
78199	MLTSS Eligible With Medicare - NF
78399	MLTSS Eligible With Medicare – SCNF (Vents and Pediatrics)
78499	MLTSS Eligible With Medicare - SCNF

A random sampling method was used to meet a minimum of records needed to reach 100 files for each MCO. If the MCO did not have 100 files, the entire universe was selected for review. IPRO selected 110 cases for UnitedHealthcare Community Plan (UHCCP), inclusive of an oversample of 10 cases to replace any excluded files as necessary.

Sampling Methodology

The criteria used to select the MLTSS NF/SCNF population were as follows:

- The Member must have been enrolled in MLTSS on June 30, 2024.
- The Member must have been enrolled as a NF/SCNF Member for 6 consecutive months during the review period and still enrolled with the MCO of record on June 30, 2024.
- The Member cannot be enrolled with another MCO at any time between the beginning of the minimum 6-month NF/SCNF enrollment and the end of the review period (June 30, 2024).

In order to collect additional information for MLTSS Members who transitioned between HCBS and NF/SCNF settings during the review period, the selected MLTSS NF/SCNF population was further identified as one of the four subgroups listed in **Table 3**.

Table 3: MLTSS NF/SCNF Population Subgroups

Group	Description
Group 1	Members permanently residing in an NF/SCNF at least 6 consecutive months from July 1, 2023 to June 30, 2024, with the MCO of record on June 30, 2024.
Group 2	Members residing in an NF/SCNF for at least 6 consecutive months from July 1, 2023 to June 30, 2024, and transitioned to HCBS during the review period with no transition from HCBS to another NF.
Group 3	Members residing in HCBS for at least 1 month between July 1, 2023 and June 30, 2024, and transitioned to an NF/SCNF for at least 6 consecutive months during the review period (and still residing in the NF/SCNF as of June 30, 2024).
Group 4	Members residing in HCBS for at least 1 month between July 1, 2023 and June 30, 2024, transitioned to an NF/SCNF for at least 6 consecutive months, and transitioned back to HCBS for at least 1 month during the review period.

Introductory E-mail

IPRO sent an introductory e-mail to the MCO prior to the scheduled offsite audit including:

- Formal notification of the audit with a file due date,
- Description of the sample,
- File listing identifying the files that needed to be submitted to IPRO, and
- Instructions for preparing files and uploading the files to IPRO's SEND File Transfer Protocol (FTP) site.

2. Offsite Audit Activities

Electronic files were prepared by the MCO for review and posted to IPRO's SEND FTP site. IPRO reviewers conducted the offsite file reviews over a five (5) week period. Reviewer inter-rater reliability (IRR) was maintained using the standardized audit tool with ongoing communication and coordination among the review team. Electronic files were prepared by the MCO for review.

3. Post-audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the 110 files selected for UHCCP, 106 Member files were reviewed. There were 6 files excluded. A total of 100 files were further reviewed for compliance in the following five (5) categories; Facility and MCO Plan of Care, MLTSS Initial Plan of Care and Ongoing Plans of Care, Ongoing Care Management, Reassessment of the Plan of Care and Critical Incident Reporting, and PASRR Communications for Transitions to NF/SCNF. Based on sample selection criteria, this included all four subpopulations (Groups 1, 2, 3 and 4). Rates for individual elements were calculated as the number of "Yes" determinations divided by the sum of "Yes" plus "No" determinations. Abbreviated review elements appear in bold in the table sections of this report (**Tables 4–8**). Rates should be considered cautiously for review elements with a denominator of less than 30.

Table 4: Facility and MCO Plan of Care

Facility and MCO Plan of Care	N	D	Rate
Member's Care Management record contained **copies of any Facility Plans of Care on file** during the review period.	82	100	82.0%
Documented review of the Facility Plan of Care by the Care Manager.	81	82	98.8%
MLTSS Plan of Care on file includes information from the Facility Plan of Care.	99	100	99.0%

Table 5: MLTSS Initial Plan of Care and Ongoing Plans of Care

MLTSS Initial Plan of Care and Ongoing Plans of Care	N	D	Rate
The Member's individualized Plan of Care (including obtaining Member's signature) **was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program.** [1]	9	13	69.2%
Care Managers used a Person-Centered approach regarding the Member's assessment and needs; taking into account not only covered services, but also formal and informal support services.	98	99	99.0%
Plan of Care reassessment for MLTSS Members conducted within 30 days of annual level of care (LOC) re-determination.[2]	70	80	87.5%
Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems, and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process.	99	99	100.0%
Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	99	99	100.0%
Member's agreement/disagreement with the Plan of Care statements were documented on the Member's Plan of Care and maintained in the Member's electronic CM record.	96	99	97.0%
Member experienced a significant change in condition requiring the Plan of Care to be amended.	10	99	10.1%

MLTSS Initial Plan of Care and Ongoing Plans of Care	N	D	Rate
Updated Plan of Care for a significant change. For any significant change in Member condition, Member's Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative.	10	10	100.0%

[1]Compliance with this measure includes completion of the Initial Plan of Care, Member signature, and a copy provided to the Member within 45 calendar days of the MLTSS enrollment date. The denominator includes all NF/SCNF Members new to MLTSS and/or new to the MCO during the review period.

[2]Members included in this measure (denominator) have an annual LOC re-determination that was due and completed during the review period and a Plan of Care on file.

Table 6: Ongoing Care Management

Ongoing Care Management	N	D	Rate
There was evidence in the file that the Member had the ability and/or desire to transition from the NF/SCNF.	5	100	5.0%
Member was identified for transfer to HCBS and was offered options, including transfer to the community.	5	5	100.0%
Evidence of the **Care Manager's participation in at least one interdisciplinary team (IDT) meeting** during the review period.	30	100	30.0%
Member was present at each onsite visit or had involvement from the Member's authorized representative regarding the Plan of Care. (If the Member was not able to participate in an onsite visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable).	100	100	100.0%
The Care Manager reviewed Member placement and services onsite with the Member present.	90	100	90.0%
Timely onsite review of Member placement and services. Onsite visits were timely and occurred within at least 180 calendar days for non-pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability).	66	90	73.3%
Member required coordination of care (physical health and/or behavioral health services) not covered by NF/SCNF.	35	100	35.0%
Members requiring coordination of care had coordination of care by the Care Manager.	35	35	100.0%

Table 7: Reassessment of the Plan of Care and Critical Incident Reporting

Reassessment of the Plan of Care and Critical Incident Reporting	N	D	Rate
The NJ Choice Assessment (NJCA) was due during the review period (initial or annual redetermination NJCA).	95	100	95.0%
Member had a NJCA completed during the review period.	94	95	98.9%
Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative.	85	99	85.9%
Care Manager reviewed the Member's rights and responsibilities.	99	100	99.0%
Care Manager educated the Member on how to file a grievance and/or an appeal.	74	100	74.0%
Member and/or representative had **training on how to report a critical incident**, specifically including how to identify abuse, neglect and exploitation.	74	100	74.0%

Table 8: PASRR Communications for Transitions to NF/SCNF

PASRR Communications for Transitions to NF/SCNF	N	D	Rate
Member transitioned to the NF/SCNF during the review period.	19	100	19.0%
Care Manager completed or confirmed PASRR Level I prior to Member transition to NF/SCNF.	17	19	89.5%
Communication of PASRR Level I to OCCO documented by the Care Manager in the NJCA.	16	17	94.1%
Member required a PASRR Level II prior to admission to the NF/SCNF.	2	17	11.8%
Care Manager completed or confirmed PASRR Level II, prior to Member transition to NF/SCNF.	1	2	50.0%
Communication of PASRR Level II to OCCO documented by the Care Manager (within 1 business day of receipt of determination).	1	1	100.0%
Member demonstrated a need for MCO coordination with DDD/DMHAS.	0	1	0.0%
Members who had a PASRR Level II indicating a need for Specialized Services setting had coordination with DDD/DMHAS.	0	0	N/A

OCCO: Office of Community Choice Options; DDD: Division of Developmental Disabilities; DMHAS: Division of Mental Health and Addiction Services
N/A: Not Applicable

MLTSS Members Transitioning Between HCBS and NF/SCNF Settings

Of the cases selected for UHCCP, 100 Member files were reviewed and included in the results. Rates were calculated for Members who transitioned from one MLTSS setting to another during the review period (Groups 2, 3, and 4; **Table 9**). Review elements are abbreviated in bold. Evaluation of MCO performance is for information purposes only.

Table 9: Member Transition Groups

Group	Member Transition	Number of Members
Group 1	Permanently residing in NF/SCNF for at least 6 months without a transition during the review period.	95
Group 2	Transitioned from NF/SCNF to HCBS with no other facility transition during the review period.	0
Group 3	Transitioned from HCBS to NF/SCNF and remained in a facility at the end of the review period.	5
Group 4	Transitioned from HCBS to NF/SCNF and back to HCBS during the review period.	0

MLTSS Members Transitioning from NF/SCNF to HCBS

A total of 0 files were reviewed for Members permanently residing in a NF/SCNF and subsequently transitioned to a home or community-based setting. Rates were calculated to profile NF/SCNF Members that transitioned to HCBS (Groups 2 and 4; **Table 9**).

Table 10: NF/SCNF Members Transitioned to HCBS

Transitions to HCBS	N	D	Rate
Member transitioned from NF/SCNF to HCBS during the review period.	0	100	0.0%
Member had a **Person-Centered transition plan on file.**	0	0	N/A
Cost effectiveness evaluation was completed for the Member prior to discharge from a NF/SCNF.	0	0	N/A
Plan of Care updated prior to discharge from a facility. Plan of Care was developed and agreed upon by the Member and/or representative prior to the effective date of transfer to the community.	0	0	N/A
Participation in an interdisciplinary team (IDT) meeting related to transition. Care Manager participated in the coordination of an IDT meeting related to transition planning.	0	0	N/A
Authorizations and procurement of transitional services for the Member were completed prior to NF/SCNF transfer.	0	0	N/A
Care Manager conducted a **face-to-face visit within 10 business days following a NF/SCNF discharge to the community.**	0	0	N/A
Services initiated upon NF/SCNF discharge were according to the Member's Plan of Care.	0	0	N/A

N/A: Not Applicable

MLTSS Members Transitioning from HCBS to NF/SCNF

A total of 5 files were reviewed for Members receiving HCBS and subsequently transitioned to an NF/SCNF for long-term placement. Rates were calculated to profile HCBS Members that transitioned to an NF/SCNF (Groups 3 and 4; **Table 9**).

Table 11: HCBS Members Transitioned to a NF/SCNF

Transitions to NF/SCNF	N	D	Rate
Member transitioned from HCBS to NF/SCNF during the review period.	5	100	5.0%
Member was admitted to NF/SCNF directly from an acute care facility.	5	5	100.0%
Care Manager determined during the reassessment process that changes in placement or services were indicated, and a **discussion with the Member occurred prior to the change in service/placement.**	5	5	100.0%

The expansion of the NF/SCNF audit components included evaluation of MLTSS Performance Measures. Population-specific findings are presented in **Table 12**, which include results on the following MLTSS Performance Measures: #8 (Plans of Care established within 45 days of MLTSS enrollment), #9 (Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination), #9a (Plan of Care for MLTSS Members amended based on change of Member condition), #11 (Plans of Care for MLTSS Members are developed using Person-Centered Principles), and #16 (MCO provided training to MLTSS Member on identifying/reporting Critical Incidents). Population results are rates calculated as the number of "Yes" determinations divided by the sum of "Yes" plus "No" determinations.

Table 12: MLTSS Performance Measures Results

Performance Measure	N	D	Rate
#8. Plans of Care established within 45 days of MLTSS enrollment.[1]	9	13	69.2%
#9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination.[2]	70	80	87.5%
#9a. Plan of Care for MLTSS Members amended based on change of Member condition.[3]	10	10	100.0%
#11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles."[4]	98	99	99.0%
#16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents.	74	100	74.0%

[1]Compliance with this measure includes completion of the Initial Plan of Care, Member signature, and a copy provided to the Member within 45 calendar days of the MLTSS enrollment date. The denominator includes all NF/SCNF Members new to MLTSS and/or new to the MCO during the review period.

[2] Members included in this measure (denominator) have an annual LOC re-determination that was due and completed during the review period and a Plan of Care on file.

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

[4] For compliance with this measure Members must have a Plan of Care on file during the review period that contains documentation 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 be addressed in the Plan of Care.

Discussion

Limitations

Results are limited due to the absence of Members in Group 2 (Members who transitioned from NF/SCNF to HCBS with no other facility transition during the review period) and Group 4 (Members who transitioned from HCBS to the NF/SCNF and returned to HCBS) during the review period.

Conclusions

Overall, the MCO scored 86% or above in the following review elements (**Tables 4–8**). Review elements evaluated for calculation of Performance Measures are resulted in the MLTSS Performance Measures section of this report.

Facility and MCO Plan of Care

- Documented review of the Facility Plan of Care by the Care Manager. (98.8%)
- MLTSS Plan of Care on file includes information from the Facility Plan of Care. (99.0%)

MLTSS Initial Plan of Care and Ongoing Plans of Care

- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems, and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process. (100.0%)
- Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this). (100.0%)
- Member's agreement/disagreement with the Plan of Care statements were documented on the Member's Plan of Care and maintained in the Member's electronic CM record. (97.0%)

Ongoing Care Management

- Member was identified for transfer to HCBS and was offered options, including transfer to the community. (100.0%)
- Member was present at each onsite visit or had involvement from the Member's authorized representative regarding the Plan of Care. (If the Member was not able to participate in an onsite visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable). (100.0%)
- Members requiring coordination of care had coordination of care by the Care Manager. (100.0%)

Reassessment of the Plan of Care and Critical Incident Reporting

- Member had a NJCA completed during the review period. (98.9%)
- Care Manager reviewed the Member's rights and responsibilities. (99.0%)

PASRR Communications for Transitions to NF/SCNF

- Care Manager completed or confirmed PASRR Level I prior to Member transition to NF/SCNF. (89.5%)
- Communication of PASRR Level I to OCCO documented by the Care Manager in the NJCA. (94.1%)
- Communication of PASRR Level II to OCCO documented by the Care Manager (within 1 business day of receipt of determination). (100.0%)

Opportunities for Improvement for Review Elements

Opportunities for improvement for MCO scores below 86% exist in the following review elements (**Tables 4–8**).

- Member's Care Management record contained copies of any Facility Plans of Care on file during the review period. (82.0%)
- Evidence of the Care Manager's participation in at least one interdisciplinary team (IDT) meeting during the review period. (30.0%)
- Timely onsite review of Member placement and services. Onsite visits were timely and occurred within at least 180 calendar days for non-pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability). (73.3%)
- Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative. (85.9%)
- Care Manager educated the Member on how to file a grievance and/or an appeal. (74.0%)
- Care Manager completed or confirmed PASRR Level II, prior to Member transition to NF/SCNF. (50.0%)

Recommendations for Review Elements

- UHCCP MLTSS Care Managers should ensure the Member's Care Management record contains copies of any Facility Plans of Care on file during the review period.
- UHCCP MLTSS Care Managers should ensure the Care Manager participates in a minimum of one interdisciplinary team (IDT) meeting per year.
- UHCCP MLTSS Care Managers should ensure review of the Member's placement and services occurs timely (at least 180 days for non-pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members).
- UHCCP MLTSS Care Managers should ensure that a copy of the Member's Plan of Care is provided to the Member and/or representative.
- UHCCP MLTSS Care Managers should ensure the Member is educated on how to file a grievance and/or an appeal.
- UHCCP MLTSS Care Managers should ensure completion or confirmation of PASRR ll prior to Member transition of NF/SCNF.

MLTSS Performance Measures

Overall, the MCO scored 86% or above in the following Performance Measures (PMs) (**Table 12**).

- PM #9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination. (87.5%)
- PM #9a. Plan of Care for MLTSS Members amended based on change of Member condition. (100.0%)
- PM #11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles." (99.0%)

Opportunities for Improvement for MLTSS Performance Measures

Opportunities for improvement for MCO scores below 86% exist for the following MLTSS Performance Measures (**Table 12**).

- PM #8. Plans of Care established within 45 days of MLTSS enrollment. (69.2%)
- PM #16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents. (74.0%)

Recommendations for MLTSS Performance Measures

- PM #8. UHCCP MLTSS Care Managers should ensure that the Member's Plan of Care is established and a copy provided to the Member within 45 days of MLTSS enrollment.
- PM #16. UHCCP MLTSS Care Managers should ensure training is provided to MLTSS Members on identifying/reporting Critical Incidents.

Appendix F – WPNJ 2024 Core Medicaid and MLTSS Care Management Audit Reports

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
Office of Quality Assurance

MCO Care Management Audit and Annual Assessment
Wellpoint New Jersey, Inc. (formerly Amerigroup New Jersey)

Review Period: January 1, 2023 to December 31, 2023

September 2024

IPRO
Better healthcare, realized.

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MCO Care Management Audit and Annual Assessment

Introduction

The purpose of the Care Management Audit and Annual Assessment was to evaluate the effectiveness of the contractually required Care Management program. The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) established Care Management requirements to ensure that the services provided to Enrollees with special health care needs are consistent with professionally recognized standards of care. The populations included in this audit include General Population (GP) Enrollees, Enrollees under the Division of Developmental Disabilities (DDD), and Enrollees under the Division of Child Protection and Permanency (DCP&P).

Annually, DMAHS evaluates Managed Care Organization (MCO) performance against these requirements through its External Quality Review Organization (EQRO) Contractor. The results of these audits are used to improve MCO performance.

MCO Care Management Chart Audit

Methodology

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

Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the prior year's report, NJ FamilyCare contract references, NJ Care Management Workbook, and CDC Immunization Schedules. For 2024, at the direction of DMAHS, the MCO Care Management audit evaluation process changed for GP, DDD, and DCP&P Enrollees. For the GP population, IPRO evaluated Enrollees new to the MCO and new to Care Management between 1/1/2023 and 11/16/2023 and existing Enrollees enrolled in Care Management between 3/1/2023 and 11/16/2023. For the DDD and DCP&P populations, IPRO evaluated newly eligible Enrollees new to Care Management during the 2023 review period and existing eligible Enrollees enrolled in Care Management prior to 1/1/2023. Audit questions are limited exclusively to 'Yes' or 'No' answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool, where appropriate, to determine whether an Enrollee met the criteria for a subsequent section or question. Therefore, for some audit questions, Enrollees represented in the numerator and denominator represent only those who met the specific applicable criteria.

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

Population Selection

The sample was determined by excluding Enrollees with Third Party Liability (TPL) from the three populations, all pregnant members from the General Population, and applying the sampling methodology described below. The sampling methodology, as shown in **Table 1**, resulted in the selection of 246 cases for Wellpoint New Jersey, Inc. (WPNJ).

Using a conservative assumption of a 65% proportion, a sample size of 100 was selected to yield sufficient statistical power to produce a 95% confidence interval, with a 10% margin of error. The confidence interval provides the range within which there is a 95% probability that the true rate falls between the lower rate and the upper rate of the confidence interval. Higher rates lead to smaller ranges in confidence intervals.

A random sample of 130 Enrollees for the General Population, DDD Population, and DCP&P Population (including a 30% oversample required for substitutions or exclusions), was selected.

Table 1: Sampling Methodology

Population Criteria	General Population (GP)	DDD	DCP&P
Criteria	Using the criteria below, the MCO will provide two (2) listings of ALL eligible New and Existing Enrollees (Exclude DDD, DCP&P, all pregnant Enrollees, and TPL). IPRO will pull a random sample of 65 Enrollees new to the MCO and Care Management anytime between 1/1/2023 through 11/16/2023 and 65 existing Enrollees new to Care Management between 3/1/2023 through 11/16/2023 from the universes provided.** **Random sample size modified by IPRO.	Using the appropriate Capitation Codes and the criteria below, the MCO will provide two (2) listings (exclude TPL) for: 1 - ALL New eligible DDD Enrollees in Care Management and; 2 - ALL Existing eligible DDD Enrollees in Care Management IPRO will select a random sample of 130 new and existing DDD Enrollees in Care Management per MCO from the universes provided.** **Random sample size modified by IPRO.	Using the appropriate Capitation Codes and the criteria below, the MCO will provide two (2) listings (exclude TPL) for: 1 - ALL New eligible DCP&P Enrollees in Care Management and; 2 - ALL Existing eligible DCP&P Enrollees in Care Management IPRO will select a random sample of 130 new and existing DCP&P Enrollees in Care Management per MCO from the universes provided.** **Random sample size modified by IPRO.
Age	>=6 months as of 12/31/2023	>= 6 months as of 12/31/2023	>= 6 months and < 18 years as of 12/31/2023
Sex	Both	Both	Both
Enrollment in MCO • New Enrollees	Initial enrollment between 1/1/2023 to 6/30/2023	Initial enrollment between 1/1/2023 and 6/30/2023	Initial enrollment between 1/1/2023 and 6/30/2023
• Existing Enrollees	Enrolled prior to 1/1/2023	Enrolled prior to 1/1/2023	Enrolled prior to 1/1/2023
Current Enrollment	Enrolled as of 12/31/2023 and with the same MCO for 6 months during the review period.	Enrolled as of 12/31/23 and with the same MCO for 6 months during the review period.	Enrolled as of 12/31/23 and with the same MCO for 6 months during the review period.
Continuous Enrollment Criteria	Enrolled in same population and same MCO through 12/31/2023 allowing no more than a one-month gap.	Enrolled in same population and same MCO at least 6 months in 2023 allowing one gap <= 45 days. Gap is not permissible at the beginning or the end of the enrollment time period. Where Enrollee meets enrollment criteria for 2 MCOs in 2023, the later MCO enrollment is selected.	Enrolled in same population and same MCO at least 6 months in 2023 allowing one gap <= 45 days. Gap is not permissible at the beginning or the end of the enrollment time period. Where Enrollee meets enrollment criteria for 2 MCOs in 2023 the later MCO enrollment is selected.

Introductory E-Mail

For this year's audit, the evaluation included an audit review for three (3) sampled populations. IPRO sent an Introductory E-Mail to the MCO prior to the offsite desk audit including:

- A description of the current year audit process and specifications for each population.
- File listings identifying the files that needed to be submitted to IPRO, along with instructions for preparing the files and uploading the files to IPRO's S.E.N.D. FTP site.

Audit Activities

IPRO reviewers conducted the file reviews over a five-week period. Reviewer inter-rater reliability was maintained through use of the standardized Audit Tool, and ongoing communication and coordination among the review team.

Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report. MCOs were not permitted to submit additional information after the offsite audit.

Audit Results

Rates were calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in Table 2, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

WPNJ's 2024 CM Audit results for the review period 1/1/2023 to 12/31/2023 ranged from 68.4% to 100% across all populations for the five audit categories.

Table 2: Aggregate Results by Category

Determination by Category	GP (n=46)	DDD (n=100)	DCP&P (n=100)
Identification[1]	82.6%		
Outreach[2,3]	93.8%	100.0%	85.7%
Preventive Services[3]	95.9%	99.0%	98.3%
Continuity of Care[3]	95.3%	92.1%	88.7%
Coordination of Services[3]	98.0%	68.4%	90.7%

[1]The Identification category is not evaluated for New and Existing DDD and DCP&P Enrollees, or Existing GP Enrollees.
[2]The Outreach category is evaluated for Enrollee files with no CNA or untimely completion of the CNA.
[3]Aggregate scores represent a combination of New and Existing population specific rates.

GP Population Findings

Identification

The Identification category applies to GP Enrollees new to the MCO and new to Care Management between 1/1/2023 and 11/16/2023. There are 14 Enrollees new to the MCO and new to Care Management during the review period.

Table 3: Identification – GP Population- Enrollees New to the MCO and New to Care Management

Identification	General Population		
	Numerator	Denominator	Rate
Enrollee has an Initial Health Screen (IHS) on file and/or an IHS score documented in the file that was completed during the review period (1/1/2023 to 12/31/2023).*	9	14	64.3%
For IHS on file, IHS was completed for the Enrollee within 45 days of MCO enrollment date.	6	9	66.7%
For no IHS on file, the MCO made outreach attempts to complete the IHS.*	4	5	80.0%
For Enrollees where no IHS was on file, initial outreach to complete the IHS was successful (even if Enrollee declined to complete the IHS).*	0	5	0.0%
For Enrollees where no IHS was on file, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment.	4	5	80.0%
Enrollees who scored less than 5 on the IHS or no IHS on file.*	9	14	64.3%
Enrollees identified by the Plan as having Care Management needs through additional sources (applies to Enrollees new to the MCO and new to CM where the IHS score is less than 5 or no IHS on file).	9	9	100.0%

**Not Included in aggregate score calculation*

Outreach

The Outreach category applies to new GP Enrollees (14) enrolled in Care Management between 1/1/2023 and 11/16/2023 and existing GP Enrollees (32) enrolled in Care Management between 3/1/2023 and 11/16/2023.

Table 4: Outreach – General Population – New and Existing Enrollees enrolled in Care Management

Outreach	General Population – New Enrollees			General Population – Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The MCO completed a Comprehensive Needs Assessment (CNA) during the review period.*	13	14	92.9%	31	32	96.9%
The Enrollee was unable to reach to complete the CNA.*	0	1	0.0%	1	1	100.0%
The MCO completed the CNA timely.*	9	13	69.2%	28	31	90.3%
Initial outreach to complete a CNA was performed.[1]	4	5	80.0%	4	4	100.0%
Initial outreach to complete the CNA was done timely, within 30 days of identification of CM needs. (30 days from IHS score 5 or greater; or IHS less than 5, no IHS, identification of CM needs through other sources).	3	4	75.0%	4	4	100.0%
Initial outreach to complete a CNA was successful (even if the Enrollee declined to complete the CNA).*	0	4	0.0%	1	4	25.0%
The MCO performed and documented aggressive outreach attempts to complete a CNA.*	4	4	100.0%	3	3	100.0%

Outreach	General Population – New Enrollees			General Population – Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
For CNAs not completed timely or no CNA, aggressive outreach attempts were made timely (30 days from IHS score 5 or greater or identification of CM needs through other sources).	4	4	100.0%	3	3	100.0%
Upon any successful outreach to the Enrollee, the Enrollee opted out of Care Management.*	0	14	0.0%	1	32	3.1%
Enrollee became lost to contact during the review period.*	1	14	7.1%	7	32	21.9%
For Enrollees who were lost to contact, aggressive outreach attempts were made and documented by the Care Manager.	1	1	100.0%	7	7	100.0%

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollee files with no CNA or a CNA completed untimely. The denominator in this measure represents 1 new GP Enrollee and 1 existing GP Enrollee with no CNA. The denominator in this measure represents the 4 untimely CNAs for new GP Enrollees and 3 untimely CNAs for existing GP Enrollees.

Preventive Services

The Preventive Services category applies to new GP Enrollees (14) enrolled in Care Management between 1/1/2023 and 11/16/2023 and existing GP Enrollees (32) enrolled in Care Management between 3/1/2023 and 11/16/2023.

Table 5: Preventive Services – General Population- New and Existing Enrollees enrolled in Care Management

Preventive Services	General Population - New Enrollees			General Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The Enrollee's EPSDT[1] exam is up to date per periodicity exam schedule (aged 0 through 20).*	8	8	100.0%	8	9	88.9%
The Enrollee's EPSDT status is confirmed by a reliable source (aged 0 through 20).	8	8	100.0%	8	8	100.0%
Aggressive outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	0	0	N/A	0	1	0.0%
The Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	0	0	N/A	0	1	0.0%
The Enrollee or legal guardian refused immunizations (aged 0 to 18).*	2	8	25.0%	1	9	11.1%
The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18).*	6	6	100.0%	5	8	62.5%
The Enrollee's immunization status is confirmed by a reliable source (aged 0 through 18).	6	6	100.0%	5	5	100.0%
Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18).	0	0	N/A	3	3	100.0%
The Enrollee or legal guardian refused immunizations (aged 19 and above).*	4	6	66.7%	10	23	43.5%
Appropriate vaccines have been administered for Enrollees (aged 19 and above).*	2	2	100.0%	9	13	69.2%
Aggressive outreach attempts were documented to confirm immunization status for Enrollees (aged 19 and above).	0	0	N/A	4	4	100.0%
The Care Manager addressed and/or discussed dental needs with Enrollees (aged 21 and above).	6	6	100.0%	23	23	100.0%
A dental visit occurred during the review period for Enrollees (aged 1 through 20).*	4	4	100.0%	5	9	55.6%

Preventive Services	General Population - New Enrollees			General Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
Care Manager made attempts to obtain dental status for Enrollees without a confirmed dental visit (aged 1 through 20).	0	0	N/A	4	4	100.0%
Dental reminders were sent to Enrollees without a confirmed dental visit (aged 1 through 20).	0	0	N/A	3	4	75.0%

**Not Included in aggregate score calculation*
[1]EPSDT: Early and Periodic Screening, Diagnostic and Treatment
N/A: Not Applicable

Continuity of Care

The Continuity of Care category applies to new GP Enrollees (14) enrolled in Care Management between 1/1/2023 and 11/16/2023 and existing GP Enrollees (32) enrolled in Care Management between 3/1/2023 and 11/16/2023.

Table 6: Continuity of Care – General Population - New and Existing Enrollees enrolled in Care Management

Continuity of Care	General Population - New Enrollees			General Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The MCO completed a CNA during the review period.*	13	14	92.9%	31	32	96.9%
The CNA contained all elements of the State approved CNA tool.	13	13	100.0%	31	31	100.0%
The Comprehensive Needs Assessment was completed timely (within 30 days of identification of CM needs).	9	13	69.2%	28	31	90.3%
The Care Manager documented a level of Care Management for the Enrollee during the review period.	13	13	100.0%	31	31	100.0%
The Enrollee is in Community Based Care Management (CBCM).[1]*	0	14	0.0%	2	32	6.2%
The Enrollee has a Care Plan on file during the review period.	11	14	78.6%	30	32	93.8%
A Care Plan was completed for the Enrollee that included all required components.	11	11	100.0%	30	30	100.0%
The Care Plan was developed within 30 days of CNA completion.[2]	10	11	90.9%	29	30	96.7%
The Enrollee's Care Plan was reviewed/monitored during the review period.	10	11	90.9%	30	30	100.0%
The Enrollee had a change in care needs or circumstances during the review period.*	3	11	27.3%	16	30	53.3%
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances.	3	3	100.0%	16	16	100.0%
Enrollee demonstrated needs requiring a comprehensive treatment plan.*	0	14	0.0%	0	32	0.0%
The Enrollee had a comprehensive treatment plan documented to address the Enrollee's specific care needs.	0	0	N/A	0	0	N/A
The comprehensive treatment plan progressed in a timely manner without unreasonable interruption.	0	0	N/A	0	0	N/A

**Not Included in aggregate score calculation*
[1] Community Based Care Management (CBCM) resumed in October 2023 following the end of the Public Health Emergency.
[2]This measure is evaluated for Enrollee's with a Care Plan and a CNA on file during the review period.
N/A: Not Applicable

Coordination of Services

The Coordination of Services category applies to new GP Enrollees (14) enrolled in Care Management between 1/1/2023 and 11/16/2023 and existing GP Enrollees (32) enrolled in Care Management between 3/1/2023 and 11/16/2023.

Table 7: Coordination of Services – General Population - New and Existing Enrollees enrolled in Care Management

Coordination of Services	General Population- New Enrollees			General Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF[1], CSOC[2], CMOs[3], Special Child Health Services (under DOH[4]) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD).	6	6	100.0%	3	3	100.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services.	8	8	100.0%	26	28	92.9%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee.	11	11	100.0%	24	24	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed.	5	5	100.0%	17	17	100.0%

[1]DCF: Department of Children and Families
[2]CSOC: Children's System of Care
[3]CMOs: Care Management Organizations
[4]DOH: Department of Health

DDD Population Findings

Outreach

The Outreach category applies to new DDD Enrollees (25) in Care Management during the 2023 review period. The Outreach category is not evaluated for the existing DDD Enrollees in Care Management.

Table 8: Outreach – DDD Population - Enrollees New to the MCO and New to Care Management

Outreach	DDD Population		
	Numerator	Denominator	Rate
The MCO completed a Comprehensive Needs Assessment (CNA) during the review period.*	22	25	88.0%
The Enrollee was unable to reach to complete the CNA.*	1	3	33.3%
The MCO completed the CNA timely (within 45 days of MCO enrollment date).*	22	22	100.0%
Initial outreach to complete a CNA was performed.[1]	3	3	100.0%
Initial outreach to complete the CNA was done timely, within 45 days from the Enrollee's enrollment date.	3	3	100.0%
Initial outreach to complete the CNA was successful (even if the Enrollee declines to complete the CNA).*	3	3	100.0%
The MCO performed aggressive outreach to complete a CNA.*	0	0	N/A
Aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment).	0	0	N/A
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA.*	1	2	50.0%
Upon any successful outreach to the Enrollee, the Enrollee declined Care Management.*	1	2	50.0%

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollee files with no CNA or a CNA completed untimely. The denominator for this measure includes 3 files with no CNA.

N/A: Not Applicable

Preventive Services

The Preventive Services category applies to new DDD Enrollees (25) and existing DDD Enrollees (75) in Care Management during the 2023 review period.

Table 9: Preventive Services – DDD Population - New and Existing Enrollees enrolled in Care Management

Preventive Services	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The Enrollee's EPSDT[1] exam is up to date per periodicity exam schedule (aged 0 through 20).*	12	19	63.2%	11	14	78.6%
The Enrollee's EPSDT status is confirmed by a reliable source (aged 0 through 20).	12	12	100.0%	11	11	100.0%
Aggressive outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	7	7	100.0%	3	3	100.0%
The Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	7	7	100.0%	2	3	66.7%
The Enrollee or legal guardian refused immunizations (aged 0 to 18).*	2	18	11.1%	1	9	11.1%

Preventive Services	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18).*	15	16	93.8%	4	8	50.0%
The Enrollee's immunization status is confirmed by a reliable source (aged 0 through 18).	15	15	100.0%	4	4	100.0%
Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18).	1	1	100.0%	4	4	100.0%
The Enrollee or legal guardian refused immunizations (aged 19 and above).*	2	7	28.6%	16	66	24.2%
Appropriate vaccines have been administered for Enrollees (aged 19 and above).*	5	5	100.0%	19	50	38.0%
Aggressive outreach attempts were documented to confirm immunization status for Enrollees (aged 19 and above).	0	0	N/A	30	31	96.8%
The Care Manager addressed and/or discussed dental needs with Enrollees (aged 21 and above).	6	6	100.0%	61	61	100.0%
A dental visit occurred during the review period for Enrollees (aged 1 through 20).*	11	19	57.9%	9	14	64.3%
Care Manager made attempts to obtain dental status for Enrollees without a confirmed dental visit (aged 1 through 20).	8	8	100.0%	5	5	100.0%
Dental reminders were sent to Enrollees without a confirmed dental visit (aged 1 through 20).	8	8	100.0%	5	5	100.0%

**Not Included in aggregate score calculation*
[1]EPSDT: Early and Periodic Screening, Diagnostic and Treatment
N/A: Not Applicable

Continuity of Care

The Continuity of Care category applies to new DDD Enrollees (25) and existing DDD Enrollees (75) in Care Management during the 2023 review period. Gray shading represents elements that are not evaluated for existing DDD Enrollees in Care Management.

Table 10: Continuity of Care – DDD Population - New and Existing Enrollees enrolled in Care Management

Continuity of Care	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The MCO completed a CNA during the review period.*	22	25	88.0%			
The CNA contained all elements of the State approved CNA tool.	22	22	100.0%			
The Comprehensive Needs Assessment was completed timely, within 45 days of Enrollee's MCO enrollment date.	22	22	100.0%			
The Care Manager documented a level of Care Management for the Enrollee during the review period.	22	22	100.0%	46	75	61.3%
The Enrollee is in Community Based Care Management (CBCM).[1]*	0	25	0.0%	1	75	1.3%
The Enrollee has a Care Plan on file during the review period.	25	25	100.0%	70	75	93.3%
A Care Plan was completed for the Enrollee that included all required components.	25	25	100.0%	70	70	100.0%

Continuity of Care	DDD Population- New Enrollees			DDD Population- Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The Care Plan was developed within 30 days of CNA completion.[2]	22	22	100.0%			
The Enrollee's Care Plan was reviewed/monitored during the review period.	25	25	100.0%	69	70	98.6%
The Enrollee had a change in care needs or circumstances during the review period.*	7	25	28.0%	10	70	14.3%
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances.	7	7	100.0%	8	10	80.0%
Enrollee demonstrated needs requiring a comprehensive treatment plan.*	0	25	0.0%	0	75	0.0%
The Enrollee had a comprehensive treatment plan documented to address the Enrollee's specific care needs.	0	0	N/A	0	0	N/A
The comprehensive treatment plan progressed in a timely manner without unreasonable interruption.	0	0	N/A	0	0	N/A

**Not Included in aggregate score calculation*

[1] Community Based Care Management (CBCM) resumed in October 2023 following the end of the Public Health Emergency.

[2] This measure is evaluated for Enrollee's with a Care Plan and a CNA on file during the review period.

N/A: Not Applicable

Coordination of Services

The Coordination of Services category applies to new DDD Enrollees (25) and existing DDD Enrollees (75) in Care Management during the 2023 review period.

Table 11: Coordination of Services – DDD Population- New and Existing Enrollees enrolled in Care Management

Coordination of Services	DDD Population - New Enrollees			DDD Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF[1], CSOC[2], CMOs[3], Special Child Health Services (under DOH[4]) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD).	25	25	100.0%	36	75	48.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services.	18	22	81.8%	28	36	77.8%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee.	9	14	64.3%	7	11	63.6%
For Enrollees who were hospitalized, adequate discharge planning was performed.	1	1	100.0%	6	6	100.0%
For Enrollees who were hospitalized with a mental/behavioral health diagnosis and	0	0	N/A	0	0	N/A

Coordination of Services	DDD Population - New Enrollees			DDD Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
discharged prior to 12/1/2023 the Care Manager documented evidence of follow up with the mental/behavioral health provider within 30 days of discharge.						
The Care Manager made aggressive attempts to determine follow up status with a mental/behavioral health provider for Enrollees hospitalized with a mental/behavioral health diagnosis.	0	0	N/A	0	0	N/A

[1]DCF: Department of Children and Families
[2]CSOC: Children's System of Care
[3]CMOs: Care Management Organizations
[4]DOH: Department of Health
N/A: Not Applicable

DCP&P Population Findings

Outreach

The Outreach category applies to new DCP&P Enrollees (50) in Care Management during the 2023 review period. The Outreach category is not evaluated for the existing DCP&P Enrollees in Care Management.

Table 12: Outreach – DCP&P Population- Enrollees New to the MCO and New to Care Management

Outreach	DCP&P Population		
	Numerator	Denominator	Rate
The MCO completed a Comprehensive Needs Assessment (CNA) during the review period.*	47	50	94.0%
The Enrollee was unable to reach to complete the CNA.*	1	3	33.3%
The MCO completed the CNA timely, within 45 days of MCO enrollment date.*	47	47	100.0%
Initial outreach to complete a CNA was performed.[1]	2	3	66.7%
Initial outreach to complete the CNA was timely, within 45 days from the Enrollee's enrollment date.	2	2	100.0%
Initial outreach was successful (even if the Enrollee declines to complete the CNA).*	0	2	0.0%
The MCO performed aggressive outreach to complete a CNA.*	2	2	100.0%
Aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment.	2	2	100.0%
Upon any successful outreach to the Enrollee, the Enrollee declined to complete the CNA.*	0	2	0.0%

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollee files with no CNA or a CNA completed untimely. The denominator includes 3 files with no CNA.

Preventive Services

The Preventive Services category applies to new DCP&P Enrollees (50) and existing DCP&P Enrollees (50) in Care Management during the 2023 review period.

Table 13: Preventive Services – DCP&P Population – New and Existing Enrollees enrolled in Care Management

Preventive Services	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The Enrollee's EPSDT[1] exam is up to date per periodicity exam schedule (aged 0 through 20).*	48	50	96.0%	46	50	92.0%
The Enrollee's EPSDT status is confirmed by a reliable source (aged 0 through 20).	48	48	100.0%	46	46	100.0%
Aggressive outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	2	2	100.0%	4	4	100.0%
The Care Manager sent EPSDT reminders (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20).	1	2	50.0%	4	4	100.0%
The Enrollee or legal guardian refused immunizations (aged 0 to 18).*	13	50	26.0%	1	50	2.0%

Preventive Services	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The Enrollee's immunizations are up to date for Enrollees (aged 0 through 18).*	28	37	75.7%	34	49	69.4%
The Enrollee's immunization status is confirmed by a reliable source (aged 0 through 18).	28	28	100.0%	34	34	100.0%
Aggressive outreach attempts were documented to confirm immunization status (aged 0 through 18).	9	9	100.0%	14	15	93.3%
A dental visit occurred during the review period for Enrollees (aged 1 through 20).*	27	34	79.4%	33	45	73.3%
Care Manager made attempts to obtain dental status for Enrollees without a confirmed dental visit (aged 1 through 20).	7	7	100.0%	12	12	100.0%
Dental reminders were sent to Enrollees without a confirmed dental visit (aged 1 through 20).	6	7	85.7%	11	12	91.7%

**Not Included in aggregate score calculation*
[1]EPSDT: Early and Periodic Screening, Diagnostic and Treatment

Continuity of Care

The Continuity of Care category applies to new DCP&P Enrollees (50) and existing DCP&P Enrollees (50) in Care Management during the 2023 review period. Gray shading represents elements that are not evaluated for existing DCP&P Enrollees in Care Management.

Table 14: Continuity of Care – DCP&P Population – New and Existing Enrollees enrolled in Care Management

Continuity of Care	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The MCO completed a CNA during the review period.*	47	50	94.0%			
The completed CNA contained all elements of the State approved CNA tool.	47	47	100.0%			
The Comprehensive Needs Assessment was completed timely (within 45 days of the Enrollee's enrollment).	47	47	100.0%			
The Care Manager documented a level of Care Management for the Enrollee during the review period.	47	47	100.0%	48	50	96.0%
The Enrollee has a Care Plan on file during the review period.	48	50	96.0%	40	50	80.0%
A Care Plan was completed for the Enrollee that included all required components.	48	48	100.0%	40	40	100.0%
The Care Plan was developed within 30 days of CNA completion.[1]	47	47	100.0%			
The Enrollee's Care Plan was reviewed/monitored during the review period.	4	48	8.3%	40	40	100.0%
The Enrollee had a change in care needs or circumstances during the review period.*	0	48	0.0%	1	40	2.5%
The Care Plan was updated upon a change in the Enrollee's care needs or circumstances.	0	0	N/A	1	1	100.0%
Enrollee demonstrated needs requiring a comprehensive treatment plan.*	0	50	0.0%	0	50	0.0%
The Enrollee had a comprehensive treatment plan documented to address the Enrollee's specific care needs.	0	0	N/A	0	0	N/A

Continuity of Care	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
The comprehensive treatment plan progressed in a timely manner without unreasonable interruption.	0	0	N/A	0	0	N/A

**Not Included in aggregate score calculation*

[1]This measure is evaluated for Enrollee's with a Care Plan and a CNA on file during the review period.

N/A: Not Applicable

Coordination of Services

The Coordination of Services category applies to new DCP&P Enrollees (50) and existing DCP&P Enrollees (50) in Care Management during the 2023 review period.

Table 15: Coordination of Services – DCP&P Population - New and Existing Enrollees enrolled in Care Management

Coordination of Services	DCP&P Population - New Enrollees			DCP&P Population - Existing Enrollees		
	Numerator	Denominator	Rate	Numerator	Denominator	Rate
When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF[1], CSOC[2], CMOs[3], Special Child Health Services (under DOH[4]) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD).	50	50	100.0%	39	50	78.0%
For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services.	3	4	75.0%	5	5	100.0%
For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee.	24	24	100.0%	2	2	100.0%
For Enrollees who were hospitalized, adequate discharge planning was performed.	1	2	50.0%	3	3	100.0%

[1]DCF: Department of Children and Families

[2]CSOC: Children's System of Care

[3]CMOs: Care Management Organizations

[4]DOH: Department of Health

Limitations

WPNJ had a combined total of 84 file exclusions for the General Population new and existing Enrollees, for Enrollees not enrolled in Care Management at any time during the review period. As a result, the total files reviewed are 14 (new Enrollees) and 32 (existing Enrollees). Audit results should be considered cautiously due to the low sample sizes.

Conclusions

Overall, the MCO scored 85% or above in the following review categories (**Table 2**):

- Outreach (General Population) (93.8%)
- Outreach (DDD Population) (100.0%)
- Outreach (DCP&P Population) (85.7%)

- Preventive Services (General Population) (95.9%)
- Preventive Services (DDD Population) (99.0%)
- Preventive Services (DCP&P Population) (98.3%)

- Continuity of Care (General Population) (95.3%)
- Continuity of Care (DDD Population) (92.1%)
- Continuity of Care (DCP&P Population) (88.7%)

- Coordination of Services (General Population) (98.0%)
- Coordination of Services (DCP&P Population) (90.7%)

Overall, the MCO scored below 85% in the following categories (**Table 2**):

- Identification (General Population) (82.6%)

- Coordination of Services (DDD Population) (68.4%)

MCO Care Management Annual Assessment

Assessment Methodology

The Care Management Annual Assessment consisted of pre-audit review of documentation provided by Wellpoint New Jersey, Inc., as evidence of compliance of the standard under review; audit review of random file samples for the GP, DDD, and DCP&P Populations; interviews with key WPNJ staff via TEAMS held on May 29, 2024; and post audit evaluation of documentation and audit activities.

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

The documentation for the audit review was requested by IPRO on March 8, 2024, and documentation was received from the MCO on March 29, 2024. The documentation review occurred offsite at IPRO beginning on April 1, 2024. The audit review team was made up of Carla Zuccarello, Cynthia Steffe, Juana Torres, Lisa Panos, and Cynthia Santangelo. The Care Management assessment covered the period from January 1, 2023 to December 31, 2023.

During the audit review, the Plan had the opportunity to provide supplemental documentation as requested by IPRO.

Table 16 shows the rating scale used to determine compliance.

Table 16: Rating Scale for the Annual Care Management Assessment

Rating	Rating Methodology
Met	All parts within this element were met.
Not Met	Not all the required parts within the element were met.
N/A	This element is not applicable and will not be considered as part of the score.
Met Prior Review	This element was met in the previous review cycle.
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.

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

There are 30 elements in this review based on Contractual provisions, which are subject to review annually. WPNJ received an overall compliance score of 73% in 2024. In 2023, the MCO received a score of 73%. Review of the elements CM2, CM4, CM5, CM6, CM7, CM8, CM11, CM14, CM15, CM16, CM17, and CM19 was based on results from the Core Medicaid CM Audit conducted in 2024. Where appropriate, assessment of other elements was informed by both documents submitted for review and the file review. This audit evaluated Core Medicaid CM files for calendar year 2023 for three populations, namely the Enrollees under the General Population (GP), Division of Developmental Disabilities (DDD), and the Division of Child Protection and Permanency (DCP&P).

Care Management Assessment Results

Table 17 presents an overview of WPNJ's Care Management Annual Assessment results; **Table 18** presents Contract language and reviewer comments for deficient element(s); and **Table 19** presents Contract language for resolved deficiencies.

Table 17: Summary of Findings for Care Management Annual Assessment

Element	Met Prior Review	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM1	X	X	-	-	-	-	-
CM2	-	-	X	-	X	-	-
CM3	-	X	-	-	-	X	-
CM4	X	X	-	-	-	-	-
CM5	-	-	X	-	X	-	-
CM6	X	-	X	-	-	-	X
CM7	-	-	X	-	X	-	-
CM8	-	X	-	-	-	X	-
CM9	X	X	-	-	-	-	-
CM10	X	X	-	-	-	-	-
CM11	-	-	X	-	X	-	-
CM12	X	X	-	-	-	-	-
CM13	X	X	-	-	-	-	-
CM14	-	-	X	-	X	-	-
CM15	-	X	-	-	-	X	-
CM16	X	X	-	-	-	-	-
CM17	X	X	-	-	-	-	-
CM18a	X	X	-	-	-	-	-

Element	Met Prior Review	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM18c	X	X	-	-	-	-	-
CM18d	X	X	-	-	-	-	-
CM19	X	-	X	-	-	-	X
CM20	X	X	-	-	-	-	-
CM21	X	X	-	-	-	-	-
CM22	X	X	-	-	-	-	-
CM23	X	X	-	-	-	-	-
CM24	X	X	-	-	-	-	-
CM25	X	X	-	-	-	-	-
CM26	X	X	-	-	-	-	-
CM27	X	X	-	-	-	-	-
CM37[1]	X	-	X	-	-	-	X
TOTAL	**22**	**22**	**8**	**0**	**5**	**3**	**3**
Compliance Percentage		**73%**					

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

Table 18: Findings for Deficient Care Management Elements

Element	Contract Language	Reviewer Comments
CM2	**4.6.2.J** **Discharge Planning** The Contractor shall have procedures to ensure adequate and appropriate discharge planning, and to include Coordination of Services for Enrollees with special needs.	**In the 2024 CM file audit the MCO scored for the DCP&P Population Enrollees:** 50.0%- For Enrollees who were hospitalized, adequate discharge planning was performed (applies to new Enrollees).
CM5	**4.6.5.A** Use a multi-disciplinary team to manage the care of Enrollees needing Care Management. While Care Management may be performed by one qualified health professional (a nurse, social worker, physician, or other professional), the process will involve coordinating with different types of health services provided by multiple providers in all care settings, including the home, clinic and hospital. Refer to Care Management Workbook at NJMMIS.com https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf for Care Management Framework, Standards, Definitions and Tools.	**In the 2024 CM file audit the MCO scored for the DDD Population Enrollees:** 64.3%- For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee (applies to new Enrollees). 63.6%- For Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee

Element	Contract Language	Reviewer Comments
		services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee (applies to existing Enrollees).
CM6	**4.6.5.B.1** **Identification of Enrollees Who Need Care Management** The MCO must have effective systems, policies, procedures, and practices in place to identify any Enrollee in need of Care Management services. All New Enrollees, including Enrollees who were disenrolled from the MCO for at least six (6) months, (except for DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD) will be screened using an approved Initial Health Screen tool (IHS) to quickly identify their immediate physical and/or behavioral health care needs, as well as the need for more extensive screening. Any Enrollee identified as having potential Care Management needs will receive a detailed Comprehensive Needs Assessment (if deemed necessary by a healthcare professional), and ongoing care coordination and management as appropriate. All elements of the State approved IHS tool that appear in the Care Management Workbook must be included in the MCO's screening tool.	**In the 2024 CM file audit the MCO scored for the General Population Enrollees:** 66.7%- IHS was completed for the Enrollee within 45 days of MCO enrollment date (applies to new Enrollees). 80%- For Enrollees where no IHS was on file, aggressive outreach attempts were documented and were done within 45 days of the Enrollee's enrollment (applies to new Enrollees).
CM7	**4.6.5. B.2** **Comprehensive Needs Assessment (CNA)** The MCO will conduct an approved CNA on New Enrollees following the evaluation by a healthcare professional of their Initial Health Screen results; any Enrollee identified as having potential Care Management needs; as well as DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD. The goal of the CNA is to identify an Enrollee's Care Management needs to determine an Enrollee's level of care and develop a Care Plan. The CNA will be conducted by a healthcare professional, either telephonically or face-to-face, depending on the Enrollee's needs. All elements of the State approved CNA tool that appears in the Care Management Workbook must be included in the MCO assessment tool. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf	**In the 2024 CM file audit the MCO scored for the General Population Enrollees:** 75%- Initial outreach to complete the CNA was done timely, within 30 days of identification of CM needs. (30 days from IHS score 5 or greater; or IHS less than 5, no IHS, identification of CM needs through other sources (applies to new Enrollees). 69.2% The Comprehensive Needs Assessment was completed timely (within 30 days of identification of CM needs) (applies to new Enrollees). **In the 2024 CM file audit the MCO scored for the DDD Population Enrollees:** 61.3%- The Care Manager documented a level of Care Management for the Enrollee during the review period (applies to existing Enrollees).

Element	Contract Language	Reviewer Comments
CM11	**4.6.5.B.6** **Modify Care Plan Based on Analysis** Following analysis, the Care Manager will modify the strategies outlined in the Care Plan to achieve its stated goals and desired outcomes. The strategies must reflect any new information received, the Enrollee's current circumstances and healthcare status, and remain consistent with the abilities, desires and level of self-direction of the Enrollee and/or caregiver.	**In the 2024 CM file audit the MCO scored for the DDD Population Enrollees:** 80.0%- The Care Plan was updated upon a change in the Enrollee's care needs or circumstances (applies to existing Enrollees).
CM14	**4.6.2.O** **Continuity of Care** The Contractor's Quality Management Plan shall include a continuity of care system including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as preventive services and maintenance of function for Enrollees with special needs.	**In the 2024 CM file audit the MCO scored for the General Population Enrollees:** 0.0%- Aggressive outreach attempts were documented to confirm EPSDT status (applies to Enrollees where EPSDT exam is not up to date) (aged 0 through 20) (applies to existing Enrollees). 0.0%- The Care Manager sent EPSDT reminders (applies to existing Enrollees aged 0 through 20 where EPSDT exam is not up to date) (applies to existing Enrollees). 75%- Dental reminders were sent to Enrollees without a confirmed dental visit (aged 1 through 20) (applies to existing Enrollees). **In the 2024 CM file audit the MCO scored for the DDD Population Enrollees:** 66.7%- The Care Manager sent EPSDT reminders (applies to existing Enrollees aged 0 through 20 where EPSDT exam is not up to date). **In the 2024 CM file audit the MCO scored for the DCP&P Population Enrollees:** 50.0%- The Care Manager sent EPSDT reminders (applies to new Enrollees where EPSDT exam is not up to date aged 0 through 20).

Element	Contract Language	Reviewer Comments
CM19	**4.6.5.E** **Documentation** The Contractor shall document all contacts and linkages to medical and other services in the Enrollee's case files.	**In the 2024 CM file audit the MCO scored for the DDD Population Enrollees:** 48.0%- When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD) (applies to existing Enrollees). 81.8%- For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services (applies to new Enrollees). 77.8%- For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services (applies to existing Enrollees). **In the 2024 CM file audit the MCO scored for the DCP&P Population Enrollees**: 78.0%- When appropriate for the applicable Enrollees, Care Manager has contacted Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD) (applies to existing Enrollees) (applies to existing enrollees). 75%- For Enrollees demonstrating needs requiring coordination of services, the Care Manager coordinated needed care/services, actively linking the Enrollee to providers, medical services, residential, social, community, and other support services (applies to new Enrollees).

Element	Contract Language	Reviewer Comments
CM37	**4.7.4.A** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	**In the 2024 CM file audit the MCO received a Not Met for the General Population file universe submission.** The GP Enrollee file universe did not meet compliance with the MCO file instructions and audit specifications.

Table 19: Findings for Resolved Deficiencies for Care Management Elements

Element	Contract Language
CM3	**4.6.5.A** Apply systems, science, and information to identify Enrollees with potential Care Management needs and assist Enrollees in managing their health care more effectively with the goal of improving, maintaining, or slowing the deterioration of their health status.
CM8	**4.6.5.B.3** **Plan of Care to Address Needs Identified** Care Plan: Based on the CNA, the Care Manager will assign Enrollees to a care level, develop a Care Plan and facilitate and coordinate the care of each Enrollee according to his/her needs or circumstances. With input from the Enrollee and/or caregiver and PCP, the Care Manager must jointly create a Care Plan with short/long-term Care Management goals, specific actionable objectives, and measurable quality outcomes. The Care Plan should be culturally appropriate and consistent with the abilities and desires of the Enrollee and/or caregiver. Understanding that Enrollees' care needs and circumstances change, the Care Manager must continually evaluate the Care Plan to update and/or change it to accurately reflect the Enrollee's needs and level of care.
CM15	**4.6.5.D.1** The Contractor shall establish and operate a system to assure that a comprehensive treatment plan for every Enrollee will progress to completion in a timely manner without unreasonable interruption.

Comprehensive Recommendations

The following recommendations are for deficiencies identified in the Care Management Audit and Annual Assessment.

For the General Population:

1. CM6: WPNJ should ensure that the IHS is completed for the Enrollee within 45 days of MCO enrollment date (applies to New Enrollees).
2. CM6: WPNJ should ensure that for Enrollees where no IHS is on file, aggressive outreach attempts are documented and were done within 45 days of the Enrollee's enrollment (applies to new Enrollees).
3. CM7: WPNJ should ensure that initial outreach to complete the CNA is done timely, within 30 days of identification of CM needs. (30 days from IHS score 5 or greater; or IHS less than 5, no IHS, identification of CM needs through other sources) (applies to new Enrollees).
4. CM7: WPNJ should ensure that the Comprehensive Needs Assessment is completed timely (within 30 days of identification of CM needs) (applies to new Enrollees).

5. CM7 *File Audit:* WPNJ should perform initial outreach to complete the CNA (applies to new Enrollees).
6. CM8 *File Audit*: WPNJ should ensure that the Enrollee has a Care Plan on file during the review period (applies to new Enrollees).
7. CM14: For Enrollees aged 0 through 20, where the EPSDT exam is not up to date, WPNJ should ensure that the Care Manager makes aggressive outreach attempts to confirm EPSDT status (applies to existing Enrollees).
8. CM14: For Enrollees aged 0 through 20 where the EPSDT exam is not up to date, WPNJ should ensure EPSDT reminders are sent (applies to existing Enrollees).
9. CM14: For Enrollees aged 1 through 20 without a confirmed dental visit, WPNJ should ensure dental reminders are sent (applies to existing Enrollees).
10. CM37: WPNJ should establish an audit process to ensure compliance and accuracy with audit preparation and submissions to the EQRO.

For the DDD Population:

1. CM5: WPNJ should ensure that for Enrollees demonstrating needs requiring coordination of services within the MCO, Care Manager has demonstrated follow up with coordination of services (including, but not limited to, Enrollee services, pharmacy, disease management, hospital discharge planning, provider services, utilization management) as appropriate for the Enrollee (applies to new and existing Enrollees).
2. CM7: WPNJ should ensure that a level of Care Management is documented for the Enrollee during the review period (applies to existing Enrollees).
3. CM11: WPNJ should ensure that the Care Plan is updated upon a change in the Enrollee's care needs or circumstances (applies to existing Enrollees).
4. CM14: For Enrollees aged 0 through 20, WPNJ should ensure EPSDT reminders are sent when the Enrollees EPSDT exam is not up to date (applies to existing Enrollees).
5. CM19: When appropriate for the applicable Enrollees, WPNJ should ensure the Care Manager contacts Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD) (applies to existing Enrollees).
6. CM19: For Enrollees demonstrating needs requiring coordination of services, WPNJ should ensure that the Care Manager documents coordination of needed care/services and linkages to providers, medical services, residential, social, community, and other support services (applies to new and existing Enrollees).

For the DCP&P Population:

1. CM2: WPNJ should ensure for Enrollees who are hospitalized, adequate discharge planning is performed (applies to new Enrollees only).
2. CM7 *File Audit:* WPNJ should perform initial outreach to complete the CNA (applies new Enrollees).
3. CM8 *File Audit*: WPNJ should ensure that the Enrollee has a Care Plan on file during the review period (applies to existing Enrollees).
4. CM8 *File Audit*: WPNJ should ensure that the Enrollee's Care Plan is reviewed/monitored during the review period (applies to new Enrollees).
5. CM14: For Enrollees aged 0 through 20, WPNJ should ensure EPSDT reminders are sent when the Enrollees EPSDT exam is not up to date (applies to new Enrollees).
6. CM19: When appropriate for the applicable Enrollees, WPNJ should ensure the Care Manager contacts Case Managers from the DDD, DCF, CSOC, CMOs, Special Child Health Services (under DOH) and DCP&P; the family, primary care providers (PCPs), specialists, and the local health department (LHD) (applies to existing Enrollees).
7. CM19: For Enrollees demonstrating needs requiring coordination of services, WPNJ should ensure that the Care Manager documents coordination of needed care/services and linkages to providers, medical services, residential, social, community, and other support services (applies to new Enrollees).

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services, Office of MLTSS Quality Monitoring

MCO MLTSS HCBS Care Management Audit
Wellpoint New Jersey, Inc.

Review Period July 1, 2023 – June 30, 2024

January 2025

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ISO 9001:2015 CERTIFIED

Introduction

The purpose of the Managed Long-Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS), established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community Based Services (HCBS) and Institutionalization for Long-Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. The U.S. Department of Health and Human Services (HHS) declared an end to the Public Health Emergency (PHE) for COVID-19 on May 11, 2023. The State issued Covid-19 flexibilities related to specific MLTSS Care Management activities ended prior to this review period (July 1, 2023 to June 30, 2024), except for the NJ DHS, Division of Aging Services (DoAS), *Temporary Waiver of Clinical Eligibility Requirements for MLTSS Enrollment for MCO Members in a Community Setting.* Effective July 5, 2023 the use of the Screen for Community Services (SCS) as presumptive eligibility was discontinued.

The populations included in this audit were Members who met eligibility requirements for MLTSS and were receiving HCBS services by residing in the community or Community Alternative Residential Setting (CARS), for at least six consecutive months within the review period July 1, 2023 to June 30, 2024.

Annually, DMAHS evaluates the MCO performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the NJ FamilyCare Contracts (Article 9), dated July 2023 and January 2024. A representative sample of files were selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities, and post-audit activities.

1. Pre-Audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology, necessary source documents, contract references, and the Division of Aging Services (DoAS), Office of Community Choice Options (OCCO) new contract requirements for MLTSS Care Management. Effective November 15, 2023, as part of the NJ Choice Assessment system, MCOs are required to complete a NJ specific Options Counseling Summary (OCS) form, whereas the Interim Plan of Care (IPOC) was no longer contractually required.

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

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

Population Selection

The sample was determined by using the following capitation codes to identify MLTSS HCBS enrollment presented in **Table 1** and applying the sampling methodology described in **Table 2**.

Table 1. Capitation Codes

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

The sampling methodology as shown in **Table 2** resulted in the selection of 156 cases for Wellpoint New Jersey, Inc. (WPNJ), including an oversample.

Table 2. Sampling Methodology

Subpopulations	Criteria
Group C: Members New to Managed care and Newly Eligible for MLTSS between 7/1/2023 and 6/30/2024.	• The Member must have been initially enrolled in MLTSS HCBS between 7/1/2023 and 1/1/2024. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2024 in the *same* MCO with no gaps in enrollment.
Group D: Current Medicaid Managed care Members enrolled in MLTSS between 7/1/2023 and 6/30/2024.	• The Member must have been initially enrolled in MLTSS HCBS between 7/1/2023 and 1/1/2024. • The Member must have been enrolled in MLTSS HCBS for the entire period from the initial MLTSS HCBS enrollment through 6/30/2024 in the *same* MCO with no gaps in enrollment. • On the first day of the month prior to the initial MLTSS HCBS enrollment, the Member was enrolled in the *same* Medicaid MCO as the MLTSS HCBS MCO.
Group E: Current Medicaid Managed care Members enrolled in MLTSS prior to 7/1/2023 and continuously enrolled in MLTSS through 6/30/2024.	• The Member must have been initially enrolled in MLTSS HCBS prior to 7/1/2023. • The Member must have remained enrolled in MLTSS HCBS through 6/30/2024 in the *same* MCO with no gaps in enrollment.
Performance Measure #9a Enhancement	• A sample of 30 MLTSS HCBS Members across subgroups C, D, and E, identified on the NJ Choice Assessment Data list with assessment code 3, 4, and 5 will be included in the base sample abstracted from the universe. All MLTSS HCBS Members were included if the MCO has less than 30 Members who meet eligibility criteria.

MLTSS HCBS subpopulations were identified depending on different enrollment criteria. A stratified methodology was used to randomly select 100 MLTSS HCBS Members across subgroups C and D, and 30 MLTSS HCBS Members in subgroup E as a base sample. A 20% oversample across subgroups C and D, and subgroup E was drawn for substitution of exclusions.

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

All MLTSS HCBS Members were included if there were less than 100 Members across subgroups C and D, or less than 30 Members in subgroup E. Members could only be excluded by the MCO if they could provide evidence that the Member did not meet eligibility requirements. An oversample was selected for the MCO to replace any excluded files, as well as ensure an adequate denominator to evaluate Performance Measures.

Introductory E-Mail

IPRO sent an Introductory E-Mail to the MCO prior to the scheduled offsite audit including:

- Confirmation of the dates for the audit.
- Description of the sample.
- File listings identifying the files that needed to be available at the time of the offsite audit.

2. Audit Activities

IPRO reviewers conducted the file reviews over a five-week period. Reviewer inter-rater reliability was maintained using the standardized audit tool, and ongoing communication and coordination among the review team. Electronic files were prepared by the MCO for review.

3. Post-Audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the 156 cases selected for WPNJ, 138 Member files were reviewed and 130 were included in the results.

Description	Group C	Group D	Group E	Subtotal
Total Number of Files Reviewed	51	56	31	138
Exclusions	3	4	1	8
Number of Files included in Results	48	52	30	130

Population-specific findings are presented in **Table 3**, which contains aggregate scores based on the results of selected review questions within each review category: Assessment, Member Outreach, Face-to-Face Visits, Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans), Ongoing Care Management, and Gaps in Care/Critical Incidents. Rates for each subpopulation and a combined score calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. Population results, as shown in **Table 3**, were calculated using the sum of the numerators divided by the sum of the denominators for determinations included in each category for each population.

WPNJ's audit results for the combined MLTSS sample ranged from 72.0% to 100.0% across all three (3) populations for the six (6) audit categories.

Table 3. Results by Category

Determination by Category	July 1, 2023 – June 30, 2024			
	Group C	Group D	Group E[2]	Combined[3]
Assessment	100.0%	100.0%	98.3%	99.5%
Member Outreach	95.8%	84.6%	--	90.0%
Face-to-Face Visits	98.1%	98.2%	99.1%	98.4%
Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans)[1]	98.1%	96.8%	99.8%	98.0%
Ongoing Care Management	84.4%	79.9%	72.0%	79.6%
Gaps in Care/Critical Incidents	100.0%	96.1%	100.0%	98.4%

[1]Initial Plan of Care is assessed for Group C and Group D Members. Ongoing Plans of Care are assessed for Group E Members as they are not new to MLTSS. Back-up Plans are assessed for Group C, D, and E Members.
[2]Member Outreach is not evaluated for Members in Group E as they are not new to the MLTSS.
[3]Calculated as an aggregate score by combining elements applicable to each category.

Members New to Managed Care and Newly Eligible for MLTSS (Group C)

A total of 51 files were reviewed for new Members enrolled in Managed Care and newly eligible for MLTSS (Group C). There were 3 files excluded. All 48 files were further reviewed for compliance in 6 categories. There were 13 Members residing in CARS.

Assessment	**N**	**D**	**Rate**
The MCO requested an NJ Choice Assessment (NJCA) for the Member from OCCO.*	22	48	45.8%
MCO requested an NJCA for the Member from OCCO within fifteen (15) business days of the effective date of the Member's enrollment (for this population, MCOs have the option of requesting a New Jersey Choice Assessment (NJCA) from the Office of Community Choice Options (OCCO).*	22	22	100.0%
OCCO response was received within 5 business days of the MCO request.*	6	22	27.3%
The MCO received an NJCA from OCCO within 5 business days of OCCO's notification that is considered valid and current.*	4	22	18.2%
OCCO completed the NJCA which is valid during the review period.*	17	48	35.4%
The MCO completed the NJCA with the Member.	31	31	100.0%

*Not included in aggregate score calculation

Member Outreach	**N**	**D**	**Rate**
Initial outreach was completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.	46	48	95.8%

Face-to-Face Visits	N	D	Rate
Member participated in all face-to-face visits.*	48	48	100.0%
Member was unable to participate in the face-to-face visit to cognitive impairment, a minor child, and/or the Member has a legal guardian.*	0	0	N/A
Member or authorized representative participated in the onsite visit with the Care Manager.*	0	0	N/A
Options Counseling was provided to the Member.[1]	31	31	100.0%
Member was offered the participant direction option.[3]	35	35	100.0%
Member chose to participate in participant direction (excludes Members residing in CARS).*	15	35	42.9%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.[3]	13	15	86.7%
Member had a completed and signed Interim Plan of Care (IPOC) or Options Counseling Summary (OCS) form on file.[1, 2]	31	31	100.0%
A cost effective analysis was completed during the review period.	47	48	97.9%
Member reached or exceeded 85% of the annual cost thresholds (ACT).*	0	47	0.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period, had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

*Not included in aggregate score calculation
[1] Denominator excludes Members where OCCO completed the New Jersey Choice Assessment
[2]Compliance was evaluated for IPOCs completed before November 15, 2023 or OCS form completed on or after November 15, 2023
[3]Denominator excludes Members residing in CARS
N/A: Not Applicable

Initial Plan of Care (Including Back-up Plans)	N	D	Rate
Member had a completed and signed Initial Plan of Care on file, that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	39	48	81.2%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	48	48	100.0%
Member refused to be assessed for PCA services (excludes Members residing in CARS).*	7	35	20.0%
Member was assessed for PCA services (excludes Members residing in CARS).*	28	28	100.0%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.[1]	28	28	100.0%
Member required another PCA assessment due to changes in condition (excludes Members in CARS).*	4	28	14.3%
Member was re-assessed for PCA due to changes in condition.[1]	4	4	100.0%

Member had a Plan of Care and NJCA on file during the review period.*	48	48	100.0%
Plans of Care for MLTSS Members are aligned with Member needs as identified during the NJCA.	48	48	100.0%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	48	48	100.0%
Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	48	48	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	48	48	100.0%
Members who required a Back-up Plan, had a completed and signed Back-up Plan using the State mandated form.[1]	34	35	97.1%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	34	34	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	33	34	97.1%
Member service preference levels were documented in the Back-up Plan.[1]	34	34	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	32	34	94.1%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	35	35	100.0%
Member file included a Member Rights and Responsibilities statement signed by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	48	48	100.0%
Care Manager educated the Member on how to file a grievance and/or an appeal.	48	48	100.0%
Members residing in their community home had a risk assessment completed that included documentation of whether a positive risk was identified or not.[1]	35	35	100.0%
Member required a Risk Management Agreement (excludes Members residing in CARS).*	35	35	100.0%
Members who were identified as having a positive risk, had a signed Risk Management Agreement with all components.[1]	35	35	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS

Ongoing Care Management	N	D	Rate
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).[1]	30	35	85.7%
Member experienced issues that impeded access to care.*	4	48	8.3%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	4	4	100.0%
Member had a documented face-to-face visit to review Member placement and services during the review period.	48	48	100.0%
Review of Member's placement and services occurred timely (an ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	31	48	64.6%
Member required a change in Plan of Care based on an increase or reduction of services.*	9	48	18.8%
Member files that indicated a change from the initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed and was provided with a copy of the Plan of Care.	6	9	66.7%
Member file indicates disagreement with the Plan of Care.*	0	3	0.0%
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	48	0.0%
A face-to-face visit was conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition, or well-being.	0	0	N/A
Member was discharged to an HCBS setting during the review period.*	6	48	12.5%
Member refused the 10 day post discharge onsite visit.*	0	6	0.0%
Care Manager completed a 10 day post discharge telephonic visit.*	0	0	N/A
For Members who were discharged to an HCBS setting the onsite review occurred within ten (10) days of discharge.	6	6	100.0%
Member was discharged to his/her own home and in home services were in place in a timely manner.	6	6	100.0%
Member experienced a significant change in condition requiring the Plan of Care to be amended.*	4	48	8.3%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed by the Member and/or authorized representative.	4	4	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS

N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation the Care Manager reviewed the process for immediately reporting gaps in service delivery with the Member.	35	35	100.0%
Member reported a gap in service delivery (excludes Members residing in CARS)*	2	35	5.7%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	2	2	100.0%
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	48	48	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS

Members Currently Enrolled in Managed Care and Newly Eligible for MLTSS (Group D)

A total of 56 files were reviewed for Members currently enrolled in Managed Care and newly eligible for MLTSS (Group D). There were 4 files excluded. All 52 files were further reviewed for compliance in all 6 categories. There was 1 Member residing in CARS.

Assessment	*N*	*D*	*Rate*
Member had a Screen for Community Services (SCS) tool completed.*	44	52	84.6%
Member enrolled in MLTSS on an SCS Waiver.*	0	44	0.0%
The NJ Choice Assessment (NJCA) was completed within 30 days of a referral to MLTSS.	44	44	100.0%
The MCO completed the NJCA with the Member.	52	52	100.0%

*Not included in aggregate score calculation

Member Outreach	N	D	Rate
Initial outreach was completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.	44	52	84.6%

Face-to-Face Visits	N	D	Rate
Member participated in all face-to-face visits.*	52	52	100.0%
Member was unable to participate in the face-to-face visit due to cognitive impairment, a minor child, and/or the Member had a legal guardian.*	0	0	N/A
Member or authorized representative participated in the onsite meeting with the Care Manager.*	0	0	N/A
Options Counseling was provided to the Member.	52	52	100.0%
Member had PPP prior to MLTSS enrollment.*	0	51	0.0%

Member had PPP pending prior to MLTSS enrollment.*	2	51	3.9%
Member was offered the participant direction option.[1]	48	49	98.0%
Member chose to participate in participant direction (excludes Members residing in CARS).*	19	48	39.6%
Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.[1]	19	19	100.0%
Member had a completed and signed Interim Plan of Care (IPOC) or Options Counseling Summary (OCS) form on file.[2]	52	52	100.0%
A cost effective analysis was completed during the review period.	49	52	94.2%
Member reached or exceeded 85% of the annual cost threshold (ACT).*	0	49	0.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period, had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS
[2]Compliance was evaluated for IPOCs completed before November 15, 2023 or OCS form completed on or after November 15, 2023
N/A: Not Applicable

Initial Plan of Care (Including Back-up Plans)	N	D	Rate
Member had a completed and signed Initial Plan of Care on file, that was provided to the Member and/or Member representative within 45 calendar days of enrollment into the MLTSS program.	43	52	82.7%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	52	52	100.0%
Member had PCA services prior to MLTSS enrollment.*	11	51	21.6%
Member refused to be assessed for PCA services (excludes Members residing in CARS).*	2	40	5.0%
Member was assessed for PCA services (excludes Members residing in CARS).*	37	38	97.4%
Member was assessed for PCA services within 45 days of enrollment into MLTSS.[1]	35	37	94.6%
Member required another PCA assessment due to changes in condition (excludes Members residing in CARS).*	6	37	16.2%
Member was re-assessed for PCA due to changes in condition.[1]	6	6	100.0%
Member had a Plan of Care and NJCA on file during the review period.*	50	52	96.2%
Plans of Care for MLTSS Members are aligned with Member needs as identified during the NJCA.	49	50	98.0%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	50	50	100.0%

Initial Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	50	50	100.0%
Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	50	50	100.0%
Members who required a Back-up Plan, had a completed and signed Back-up Plan using the State mandated form.[1]	49	51	96.1%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	49	49	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	48	49	98.0%
Member service preference levels were documented in the Back-up Plan.[1]	49	49	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	45	49	91.8%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	49	51	96.1%
Member file included a Member Rights and Responsibilities statement signed by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	50	52	96.2%
The Care Manager educated the Member on how to file a grievance and/or an appeal.	50	52	96.2%
Members residing in their community home had a risk assessment completed that included documentation of whether a positive risk was identified or not.[1]	49	51	96.1%
Member required a Risk Management Agreement (excludes Members residing in CARS).*	49	49	100.0%
Members who were identified as having a positive risk, had a signed Risk Management Agreement with all components.[1]	49	49	100.0%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS

Ongoing Care Management	**N**	**D**	**Rate**
Member had services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modification are exempt from the 45 calendar day standard and are not included in this calculation).[1]	42	51	82.4%
Member experienced issues that impeded access to care.*	3	52	5.8%

Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	3	3	100.0%
Member had a documented face-to-face visit to review Member placement and services during the review period.	50	52	96.2%
Review of Member's placement and services occurred timely (an ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	29	50	58.0%
Member required a change in Plan of Care based on an increase or reduction of services.*	8	52	15.4%
Member files that indicated a change from the Initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed and was provided with a copy of the Plan of Care.	8	8	100.0%
Member file indicates disagreement with the Plan of Care.*	0	0	N/A
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service) were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	52	0.0%
Face-to-face visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition, or well-being.	0	0	N/A
Member was discharged to an HCBS setting during the review period.*	11	52	21.2%
Member refused the 10 day post discharge onsite visit.*	0	11	0.0%
Care Manager completed a 10 day post discharge telephonic visit.*	0	0	N/A
For Members who were discharged to an HCBS setting the onsite review occurred within ten (10) days of discharge.	7	11	63.6%
Member was discharged to his/her own home and in home services were in place in a timely manner.	9	11	81.8%
Member experienced a significant change in condition requiring the Plan of Care to be amended.*	8	52	15.4%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed by the Member and/or authorized representative.	7	8	87.5%

*Not included in aggregate score calculation

[1]Denominator excludes Members residing in CARS

N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	49	51	96.1%
Member reported a gap in service delivery (excludes Members residing in CARS).*	0	51	0.0%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	0	0	N/A
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	50	52	96.2%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS
N/A: Not Applicable

Members Enrolled in Managed Care and MLTSS Prior to the Review Period (Group E)

A total of 31 files were reviewed for the Members enrolled in Managed Care and MLTSS prior to the review period (Group E). There was 1 file excluded. The Member Outreach category is not assessed for Members in Group E. All 30 files were reviewed for compliance in 5 categories. There were 2 Members residing in CARS.

Assessment	*N*	*D*	*Rate*
The NJ Choice Assessment (NJCA) was due during the review period.*	30	30	100.0%
The MCO completed the NJCA with the Member.	30	30	100.0%
Member had an NJCA completed to reassess clinical eligibility for MLTSS within 11 to 13 months from the last NJCA authorized by OCCO.	29	30	96.7%

*Not included in aggregate score calculation

Face-to-Face Visits	N	D	Rate
Member participated in all face-to-face visits.*	30	30	100.0%
Member was unable to participate in the face-to-face visit due to cognitive impairment, a minor child, and/or the Member had a legal guardian.*	0	0	N/A
Member or authorized representative participated in the onsite visit with the Care Manager.*	0	0	N/A
Options Counseling was provided to the Member.	30	30	100.0%
Member had PPP prior to review period (excludes Members residing in CARS).*	12	28	42.9%
Member had PPP pending prior to review period (excludes Members residing in CARS).*	0	28	0.0%
Member was offered the participant direction option.[1]	16	16	100.0%
Member chose to participate in participant direction (excludes Members residing in CARS).*	1	16	6.2%

Members who selected the option of participant direction, application packages were submitted within thirty (30) business days of completion.[1]	1	1	100.0%
Member had a completed and signed Interim Plan of Care (IPOC) or Options Counseling Summary (OCS) form on file.[2]	30	30	100.0%
A cost effective analysis was completed during the review period.	29	30	96.7%
Member reached or exceeded 85% of the annual cost thresholds (ACT).*	0	29	0.0%
Members' annual cost thresholds (ACT) that were at or above 85% with significant changes during the audit period, had documentation that a pre-call meeting and IDT meeting were requested or held within the appropriate timeframes.	0	0	N/A

*Not included in aggregate score calculation

[1]Denominator excludes Members in CARS

[2]Compliance was evaluated for IPOCs completed before November 15, 2023 or OCS form completed on or after November 15, 2023

N/A: Not Applicable

Ongoing Plans of Care (Including Back-up Plans)	N	D	Rate
Plan of Care reassessment for MLTSS Members was conducted within 30 days of annual LOC re-determination.	29	30	96.7%
Member file included documentation of coordination with the Member's primary care physician (PCP) regarding the development of the care plan.	30	30	100.0%
Member file had documentation to demonstrate contact with the Members' HCBS providers at least annually to discuss the providers' reviews of the Member's needs and status and quarterly for Members receiving skilled nursing care, treatment for traumatic brain injury or behavioral health services.	30	30	100.0%
Member had PCA services prior to the review period (excludes Members residing in CARS).*	17	28	60.7%
Member refused to be assessed for PCA services (excludes Members residing in CARS).*	0	11	0.0%
Member was assessed for PCA services (excludes Members residing in CARS).*	11	11	100.0%
Member required another PCA assessment due to changes in condition (excludes Members in CARS).*	3	11	27.3%
Member was re-assessed for PCA due to changes in condition.[1]	3	3	100.0%
Member had a Plan of Care and NJCA on file during the review period.*	30	30	100.0%
Plans of Care for MLTSS Members are aligned with Member needs as identified during the NJCA.	30	30	100.0%
There is documentation in the file that the Member was included in the development of his/her goals and the goals met the Member's needs/strengths and support systems.	30	30	100.0%
Member's Plan of Care contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	30	30	100.0%

Member files had documentation to reflect all of the following; a Member-Centric approach demonstrating involvement of the Member in the development and modification to the agreed-upon goals; this includes the requirement that the Member and/or Member representative, as applicable, was present during the development of his/her goals, offered options, given the opportunity to express his/her needs or preferences, and that these needs or preferences were acknowledged and addressed in the Plan of Care.	30	30	100.0%
Members who required a Back-up Plan, had a completed and signed Back-up Plan using the State mandated form.[1]	28	28	100.0%
Back-up Plan included actions that a Member should take to report any gaps in care to the Care Manager.[1]	28	28	100.0%
Back-up Plan included telephone numbers for the provider and/or the MCO.[1]	28	28	100.0%
Member service preference levels were documented in the Back-up Plan.[1]	28	28	100.0%
Members who were enrolled long enough for a quarterly update and had services that required a Back-up Plan, had the Back-up Plan reviewed with the Member at least on a quarterly basis.[1]	28	28	100.0%
There is documentation that the Care Manager counseled the Member on disaster/emergency planning during the review period.[1]	28	28	100.0%
Member file included a Member Rights and Responsibilities statement signed by the Member and dated during the review period, stating that the Member had received his/her rights and responsibilities in writing, that these rights and responsibilities had been explained to the Member, and that the Member understood them.	30	30	100.0%
Care Manager educated the Member on how to file a grievance and/or an appeal.	30	30	100.0%
Care Manager completed an Annual Risk Assessment for the Member.[1]	28	28	100.0%
Members who were identified as having a positive risk (excludes Members residing in CARS).*	28	28	100.0%
IPRO identified the Member as having a potential risk during the review period that the Care Manager failed to identify.[1,2]	0	0	N/A[2]
Members who were identified as having a positive risk, had a signed Risk Management Agreement with all components.[1]	28	28	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members in CARS
[2]Percentage rate is indicative of compliant cases
N/A: Not Applicable

Ongoing Care Management	**N**	**D**	**Rate**
Member experienced issues that impeded access to care.*	5	30	16.7%
Member file with documented issues that impeded access to care contained sufficient documentation to demonstrate Care Manager follow-up to resolve the issue by the end of the review period.	5	5	100.0%
Member had a documented face-to-face visit to review Member placement and services during the review period.	30	30	100.0%
Review of Member's placement and services occurred timely (an ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).	5	30	16.7%

Member required a change in Plan of Care based on an increase or reduction of services.*	11	30	36.7%
Member files that indicated a change from the Initial Plan of Care had documentation that the Member's Plan of Care was updated and/or reviewed, that the Member agreed with the Plan of Care, and that the Member signed and was provided with a copy of the Plan of Care.	10	11	90.9%
Member file indicated a disagreement with the Plan of Care.*	0	1	0.0%
Members with documentation of a disagreement with the assessment and/or authorization of placement/service (including the amount and/or frequency of a service), were counseled by the Care Manager about a written notice of action that explains the Member's right to file an appeal.	0	0	N/A
Member required a face-to-face visit for an urgent/emergent need within 24 hours.*	0	30	0.0%
Face-to-face visits were conducted by a Care Manager within 24 hours for an urgent/emergent situation that was identified related to a Member's needs, condition, or well-being.	0	0	N/A
Member was discharged to an HCBS setting during the review period.*	10	30	33.3%
Member refused the 10 day post discharge onsite visit.*	0	10	0.0%
Care Manager completed a 10 day post discharge telephonic visit.*	0	0	N/A
For Members who were discharged to an HCBS setting the onsite review occurred within ten (10) days of discharge.	9	10	90.0%
Member was discharged to his/her own home and in home services were in place in a timely manner.	8	10	80.0%
Member experienced a significant change in condition requiring the Plan of Care to be amended.*	8	30	26.7%
Member files that indicated a significant change in Member condition had documentation that the Member's Plan of Care was amended, reviewed, and signed by the Member and/or authorized representative.	8	8	100.0%
Member had a change in placement occur during the review period.*	3	30	10.0%
Member had a change in placement indicated and there was documentation of discussion with the Member before the change was made.	2	3	66.7%

*Not included in aggregate score calculation
N/A: Not Applicable

Gaps in Care/Critical Incidents	N	D	Rate
Members receiving MLTSS services and not residing in community alternative residential settings (CARS) during this review period had documentation of the Care Manager reviewing the process for immediately reporting gaps in service delivery with the Member.	28	28	100.0%
Member reported a gap in service delivery (excludes Members in CARS).*	1	28	3.6%
Members who had a reported gap in service had documentation that the MCO contacted the Member immediately to resolve the issue related to the gap in service.[1]	1	1	100.0%
Member file had documentation that the Care Manager explained the Member's rights and responsibilities under the MLTSS program, including the procedures for filing a grievance and/or an appeal and how to report a critical incident.	30	30	100.0%

*Not included in aggregate score calculation
[1]Denominator excludes Members residing in CARS

Performance Measures

Population-Specific findings are presented in **Table 4**, which present results on the following MLTSS Performance Measures: #8 (Plans of Care established within 45 days of MLTSS enrollment), #9 (Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination), #9a (Plan of Care for MLTSS Members amended based on change of Member condition), #10 (Plans of Care for MLTSS Members are aligned with Member needs identified during the NJ Choice Assessment), #11 (Plans of Care for MLTSS Members are developed using "Person-Centered Principles"), #12 (MLTSS Home and Community Based Services (HCBS) Plans of Care that include a Back-up Plan), and #16 (MCO provided training to MLTSS Member on identifying/reporting Critical Incidents).

Population results, as shown in **Table 4**, are rates calculated as the number of "Yes" determinations divided by the sum of the "Yes" plus "No" determinations. **Table 4** shows the results of the 2023-2024 audit findings. Overall, WPNJ's audit results ranged from 82.0% to 100.0% across all groups for seven (7) Performance Measures for the current review period.

Table 4. Results of MLTSS Performance Measures

Performance Measure	Group[1]	Numerator	Denominator	Rate
#8. Plans of Care established within 45 days of MLTSS enrollment.	Group C	39	48	81.2%
	Group D	43	52	82.7%
	Group E[4]			
	Total	82	100	82.0%
#9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination.	Group C[5]			
	Group D[5]			
	Group E	29	30	96.7%
	Total	29	30	96.7%
#9a. Plan of Care for MLTSS Members amended based on change of Member condition.[2]	Group C	4	4	100.0%
	Group D	7	8	87.5%
	Group E	8	8	100.0%
	Total	19	20	95.0%
#10. Plans of Care for MLTSS Members are aligned with Member needs identified during the NJ Choice Assessment.	Group C	48	48	100.0%
	Group D	49	50	98.0%
	Group E	30	30	100.0%
	Total	127	128	99.2%

#11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles."	Group C	48	48	100.0%
	Group D	50	50	100.0%
	Group E	30	30	100.0%
	Total	128	128	100.0%
#12. MLTSS Home and Community-Based Services (HCBS) Plans of Care that include a Back-up Plan.[3]	Group C	34	35	97.1%
	Group D	49	51	96.1%
	Group E	28	28	100.0%
	Total	111	114	97.4%
#16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents.	Group C	48	48	100.0%
	Group D	50	52	96.2%
	Group E	30	30	100.0%
	Total	128	130	98.5%

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

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

[3]Members in Community Alternative Residential Settings (CARS) are excluded from this measure

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

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

Discussion

Limitations

None.

Conclusions and Recommendations

Population-Specific conclusions and recommendations are presented by category below.

Assessment

Across all three groups, the MCO had a combined score of 99.5% in the Assessment category.

Group	7/1/23 to 6/30/24
Group C	100.0%
Group D	100.0%
Group E	98.3%
Combined	99.5%

Member Outreach

Across groups, the MCO had a combined score of 90.0% in the Member Outreach category.

Group	7/1/23 to 6/30/24
Group C	95.8%
Group D	84.6%
Group E[1]	--
Combined	90.0%

[1]Member Outreach is not assessed for Members in Group E because Group E Members are not new to MLTSS

Opportunities for Improvement for elements at the group level in the *Member Outreach* category include the following:

- **Group D:** WPNJ should ensure that Initial outreach is completed to schedule a face-to-face visit for the purpose of creating an individualized and comprehensive Plan of Care (POC) within five (5) business days from the effective date of MLTSS enrollment.

Face-to-Face Visits

Across all three groups, the MCO had a combined score of 98.4% in the Face-to-Face Visits category.

Group	7/1/23 to 6/30/24
Group C	98.1%
Group D	98.2%
Group E	99.1%
Combined	98.4%

Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans)

Across all three groups, the MCO had a combined score of 98.0% in the Initial Plan of Care/Ongoing Plans of Care (Including Back-up Plans) category.

Group	7/1/23 to 6/30/24
Group C	98.1%
Group D	96.8%
Group E	99.8%
Combined	98.0%

Ongoing Care Management

Across all three groups, the MCO had a combined score of 79.6% in the Ongoing Care Management category.

Group	7/1/23 to 6/30/24
Group C	84.4%
Group D	79.9%
Group E	72.0%
Combined	79.6%

Opportunities for Improvement for elements at the group level in the *Ongoing Care Management* category include the following:

- **Group C, Group D, and Group E:** WPNJ should ensure that review of Member's placement and services occurs timely (An ongoing face-to-face visit to review Member placement and services should occur at least every 90 days for Members in the community setting and at least every 180 days for Members in CARS from the date of the initial visit).

- **Group C and Group D:** WPNJ should ensure the Member has services in place within 45 calendar days of enrollment into MLTSS (residential and vehicle modifications are exempt from the 45 calendar day standard).

- **Group C:** WPNJ should ensure that Member files that indicate a change from the Initial Plan of Care have documentation that the Member's Plan of Care is updated and/or reviewed, that the Member agrees with the Plan of Care, and that the Member signs and is provided with a copy of the Plan of Care.

- **Group D:** WPNJ should ensure for Members who are discharged to a HCBS setting the onsite review occurs within ten (10) days of discharge.

- **Group D and Group E:** For the Member discharged to his/her own home, WPNJ should ensure in home services are in place timely.

- **Group E:** For Members with a change in placement indicated, WPNJ should ensure there is documentation of a discussion with the Member before the change is made.

Gaps in Care/Critical Incidents

Across all three groups, the MCO had a combined score of 98.4% in the Gaps in Care/Critical Incidents category.

Group	7/1/23 to 6/30/24
Group C	100.0%
Group D	96.1%
Group E	100.0%
Combined	98.4%

Performance Measures

Overall, the MCO scored below 86% in one (1) of the seven (7) Performance Measures.

PM #8: Plans of Care established within 45 days of MLTSS enrollment.

Opportunities for Improvement at the group level in MLTSS Performance Measures *for scores less than 86%* include the following:

- **Group C and Group D:** WPNJ should ensure the Initial Plan of Care is completed and a copy mailed to the Member/authorized representative within 45 days of MLTSS enrollment.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
Managed Long Term Services and Supports (MLTSS)

2024 Annual Assessment Review of Care Management
Wellpoint New Jersey, Inc.

Review Period - July 1, 2023 to June 30, 2024
December 2024

Corporate Headquarters
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Introduction

The NJ Family Care Managed Care Program, administered by the NJ Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), provides healthcare benefits for certain groups of children and adults with low-to-moderate incomes. The program provides health coverage to children, pregnant women, single adults, childless couples, aged, blind, and disabled individuals, and individuals qualified for long-term care services.

Background

The purpose of the Managed Long-Term Services and Supports (MLTSS) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS CM program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure "That services were provided" to special needs members who met MLTSS eligibility requirements as specified in Article 9.

Annually, DMAHS evaluates Managed Care Organization (MCO) performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Assessment Methodology

The review consisted of pre-offsite review of documentation provided by Wellpoint New Jersey, Inc. (WPNJ) as evidence of compliance of the standards under review; interviews with key WPNJ staff (held via Teams meeting on December 4, 2024) and post-offsite evaluation of documentation and offsite activities.

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

The offsite review of documentation was requested by IPRO on July 26, 2024, and received from the MCOs on August 9, 2024. The documentation review occurred offsite at IPRO beginning on August 12, 2024. The IPRO review team consisted of Carla Zuccarello, Karen Halley, and Cynthia Santangelo. The Care Management assessment covered the period from July 1, 2023 to June 30, 2024. The MCOs were advised to provide both MLTSS and FIDE SNP/MLTSS documents if their Care Management documentation differed between MLTSS and FIDE SNP/MLTSS.

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

Table 1: All MLTSS CM elements are subject to be reviewed annually regardless of a prior year Met, and therefore be considered full reviews every year.

Table 1: Rating Scale for the MCO (MLTSS) Annual Assessment Review of Care Management

Rating	Rating Methodology	Review Type
Met in Prior Review	This element was met in the previous review cycle.	Full, Partial
Met	All parts within this element were met.	Full, Partial
Not Met	Not all required parts within the element were met.	Full, Partial
N/A	This element is not applicable and will not be considered as part of the score.	Full, Partial
Deficiency Status: Prior	This element was not met in the previous review cycle and remains deficient in this review cycle.	Full, Partial
Deficiency Status: Resolved	This element was not met in the previous review cycle but was met in the current review cycle.	Full, Partial
Deficiency Status: New	This element was met in the previous review cycle but was not met in the current review cycle.	Full, Partial

Report Organization

This report provides findings for the MLTSS Care Management and Continuity of Care document submission portion of the 2024 MLTSS Care Management review.

A table is presented which provides the number of elements under review, the number *Met*, *Not Applicable* (*N/A*), and the number *Not Met* for this review. Percentages are based on the total number of applicable elements in the standard. Credit is given for receiving a *Met* finding in the current review. Contract language and reviewer comments are provided for *Not Met* elements. Contract language is provided for *N/A* elements and resolved deficiencies.

Following this summary, Strengths, Recommendations and Findings for Improvement are reported where applicable. Recommendations relate to those elements that are deficient and must be addressed by the Plan. Findings for Improvement relate to suggestions by the IPRO review team to strengthen current processes.

Care Management and Continuity of Care

The Care Management and Continuity of Care review category examines if the MCO has an effective care and case management service structure. This structure includes written policies, procedures, processes, and systems to identify, assess and manage its member population in care and case management program(s). This review category also examines whether the MCO has developed and implemented MLTSS Care Management Programs for enrollees who may benefit from these services in accordance with State requirements.

There are 10 contractual provisions in this category. WPNJ received an overall compliance score of 100% in 2024. In 2023, the MCO received a score of 100% for this category. **Table 1a** presents an overview of the results.

Table 1a: Summary of Findings for MLTSS Care Management and Continuity of Care

Element	Met Prior Year	Met	Not Met	N/A	Deficiency Status		
					Prior	Resolved	New
CM18b	X	X	-	-	-	-	-
CM28	X	X	-	-	-	-	-
CM29	X	X	-	-	-	-	-
CM30	X	X	-	-	-	-	-
CM31	X	X	-	-	-	-	-
CM32	X	X	-	-	-	-	-
CM34	X	X	-	-	-	-	-
CM36	X	X	-	-	-	-	-
CM37	X	X	-	-	-	-	-
CM38	X	X	-	-	-	-	-
TOTAL	**10**	**10**	**0**	**0**	**0**	**0**	**0**
Compliance Percentage		**100%**					

Strengths

None

Recommendations

None

Findings for Improvement

None

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services
Office of MLTSS Quality Monitoring

MCO MLTSS Nursing Facility/Special Care Nursing Facility Ancillary Review
Compliance Evaluation of MLTSS Performance Measures

Wellpoint New Jersey, Inc.

July 2024

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Introduction

The purpose of the Managed Long Term Services and Supports (MLTSS) Nursing Facility (NF)/Special Care Nursing Facility (SCNF) Ancillary Review is to evaluate Managed Care Organizations (MCOs) compliance with the Division of Medical Assistance and Health Services (DMAHS) NJ FamilyCare Contract Article 9.11.G, MLTSS Performance Measures. IPRO conducted a review of the following MLTSS Performance Measures: PM #8, PM #9, PM #9a, PM #11, and PM #16 for the review period September 1, 2022 through June 30, 2023.

Sampling Methodology

Population Selection

Population Criteria	September 1, 2022 to June 30, 2023
Codes	Capitation Codes **MLTSS NF Codes:** 88199, 88399, 88499, 78199, 78399 and 78499 **MLTSS HCBS Codes:** 89399 and 79399 *Needs to include **both** Core Medicaid and FIDE SNP Plan codes. Moving from one Plan Code to another does not constitute a change in MCO.
Age	No age requirements
Sex	Both
Nursing Facility Placement	Enrolled in a NF/SCNF for at least six (6) consecutive months, between 9/1/2022 and up to and including 6/30/2023.
Anchor Date	Enrolled in NF on 6/30/2023.
Continuous Enrollment Criteria	Enrolled in the same MCO for the entire period, from the initial six (6) consecutive months of residence in a NF/SCNF and remains in MLTSS through 6/30/2023 with no gaps in MLTSS enrollment.

Methodology

A random sample of 35 NF/SCNF Members new to MLTSS and/or new to the MCO during the review period and 25 NF/SCNF Members enrolled in MLTSS and the MCO prior to 9/1/2022 was selected to meet a minimum of 60 files (including a 20% oversample required for substitutions or exclusions) for each MCO. IPRO reviewed a total of 51 Member files for Wellpoint New Jersey, Inc. (WPNJ). One (1) file was excluded, resulting in 50 files evaluated for compliance with MLTSS Performance Measures #8, #9, #9a, #11, and #16.

Evaluation of MLTSS Performance Measures

The following Performance Measures were evaluated to determine MCO compliance; PM #8: Plans of Care established within 45 days of MLTSS enrollment; PM #9: Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination; PM #9a: Plan of Care for MLTSS Members amended based on change of Member condition; PM #11: Plans of Care for MLTSS Members are developed using "Person-Centered Principles;" and PM #16: MCO provided training to MLTSS Member on identifying/reporting Critical Incidents. WPNJ's results for each MLTSS Performance Measure are shown below in **Table 1**.

Table 1: MLTSS Performance Measures Results

Performance Measure	Numerator	Denominator	Rate
#8. Plans of Care established within 45 days of MLTSS enrollment.[1]	27	30	90.0%
#9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination.[2]	20	20	100.0%
#9a. Plan of Care for MLTSS Members amended based on change of Member condition.[3]	1	1	100.0%
#11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles."[4]	50	50	100.0%
#16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents.	50	50	100.0%

[1] Compliance with this measure includes completion of the Initial Plan of Care and timeliness of completion. The denominator includes all NF/SCNF Members new to MLTSS and/or new to the MCO during the review period.

[2] Members included in this measure (denominator) have an annual LOC re-determination that was due and completed during the review period and a Plan of Care on file.

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

[4] For compliance with this measure Members must have a Plan of Care on file during the review period that contains documentation 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 be addressed in the Plan of Care.

Limitations

None.

Conclusions

As directed by DMAHS, no Corrective Action Plans (CAPs) will be required for MLTSS Performance Measures that score below the MLTSS compliance threshold of 86%.

Overall, the MCO scored 86% or above for all five (5) MLTSS Performance Measures (**Table 1**):

- PM #8: Plans of Care established within 45 days of MLTSS enrollment.
- PM #9: Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination.
- PM #9a: Plan of Care for MLTSS Members amended based on change of Member condition.
- PM #11: Plans of Care for MLTSS Members are developed using "Person-Centered Principles."
- PM #16: MCO provided training to MLTSS Member on identifying/reporting Critical Incidents.

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services,
Office of MLTSS Quality Monitoring

MCO MLTSS Nursing Facility/Special Care Nursing Facility Care Management Audit

Wellpoint New Jersey, Inc.

February 2025

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Introduction

The purpose of the Managed Long-Term Services and Supports (MLTSS) Nursing Facility/Special Care Nursing Facility (NF/SCNF) Care Management (CM) audit was to evaluate the effectiveness of the contractually required MLTSS Care Management program. Effective July 1, 2014, the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS) established MLTSS CM requirements to ensure that the services provided to special needs Members who met MLTSS eligibility requirements as specified in Article 9, Home and Community-Based Services (HCBS) and Institutionalization for Long Term Care in a Nursing Facility (NF) or Special Care Nursing Facility (SCNF), are consistent with professionally recognized standards of care. Specifically, the populations included in this audit were Members who met the eligibility requirements for MLTSS and were receiving services in a Nursing Facility/Special Care Nursing Facility for at least six consecutive months within the review period from July 1, 2023 through June 30, 2024.

The U.S. Department of Health and Human Services (HHS) declared an end to the Public Health Emergency (PHE) for COVID-19 on May 11, 2023. State issued COVID-19 flexibilities related to specific Care Management activities and Nursing Facilities with visitation protocols (restricting Care Manager access) discontinued prior to this review period.

In addition to the CM audit, MLTSS Performance Measures #8 (Plans of Care established within 45 days of MLTSS enrollment), #9 (Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination), #9a (Plan of Care for MLTSS Members amended based on change of Member condition), #11 (Plans of Care for MLTSS Members are developed using “Person-Centered Principles”), and #16 (MCO provided training to MLTSS Member on identifying/reporting Critical Incidents) were calculated. Annually, DMAHS will evaluate the Managed Care Organization (MCO) performance against these requirements through its External Quality Review Organization (EQRO) contractor. The results of these audits are used to improve MCO performance.

Methodology

The audit addressed MCO contract requirements for monitoring performance based on the NJ FamilyCare Contracts (Article 9), dated July 2023 and January 2024. A representative sample of files were selected for each MCO for review. The audit included three phases: pre-audit activities, offsite audit activities, and post-audit activities.

1. Pre-audit Activities

Planning

IPRO and DMAHS discussed the proposed audit methodology and necessary source documents, such as the NJ Choice Assessment System, Plan of Care, contract references, and revision of elements for review. Audit questions are limited exclusively to ”Yes” or ”No” answers that can be clearly quantified and presented for reporting purposes. Supplemental questions were added into the tool in 2024, where appropriate, to determine whether a Member met the criteria for a subsequent section or question. Therefore, for some audit questions, Members represented in the numerator and denominator represent only those who met the specific applicable criteria. IPRO prepared an audit tool structured to collect requirement-specific information related to Facility and MCO Plan of Care, MLTSS Initial Plan of Care and Ongoing Plans of Care, Ongoing Care Management, Reassessment of the Plan of Care and Critical Incident Reporting, and Preadmission Screening and Resident Review (PASRR) Communications for Transitions to NF/SCNF. In addition, MLTSS Performance Measures #8, #9, #9a, #11, and #16 were calculated for the applicable NF/SCNF population. Rates calculated from these audit tool sections are utilized to determine MCO performance.

Separate rates were calculated on requirement-specific questions related to MLTSS Members who transitioned between HCBS and NF/SCNF settings during the review period. These rates are utilized solely for informational purposes.

Population Selection

Capitation and Plan codes were used to identify MLTSS HCBS and MLTSS NF/SCNF enrollment. The study sample was selected by using the capitation codes to identify MLTSS HCBS and NF/SCNF enrollment listed in **Table 1** and **Table 2**, and applying the sampling methodology described below.

Table 1: Capitation Codes for MLTSS HCBS Enrollment

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

Table 2: Capitation Codes for MLTSS NF Enrollment

Capitation Code	Description
88199	MLTSS Eligible Without Medicare – NF
88399	MLTSS Eligible Without Medicare – SCNF (Vents and Pediatrics)
88499	MLTSS Eligible Without Medicare – SCNF
78199	MLTSS Eligible With Medicare - NF
78399	MLTSS Eligible With Medicare – SCNF (Vents and Pediatrics)
78499	MLTSS Eligible With Medicare - SCNF

A random sampling method was used to meet a minimum of records needed to reach 100 files for each MCO. If the MCO did not have 100 files, the entire universe was selected for review. IPRO selected 110 cases for Wellpoint New Jersey, Inc. (WPNJ), inclusive of an oversample of 10 cases to replace any excluded files as necessary.

Sampling Methodology

The criteria used to select the MLTSS NF/SCNF population were as follows:

- The Member must have been enrolled in MLTSS on June 30, 2024.
- The Member must have been enrolled as a NF/SCNF Member for 6 consecutive months during the review period and still enrolled with the MCO of record on June 30, 2024.
- The Member cannot be enrolled with another MCO at any time between the beginning of the minimum 6-month NF/SCNF enrollment and the end of the review period (June 30, 2024).

In order to collect additional information for MLTSS Members who transitioned between HCBS and NF/SCNF settings during the review period, the selected MLTSS NF/SCNF population was further identified as one of the four subgroups listed in **Table 3**.

Table 3: MLTSS NF/SCNF Population Subgroups

Group	Description
Group 1	Members permanently residing in an NF/SCNF at least 6 consecutive months from July 1, 2023 to June 30, 2024, with the MCO of record on June 30, 2024.
Group 2	Members residing in an NF/SCNF for at least 6 consecutive months from July 1, 2023 to June 30, 2024, and transitioned to HCBS during the review period with no transition from HCBS to another NF.
Group 3	Members residing in HCBS for at least 1 month between July 1, 2023 and June 30, 2024, and transitioned to an NF/SCNF for at least 6 consecutive months during the review period (and still residing in the NF/SCNF as of June 30, 2024).
Group 4	Members residing in HCBS for at least 1 month between July 1, 2023 and June 30, 2024, transitioned to an NF/SCNF for at least 6 consecutive months, and transitioned back to HCBS for at least 1 month during the review period.

Introductory E-mail

IPRO sent an introductory e-mail to the MCO prior to the scheduled offsite audit including:

- Formal notification of the audit with a file due date,
- Description of the sample,
- File listing identifying the files that needed to be submitted to IPRO, and
- Instructions for preparing files and uploading the files to IPRO's SEND File Transfer Protocol (FTP) site.

2. Offsite Audit Activities

Electronic files were prepared by the MCO for review and posted to IPRO's SEND FTP site. IPRO reviewers conducted the offsite file reviews over a five (5) week period. Reviewer inter-rater reliability (IRR) was maintained using the standardized audit tool with ongoing communication and coordination among the review team. Electronic files were prepared by the MCO for review.

3. Post-audit Activities

Following the audit, IPRO aggregated the MCO's results by population and prepared this report.

Audit Results

Of the 110 files selected for WPNJ, 100 Member files were reviewed. There were no files excluded. A total of 100 files were further reviewed for compliance in the following five (5) categories; Facility and MCO Plan of Care, MLTSS Initial Plan of Care and Ongoing Plans of Care, Ongoing Care Management, Reassessment of the Plan of Care and Critical Incident Reporting, and PASRR Communications for Transitions to NF/SCNF. Based on sample selection criteria, this included all four subpopulations (Groups 1, 2, 3 and 4). Rates for individual elements were calculated as the number of "Yes" determinations divided by the sum of "Yes" plus "No" determinations. Abbreviated review elements appear in bold in the table sections of this report (**Tables 4–8**). Rates should be considered cautiously for review elements with a denominator of less than 30.

Table 4: Facility and MCO Plan of Care

Facility and MCO Plan of Care	N	D	Rate
Member's Care Management record contained **copies of any Facility Plans of Care on file** during the review period.	96	100	96.0%
Documented review of the Facility Plan of Care by the Care Manager.	96	96	100.0%
MLTSS Plan of Care on file includes information from the Facility Plan of Care.	100	100	100.0%

Table 5: MLTSS Initial Plan of Care and Ongoing Plans of Care

MLTSS Initial Plan of Care and Ongoing Plans of Care	N	D	Rate
The Member's individualized Plan of Care (including obtaining Member's signature) **was developed in collaboration with the Member and a copy mailed to the Member within forty-five (45) calendar days of enrollment notification into the MLTSS program**.[1]	3	4	75.0%
Care Managers used a Person-Centered approach regarding the Member's assessment and needs; taking into account not only covered services, but also formal and informal support services.	100	100	100.0%
Plan of Care reassessment for MLTSS Members conducted within 30 days of annual level of care (LOC) re-determination.[2]	93	93	100.0%
Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems, and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process.	100	100	100.0%
Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this).	100	100	100.0%
Member's agreement/disagreement with the Plan of Care statements were documented on the Member's Plan of Care and maintained in the Member's electronic CM record.	100	100	100.0%
Member experienced a significant change in condition requiring the Plan of Care to be amended.	0	100	0.0%

MLTSS Initial Plan of Care and Ongoing Plans of Care	N	D	Rate
Updated Plan of Care for a significant change. For any significant change in Member condition, Member's Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative.	0	0	N/A

[1]Compliance with this measure includes completion of the Initial Plan of Care, Member signature, and a copy provided to the Member within 45 calendar days of the MLTSS enrollment date. The denominator includes all NF/SCNF Members new to MLTSS and/or new to the MCO during the review period.
[2]Members included in this measure (denominator) have an annual LOC re-determination that was due and completed during the review period and a Plan of Care on file.
N/A: Not Applicable

Table 6: Ongoing Care Management

Ongoing Care Management	N	D	Rate
There was evidence in the file that the Member had the ability and/or desire to transition from the NF/SCNF.	6	100	6.0%
Member was identified for transfer to HCBS and was offered options, including transfer to the community.	6	6	100.0%
Evidence of the **Care Manager's participation in at least one interdisciplinary team (IDT) meeting** during the review period.	64	100	64.0%
Member was present at each onsite visit or had involvement from the Member's authorized representative regarding the Plan of Care. (If the Member was not able to participate in an onsite visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable).	96	100	96.0%
The Care Manager reviewed Member placement and services onsite with the Member present.	96	100	96.0%
Timely onsite review of Member placement and services. Onsite visits were timely and occurred within at least 180 calendar days for non-pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability).	62	96	64.6%
Member required coordination of care (physical health and/or behavioral health services) not covered by NF/SCNF.	0	100	0.0%
Members requiring coordination of care had coordination of care by the Care Manager.	0	0	N/A

N/A: Not Applicable

Table 7: Reassessment of the Plan of Care and Critical Incident Reporting

Reassessment of the Plan of Care and Critical Incident Reporting	N	D	Rate
The NJ Choice Assessment (NJCA) was due during the review period (initial or annual redetermination NJCA).	97	100	97.0%
Member had a NJCA completed during the review period.	97	97	100.0%
Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative.	82	100	82.0%
Care Manager reviewed the Member's rights and responsibilities.	100	100	100.0%
Care Manager educated the Member on how to file a grievance and/or an appeal.	100	100	100.0%

Reassessment of the Plan of Care and Critical Incident Reporting	N	D	Rate
Member and/or representative had **training on how to report a critical incident**, specifically including how to identify abuse, neglect and exploitation.	100	100	100.0%

Table 8: PASRR Communications for Transitions to NF/SCNF

PASRR Communications for Transitions to NF/SCNF	N	D	Rate
Member transitioned to the NF/SCNF during the review period.	5	100	5.0%
Care Manager completed or confirmed PASRR Level I prior to Member transition to NF/SCNF.	5	5	100.0%
Communication of PASRR Level I to OCCO documented by the Care Manager in the NJCA.	5	5	100.0%
Member required a PASRR Level II prior to admission to the NF/SCNF.	0	5	0.0%
Care Manager completed or confirmed PASRR Level II, prior to Member transition to NF/SCNF.	0	0	N/A
Communication of PASRR Level II to OCCO documented by the Care Manager (within 1 business day of receipt of determination).	0	0	N/A
Member demonstrated a need for MCO coordination with DDD/DMHAS.	0	0	N/A
Members who had a PASRR Level II indicating a need for Specialized Services setting had coordination with DDD/DMHAS.	0	0	N/A

OCCO: Office of Community Choice Options; DDD: Division of Developmental Disabilities; DMHAS: Division of Mental Health and Addiction Services
N/A: Not Applicable

MLTSS Members Transitioning Between HCBS and NF/SCNF Settings

Of the cases selected for WPNJ, 100 Member files were reviewed and included in the results. Rates were calculated for Members who transitioned from one MLTSS setting to another during the review period (Groups 2, 3, and 4; **Table 9**). Review elements are abbreviated in bold. Evaluation of MCO performance is for information purposes only.

Table 9: Member Transition Groups

Group	Member Transition	Number of Members
Group 1	Permanently residing in NF/SCNF for at least 6 months without a transition during the review period.	97
Group 2	Transitioned from NF/SCNF to HCBS with no other facility transition during the review period.	1
Group 3	Transitioned from HCBS to NF/SCNF and remained in a facility at the end of the review period.	2
Group 4	Transitioned from HCBS to NF/SCNF and back to HCBS during the review period.	0

MLTSS Members Transitioning from NF/SCNF to HCBS

A total of 1 file was reviewed for Members permanently residing in a NF/SCNF and subsequently transitioned to a home or community-based setting. Rates were calculated to profile NF/SCNF Members that transitioned to HCBS (Groups 2 and 4; **Table 9**).

Table 10: NF/SCNF Members Transitioned to HCBS

Transitions to HCBS	N	D	Rate
Member transitioned from NF/SCNF to HCBS during the review period.	1	100	1.0%
Member had a **Person-Centered transition plan on file.**	1	1	100.0%
Cost effectiveness evaluation was completed for the Member prior to discharge from a NF/SCNF.	0	1	0.0%
Plan of Care updated prior to discharge from a facility. Plan of Care was developed and agreed upon by the Member and/or representative prior to the effective date of transfer to the community.	1	1	100.0%
Participation in an interdisciplinary team (IDT) meeting related to transition. Care Manager participated in the coordination of an IDT meeting related to transition planning.	1	1	100.0%
Authorizations and procurement of transitional services for the Member were completed prior to NF/SCNF transfer.	1	1	100.0%
Care Manager conducted a **face-to-face visit within 10 business days following a NF/SCNF discharge to the community.**	1	1	100.0%
Services initiated upon NF/SCNF discharge were according to the Member's Plan of Care.	1	1	100.0%

MLTSS Members Transitioning from HCBS to NF/SCNF

A total of 2 files were reviewed for Members receiving HCBS and subsequently transitioned to an NF/SCNF for long-term placement. Rates were calculated to profile HCBS Members that transitioned to an NF/SCNF (Groups 3 and 4; **Table 9**).

Table 11: HCBS Members Transitioned to a NF/SCNF

Transitions to NF/SCNF	N	D	Rate
Member transitioned from HCBS to NF/SCNF during the review period.	2	100	2.0%
Member was admitted to NF/SCNF directly from an acute facility.	1	2	50.0%
Care Manager determined during the reassessment process that changes in placement or services were indicated, and a **discussion with the Member occurred prior to the change in service/placement.**	2	2	100.0%

The expansion of the NF/SCNF audit components included evaluation of MLTSS Performance Measures. Population-specific findings are presented in **Table 12**, which include results on the following MLTSS Performance Measures: #8 (Plans of Care established within 45 days of MLTSS enrollment), #9 (Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination), #9a (Plan of Care for MLTSS Members amended based on change of Member condition), #11 (Plans of Care for MLTSS Members are developed using Person-Centered Principles), and #16 (MCO provided training to MLTSS Member on identifying/reporting Critical Incidents). Population results are rates calculated as the number of "Yes" determinations divided by the sum of "Yes" plus "No" determinations.

Table 12: MLTSS Performance Measures Results

Performance Measure	N	D	Rate
#8. Plans of Care established within 45 days of MLTSS enrollment.[1]	3	4	75.0%
#9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination.[2]	93	93	100.0%
#9a. Plan of Care for MLTSS Members amended based on change of Member condition.[3]	0	0	N/A
#11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles."[4]	100	100	100.0%
#16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents.	100	100	100.0%

[1]Compliance with this measure includes completion of the Initial Plan of Care, Member signature, and a copy provided to the Member within 45 calendar days of the MLTSS enrollment date. The denominator includes all NF/SCNF Members new to MLTSS and/or new to the MCO during the review period.
[2] Members included in this measure (denominator) have an annual LOC re-determination that was due and completed during the review period and a Plan of Care on file.
[3] Members who did not have a documented change in condition during the study period are excluded from this measure.
[4] For compliance with this measure Members must have a Plan of Care on file during the review period that contains documentation 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 be addressed in the Plan of Care.
N/A: Not Applicable

Discussion

Limitations

Results are limited due to the absence of Members in Group 4 (Members who transitioned from HCBS to the NF/SCNF and returned to HCBS) during the review period. Additionally, there were no Members with a documented change in condition during the review period, therefore compliance with PM #9a could not be evaluated.

Conclusions

Overall, the MCO scored 86% or above in the following review elements (**Tables 4–8**). Review elements evaluated for calculation of Performance Measures are resulted in the MLTSS Performance Measures section of this report.

Facility and MCO Plan of Care

- Member's Care Management record contained copies of any Facility Plans of Care on file during the review period. (96.0%)
- Documented review of the Facility Plan of Care by the Care Manager. (100.0%)
- MLTSS Plan of Care on file includes information from the Facility Plan of Care. (100.0%)

MLTSS Initial Plan of Care and Ongoing Plans of Care

- Care Manager and Member developed goals that address the issues that are identified during the assessment and Plan of Care process. Goals shall be built on the Member's identified needs, strengths, and support systems, and include measures to achieve the goal. Goals are written to outline clear expectations about what is to be achieved through the service delivery and care coordination process. (100.0%)
- Plan of Care that was given to the Member contained goals that met all the criteria (1- Member specific, 2- measurable, 3- specified plan of action/intervention to be used to meet the goals and 4- include a timeframe for the attainment of the desired outcome, 5- be reviewed at a minimum during each visit and progress documented. Progress means information regarding potential barriers, changes that need to be made to the goal and/or plan of action, and, if the goal has been met but will be continued, the reason(s) for this). (100.0%)
- Member's agreement/disagreement with the Plan of Care statements were documented on the Member's Plan of Care and maintained in the Member's electronic CM record. (100.0%)

Ongoing Care Management

- Member was identified for transfer to HCBS and was offered options, including transfer to the community. (100.0%)
- Member was present at each onsite visit or had involvement from the Member's authorized representative regarding the Plan of Care. (If the Member was not able to participate in an onsite visit for reasons such as cognitive impairment, and the Member did not have a legal guardian or representative, this requirement was not applicable). (96.0%)

Reassessment of the Plan of Care and Critical Incident Reporting

- Member had a NJCA completed during the review period. (100.0%)
- Care Manager reviewed the Member's rights and responsibilities. (100.0%)
- Care Manager educated the Member on how to file a grievance and/or an appeal. (100.0%)

PASRR Communications for Transitions to NF/SCNF

- Care Manager completed or confirmed PASRR Level I prior to Member transition to NF/SCNF. (100.0%)
- Communication of PASRR Level I to OCCO documented by the Care Manager in the NJCA. (100.0%)

Opportunities for Improvement for Review Elements

Opportunities for improvement for MCO scores below 86% exist in the following review elements (**Tables 4–8**).

- Evidence of the Care Manager's participation in at least one interdisciplinary team (IDT) meeting during the review period. (64.0%)
- Timely onsite review of Member placement and services. Onsite visits were timely and occurred within at least 180 calendar days for non-pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members. (Member's presence at these visits was required regardless of cognitive capability). (64.6%)
- Plan of Care was updated, reviewed, and signed by the Member and/or representative, and a copy was provided to the Member and/or representative. (82.0%)

Recommendations for Review Elements

- WPNJ MLTSS Care Managers should ensure the Care Manager participates in a minimum of one interdisciplinary team (IDT) meeting per year.
- WPNJ MLTSS Care Managers should ensure review of the Member's placement and services occurs timely (at least 180 days for non-pediatric NF/SCNF Members or at least 90 calendar days for pediatric SCNF Members).
- WPNJ MLTSS Care Managers should ensure that a copy of the Member's Plan of Care is provided to the Member and/or representative.

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MLTSS Performance Measures

Overall, the MCO scored 86% or above in the following Performance Measures (PMs) (**Table 12**).

- PM #9. Plan of Care reassessment for MLTSS Members conducted within 30 days of annual LOC re-determination. (100.0%)
- PM #11. Plans of Care for MLTSS Members are developed using "Person-Centered Principles." (100.0%)
- PM #16. MCO provided training to MLTSS Member on identifying/reporting Critical Incidents. (100.0%)

Opportunities for Improvement for MLTSS Performance Measures

Opportunities for improvement for MCO scores below 86% exist for the following MLTSS Performance Measures (**Table 12**).

- PM #8 Plans of Care established within 45 days of MLTSS enrollment. (75.0%)

Recommendations for MLTSS Performance Measures

- WPNJ MLTSS Care Managers should ensure that a copy of the Member's Plan of Care is provided to the Member within 45 days of MLTSS enrollment.

Appendix G – 2024 Network Adequacy Provider Directory Validation Surveys

IPRO

Better healthcare, realized.

Aetna Better Health of New Jersey

2024 Provider Directory Validation Survey

Survey Period: May 2024 – July 2024

Prepared on behalf of:

The New Jersey Division of Medical Assistance and Health Services

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Introduction

The Centers for Medicare and Medicaid Services (CMS) established network adequacy standards in Medicaid and Children's Health Insurance Program (CHIP) for certain providers while granting flexibility to the states to set and enforce state-specific Medicaid network standards. New Jersey has Medicaid network standards in place that address this requirement. CMS also requires that the adequacy of Medicaid networks maintained by a managed care organization (MCO) be evaluated annually by the state or an External Quality Review Organization (EQRO). To comply with this requirement, the New Jersey Division of Medical Assistance and Health Services (DMAHS) contracted with Island Peer Review Organization, Inc. (IPRO), an EQRO, to evaluate the state's Medicaid and CHIP MCO provider networks, called NJ FamilyCare.

In 2024, IPRO's evaluation included the NJ FamilyCare network for Aetna Better Health of New Jersey (ABHNJ).

Aim

IPRO's evaluation aimed to:

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

This report reflects the results of the 2024 Provider Directory Validation Survey for ABHNJ.

Objectives

Title 42 Code of Federal Regulations Section 438.356 State contract options for external quality review and *Title 42 Code of Federal Regulations Section 438.358 Activities related to external quality review* establish that state agencies must contract with an EQRO to perform the Annual Validation of Network Adequacy. To meet these federal regulations, DMAHS contracted with IPRO to validate the accuracy of provider information available to Medicaid members through the provider look-up systems on each MCO's website, and to evaluate the breadth and scope of how accessibility information is presented in these look-up systems. The study methodology aligns with the Centers for Medicare & Medicaid Services' External Quality Review (EQR) Protocol 4 – Validation of Network Adequacy.

Technical Methods of Data Collection and Analysis

Validation of the Accuracy of Information Reported in the Provider Directory

IPRO accessed ABHNJ's provider look-up system between May 2024 and July 2024 to prepare the MCO's sample. Table 1 displays the website address of the MCO's provider look-up system, the date range the look-up system was accessed by IPRO to prepare the sample, and the date range IPRO administered the survey.

Table 1: Survey Administration Summary

URL for Provider Directory	https://www.aetnabetterhealth.com/newjersey/find-provider
Website Access Dates	5/20/2024-6/12/2024
Survey Date Range	5/31/2024-7/12/2024

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

- practices primary care, a pediatric specialty, dentistry, or is a managed long-term services and supports (MLTSS) provider, and
- participates in the NJ FamilyCare network, and
- accepts new patients enrolled with ABHNJ.

A random sample totaling 350 providers was prepared for ABHNJ. Primary care providers, pediatric specialists, dental providers, and MLTSS providers were included in the sample.

To conduct this study, IPRO surveyors called provider offices using the telephone numbers reported by the MCO in the online provider look-up system. Calls were conducted Monday through Friday, 8:30 AM – 5:30 PM, excluding holidays; however, if there was any indication that a provider has alternative office hours, IPRO then called the provider during those alternative hours. Surveyors utilized the "reveal" method, in which the surveyors disclosed that the call was being made on behalf of DMAHS to verify the accuracy of the provider's information. Specifically, IPRO surveyors requested that the provider or representative verbally verify the accuracy of the following data reported in the provider look-up system:

- participation status with the named MCO,
- Medicaid panel status,
- specialty,
- board certification status*,
- disability access status*, and
- physical location.

* Board Certification Status was applicable only when the online provider directory indicated that the provider is board certified. Disability Access Status was applicable only when the online provider directory indicated that the practice location has accessibility features.

Surveyors made up to three (3) attempts to contact a live staff person at each practice to complete the survey. For each call made, the surveyor documented the date, time, name of the provider representative or the reason no contact was made with a live representative.

Survey responses were used to assess both access to providers and the validity of information available to members through the MCO's online directories.

Evaluation of Accessibility Information Reported in the Provider Directory

IPRO reviewed ABHNJ's provider look-up system to assess the availability of accessibility information and how this information is presented to users. The breadth of accessibility information in the online provider directories was evaluated through a desk review. This review included assessing the search capabilities that allow members to identify providers with accessibility features and the extent of information available to help members identify providers with specific accessibility features.

Results

ABHNJ Provider Directory Access Results

Provider directory access was determined based on whether the provider could be contacted via telephone, was still contracted with the specified managed care plan, and was accepting new patients. As presented in Table 2, ABHNJ has an overall provider directory access rate of 35.7%, with the highest compliance rate observed among dental providers (Table 3).

Table 2: Provider Directory Access Rate

Total Providers Surveyed[1]	Compliant Providers[2]	Access Rate
350	125	35.7%

[1] Total number of providers in the sample (no exclusions).

[2] Total number of providers who positively confirmed participation with the MCO and open panel status for the listed specialty.

Table 3: Provider Directory Access Rates by Specialty

Provider Specialty (Reporting Group)	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	200	50	25.0%
Pediatric Specialists	50	26	52.0%
Dental	50	28	56.0%
Managed Long-Term Services and Supports	50	21	42.0%
Total	**350**	**125**	**35.7%**

[1] Providers who positively confirmed participation with the MCO and open panel status for the listed specialty.

The provider directory access failure summary presented in **Table 4** includes office representative(s) who either refused to participate, or did not know the information to answer the question(s). Additionally, some providers had more than one (1) failure reason; therefore, the total failure reasons plus the compliant providers exceeded the 350 providers surveyed.

Table 4: Provider Directory Access Failure Summary

Failure Reasons	Total Failed Reasons[1]	Failure Rate
Provider not at site[2]	107	30.6%
Answering machine/Voice mail system	37	10.6%
Provider not a plan participant	17	4.9%
Provider not accepting new patients (closed panel)	13	3.7%
Provider practices a different specialty	12	3.4%
Constant busy signal	12	3.4%
Disconnected/Not in Service	6	1.7%
Representative refuses to participate in audit	6	1.7%
Wrong telephone number	6	1.7%
Put on hold (>10 minutes)	5	1.4%
Representative does not have enough information to answer the survey questions	5	1.4%
Not Answered (>11 rings)	3	0.9%
Total	**229**	

[1]Failure totals may include providers that have multiple failures.

[2]Provider not at site is an umbrella term that includes; provider retired, provider no longer at that location, or provider was never at that location.

ABHNJ Provider Directory Accuracy Results

Provider directory accuracy was determined by the validity of the provider information in the MCO's online directory. IPRO evaluated the accuracy of the provider directory information by analyzing the survey results on the following key aspects: providers' contract status with ABHNJ, their availability to accept new patients, their specialty type, and their telephone number and address. ABHNJ has a provider directory accuracy rate of 28.3%, with the highest compliance rate observed among dental providers.

Table 5: Provider Directory Accuracy Rate

Total Providers Surveyed[1]	Compliant Providers[2]	Access Rate
350	99	28.3%

[1] Total number of providers in the sample (no exclusions).

[2] Total number of providers who positively confirmed participation with the MCO, open panel status, specialty, telephone number, and address.

Table 6: Provider Directory Accuracy Rates by Specialty

Provider Specialty (Reporting Group)	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	200	35	17.5%
Pediatric Specialists	50	18	36.0%
Dental	50	27	54.0%
Managed Long-Term Services and Supports	50	19	38.0%
Total	**350**	**99**	**28.3%**

[1] Providers who positively confirmed participation with the MCO, open panel status, specialty, telephone number, and address.

The provider directory accuracy failure summary presented in **Table 7** includes "wrong address," in addition to the failure reasons listed above for provider directory access. Additionally, some providers had more than one (1) failure reason; therefore, the total failure reasons plus the compliant providers exceeded the 350 providers surveyed.

Table 7: Provider Directory Accuracy Failure Summary

Failure Reasons	Total Failed Reasons[1]	Failure Rate
Provider not at site[2]	107	30.6%
Answering machine/Voice mail system	37	10.6%
Wrong address	33	9.4%
Provider not a plan participant	17	4.9%
Provider not accepting new patients (closed panel)	13	3.7%
Provider practices a different specialty	12	3.4%
Constant busy signal	12	3.4%
Wrong telephone number	6	1.7%
Disconnected/Not in Service	6	1.7%
Representative refuses to participate in audit	6	1.7%
Put on hold (>10 minutes)	5	1.4%
Representative does not have enough information to answer the survey questions	5	1.4%
Not Answered (>11 rings)	3	0.9%
Total	**262**	

[1]Failure totals may include providers that have multiple failures.

[2]Provider not at site is an umbrella term that includes; provider retired, provider no longer at that location, or provider was never at that location.

Table 8 and **Table 9** represent the validation of board certification status as printed in the online provider directory. Out of the 350 providers surveyed, 221 had their board certification listed in the online provider directory. Among these providers, 38.0% positively confirmed their board certification status. The highest compliance rate was observed among managed long-term services and supports providers.

Table 8: Provider Directory Board Certification Accuracy Rate

Total Providers Surveyed	Providers With Board Certification Listed[1]	Compliant Providers[2]	Access Rate
350	221	84	38.0%

[1]Total Providers with board certification status listed in the online provider directory.

[2] Total number of providers who positively confirmed board certification status.

Table 9: Provider Directory Board Certification Accuracy Rates by Specialty

Provider Specialty (Reporting Group)	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	144	46	31.9%
Pediatric Specialists	38	16	42.1%
Dental	2	1	50.0%
Managed Long-Term Services and Supports	37	21	56.8%
Total	**221**	**84**	**38.0%**

[1] Providers who positively confirmed board certification status.

Table 10 and Table 11 represent the validation of disability access status as printed in the online provider directory. Out of the 350 providers surveyed, 57 had their disability access listed in the online provider directory. Among these providers, 59.6% positively confirmed disability access status. The highest compliance rate was observed among dental providers.

Table 10: Provider Directory Disability Accuracy Rate

Total Providers Surveyed	Providers With Disability Access Listed[1]	Compliant Providers[2]	Access Rate
350	57	34	59.6%

[1]Total Providers with disability access listed in the online provider directory.
[2] Total number of providers who positively confirmed disability access status.

Table 11: Provider Directory Disability Accuracy Rates by Specialty

Provider Specialty Reporting Group	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	4	1	25.0%
Pediatric Specialists	0	0	---
Dental	47	31	66.0%
Managed Long-Term Services and Supports	6	2	33.3%
Total	**57**	**34**	**59.6%**

[1] Providers who positively confirmed disability access status.

Evaluation of Practice Site Accessibility Information Results

As presented in Table 12, IPRO conducted a review of ABHNJ's online provider directory to assess how members are informed about a practice site's accessibility features. ABHNJ's online provider directory does have the ability to filter providers with accessibility features, but the degree of information is limited (Table 13).

Table 12: Provider Directory Search Capabilities for Accessibility Information

Review Question	Determination (Yes or No)
Does the site have the ability to filter for providers who have accessibility features?	Yes
Does the site have the ability to filter for specific accessibility features?	No
Are there clear and easy to find instructions for the member to call the managed care plan for assistance in finding a provider who meets accessibility need?	No

Table 13: Provider Directory Degree of Information Available for Accessibility Information

Degree of Information	Information Reported (Yes or No)
Accessible examination tables	No
Accessible scales	No
Accessible restrooms	No
Bariatric examination tables	No
Bariatric scales	No
Elevators in multistory buildings	No
Handicapped parking	No
Lifts	No
Signs in braille	No
Video access to offsite interpreter	No
Wheelchair ramps	No
General “handicap accessibility” indicator	Yes

Recommendations

Based on the findings of this provider directory validation study, IPRO recommends the following:

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

Opportunity for Improvement

- ABHNJ should consider including detailed accessibility filters in their online directories. This enhancement will ensure that members can easily find providers who meet their individual needs, such as those who require accessible examination tables and scales.

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Fidelis Care of New Jersey

2024 Provider Directory Validation Survey

Survey Period: May 2024 – July 2024

Prepared on behalf of:

The New Jersey Division of Medical Assistance and Health Services

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Introduction

The Centers for Medicare and Medicaid Services (CMS) established network adequacy standards in Medicaid and Children's Health Insurance Program (CHIP) for certain providers while granting flexibility to the states to set and enforce state-specific Medicaid network standards. New Jersey has Medicaid network standards in place that address this requirement. CMS also requires that the adequacy of Medicaid networks maintained by a managed care organization (MCO) be evaluated annually by the state or an External Quality Review Organization (EQRO). To comply with this requirement, the New Jersey Division of Medical Assistance and Health Services (DMAHS) contracted with Island Peer Review Organization, Inc. (IPRO), an EQRO, to evaluate the state's Medicaid and CHIP MCO provider networks, called NJ FamilyCare.

In 2024, IPRO's evaluation included the NJ FamilyCare network for Fidelis Care of New Jersey (Fidelis Care).

Aim

IPRO's evaluation aimed to:

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

This report reflects the results of the 2024 Provider Directory Validation Survey for Fidelis Care.

Objectives

Title 42 Code of Federal Regulations Section 438.356 State contract options for external quality review and *Title 42 Code of Federal Regulations Section 438.358 Activities related to external quality review* establish that state agencies must contract with an EQRO to perform the Annual Validation of Network Adequacy. To meet these federal regulations, DMAHS contracted with IPRO to validate the accuracy of provider information available to Medicaid members through the provider look-up systems on each MCO's website, and to evaluate the breadth and scope of how accessibility information is presented in these look-up systems. The study methodology aligns with the Centers for Medicare & Medicaid Services' External Quality Review (EQR) Protocol 4 – Validation of Network Adequacy.

Technical Methods of Data Collection and Analysis

Validation of the Accuracy of Information Reported in the Provider Directory

IPRO accessed Fidelis Care's provider look-up system between May 2024 and July 2024 to prepare the MCO's sample. Table 1 displays the website address of the MCO's provider look-up system, the date range the look-up system was accessed by IPRO to prepare the sample, and the date range IPRO administered the survey.

Table 1: Survey Administration Summary

URL for Provider Directory	https://findaprovider.fideliscarenj.com/location
Website Access Dates	5/20/2024-5/29/2024
Survey Date Range	6/5/2024-7/17/2024

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

- practices primary care, a pediatric specialty, dentistry, or is a managed long-term services and supports (MLTSS) provider, and
- participates in the NJ FamilyCare network, and
- accepts new patients enrolled with Fidelis Care.

A random sample totaling 350 providers was prepared for Fidelis Care. Primary care providers, pediatric specialists, dental providers, and MLTSS providers were included in the sample.

To conduct this study, IPRO surveyors called provider offices using the telephone numbers reported by the MCO in the online provider look-up system. Calls were conducted Monday through Friday, 8:30 AM – 5:30 PM, excluding holidays; however, if there was any indication that a provider has alternative office hours, IPRO then called the provider during those alternative hours. Surveyors utilized the "reveal" method, in which the surveyors disclosed that the call was being made on behalf of DMAHS to verify the accuracy of the provider's information. Specifically, IPRO surveyors requested that the provider or representative verbally verify the accuracy of the following data reported in the provider look-up system:

- participation status with the named MCO,
- Medicaid panel status,
- specialty,
- board certification status*,
- disability access status*, and
- physical location.

* Board Certification Status was applicable only when the online provider directory indicated that the provider is board certified. Disability Access Status was applicable only when the online provider directory indicated that the practice location has accessibility features.

Surveyors made up to three (3) attempts to contact a live staff person at each practice to complete the survey. For each call made, the surveyor documented the date, time, name of the provider representative or the reason no contact was made with a live representative.

Survey responses were used to assess both access to providers and the validity of information available to members through the MCO's online directories.

Evaluation of Accessibility Information Reported in the Provider Directory

IPRO reviewed Fidelis Care's provider look-up system to assess the availability of accessibility information and how this information is presented to users. The breadth of accessibility information in the online provider directories was evaluated through a desk review. This review included assessing the search capabilities that allow members to identify providers with accessibility features and the extent of information available to help members identify providers with specific accessibility features.

Results

Fidelis Care Provider Directory Access Results

Provider directory access was determined based on whether the provider could be contacted via telephone, was still contracted with the specified managed care plan, and was accepting new patients. As presented in Table 2, Fidelis Care has an overall provider directory access rate of 50.3%, with the highest compliance rate observed among pediatric specialists (Table 3).

Table 2: Provider Directory Access Rate

Total Providers Surveyed[1]	Compliant Providers[2]	Access Rate
350	176	50.3%

[1] Total number of providers in the sample (no exclusions).

[2] Total number of providers who positively confirmed participation with the MCO and open panel status for the listed specialty.

Table 3: Provider Directory Access Rates by Specialty

Provider Specialty (Reporting Group)	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	200	103	51.5%
Pediatric Specialists	50	29	58.0%
Dental	50	17	34.0%
Managed Long-Term Services and Supports	50	27	54.0%
Total	**350**	**176**	**50.3%**

[1] Providers who positively confirmed participation with the MCO and open panel status for the listed specialty.

The provider directory access failure summary presented in **Table 4** includes office representative(s) who either refused to participate, or did not know the information to answer the question(s). Additionally, some providers had more than one (1) failure reason; therefore, the total failure reasons plus the compliant providers exceeded the 350 providers surveyed.

Table 4: Provider Directory Access Failure Summary

Failure Reasons	Total Failed Reasons[1]	Failure Rate
Provider not at site[2]	54	15.4%
Answering machine/Voice mail system	39	11.1%
Provider not a plan participant	30	8.6%
Provider not accepting new patients (closed panel)	29	8.3%
Provider practices a different specialty	14	4.0%
Constant busy signal	8	2.3%
Disconnected/Not in Service	3	0.9%
Not Answered (>11 rings)	3	0.9%
Put on hold (>10 minutes)	3	0.9%
Representative does not have enough information to answer the survey questions	3	0.9%
Representative refuses to participate in audit	1	0.3%
Wrong telephone number	1	0.3%
Total	**188**	

[1]Failure totals may include providers that have multiple failures.

[2]Provider not at site is an umbrella term that includes; provider retired, provider no longer at that location, or provider was never at that location.

Fidelis Care Provider Directory Accuracy Results

Provider directory accuracy was determined by the validity of the provider information in the MCO's online directory. IPRO evaluated the accuracy of the provider directory information by analyzing the survey results on the following key aspects: providers' contract status with Fidelis Care, their availability to accept new patients, their specialty type, and their telephone number and address. Fidelis Care has a provider directory accuracy rate of 43.7%, with the highest compliance rate observed among MLTSS providers.

Table 5: Provider Directory Accuracy Rate

Total Providers Surveyed[1]	Compliant Providers[2]	Access Rate
350	**153**	**43.7%**

[1] Total number of providers in the sample (no exclusions).

[2] Total number of providers who positively confirmed participation with the MCO, open panel status, specialty, telephone number, and address.

Table 6: Provider Directory Accuracy Rates by Specialty

Provider Specialty (Reporting Group)	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	200	89	44.5%
Pediatric Specialists	50	23	46.0%
Dental	50	16	32.0%
Managed Long-Term Services and Supports	50	25	50.0%
Total	**350**	**153**	**43.7%**

[1] Providers who positively confirmed participation with the MCO, open panel status, specialty, telephone number, and address.

The provider directory accuracy failure summary presented in **Table 7** includes "wrong address," in addition to the failure reasons listed above for provider directory access. Additionally, some providers had more than one (1) failure reason; therefore, the total failure reasons plus the compliant providers exceeded the 350 providers surveyed.

Table 7: Provider Directory Accuracy Failure Summary

Failure Reasons	Total Failed Reasons[1]	Failure Rate
Provider not at site[2]	54	15.4%
Answering machine/Voice mail system	39	11.1%
Provider not a plan participant	30	8.6%
Provider not accepting new patients (closed panel)	29	8.3%
Wrong address	29	8.3%
Provider practices a different specialty	14	4.0%
Constant busy signal	8	2.3%
Disconnected/Not in Service	3	0.9%
Not Answered (>11 rings)	3	0.9%
Put on hold (>10 minutes)	3	0.9%
Representative does not have enough information to answer the survey questions	3	0.9%
Representative refuses to participate in audit	1	0.3%
Wrong telephone number	1	0.3%
Total	**217**	

[1]Failure totals may include providers that have multiple failures.
[2]Provider not at site is an umbrella term that includes; provider retired, provider no longer at that location, or provider was never at that location.

Table 8 and **Table 9** represent the validation of board certification status as printed in the online provider directory. Out of the 350 providers surveyed, 219 had their board certification listed in the online provider directory. Among these providers, 66.7% of providers positively confirmed board certification status. The highest compliance rate was observed among dental providers.

Table 8: Provider Directory Board Certification Accuracy Rate

Total Providers Surveyed	Providers With Board Certification Listed[1]	Compliant Providers[2]	Access Rate
350	219	146	66.7%

[1]Total Providers with board certification status listed in the online provider directory.
[2] Total number of providers who positively confirmed board certification status.

Table 9: Provider Directory Board Certification Accuracy Rates by Specialty

Provider Specialty (Reporting Group)	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	161	107	66.5%
Pediatric Specialists	42	29	69.0%
Dental	8	6	75.0%
Managed Long-Term Services and Supports	8	4	50.0%
Total	**219**	**146**	**66.7%**

[1] Providers who positively confirmed board certification status.

Table 10 and Table 11 represent the validation of disability access status as printed in the online provider directory. Out of the 350 providers surveyed, 319 had their disability access listed in the online provider directory. Among these providers, 60.5% of providers positively confirmed disability access status. The highest compliance rate was observed among pediatric specialists.

Table 10: Provider Directory Disability Accuracy Rate

Total Providers Surveyed	Providers With Disability Access Listed[1]	Compliant Providers[2]	Access Rate
350	319	193	60.5%

[1]Total Providers with disability access listed in the online provider directory.
[2] Total number of providers who positively confirmed disability access status.

Table 11: Provider Directory Disability Accuracy Rates by Specialty

Provider Specialty Reporting Group	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	190	117	61.6%
Pediatric Specialists	38	27	71.1%
Dental	46	25	54.3%
Managed Long-Term Services and Supports	45	24	53.3%
Total	**319**	**193**	**60.5%**

[1] Providers who positively confirmed disability access status.

Evaluation of Practice Site Accessibility Information Results

As presented in Table 12, IPRO conducted a review of Fidelis Care's online provider directory to assess how members are informed about a practice site's accessibility features. Fidelis Care's online provider directory does have the ability to filter providers with accessibility features, but the degree of information is limited (Table 13).

Table 12: Provider Directory Search Capabilities for Accessibility Information

Review Question	Determination (Yes or No)
Does the site have the ability to filter for providers who have accessibility features?	Yes
Does the site have the ability to filter for specific accessibility features?	Yes
Are there clear and easy to find instructions for the member to call the managed care plan for assistance in finding a provider who meets accessibility need?	Yes

Table 13: Provider Directory Degree of Information Available for Accessibility Information

Degree of Information	Information Reported (Yes or No)
Accessible examination tables	No
Accessible scales	No
Accessible restrooms	No
Bariatric examination tables	No
Bariatric scales	No
Elevators in multistory buildings	No
Handicapped parking	No
Lifts	No
Signs in braille	No
Video access to offsite interpreter	No
Wheelchair ramps	Yes
General “handicap accessibility” indicator	Yes

Recommendations

Based on the findings of this provider directory validation study, IPRO recommends the following:

- Fidelis Care should conduct routine assessments of their provider directories to ensure provider data is accurate and updated timely, as many failures resulted from the provider not being at the listed site and surveyors reaching an answering machine on all call attempts.
- Fidelis Care should conduct reviews and verification processes to ensure the accuracy of board certification status for all providers listed in the online provider directory.
- Fidelis Care should ensure its provider network includes providers with disability accommodations. This will enable members to easily find providers who can meet their specific needs, such as those offering accessible facilities and specialized equipment.

Opportunity for Improvement

- Fidelis Care should consider including detailed accessibility filters in their online directories. This enhancement will ensure that members can easily find providers who meet their specific needs, such as those who require accessible examination tables and scales.

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Horizon New Jersey Health

2024 Provider Directory Validation Survey

Survey Period: May 2024 – July 2024

Prepared on behalf of:

The New Jersey Division of Medical Assistance and Health Services

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Introduction

The Centers for Medicare and Medicaid Services (CMS) established network adequacy standards in Medicaid and Children's Health Insurance Program (CHIP) for certain providers while granting flexibility to the states to set and enforce state-specific Medicaid network standards. New Jersey has Medicaid network standards in place that address this requirement. CMS also requires that the adequacy of Medicaid networks maintained by a managed care organization (MCO) be evaluated annually by the state or an External Quality Review Organization (EQRO). To comply with this requirement, the New Jersey Division of Medical Assistance and Health Services (DMAHS) contracted with Island Peer Review Organization, Inc. (IPRO), an EQRO, to evaluate the state's Medicaid and CHIP MCO provider networks, called NJ FamilyCare.

In 2024, IPRO's evaluation included the NJ FamilyCare network for Horizon NJ Health (HNJH).

Aim

IPRO's evaluation aimed to:

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

This report reflects the results of the 2024 Provider Directory Validation Survey for HNJH.

Objectives

Title 42 Code of Federal Regulations Section 438.356 State contract options for external quality review and *Title 42 Code of Federal Regulations Section 438.358 Activities related to external quality review* establish that state agencies must contract with an EQRO to perform the Annual Validation of Network Adequacy. To meet these federal regulations, DMAHS contracted with IPRO to validate the accuracy of provider information available to Medicaid members through the provider look-up systems on each MCO's website, and to evaluate the breadth and scope of how accessibility information is presented in these look-up systems. The study methodology aligns with the Centers for Medicare & Medicaid Services' External Quality Review (EQR) Protocol 4 – Validation of Network Adequacy.

Technical Methods of Data Collection and Analysis

Validation of the Accuracy of Information Reported in the Provider Directory

IPRO accessed HNJH's provider look-up system between May 2024 and July 2024 to prepare the MCO's sample. Table 1 displays the website address of the MCO's provider look-up system, the date range the look-up system was accessed by IPRO to prepare the sample, and the date range IPRO administered the survey.

Table 1: Survey Administration Summary

URL for Provider Directory	https://www.horizonnjhealth.com/findadoctor
Website Access Dates	5/20/2024-5/30/2024
Survey Date Range	6/7/2024-7/16/2024

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

- practices primary care, a pediatric specialty, dentistry, or is a managed long-term service and supports (MLTSS) provider, and
- participates in the NJ FamilyCare network, and
- accepts new patients enrolled with HNJH.

A random sample totaling 350 providers was prepared for HNJH. Primary care providers, pediatric specialists, dental providers, and MLTSS providers were included in the sample.

To conduct this study, IPRO surveyors called provider offices using the telephone numbers reported by the MCO in the online provider look-up system. Calls were conducted Monday through Friday, 8:30 AM – 5:30 PM, excluding holidays; however, if there was any indication that a provider has alternative office hours, IPRO then called the provider during those alternative hours. Surveyors utilized the "reveal" method, in which the surveyors disclosed that the call was being made on behalf of DMAHS to verify the accuracy of the provider's information. Specifically, IPRO surveyors requested that the provider or representative verbally verify the accuracy of the following data reported in the provider look-up system:

- participation status with the named MCO,
- Medicaid panel status,
- specialty,
- board certification status*,
- disability access status*, and
- physical location.

* Board Certification Status was applicable only when the online provider directory indicated that the provider is board certified. Disability Access Status was applicable only when the online provider directory indicated that the practice location has accessibility features.

Surveyors made up to three (3) attempts to contact a live staff person at each practice to complete the survey. For each call made, the surveyor documented the date, time, name of the provider representative or the reason no contact was made with a live representative.

Survey responses were used to assess both access to providers and the validity of information available to members through the MCO's online directories.

Evaluation of Accessibility Information Reported in the Provider Directory

IPRO reviewed HNJH's provider look-up system to assess the availability of accessibility information and how this information is presented to users. The breadth of accessibility information in the online provider directories was evaluated through a desk review. This review included assessing the search capabilities that allow members to identify providers with accessibility features and the extent of information available to help members identify providers with specific accessibility features.

Results

HNJH Provider Directory Access Results

Provider directory access was determined based on whether the provider could be contacted via telephone, was still contracted with the specified managed care plan, and was accepting new patients. As presented in Table 2, HNJH has an overall provider directory access rate of 50.3%, with the highest compliance rates observed among primary care and dental providers (Table 3).

Table 2: Provider Directory Access Rate

Total Providers Surveyed[1]	Compliant Providers[2]	Access Rate
350	176	50.3%

[1] Total number of providers in the sample (no exclusions).

[2] Total number of providers who positively confirmed participation with the MCO and open panel status for the listed specialty.

Table 3: Provider Directory Access Rates by Specialty

Provider Specialty (Reporting Group)	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	200	104	52.0%
Pediatric Specialists	50	25	50.0%
Dental	50	26	52.0%
Managed Long-Term Services and Supports	50	21	42.0%
Total	**350**	**176**	**50.3%**

[1] Providers who positively confirmed participation with the MCO and open panel status for the listed specialty.

The provider directory access failure summary presented in **Table 4** includes office representative(s) who either refused to participate, or did not know the information to answer the question(s). Additionally, some providers had more than one (1) failure reason; therefore, the total failure reasons plus the compliant providers exceeded the 350 providers surveyed.

Table 4: Provider Directory Access Failure Summary

Failure Reasons	Total Failed Reasons[1]	Failure Rate
Provider not at site[2]	64	18.3%
Answering machine/Voice mail system	33	9.4%
Provider not a plan participant	17	4.9%
Provider not accepting new patients (closed panel)	16	4.6%
Provider practices a different specialty	11	3.1%
Constant busy signal	11	3.1%
Disconnected/Not in Service	10	2.9%
Put on hold (>10 minutes)	5	1.4%
Not Answered (>11 rings)	4	1.1%
Representative does not have enough information to answer the survey questions	4	1.1%
Representative refuses to participate in audit	3	0.9%
Wrong telephone number	3	0.9%
Total	**181**	

[1]Failure totals may include providers that have multiple failures.

[2]Provider not at site is an umbrella term that includes; provider retired, provider no longer at that location, or provider was never at that location.

HNJH Provider Directory Accuracy Results

Provider directory accuracy was determined by the validity of the provider information in the MCO's online directory. IPRO evaluated the accuracy of the provider directory information by analyzing the survey results on the following key aspects: providers' contract status with HNJH, their availability to accept new patients, their specialty type, and their telephone number and address. HNJH has a provider directory accuracy rate of 46.0%, with the highest compliance rate observed among dental providers.

Table 5: Provider Directory Accuracy Rate

Total Providers Surveyed[1]	Compliant Providers[2]	Access Rate
350	161	46.0%

[1] Total number of providers in the sample (no exclusions).

[2] Total number of providers who positively confirmed participation with the MCO, open panel status, specialty, telephone number, and address.

Table 6: Provider Directory Accuracy Rates by Specialty

Provider Specialty (Reporting Group)	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	200	96	48.0%
Pediatric Specialists	50	19	38.0%
Dental	50	25	50.0%
Managed Long-Term Services and Supports	50	21	42.0%
Total	**350**	**161**	**46.0%**

[1] Providers who positively confirmed participation with the MCO, open panel status, specialty, telephone number, and address.

The provider directory accuracy failure summary presented in **Table 7** includes "wrong address," in addition to the failure reasons listed above for provider directory access. Additionally, some providers had more than one (1) failure reason; therefore, the total failure reasons plus the compliant providers exceeded the 350 providers surveyed.

Table 7: Provider Directory Accuracy Failure Summary

Failure Reasons	Total Failed Reasons[1]	Failure Rate
Provider not at site[2]	64	18.3%
Answering machine/Voice mail system	33	9.4%
Wrong address	20	5.7%
Provider not a plan participant	17	4.9%
Provider not accepting new patients (closed panel)	16	4.6%
Provider practices a different specialty	11	3.1%
Constant busy signal	11	3.1%
Disconnected/Not in Service	10	2.9%
Put on hold (>10 minutes)	5	1.4%
Not Answered (>11 rings)	4	1.1%
Representative does not have enough information to answer the survey questions	4	1.1%
Representative refuses to participate in audit	3	0.9%
Wrong telephone number	3	0.9%
Total	**201**	

[1]Failure totals may include providers that have multiple failures.

[2]Provider not at site is an umbrella term that includes; provider retired, provider no longer at that location, or provider was never at that location.

Table 8 and **Table 9** represent the validation of board certification status as printed in the online provider directory. Out of the 350 providers surveyed, 31 had their board certification listed in the online provider directory. Among these providers, 55.4% of providers positively confirmed board certification status. The highest compliance rate was observed among primary care providers. There were no board-certified dental or MLTSS providers listed in HNJH's provider directory.

Table 8: Provider Directory Board Certification Accuracy Rate

Total Providers Surveyed	Providers With Board Certification Listed[1]	Compliant Providers[2]	Access Rate
350	56	31	55.4%

[1]Total Providers with board certification status listed in the online provider directory.
[2] Total number of providers who positively confirmed board certification status.

Table 9: Provider Directory Board Certification Accuracy Rates by Specialty

Provider Specialty (Reporting Group)	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	37	23	62.2%
Pediatric Specialists	19	8	42.1%
Dental	0	0	---
Managed Long-Term Services and Supports	0	0	---
Total	**56**	**31**	**55.4%**

[1] Providers who positively confirmed board certification status.

Table 10 and Table 11 represent the validation of disability access status as printed in the online provider directory. Out of the 350 providers surveyed, 254 had their disability access listed in the online provider directory. Among these providers, 52.0% of providers positively confirmed disability access status. The highest compliance rate was observed among primary care providers.

Table 10: Provider Directory Disability Accuracy Rate

Total Providers Surveyed	Providers With Disability Access Listed[1]	Compliant Providers[2]	Access Rate
350	254	132	52.0%

[1]Total Providers with disability access listed in the online provider directory.
[2] Total number of providers who positively confirmed disability access status.

Table 11: Provider Directory Disability Accuracy Rates by Specialty

Provider Specialty Reporting Group	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	158	94	59.5%
Pediatric Specialists	46	19	41.3%
Dental	35	15	42.9%
MLTSS Services	15	4	26.7%
Total	**254**	**132**	**52.0%**

[1] Providers who positively confirmed disability access status.

Evaluation of Practice Site Accessibility Information Results

As presented in **Table 12**, IPRO conducted a review of HNJH's online provider directory to assess how members are informed about a practice site's accessibility features. HNJH's online provider directory does have the ability to filter providers with accessibility features, but the degree of information is limited (**Table 13**).

Table 12: Provider Directory Search Capabilities for Accessibility Information

Review Question	Determination (Yes or No)
Does the site have the ability to filter for providers who have accessibility features?	Yes
Does the site have the ability to filter for specific accessibility features?	Yes
Are there clear and easy to find instructions for the member to call the managed care plan for assistance in finding a provider who meets accessibility need?	No

Table 13: Provider Directory Degree of Information Available for Accessibility Information

Degree of Information	Information Reported (Yes or No)
Accessible examination tables	No
Accessible scales	No
Accessible restrooms	No
Bariatric examination tables	No
Bariatric scales	No
Elevators in multistory buildings	No
Handicapped parking	No
Lifts	No
Signs in braille	No
Video access to offsite interpreter	Yes
Wheelchair ramps	Yes
General “handicap accessibility” indicator	Yes

Recommendations

Based on the findings of this provider directory validation study, IPRO recommends the following:

- HNJH should conduct routine assessments of their provider directories to ensure provider data is accurate and updated timely, as many failures resulted from the provider not being at the listed site and surveyors reaching an answering machine on all call attempts.
- HNJH should conduct reviews and verification processes to ensure the accuracy of board certification status for all providers listed in the online provider directory.
- HNJH should ensure its provider network includes providers with disability accommodations. This will enable members to easily find providers who can meet their specific needs, such as those offering accessible facilities and specialized equipment.

Opportunity for Improvement

- HNJH should consider including additional accessibility filters in their online directories. This enhancement will ensure that members can easily find providers who meet their individual needs, such as those who require accessible examination tables and scales.

IPRO

Better healthcare, realized.

UnitedHealthcare Community Plan

2024 Provider Directory Validation Survey

Survey Period: May 2024 – July 2024

Prepared on behalf of:

The New Jersey Division of Medical Assistance and Health Services

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Introduction

The Centers for Medicare and Medicaid Services (CMS) established network adequacy standards in Medicaid and Children's Health Insurance Program (CHIP) for certain providers while granting flexibility to the states to set and enforce state-specific Medicaid network standards. New Jersey has Medicaid network standards in place that address this requirement. CMS also requires that the adequacy of Medicaid networks maintained by a managed care organization (MCO) be evaluated annually by the state or an External Quality Review Organization (EQRO). To comply with this requirement, the New Jersey Division of Medical Assistance and Health Services (DMAHS) contracted with Island Peer Review Organization, Inc. (IPRO), an EQRO, to evaluate the state's Medicaid and CHIP MCO provider networks, called NJ FamilyCare.

In 2024, IPRO's evaluation included the NJ FamilyCare network for UnitedHealthcare Community Plan (UHCCP).

Aim

IPRO's evaluation aimed to:

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

This report reflects the results of the 2024 Provider Directory Validation Survey for UHCCP.

Objectives

Title 42 Code of Federal Regulations Section 438.356 State contract options for external quality review and *Title 42 Code of Federal Regulations Section 438.358 Activities related to external quality review* establish that state agencies must contract with an EQRO to perform the Annual Validation of Network Adequacy. To meet these federal regulations, DMAHS contracted with IPRO to validate the accuracy of provider information available to Medicaid members through the provider look-up systems on each MCO's website, and to evaluate the breadth and scope of how accessibility information is presented in these look-up systems. The study methodology aligns with the Centers for Medicare & Medicaid Services' External Quality Review (EQR) Protocol 4 – Validation of Network Adequacy.

Technical Methods of Data Collection and Analysis

Validation of the Accuracy of Information Reported in the Provider Directory

IPRO accessed UHCCP's provider look-up system between May 2024 and July 2024 to prepare the MCO's sample. Table 1 displays the website address of the MCO's provider look-up system, the date range the look-up system was accessed by IPRO to prepare the sample, and the date range IPRO administered the survey.

Table 1: Survey Administration Summary

URL for Provider Directory	https://member.uhc.com/communityplan
Website Access Dates	5/20/2024-5/30/2024
Survey Date Range	6/13/2024-7/25/2024

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

- practices primary care, a pediatric specialty, dentistry, or is a managed long-term services and supports (MLTSS) provider, and
- participates in the NJ FamilyCare network, and
- accepts new patients enrolled with UHCCP.

A random sample totaling 350 providers was prepared for UHCCP. Primary care providers, pediatric specialists, dental providers, and MLTSS providers were included in the sample.

To conduct this study, IPRO surveyors called provider offices using the telephone numbers reported by the MCO in the online provider look-up system. Calls were conducted Monday through Friday, 8:30 AM – 5:30 PM, excluding holidays; however, if there was any indication that a provider has alternative office hours, IPRO then called the provider during those alternative hours. Surveyors utilized the "reveal" method, in which the surveyors disclosed that the call was being made on behalf of DMAHS to verify the accuracy of the provider's information. Specifically, IPRO surveyors requested that the provider or representative verbally verify the accuracy of the following data reported in the provider look-up system:

- participation status with the named MCO,
- Medicaid panel status,
- specialty,
- board certification status*,
- disability access status*, and
- physical location.

* Board Certification Status was applicable only when the online provider directory indicated that the provider is board certified. Disability Access Status was applicable only when the online provider directory indicated that the practice location has accessibility features.

Surveyors made up to three (3) attempts to contact a live staff person at each practice to complete the survey. For each call made, the surveyor documented the date, time, name of the provider representative or the reason no contact was made with a live representative.

Survey responses were used to assess both access to providers and the validity of information available to members through the MCO's online directories.

Evaluation of Accessibility Information Reported in the Provider Directory

IPRO reviewed UHCCP's provider look-up system to assess the availability of accessibility information and how this information is presented to users. The breadth of accessibility information in the online provider directories was evaluated through a desk review. This review included assessing the search capabilities that allow members to identify providers with accessibility features and the extent of information available to help members identify providers with specific accessibility features.

Results

UHCCP Provider Directory Access Results

Provider directory access was determined based on whether the provider could be contacted via telephone, was still contracted with the specified managed care plan, and was accepting new patients. As presented in Table 2, UHCCP has an overall provider directory access rate of 56.3%, with the highest compliance rate observed among pediatric specialists (Table 3).

Table 2: Provider Directory Access Rate

Total Providers Surveyed[1]	Compliant Providers[2]	Access Rate
350	197	56.3%

[1] Total number of providers in the sample (no exclusions).

[2] Total number of providers who positively confirmed participation with the MCO and open panel status for the listed specialty.

Table 3: Provider Directory Access Rates by Specialty

Provider Specialty (Reporting Group)	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	200	109	54.5%
Pediatric Specialists	50	34	68.0%
Dental	50	26	52.0%
Managed Long-Term Services and Supports	50	28	56.0%
Total	**350**	**197**	**56.3%**

[1] Providers who positively confirmed participation with the MCO and open panel status for the listed specialty.

The provider directory access failure summary presented in **Table 4** includes office representative(s) who either refused to participate, or did not know the information to answer the question(s). Additionally, some providers had more than one (1) failure reason; therefore, the total failure reasons plus the compliant providers exceeded the 350 providers surveyed.

Table 4: Provider Directory Access Failure Summary

Failure Reasons	Total Failed Reasons[1]	Failure Rate
Provider not at site[2]	47	13.4%
Answering machine/Voice mail system	29	8.3%
Provider not accepting new patients (closed panel)	25	7.1%
Provider not a plan participant	24	6.9%
Representative refuses to participate in audit	12	3.4%
Provider practices a different specialty	11	3.1%
Constant busy signal	11	3.1%
Put on hold (>10 minutes)	5	1.4%
Disconnected/Not in Service	4	1.1%
Representative does not have enough information to answer the survey questions	2	0.6%
Wrong telephone number	1	0.3%
Not Answered (>11 rings)	1	0.3%
Total	**172**	

[1]Failure totals may include providers that have multiple failures.

[2]Provider not at site is an umbrella term that includes; provider retired, provider no longer at that location, or provider was never at that location.

UHCCP Provider Directory Accuracy Results

Provider directory accuracy was determined by the validity of the provider information in the MCO's online directory. IPRO evaluated the accuracy of the provider directory information by analyzing the survey results on the following key aspects: providers' contract status with UHCCP, their availability to accept new patients, their specialty type, and their telephone number and address. UHCCP has a provider directory accuracy rate of 50.9%, with the highest compliance rate observed among pediatric specialists.

Table 5: Managed Care Plan Provider Directory Accuracy Rate

Total Providers Surveyed[1]	Compliant Providers[2]	Access Rate
350	178	50.9%

[1] Total number of providers in the sample (no exclusions).

[2] Total number of providers who positively confirmed participation with the MCO, open panel status, specialty, telephone number, and address.

Table 6: Provider Directory Accuracy Rates by Specialty

Provider Specialty (Reporting Group)	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	200	99	49.5%
Pediatric Specialists	50	30	60.0%
Dental	50	23	46.0%
Managed Long-Term Services and Supports	50	26	52.0%
Total	**350**	**178**	**50.9%**

[1] Providers who positively confirmed participation with the MCO, open panel status, specialty, telephone number, and address.

The provider directory accuracy failure summary presented in **Table 7** includes "wrong address," in addition to the failure reasons listed above for provider directory access. Additionally, some providers had more than one (1) failure reason; therefore, the total failure reasons plus the compliant providers exceeded the 350 providers surveyed.

Table 7: Provider Directory Accuracy Failure Summary

Failure Reasons	Total Failed Reasons[1]	Failure Rate
Provider not at site[2]	47	13.4%
Answering machine/Voice mail system	29	8.3%
Provider not accepting new patients (closed panel)	25	7.1%
Provider not a plan participant	24	6.9%
Wrong address	23	6.6%
Representative refuses to participate in audit	12	3.4%
Provider practices a different specialty	11	3.1%
Constant busy signal	11	3.1%
Put on hold (>10 minutes)	5	1.4%
Disconnected/Not in Service	4	1.1%
Representative does not have enough information to answer the survey questions	2	0.6%
Wrong telephone number	1	0.3%
Not Answered (>11 rings)	1	0.3%
Total	**195**	

[1]Failure totals may include providers that have multiple failures.

[2]Provider not at site is an umbrella term that includes; provider retired, provider no longer at that location, or provider was never at that location.

Table 8 and **Table 9** represent the validation of board certification status as printed in the online provider directory. Out of the 350 providers surveyed, 194 had their board certification listed in the online provider directory. Among these providers, 67.5% of providers positively confirmed board certification status. The highest compliance rate was observed among pediatric specialists. There were no board-certified dental or MLTSS providers listed in UHCCP's provider directory.

Table 8: Provider Directory Board Certification Accuracy Rate

Total Providers Surveyed	Providers With Board Certification Listed[1]	Compliant Providers[2]	Access Rate
350	194	131	67.5%

[1]Total Providers with board certification status listed in the online provider directory.
[2] Total number of providers who positively confirmed board certification status.

Table 9: Provider Directory Board Certification Accuracy Rates by Specialty

Provider Specialty (Reporting Group)	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	157	102	65.0%
Pediatric Specialists	37	29	78.4%
Dental	0	0	---
Managed Long-Term Services and Supports	0	0	---
Total	**194**	**131**	**67.5%**

[1] Providers who positively confirmed board certification status.

Table 10 and **Table 11** represent the validation of disability access status as printed in the online provider directory. Out of the 350 providers surveyed, 308 had their disability access listed in the online provider directory. Among these providers, 63.0% of providers positively confirmed disability access status. The highest compliance rate was observed among pediatric specialists.

Table 10: Provider Directory Disability Accuracy Rate

Total Providers Surveyed	Providers With Disability Access Listed[1]	Compliant Providers[2]	Access Rate
350	308	194	63.0%

[1]Total Providers with disability access listed in the online provider directory.
[2] Total number of providers who positively confirmed disability access status.

Table 11: Provider Directory Disability Accuracy Rates by Specialty

Provider Specialty (Reporting Group)	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	199	119	59.8%
Pediatric Specialists	49	38	77.6%
Dental	13	6	46.2%
Managed Long-Term Services and Supports	47	31	66.0%
Total	**308**	**194**	**63.0%**

[1] Providers who positively confirmed disability access status.

Evaluation of Practice Site Accessibility Information Results

As presented in **Table 12**, IPRO conducted a review of UHCCP's online provider directory to assess how members are informed about a practice site's accessibility features. UHCCP's online provider directory does not have the ability to filter providers with accessibility features, but all provider profiles include a detailed list of available accessibility options. (**Table 13**).

Table 12: Provider Directory Search Capabilities for Accessibility Information

Review Question	Determination (Yes or No)
Does the site have the ability to filter for providers who have accessibility features?	No
Does the site have the ability to filter for specific accessibility features?	No
Are there clear and easy to find instructions for the member to call the managed care plan for assistance in finding a provider who meets accessibility need?	No

Table 13: Provider Directory Degree of Information Available for Accessibility Information

Degree of Information	Information Reported (Yes or No)
Accessible examination tables	Yes
Accessible scales	Yes
Accessible restrooms	Yes
Bariatric examination tables	Yes
Bariatric scales	Yes
Elevators in multistory buildings	Yes
Handicapped parking	Yes
Lifts	Yes
Signs in braille	Yes
Video access to offsite interpreter	No
Wheelchair ramps	Yes
General “handicap accessibility” indicator	Yes

Recommendations

Based on the findings of this provider directory validation study, IPRO recommends the following:

- UHCCP should conduct routine assessments of their provider directories to ensure provider data is accurate and updated timely, as many failures resulted from the provider not being at the listed site and surveyors reaching an answering machine on all call attempts.
- UHCCP should ensure the online provider directory accurately lists all board-certified providers and routinely conduct reviews and verification processes to maintain the accuracy of this information.
- UHCCP should regularly review the accessibility options listed under providers' profiles to ensure their accuracy.

Opportunity for Improvement

- While UHCCP’s online provider directory contains detailed accessibility information, UHCCP should consider adding a filter option for members to easily find this information. This enhancement will ensure that members can easily find providers who meet their individual needs, such as those who require accessible examination tables and scales.

IPRO

Better healthcare, realized.

Wellpoint New Jersey, Inc.

2024 Provider Directory Validation Survey

Survey Period: May 2024 – July 2024

Prepared on behalf of:

The New Jersey Division of Medical Assistance and Health Services

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Introduction

The Centers for Medicare and Medicaid Services (CMS) established network adequacy standards in Medicaid and Children's Health Insurance Program (CHIP) for certain providers while granting flexibility to the states to set and enforce state-specific Medicaid network standards. New Jersey has Medicaid network standards in place that address this requirement. CMS also requires that the adequacy of Medicaid networks maintained by a managed care organization (MCO) be evaluated annually by the state or an External Quality Review Organization (EQRO). To comply with this requirement, the New Jersey Division of Medical Assistance and Health Services (DMAHS) contracted with Island Peer Review Organization, Inc. (IPRO), an EQRO, to evaluate the state's Medicaid and CHIP MCO provider networks, called NJ FamilyCare.

In 2024, IPRO's evaluation included the NJ FamilyCare network for Wellpoint New Jersey, Inc. (WPNJ).

Aim

IPRO's evaluation aimed to:

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

This report reflects the results of the 2024 Provider Directory Validation Survey for WPNJ.

Objectives

Title 42 Code of Federal Regulations Section 438.356 State contract options for external quality review and *Title 42 Code of Federal Regulations Section 438.358 Activities related to external quality review* establish that state agencies must contract with an EQRO to perform the Annual Validation of Network Adequacy. To meet these federal regulations, DMAHS contracted with IPRO to validate the accuracy of provider information available to Medicaid members through the provider look-up systems on each MCO's website, and to evaluate the breadth and scope of how accessibility information is presented in these look-up systems. The study methodology aligns with the Centers for Medicare & Medicaid Services' External Quality Review (EQR) Protocol 4 – Validation of Network Adequacy.

Technical Methods of Data Collection and Analysis

Validation of the Accuracy of Information Reported in the Provider Directory

IPRO accessed WPNJ's provider look-up system between May 2024 and July 2024 to prepare the MCO's sample. Table 1 displays the website address of the MCO's provider look-up system, the date range the look-up system was accessed by IPRO to prepare the sample, and the date range IPRO administered the survey.

Table 1: Survey Administration Summary

URL for Provider Directory	https://www.wellpoint.com/nj/medicaid/search-providers
Website Access Dates	5/21/2024-5/30/2024
Survey Date Range	5/28/2024-7/25/2024

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

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

A random sample totaling 350 providers was prepared for WPNJ. Primary care providers, pediatric specialists, dental providers, and MLTSS providers were included in the sample.

To conduct this study, IPRO surveyors called provider offices using the telephone numbers reported by the MCO in the online provider look-up system. Calls were conducted Monday through Friday, 8:30 AM – 5:30 PM, excluding holidays; however, if there was any indication that a provider has alternative office hours, IPRO then called the provider during those alternative hours. Surveyors utilized the "reveal" method, in which the surveyors disclosed that the call was being made on behalf of DMAHS to verify the accuracy of the provider's information. Specifically, IPRO surveyors requested that the provider or representative verbally verify the accuracy of the following data reported in the provider look-up system:

- participation status with the named MCO,
- Medicaid panel status,
- specialty,
- board certification status*,
- disability access status*, and
- physical location.

* Board Certification Status was applicable only when the online provider directory indicated that the provider is board certified. Disability Access Status was applicable only when the online provider directory indicated that the practice location has accessibility features.

Surveyors made up to three (3) attempts to contact a live staff person at each practice to complete the survey. For each call made, the surveyor documented the date, time, name of the provider representative or the reason no contact was made with a live representative.

Survey responses were used to assess both access to providers and the validity of information available to members through the MCO's online directories.

Evaluation of Accessibility Information Reported in the Provider Directory

IPRO reviewed WPNJ's provider look-up system to assess the availability of accessibility information and how this information is presented to users. The breadth of accessibility information in the online provider directories was evaluated through a desk review. This review included assessing the search capabilities that allow members to identify providers with accessibility features and the extent of information available to help members identify providers with specific accessibility features.

Results

WPNJ Provider Directory Access Results

Provider directory access was determined based on whether the provider could be contacted via telephone, was still contracted with the specified managed care plan, and was accepting new patients. As presented in Table 2, WPNJ has an overall provider directory access rate of 43.7%, with the highest compliance rate observed among pediatric specialists (Table 3).

Table 2: Provider Directory Access Rate

Total Providers Surveyed[1]	Compliant Providers[2]	Access Rate
350	153	43.7%

[1] Total number of providers in the sample (no exclusions).

[2] Total number of providers who positively confirmed participation with the MCO and open panel status for the listed specialty.

Table 3: Provider Directory Access Rates by Specialty

Provider Specialty (Reporting Group)	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	200	90	45.0%
Pediatric Specialists	50	27	54.0%
Dental	50	11	22.0%
Managed Long-Term Services and Supports	50	25	50.0%
Total	**350**	**153**	**43.7%**

[1] Providers who positively confirmed participation with the MCO and open panel status for the listed specialty.

The provider directory access failure summary presented in **Table 4** includes office representative(s) who either refused to participate, or did not know the information to answer the question(s). Additionally, some providers had more than one (1) failure reason; therefore, the total failure reasons plus the compliant providers exceeded the 350 providers surveyed.

Table 4: Provider Directory Access Failure Summary

Failure Reasons	Total Failed Reasons[1]	Failure Rate
Provider not at site[2]	85	24.3%
Provider not accepting new patients (closed panel)	18	5.1%
Answering machine/Voice mail system	17	4.9%
Provider not a plan participant	17	4.9%
Provider practices a different specialty	15	4.3%
Disconnected/Not in Service	13	3.7%
Constant busy signal	9	2.6%
Put on hold (>10 minutes)	7	2.0%
Representative refuses to participate in audit	6	1.7%
Not Answered (>11 rings)	5	1.4%
Representative does not have enough information to answer the survey questions	2	0.6%
Wrong telephone number	1	0.3%
Total	**195**	

[1]Failure totals may include providers that have multiple failures.

[2]Provider not at site is an umbrella term that includes; provider retired, provider no longer at that location, or provider was never at that location.

WPNJ Provider Directory Accuracy Results

Provider directory accuracy was determined by the validity of the provider information in the MCO's online directory. IPRO evaluated the accuracy of the provider directory information by analyzing the survey results on the following key aspects: providers' contract status with WPNJ, their availability to accept new patients, their specialty type, and their telephone number and address. WPNJ has a provider directory accuracy rate of 38.3%, with the highest compliance rate observed among pediatric specialists.

Table 5: Provider Directory Accuracy Rate

Total Providers Surveyed[1]	Compliant Providers[2]	Access Rate
350	**134**	**38.3%**

[1] Total number of providers in the sample (no exclusions).

[2] Total number of providers who positively confirmed participation with the MCO, open panel status, specialty, telephone number, and address.

Table 6: Provider Directory Accuracy Rates by Specialty

Provider Specialty (Reporting Group)	Total Provider Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	200	81	40.5%
Pediatric Specialists	50	23	46.0%
Dental	50	8	16.0%
Managed Long-Term Services and Supports	50	22	44.0%
Total	**350**	**134**	**38.3%**

[1] Providers who positively confirmed participation with the MCO, open panel status, specialty, telephone number, and address.

The provider directory accuracy failure summary presented in **Table 7** includes "wrong address," in addition to the failure reasons listed above for provider directory access. Additionally, some providers had more than one (1) failure reason; therefore, the total failure reasons plus the compliant providers exceeded the 350 providers surveyed.

Table 7: Provider Directory Accuracy Failure Summary

Failure Reasons	Total Failed Reasons[1]	Failure Rate
Provider not at site[2]	85	24.3%
Wrong address	28	8.0%
Provider not accepting new patients (closed panel)	18	5.1%
Answering machine/Voice mail system	17	4.9%
Provider not a plan participant	17	4.9%
Provider practices a different specialty	15	4.3%
Disconnected/Not in Service	13	3.7%
Constant busy signal	9	2.6%
Put on hold (>10 minutes)	7	2.0%
Representative refuses to participate in audit	6	1.7%
Not Answered (>11 rings)	5	1.4%
Representative does not have enough information to answer the survey questions	2	0.6%
Wrong telephone number	1	0.3%
Total	**223**	

[1]Failure totals may include providers that have multiple failures.

[2]Provider not at site is an umbrella term that includes; provider retired, provider no longer at that location, or provider was never at that location.

Table 8 and **Table 9** represent the validation of board certification status as printed in the online provider directory. Out of the 350 providers surveyed, 116 had their board certification listed in the online provider directory. Among these providers, 59.5% of providers positively confirmed board certification status. The highest compliance rate was observed among dental providers. There were no board-certified MLTSS providers listed in WPNJ's provider directory.

Table 8: Provider Directory Board Certification Accuracy Rate

Total Providers Surveyed	Providers With Board Certification Listed[1]	Compliant Providers[2]	Access Rate
350	116	69	59.5%

[1]Total Providers with board certification status listed in the online provider directory.
[2] Total number of providers who positively confirmed board certification status.

Table 9: Provider Directory Board Certification Accuracy Rates by Specialty

Provider Specialty (Reporting Group)	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	88	50	56.8%
Pediatric Specialists	24	16	66.7%
Dental	4	3	75.0%
Managed Long-Term Services and Supports	0	0	---
Total	116	69	59.5%

[1] Providers who positively confirmed board certification status.

Table 10 and Table 11 represent the validation of disability access status as printed in the online provider directory. Out of the 350 providers surveyed, 316 had their disability access listed in the online provider directory. Among these providers, 54.7% of providers positively confirmed disability access status. The highest compliance rate was observed among MLTSS providers.

Table 10: Provider Directory Disability Accuracy Rate

Total Providers Surveyed	Providers With Disability Access Listed[1]	Compliant Providers[2]	Access Rate
350	316	173	54.7%

[1]Total Providers with disability access listed in the online provider directory.
[2] Total number of providers who positively confirmed disability access status.

Table 11: Provider Directory Disability Accuracy Rates by Specialty

Provider Specialty (Reporting Group)	Total Providers Surveyed	Compliant Providers[1]	Compliance Rate
Primary Care	176	100	56.8%
Pediatric Specialists	45	25	55.6%
Dental	47	17	36.2%
Managed Long-Term Services and Supports	48	31	64.6%
Total	316	173	54.7%

[1] Providers who positively confirmed disability access status.

Evaluation of Practice Site Accessibility Information Results

As presented in Table 12, IPRO conducted a review of WPNJ's online provider directory to assess how members are informed about a practice site's accessibility features. WPNJ's online provider directory has the ability to filter providers with accessibility features. Additionally, the MCO provides information on a variety of accessibility features. (Table 13).

Table 12: Provider Directory Search Capabilities for Accessibility Information

Review Question	Determination (Yes or No)
Does the site have the ability to filter for providers who have accessibility features?	Yes
Does the site have the ability to filter for specific accessibility features?	Yes
Are there clear and easy to find instructions for the member to call the managed care plan for assistance in finding a provider who meets accessibility need?	Yes

Table 13: Provider Directory Degree of Information Available for Accessibility Information

Degree of Information	Information Reported (Yes or No)
Accessible examination tables	Yes
Accessible scales	Yes
Accessible restrooms	Yes
Bariatric examination tables	Yes
Bariatric scales	Yes
Elevators in multistory buildings	Yes
Handicapped parking	Yes
Lifts	Yes
Signs in braille	No
Video access to offsite interpreter	Yes
Wheelchair ramps	Yes
General “handicap accessibility” indicator	Yes

Recommendations

Based on the findings of this provider directory validation study, IPRO recommends the following:

- WPNJ should conduct routine assessments of their provider directories to ensure provider data is accurate and updated timely, as many failures resulted from the provider not being at the listed site and wrong addresses.
- WPNJ should conduct reviews and verification processes to ensure the accuracy of board certification status for all providers listed in the online provider directory.
- WPNJ should conduct reviews and verification processes to ensure the accuracy of providers with disability accommodations. This will enable members to easily find providers who can meet their specific needs, such as those offering accessible facilities and specialized equipment.

Opportunity for Improvement

- WPNJ should consider adding signs in braille to the accessibility information provided in the online provider directory.

Appendix H – Supplemental Documents for all MCOs

Submission Guides for 2024 Annual Assessment Review Enhanced, 2024 Care Management Audits (Core Medicaid and MLTSS), and 2024 ISCA RedCAP Template

New Jersey Annual Assessment of MCO Operations

Core Medicaid and MLTSS Medicaid
Document Submission Guide
2024
Enhanced Access and
New Emergency and Post Stabilization Category

Appendix H1

Access			
2024 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
A1		**In 2024, this element (A1) was repositioned under Emergency and Post Stabilization Services. Contract requirements will be addressed under EPS1.**	
A2*		**In 2024, this element (A2) was repositioned under Emergency and Post Stabilization Services. Contract requirements will be addressed under EPS2.**	
A3	4.6.3 4.1.1.L. 4.8.7.G 4.1.1.L.3	**4.6.3** **Referral Systems** A. The Contractor shall have a system whereby enrollees needing specialty medical, dental, behavioral health and/or long term services and supports will be referred timely and appropriately. The Contractor shall coordinate the referral process for members with substance use disorders (SUD) with the State's IME. The system shall address authorization for specific services with specific limits or authorization of treatment and management of a case when medically indicated. The Contractor shall maintain and submit a flow chart accurately describing the Contractor's referral system, including the title of the person(s) responsible for approving referrals. The following items shall be contained within the referral system: 1. Procedures for recording and tracking each authorized referral. 2. Documentation and assurance of completion of referrals. 3. Policies and procedures for identifying and rescheduling broken referral appointments with the providers and/or Contractor as appropriate. 4. Policies and procedures for accepting, resolving and responding to verbal and written Member requests for referrals made to the PCP and/or Contractor as appropriate. Such requests shall be logged and documented. Requests that cannot be decided upon immediately shall be responded to in writing no later than five (5) business days from the date of receipt of the request (with a call made to the Member on final disposition) and postmarked the next day. 5. Policies and procedures for proper notification of the Member and where applicable, authorized person, the Member's provider, and the Member's Care Manager, including notice of right to appeal and/or right to request a second opinion when services are denied.	▪ Utilization Management (UM)/Care Management/Pharmacy Referral Policy and Procedures ▪ UM Program Description ▪ Policies and Procedures addressing the following: ▪ Accepting, resolving and responding to verbal and written enrollee requests for referrals made to the PCP and/or Contractor as appropriate ▪ Proper notification of the right to appeal and/or right to request a second opinion when services are denied ▪ Special Needs ▪ Identifying and rescheduling broken referral appointments ▪ Dental Specialty Needs ▪ Long term services and supports ▪ Complex Needs Assessment (CNA) Form ▪ Case Examples ▪ Referral process for MLTSS services; i.e., PDN, TBI therapies, ALR, etc. ▪ Evidence of tracking requests for referrals (including second opinions) to ensure referral timeliness, dates and methods of member/provider/internal communication, and outcome ▪ Evidence of tracking missed referral appointments and member/provider follow-up ▪ Evidence of standing referrals to specialists in cases of ongoing specialty care

		6. A referral form which can be given to the Member or, where applicable, an authorized person to take to a specialist. 7. Referral form mailed, faxed, or sent by electronic means directly to the referral provider. 8. Telephoned authorization for urgent situations or when deemed appropriate by the Member's PCP or the Contractor. 9. Where applicable, the Contractor must also notify the Contractor Care Manager or authorized person. B. The Contractor shall provide a mechanism to assure the facilitation of referrals when traveling by an enrollee (especially when very ill) from one location to another to pick-up and deliver forms can cause undue hardship for the enrollee. Referrals from practitioners or prior authorizations by the Contractor shall be sent/processed within two (2) working days of the request, one (1) day for urgent cases. The Contractor shall have procedures to allow enrollees to receive a standing referral to a specialist in cases where an enrollee needs ongoing specialty care. C. The Contractor shall not impose an arbitrary number of attempted dental treatment visits by a PCD as a condition prior to the PCD initiating any specialty referral requests. Neither the Contractor nor its vendor shall obligate the referring dentist to supply diagnostic documentation similar to that required for a prior authorization request for treatment services as part of a referral request. Neither the Contractor nor its vendor shall obligate the dentist receiving the referral to prepare and submit diagnostic materials in order to approve or reimburse for a referral. D. The Contractor shall authorize any reasonable referral request from a PCP/PCD without imposing any financial penalties to the same PCP/PCD. E. All final decisions regarding denials of referrals, PAs, treatment and treatment plans for non-emergency services shall be made by a physician and/or peer physician specialist or by a licensed New Jersey dentist/dental specialist in the case of dental services, or by a licensed mental health and/or behavioral health specialist in the case of behavioral health services. Prior authorization decisions for nonemergency services shall be made within fourteen (14) calendar days or sooner as required by the needs of the enrollee. **4.1.1.L** **Second Opinions** The Contractor shall have a Second Opinion program that can be utilized at the enrollee's option for diagnosis and treatment of serious medical	▪ Medical and dental prior authorization procedures and guidelines for decision making ▪ Utilization Management policies and procedures that demonstrate the UM denial process for medical and dental referrals ▪ Member Handbook ▪ Policies and Procedures addressing the following: ▪ Coverage for second opinions ▪ Coverage for out-of-network providers when a participating provider is not available ▪ Single case agreements for covering out-of-network providers

		conditions, for elective surgical procedures, when a physician recommends a treatment other than what the Member believes is necessary, or if the Member believes they have a condition that the physician failed to diagnose. The program can also be utilized at the enrollee's option for diagnosis and treatment of dental conditions that are treated within a dental specialty. In addition, the Member may receive the second opinion within the Contractor's network or the Contractor may arrange for the Member to obtain a second opinion outside the network at no cost to the Member. The Second Opinion program shall be incorporated into the Contractor's medical and dental procedures and submitted to DMAHS for review and approval. **4.8.7.G** **Out-of-Network Providers** If the Contractor determines that it does not have a health care provider with appropriate training and experience in its panel or network to meet the particular health care needs of an enrollee, the Contractor shall make a referral to an appropriate out-of-network provider, pursuant to a treatment plan approved by the Contractor in consultation with the primary care provider, the non-Contractor participating provider and the enrollee or where applicable, authorized person, at no additional cost to the enrollee. The Contractor shall provide for a review by a specialist of the same or similar specialty as the type of physician or provider to whom a referral is requested before the Contractor may deny a referral. If the Contractor does not have an MLTSS network provider with the appropriate training, experience and availability to meet the particular service needs of the Member, or if the Contractor's network provider cannot meet the timeliness standards set forth by the State, the Contractor shall make a referral to an appropriate out-of-network provider. **4.1.1.I.3** **Out-of-Network Providers** Whenever the Contractor authorizes services by out-of-network providers, the Contractor shall require those out-of-network providers to coordinate with the Contractor with respect to payment. Further, the Contractor shall ensure that the cost to the enrollee is no greater than it would be if the services were furnished within the network.	
A4*/**	4.5.1.F 4.8.1.A 4.8.1.E 4.8.1.J 4.2.2.A	**4.5.1.F** **Dental.** While the Contractor must assure that Enrollees with special needs have access to all medically necessary care, the State considers dental services to be an area meriting particular attention. The Contractor, therefore, shall accept for network participation dental providers with	▪ Access and Availability Policy and Procedure (GEO Access Reports) ▪ Network Development Policy and Procedure

	4.2.3.C
	7.8.E
		expertise in the dental management of Enrollees with developmental disabilities or medical or behavioral health conditions that limit their tolerance for dental services. All current providers of dental services to these Members shall be considered for participation in the Contractor's dental provider network. Credentialing and recredentialing standards must be maintained. The Contractor shall make provisions for providers of dental services to these Enrollees to allow for limiting their dental practices at their choice to only those patients with developmental disabilities or medical or behavioral health conditions that limit their tolerance for dental services.
		
		4.8.1.A
		Provider Network
		The Contractor shall establish, maintain and monitor at all times a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate and timely access (in accordance with 42 CFR 438.206 and N.J.A.C. 11:24-6 et seq.) to all services covered under this contract including those with limited English proficiency or physical or mental disabilities.
		
		1. The provider network shall consist of traditional providers for primary and specialty care, including primary care physicians, other approved non-physician primary care providers, physician specialists, non-physician practitioners, hospitals (including teaching hospitals), Federally Qualified Health Centers (FQHCs), nursing facilities, residential setting providers for recipients of MLTSS, home and community based services providers and other essential community providers/safety-net providers, and ancillary providers.
		2. The provider network shall be reviewed and approved by DMAHS and the sufficiency of the number of participating providers shall be determined by DMAHS in accordance with the standards found in Article 4.8.8 "Provider Network Requirements."
		3. In accordance with Section 1932(d) of the Social Security Act (42 U.S.C. 1396u-2(d)), as amended by subsection (a)(2), beginning not later than January 1, 2018, the State shall require that, in order to participate as a provider in the Contractor's network that provides services to, or orders, prescribes, refers or certifies eligibility for services for, individuals who are eligible for medical assistance under NJ FamilyCare and who are enrolled with the Contractor, the provider is enrolled consistent with section 1902(kk) with DMAHS.
			▪ Provider Recruitment and Retention Committee Charter
			▪ Provider Directory
			▪ Screen print of the Provider Directory on the MCO Website
			▪ Network of dental providers who provide care to special needs enrollees
			▪ Policies and procedures addressing the following:
			  ▪ Family Planning Services
			  ▪ Women's Health Services
			  ▪ Nondiscrimination with respect to provider participation

		4. The Contractor may execute network provider agreements, pending the outcome of section 1902(kk) screening, enrollment, and revalidation, of up to 120 days but must terminate a network provider immediately upon notification from the State that the network provider cannot be enrolled, or the expiration of one 120 day period without enrollment of the Provider, and notify affected Members. **4.8.1.E** The Contractor shall include in its network mental health/Substance Use Disorder providers for the Medicaid covered MH/SUD services (as stated in Article 4.1) with expertise to serve enrollees who are clients of the Division of Developmental Disabilities and providers for MH/SUD services (as stated in Article 4.4) for MLTSS Members. **4.8.1.J** The Contractor shall include in its network providers for Managed Long Term Services and Supports. The Contractor's network shall include all MLTSS provider types listed in the MLTSS Services Dictionary (see Appendix B.9.0). **4.2.2.A** **Family Planning Services and Supplies** Except where specified in Section 4.1, the Contractor's MCO enrollees are permitted to obtain family planning services and supplies from either the Contractor's family planning provider network or from any other qualified Medicaid family planning provider. The Contractor shall reimburse family planning services provided by non-participating Network providers based on the Medicaid fee schedule. All Providers must be registered with New Jersey Medicaid as 21st Century Cures Act Providers in order to provide services to NJ FamilyCare members. **4.2.3.C** **Women's Health Services** The Contractor shall provide female enrollees with direct access to a woman's health specialist within its network for covered care necessary to provide women's routine and preventive health care services. This shall be in addition to the enrollee's designated PCP if that PCP is not a women's health specialist. **7.8.E** **Nondiscrimination Requirements**	

		The Contractor shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification or against any provider that serves high-risk populations or specializes in conditions that require costly treatment. This paragraph shall not be construed to prohibit an organization from including providers only to the extent necessary to meet the needs of the organization's enrollees, from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the organization, or use different reimbursement amounts for different specialties or for different practitioners in the same specialty. If the Contractor declines to include individual or groups of providers in its network, it shall give the affected providers written notice of the reason for the decision.	
A4a* – Core Medicaid PCPs - Adults	4.8.3 4.8.3.D 4.11 4.11.A	**4.8.3** **Provider Network File Requirements** The Contractor shall provide a certified provider network file quarterly, to be reported electronically in a format and software application system determined by DMAHS that will include <u>every</u> provider including MLTSS, Behavioral Health (BH), and dental providers in the Contractor's network. The Contractor shall demonstrate its compliance with provider network requirements and how it will assure enrollee access to all benefits covered under this contract. **4.8.3.D** The quarterly provider file shall include a unique identifying number for each individual provider. The National Provider Identifier (NPI) for covered entities and the professional license number are required. Non Traditional Providers shall be identified with the provider's EIN, tax number, license number, UPIN, Medicaid provider number, Medicare provider number, and Social Security Number where applicable. **4.11** **Expanded Readiness Review (ERR) Submission Requirements** The Contractor shall submit any significant or material changes regarding changes to the health care delivery systems or changes to Contractor operations including vendor and subcontractors relationships to DMAHS for final approval. **4.11.A**	▪ GeoAccess Reports ▪ Evidence of submitting quarterly network files to DMAHS ▪ Copy of DMAHS responses to quarterly network submissions ▪ Evidence of submitting any significant or material changes to the provider network to DMAHS timely

		Requirements for ERR Submission The submission must be sent at least 90 days prior to being published, distributed, and/or implemented. The Contractor may propose effective dates for the changes to be implemented, but the changes may not be implemented until DMAHS reviews and approves the proposed change. Submissions must follow DMAHS guidance. Implementation without DMAHS approval may result in corrective actions taken by DMAHS	
A4b* – Core Medicaid PCPs – Pediatric		See A4a - Contract Requirement Language	▪ GeoAccess Reports ▪ Evidence of submitting quarterly network files to DMAHS ▪ Copy of DMAHS responses to quarterly network submissions ▪ Evidence of submitting any significant or material changes to the provider network to DMAHS timely
A4c* – Core Medicaid Specialty Providers		See A4a - Contract Requirement Language	▪ GeoAccess Reports ▪ Evidence of submitting quarterly network files to DMAHS ▪ Copy of DMAHS responses to quarterly network submissions ▪ Evidence of submitting any significant or material changes to the provider network to DMAHS timely
A4d* – Core Medicaid Dental/ Specialty Dental		See A4a - Contract Requirement Language	▪ GeoAccess Reports ▪ Evidence of submitting quarterly network files to DMAHS ▪ Copy of DMAHS responses to quarterly network submissions ▪ Evidence of submitting any significant or material changes to the provider network to DMAHS timely
A4e* - Core Medicaid Hospitals		See A4a - Contract Requirement Language	▪ GeoAccess Reports ▪ Evidence of submitting quarterly network files to DMAHS ▪ Copy of DMAHS responses to quarterly network submissions ▪ Evidence of submitting any significant or material changes to the provider network to DMAHS timely
A4f** – MLTSS Providers		See A4a - Contract Requirement Language	▪ Provider Report/Grid of MLTSS Network ▪ Evidence of submitting quarterly network files to DMAHS ▪ Copy of DMAHS responses to quarterly network submissions

			▪ Evidence of submitting any significant or material changes to the provider network to DMAHS timely
A5	4.8.1.L **4.5.3.A**	**4.8.1.L** **Enrollees with Special Needs** The Contractor's provider network shall include providers who are trained and experienced in treating individuals with special needs. 1. The Contractor shall operate a program to provide services for enrollees with special needs that emphasizes: (a) that providers are educated regarding the needs of enrollees with special needs; (b) that providers will reasonably accommodate enrollees with special needs; (c) that providers will assist enrollees in maximizing involvement in the care they receive and in making decisions about such care; and (d) that providers maximize for enrollees with special needs independence and functioning through health promotions and preventive care, decreased hospitalization and emergency room care, and the ability to be cared for at home. 2. The Contractor shall describe how its provider network will respond to the cultural and linguistic needs of enrollees with special needs. **4.5.3.A** **CLIENTS OF THE DIVISION OF DEVELOPMENTAL DISABILITIES** The Contractor shall provide all physical health services required by this contract as well as the MH/SUD services included in the Medicaid State Plan to enrollees who are adult clients of DDD and children who were transitioned from DDD to DCF. The Contractor shall include in its provider network a specialized network of providers who will deliver both physical as well as MH/SUD services, in accordance with Medicaid program standards to adult clients of DDD and children who were transitioned from DDD to DCF, and ensure continuity of care within that network. The Contractor shall be responsible for MH/SUD services to clients of DDD until the behavioral health ASO is implemented.	▪ Policies and Procedures addressing the following: ➢ Access and Availability ➢ Credentialing /Recredentialing ➢ Specialized Network for DDD members ▪ Provider Manual ▪ Provider application (with special needs check list and age group physician treatments) ▪ Provider Contract ▪ Provider Directory ▪ Special Needs Survey
A6	4.8.4	**4.8.4** **Provider Directory Requirements** A. As cited by HHS in the ONC 21st Century Cures Act final rule (also published of the Federal Register) at 45 CFR170.215, Effective beginning January 1, 2021 (with enforcement date of July 1, 2021), Provider Directory Application Programming Interface (API) must be accessible via a public-facing digital endpoint on the payer's website to ensure public discovery and access. At a minimum, Contractors must make available via the Provider Directory API provider names, addresses, phone numbers, and specialties. All directory information must be made	▪ Provider Directory

		available to current and prospective enrollees and the public through the Provider Directory API within 30 calendar days of Contractor receiving provider directory information or an update to the provider directory information. B. The Contractor shall maintain a web-based/on-line provider directory. DMAHS staff and HBC staff will access the web-based/on-line directory as needed to assist members. The web-based provider directories shall be maintained with updates made no later than every seven (7) days. C. Primary care providers and dentists/PCDs who will serve enrollees listed by • County, by city, by specialty • Provider name and degree; specialty board eligibility/certification status; office address(es) (actual street address); website URLs as appropriate, telephone number; fax number if available; office hours at each location; whether the provider is accepting new enrollees, indicates whether a provider serves enrollees under the age of six, indicate if a provider serves enrollees with disabilities and how to receive additional information such as type of disability; hospital affiliations; transportation availability; special appointment instructions if any; languages spoken; disability access; and any other pertinent information that would assist the enrollee in choosing a PCP or PCD. • This shall include a separate listing of dental providers who: ➢ Provide mobile dental services through use of mobile equipment or van outside of an office/clinic in facilities, schools and residences. ➢ Provide dental services to members under the age of six (6). ➢ Provide dental services to members with intellectual and developmental disabilities. Separate lists shall be available for providers treating children and adult members. ➢ All of these listings shall be updated as needed and at a minimum quarterly. D. Contracted specialists and ancillary services providers who will serve enrollees • Listed by county, by city, by physician specialty, by non-physician specialty, and by adult specialist and by pediatric specialist for those specialties indicated in Article 4.8.8.C. • MLTSS providers listed by county, by city, by specialty/MLTSS offered; with name, office address(es), website URLs as appropriate, telephone number and fax number if available and information on service area and services offered and whether the provider is accepting new enrollees.	

		• Behavioral Health Providers should be listed in on-line directory by the service description below: o Acute Partial Hospitalization Mental Health/Psychiatric Partial Hospitalization o Adult Mental Health Rehabilitation (AMHR) o Autism Treatment Services - ABA (Independent Practitioner) o Autism Treatment Services - ABA (Group Practice) o Autism Treatment Services - DIR (Independent Practitioner) o Autism Treatment Services - DIR (Group Practice) o Inpatient Psychiatric Hospital Care o Independent Practitioner(s) (Neuropsychologist; Psychiatry; NP Psychiatric MH; Neurology (Osteopaths Only); Psychologist) o Medication Monitoring o Outpatient Mental Health Hospital o Outpatient Mental Health Independent Clinic o Partial Care • SUD - Substance Use Disorder Providers should be listed in the on-line directory by the service description below: o Inpatient Medical Detox / Medically Managed Inpatient withdrawal management (hospital) ASAM 4 – WM o Non-Medical Detoxification / Non-Hospital based withdrawal management ASAM 3.7 – WM o Substance Use Disorder Short Term Residential (STR) ASAM 3.7 o Substance Use Disorder Long Term Residential (LTR) ASAM 3.5 o Ambulatory Withdrawal Management with extended on-site monitoring / Ambulatory Detoxification ASAM 2 – WM o Substance Use Disorder Partial Care (PC) ASAM 2.5 o Substance Use Disorder Intensive Outpatient (IOP) ASAM 2.1 o Substance Use Disorder Outpatient (OP) ASAM 1 o Opioid Treatment Services ASAM OTP (Methadone Maintenance) o Opioid Treatment Services (Non-Methadone Maintenance) o Medication Assisted Treatment in Physician Office (w/ Navigator) o Medication Assisted Treatment in Physician Office (w/o Navigator) E. Subcontractors • Provide, at a minimum, a list of all other health care providers by county, by service specialty, and by name. The Contractor shall demonstrate its ability to provide all of the services included under this contract.	

A7*	4.7.2.A.3 4.7.2.A.10 5.12 B.4.14.X.I B.4.14.XI Appendices	**4.7.2.A.3** **Appointment Availability Studies** The Contractor shall conduct a review of appointment availability and submit a report to DMAHS annually. The report must list the average time that enrollees wait for appointments to be scheduled in each of the following categories: baseline physical, routine, specialty, and urgent care appointments. DMAHS must approve the methodology for this review. **4.7.2.A.10** **Annual PCP After-Hour Availability Study** The Contractor shall conduct an annual PCP After-Hour Availability study in order to monitor availability and accessibility to primary care providers (PCPs). The study shall be designed to determine a provider's availability for telephone consultation after regular business hours. The Contractor shall survey, at a minimum, no less than 25% of its PCP network. The PCPs are to be randomly selected from the Contractor's provider network file. Providers shall be contacted after business hours or on weekends. Providers and staff should be asked to identify the system the office uses for telephone coverage after regular business hours. A telephone response should be considered acceptable/unacceptable based on the following criteria: Acceptable – An active provider response, such as: 1. Telephone is answered by PCP, office staff, answering service or voice mail. 2. The answering service either: • Connects the caller directly to the provider; • Contacts the PCP on behalf of the caller and the provider returns the call; or • Provides a telephone number where the PCP/covering provider can be reached. 3. The provider's answering machine message provides a telephone number to contact the PCP/covering provider. Unacceptable: 1. The answering service:	• Evidence of submitting annual appointment availability report to DMAHS ▪ Copy of DMAHS responses to appointment availability report ▪ Provider Manual ▪ Provider Directory ▪ Member Handbook ▪ Member Newsletter ▪ Policies and Procedures addressing the following: ➢ Access and Appointment Availability Standards ➢ Appointment Scheduling Assistance ➢ PCP Appointment Availability ➢ Verification of Appointment Availability ▪ PCP Appointment Availability Audit tool, results and follow-up with non-compliant providers ▪ PCP After Hours Availability Audit tool, results and follow-up with non-compliant providers ▪ Call Center Performance Measures ▪ Call Center Monthly or Quarterly Performance Reports ▪ Telecommunications Device for the Deaf Contract

		• Leaves a message for the provider on the PCP/covering provider's answering machine; or • Responds in an unprofessional manner. 2. The provider's answering machine message: • Instructs the caller to go to the emergency room, regardless of the exigencies of the situation, for care without enabling the caller to speak with the provider for non-emergent situations. • Instructs the caller to leave a message for the provider. 3. No answer; 4. Listed number no longer in service; 5. Provider no longer participating in the Contractor's network; 6. On hold for longer than five (5) minutes; 7. Answering Service refuses to provide information for survey; 8. Telephone lines persistently busy despite multiple attempts to contact the provider. The Contractor shall submit a report of the results of the survey and its corrective action plan to the DMAHS annually. The report shall also include the methodology and sample size used for the survey. **5.12** **Appointment Availability** A. The Contractor shall have policies and procedures to ensure appointments for medical, mental health/substance use disorder (for DDD clients and MLTSS Members) and dental care are available in accordance with the following standards at no less than a 90% benchmark and are reported in a format approved by the State: Emergency Services. Immediately upon presentation at a service delivery site. B. Urgent Care. Within twenty-four (24) hours. An urgent, symptomatic visit is an encounter with a health care provider associated with the presentation of medical signs that require immediate attention, but are not life-threatening. C. Symptomatic Acute Care. Within seventy-two (72) hours. A non-urgent, symptomatic office visit is an encounter with a health care provider associated with the presentation of medical signs, but not requiring immediate attention. D. Routine Care. Within twenty-eight (28) days. Non-symptomatic office visits shall include but shall not be limited to: well/preventive care appointments such as annual gynecological examinations or pediatric and adult immunization visits.	

		E. Specialist Referrals. Within four (4) weeks or shorter as medically indicated. A specialty referral visit is an encounter with a medical specialist that is required by the enrollee's medical condition as determined by the enrollee's Primary Care Provider (PCP). Emergency appointments must be provided within 24 hours of referral. F. Urgent Specialty Care. Within twenty-four (24) hours of referral. G. Baseline Physicals for New Adult Enrollees. Within one hundred-eighty (180) calendar days of initial enrollment. H. Baseline Physicals for New Children Enrollees and Adult Clients of DDD. Within ninety (90) days of initial enrollment, or in accordance with EPSDT guidelines. I. Prenatal Care. Enrollees shall be seen within the following timeframes: 1. Three (3) weeks of a positive pregnancy test (home or laboratory) 2. Three (3) days of identification of high-risk 3. Seven (7) days of request in first and second trimester 4. Three (3) days of first request in third trimester J. Routine Physicals. Within four (4) weeks for routine physicals needed for school, camp, work or similar. K. Lab and Radiology Services. Three (3) weeks for routine appointments; forty-eight (48) hours for urgent care. L. Waiting Time in Office. Less than forty-five (45) minutes. M. Initial Pediatric Appointments. Within three (3) months of enrollment. The Contractor shall attempt to contact and coordinate initial appointments for all pediatric enrollees. N. For dental appointments, the Contractor shall be able to provide: 1. Emergency dental care, which is the immediate care, treatment and/or referral for emergent dental conditions, and defined previously as serious orofacial conditions which require immediate medical intervention, to avoid placing the health of the individual in jeopardy. 2. Urgent dental care, which is defined as oral and/or dental conditions which require timely treatment to alleviate pain, address infection risk and avoid additional degradation of the teeth and/or other oral structures, within forty-eight (48) hours of member request. 3. Routine non-symptomatic care and/or specialist referrals within twenty-eight (28) days of member request. O. For MH/SUD appointments, the Contractor shall provide: 1. Emergency services immediately upon presentation at a service delivery site. 2. Urgent care appointments within twenty-four (24) hours of the request.	

		3. Routine care appointments within ten (10) days of the request. P. Maximum Number of Intermediate/Limited Patient Encounters. Four (4) per hour for adults and four (4) per hour for children. Q. For SSI and New Jersey Care – ABD elderly and disabled enrollees, the Contractor shall ensure that each new enrollee or, as appropriate, authorized person is contacted to offer an Initial Visit to the enrollee's selected PCP. Each new enrollee shall be contacted within forty-five (45) days of enrollment and offered an appointment date according to the needs of the enrollee, except that each enrollee who has been identified through the enrollment process as having special needs shall be contacted within ten (10) business days of enrollment and offered an expedited appointment. **B.4.14.X.I** The MCO takes steps to promote accessibility of all services offered to Members, including those with limited English proficiency and reading skills, with diverse cultural and ethnic backgrounds, the homeless and individuals with physical and mental disabilities. These steps include: 1. The points of access to primary care, behavioral health, specialty care, inpatient services and MLTSS are identified for Members. 2. At a minimum, Members are given information about: a. how to obtain services during regular hours of operations; b. how to obtain emergency and after-hours care; c. how to obtain second opinions; d. how to obtain the names, qualifications, and titles of the professionals providing and/or responsible for their care; e. how to select a PCP from among those accepting new enrollees; and. f. physical accessibility. **B.4.14.XI** The MCO has established standards for access (e.g., to routine, urgent and emergency care; telephone appointments; advice; and Member service lines and MLTSS contact lines). Performance on these dimensions of access are assessed against the standards.	
A8*	**4.7.4.A**	**4.7.4.A** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the	▪ Narratives and supporting documentation should be filed within each review element as appropriate ▪ Documentation should reflect the review period.

		notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance

Emergency and Post Stabilization Services

2024 Element	Contract Reference	Contract Requirement Language	Documentation Examples
EPS1	4.2.1.B 4.2.1.H.4	**4.2.1.B** **Emergency Services** The Contractor shall be responsible for emergency services, both within and outside the Contractor's enrollment area, as required by an enrollee in the case of an emergency. Emergency services shall also include: 1. Medical examination at an Emergency Room which is required by N.J.A.C. 10:122D-2.5(b) when a foster home placement of a child occurs after business hours. 2. Examinations at an Emergency Room for suspected physical/child abuse and/or neglect. 3. Post-Stabilization of Care. The Contractor shall comply with 42 CFR 438.114(e) and 42 C.F.R. § 422.113(c). The Contractor must cover post-stabilization services without requiring authorization and regardless of whether the enrollee obtains the services within or outside the Contractor's network if: a. The services were pre-approved by the Contractor or its providers; or b. The services were not pre-approved by the Contractor because the Contractor did not respond to the provider of post-stabilization care services' request for pre-approval within one (1) hour after being requested to approve such care; or c. The Contractor could not be contacted for pre-approval. The Contractor's financial responsibility for post-stabilization care services, if not pre-approved, ends when: i. A physician in the Contractor's network with privileges at the treating hospital assumes responsibility for the Member's care. ii. A physician in the Contractor's network assumes responsibility for the Member's care through transfer. iii. Contractor and the treating physician reach an agreement concerning the Member's care.	• Policies and Procedures addressing the following: ➢ Emergency Care/Post Stabilization ➢ Access and Availability, and Primary Care Provider (PCP) After Hours Availability ▪ Member Handbook ▪ Provider Manual ▪ Certificate of Coverage ▪ Enrollee Website, Emergency Services Screen Print

		iv. The Member is discharged. **4.2.1.H.4** **Emergency Services** The Contractor shall be liable for payment for the following emergency services provided to an enrollee: If the enrollee's PCP or other Contractor representative instructs the enrollee to seek emergency care in-network or out-of-network, whether or not the patient meets the prudent layperson definition.	
EPS2*	4.6.2.L	**4.6.2.L** **Emergency Care** The Contractor shall have methods to track emergency care utilization and to take follow-up action, including individual counseling, to improve appropriate use of urgent and emergency care settings.	▪ Policies and Procedures addressing the following for the Core Medicaid population and the MLTSS population ➢ Over/Under Utilization ▪ Over/Under Utilization Reports ▪ Provider Profiling Programs ▪ Provider Profiles ▪ ER Utilization Report ▪ ER Utilization Programs ▪ ER Initiatives Including Outcomes ▪ MLTSS Critical Incident Reports
EPS3	4.2.1.l	**4.2.1.I** **Emergency Services – Lists of Diagnoses or Symptoms** The Contractor may not limit what constitutes an emergency medical condition based on lists of diagnoses or symptoms.	▪ Policies and Procedures addressing the following: ➢ Emergency Care ▪ Member Handbook ▪ Provider Manual ▪ Certificate of Coverage ▪ Enrollee Website, Emergency Services Screen Print
EPS4	4.2.1.K.2	**4.2.1.K.2** **Emergency Services - Notification** The Contractor may not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the Contractor or the enrollee's PCP of the enrollee's screening and treatment.	• Policies and Procedures addressing the following: ➢ Emergency Care ▪ Member Handbook ▪ Provider Manual ▪ Certificate of Coverage ▪ Enrollee Website, Emergency Services Screen Print
EPS5	4.2.1.H.2	**4.2.1.H.2** **Emergency Services – Stabilization** All emergency services are medically necessary until the clinical emergency is stabilized. This includes all treatment that is necessary to assure, within reasonable medical probability, that no material deterioration of the patient's condition is likely to result from, or occur during, discharge of the patient or transfer of the patient to another facility.	• Policies and Procedures addressing the following: ➢ Post Stabilization ▪ Member Handbook ▪ Provider Manual ▪ Certificate of Coverage ▪ Enrollee Website, Emergency Services Screen Print

		If there is a disagreement between a hospital and the Contractor concerning whether the patient is stable enough for discharge or transfer, or whether the medical benefits of an unstabilized transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the enrollee at the treating facility prevails and is binding on the Contractor. The Contractor may establish arrangements with hospitals whereby the Contractor may send one of its physicians with appropriate ER privileges to assume the attending physician's responsibilities to stabilize, treat, or transfer the patient.	
EPS6*	**4.7.4.A**	**4.7.4.A** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate ▪ Documentation should reflect the review period ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance

Quality Assessment and Performance Improvement

2024 Element	Contract Reference	Contract Requirement Language	Documentation Examples
Q1*	4.6.1.A	**4.6.1.A** **Quality Assessment and Performance Improvement Plan** The Contractor shall implement and maintain a Quality Assessment and Performance Improvement (QAPI) program that is capable of producing prospective, concurrent, and retrospective analyses. Delegation of any QAPI activities shall not relieve the Contractor of its obligations to perform all QAPI functions.	▪ Quality Management/Quality Assurance Program Description ▪ QI Work Plan - Previous year and current ▪ Quality Management Program Evaluation for the previous year ▪ Entire Year of the most recent Meeting Minutes – QI, Provider Advisory, etc. ▪ Various committee meeting minutes (e.g., QI, Provider Advisory, etc.) that may demonstrate oversight.
Q2*	4.6.2	**4.6.2** **QAPI Activities** The Contractor shall carry out the activities described in its QAPI. The Contractor shall develop and submit to DMAHS and/or the EQRO at the direction of the State, an annual work plan of expected accomplishments which includes a schedule of clinical standards to be developed, medical care evaluations to be completed, and other key quality assurance activities to be completed, including MLTSS-related quality activities.	▪ QI/Annual Work Plan – previous year and current ▪ Documentation demonstrating implementation and evaluation of the plan ▪ Documentation demonstrating the inclusion and implementation evaluation **of MLTSS related activities in QAPI.**
Q3*	4.6.2	**4.6.2**	▪ QI Program Evaluation for previous year

		QAPI Activities The Contractor shall also prepare and submit to DMAHS and/or the EQRO at the direction of the State, an annual report on quality assurance activities which demonstrate the Contractor's accomplishments, compliance and/or deficiencies in meeting its previous year's work plan and should include studies undertaken, subsequent actions, and aggregate data on utilization and clinical quality of medical care rendered.	▪ Annual Quality Reports
Q4*	B.4.14.II.A-G Appendix	**B.4.14.II.A-G** The Quality Assessment and Performance Improvement program has written guidelines for its quality of care studies and related activities which include: A) specification of clinical or health services delivery areas to be monitored; B) use of quality indicators; C) use of clinical care standards/practice guidelines; D) analysis of clinical care and related services; E) implementation of remedial/corrective actions; F) assessment of effectiveness of corrective actions; and G) evaluation of continuing and effectiveness of the QAPI.	▪ QI Program Description - Current ▪ QI Work Plan - Previous year and current ▪ Clinical Studies and Projects Policy and Procedure ▪ Desk top procedures
Q5*	B.4.14.II Appendix	**B.4.14.II** The Quality Assessment and Performance Improvement program objectively and systematically monitors and evaluates the quality and appropriateness of care and service, including MLTSS, to enrollees, through quality of care studies and related activities, and pursues opportunities for improvement on an ongoing basis.	▪ QI Program Description ▪ QI Work Plan
Q6*	B.4.14.VI Appendix	**B.4.14.VI** The Quality Assessment and Performance Improvement program has sufficient material resources; and staff with the necessary education, experience, or training; to effectively carry out its specified activities.	▪ Current QI Program Description ▪ Quality Management Organizational Chart ▪ Departmental job descriptions or bios
Q7*	B.4.14.VII.A B.4.14.VII.E Appendices	**B.4.14.VII.A** Participating physicians and other providers are kept informed about the written QA plan. **B.4.14.VII.E** The MCO has a description of how providers are to be involved in the design, implementation, review and follow-up of quality activities.	▪ QI Program Description ▪ Provider Manual ▪ Provider Newsletters ▪ Screen Prints of the MCO's – Provider Website ▪ PAC Charter ▪ Entire Year of the most recent Provider Advisory Committee (PAC) Meeting Minutes, Agendas, and Attendance Sheets
Q8*	B.4.14.XV.A Appendix	**B.4.14.XV.A** **Scope** The MCO shall document that it is monitoring the quality of care across all services, including MLTSS, and all treatment modalities, according to its	▪ QI Program Description ▪ QI Work Plan ▪ Entire Year of the most recent QI Committee Meeting Minutes, Agenda, Attendance Sheets ▪ QI Program Evaluation for previous year

		written QAPI . (The review of the entire range of care is expected to be carried out over multiple review periods and not on a concurrent basis.)	▪ Member Quality of Care Compliant Analysis ▪ Quarterly and Annual Quality of Care Reports MLTSS related reports
Q9*	B.4.14.XVI Appendix	**B.4.14.XVI** The findings, conclusions, recommendations, actions taken, and results of the actions taken as a result of QA activity, are documented and reported to appropriate individuals within the organization and through the established QA channels. A. QA information is used in recredentialing, recontracting and/or annual performance evaluations. B. QA activities are coordinated with other performance monitoring activities, including utilization management, Care Management, risk management, and resolution and monitoring of Member grievances. C. There is a linkage between QA and the other management functions of the health plan such as: 1. network changes; 2. benefits redesign; 3. medical management systems (e.g., pre-certification); 4. practice feedback to physicians; 5. patient education; 6. Member services, and; 7. Care Management including MLTSS Care Management.	▪ QI Program Description ▪ QI Work Plan ▪ Entire Year of the most recent QI Committee Meeting Minutes ▪ QI Program Evaluation for previous year
Q10*	4.7.4.A	**4.7.4.A** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion. ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.

Quality Management

2024 Element	Contract Reference	Contract Requirement Language	Documentation Examples
Sub-heading	4.6	**4.6** A. The Contractor shall provide for medical care, health services, and services required under managed long-term services and supports that comply with federal and State Medicaid and NJ FamilyCare standards and regulations and shall satisfy all applicable requirements of the federal and State statutes and regulations pertaining to medical care, health services and long-term services and supports.	

		B. The Contractor shall use its best efforts to ensure that persons and entities providing care and services for the Contractor, including long-term services and supports, in the capacity of physician, dentist, CNP/CNS, physician's assistant, CNM, or other medical service professional meet applicable licensing, certification, or qualification requirements under New Jersey law or applicable state laws in the state where service is provided, and that the functions and responsibilities of such persons and entities in providing medical, behavioral, dental and/or MLTSS care and services under this contract do not exceed those permissible under New Jersey law. This shall also include knowledge, training and experience in providing care and services to individuals with special needs as well as services provided by non-traditional MLTSS service providers.	
QM1	4.6.2.A	**4.6.2.A** **Guidelines** The Contractor shall develop guidelines that meet the requirements of 42 CFR 438 for the management of selected diagnoses and basic health maintenance, and shall distribute all standards, protocols, and guidelines to all providers and upon request to enrollees and potential enrollees.	▪ Provider Manual ▪ Documentation showing how providers are notified of guideline updates including MLTSS. ▪ Provider/Member Newsletter ▪ Screen Prints of MCO Provider Website with list of Clinical Practice Guidelines ▪ Policies and Procedures addressing the following: ➢ Clinical Practice Guidelines ▪ Individual Practice Guidelines ▪ MLTSS Guidelines
QM2	4.6.2.B	**4.6.2.B** **Treatment Protocols** The Contractor may use treatment protocols, however, such protocols shall allow for adjustments based on the enrollee's medical condition, level of functioning and contributing family and social factors.	▪ Care Management /UM Workflow Diagrams ▪ QI or UM Program Descriptions ▪ Redacted cases showing adjustments based on the enrollee's medical condition and/or contributing family and social factors ▪ Policies and Procedures addressing the following: ➢ Treatment Protocol Adjustment
QM3*	4.6.2.C	**4.6.2.C** **Monitoring** The Contractor shall have procedures for monitoring the quality and adequacy of medical care including: 1) assessing use of the distributed guidelines and 2) assessing possible over-treatment/over-utilization of services and 3) assessing possible under-treatment/under-utilization of services.	▪ Clinical Practice Guidelines ▪ HEDIS® and CAHPS® Results and Analysis ▪ Provider Profiles ▪ Utilization Reports specific to individual providers ▪ UM Program Description ▪ QI Program Description ▪ QI Work Plan ▪ Provider Profiling Program ▪ Provider files to demonstrate corrective action taken to bring practitioner into compliance with clinical practice guidelines or average utilization of services

QM4*	4.6.2.D	**4.6.2.D** **Focused Evaluations** The Contractor shall have procedures for focused medical care evaluations to be employed when indicators suggest that quality may need to be studied. The Contractor shall also have procedures for conducting problem-oriented clinical studies of individual care.	▪ QI Program ▪ QI Program Evaluation ▪ Quality of care case examples and tracking ▪ Entire Year of the most recent Meeting Minutes showing discussion and follow-up of quality of care concerns ▪ Policies and Procedures addressing the following: ➢ Quality of Care ➢ Over/Under Utilization ➢ Emergency Room Utilization ➢ Monitoring of Mortality Rates ▪ Credentialing - Covers the monitoring of quality of care concerns during the re-credentialing process ▪ Provider Monitoring Reports
QM5*	4.6.2.E	**4.6.2.E** **Follow-up** The Contractor shall have procedures for prompt follow-up of reported problems and grievances involving quality of care issues. Timeframes for prompt follow-up and resolution shall follow the standard described in Article 5.15.1B.	▪ Policies and Procedures addressing the following: ➢ Quality of Care/Service ▪ Grievance Database Report/Logs ▪ Example of a Grievance Acknowledgement Letter ▪ Entire Year of the most recent Meeting Minutes showing discussion and follow-up of quality of care concerns ▪ Blinded Case Example of Quality of Care Concern
QM6	4.6.2.F	**4.6.2.F** **Hospital Acquired Conditions and Provider–Preventable Conditions** The Contractor shall implement a no payment policy and a quality monitoring program consistent with the Centers for Medicare and Medicaid Services (CMS) that addresses Hospital Acquired Conditions and Provider-Preventable Conditions and according to federal regulations at 42 CFR 434, 438, and 447. Policies and procedures shall be submitted to the DMAHS for review and approval prior to implementation of the Contractor's program. Updates to the program shall be made as the CMS and the Medicaid FFS program changes. The Contractor shall identify Hospital-Acquired Conditions for non-payment as identified by Medicare other than Deep Vein Thrombosis (DVT/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients. The Contractor shall identify Other Provider-Preventable Conditions for non-payment as wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient. The ICD-10 Version 33 Hospital Acquired Condition (HAC) list may be accessed at:	▪ Policies and Procedures addressing the following: ➢ Hospital Acquired Conditions ➢ Claims Payment ▪ Quality Outcomes Reports ▪ Denial Letters ▪ Educational Materials

		https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/icd10_hacs.html	
QM7	4.6.2.G	**4.6.2.G** **Data Collection** The Contractor shall have procedures for gathering and trending data including outcome data.	▪ Policies and Procedures addressing the following: ➢ Data Collection Methods ➢ Analysis of Outcome Data ▪ Work Plans ▪ QI Program Description ▪ QI Program Evaluation ▪ Monitoring Reports ▪ ER utilization Reports ▪ Enrollee & Provider Grievances Policy and Procedure
QM8*	4.6.2.H	**4.6.2.H** **Mortality Rates** The Contractor shall review inpatient hospital mortality rates of its enrollees.	▪ Policies and Procedures addressing the following: ➢ Quality of Care ▪ Monthly Mortality Reports ▪ Entire Year of the most recent QI Committee Meeting Minutes ▪ Flowcharts, Algorithm ▪ QI Program Description ▪ QI Work Plan ▪ QI Program Evaluation ▪ Mortality Initiatives Including Outcomes
QM9*	4.6.2.I	**4.6.2.I** **Corrective Action** In compliance with 42 CFR 438.230(b)(4), the Contractor shall have procedures for informing subcontractors and providers of identified deficiencies, or areas of improvement, conducting ongoing monitoring of corrective actions, and taking appropriate follow-up actions, such as instituting progressive sanctions and appeal processes. The Contractor shall conduct reassessments to determine if corrective action yields intended results.	▪ Policies and Procedures addressing the following: ➢ Quality of Care/Service and/or Flowchart ➢ Credentialing/Recredentialing ➢ Corrective Action Plan procedure if separate from Quality of Care Policy and Procedure ▪ Request for a Corrective Action Plan (CAP) Letter to provider ▪ CAP Reminder Letters ▪ CAP Approval Letter; Closure Letter to provider ▪ Entire Year of the most recent Oversight Committee Meeting Minutes ▪ Confirmed Quality of Care Case Example

QM10	4.6.2.M	**4.6.2.M** **New Medical Technology** The Contractor shall have policies and procedures for criteria which are based on scientific evidence for the evaluation of the appropriate use of new medical technologies or new applications of established technologies including medical procedures, drugs, devices, assistive technology devices, and durable medical equipment (DME).	▪ Policies and Procedures addressing the following: ➢ Technology Assessment ➢ Decisions Policy ▪ Evidence-based literature from peer-reviewed journals ▪ Provider Manual ▪ Provider Newsletters ▪ Entire Year of the most recent Oversight/New Technology Committee Meeting Minutes
QM11a*	4.6.2.Q	**4.6.2.Q** **Performance Improvement Projects (PIPs)** The Contractor shall participate in PIPs defined by the State with input from the Contractor and the EQRO. Each Contractor will, with input from the State and possibly other Contractors, define measurable improvement goals and PIP-specific measures which shall serve as the focus for each PIP. The Contractor must conduct performance improvement project(s) designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Projects must comply with 42 CFR § 438.330(b)(1) and (d) and the current CMS protocol, entitled: "Validating Performance Improvement Projects."	▪ Core Medicaid PIP Submission Worksheets or Other PIP Documentations ▪ Core Medicaid Special Initiatives Including Outcomes
QM11b**	4.6.2.Q	**4.6.2.Q** **Performance Improvement Projects (PIPs)** The Contractor shall participate in PIPs defined by the State with input from the Contractor and the EQRO. Each Contractor will, with input from the State and possibly other Contractors, define measurable improvement goals and PIP-specific measures which shall serve as the focus for each PIP. The Contractor must conduct performance improvement project(s) designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. Projects must comply with 42 CFR § 438.330(b)(1) and (d) and the current CMS protocol, entitled: "Validating Performance Improvement Projects."	▪ MLTSS PIP Submission Worksheets or Other PIP Documentations ▪ MLTSS Special Initiatives Including Outcomes
QM12*	4.7.2.D	**4.7.2.D** The Contractor shall conduct reviews/audits which focus on the special dental needs of enrollees with developmental disabilities. Using encounter data reflecting the utilization of dental services and other data sources, the Contractor shall measure clinical outcomes; have these outcomes evaluated by clinical experts; identify quality management tools to be applied; and	▪ Encounter Data Reports/Other Data Reports ▪ Audit Procedure ▪ Most recent Audit Results ▪ Dental Initiatives for enrollees with Developmental Disabilities including outcomes

		recommend changes in clinical practices intended to improve the quality of dental care to enrollees with developmental disabilities.	
QM13*	4.7.4.A	**4.7.4.A** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.
QM14	4.2.6.B.1.d	**4.2.6.B.1.d** Section 1905(r) of the Social Security Act (42 U.S.C. § 1396(d) and federal regulation 42 C.F.R. § 441.50 et seq. requires EPSDT services to include: 1. d. Appropriate laboratory tests: A recommended sequence of screening laboratory examinations must be provided by the Contractor. The following list of screening tests is not all inclusive: ▪ Hemoglobin/hematocrit/EP ▪ Urinalysis ▪ Tuberculin test – intradermal, administered annually and when medically indicated ▪ Lead screening using blood lead level determinations must be done for every Medicaid-eligible and NJ FamilyCare child: - between nine (9) months and eighteen (18) months, preferably at twelve (12) months of age - at 18-26 months, preferably at twenty-four (24) months of age - test any child between twenty-seven (27) to seventy-two (72) months of age not previously tested ▪ Additional laboratory tests may be appropriate and medically indicated (e.g., for ova and parasites) and shall be obtained as necessary.	▪ QI Evaluation ▪ Data Reports
QM15	4.2.6.B.10.a,b	**4.2.6.B.10.a,b** **Lead Screening** The Contractor shall provide a screening program for the presence of lead toxicity in children which shall consist of two components: verbal risk assessment and blood lead testing. a. Verbal Risk Assessment – The provider shall perform a verbal risk assessment for lead toxicity at every periodic visit to children at least six (6) months and less than seventy two (72) months as indicated on the schedule. The verbal risk assessment includes, at a minimum, the following types of questions:	▪ QI Program Description ▪ QI Evaluation ▪ Policy and Procedures

		i. Does your child live in or regularly visit a house built before 1978? Does the house have chipping or peeling paint? ii. Was your child's day care center/preschool/babysitter's home built before 1978? Does the house have chipping or peeling paint? iii. Does your child live in or regularly visit a house built before 1978 with recent, ongoing, or planned renovation or remodeling? iv. Have any of your children or their playmates had lead poisoning? v. Does your child frequently come in contact with an adult who works with lead? Examples include construction, welding, pottery, or other trades practiced in your community. vi. Do you give your child home or folk remedies that may contain lead? Generally, a child's level of risk for exposure to lead depends upon the answers to the above questions. If the answer to all questions are negative, a child is considered at low risk for high doses of lead exposure. If the answer to any question is affirmative or "I don't know," a child is considered at high risk for high doses of lead exposure. Regardless of risk, each child must be tested according to age groups specified in 4.2.6.B.8.b. A child's risk category can change with each administration of the verbal risk assessment. b. <u>Blood Lead Testing</u> – All screening must be done through a blood lead level determination. The Contractor must implement a screening program to identify and treat high-risk children for lead-exposure and toxicity. The screening program shall include blood level screening, diagnostic evaluation and treatment with follow-up care of children whose blood lead levels are elevated. The EP test is no longer acceptable as a screening test for lead poisoning; however, it is still valid as a screening test for iron deficiency anemia. Screening blood lead testing may be performed by either a capillary sample (fingerstick) or a venous sample. However, all elevated blood levels (equal to or greater than five (5) micrograms per one (1) deciliter) obtained through a capillary sample must be confirmed by a venous sample. A confirmatory blood lead test must be performed by a New Jersey Department of Health licensed laboratory. The frequency with which the blood test is to be administered depends upon the results of the verbal risk assessment. For children determined to be at low risk for high doses of lead exposure, a screening blood lead test must be	

		performed once between the ages of nine (9) and eighteen (18) months, preferably at twelve (12) months, and once between 18-26 months, preferably at twenty-four (24) months If a child between the ages of twenty four (24) months and seventy two (72) months has not received a screening blood lead test, the child must receive the blood lead test immediately, regardless of whether the child is determined to be a low or high risk according to the answers to the above-listed questions. For children determined to be at high risk for high doses of lead exposure, a screening blood test must be performed at the time a child is determined to be a high risk beginning at six months of age if there is pertinent information or evidence that the child may be at risk at younger ages than stated in 4.2.6.B.1.d. i. If the initial blood lead test results are less than five (5) micrograms per deciliter, a verbal risk assessment is required at every subsequent periodic visit through seventy-two (72) months of age, with mandatory blood lead testing performed according to the schedule in 4.2.6.B.8. ii. If the child is found to have a blood lead level equal to or greater than five (5) micrograms per deciliter, providers should use their professional judgment, in accordance with the CDC guidelines regarding patient management and treatment, as well as follow-up blood testing. iii. If the child is found to have a blood lead level equal to or greater than five (5) micrograms per deciliter, the contractor should recommend a follow-up venous blood screening for the child, and blood lead testing for the other children and pregnant women living in the household. iv. When a child is found to have one confirmed blood lead level between 5 - 9 µg/dl, the contractor shall ensure its PCPs cooperate with the local health department in whose jurisdiction the child resides to facilitate the preliminary environmental evaluation. v. When a child is found to have a confirmed blood lead level equal to or greater than ten (10) µg/dl, or two (2) confirmed consecutive tests one to four months apart with results between 5 - 9 µg/dl, the Contractor shall ensure its PCPs cooperate with the local health department in whose jurisdiction the child resides to facilitate an environmental intervention to determine and remediate the source of lead. This cooperation shall include sharing of information regarding	

		the child's care, including the scheduling and results of follow-up blood lead tests. vi. When laboratory results are received, the Contractor shall require PCPs to report to the Contractor all children with blood lead levels > 5 µg/dl. Conversely, when a provider other than the PCP has reported the lead screening test to the Contractor, the Contractor shall ensure that this information is transmitted to the PCP.	
QM16	4.2.6.B.10.c	**4.2.6.B.10.c** c. On a semi-annual basis, the Contractor shall outreach, via letters and informational materials to parents/custodial caregivers of all children enrolled in the Contractor's plan who have not been screened, educating them as to the need for a lead screen and informing them how to obtain lead screening and transportation to the screening location.	▪ QI Program Description ▪ Policy and Procedures ▪ Outreach Reports ▪ Member Letters ▪ Member Educational Materials
QM17	4.2.6.B.10.d	**4.2.6.B.10.d** d. On an annual basis, the Contractor shall send letters to PCPs who have lead screening rates of less than 80% for two consecutive six-month periods, educating them on the need and their responsibility to provide lead screening services. The eligible population of children shall be identified using methodology as defined by the State.	▪ QI Program Description ▪ QI Program Evaluation ▪ Policy and Procedures ▪ Reports ▪ Provider Letters ▪ Provider Educational Materials
QM18*	4.6.2.P	**4.6.2.P** **PERFORMANCE MEASURES** The Contractor shall submit to DMAHS and/or the EQRO at the direction of the State, annually, on a date specified by the State, performance measures in accordance with the following: 1. HEDIS and NJ Specific Performance Measures. a. HEDIS 3.0 data or more updated version, aggregate population data as well as, if available, the Contractor's commercial and Medicare enrollment HEDIS data for its aggregate, enrolled commercial and Medicare population in the State or region (if these data are collected and reported to DOBI, a copy of the report should be submitted also to DMAHS). b. HEDIS reporting requirements shall be consistent with National Committee for Quality Assurance (NCQA) requirements found in the current HEDIS Technical Specifications. Measure rotation is not permitted. c. Electronic Submission requirements include: • HEDIS ROADMAP; • Complete HEDIS Workbook; • Interactive Data Submission System (IDSS) results;	▪ TPL Allocation Table ▪ Member Level Files ▪ HEDIS Roadmap ▪ Locked IDSS ▪ CSV Data File ▪ ART ▪ Final Audit Report ▪ NJ Specific Measures ▪ Source Code as needed For Core Set Measure(s): ▪ Member Level Files ▪ Source Code as needed ▪ Rate Tables ▪ Workplans and/or CAPs as needed

		• Final Audit Report; • Source Code; • New Jersey Performance Measures results; • Member level data for select HEDIS and New Jersey Specific measures, at the discretion of the State, per EQRO file layout and submission instructions; and • A table that delineates how the populations are defined and included or excluded from performance measures following yearly guidance provided by the State and/or EQRO. d. Contractors must comply with all audit standards and requirements determined by NCQA. e. Contractors must comply with Medicaid reporting requirements, including but not limited to beneficiary category assignments as defined by the State. f. HEDIS Reporting Set Measures - Report all measures in the complete HEDIS Workbook. g. New Jersey Performance Measures o Annual Preventive Dental Visits - by Dual, Disability, Other and Total categories (all duals must be included in this measure) o Age Appropriate Blood Lead Testing in Children (Multiple Lead Testing in Children through 26 months of age) h. Following yearly guidance provided by the State and/or EQRO, Contractors shall submit a Workplan by each August 15th, or other time period as requested by the DMAHS. At the State's discretion, a CAP may be required. Each Workplan will use performance standards as defined by the State, e.g. NCQA 50th percentile, to identify areas where services are potentially below quality standards. These performance standards will reflect the minimum acceptable service level. The performance standards may be revised as necessary to ensure that they are reasonable and accurately reflect quality expectations. The Contractor shall provide updates as requested by the State to confirm the progress of the interventions proposed to the DMAHS. 2. Core Set Measure(s) a. Following yearly guidance provided by the State and/or EQRO, the Contractor shall submit specified Core Set Measures. Electronic submission requires member level data for select Core Set Measures, at the discretion of the State, per EQRO file layout and submission instructions. b. At the State's discretion, a Workplan and/or CAP may be requested of the MCOs if the performance does not reflect the minimal acceptable service level.	

QM19**	9.11.F	**9.11.F** **MLTSS Performance Measures** The Contractor shall comply with all quality metric reporting requirements, including but not limited to: a. Contractor shall utilize the State's electronic templates for Performance Measures (PMs). b. Contractor shall comply with the EQRO PM validation process. c. Contractor shall comply with the State's requirements for timeliness, accuracy, and quality of report submissions. d. Monthly reporting of MLTSS Operational Metrics tracking and quarterly reporting of claims and provider statistics per reporting templates specified by the DMAHS.	▪ Process description for production of each MLTSS performance measure ▪ Source Code (as required) ▪ Data sources used in producing the measures ▪ Preliminary rates (sample file) for all measures ▪ Member/Event-level detail files NOTE: If the above documents have been submitted for all MLTSS PMs during the review period, do not submit again. ▪ Report of all submissions (monthly, quarterly and annual) of MLTSS measures during the review period showing date due to State, date initially submitted to IPRO, and date initially submitted to State.
QM20*	4.2.6.A.6 4.2.6.A.6.a 4.2.6.A.6.b 4.2.6.B.3.a.i 4.2.6.B.3.a.ii	**4.2.6.A.6** The contractor shall provide all PCDs on a quarterly basis a list of the PCD's enrollees who have not complied with the NJFC requirement (4.2.6.B) for dental services beginning by the age of 12 months or who have not had a subsequent dental visit for oral evaluation or preventive service bi-annually. The PCD shall be required to contact these Enrollees to schedule an appointment. Documentation by the PCD of outreach efforts and responses in the patient's record is required. **4.2.6.A.6.a** When members are assigned a PCD, the list will be generated based on assignment. **4.2.6.A.6.b** When members are not assigned a PCD, the list will be generated for the dentist based on member's previous 12 months claim history. **4.2.6.B.3.a.i** A referral to a dentist by one year of age or soon after the eruption of the first primary tooth is recommended. **4.2.6.B.3.a.ii** Follow up at well child visits through the age of twenty (20) to determine that dental visits twice a year for oral evaluation and preventive services occurred and that needed treatment services are being or were provided.	▪ Provider training on Dental EPSDT requirements ▪ Evidence of tracking Dental EPSDT services ▪ Monitoring Reports on PCP Dental referrals based on EPSDT requirements ▪ Referrals during PCP visits for dental follow-up ▪ Provider Site Visit Audit Tool showing evidence of NJ Dental EPSDT requirements ▪ Most recent Medical Record Review audit findings
Efforts to Reduce Healthcare Disparities			

2024 Element	Contract Reference	Contract Requirement Language	Documentation Examples
D1*	4.6.2.T.1 4.6.2.T.2	**4.6.2.T.1** The contractor shall develop a program to identify, prevent and reduce health care disparities. This program shall include, but is not limited to the following: Evidence of a process to identify and evaluate healthcare disparities within the MCO, by subgroups including but not limited to: race, ethnicity, language, disability status, sexual orientation, gender identity, geography, and/or other variables;**4.6.2.T.2** Barrier analysis and a written action plan to address the disparities identified;	▪ Reports and Analysis conducted by the plan to identify disparities ▪ Action Plan to address disparities identified ▪ Policies and Procedures related to the identification of disparities
D2*	4.6.2.T.3	**4.6.2.T.3** Implementation of an action plan with continuous monitoring of outcomes; and	▪ Disparities in the healthcare workplan ▪ Documentation demonstrating incorporation of disparities in healthcare into plan activities
D3*	4.6.2.T.4	**4.6.2.T.4** Ongoing evaluation of the effectiveness of the action plan	▪ Policies and Procedures relating to the identification and monitoring of disparities in healthcare ▪ Disparities in the healthcare workplan ▪ Reports and Analysis conducted by the plan to re-evaluate disparities in healthcare
D4*	4.7.4.A	**4.7.4.A** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.
D5*/**	**4.6.2.Q.5**	**4.6.2.Q.5** **Performance Improvement Project Categories.** PIPs should address the full spectrum of clinical and nonclinical areas associated with the topic and shall not consistently eliminate any particular subset of enrollees when viewed over multiple years. PIPs are to be implemented for NJ FamilyCare/Medicaid Members. At least one PIP must include activities that advance health equity, through the identification and reduction of health care disparities.	▪ MCOs PIP submissions should clearly identify and reduce healthcare disparities.
Committee Structure			

2024 Element	Contract Reference	Contract Requirement Language	Documentation Examples
CS1*	4.2.9	**4.2.9** The Contractor shall identify relevant community issues (such as disease outbreaks, violence, social determinants of health, chronic disease) and health promotion and education needs of its enrollees, and implement plans that are culturally appropriate to meet those identified needs and, issues relevant to each of the target population groups of enrollees served, as defined in Article 5.2, and the promotion of health. The Contractor shall use community-based needs assessments and other relevant information available from State and local governmental agencies and community groups. Health promotion and education activities shall be evidence-based, whenever possible, and made available in formats and presented in ways that meet the needs of all enrollee groups including elderly enrollees and enrollees with special needs, including enrollees with cognitive impairments. The Contractor shall comply with all applicable State and federal statutes, regulations and protocols on health wellness programs. The Contractor shall submit a written description of all planned health promotion and education activities and targeted implementation dates for DMAHS' approval, prior to implementation, including culturally and linguistically appropriate materials and materials developed to accommodate each of the enrolled target population groups. Health promotion and education program proposals submitted to DMAHS shall be in the format described in Article 4.11 and Appendix B.4.11. The Contractor may utilize a direct service, contractual or combined approach. Minimally the methodology for providing evidence-based disease prevention programs shall include: 1. Direct provision of evidence-based disease prevention programs for Members; OR Care Manager referral and linkage to local providers of such programs. 2. Guidelines for Member referral. 3. Training of Care Management staff to ensure working knowledge of evidence-based disease prevention programs and Contractor's guidelines for assessment and referral. 4. Embedding information about evidence-based programs in provider and Member training initiatives. 5. A tracking mechanism for referral and program completion. 6. Designation of a liaison to DHS for evidence-based disease prevention. Health promotion topics shall include, but are not limited to, the following: A. Smoking cessation programs, with targeted outreach for adolescents and pregnant women	▪ Community Needs Assessment from State and local governmental agencies ▪ QI Program Description ▪ QI Work Plan ▪ List/Schedule of Community Outreach Activities for the previous year and planned for the upcoming year ▪ Tracking Log of Completed Activities ▪ Community Needs Assessment from State and local governmental agencies ▪ HEDIS® and CAHPS® Results and Analysis ▪ Entire year of the most recent meeting minutes showing discussion of activities

		B. Childbirth education classes C. Nutrition counseling, with targeted outreach for pregnant women, elderly enrollees, families with young children, and enrollees with special needs D. In accordance with P.L. 1968, c. 413, as amended by P.L. 2017, c. 161. Diabetes services to include but are not limited to: 1. Medical Nutrition Therapy (MNT) provided by a Registered Dietitian (RD) or Certified Nutrition Specialist (CNS) for members diagnosed with diabetes, gestational diabetes or pre-diabetes. MNT shall be consistent with evidence-based practice guidelines published by the Academy of Nutrition and Dietetics (formerly the American Dietetic Association) . 2. Diabetes Self-Management Education (DSME) to be provided by a Certified Diabetes Educator for members diagnosed with diabetes or gestational diabetes. The DSME program shall meet current quality standards established by either The American Association of Diabetes Educators (AADE) or The American Diabetes Association (ADA). 3. The National Diabetes Prevention Programs (NDPPs), for members diagnosed with prediabetes, which meets the standards of The National Diabetes Prevention Program established by the Center for Disease Control and Prevention (CDC). E. Signs and symptoms of common diseases and complications F. Early intervention and risk reduction strategies to avoid complications of disability and chronic illness G. Self-management of chronic conditions through evidence-based programs such as Stanford University's Chronic Disease Self-Management Program (CDSMP), Tomando Control de su Salud (a version of CDSMP delivered in Spanish). H. Prevention and treatment of alcohol and Substance Use Disorder I. Coping with losses resulting from disability or aging J. Self-care training, including self-examination K. Need for clear understanding of how to take over-the-counter and prescribed medications and the importance of coordinating all such medications L. Understanding the difference between emergent, urgent and routine health conditions M. Information and education on good oral hygiene practices and habits, and the need for regular dental visits and completion of treatment as prescribed by a dentist. N. Strategies to reduce the risk of unintentional injuries	
CS2*	4.6.1.C.1 4.6.1.C.2 4.7.2.A.8	**4.6.1.C.1** **QM Committee**	▪ QI Program Description ▪ QI Work Plan

	B.4.14.IV A-E B.4.14.V Appendices	The Contractor shall have adequate general liability insurance for Members of the QM committee and subcommittees, if any. The committee shall include representation by providers who serve enrollees with special needs and those eligible for MLTSS. **4.6.1.C.2** **Medical Director(s):** The Contractor shall have at least one on-site Medical Director(s) currently licensed in New Jersey as a Doctor of Medicine or Doctor of Osteopathic Medicine. The Contractor shall determine the requisite number of additional Medical Director(s) necessary to ensure the delivery of integrated medical, behavioral, and dental and MLTSS services. The Contractor shall ensure that Medical Director(s) have training and experience including but not limited to, serving populations: • With chronic health care conditions • With co-occurring medical and behavioral health disorders • With physical and or intellectual disabilities • Who meet or are at risk to meet nursing facility level of care The Medical Director(s) shall be responsible for: a. The development, interpretation and implementation of medical, behavioral and dental health policies and procedures to guide and support the provision of medical, behavioral and dental care to enrollees; b. The development, interpretation and implementation of MLTSS policies and procedures to guide and support the provision of MLTSS to enrollees; c. Oversight of physical, behavioral and MLTSS provider recruitment activities; d. Reviewing all providers' applications and making recommendations to those with contracting authority regarding credentialing and reappointing all providers prior to the providers' contracting (or renewal of contract) with the Contractor's plan; e. Continuing surveillance of the performance of providers in their provision of health care to enrollees; f. Administration of all clinical activities of the Contractor; g. Continuous assessment and improvement of the quality of care and services provided to enrollees;	▪ Quality Management/QI Committee Charter ▪ Entire Year of the most recent QI Committee Meeting Minutes, Membership List and Attendance Sheets ▪ Organizational Chart ▪ Medical Director Job Description ▪ Copy of medical director's valid and current medical license ▪ Provider Advisory Committee (PAC)/Medical Advisory Committee (MAC) membership lists ▪ Entire Year of the most recent PAC/MAC Charter, Meeting Minutes and Attendance Sheets ▪ Credentialing Application or other documentation showing provider serves enrollees with special needs ▪ Forms showing attestations regarding ability to treat enrollees with special needs

		h. Serving as Chairperson of Quality Management Committee; [Note: the medical director may designate another physician to serve as chairperson with prior approval from DMAHS.] i. Oversight of all provider education, in-service training and orientation; j. Assuring that adequate staff and resources are available for the provision of medical, behavioral and MLTSS services to enrollees; k. Coordinating with other Medical Directors, as necessary, to ensure integrated and coordinated medical, behavioral, dental and MLTSS services (formal and informal) for MLTSS Members; and l. The review and approval of studies and responses to DMAHS concerning QM matters. **4.7.2.A.8** The Contractor shall submit on an annual basis to DMAHS and/or the EQRO at the direction of the State, documentation of its ongoing internal quality assurance activities. Such documentation shall include at a minimum: a. Agenda of quality assurance meetings of its medical and service professionals; and b. Attendance sheets with attendee signatures. c. Minutes of all Quality Assurance meetings, approved and signed. **B.4.14.IV** **ACTIVE QA COMMITTEE** - The QAPI delineates an identifiable structure responsible for performing QA functions within the MCO, including those QA functions regarding MLTSS. This committee or other structure has: **A. regular meetings** - The structure/committee meets on a regular basis with specified frequency to oversee QAPI activities. This frequency is sufficient to demonstrate that the structure/committee is following-up on all findings and required actions, but in no case are such meetings less frequent that quarterly. **B. established parameters for operating** - The role, structure and function of the structure/committee are specified. **C. documentation** - There are records documenting the structure's/committee's activities, findings, recommendations and actions. **D. accountability** - The QAPI committee is accountable to the Governing Body and reports to it (or its designee) on a scheduled basis on activities, findings, recommendations and actions.	

		E. membership - There is active participation in the QA committee from health plan providers, who are representative of the composition of the health plan's providers, including MLTSS providers whose function is to support the enrollee's ability to receive services in the setting of their choice. **B.4.14.V** **QAPI SUPERVISION** - There is a designated senior executive who is responsible for program implementation. The organization's Medical Director has substantial involvement in QA activities.	
CS3	4.6.2.BB	**4.6.2.BB** **Provider Advisory Committee (PAC)** The Contractor shall establish and maintain a provider advisory committee, consisting of providers contracting with the Contractor to serve enrollees. At least two providers on the committee shall maintain practices or provide services that predominantly serve Medicaid beneficiaries and other indigent populations, in addition to one or more other practicing providers on the committee who have experience and expertise in serving enrollees with long term care needs and special needs. The committee shall meet at least quarterly and its input and recommendations shall be employed to inform and direct Contractor quality management activities and policy and operations changes. The DMAHS and/or its EQRO shall conduct a review of the membership of this committee, as well as the committee's activities throughout the year.	▪ QI Program Description ▪ QI/PAC Charter ▪ Entire Year of the most recent PAC Meeting Minutes, Agendas, membership Lists and Attendance Sheets ▪ Reports showing the percentage of Medicaid enrollees served by providers on the committee ▪ Credentialing Application or other documentation showing provider serves enrollees with special needs ▪ Provider Directory ▪ Provider Database File ▪ Entire Year of the most recent QI Committee Meeting Minutes, Agendas, and Sign-In Sheets
CS4	4.6.2.BB.1	**4.6.2.BB.1** The Contractor shall have a Dental Affairs Advisory Subcommittee to give participating dental providers the opportunity to provide input to the MCO in improving dental performance rates based on CMS-416 data and quality of care.	▪ Dental Affairs Advisory Subcommittee Charter ▪ Entire Year of the most recent Dental Affairs Advisory Subcommittee Meeting Minutes, Agendas, and Attendance Sheets ▪ Dental Affairs Advisory Subcommittee Membership List ▪ Entire Year of the most recent PAC Meeting Minutes ▪ Entire Year of the most recent QI Meeting Minutes ▪ Dental initiatives including outcomes
CS5	4.6.1.C.9	**4.6.1.C.9** **Dental Director** The Contractor shall have on staff a full time (minimum 40 hours per week) Dental Director who is currently licensed in New Jersey as a Doctor of Dental Surgery or a Doctor of Dental Medicine. The Dental Director must have practiced in New Jersey and shall be responsible for: a. The development, implementation and interpretation of clinical criteria and dental policies and procedures in accordance with DMHAS and NJFC	▪ Dental Service Coordinator Job Description ▪ Organizational Chart ▪ Entire Year of the most recent Dental Advisory Meeting Minutes, Agenda, and Attendance Sheets

		regulations (N.J.A.C> 10:56, DMHAS Newsletters and the NJ FamilyCare Dental Clinical Criteria Policy) to guide and support the provision of dental care by both the Contractor and its subcontractor (if applicable) to include Provider notification of changes within 30 days. b. Oversight or shared oversight of dental provider recruitment, credentialing and re-credentialing activities with emphasis placed on the recruitment and retention of providers who treat members with special needs and/or disabilities; c. Monitoring of the dental network, including review of all dental applications, to ensure network adequacy standards are met, including but not limited to provider ratios, in-county minimum, office hour minimums, and geographical accessibility standards, as set for in the Contract; d. Surveillance of the performance of providers (including the providers of their subcontractor), in their provision of dental care to enrollees. This includes but is not limited to; identifying and addressing quality of care, continuity of care (to include orthodontic treatment and other multi-visit procedures), member outreach for missing EPSDT dental periodicity services and fraud, waste and abuse; e. Administration and oversight of all dental activities of the Contractor and review all written information and materials provided to the public, Members and Providers for contract compliance; f. Where applicable, monitors IDD, SHCN and pediatric member assignment for appropriateness; g. Continuous assessment and improvement of utilization of dental services and the quality of dental care provided to Members. This shall apply to the EPSDT requirement for the first year dental visit, establishing a dental home by the age of two (2), increased utilization for pediatric preventive dental services by PCDs and oral health services by non-dental providers/medical personnel for members through age five (5).; h. Serving on the Contractor's Quality Management Committee; serving on the Contractor's credentialing committee and/or the subcontractor's credentialing committee when applicable;	

		i. Oversight of the orientation, education, and in-service training provided to network providers to include collection of attestations for fluoride varnish application by medical personnel; j. Reviewing dental consultants for inter-rater reliability and monitor consultants' activities quarterly for compliance; k. Assuring that adequate Contractor staff and resources are available for prompt response to member and provider concerns, State referrals, requests for various deliverables and the appeals process; l. The review and approval of studies, reports and responses to DMAHS concerning utilization and Quality matters; m. Representing the Contractor at Medicaid Fair Hearings and IUROs; n. Representing the Contractor at meetings of the Dental Advisory Council of DMAHS; o. If the Contractor contracts with a dental subcontractor, the Contractor's Dental Director shall provide direction and monitor its performance to ensure contract compliance and continuous quality improvement; ensure that decisions are made in a clinically-appropriate and timely manner based on the current clinical criteria policy; review all written information and materials provided to the public, Members and Providers to ensure the subcontractor complies with NJ FamilyCare policies, New Jersey State Board of Dentistry regulations, and that the Contractor's name is prominently displayed on all subcontractor materials; p. Verification on a monthly basis that dental providers and subcontractors have not been suspended, debarred, disqualified, terminated or otherwise excluded from Medicaid, Medicare, or any other federal or state health care programs.	
CS6	4.6.2.Z	**4.6.2.Z** **Community/Health Education Advisory Committee** The Contractor shall establish and maintain a community advisory committee, consisting of Members being served by the Contractor, including MLTSS Members, authorized persons, individuals and providers with knowledge of and experience with serving elderly people, people with disabilities or people eligible for MLTSS; and representatives from community agencies that do not provide Contractor-covered services but are important to the health and well-being of Members. The committee shall meet at least quarterly and its input and recommendations shall be employed to inform and direct Contractor	▪ Community/Health Education Advisory Committee (HEAC) Charter ▪ Committee Membership List including titles ▪ Entire Year of the most recent committee Attendance Sheets and Meeting Minutes ▪ Entire Year of the most recent QI Committee Meeting Minutes or other meeting minutes showing discussion of the Community/Health Education Advisory Committee activities

		quality management activities and policy and operations changes. The DMAHS and/or its EQRO shall conduct a review of the membership of this committee, as well as the committee's activities throughout the year(s).	▪ QI Program Description
CS7	B.4.14.X.H	**B.4.14.X.H** Opportunity is provided for Members to offer suggestions for changes in policies and procedures.	▪ Policies and Procedures addressing the following: ➢ Enrollee Rights and Responsibilities ▪ HEAC Charter ▪ Entire Year of the most recent HEAC Meeting Minutes, Attendance List, Agendas ▪ Entire Year of the most recent Committee Meeting Minutes as appropriate ▪ Member Handbook
CS8***	4.6.2.AA	**4.6.2.AA** MLTSS Consumer Advisory Committee. The Contractor shall establish an MLTSS Consumer Advisory Committee including representation of MLTSS stakeholders, a representative group of MLTSS population participants, or individuals representing those enrollees, case managers, and others, and will address issues related to MLTSS. Contractor shall forward results and follow-up items to DMAHS on a quarterly basis.	▪ MLTSS CAC Charter ▪ Committee Membership List including titles ▪ Entire Year of the most recent committee Attendance Sheets and Meeting Minutes ▪ Entire Year of the most recent QI Committee Meeting Minutes or other meeting minutes showing discussion of the MLTSS CAC activities ▪ QI Program Description
CS9*	4.7.4.A	**4.7.4.A** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion. ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.
Programs for the Elderly and Disabled			
2024 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
Sub-heading	4.6.2.R 4.6.2.R.1 4.6.2.R.1.g	**4.6.2.R** **Care for Persons with Disabilities and the Elderly** (Defined as SSI-Aged and New Jersey Care – Aged enrollees and SSI and New Jersey Care enrollees with disabilities). The Contractor shall have the system capability to track and report on each population separately. **4.6.2.R.1** The Contractor's Quality Department shall promote improved clinical outcomes and enhanced quality of life for NJ FamilyCare elderly enrollees and enrollees with disabilities, and MLTSS Members.	

		4.6.2.R.1.g The Contractor shall make results of the quality activities of this Article available to DMAHS during the annual assessment audit (See Article 4.7). The Quality Department shall:	
ED1	4.6.2.R.1.a	**4.6.2.R.1.a** Oversee quality of life indicators, such as: i. Degree of personal autonomy; ii. Provision of services and supports that assist people in exercising medical and social choices; iii. Self-direction of care to the greatest extent appropriate; iv. Maximum use of natural support networks; and v. Maintenance of optimal level of functioning.	▪ QI Work Plan ▪ Adult and Pediatric Complex Needs Assessment (CNA) ▪ New Jersey Choice Assessment ▪ Health Risk Assessment (HRA) ▪ Quality Improvement Program Description ▪ Care Management Program Description ▪ Care of Persons with Disabilities and the Elderly Program Description ▪ QI Work Plan ▪ Entire Year of the most recent QI Committee Meeting Minutes ▪ Care Management examples for the specific population
ED2	4.6.2.R.1.b	**4.6.2.R.1.b** Review persistent or significant grievances from elderly enrollees, enrollees with disabilities, and MLTSS Members or their authorized person, identified through Contractors' grievance procedures and through external oversight;	▪ Policies and procedures addressing the following: ▪ Grievances ▪ Special Needs Enrollee Grievance Summary by category and analysis of findings ▪ Entire Year of the most recent QI Committee Meeting Minutes ▪ Enrollee Appeals Summary and Analysis
ED3	4.6.2.R.1.c	**4.6.2.R.1.c** Review quality assurance policies, standards and written procedures to ensure they adequately address the needs of elderly enrollees, enrollees with disabilities, and MLTSS Members;	▪ Policies and Procedures addressing the following: ➢ Care Management of the Elderly and the Disabled ➢ Review and Revision of Policies and Procedures ▪ Quality of Care/Service Policy and Procedure ▪ QI Program Description ▪ Clinical Practice Guidelines
ED4	4.6.2.R.1.d	**4.6.2.R.1.d** Review utilization of services, including any relationship to adverse or unexpected outcomes specific to elderly enrollees, enrollees with disabilities, and MLTSS Members;	▪ Disabled and Elderly quarterly, semiannual or annual grievance summary and analysis ▪ Over/Under Utilization of Services Report ▪ Quality of Care/Services Reports ▪ Drug Utilization Review Report and Analysis ▪ Quality Outcomes Report and Analysis

			▪ QI Work Plan ▪ Initiatives Developed to Address Deficiencies including Outcomes
Sub-heading	4.6.2.R.1.e	**4.6.2.R.1.e** **Care for Persons with Disabilities and the Elderly** Develop written procedures and protocols for at least the following:	
ED5	4.6.2.R.1.e.i	**4.6.2.R.1.e.i** Assessing the quality of complex health care/Care Management;	▪ Policies and Procedures addressing the following: ➢ Care Management of Enrollees with Special Needs ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Adult CNA Form ▪ HRA ▪ Initiatives Developed to Address Deficiencies including Outcomes
ED6	4.6.2.R.1.e.ii	**4.6.2.R.1.e.ii** Ensuring Contractor compliance with the Americans with Disabilities Act (ADA); and	▪ Policies and Procedures addressing the following: ➢ Americans with Disabilities Act Policy ➢ Credentialing/Recredentialing ▪ Provider Manual ▪ Provider Participating Agreement ▪ Provider Office Site Audit Tool ▪ Provider Application ▪ Corrective Action Plans for non-compliant providers ▪ Examples of provider site visit summaries ▪ Initiatives Developed to Address Deficiencies including Outcomes
ED7	4.6.2.R.1.e.iii	**4.6.2.R.1.e.iii** Instituting effective health and function management protocols for elderly enrollees, enrollees with disabilities, and MLTSS Members.	▪ Policies and Procedures addressing the ▪ following: ➢ Care of Persons with DDD and the Elderly and the institution of effective health management protocols ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Health Risk Assessment ▪ Adult CNA Form ▪ New Jersey Choice Assessment ▪ MLTSS Level of Supervision Assessment (CRS-settings)

			▪ Treatment Protocols (e.g., Milliman & Robertson® or InterQual®) ▪ Preventive Health Guidelines
ED8	4.6.2.R.1.f	**4.6.2.R.1.f** Develop and test methods to identify and collect quality measurements including measures of treatment efficacy of particular relevance to elderly enrollees, enrollees with disabilities, and MLTSS Members.	▪ Policies and Procedures addressing the following: ➢ Care of Persons with DDD and the Elderly ▪ Quality Outcomes Report and Analysis ▪ QI Program Description ▪ Provider Manual ▪ QI Program Evaluation ▪ QI Work Plan ▪ Initiatives Developed to Address Deficiencies including Outcomes
Sub-heading	4.6.2.R.2	**4.6.2.R.2** **Initiatives for Aged, including MLTSS Members** The Contractor shall implement specific initiatives for the aged population through the development of programs and protocols approved by DMAHS annually including:	
ED9	4.6.2.R.2.a	**4.6.2.R.2.a** The Contractor shall develop a program to ensure provision of the pneumococcal vaccine and influenza immunizations, as recommended by the Centers for Disease Control (CDC). The adult preventive immunization program shall include the following components:	▪ Pneumococcal Vaccination and Influenza Immunizations Program Description ▪ QI Work Plan ▪ QI Program ▪ Preventive Health Guidelines ▪ Specialty Programs developed to address the needs of the elderly ▪ State Program Approval ▪ Provider Manual ▪ Provider Newsletters ▪ Pneumococcal Vaccination and Influenza Immunization Initiatives
ED10	4.6.2.R.2.a.i	**4.6.2.R.2.a.i** Development, distribution, and measurement of PCP compliance with practice guidelines;	▪ Preventive Service Reports and Analysis ▪ Provider Newsletters ▪ Provider communications specifying enrollees in need of services ▪ Provider Specific HEDIS® Results ▪ Provider Profiling Program ▪ Provider Profiling Reports ▪ Physician Practice Overview Reports ▪ Follow-up on non-compliant providers

			▪ Screen Prints
ED11	4.6.2.R.2.a.ii	**4.6.2.R.2.a.ii** Educational outreach for enrollees and practitioners;	▪ Pneumococcal vaccination and Influenza Immunizations Program Description ▪ MCO Enrollee and Provider Website Screen Prints ▪ Reminder Letters ▪ Enrollee and Provider Newsletters ▪ Provider Letters ▪ Initiatives developed to address deficiencies including outcomes
ED12	4.6.2.R.2.a.iii	**4.6.2.R.2.a.iii** Access for ambulatory and homebound enrollees;	▪ Policies and Procedures addressing the following: ➢ Access to pneumococcal vaccines and influenza immunizations for homebound enrollees ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Member Handbook ▪ Screen Prints of the Enrollee Website ▪ Health Risk Assessment ▪ 3 Blinded Care Management Records
ED13	4.6.2.R.2.b	**4.6.2.R.2.b** The Contractor shall develop a program to ensure the provision of preventive cancer screening services including, at a minimum, breast and prostate cancer screening. The Program shall include the following components:	▪ Preventive Cancer Screening Program Description ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ HEDIS® Results and Analysis ▪ Enrollee Preventive Health Screenings Reports including barrier analysis, initiatives developed to address deficiencies and outcomes ▪ QI Work Plan ▪ QI Program ▪ Preventive Health Guidelines ▪ Specialty Programs developed to address the needs of the elderly ▪ Provider Manual ▪ Provider Newsletters
ED14	4.6.2.R.2.b.i	**4.6.2.R.2.b.i** Measurement of provider compliance with performance standards;	▪ Provider Profiling Program ▪ Provider Profiling Results ▪ HEDIS® Results and Analysis ▪ Preventive Service Reports and Analysis ▪ Provider Newsletters

			▪ Provider communications specifying enrollees in need of services ▪ Physician Practice Overview Reports ▪ Provider Follow- up ▪ Screen Prints
ED15	4.6.2.R.2.b.ii	**4.6.2.R.2.b.ii** Education outreach for both enrollees and practitioners regarding preventive cancer screening services;	▪ Preventive Cancer Screening Program Description ▪ MCO Enrollee and Provider Website Screen Prints ▪ Reminder Letters ▪ Enrollee and Provider Newsletters ▪ Provider Letters ▪ Initiatives Developed to Address Deficiencies including Outcomes
ED16	4.6.2.R.2.b.iii	**4.6.2.R.2.b.iii** Breast cancer screening in accordance with Centers for Disease Control (CDC) recommendations;	▪ Preventive Health Guidelines ▪ Reminder Notices ▪ Reminder Call Scripts ▪ Member Handbook ▪ Provider Manual
ED17	4.6.2.R.2.b.iv	**4.6.2.R.2.b.iv** Prostate cancer screening in accordance with CDC recommendations.	▪ Preventive Health Guidelines ▪ Reminder Notices ▪ Reminder Call Scripts ▪ Member Handbook ▪ Provider Manual
ED18	4.6.2.R.2.b.v	**4.6.2.R.2.b.v** Documentation on medical records of all tests given, positive findings and actions taken to provide appropriate follow-up care.	▪ Provider Manual ▪ Policies and Procedures addressing the following: ➢ Medical Record Documentation Standards ➢ Medical Records Audit ▪ Medical Record Review Program ▪ Medical Record Review Audit Tool ▪ Most recent Medical Record Review Audit Findings ▪ Provider medical review results notification letter ▪ Documentation showing follow-up with non-compliant providers (e.g., letters, education, corrective action plans and re-monitoring) ▪ Initiatives Developed to Address Deficiencies including Outcomes
ED19	4.6.2.R.2.c	**4.6.2.R.2.c** The Contractor shall develop specific programs for the care of enrollees identified with congestive heart failure, chronic obstructive lung disease	▪ Disease Management Program Descriptions for the following: ➢ Congestive heart failure (CHF)

		(COPD), diabetes, hypertension, and depression. The program shall include the following:	➢ Chronic obstructive pulmonary disease (COPD) ➢ Diabetes ➢ Hypertension (HTN) ➢ Depression ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ CHF, COPD, Diabetes, HTN and Depression Initiatives Including Outcomes ▪ Educational Materials
ED20	4.6.2.R.2.c.i	**4.6.2.R.2.c.i** Written quality of care plan to monitor clinical management, including diagnostic, pharmacological, and functional standards and to evaluate outcomes of care;	▪ Care Management Program Description ▪ Community Based Care Management Description ▪ 3 Blinded Examples of Enrollee Care Plans ▪ Screen Prints
ED21	4.6.2.R.2.c.ii	**4.6.2.R.2.c.ii** Measurement and distribution to providers of reports on outcomes of care;	▪ Disease Management/Complex Case Management Annual Outcomes Report for the Specified Populations ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Provider Profiling Program Description ▪ Provider Profiling Results ▪ HEDIS® Results and Analysis ▪ Provider Newsletters ▪ Physician Practice Overview Reports ▪ Provider Follow- up ▪ Screen Prints ▪ Utilization Reports
ED22	4.6.2.R.2.c.iii	**4.6.2.R.2.c.iii** Educational programming for enrollees and significant caregivers which emphasizes self-care and maximum independence;	▪ Examples of educational materials for enrollee and caregivers ▪ Disease Management Programs for specified disease states ▪ Educational Program Evaluations
ED23	4.6.2.R.2.c.iv	**4.6.2.R.2.c.iv** Educational materials for clinical providers in the best practices of managing the disease; and	▪ Clinical Practice Guidelines ▪ Provider Manual ▪ Provider Newsletters ▪ MCO Website ▪ Provider Educational Materials
ED24	4.6.2.R.2.c.v	**4.6.2.R.2.c.v** Evaluation of effectiveness of each program by measuring outcomes of care.	▪ Disease Management Program ▪ Disease Specific Outcomes Report

			▪ HEDIS® Results and Analysis ▪ Annual Disease Management Program Evaluation ▪ QI Evaluation ▪ Outcomes Report ▪ Disease Specific Program Evaluations
ED25	4.6.2.R.2.d	**4.6.2.R.2.d** The Contractor shall develop a program to manage the care for enrollees identified with cognitive impairments. The program shall include the following:	▪ Policies and Procedures addressing the following: ➢ Care of Persons with cognitive impairments and the elderly ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Annual Outcomes Report ▪ Annual Outcomes Analysis ▪ HRA
ED26	4.6.2.R.2.d.i	**4.6.2.R.2.d.i** Written quality of care plans to monitor clinical management, including functional standards, and to evaluate outcomes of care;	▪ Care Management Program Description ▪ Community Based Care Management Description Care Management of enrollees with cognitive impairments ▪ 3 Blinded Examples of Enrollee Care Plans
ED27	4.6.2.R.2.d.ii	**4.6.2.R.2.d.ii** Measurement and distribution to providers of reports on outcomes of care;	▪ Outcome Reports ▪ Policies and Procedures addressing the following: ➢ Management of Members with Special Needs ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ QI Work Plan ▪ QI Evaluation ▪ Disease Management/Complex Care Management Annual Outcomes Report for the Specified Population ▪ Provider Profiling Program ▪ Provider Profiling Results ▪ HEDIS® Results and Analysis ▪ Provider Newsletters ▪ Physician Practice Overview Reports ▪ Provider Follow- up ▪ Screen Prints ▪ Utilization Reports
ED28	4.6.2.R.2.d.iii	**4.6.2.R.2.d.iii**	▪ Policies and Procedures addressing the following: ➢ Management of Members with Special Needs

		Educational programming for significant caregivers which emphasizes community based care and support systems for caregivers; and	▪ Examples of Educational Material for Enrollee and Caregivers ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Case Examples
ED29	4.6.2.R.2.d.iv	**4.6.2.R.2.d.iv** Educational materials for clinical providers in the best practices of managing cognitive impairments.	▪ Clinical Practice Guidelines ▪ Provider Manual ▪ Provider Newsletters ▪ MCO Website ▪ Provider Educational Materials
ED30*	4.6.2.R.2.e	**4.6.2.R.2.e** **Initiatives to Prevent Long-Term Institutionalization (LTI)** Contractor shall develop a program to prevent unnecessary or inappropriate nursing facility admissions. This program shall include, but is not limited to, the following:	▪ LTI Program Description ▪ LTI Initiatives Including Outcomes
ED31*	4.6.2.R.2.e.i	**4.6.2.R.2.e.i** Identification of medical and social conditions that indicate risk of being institutionalized;	▪ Desk Top Procedures ▪ CNA ▪ Utilization Management Process Flowcharts ▪ Risk Assessments ▪ Redacted cases of Identification of At-risk Enrollees
ED32*	4.6.2.R.2.e.ii	**4.6.2.R.2.e.ii** Monitoring and risk assessment mechanisms that assist PCPs and others to identify enrollees at-risk of institutionalization;	▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Utilization Management Program Description ▪ CNA ▪ New Jersey Choice Assessment ▪ HRA ▪ Utilization Management cases ▪ Examples of Care Plans ▪ Provider Communications ▪ Desk-Top Procedures ▪ Utilization Management/Case Management Notes ▪ Provider Programs addressing the prevention of LTI
ED33*	4.6.2.R.2.e.iii	**4.6.2.R.2.e.iii** Protocols to ensure the timely provision of appropriate preventive care services to at-risk enrollees. Such protocols should emphasize continuity of care and coordination of services; and	▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Protocols addressing preventive services for at-risk enrollees ▪ CNA

			▪ HRA ▪ UM Cases ▪ Blinded Enrollee Care Plans ▪ Prevention of LTI Desk-Top Procedures
ED34*	4.6.2.R.2.e.iv	**4.6.2.R.2.e.iv** Provision of home/community services covered by the Contractor.	▪ Policies and Procedures addressing the following: ➢ Home Care and Private Duty Nursing ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Referral Desk-Top Procedure ▪ CNA ▪ Blinded Enrollee Care Plan ▪ Blinded Case File
ED35	4.6.2.R.2.f	**4.6.2.R.2.f** Abuse and Neglect Identification Initiative: Contractor shall develop a program on prevention, awareness, and treatment of abuse and neglect of enrollees, to include the following:	▪ Policies and Procedures addressing the following: ➢ Identification of enrollees at risk for abuse and neglect ➢ Care Management ▪ Risk Assessments ▪ CNA ▪ Employee Training ▪ Blinded Case Example showing suspected abuse and neglect ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ MLTSS Member training on Abuse/Neglect identification and reporting.
ED36	4.6.2.R.2.f.i	**4.6.2.R.2.f.i** Diagnostic tools for identifying enrollees who are experiencing or who are at risk of abuse and neglect;	▪ Policies and Procedures addressing the following: ➢ Identification of enrollees at risk for abuse and neglect ▪ CNA ▪ New Jersey Choice Assessment ▪ HRA ▪ Diagnostic tools for identifying enrollee abuse and neglect ▪ Customer Service Script ▪ Customer Service Education related to potential abuse and neglect ▪ Data Triggers

ED37	4.6.2.R.2.f.ii	**4.6.2.R.2.f.ii** Protocols and interventions to treat abuse and neglect of enrollees, including ongoing evaluation of the effectiveness of these protocols and interventions; and	▪ Policies and Procedures addressing the following: ➢ Identification of enrollees at risk for abuse and neglect ➢ Abuse and Neglect Protocols ▪ Case Management file of an enrollee that has had confirmed abuse and neglect ▪ Descriptions of interventions for treating abuse and neglect ▪ Program Evaluation ▪ Care Management Program Description ▪ Community Based Care Management Description
ED38	4.6.2.R.2.f.iii 4.6.2.R.2.f.iv	**4.6.2.R.2.f.iii** Coordination of these efforts through the PCP. **4.6.2.R.2.f.iv** Reporting of MLTSS-related critical incidents in accordance with Article 9.	▪ Policies and Procedures addressing the following: ➢ Identification of enrollees at risk for abuse and neglect ▪ Case example of confirmed abuse and neglect ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Provider Educational Materials ▪ CI reporting procedures and reports
Sub-heading	4.6.2.S	**4.6.2.S** For the elderly, enrollees with disabilities, and MLTSS Members, the Contractor shall monitor, evaluate and report on Member outcomes at least annually. The Contractor shall have the system capability to track and report on each population separately, and make available the results of the evaluation to DMAHS during the annual assessment audits. (See Article 4.7). The Contractor shall include of the following quality indicators of potential adverse outcomes and provide for appropriate education, outreach and Care Management, and other activities as indicated:	
ED39*	4.6.2.S.1	**4.6.2.S.1** Aspiration pneumonia	▪ Outcomes Reports addressing the specified condition in the elderly and enrollees with disabilities ▪ QI Program Description ▪ QI Work Plan ▪ Program Evaluation ▪ Educational Materials ▪ Aspiration pneumonia Initiatives Including Outcomes
ED40*	4.6.2.S.2	**4.6.2.S.2** Injuries, fractures, and contusions	▪ Outcome Reports addressing the specified condition in the elderly and enrollees with disabilities ▪ QI Program Description

			▪ QI Work Plan ▪ Program Evaluation ▪ Educational Materials ▪ Injuries, fractures, and contusions Initiatives Including Outcomes
ED41*	4.6.2.S.3	**4.6.2.S.3** Decubiti	▪ Outcomes Reports addressing the specified condition in the elderly and enrollees with disabilities ▪ QI Program Description ▪ QI Work Plan ▪ Program Evaluation ▪ Educational Materials ▪ Decubiti Initiatives Including Outcomes
ED42*	4.6.2.S.4	**4.6.2.S.4** Seizure management	▪ Outcomes Reports addressing the specified condition in the elderly and enrollees with disabilities ▪ QI Program Description ▪ QI Work Plan ▪ Program Evaluation ▪ Educational Materials ▪ Seizure Management Initiatives Including Outcomes

ED43**	9.7.5	**9.7.5**
		Nursing Facility Diversion
		A. The Contractor shall develop and implement a nursing facility diversion process that shall be approved by the State and CMS prior to implementation. The nursing facility diversion plan shall include, but not be limited to the following provisions:
		1. Comprehensive clinical assessment process that identifies Members' health care and service needs;
		2. Options Counseling process that ensures Members are educated on the full range of LTSS and offered a choice of care (institutional/home and community based services) and option to choose MLTSS or PACE (if available); and
		3. A person-centered Plan of Care (POC) approach is implemented;
		4. Monitoring hospitalizations, short term NF stays and identifying issues and strategies to improve diversion outcomes, and
		
		B. The diversion process shall not prohibit or delay a member's access to nursing facility services when these services are medically necessary. The
			▪ State approved Nursing Facility Diversion program which includes:
			  ▪ Identification of members for inclusion in the program
			  ▪ Clinical assessment process
			  ▪ Education to members regarding the process

		Contractor's nursing facility diversion process shall be tailored to meet the needs of each group identified below: 1. MLTSS members who request admission to a nursing facility for custodial care; 2. MLTSS members residing in the community who have a negative change in circumstances and/or deterioration in health or functional status and who request nursing facility services; 3. MLTSS members that the Contractor becomes aware are admitted to an inpatient hospital and who are not residents of a nursing facility.	
ED44*	4.7.4.A	**4.7.4.A** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion. ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.
Provider Training and Performance			
2024 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
PT1	3.7.1.A.1 4.6.2.V 4.6.4.A.3 7.24.D 7.24.E	**3.7.1.A.1** The system shall provide reports to monitor and identify deviations of patterns of treatment from established standards or norms and established baselines. These reports shall profile utilization of providers and enrollees and compare them against experience and norms for comparable individuals. **4.6.2.V** **Provider Performance Measures** The Contractor shall conduct a multi-dimensional assessment of a provider's performance, including non-traditional providers, and utilize such measures in the evaluation and management of those providers. Data shall be supplied to providers for their management activities. The Contractor shall indicate in its QAPI/Utilization Management Plan New Jersey QAPI Standards, how it will address this provision subject to DHS approval. At a minimum, the evaluation management approach shall address the following, as appropriate: 1. Resource utilization of services, specialty and ancillary services; 2. Clinical performance measures on outcomes of care; 3. Maintenance and preventive services; 4. Enrollee experience and perceptions of service delivery; and	▪ Policies and Procedures addressing the following: ➢ Provider Profiling including panel size requirements ▪ Provider Profiling Program Description ▪ Most recent Provider Profile Results ▪ Cover letter for Provider Profiling ▪ Utilization of Special Services Report (MRI, CT SCAN, etc.) ▪ Various data including ER, Drug and Dental Services Utilization ▪ HEDIS® Results and Analysis ▪ EPSDT Monitoring ▪ Outcomes Reports ▪ CAHPS® Reports ▪ Member Grievance Analysis Reports ▪ Access Reports ▪ Documentation showing follow-up with non-compliant providers (e.g., letters, education, corrective action plans and re-monitoring)

		5. Access. **4.6.4.A.3** **Data Collection and Reporting** The plan shall provide for systematic utilization data collection and analysis, including profiling of provider utilization patterns and patient results. The Contractor must use aggregate data to establish utilization patterns, allow for trend analysis, and develop statistical profiles of both individual providers and all network providers. Such data shall be regularly reported to the Contractor management and Contractor providers. The plan shall also provide for interpretation of the data to providers. **7.24.D** The Contractor shall provide its primary care practitioners with quarterly utilization data within forty-five (45) days of the end of the program quarter comparing the average medical care utilization data of their enrollees to the average medical care utilization data of other managed care enrollees. These data shall include, but not be limited to, utilization information on enrollee encounters with PCPs, children who have not received an EPSDT examination or a blood lead screening, specialty claims, prescriptions, inpatient stays, and emergency room use. **7.24.E** The Contractor shall collect and analyze data to implement effective quality assurance, utilization review, and peer review programs in which physicians and other health care practitioners participate. The Contractor shall review and assess data using statistically valid sampling techniques including, but not limited to, the following: Primary care practitioner audits; specialty audits; inpatient mortality audits; quality of care and provider performance assessments; quality assurance referrals; credentialing and recredentialing; verification of encounter reporting rates; quality assurance committee and subcommittee meeting agendas and minutes; enrollee grievances, appeals, and follow-up actions; providers identified for trending and sanctioning, including providers with low blood lead screening rates; special quality assurance studies or projects; prospective, concurrent, and retrospective utilization reviews of inpatient hospital stays; and denials of off-formulary drug requests.	
PT2	4.6.1.C.4	**4.6.1.C.4** Medical Record standards shall address Medical, Behavioral, Dental, and MLTSS records. Records shall also contain notation of any cultural/linguistic needs of the enrollee.	▪ Policies and Procedures addressing the following: ➢ Medical Record Documentation Standards ➢ Dental Record Documentation Standards

			➢ Medical Records Audit ▪ Provider Manual ▪ Medical and Dental Record Review Programs ▪ Medical and Dental Record Review Audit Tools ▪ Most recent Medical and Dental Record Review Audit Findings ▪ Provider medical/dental review results notification letter ▪ Documentation showing follow-up with non-compliant providers (e.g., letters, education, corrective action plans and re-monitoring) ▪ Initiatives Developed to Address Deficiencies including Outcomes
PT3	4.6.2.K	**4.6.2.K** **Ethical Issues** The Contractor shall comply and monitor its providers for compliance with state and federal laws and regulations concerning ethical issues, including, but not limited to: ▪ Advance Directives, ▪ Family Planning services for minors, and ▪ Other issues as identified. The Contractor shall submit a report within thirty (30) days to DMAHS with changes or updates to the policies.	▪ Policies and Procedures addressing the following: ➢ Medical Records Documentation Standards ➢ Treatment of Minors ➢ Medical Records Audit ➢ Advance Directives ➢ Medical Records Standards ▪ Most recent Medical Records Audit findings ▪ Provider Manual ▪ Documentation showing follow-up with non-compliant providers (e.g., letters, education, corrective action plans and re-monitoring) ▪ Initiatives Developed to Address Deficiencies including Outcomes
PT4	4.6.2.N	**4.6.2.N** **Informed Consent** The Contractor is required and shall require all participating providers to comply with the informed consent forms and procedures for hysterectomy and sterilization as specified in 42 CFR 441, Sub-part F, and shall include the annual audit for such compliance in its quality assurance reviews of participating providers. Copies of the forms are included in Section B.4.15 of the Appendices.	▪ Policies and Procedures addressing the following: ➢ Informed Consent ➢ Informed Consent for hysterectomies and sterilizations ▪ Examples of Consent Forms with instructions ▪ Provider Manual ▪ Monitoring Procedures ▪ Claims Denial Logs ▪ Documentation showing follow-up with non-compliant providers (e.g., letters, education, corrective action plans and re-monitoring)
PT5*	4.7.2.E	**4.7.2.E**	▪ Provider Profiling Program ▪ Provider Profiling Procedures

		The Contractor shall produce reports of all PCPs in its network (regardless of panel size), who are treating children under 21 years old, that provide information to the PCPs of underutilization or no utilization of their enrollee panel Members as compared to Early Periodic Screening and Diagnostic Testing (EPSDT) utilization requirements.	▪ Provider Profiles ▪ EPSDT Monitoring ▪ Documentation showing follow-up with non-compliant providers (e.g., letters, education, corrective action plans and re-monitoring)
PT6	6.3.A	**6.3.A** **Provider Education and Training** A. Initial Training. The Contractor shall ensure that all providers receive sufficient training regarding the managed care program in order to operate in full compliance with program standards and all applicable federal and State regulations. At a minimum, all providers shall receive initial training in managed care services, the Contractor's policies and procedures, and information about the needs of enrollees with special needs. Ongoing training shall be provided as deemed necessary by either the Contractor or the State in order to ensure compliance with program standards. The contractor shall maintain evidence of training which shall include, at a minimum, documenting the date of the training, the materials covered, and the participants. Subjects for provider training shall be tailored to the needs of the Contractor's plan's target groups.	▪ Policies and Procedures addressing the following: ➢ Provider Education ▪ Provider Training Overview/Program ▪ Provider Toolkit/Training Curriculum ▪ Signed Acknowledgement of Training Forms ▪ Training Attendance Forms or Learning Management System (LMS) attendance reports ▪ Provider Manual ▪ Dental Services Provider Manual ▪ Medical and Dental Provider Welcome Letters ▪ PowerPoint Presentations ▪ Tracking Logs for provider trainings
PT7	6.3.B	**6.3.B** **Ongoing Training** The Contractor shall continue to provide communications and guidance for PCPs, specialty providers, and others about the health care needs of enrollees with special needs and foster cultural sensitivity to the diverse populations enrolled with the Contractor.	▪ Policies and Procedures addressing the following: ➢ Ongoing Provider Education ▪ Provider Training Overview/Program ▪ Provider Communications/Newsletters/ Updates ▪ Provider Manual ▪ MCO Provider Website Screen Prints ▪ PowerPoint Presentations ▪ Provider Office Site Visit Forms ▪ Examples of Completed Provider Office Site Visit Forms ▪ Tracking Forms ▪ Training materials for MLTSS providers ▪ Schedules of training for new MLTSS providers
PT8*	B.4.14.XII.A Appendix	**B.4.14.XII.A** **Accessibility and Availability of Medical Records** 1. The MCO shall include provisions in provider contracts for appropriate access to the medical records of its enrollees for purposes of quality reviews conducted by the Secretary, State Medicaid agencies, or agents thereof.	▪ Policies and Procedures addressing the following: ➢ Medical Record Documentation Standards ➢ Medical Record Accessibility and Availability ▪ Provider Participation Agreement ▪ Provider Manual ▪ Provider Site Visit Audit Tool

		2. Records are available to providers at each encounter. 3. The MCO conducts ongoing programs to monitor compliance with its policies and procedures for medical and service records.	▪ Examples of Provider Site Visit Audits ▪ Medical Record Review Audit Tool ▪ Most recent Medical Record Review Audit Findings ▪ Provider Review Results Notification Letters ▪ Documentation showing follow-up with non-compliant providers (e.g., letters, education, and re-monitoring)
PT9	B.4.14.X.K Appendix	**B.4.14.X.K** The organization acts to ensure that the confidentiality of specified patient information and records is protected. 1. The organization has established in writing, and enforced, policies and procedures on confidentiality, including confidentiality of medical records. 2. Information from, or copies of, records may be released only to authorized individuals, and the Contractor must ensure that unauthorized individuals cannot gain access to or alter patient records. Original medical and service records must be released only in accordance with federal or state laws, court orders, or subpoenas. 3. The organization ensures that patient care offices/sites have implemented mechanisms that guard against the unauthorized or inadvertent disclosure of confidential information to persons outside of the medical care organization. 4. The organization shall hold confidential all information obtained by its personnel about enrollees related to their examination, care and treatment and shall not divulge it without the enrollee's authorization, unless: a. it is required by law; b. it is necessary to coordinate the patient's care with physicians, hospitals, or other health care entities, or to coordinate insurance or other matters pertaining to payment; c. it is necessary in compelling circumstances to protect the health or safety of an individual. 5. Any release of information in response to a court order is reported to the patient in a timely manner. 6. Enrollee records may be disclosed, whether or not authorized by the enrollee, to qualified personnel for the purpose of conducting scientific research, but these personnel may not identify, directly or indirectly, any individual enrollee in any report of the research or otherwise disclose participant identity in any manner.	▪ Policies and procedure addressing the following: ➢ Privacy and Confidentiality ➢ Medical Record Storage ➢ Medical Record Standards ➢ Medical Record Accessibility and Availability ▪ Compliance Program Description ▪ Provider Manual ▪ Provider Agreement ▪ Medical Record Audit Tool ▪ Most recent Medical Record Review Audit findings ▪ Provider Site Visit Audit Tool ▪ Examples of Provider Site Visit Audits ▪ Provider review results notification letters ▪ Documentation showing follow-up with non-compliant providers (e.g., letters, education, and re-monitoring)
PT10**	6.3.C	**6.3.C** MLTSS Provider Education and Training 1. The Contractor shall work with the State and other contracted MCOs to establish and conduct universal MLTSS provider training.	▪ Policies and Procedures addressing the following: ➢ Ongoing Provider Education ▪ Provider Training Overview/Program ▪ Provider Communications/Newsletters/ Updates

		2. The training curriculum shall include written materials for nursing facilities, assisted living and HCBS providers. This standardized curriculum shall address at a minimum the credentialing processes, service authorizations, continuity of care, community resources, options counseling, claims processes, cultural competency and the responsibility of nursing facility and assisted living providers in the collection of patient payment liability and room and board. 3. The Contractor shall conduct provider training with all new MLTSS providers and on an ongoing basis as needed.	▪ Provider Manual ▪ MCO Provider Website Screen Prints ▪ PowerPoint Presentations ▪ Provider Office Site Visit Forms ▪ Examples of Completed Provider Office Site Visit Forms ▪ Tracking Forms ▪ Training materials for MLTSS providers ▪ Schedules of training for new MLTSS providers
PT11*	4.7.4	**4.7.4.A** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.
Satisfaction			
2024 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
S1*	4.6.2.W	**4.6.2.W** **Member Satisfaction** The State will assess Member satisfaction of Contractor services via the Contractor's adult and child Medicaid Consumer Assessment of HealthCare Providers and Systems (CAHPS) survey version 5.1H, or the version required for NCQA accreditation, including Children with Chronic Conditions (CCC), as well as supplemental questions to be done at the discretion of the State. The Contractor must administer the entire adult and child CAHPS surveys, including CCC, without amendment and follow the instructions contained in the NCQA Specifications for Survey Measures for the current HEDIS year. The Contractor shall fully cooperate with its independent survey administrator such that the MCO's final, analyzed survey results shall be available to the State and/or its designee by June 15th of each contract year.	▪ MCO CAHPS® analysis including improvement actions ▪ State communications regarding results
S2	4.6.2.W	**4.6.2.W** On an annual basis, the Contractor must also ensure that its independent survey administrator submits the final CAHPS raw data to the Agency for Healthcare Research and Quality (AHRQ), and/or entity responsible for maintaining the national CAHPS database and authorizes its use for State level reporting.	▪ Corrective Action Plans ▪ Acknowledgement of receipt of submitted corrective action plans from the State ▪ Monitoring of corrective action ▪ Outcome Reports

		Contractors shall submit a Workplan by August 15th, or other time period as requested by the DMAHS. Each Workplan will use performance standards as defined by the State, e.g. NCQA 50th percentile, to identify areas where consumer satisfaction is potentially below quality standards. At the State's discretion, a CAP may be required. The Contractor shall submit corrective actions in a format approved by the State, to identify leading sources of enrollee dissatisfaction, specify additional measurement or intervention efforts developed to address enrollee dissatisfaction, and a timeline indicating when such activities will be completed. Upon the State's request, a status report on the additional measurement or intervention efforts shall be submitted by the Contractor to the State by a date specified by DMAHS. If the Contractor conducts a Member satisfaction survey of its own, it shall send to DMAHS the results of the survey. Additionally, for any CAHPS Survey or other member satisfaction survey conducted by the State and/or its designee, on behalf of the State, the Contractor and/or its vendor shall fully cooperate with the State and/or its designee, and make available all survey related data in a timely manner. Results will be shared with the MCOs, and at the discretion of the State, a Workplan may be requested for areas of enrollee dissatisfaction.	▪ Quality Improvement Work Plan
S3	B.4.14.X.M Appendix	**B.4.14.X.M** **Assessment of Member Satisfaction** If the organization conducts periodic surveys of Member satisfaction with its services, including MLTSS, the following must be included in the surveys. 1. The surveys include content on perceived problems in the quality, availability, and accessibility of care including difficulties experienced by people with disabilities in finding primary care doctors, specialists, MLTSS providers who are trained and experienced in treating people with disabilities. 2. The surveys assess at least a sample of: a. all Medicaid Members; b. Medicaid Member requests to change practitioners and/or facilities; and c. disenrollment by Medicaid Members; and d. enrollees receiving MLTSS. 3. As a result of the surveys, the organization: a. identifies and investigates sources of dissatisfaction; b. outlines action steps to follow-up on the findings; and c. informs practitioners and providers of	▪ Enrollee Satisfaction Survey Results performed by the MCO including those for targeted populations

		assessment results. 4. The organization reevaluates the effects of the above activities.	
S4*	4.7.4.A	**4.7.4.A** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.
S5*	5.16.1.X.1	**5.16.1.X.1** **Periodic Survey of Enrollees** The Contractor shall quarterly survey new enrollees, in person, by phone, or other means, on a random basis to verify the enrollees' understanding of the Contractor's procedures and services availability. Results of the surveys shall be made available to DMAHS and/or the EQRO at the direction of the State for review on request at regularly scheduled on site visits.	▪ Results of surveys performed by the MCOs. ▪ Quarterly breakout of number of surveys fielded.

Enrollee Rights and Responsibilities

2024 Element	Contract Reference	Contract Requirement Language	Documentation Examples
ER1	B.4.14.X.A B.4.14.X.C Appendices	**B.4.14.X.A** **Written Policy on Enrollee Rights** The organization shall have a written policy that complies with federal and state laws affecting the rights of enrollees and that recognizes the following rights of Members: **<u>Enrollee Rights</u>** 1. to be treated with respect, dignity, and need for privacy; 2. to be provided with information about the organization, its services, the practitioners providing care, and Members rights and responsibilities and to be able to communicate and be understood with the assistance of a translator if needed; 3. to be able to choose primary care practitioners, within the limits of the plan network, including the right to refuse care from specific practitioners; 4. to participate in decision-making regarding their health care, to be fully informed by the Primary Care Practitioner, other health care provider or Care Manager of health and functional status, and to participate in the	▪ Policies and Procedures addressing the following: ➢ Enrollee Rights and Responsibilities ▪ Provider Manual ▪ MCO Member Website Screen Prints ▪ Member Handbook ▪ MLTSS Member Handbook

		development and implementation of a plan of care designed to promote functional ability to the optimal level and to encourage independence; 5. to voice grievances about the organization or care provided and recommend changes in policies and services to plan staff, providers and outside representatives of the enrollee's choice, free of restraint, interference, coercion, discrimination or reprisal by the plan or its providers; 6. to formulate advance directives; 7. to have access to his/her medical records in accordance with applicable Federal and State laws; 8. to be free from harm, including unnecessary physical restraints or isolation, excessive medication, physical or mental abuse or neglect; 9. to be free of hazardous procedures; 10. to receive information on available treatment options or alternative courses of care; 11. to refuse treatment and be informed of the consequences of such refusal; and 12. to have services provided that promote a meaningful quality of life and autonomy for Members, independent living in Members' homes and other community settings as long as medically and socially feasible, and preservation and support of Members' natural support systems. **B.4.14.X.C** **Written Policy on Enrollee Responsibilities** The MCO shall have a written policy that addresses Members' responsibility for cooperating with those providing health care services. This written policy addresses Members' responsibility for: 1. providing, to the extent possible, information needed by professional staff in caring for the Member; and 2. following instructions and guidelines given by those providing health care services.	
ER2	B.4.14.X.E Appendix	**B.4.14.X.E** **Communication of policies to providers and organization staff** The MCO shall assure a copy of the organization's policies on Members' rights and responsibilities is provided to all participating providers annually. The MCO must monitor and promote compliance with the policies by the Contractor's staff and affiliated providers.	▪ Policies and Procedures addressing the following: ➢ Enrollee Rights and Responsibilities ▪ Provider Manual ▪ MCO provider Website Screen Prints ▪ Monitoring Procedures
ER3*	B.4.14.X.F Appendix	**B.4.14.X.F** **Communication of policies to enrollees/Members** Upon enrollment and annually thereafter, Members are provided a written statement that includes information on the following:	▪ Policies and Procedures addressing the following: ➢ Enrollee Rights and Responsibilities ▪ Member Handbook ▪ Website Screen Prints ▪ Member Letters

		1. rights and responsibilities of Members including the specific informational requirements of this section; 2. benefits and services, including MLTSS, included and excluded as a condition of membership, and how to obtain them, including a description of: a. procedures for obtaining services, including MLTSS, including authorization requirements; b. any special benefit provisions (for example, co-payment, higher deductibles, rejection of claim) that may apply to service obtained outside the system; c. procedures for obtaining services covered by the Medicaid fee-for-service program; d. the procedures for obtaining out-of-area coverage; and e. policies on referrals for specialty and ancillary care. 3. provisions for after-hours and emergency coverage and for MLTSS Members provision of key contact information such as the emergency after hours number with immediate access to a Contractor's staff Member who has access to the Member's plan of care and who can make immediate service authorizations and perform care coordination functions; 4. the organization's policy and procedures on referrals for specialty care, ancillary services and MLTSS; 5. charges to Members, if applicable, including: a) policy on payment of charges; b) co-payments, patient pay liability and fees for which the Member is responsible; and c) what to do if a Member receives a bill for services or is non-compliant with payment of co-payments, patient pay liabilities or other fees. 6. procedures for notifying those Members affected by the termination or change in any benefits, services, service delivery office/site, or affiliated providers. 7. procedures for appealing decisions adversely affecting the Member's coverage, benefits, or relationship to the organization; 8. procedures for changing providers; 9. procedures for disenrollment; and 10. procedures for voicing complaints and/or grievances and for recommending changes in policies and services.	
ER4	B.4.14.X.J Appendix	**B.4.14.X.J** **Written information for Members -**. 1. Member information (for example, subscriber brochures, announcements, handbooks) is written in prose that is readable and easily understood at a 5th grade reading level using a font size no smaller than 12 point. All written materials for potential enrollees	▪ Enrollee educational materials in different languages ▪ Approval letters from the State on enrollee educational literature ▪ Population Study Results ▪ Written information in various languages

		and enrollees must include taglines in the prevalent non-English languages in the State, as well as large print, explaining the availability of written translations or oral interpretation to understand the information provided and the toll-free number of the choice counseling services. Large print means printed in a font no smaller than 18 point. 2. Written information is available, as needed, in the languages of the major population groups served. A "major" population is one which represents at least 5% of a plan's membership.	▪ Readability Scores
ER5	B.4.14.X.L Appendix	**B.4.14.X.L** **Treatment of Minors and Individuals with Disabilities -** The organization has written policies regarding the appropriate treatment of minors and individuals with disabilities.	▪ Policies and Procedures addressing the following: ➢ Treatment of Minors and Individuals with Disabilities ▪ Program Descriptions for the following: ➢ Care Management ➢ Quality Improvement ➢ Utilization Management
ER6**	B.4.14.X.B B.4.14.X.C B.4.14.X.D Appendices	**B.4.14.X.B** **Written policy on MLTSS Member rights** - The organization has a written policy that recognizes the following rights of MLTSS Members: 1. To request and receive information on choice of services available; 2. Have access to and choice of qualified service providers; 3. Be informed of your rights prior to receiving chosen and approved services; 4. Receive services without regard to race, religion, color, creed, gender, national origin, political beliefs, sexual orientation, marital status, or disability; 5. Have the right, as a resident of an MLTSS community, to have a key to lock/unlock the home and bedroom doors, to have visitors of the Member's choosing, make and receive phone calls, make independent schedules, and have access to food at any time, unless otherwise determined in a documented person-centered process; 6. Have access to appropriate services that support your health and welfare; 7. To assume risk after being fully informed and able to understand the risks and consequences of the decisions made; 8. To make decisions concerning your care needs; 9. Participate in the development of and changes to the Plan of Care; 10. Request changes in services at any time, including add, increase, decrease or discontinue;	▪ Policies and Procedures addressing the following: ➢ Enrollee Rights and Responsibilities ▪ Provider Manual ▪ MCO Member Website Screen Prints ▪ Member Handbook ▪ MLTSS Member Handbook

		11. Request and receive from your Care Manager a list of names and duties of any person(s) assigned to provide services to you under the Plan of Care; 12. Receive support and direction from your Care Manager to resolve concerns about your care needs and/or grievances about services or providers; 13. Be informed of and receive in writing facility specific resident rights upon admission to an Institutional or residential settings; 14. Be informed of all the covered/required services you are entitled to, required by and/or offered by the Institutional or residential setting, and any charges not covered by the managed care plan while in the facility; 15. Not to be transferred or discharged out of a facility except for medical necessity; to protect your physical welfare and safety or the welfare and safety of other residents; or because of failure, after reasonable and appropriate notice of non-payment to the facility from available income as reported on the statement of available income for Medicaid payment. 16. Have your health plan protect and promote your ability to exercise all rights identified in this document. 17. Have all rights and responsibilities outlined here forwarded to your authorized representative or court appointed legal guardian. **B.4.14.X.C** **Written policy on enrollee responsibilities** - The organization has a written policy that addresses Members' responsibility for cooperating with those providing health care services. This written policy addresses Members' responsibility for: 1. providing, to the extent possible, information needed by professional staff in caring for the Member; and 2. following instructions and guidelines given by those providing health care services. **B.4.14.X.D** **Written policy on MLTSS Member responsibilities** - The organization has a written policy that addressees Members' responsibility for cooperating with those providing services. This written policy addresses Members' responsibility for: 1. Provide all health and treatment related information, including but not limited to, medication, circumstances, living arrangements, informal and formal supports to the Plan's Care Manager in order to identify care needs and develop a plan of care; 2. Understand your health care needs and work with your Care Manager to develop or change goals and services;	

		3. Work with your Care Manager to develop and/or revise your Plan of Care to facilitate timely authorization and implementation of services; 4. Ask questions when additional understanding is needed; 5. Understand the risks associated with your decisions about care; 6. Report any significant changes on your health condition, medication, circumstances, living arrangements, informal and formal supports to the Care Manager; 7. Notify your Care Manager should any problem occur or if you are dissatisfied with the services being provided; and 8. Follow your health plan's rules and/or those rules of Institutional or residential settings (including any applicable cost share).	
ER7**	4.6.1.B.2	**4.6.1.B.2** Provide for MLTSS to allow an individual to maintain themselves in the least restrictive, most integrated setting of their choice, to the extent possible. Such service provision shall promote the enrollee's ability to age in place through coordination of formal and informal supports to address the assessed needs of the individual.	▪ Policies and Procedures addressing the following: ➢ Enrollee Rights and Responsibilities ▪ Member Handbook ▪ MLTSS Member Handbook ▪ Care Management
ER8*	4.7.4.A	**4.7.4.A** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion. ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.
Member Disenrollment			
2024 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
Sub-heading	5.10.2	**DISENROLLMENT FROM THE CONTRACTOR'S PLAN AT THE ENROLLEE'S REQUEST**	
MD1	5.10.2.A 5.10.2.A.1	**5.10.2.A** **5.10.2.A.1** A. An individual enrolled in a Contractor's plan may elect to change Contractors during an Annual Open Enrollment Period from October 1 to November 15. 1. All enrollees are subject to the Annual Open Enrollment Period and may initiate disenrollment from one Contractor and transfer to another	▪ Policies and Procedures addressing the following: ▪ Enrollee's right to change MCO – open enrollment ▪ Member Handbook

		Contractor for any reason during the first ninety (90) days after the latter of the date the individual is enrolled or the date they receive notice of enrollment with a new Contractor and during the period DMAHS has identified for the Annual Open Enrollment Period without cause. a. An individual may transfer from the Contractor's plan upon automatic re-enrollment if he or she was disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less, if the temporary loss of Medicaid eligibility has caused the individual to miss the Annual Open Enrollment Period.	
MD2	5.10.2.A.2	**5.10.2.A.2** 2. An enrollee may initiate disenrollment and a transfer to another Contractor's plan at any time if they meet one of the good cause reasons defined in this contract. a. Good cause reasons for disenrollment and transfer shall include, unless otherwise defined by DMAHS: i. Failure of the Contractor to provide services including physical access to the enrollee in accordance with the terms of this contract. ii. Enrollee has filed a grievance/appeal with the Contractor pursuant to the applicable grievance/appeal procedure and has not received a response within the specified time period stated therein, or in a shorter time period required by federal law. iii. Documented grievance/appeal, by the enrollee against the Contractor's plan without satisfaction. iv. Enrollee has substantially more convenient access to a primary care physician who participates in another MCO in the same enrollment area. v. Poor quality of care. vi. Enrollee is eligible to participate through DCP&P/DCF. vii. Enrollee has met NF LOC and is MLTSS eligible.	▪ Policies and Procedures addressing the following: ▪ Enrollee's right to change MCO for good cause ▪ Member Handbook

		viii. Other for cause reasons pursuant to 42 CFR 438.56.	
Sub-heading	5.10.3	**DISENROLLMENT FROM THE CONTRACTOR'S PLAN AT THE CONTRACTOR'S REQUEST AND REPORTING OF ENROLLEE NON-COMPLIANCE**	
MD3	5.10.1.A 5.10.3.A 5.10.3.A.1	**5.10.1.A** A. Non-discrimination. Disenrollment from Contractor's plan shall not be based in whole or in part on an adverse change in the enrollee's health, on any of the factors listed in Article 7.8 (race, color, creed, religion, ancestry, marital status, sexual orientation, gender identity, national origin, age, sex, physical or mental handicap or disability) or on amounts payable to the Contractor related to the enrollee's participation in the Contractor's plan. **5.10.3.A** **5.10.3.A.1**A. Criteria for Contractor Disenrollment Request. The Contractor may recommend, with written documentation to DMAHS, the disenrollment of an enrollee. (See Section B.5.1 of the Appendices, for the applicable Notification forms and amendments thereto). In no event may an enrollee be disenrolled due to health status, need for health services or a change in health status. Enrollees may be disenrolled in any of the following circumstances: 1. The Contractor becomes aware that the enrollee falls into an aid category that is not set forth in Article 5.2 of this contract, has become ineligible for enrollment pursuant to Article 5.3.1 of this contract, or has moved to a residence outside of the enrollment area covered by this contract.	▪ Policies and Procedures addressing the following: ▪ Nondiscrimination ▪ Criteria for disenrollment request ▪ Member Handbook
MD4	5.10.3.A.2	**5.10.3.A.2** 2. The Contractor learns that the enrollee is residing outside the State of New Jersey for more than 30 days. This does not apply to: a. situations when the enrollee is out of State for care provided/authorized by the Contractor. b. full-time students, or c. Clients of DCP&P who are temporarily residing in a state adjacent to New Jersey but are still in the custody of DCP&P. For an MLTSS enrollee who has moved out of state; the Contractor must comply with all requirements set forth in article 9.3.5 and 9.3.6. In addition, the Contractor shall certify that outreach to providers has occurred and a query of Medicaid/MLTSS services was completed and member has not been authorized for, or received any Medicaid services for the last 30 days. The Contractor shall then submit the LTC-50 Unable to Contact/ Inaccessible Disenrollment form to DoAS as per instructions	▪ Policies and Procedures addressing the following: ▪ Criteria for disenrollment request ▪ Member Handbook

MD5	5.10.3.A.3	**5.10.3.A.3** 3. If a Member is admitted to an out of state NF or SCNF by the Contractor, and the Member is not returning to New Jersey.	▪ Policies and Procedures addressing the following: ▪ Criteria for disenrollment request ▪ Member Handbook
MD6	5.10.3.A.4	**5.10.3.A.4** 4. Upon death of the enrollee.	▪ Policies and Procedures addressing the following: ▪ Criteria for disenrollment request
MD7	5.10.3.A.5	**5.10.3.A.5** 5. An enrollee is institutionalized in a facility other than a NF/SCNF.	▪ Policies and Procedures addressing the following: ▪ Criteria for disenrollment request ▪ Member Handbook
MD8	5.10.3.A.6	**5.10.3.A.6** 6. Incarceration of an enrollee (other than a DSNP enrollee) shall result in suspension of the Contractor's capitation payment and provision of Managed Care services to the enrollee from the day following the start of incarceration through the day of release. During this period, the incarcerated enrollee's benefits shall be suspended, but enrollee shall not be disenrolled. The enrollee shall remain a Member of the Contractor.	▪ Policies and Procedures addressing the following: ▪ Criteria for disenrollment request ▪ Member Handbook
MD9	5.10.3.B	**5.10.3.B** B. Criteria for Non-Compliant Enrollees. The Contractor shall submit quarterly reports that includes written documentation to DMAHS of enrollees determined by the Contractor to be non-compliant. The documentation should include detail of any willful actions of the enrollee that are inconsistent with membership in the Contractor's plan. The Contractor shall provide DMAHS with documentation of at least three attempts to reconcile the situation. Examples of inconsistent actions include but are not limited to: persistent refusal to cooperate with any participating provider regarding procedures for consultations or obtaining appointments (this does not preclude an enrollee's right to refuse treatment), intentional misconduct, willful refusal to receive prior approval for non-emergency care; willful refusal to comply with reasonable approval for non-emergency care; willful refusal to comply with reasonable administrative policies of the Contractor, fraud, or making a material misrepresentation to the Contractor. In no way can this provision be applied to individuals on the basis of their physical condition, utilization of services, age, socio-economic status, mental disability, or uncooperative or disruptive behavior resulting from his/her special needs. (See Article 4.5 regarding special needs enrollees.) The DMAHS shall review each quarterly report and each case may require an in-depth review by State staff, including but not limited to patient and provider interviews, medical record review, and home assessment to determine with the enrollee what plan of action would serve the best interests of the enrollee (and family as applicable.)	▪ Policies and Procedures addressing the following: ▪ Criteria for non-compliant enrollees ▪ Example of quarterly report to DMAHS of non-compliant enrollees ▪ Member Handbook

MD10	5.10.2.D	**5.10.2.D** D. Effective Date. The effective date of disenrollment or transfer shall be no later than the first day of the month immediately following the full calendar month the disenrollment is initiated by DMAHS. If DMAHS fails to make a disenrollment determination for initiated disenrollments that meet the disenrollment terms under this Contract, the disenrollment is considered approved. Notwithstanding anything herein to the contrary, the remittance tape, along with any changes reflected in the register or agreed upon by DMAHS and the Contractor in writing, shall serve as official notice to the Contractor of disenrollment of an enrollee from the Contractor's plan.	▪ Policies and Procedures addressing the following: ▪ Effective date of disenrollment or transfer ▪ Report showing effective date of disenrollment or transfer
Sub-heading	9.4.2	**VOLUNTARY WITHDRAWAL FROM MANAGED LONG TERM SERVICES AND SUPPORTS**	
MD11***	9.4.2.A	**9.4.2.A** A. MLTSS enrolled participants who indicate they would like to withdraw from MLTSS are required to be counseled by their Managed Care Organization Care Manager (MCO CM). This counseling shall be face-to-face with the participant. If the member declines a face-to-face visit, the counseling may occur via telephone. The MCO CM will: 1. Counsel the participant that withdrawal from MLTSS may result in loss of eligibility for Medicaid State Plan services due to the financial eligibility requirement; 2. Ensure the participant has full understanding that if they were not receiving Medicaid State Plan services prior to enrollment into MLTSS, they may NOT be eligible for NJ FamilyCare upon withdraw from MLTSS; 3. Counsel the participant on what MLTSS and State Plan services will be lost or unavailable as a result of the withdrawal; 4. Counsel the participant on how to ensure they remain eligible to receive NJ FamilyCare; 5. Counsel the participant on other services or programs for which they may be eligible, including information about contacting the Aging and Disability Resource Connection (ADRC); 6. Counsel the participant on how to access MLTSS services in the future; and,	▪ Policies and Procedures addressing the following: ▪ Counseling of MLTSS enrollees requesting withdrawal from MLTSS ▪ MLTSS Handbook

		7. Ensure the participant understands the withdrawal process, timeframes, outcomes, and signs the consent form.	
MD12***	9.4.2.B	**9.4.2.B** B. The MCO CM is responsible for documenting the discussion with the participant and completing the required paperwork. The participant will be asked to sign the NJ Department of Human Services Voluntary Withdrawal Form indicating their understanding and consent to withdraw from MLTSS. The voluntary withdrawal process is not to be initiated with participants who do not continue to meet the eligibility requirements for MLTSS. Instead, participants deemed not eligible for MLTSS are to follow the disenrollment and grievance and appeals guidelines.	▪ Policies and Procedures addressing the following: ▪ Documentation of discussion with enrollee regarding withdrawal from MLTSS request ▪ Completion of required paperwork for withdrawal request ▪ Example of documentation of enrollee discussion regarding MLTSS withdrawal
MD13***	9.4.2.C	**9.4.2.C** C. The MCO is responsible for adhering to MLTSS Care Management Case Closure Standards as outlined in Section 9.6.6 of the Managed Care Contract. The MCO CM is responsible for notifying and forwarding a copy of the withdrawal request to the Central Office of The Division of Aging Services (DoAS), using the Voluntary Withdrawal Form found at Appendix B.5.1, within three business days of completion. DoAS will process the voluntary withdrawal within ten business days of receipt. The Contractor shall validate the disenrollment action in the eMEVS system.	▪ Policies and Procedures addressing the following: ▪ MLTSS Care Management Case Closure standards
MD14***	9.4.2.D	**9.4.2.D** D. The withdrawal request must specify the member's address, phone number, and legal representative (if applicable) for potential follow up counseling by the Office of Community Choice Options (OCCO). The Program Status Code (PSC) as identified in the State's MMIS systems is to be provided by the MCO and indicated on the withdrawal request.	▪ Policies and Procedures addressing the following: ▪ Requirements for MLTSS withdrawal request
MD15***	9.4.2.E	**9.4.2.E** E. The Contractor shall provide the member with the voluntary withdrawal form found in Appendix A.9.4.2 as well as a copy of the fully executed form.	▪ Policies and Procedures addressing the following: ▪ Providing member with voluntary withdrawal form ▪ Copy of voluntary withdrawal form
MD16***	9.4.2.F	**9.4.2.F** F. OCCO shall outreach members who are identified through the PSC as being above the FPL to ensure the member understands the withdrawal will result in loss of Medicaid coverage. OCCO shall outreach within three business days of receipt of the form, document the date of discussion and confirm the member's withdrawal request. If the member indicates they wish to continue with MLTSS, then the form will be returned to the MCO Care Management designee indicating the member's request. The MCO is responsible to facilitate the reenrollment, if necessary.	▪ Policies and Procedures addressing the following: ▪ Facilitation of MLTSS reenrollment

Sub-heading	9.4.3	**DISENROLLMENT DUE TO MEMBER NON-COMPLIANCE WITH MLTSS CARE MANAGEMENT REQUIREMENTS**	
MD17***	9.4.3.A	**9.4.3.A** A. The Contractor shall include notice of member requirement to comply with care management requirements including face to face visits and reassessment of clinical eligibility. These requirements must be reviewed during the assessment for MLTSS, if appropriate, upon enrollment, and annually thereafter.	▪ Policies and Procedures addressing the following: ➢ Member requirements to comply with care management requirements, including review of requirements during MLTSS assessment upon enrollment and annually thereafter ▪ Notice to members of requirements to comply with care management requirements
MD18***	9.4.3.B	**9.4.3.B** B. The Contractor shall include notice of enrollment and disenrollment processes and procedures in the Member handbook as outlined in 5.8.2.	▪ Member handbook section on enrollment and disenrollment processes and procedures
MD19***	9.4.3.C	**9.4.3.C** C. The Contractor shall develop and implement a policy and process for instances in which the MLTSS member declines to consent to care management services.	▪ Policies and Procedures addressing the following: ➢ Situations when the MLTSS member declines to consent to care management services
MD20***	9.4.3.D	**9.4.3.D** D. Members who decline to consent to clinical eligibility reassessment or face to face visits after counseling and a minimum of two contacts to obtain consent by the Contractor or OCCO, the Contractor or OCCO, shall send written notification of the intent to terminate MLTSS eligibility no sooner than 20 business days from the date of notification due to lack of consent to care management services. The written notification of intent to request involuntary disenrollment will inform the member that: 1. The member may voluntarily change health plans if they wish to receive care management services and continue to receive MLTSS services 2. The member may voluntarily withdrawal from MLTSS if they do not wish to receive care management and MLTSS services 3. Withdrawal from MLTSS may result in loss of eligibility for Medicaid State Plan services due to the financial eligibility requirement; 4. The individual is required to establish Medicaid status through the County Welfare Agency (CWA). a. The MCO Care Manager shall provide county specific contact information and assist participant with this outreach upon request. 5. Provide information and contact numbers for community resources including the Aging and Disability Resource Connection (ADRC); 6. Provide information on how to apply for MLTSS services in the future;	▪ Policies and Procedures addressing the following: ➢ Notice to terminate MLTSS eligibility when the member declines to consent to clinical eligibility reassessment or face-to-face visits ➢ Notice to include the six requirements for notice of involuntary disenrollment to member ▪ Sample notice of intent to terminate MLTSS eligibility
MD21***	9.4.3.E	**9.4.3.E** E. If the member requests voluntary disenrollment, the MCO shall process the request in accordance with established protocols.	▪ Policies and Procedures addressing the following: ➢ Process for when the member requests voluntary disenrollment
MD22***	9.4.3.F	**9.4.3.F**	▪ Policies and Procedures addressing the following:

		F. If the member fails to respond to the notification or fails to make arrangements to comply with the requirements, the MCO Care Manager Supervisor shall submit the Request for Involuntary Disenrollment Form to the Division of Aging Services (DoAS) MLTSS Operations within three business days of completion.	➢ If member fails to respond to termination notification, MCO shall submit request for Involuntary Disenrollment form to the DoAS ▪ Sample of Involuntary Disenrollment Form
MD23***	9.4.3.G	**9.4.3.G** G. Upon receipt of the Involuntary Disenrollment request, the DoAS shall send the member the Intent to Involuntarily Disenroll letter within three business days. If the participant fails to respond within ten business days, the DoAS shall send a Notice of Disenrollment from MLTSS letter which will include notice of the participant's Medicaid Fair Hearing Rights. The termination of clinical eligibility will be entered by DoAS ten business days after the date of the letter which will trigger disenrollment from MLTSS based on the standard enrollment cycle. DoAS will notify DMAHS Managed Care Account Coordinator Unit, DMAHS County Operations Office, and the MCO Care Manager designee of the clinical eligibility termination within 2 business days of entry.	▪ Policies and Procedures addressing the following: ➢ DoAS Process for involuntary disenrollment request
MD24***	9.4.3.H	**9.4.3.H** H. If the participant contacts DoAS or the MCO indicating they wish to continue with MLTSS and are in agreement with complying with the requirements, the recipient of the request shall notify the appropriate entity, DoAS or the MCO. The MCO MLTSS Care Manager shall initiate a face to face visit within ten (10) business days of notification.	▪ Policies and Procedures addressing the following: ➢ Situations when the participant wishes to continue with MLTSS ➢ Initiation of face to face visits within ten (10) days of notification
MD25***	9.4.3.I	**9.4.3.I** I. The MCO CM is responsible for documenting the discussion with the participant and completing the required paperwork.	▪ Policies and Procedures addressing the following: ➢ Care Manager responsibility for documenting discussion with participant and completing required paperwork ➢ Sample of CM documentation of participant discussion
MD26***	9.4.3.J	**9.4.3.J** J. The MCO is responsible for adhering to MLTSS Care Management Case Closure Standards as outlined in Section 9.6.6 of the Managed Care Contract. The MCO CM is responsible for notifying and forwarding a copy of the disenrollment request to the Regional Office of Community Choice Options via the "DHS Participant Termination Request Due to Non-Compliance with Reassessment" Form within three business days of completion:	▪ Policies and Procedures addressing the following: ➢ MLTSS Care Management Case Closure standards ▪ Sample of DHS Participant Termination Request Due to Non-Compliance with Assessment form
MD27***	9.4.3.K	**9.4.3.K** K. The disenrollment request certifies that outreach, counseling, and notification has occurred without response or appeal.	▪ Policies and Procedures addressing the following: ➢ Process when outreach, counseling, and notification has occurred without response or appeal ▪ Sample documentation of outreach, counseling, notification

MD28***	9.4.3.L	**9.4.3.L** L. The disenrollment due to member non-compliance of determination of continued clinical eligibility is not to be used for Unable to Contact, Inaccessible, or Voluntary Withdrawal processes. Contact with the member and counseling must occur prior to sending the Involuntary Disenrollment. The member can stop the pending disenrollment process by consenting to the reassessment requirements.	▪ Policies and Procedures addressing the following: ➢ Requirement that disenrollment for non-compliance is not to be used for Unable to Contact, Inaccessible, or Voluntary Withdrawal ➢ Member can pend disenrollment process by consenting to reassessment requirements
MD29*	4.7.4.A	**4.7.4.A** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion. ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.

Credentialing and Re-credentialing			
2024 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CR1	4.8.5.C	**4.8.5.C** C. The Contractor shall collect and maintain, as part of its credentialing process, through special survey process, or other means information from licensed practitioners including pediatricians and pediatric subspecialists about the nature and extent of their experience in serving children with special health care needs including developmental disabilities.	▪ Policies and Procedures addressing the following: ➢ Credentialing and Re-credentialing ▪ Entire Year of the most recent Credentialing/Re-credentialing Committee Meeting Minutes ▪ Process for collecting data on a provider's experience in treating children with special healthcare needs including how it maintains and updates the information ▪ Survey for collecting provider experience in treating children with special healthcare needs including examples ▪ Documentation showing monitoring of the credentialing and re-credentialing timeliness
CR2*	4.6.1.C.5	**4.6.1.C.5** Provider Credentialing. New Jersey requires a credentialing process that follows a systematic and timely approach to the collection and verification of providers' professional qualifications and the assessment of whether the provider meets professional competence and conduct criteria. Before any provider/subcontractor may become part of the Contractor's network, that provider/subcontractor shall	▪ Policies and Procedures addressing the following: ➢ Credentialing and Re-credentialing ▪ Entire Year of the most recent Credentialing/Re-credentialing Committee Meeting Minutes

		be credentialed by the Contractor. The Contractor must comply with N.J.A.C. 11:24C-1 et seq. and Standard IX of New Jersey QAPI Standards, (Section B.4.14 of the Appendices). Additionally, the Contractor's credentialing procedures shall include verification on a monthly basis that providers and subcontractors have not been suspended, debarred, disqualified, terminated or otherwise excluded from Medicaid, Medicare, or any other federal or state health care program. The Contractor shall obtain federal and State lists of suspended/debarred providers from the appropriate agencies and comply with the specifications at Article 3.3.2. The Contractor shall obtain a completed Disclosure Form from every provider at time of credentialing and recredentialing, and maintain it in the credentialing file that complies with provisions of Article 7.35 and found at B.7.35. The Contractor shall ensure providers comply with N.J.S.A. 45:1-30 et seq. requiring a criminal history background check for every person who possesses a license or certificate as a health care professional as well as finger-print based background check for all Providers and their employees who provide face-to-face services to Members, when required by statute or regulation. The Contractor's process for credentialing shall include notification to providers of errors in the credentialing application within three (3) business days of receipt. The Contractor's credentialing committee shall meet to review credentialing applications monthly and notify each applicant of the status of their application within five (5) business days of the meeting.	▪ Ongoing monitoring of State and federal sanctions and suspensions ▪ File review of provider terminated from MCO due to suspension of licensure to practice by CMS or the State of New Jersey ▪ Monitoring of MLTSS providers for suspension
Sub-heading	B.4.14.IX Appendix	**B.4.14.IX** **Credentialing and Re-credentialing** The QAPI contains the following provisions to determine whether physicians, other health care professionals and other providers of services to the Contractor's enrollees meet all applicable state licensing standards, Contractor participation or credentialing criteria and are qualified to provide the care or services for which they have been contracted. (See Article 3.3.2, 4.6.1, 4.8.5, and 7.4E for additional detail regarding credentialing and recredentialing.)	
CR3	B.4.14.IX.A Appendix	**B.4.14.IX.A** **Written Policies and Procedures** The managed care organization has, at a minimum, written policies and procedures consistent with NCQA standards and State requirements, to address the following: 1. Types of providers, including organizational providers such as Hospitals, Home Health Agencies, NFs, SCNFs, Free-standing surgical centers, ambulatory care centers, inpatient Behavioral Health providers, and residential care settings, to credential and (re)credential, 2. The verification sources used, 3. Criteria for (re)credentialing, 4. Process for making (re)credentialing decisions,	▪ Policies and Procedures addressing the following: ➢ Credentialing and Re-credentialing

		5. Process for managing credentialing files that meet established criteria, 6. Process for delegating credentialing activities, 7. Process for ensuring (re)credentialing activity is conducted in a non-discriminatory manner, 8. Process for notifying providers if information collected during the (re)credentialing process substantially varies from information they provided as part of the (re)credential process, 9. Process for ensuring providers are notified of the (re)credentialing decision within 60 days of the Committee's decision, 10. Medical Director or other designated physician's direct responsibility and participation in the credentialing program, 11. Process for ensuring confidentiality of information obtained in the (re)credentialing process, except as otherwise provided by law, 12. Process for ensuring that listings in provider directories and other materials for Members are consistent with (re)credentialing data, including education, training, board certification and specialty and 13. Process for ensuring that organizational and non-traditional providers are: • In good standing with State and Federal regulatory bodies • Reviewed and approved by a recognized accrediting body, based on requirements outlined in the MLTSS Services Dictionary found in Appendix B.9.0.	
CR4	B.4.14.IX.B Appendix	**B.4.14.IX.B** **Oversight by Governing Body** The Governing Body, or the group or individual to which the Governing Body has formally delegated the credentialing function, has reviewed and approved the credentialing policies and procedures.	▪ Policies and Procedures addressing the following: ➢ Credentialing and Re-credentialing ▪ Quality Improvement Program Description ▪ Credentialing/Re-credentialing Committee Charter ▪ Entire Year of the most recent Credentialing/Re-credentialing Committee Meeting Minutes ▪ Documentation showing monitoring of the credentialing and re-credentialing process including timeliness
CR5	B.4.14.IX.C Appendix	**B.4.14.IX.C** **Credentialing Entity** The plan shall designate a credentialing committee or other peer review body that includes participating providers from the Contractor's network, which makes recommendations regarding credentialing decisions.	▪ Policies and Procedures addressing the following: ➢ Credentialing and Re-credentialing ▪ Credentialing/Re-credentialing Committee Charter ▪ Entire Year of the most recent Credentialing/ Re-credentialing Committee Meeting Minutes

CR6	B.4.14.IX.D Appendix	**B.4.14.IX.D** **Scope** The plan identifies those providers who fall under its scope of authority and action. This shall include, at a minimum, all physicians, dentists, behavioral health clinicians, facilities and providers of MLTSS included in the Contractor's literature for Members, as an indication of those providers whose service to Members is contracted or anticipated.	▪ Policies and Procedures addressing the following: ➢ Credentialing and Re-credentialing ▪ Credentialing Committee Charter
CR7	B.4.14.IX.E Appendix	**B.4.14.IX.E** **Process** The initial credentialing process obtains and reviews verification of the following information, at a minimum: 1. the provider holds a current valid license to practice; 2. a dentist with certification in the following specialties: Endodontics, Oral and Oral Maxillofacial Surgery, Periodontics and Prosthodontics must have or have confirmations of application submission, of valid DEA and CDS certificates. As required by the State of New Jersey, any provider that holds a valid DEA or CDS certificate must submit it; 3. graduation from medical school and completion of a residency, or other post-graduate training, as applicable; 4. work history; 5. professional liability claims history; 6. good standing of clinical privileges at the hospital designated by the provider as the primary admitting facility; (This requirement may be waived for practices which do not have or do not need access to hospitals.) 7. the providers hold current, adequate malpractice insurance according to the plan's policy; 8. any revocation or suspension of a State license or DEA number; 9. any sanctions imposed by Medicare and/or Medicaid for example, suspensions, debarment, or recovery action; and 10. any censure by the State or County Medical Association. 11. The organization requests information on the provider from the National Practitioner Data Bank and the State Board of Medical Examiners or other appropriate licensing board, depending on the provider type. 12. The application process includes a statement by the applicant regarding: a. any physical or mental health problems that may affect current ability to provide health care; b. any history of chemical dependency/ substance use disorder; c. history of loss of license and/or felony convictions; d. history of loss or limitation of hospital privileges or disciplinary activity; and	**Assessment will also include a file review to verify compliance.** ▪ Policies and Procedures addressing the following: ➢ Credentialing Process ▪ Credentialing Desk-Top Procedure ▪ Credentialing Application ▪ Practitioner Office Site Audit Tool ▪ Regulatory and Accreditation Verification Source Table ▪ Documentation showing monitoring of the credentialing timeliness

		e. an attestation to correctness/ completeness of the applications. This information should be used to evaluate the practitioner's current ability to practice. 13. There is an attestation from each potential primary care provider's office, that the physical office meets ADA requirements or describes how accommodation for ADA requirements are made and that medical recordkeeping practices conform with the managed care organization's standards.	
CR8	B.4.14.IX.F Appendix	**B.4.14.IX.F** **Re-credentialing** A process for the periodic re-verification of credentials (re-credentialing, reappointment, or recertification) described in the organization's policies and procedures. 1. There is evidence that the procedure is implemented at least every three years or more frequently, as necessary, to be in accordance with the providers' licensing requirements. 2. The Contractor shall develop and implement a mechanism for monitoring of critical incident events and grievances related to the care and/or services received that identified trends and determine a threshold at which an off-cycle re-credentialing event would be triggered. 3. The MCO conducts periodic review of information from the National Practitioner Data Bank, along with performance data, on all providers, to decide whether to renew the participating provider agreement. At a minimum, the re-credentialing, recertification or reappointment process is organized to verify current standing on items listed in "E-1" through "E-7" above and item "E-12" as well. 4. The re-credentialing, recertification or reappointment process also includes review of data from: a. Member grievances; b. results of quality reviews; c. performance indicators; d. utilization management; e. critical incidents; and f. re-verifications of hospital privileges and current licensure.	**Assessment will also include a file review to verify compliance.** ▪ Policies and Procedures addressing the following: ➢ Re-credentialing Process ▪ Re-credentialing Desk Top Procedures ▪ Documentation showing monitoring of re-credentialing timeliness ➢ Ongoing monitoring of critical incidents and grievances and process to trigger off-cycle recredentialing Practitioner-Specific: ➢ Member Grievance Reports ➢ Quality of Care Concerns ➢ Performance Indicators ➢ Utilization Management ➢ Member Satisfaction ➢ Critical incident report monitoring
CR9***	4.6.1.C.7	**4.6.1.C.7** For MLTSS providers the Contractor shall: a. Have a credentialing/re-credentialing process meeting the requirements at 42 CFR 438.214, the requirements above, and the credentialing/re-credentialing requirements in Appendix B.4.14 Standard IX for each provider type or service available under MLTSS, including non-licensed/non-certified providers.	**Assessment will also include a file review to verify compliance.** ▪ Policies and Procedures addressing the following: ➢ Credentialing and Re-credentialing of MLTSS providers

		b. Ensure that all providers who provide direct support and/or services to MLTSS Members have policies and procedures to demonstrate compliance with State requirements to have a pre-employment criminal history check and/or background investigation on all staff Members. c. Develop and implement a process to ensure all contracted providers conduct criminal background checks on all prospective employees/providers with direct physical access to MLTSS Members. i. Have a credentialing/re-credentialing process meeting the requirements at 42 CFR 438.214, the requirements above, and the credentialing/re-credentialing requirements in Appendix B.4.14 Standard IX for each provider type or service available under MLTSS, including non-licensed/non-certified providers. ii. Ensure all providers who provide direct support and/or services to MLTSS members comply with State requirements to have a pre-employment criminal history check and/or background investigation on all staff members. MLTSS providers or those who provide services to MLTSS members who are required by state law or regulation to have criminal history background checks shall provide proof of the completion of the Criminal History Record Information (CHRI) during credentialing process. iii. At minimum, have a re-credentialing process for HCBS providers that shall include verification of continued licensure and/or certification (as applicable) and compliance with policies and procedures identified during credentialing, including criminal history background checks (CHRI). iv. At minimum verify monthly that each HCBS provider has not been excluded from participation in the Medicare or Medicaid or NJFamilyCare programs. v. Develop and implement a policy and procedure, approved by the Office of Managed Health Care, to require all contracted community based providers to certify in writing that they conduct effective, accurate and economical background checks on all prospective employees/providers expected to have direct physical access to MLTSS members. Providers who are required to have CHRI checks done as a condition of licensure by the State of NJ and are in good standing and submit documentation to the Contractor of same updated annually or in accord with the time frame established in governing statutes or regulations, shall be determined to have met the requirements for CHRI. vi. Ensure that providers who are non-licensed or non-credentialed or who do not have a governing statute to conduct CHRI background checks must undergo state	▪ Entire Year of the most recent Credentialing/Re-credentialing Committee Meeting Minutes ▪ Documentation showing monitoring of the credentialing and re-credentialing timeliness ▪ Criminal background checks ▪ Monitoring of continued licensure/and or certification ▪ Monitoring of sanctions

		CHRI through the NJ State Police using the Universal Fingerprint form for Personal Record Review. vii. Have policies and procedures that ensure that no provider shall be permitted to provide any HCBS service with direct physical access to an MLTSS member until appropriate proofs and documentation are submitted to the Contractor. This documentation shall be provided to the Contractor at credentialing and/or re-credentialing. viii. Requirements for frequency of updates, disqualifying offenses and rehabilitation to be adapted from las/regulation. ix. Shall not permit any providers or their employees or subcontractors to render direct support and/or services to MLTSS members absent such proof. x. Shall not be responsible for conducting CHRI checks, but are required to maintain documentary proof that CHRI checks are done in compliance with State rule and the NJ FamilyCare MCO contract. xi. Follow state protocols for addressing exception requests for providers/their employees who fail a CHRI within state/federal law or statute.	
CR10*	4.7.4.A	**4.7.4.A** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion. ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.

Utilization Management

2024 Element	Contract Reference	Contract Requirement Language	Documentation Examples
UM1	4.2.4.F	**4.2.4.F** Drug Utilization Review (DUR) Program. In accordance with section 1927(g) of the SSA and 42 CFR part 456, subpart K, and Section 1004 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act, also referred to as the SUPPORT for Patients and Communities Act or the SUPPORT Act, effective October	▪ Policies and Procedures addressing the following: ➢ Formulary Denials ➢ Prior Authorization Requests ➢ Type of Drug Denials

		1, 2019, requiring the Contractor to implement provisions intended to monitor opioid and antipsychotic prescription utilization, the Contractor shall establish and maintain a drug utilization review (DUR) program that satisfies the minimum requirements for prospective and retrospective DUR as described in Section 1927(g) of the Social Security Act, amended by the Omnibus Budget Reconciliation Act (OBRA) of 1990. The Contractor shall include review of Mental Health/Substance Use Disorder drugs, opioid and antipsychotic drugs in its DUR program. The State or its agent shall provide its expertise in developing review protocols and shall assist the Contractor in analyzing MH/SUD, opioid and antipsychotic drug utilization. Results of the review shall be provided to the State or its agent and, where applicable, to the Contractor's network providers. The State or its agent will take appropriate corrective action to report its actions and outcomes to the Contractor.	➢ Denial Criteria ➢ That scripts written by mental health/substance use disorder providers do not require prior authorization ➢ Pharmacy Prior Authorization ▪ Drug Utilization Review Program Description ▪ Excel spreadsheet of all prior authorization activity with request date, decision date, and type of request, date of consultation with referring provider, date of enrollee and provider notification ▪ Various retrospective reports looking at the utilization of drugs in relationship to fraud and abuse (narcotics) over/under utilization of specific drugs, and mental health/substance use disorder drugs ▪ Various reports revealing clinical conflicts as related to drug interactions, drug-allergy conflicts, drug-disease conflicts, cumulative early refill, therapeutic duplication, drug exceeding maximum daily dosage, drug under minimum daily dosage, drug-age conflict, drug-gender conflict and duration of therapy ▪ Initiatives Developed to Address Deficiencies including Outcomes
UM2	4.6.1.C.3	**4.6.1.C.3** Enrollee Rights and Responsibilities. Shall include the right to the Medicaid Fair Hearing Process for Medicaid enrollees.	▪ Policy and Procedure addressing the following: ➢ Medicaid Fair Hearing Process ➢ Adverse Determinations ➢ Member Appeals ▪ Certificate of Coverage ▪ Cited page/s in the Provider Manual ▪ MCO Website ▪ Notice of Action ▪ Member Handbook
Sub-heading	4.6.4 B.4.14.XIII Appendix	**4.6.4** **B.4.14.XIII** The Contractor shall develop a written Utilization Review Plan that includes all standards described in the NJ QAPI Standards.	

UM3	4.6.4.A B.4.14.XIII Appendix	**4.6.4.A** Utilization Review Plan. The Contractor shall develop a written Utilization Review Plan that includes all standards described in the New Jersey QAPI Standards (See Section B.4.14 of the Appendices) and the standards provided in Article 4.4 for MLTSS and DDD behavioral health utilization management. Decisions regarding utilization management, enrollee education, coverage of services, and other areas to which practice guidelines apply should be consistent with such practice guidelines. **B.4.14.XIII** **A. written program description** - The organization has a written utilization management program description which includes at a minimum: • procedures to evaluate medical necessity and the criteria and tools used for MLTSS Members • procedures to evaluate functional care needs and authorize services to address those needs • information sources and the process used to review and approve the provision of services • the mechanism and metrics used to evaluate the utilization management program effectiveness **B. scope** - The program has mechanisms to detect underutilization as well as overutilization.	▪ Utilization Management Program Description ▪ QI Work Plan ▪ CAHPs reports ▪ Provider Surveys ▪ Documentation for Delegated Entities ➢ Policies and Procedures ➢ Workflows ➢ MCO's role in oversight of Delegated Entities
UM4		**In 2019, this element (UM4) was removed – Contract requirements will be addressed under UM3.**	
UM5	4.6.4.A.10	**4.6.4.A.10** **Prohibited Actions** Neither the Contractor's UM committee nor its utilization review agent shall take any action with respect to an enrollee or a health care provider that is intended to penalize or discourage the enrollee or the enrollee's health care provider from undertaking an appeal, dispute resolution or judicial review of an adverse determination. Additionally, neither the Contractor's UM committee nor its utilization review agent shall take any punitive action against a Provider who requests an expedited resolution or supports a Member's appeal.	▪ Policies and Procedures addressing the following: ➢ Member and Provider Appeals ➢ Prior Authorizations ➢ Adverse Determinations ▪ Adverse Determination Letters ▪ Provider Manual ▪ Member Handbook
UM6	4.6.4.B	**4.6.4.B** **Prior Authorization** The Contractor shall have policies and procedures for prior-authorization and have in effect mechanisms to ensure consistent application of service criteria for authorization decisions.	▪ Policies and Procedures addressing the following: ➢ Prior Authorizations ➢ UM Program Description ➢ Clinical Criteria for UM decisions

			➢ Inter-Rater Reliability Testing Policy and Procedure ▪ Inter-Rater Reliability Testing Results
UM7	4.6.4.B	**4.6.4.B** Prior authorization shall be conducted by a currently licensed, registered or certified health care professional, including a registered nurse or a physician who is appropriately trained in the principles, procedures and standards of utilization review.	**Assessment will also include a file review to verify compliance.** **Requires a State-approved policy and procedure.** ▪ QI Program Description ▪ UM Program Description ▪ Inter-rater Reliable Policy and Procedure ▪ UM Reviewer Job Description ▪ Physician-Reviewer Job Description ▪ Resumes/Bios ▪ Pharmacy personnel making authorizations for pharmaceuticals job description
Sub-heading	4.6.4.B	**4.6.4.B** The following timeframes and requirements shall apply to all **prior authorization** determinations:	
UM8	4.6.4.B.1	**4.6.4.B.1** **Routine determinations** Prior authorization determinations for non-urgent services shall be made and a notice of approved determination provided by telephone or in writing to the provider within fourteen (14) calendar days (or sooner as required by the needs of the enrollee) of receipt of necessary information sufficient to make an informed decision. Prior authorization denials and limitations must be provided in writing in accordance with the Health Claims Authorization Processing and Payment Act, P.L. 2005, c.352, 42 CFR 438.404(c), NJAC §11:24, and the Notice of Action standards established in this contract in Articles 4.6.4 and 5.15 et seq. The dental prior authorization shall be active for a minimum of six (6) months.	▪ Policies and Procedures addressing the following: ➢ Prior Authorizations ➢ Authorization Timeframes ▪ Prior Authorization Activity Reports ▪ Excel spreadsheet of all prior authorization activity with request date, decision date, and type of request, date of consultation with referring provider, date of enrollee and provider notification
UM9	4.6.4.B.2	**4.6.4.B.2** **Urgent determinations** Prior authorization determinations for urgent services shall be made within twenty-four (24) hours of receipt of the necessary information, but no later than seventy-two (72) hours after receipt of the request for service. Written notification shall be provided in accordance with the Notice of Action standards established in this contract in Articles 4.6.4 and 5.15 et seq.	▪ Policies and Procedures addressing the following: ➢ Prior Authorizations ➢ Authorization Timeframes ▪ Prior Authorization Activity Reports ▪ Excel spreadsheet of all prior authorization activity with request date, decision date, and type of request, date of consultation with referring provider, date of enrollee and provider notification

UM10	4.6.4.B.3	**4.6.4.B.3** **Determination for Services that have been delivered.** Determinations involving health care services which have been delivered shall be made within thirty (30) days of receipt of the necessary information.	▪ Policies and Procedures addressing the following: ➢ Prior Authorizations ➢ Authorization Timeframes ▪ Prior Authorization Activity Reports ▪ Excel spreadsheet of all prior authorization activity with request date, decision date, and type of request, date of consultation with referring provider, date of enrollee and provider notification
UM11	4.6.4.B.4	**4.6.4.B.4** **Adverse Determinations** A physician with appropriate clinical experience in treating the enrollee's condition or disease and/or a physician peer reviewer shall make the final determination in all adverse determinations. A NJ licensed orthodontist shall make the final determination in all adverse determinations for comprehensive orthodontic treatment service requests.	▪ Policies and Procedures addressing the following: ➢ Prior Authorizations ➢ Consultant/Medical Peer Review Process ▪ UM Program Description
UM12	4.6.4.B.5	**4.6.4.B.5** **Continued/Extended Services** A utilization review agent shall make a determination involving continued or extended health care services, or additional services for an enrollee undergoing a course of continued treatment prescribed by a health care provider and provide notice of such determination to the enrollee or the enrollee's designee and to the enrollee's health care provider, by telephone and in writing within one (1) business day of receipt of the necessary information. In the case of an enrollee currently receiving inpatient hospital service or emergency room care, the Contractor shall make the determination involving continued or extended health care services within 24 hours. Notification of continued or extended services shall include the number of extended services approved, the new total of approved services, the date of onset of services and the next review date. For services that require multiple visits, a series of tests, etc. to complete the service, the authorized time period shall be adequate to cover the anticipated span of time that best fits the service needs and circumstances of each individual enrollee.	▪ Policies and Procedures addressing the following: ➢ Concurrent Review ➢ Authorization Timeframes ▪ Excel spreadsheet of concurrent review activity with request date, decision date, date of consultation with referring provider, date of enrollee and provider notification
UM13	4.6.4.B.6	**4.6.4.B.6** **Reconsiderations** The Contractor's policies and procedures for authorization shall include consulting with the requesting provider when appropriate. The Contractor shall have policies and procedures for reconsideration in the event that an adverse determination is made without an attempt to discuss such determination with the referring	▪ Policies and Procedures addressing the following: ➢ Prior Authorizations ➢ Adverse Determinations ▪ UM Program Description

		provider. Determinations in such cases shall be made within the timeframes established for initial considerations.	
UM14	4.6.4.B.7	**4.6.4.B.7** The Contractor shall provide written notification to enrollees and/or, where applicable, an authorized person at the time of denial, deferral or modification of a request for prior approval to provide a medical/dental/behavioral health/MLTSS service(s) when the following conditions exist: a. The request is made by a medical/dental or other health care provider who has a formal arrangement with the Contractor to provide services to the enrollee. b. The request is made by the provider through the formal prior authorization procedures operated by the Contractor. c. The service for which prior authorization is requested is a Medicaid covered service for which the Contractor has established a prior authorization requirement. d. The prior authorization decision is being made at the ultimate level of responsibility within the Contractor's organization for approving, denying, deferring, pending or modifying (as allowed) the service requested but prior to the point at which the enrollee must initiate the Contractor's appeal process.	▪ Policies and Procedures addressing the following: ➢ Prior Authorizations ➢ Adverse Determinations ▪ Notice of Action ▪ Tracking System
UM15	4.6.4.B.8	**4.6.4.B.8** **Notice of Action.** Notice of action shall be in writing and shall meet the language and format requirements of 42 CFR 438.10 to ensure ease of understanding. The member, member's authorized representative, and provider acting on behalf of a member with the member's written consent (if the latter is applicable) shall receive written notice of any adverse determination within two business days of said determination. The written notice shall be generated on the date of the determination. In the case of expedited appeal process, the Contractor shall also provide oral notice. Written notification shall be given on a standardized form approved by the Department and shall inform the provider, and the enrollee (or their authorized representative) of the following: a. Results of the resolution process and the effective date of the denial, reduction, suspension or termination of service, or other coverage determination; b. The enrollee's rights to, and method for obtaining, an external (IURO) appeal and/or Fair Hearing to contest the denial, deferral or modification action; c. The enrollee's right to represent himself/herself at the Fair Hearing or to be represented by legal counsel, or a friend or other spokesperson designated in writing as an authorized representative; d. The action taken or intended to be taken by the Contractor on the request for prior authorization and the reason for such action including clinical or other rationale and the underlying contractual basis or Medicaid authority;	▪ Policies and Procedures addressing the following: ➢ Adverse Determinations ▪ Notice of Action Letter templates – Enrollee and Provider ▪ Examples of Notice of Action Letters – Enrollee and Provider

		e. The name and address of the Contractor; f. Notice of internal (Contractor) appeal rights and instructions on how to initiate such appeal; g. Notice of the availability of the clinical or other review criteria relied upon to make the determination; h. The notice to the enrollee shall inform the enrollee that he or she may file an appeal concerning the Contractor's action using the Contractor's appeal procedure prior to or concurrent with the initiation of the State hearing process; i. The Contractor shall notify enrollees, and/or authorized persons within the time frames set forth in this contract, P.L. 2005, c.352 42 CFR 438.404(c), and in NJAC §11:24-8.3; j. The enrollee's right to have benefits continue (see Article 4.6.4C) pending resolution of the appeal.	
UM16*/**	5.8.2.F 5.15.1.A 6.5.B 4.6.4.B.1 4.6.4.B.2 4.6.4.B.3 4.6.4.B.4 4.6.4.B.5 4.6.4.B.7 4.6.4.B.8	**5.8.2.F** **Grievances and Appeals** 1. Procedures for resolving grievances, as approved by the DMAHS including a member facing explanation of the process for filing a grievance. 2. A description of the appeal procedures to be used to resolve an adverse benefit determination, including: the name, title, or department, address, and telephone number of the person(s) responsible for assisting enrollees in adverse benefit determination appeals; the time frames and circumstances for expedited and standard appeals; the right to appeal an adverse benefit determination; the right to designate a representative; a notice that all disputes involving clinical decisions will be made by qualified clinical personnel; and that all notices of determination will include information about the basis of the decision and further appeal rights, if any. 3. The Contractor shall notify all enrollees in their primary language of their rights to file grievances and appeals by the Contractor. 4. An explanation that, in addition to the MCO Appeal process, Medicaid/NJ FamilyCare A enrollees, and NJ FamilyCare ABP enrollees have the right to a Fair Hearing (which must be requested within 120 days of the date of the notice of action letter following an adverse determination resulting from an internal appeal) with DMAHS and the appeal process through the New Jersey Department of Banking and Insurance (DOBI), including instructions on the procedures involved in making such a request. 5. Notification that benefits that the Contractor seeks to reduce, suspend, or terminate will continue while an appeal is pending if the enrollee files an appeal or a request for Fair Hearing (and requests that benefits continue during the Fair Hearing) within the timeframes specified at 4.6.4.C, and that the enrollee may be required to pay the cost of services furnished while the Fair Hearing is pending if the final decision is adverse to the enrollee.	**Requires a State-approved policy and procedure addressing grievances and appeals.** ▪ Policies and Procedures addressing the following: ➢ Prior Authorization processes ➢ Enrollee, appeals, and grievances ➢ Provider, appeals, and grievances ▪ Tracking logs ▪ Letters templates ▪ Examples of Provider/Enrollee letters ▪ Member Handbook ▪ Provider Manual

		6. A copy of the Grievance Form (based on the approved, DMAHS-issued template). 7. The URL for the online Grievance Form, located on the plan website (as described in Article 5.15.2.E). **5.15.1.A** DMAHS Approval. The Contractor shall draft and disseminate to enrollees, providers, and subcontractors, a system and procedure which has the prior written approval of DMAHS for the receipt and adjudication of grievances and appeals by enrollees. The grievance and appeal policies and procedures shall be in accordance with. 42 C.F.R. 438, with the modifications that are incorporated in the contract. The Contractor shall not modify the grievance or appeal procedure without the prior approval of DMAHS, and shall provide DMAHS with a copy of the modification. The Contractor's grievance and appeal procedures shall provide for expeditious resolution of grievances and appeals by Contractor personnel at a decision-making level with authority to require corrective action, and will have separate tracks for administrative and utilization management appeals. (For the utilization management appeal process, see Article 4.6.4C.) The Contractor shall review the grievance and appeal procedure at reasonable intervals, but no less than annually, for the purpose of amending same as needed, with the prior written approval of the DMAHS, in order to improve said system and procedure. The Contractor's system and procedure shall be available to both Medicaid beneficiaries and NJ FamilyCare beneficiaries. All enrollees have available the grievance and appeal processes under the Contractor's plan, the Department of Banking and Insurance and, for certain NJ FamilyCare beneficiaries (i.e., Medicaid/NJ FamilyCare A and NJ FamilyCare ABP enrollees), the Fair Hearing process. Individuals eligible solely through NJ FamilyCare B, C, and D, do not have the right to a Fair Hearing. **6.5.B** Grievances and Appeals. The Contractor shall establish and maintain provider grievance and appeal procedures for any provider who is not satisfied with the Contractor's policies and procedures, or with a decision made by the Contractor, or disagrees with the Contractor as to whether a service, supply, or procedure is a covered benefit, is medically necessary, or is performed in the appropriate setting. **4.6.4.B.1, 2, 3, 4, 5, 7, 8: See above elements for contract language relating to UM files and appeals.**	

UM16a* Member Grievances – Core Medicaid			▪ File Review
UM16b* Provider Grievance – Core Medicaid			▪ File Review
UM16c* Member Appeals – Core Medicaid			▪ File Review
UM16d* Provider Appeals – Core Medicaid			▪ File Review
UM16e* UM – Core Medicaid			▪ File Review
UM16f** Member Grievance – MLTSS			▪ File Review
UM16g** Provider Grievance – MLTSS			▪ File Review
UM16h** Member Appeals – MLTSS			▪ File Review
UM16i** Provider Appeals – MLTSS			▪ File Review

UM16j** UM - MLTSS			▪ File Review
UM17	4.6.4.C	**4.6.4.C** **Appeal Process for UM Determinations** The Contractor shall have policies and procedures for the appeal of utilization management determinations and similar determinations. In the case of an enrollee who was receiving a service (from the Contractor, another Contractor, or the Medicaid Fee-for-Service program) prior to the determination, the Contractor shall continue to provide the same level of service while the determination is in appeal.	▪ Policies and Procedures Addressing the following: ➢ Prior Authorizations ➢ Addressing Timeliness of Decisions ➢ Adverse Determinations ➢ Enrollee and Provider Appeals ▪ Excel spreadsheet of all prior authorization activity with request date, decision date, and type of request, date of consultation with referring provider, date of enrollee and provider notification ▪ Notice of Action ▪ Member Handbook ▪ Provider Manual
UM18	B.4.14.XIII.C Appendix	**B.4.14.XIII.C** **Pre-authorization and concurrent review requirements** For organizations with preauthorization or concurrent review programs: 1. The organization implements written policies and procedures, reflecting current standards of medical practice and standards of functionality for long term services and supports, for processing requests for initial authorization of services or requests for continuation of services. a) The policies specify time frames for responding to requests for initial and continued determinations, specify information required for authorization decisions, provide for consultation with the requesting provider when appropriate, and provide for expedited response to requests for authorization of urgently needed services. b) Criteria for decisions on coverage, medical and /or functional necessity and service authorization are clearly documented, are based on reasonable medical evidence, or a consensus of relevant health care professionals, or policy guidance by DMAHS and are regularly updated. c) Mechanisms are in place to ensure consistent application of review criteria and comparable decisions on service authorizations are made across reviewers, including Medical Directors.	▪ Policies and Procedures addressing the following: ➢ Monitoring the effects of UM program using enrollee and provider satisfaction data ➢ UM program analysis using enrollee and provider satisfaction data ▪ Improvement Plans ▪ Outcome Data

		d) A clinical peer, in a same or similar specialty, reviews all decisions to deny or limit in scope, duration and intensity, service authorizations on the grounds of medical and /or functional appropriateness. The requesting provider and the enrollee are promptly notified of any decision to deny, limit, or discontinue authorization of services, including MLTSS. The notice specifies the criteria used in denying or limiting authorization and includes information on how to request reconsideration of the decision pursuant to the procedures established. The notice to the enrollee must be in writing. e) Compensation to persons or organizations conducting utilization management activities shall not be structured so as to provide inappropriate incentives for denial, limitation or discontinuation of authorization of services. f) The organization does not prohibit providers from advocating on behalf of enrollees within the utilization management process. g) Mechanisms are in effect to detect both underutilization and overutilization of services. 2. Preauthorization and concurrent review decisions are supervised by qualified medical professionals with appropriate subject matter expertise in the populations and services being authorized. 3. Efforts are made to obtain all necessary information, including pertinent clinical and/or functional information, and consult with the treating provider as appropriate. 4. The reasons for decisions are clearly documented and available to the Member. 5. There are well-publicized and readily available appeals mechanisms for both providers and Members. Notification of a denial includes a description of how to file an appeal. 6. Decisions and appeals are made in a timely manner as required by the exigencies of the situation. 7. There are mechanisms to evaluate the effects of the program using data on Member satisfaction, provider satisfaction or other appropriate measures. 8. If the organization delegates responsibility for utilization management, it has mechanisms to ensure that these standards are met by the delegate.	

UM19*/**	B.9.0 MLTSS Service Dictionary for PDN services. 4.5.3.H N.J.A.C. §10:60-5.4(b)	**B.9.0 MLTSS Service Dictionary** Private Duty Nursing shall be a covered service only for those beneficiaries enrolled in MLTSS and the DDD Supports Plus PDN program operated by DDD. When payment for private duty nursing services is being provided or paid for by another source, the benefit of private duty nursing hours shall supplement the other source up to a maximum of 16 hours per day, including services provided or paid for by the other sources, if medically necessary, and if cost of service provided is less than institutional care. The 16 hours per day limitation for PDN services noted above and below shall not apply to children under the age of twenty one years who are eligible for Medicaid/NJ FamilyCare EPSDT services. MLTSS Private Duty Nursing Per Medical Necessity as defined in the contract. Private Duty Nursing services are provided in the community only (the home or other community setting of the individual), and not in hospital inpatient or nursing facility settings. Private Duty Nursing services are a State Plan benefit for children under the age of 21. EPSDT services must be exhausted before accessing MLTSS PDN. Children who meet the eligibility criteria for MLTSS services contained in this dictionary shall not have their access to Medicaid EPSDT services limited through the language contained in this document. For adults over the age of 21, private duty nursing is provided under the MLTSS benefit and through the DDD Supports Plus program. Persons meeting NF level of Care are eligible to receive private duty nursing. Private Duty Nursing criteria is based on medical necessity, and is prior approved by the MCO in a plan of care. Private duty nursing is individual, continuous, ongoing nursing care in the home, and is a service available to a beneficiary only after enrollment in MLTSS or, in the case of DDD Supports Plus PDN, being determined as meeting nursing facility level of care. (a) Private duty nursing services shall be provided in the community only and not in an inpatient hospital or nursing facility setting. Services shall be provided by a registered nurse (RN) or a licensed practical nurse (LPN). 1. Private Duty Nursing (PDN) services rendered during hours when the beneficiary's normal life activities take him or her outside the home will be reimbursed. If a beneficiary seeks to obtain PDN services to attend school or other activities outside the home, but does not need such services in the home, there is no basis for authorizing PDN services. Only those PDN beneficiaries who require, and are authorized to receive, private duty nursing	▪ Policies and Procedures addressing the following: ➢ Private Duty Nursing (PDN) ➢ Prior Authorization ▪ Case Examples ▪ Tracking Mechanisms ▪ Member Handbook ▪ Oversight Documentation ▪ Denial Letters ▪ New Jersey Choice Assessment Narrative ▪ Special Care Nursing Facility Level of Care Approval Request

		services in the home may utilize the approved hours outside the home during those hours when normal life activities take the beneficiary out of the home. 2. Due to safety concerns, the nurse shall not be authorized to engage in non-medical activities while accompanying the client, including the operation of a motor vehicle. (b) Private Duty Nursing shall be a covered service only for those beneficiaries enrolled MLTSS or the DDD Supports Plus program, when payment for Private Duty Nursing services is being provided or paid for by another source (that is, insurance), Private Duty Nursing hours shall supplement up to a maximum of 16 hours per day, including services provided or paid for by the other sources, if medically necessary, and if cost of service provided is less than institutional care. (c) Private Duty Nursing services shall be limited to a maximum of 16 hours, including services provided or paid for by other sources, in a 24-hour period, per person. There shall be a live-in primary adult caregiver (as defined in N.J.A.C. 10:60-1.2) who accepts 24-hour per day responsibility for the health and welfare of the beneficiary unless the sole purpose of the private duty nursing is the administration of IV therapy. (See N.J.A.C. 10:60-6.3(b)2 and 7.4(a)2 for exceptions to 16-hour maximum in a 24-hour period.) Approval for private duty nursing service is provided by the Managed Care Organization for MLTSS beneficiaries and DDD Supports Plus PDN enrollees. Approval is provided by the State for Fee For Service beneficiaries. **4.5.3.H** Individuals who are 20 years and older with an intellectual/developmental disability who are identified as receiving Private Duty Nursing shall be referred to the Division of Developmental Disabilities for consideration of the DDD Supports Plus Private Duty Nursing (SPPDN) program. If SPPDN is indicated the MCO shall complete a NJ Choice Assessment when the member is 20.5 years or older and submit to OCCO as assessment type "MCO-Supports Plus PDN" along with the DDD determination. If the member meets Nursing Faculty Level of Care and DDD program requirements the member will be enrolled into the program. A NJ Choice assessment is required annually for all members enrolled in SPPDN program. **N.J.A.C. §10:60-5.4(b)** (b) Medical necessity for EPSDT/PDN services shall be based upon, but may not be limited to, the following criteria in (b)1 or 2 below: 1. A requirement for all of the following medical interventions:	

		i. dependence on mechanical ventilation; ii. the presence of an active tracheotomy; and iii. the need for deep suctioning; or 2. A requirement for any of the following medical interventions: i. the need for around-the-clock nebulizer treatments, with chest physiotherapy; ii. Gastrostomy feeding when complicated by frequent regurgitation and/or aspiration; or iii. a seizure disorder manifested by frequent prolonged seizures, requiring emergency administration of anticonvulsants.	
UM20*/**	9.6.5.E 9.6.5.I N.J.A.C. §10:60-5.5(f)3	**Private Duty Nursing Services** **9.6.5.E MLTSS** The Care Manager shall continuously assess/identify a problem or situation and take appropriate action. The Care Manager shall provide more frequent case monitoring when the Care Manager is notified of an urgent/emergent need or change of condition that may require revisions to the existing plan of care. The Care Manager shall conduct a face-to-face visit within twenty-four (24) hours when the situation resulting from the need or change of condition cannot be handled over the telephone or when the Care Manager has reason to believe the Member's well-being is at risk. **9.6.5.I** The Care Manager shall update the written plan of care, in accordance with the Member's assessed needs and goals, at each visit. The Member must indicate his/her agreement with the plan of care each time there is an increase or reduction in services. The Care Manager shall provide the Member a copy of the revised and signed plan of care. **N.J.A.C. §10:60-5.5(f) EPSDT** A nursing reassessment shall be conducted by the nurse assessor prior to the end of the PDN authorization period, in accordance with the following: 1. The reassessment will be conducted in the beneficiary's home, in order to determine the on-going medical necessity of EPSDT/PDN services, and shall include a 24-hour inventory of needed services. 2. The nurse assessor shall utilize the reports from the provider agency for documentation of specific functions performed by the provider agency nurse(s). 3. Any changes in the child's status or circumstances, including the frequency and type of interventions required, shall be noted. These changes shall be clearly identified in the reassessment summary, and shall be used to support any decision to continue, reduce or increase PDN hours.	▪ Policies and Procedures addressing the following: ➢ Private Duty Nursing (PDN) ➢ Tracking Mechanisms ▪ Documentation Standards ▪ Care Plans ▪ Oversight Documentation ▪ MLTSS Plan of Care or Service Plans

UM21		**In 2019, this element (UM21) was removed and will no longer be reviewed.**	
UM22*	4.7.4.A	**4.7.4.A** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion. ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.
Administration and Operations			
2024 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
AO1	4.9.3.A 4.9.3.B	**4.9.3.A** The Contractor shall comply with all the provisions of the New Jersey MCO regulations at N.J.A.C. 11.24 et seq. regarding Provider termination, including but not limited to the 30 business day prior written notice to enrollees regarding termination or withdrawal of PCPs and any other physician or provider from which the Members receiving a course of treatment; continuity of care; and, in the case of a hospital termination/non-renewal, written notification within the first fifteen (15) business days of the four month extension to all contracted providers and Members who reside in the county in which the hospital is located or in an adjacent county within the Contractor's service area. **4.9.3.B** The Contractor shall notify DMAHS and the MFD, in a data format defined by the State, at least 45 days or as soon as practicable prior to the effective date of suspension, termination, non-renewal of contract, or voluntary withdrawal, or any other form of non-participation of a provider or subcontractor from participation in this program. The Contractor's notice to DMAHS and the MFD shall include the reason for the provider's non-participation in the plan. Failure to report the information required by this section and or failure to report the information in the time period specified will subject the contractor to the provisions of Section 7.36.6 of the Contract. If the termination was "for cause", the Contractor's notice to DMAHS shall include the reasons for the termination.	▪ Policies and Procedures addressing the following: ➢ Medical Services Continuity and Coordination of Care ➢ Dental Services Continuity and Coordination of Care ▪ Member letter of specialist termination in English and Spanish ▪ Notification to or from a provider regarding termination and associated enrollee letters of termination ▪ Notification to providers and enrollees of hospital termination/non-renewal with associated hospital termination/non-renewal date ▪ Notification to DMAHS of terminations ▪ Evidence of notification within 45 days

		1. Provider resource consumption patterns shall not constitute "cause" unless the Contractor can demonstrate it has in place a risk adjustment system that takes into account enrollee health-related differences when comparing across providers. 2. The Contractor shall assure immediate coverage by a provider of the same specialty, expertise, or service provision and shall submit a new contract with a replacement provider to DMAHS 45 days prior to the effective date. 3. The Contractor shall, on request, provide DMAHS with periodic updates and information pertaining to specific potential provider terminations, including status of renegotiation efforts.	
AO2	4.9.3.C	**4.9.3.C** If a primary care provider ceases participation in the Contractor's organization, the Contractor shall provide written notice at least thirty (30) days from the date that the Contractor becomes aware of such change in status to each enrollee who has chosen the provider as their primary care provider. If an enrollee is in an ongoing course of treatment with any other participating provider who becomes unavailable to continue to provide services to such enrollee and Contractor is aware of such ongoing course of treatment, the Contractor shall provide written notice within fifteen days from the date that the Contractor becomes aware of such unavailability to such enrollee. Each notice shall also describe the procedures for continuing care and choice of other providers who can continue to care for the enrollee.	▪ Policies and Procedures addressing the following: ➢ Medical Services Continuity and Coordination of Care ➢ Dental Services Continuity and Coordination of Care ▪ Notification to or from a provider regarding termination and associated enrollee letters of termination
AO3*	5.7.A	**5.7.A** The Contractor shall have in place a Member Services Unit to coordinate and provide services to Medicaid/NJ FamilyCare managed care enrollees. The services include, but are not limited to, enrollee selection, changes, assignment, and/or reassignment of a PCP, explanation of benefits, assistance with filing and resolving inquiries, billing problems, grievances and appeals, referrals, appointment scheduling and cultural and/or linguistic needs. This unit shall also provide orientation to Contractor operations and assistance in accessing care.	▪ Customer Service Departmental Organizational Chart ▪ Customer Service Staff Job Descriptions ▪ Customer Service Department Training Manual ▪ Ongoing Training Materials ▪ Customer Service Desk-Top Procedures ▪ Customer Service Department Orientation schedules ▪ Service Standards ▪ Monitoring reports and documentation showing efforts to address identified deficiencies ▪ Review of Call Center systems
AO4	5.8.5.A 7.24.M	**5.8.5.A** Except as set forth in Section 5.9.1C. the Contractor shall deliver to each new enrollee prior to the effective enrollment date but no later than seven (7) days after the enrollee's effective date of enrollment a Contractor Identification Card for those enrollees who have selected a PCP. The Identification Card shall have at least the following information:	▪ Policies and Procedures addressing the following: ➢ Customer Service Department ➢ New Member Process ➢ Post Enrollment ID Card Production

		1. Name of enrollee 2. Issue date for use in automated care replacement process 3. Primary Care Provider name "or your Medicare PCP" (may be affixed by sticker) 4. Primary Care Provider phone number (may be affixed by sticker) 5. What to do in case of emergency and that no prior authorization is required 6. Relevant co-payments/personal contributions to care 7. Contractor 800 number – emergency message 8. Dental Benefit information. The contractor will provide information on the contractor ID card to assist members with obtaining information for the NJFC dental benefit. If dental services are provided through a subcontractor, both the name of the Contractor and the subcontractor must appear on the card. a. The contractor ID card includes Dental Services as a benefit on the card and a toll free contact number (may be affixed by sticker for existing members) b. For those enrollees that are assigned and change PCD and for new enrollees that are assigned a PCD, a separate ID card from the contractor shall be included in the letter that provides information for the selected or assigned PCD (dentists/dental group). It will include: 1. Name of enrollee 2. Issue Date for use in automated card replacement process 3. Primary Care dentist/office Phone Number 4. Relevant copayments/Personal Contributions to Care 5. Contractor 800 number – indicate types of assistance such as dental benefit questions/assistance 6. Subcontractor 800 number – indicate types of assistance such as assistance in locating a dentist Any additional information shall be approved by DMAHS prior to use on the ID card. **7.24.M** M. The Contractor shall, on a monthly basis, submit a report indicating all undeliverable member identification cards in the format prescribed by DMAHS. The Undeliverable ID Card Report shall be submitted to the State's Health Benefits Coordinator.	▪ Customer Service Departmental ID Card Production Reports ▪ Monitoring Reports ▪ Example of current ID Card ▪ Example of Dental ID Card for members with PCD
Sub-heading	4.9.6	**4.9.6** **Subcontracts:** In carrying out the terms of the contract, the Contractor may elect to enter into subcontracts with other entities for the provision of health care services and/or administrative services as defined in Article 1. In doing so, the Contractor shall, at a minimum, be responsible for adhering to the following criteria and procedures.	
AO5	4.9.6.A - I	**4.9.6.A-I**	▪ Provider Participation Agreement Template Letter

		A. All subcontracts shall be in writing and shall be submitted to DMAHS for prior approval at least 90 days prior to the anticipated implementation date. DMAHS approval shall also be contingent on regulatory agency review and approval. B. The Department shall prior approve all provider contracts and all subcontracts. C. All provider contracts and all subcontracts shall include the terms in Section B.7.2 of the Appendices, Provider/Subcontractor Contract Provisions. D. The Contractor shall monitor the performance of its subcontractors on an ongoing basis and ensure that performance is consistent with the contract between the Contractor and the Department. E. Unless otherwise provided by law, Contractor shall not cede or otherwise transfer some or all financial risk of the Contractor to a subcontractor. F. Every third party administrator engaged by the Contractor shall be licensed or registered by the Department of Banking and Insurance pursuant to P.L. 2001, c. 267 G. All Contractors entering into subcontracts with other entities for the provision of health care services should also comply with requirements under 42 CFR 438.3(k), 42 CFR 438.230(a),42 CFR 438.230(b)(1), (2), (3). H. All subcontractors are to comply with requirements in terms of this contract listed in 5.8.2 Enrollee Notification and Handbooks and 6.2 Provider Publications. These documents are to be subject to DMAHS review and approval following the same timelines and requirements as comparable documents produced by contractors. I. Any subcontract where the subcontractor (vendor) provides claims adjudication activities must state that the subcontractor will provide all data required for Medical Loss Ratio (MLR) reporting within 180 days of the end of the fiscal year, or within 30 days of the request by the Contractor if requested sooner. This time limit cannot be extended by any other contract provision.	▪ Administrative Services Agreement between MCO and Service Provider ▪ Copies of agreements or subcontracts with other entities contracted to provide services to MCO enrollee ▪ Contracts between the MCO and subcontractor ▪ QI Program Description ▪ Annual QI Program Evaluation

AO6	7.3.A	**7.3.A** **Staffing**: The Contractor shall have in place the organization, management and administrative systems necessary to fulfill all contractual arrangements. The Contractor shall demonstrate to DMAHS' satisfaction that it has the necessary dedicated, non-delegable New Jersey staffing, by function and qualifications, to fulfill its obligations under this contract which include at a minimum: 1. A designated administrative liaison for the Medicaid/NJ FamilyCare contract who shall be the main point of contact responsible for coordinating all administrative activities for this contract ("Contractor's Representative"; See also Article 7.5 below) 2. A full-time Medical Director(s) who shall be licensed as an M.D. or D.O. in New Jersey and meets the experience requirements pursuant to Article 4.6.1(C)(2). 3. A full-time designated position who shall be accountable for: supporting organizational health equity goals through identifying, analyzing, and addressing health disparities, performance improvement plans and interventions related to health disparities, cultural competence training, modifying and establishing internal and external policies and procedures to address and incorporate health equity, and reporting on organizational diversity activities to facilitate an inclusive workforce to support beneficiaries. 4. A full-time senior executive dedicated to MLTSS who has at least five (5) years of experience administering managed long term care programs. Equivalent experience administering long term care programs and services, including HCBS, or in managed care may be substituted, subject to DMAHS approval. 5. A Dental Director - who shall be licensed as a DDS or DMD in New Jersey 6. Behavioral Health a. A full time behavioral health administrator who is a New Jersey licensed social worker (LSW), licensed registered nurse (RN), clinical nurse specialist (CNS), licensed advanced practice nurse (APN), physician or psychologist with experience serving chronically ill populations with mental health and Substance Use Disorders, at least three (3) years of experience serving in a managerial/leadership role and knowledge of managed care. This individual shall be responsible for developing, implementing, and coordinating behavioral health services and settings that can meet the needs of Members with behavioral health needs. b. A Behavioral Health Medical Director who is a board-certified psychiatrist licensed in the State of New Jersey. The Behavioral Health Medical Director shall also have significant clinical experience in the treatment of substance use disorders, including utilization of ASAM criteria, and an understanding of the New Jersey system of care. Subspecialty board certification can be by the American Board of Psychiatry and Neurology (ABPN), the American Osteopathic	▪ Organizational Chart ▪ Individual Departmental Organizational Charts ▪ Key staff job descriptions listing essential duties and responsibilities, education, experience, required qualifications, licensure and/or certification for the position

		Association (AOA), or the American Board of Preventive Medicine (ABPN). The BH Medical Director must possess at least five years combined experience in mental health and substance use services and at least two (2) years of BH leadership experience in a government, health management, or managed care organization, and/or at least two (2) years of experience as a Medical Director in clinical practice, and/or at least three (3) years of clinical BH experience (excluding psychiatric residency). This individual shall be responsible for leadership and counsel for utilization management and case management programs for mental health and substance use disorder services and collaboration with DMAHS, and other state agencies, to oversee the implementation of BH integration efforts. The responsibilities of the Behavioral Health Medical Director include: i. Participation in the development of clinical practice standards, policies, and procedures, ii. Responsibility for behavioral health care management performance and coordination with physical health care management, iii. Participation in DMAHS and other agency/stakeholder meetings when requested, iv. Oversight and implementation of the utilization management program for behavioral health services, including preventing contraindicated care, v. Ensuring consistency in the application of utilization management standards, including those implemented by subcontracted entities, vi. Overseeing the complaint and grievance process for behavioral health denials, vii. Review and resolution of quality of care concerns, and viii. Participation in clinical staff recruitment and ongoing performance improvement. c. A full-time Behavioral Health Care Management Supervisor who is a New Jersey licensed clinical social worker (LCSW), licensed professional counselor (LPC), licensed advanced practice nurse (APN), physician, or psychologist with experience serving chronically ill populations with mental health and/or Substance Use Disorders, at least two (2) years of care management experience, at least three (3) years of experience serving in a managerial/leadership role, and knowledge of managed care. The behavioral health care management supervisor shall be responsible for the overall day to day administrative and clinical supervision of the behavioral health care management unit. Their responsibilities shall include: i. Monitoring treatment plans to ensure integration of care, ii. Promoting cost-effective treatment planning, iii. Supporting coordination of care across contractor units and community providers.	

		iv. Developing strategies to improve outcomes d. A full-time Behavioral Health Director of Network Relations. The Director of Network Relations must have an office located in New Jersey that they are able to utilize on a regular basis and shall have at least five (5) years of experience in managed care network management. The primary functions of the Director of Network Relations are: i. Involvement in the development and maintenance of a credentialed Provider network that is geographically proportionate for provider specialties, ii. Meet provider services requirements under this Agreement; iii. Provide provider education and develop and deliver provider training; iv. Ensure network adequacy and appointment access, including development of network resources for identified unmet needs; this includes single case agreements, recruiting providers to meet unmet service capacity; v. Ensure that contracted providers impacted by population health initiatives, such as quality improvement projects, are included on project teams to identify provider perceived barriers and provide input on design and intervention test that may impact providers; vi. Collaborate with other managed care entities to simplify provider requirements and remove administrative barriers across credentialing health plans and; vii. Develop and implement provider claim dispute resolution process. viii. Conduct access and availability rounds with care managers e. A Behavioral Health Quality Management Supervisor that may report to the existing QM Director. The Supervisor shall be either, a Certified Professional in Healthcare Quality (CPHQ) by the National Association for Healthcare Quality, or be Certified in Healthcare Quality and Management (HCQM) by the American Board of Quality Assurance and Utilization Review Physicians. The Supervisor shall have at least three (3) years of experience in quality management and quality improvement. Key responsibilities shall include: i. Ensuring that systems and procedures exist that assess provider satisfaction. Assessment shall include provider experiences with claims processing, prior authorization, utilization management, and provider complaint resolution, ii. Implementation of quality measures of network adequacy, iii. Implementation of processes designed to improve access to care for special needs populations including, but not limited to, physically handicapped individuals, individuals with co-occurring conditions, victims of sexual abuse, deaf or blind individuals, pregnant people, and individuals with developmental delays,	

		iv. Resolving, tracking, and trending quality of care complaints, v. Ensuring the contractor or its behavioral health subcontractor comply with quality management requirements included in this agreement, and vi. Ensuring the network is capable of providing services to a culturally and ethnically diverse population with attention to disparities in access or outcomes experienced by traditionally marginalized populations. f. Behavioral Health Care Managers shall have a minimum of a Bachelor's degree in psychology, social sciences, social work, nursing, or a related field, at least two (2) years of work experience in public health or related field, and at least two (2) years of care management experience serving chronically ill populations with mental health and/or substance use disorders. Certified case managers (CCM) are preferred. 7. Financial officer(s) or accounting and budgeting officer 8. QM/UR coordinator who is a New Jersey-licensed registered nurse or physician 9. Prior authorization staff sufficient to authorize medical, behavioral, dental and MLTSS services twenty-four (24) hours per day/seven (7) days per week 10. A full-time Care Management Supervisor who is a New Jersey-licensed physician or has a Bachelor's degree in nursing and has a minimum of four (4) years of experience serving enrollees with special needs. The Care Management Supervisor shall be responsible for the management and supervision of the Care Management staff 11. A designated Care Manager or supervisor to act as administrative liaison between the Contractor and the various State entities for the MLTSS Care Management requirements set forth in this contract. At a minimum, this individual shall meet the Care Manager requirements pursuant to Article 9.5.2 and have a minimum of four (4) years experience serving enrollees receiving long term services and supports 12. Designated Medicaid Care Manager(s) who shall be available to DMAHS medical staff to respond to medical, behavioral or MLTSS related problems, grievances, and emergent or urgent situations 13. Member services unit head 14. Provider services unit head as well as a provider services liaison dedicated to MLTSS. The Contractor shall identify one or more MLTSS provider representatives for MLTSS providers. MLTSS provider representative(s) shall be responsible for internal representation of providers' interests including, but not limited to, contracting, service authorizations, claims processing and other MLTSS provider needs. The MLTSS provider representatives shall conduct ongoing communications with MLTSS providers through provider forums, webinars, dedicated toll-free MLTSS provider telephone lines and other means to ensure resolution of issues that include but are not limited to: enrollment/eligibility determinations; credentialing issues; authorization issues; and claims processing/payment disputes	

		15. Encounter reporting staff/claims processors supervisors 16. Grievance coordinator 17. A full-time designated MLTSS Member Representative responsible for internal representation of the interests of MLTSS Members including but not limited to input into planning and delivery of long term services and supports, participation in QM/QI activities, assistance with program monitoring and evaluation, and provision of education to enrollees, families, and providers on issues related to the MLTSS program. The MLTSS Member Representative shall assist MLTSS Members in navigating the Contractor's system. This shall include, but not be limited to, helping MLTSS Members understand and use the Contractor's system, being a resource for MLTSS Members, providing information, making referrals to appropriate Contractor staff Members, and facilitating resolution of any issues. The MLTSS Member Representative shall make recommendations to the Contractor on any changes needed to improve the Contractor's system for MLTSS Members, and participate as an ex officio Member of the Contractor's Consumer Advisory Committee. 18. A Nursing Facility Transition/Money Follows the Person program staff person possessing the skill and knowledge to assist in coordinating and facilitating Member transition from nursing facilities to the community. 19. A fulltime, dedicated Participant Direction Program Director who is knowledgeable in all aspects of participant direction operations and service delivery including, but not limited to: enrollment, eligibility, fiscal intermediary operations, claims payment, member communications, and coordination of services for all enrollees. This person will serve as the liaison between the MCO, the Member, and the State. 20. Adequate administrative and support staff 21. Compliance Officer 22. Housing Specialists who shall directly assist Members enrolled in MLTSS and those participating in Healthy Homes to identify, secure, and maintain community-based housing; act as the Contractor's central housing expert(s) to provide housing education and assistance to relevant Contractor staff (care managers and others); and act as a liaison to DMAHS staff, or its designee, to receive training and capacity building assistance and to submit required reports. Housing Specialist(s) must be dedicated, full-time staff persons whose primary responsibility is housing-related work. This shall not be staff to whom housing-related work has been added to their existing responsibilities and function within the MCO. a. Housing Specialist(s) shall have at least three (3) years' full-time experience in assisting vulnerable populations (e.g. homeless, elderly, people with disabilities, etc.) to secure accessible, affordable housing. The Specialist must be familiar with relevant public and private housing resources and stakeholders, including but not limited to HUD subsidized housing, all Department of Community Affairs (DCA), New Jersey Housing and Mortgage	

		Finance Agency (NJ HMFA) housing program voucher programs, public housing authorities, realtors, and online housing locator resources. b. The Contractor shall provide evidence of the aforementioned qualifications for those individuals or entities hired/designated as Housing Specialist(s) and/or Housing Intake Coordinator(s) upon request of DMAHS. c. At least one, and more if needed, Housing Specialist(s) will be designated as the Nursing Home Transition Housing Specialist and shall assist Members residing in nursing homes who wish to return to the community to identify, secure and maintain community-based housing. 23. Housing Services Manager, or an equivalent position will be a full-time manager-level position providing oversight of all housing-related services and Contractor housing staff and must be hired prior to April 1, 2024. The manager must be dedicated to the Contractor's New Jersey program only and will be responsible for ensuring coordination of Housing Services with all other services provided to Members by the Contractor. The manager will be responsible for creating an integrated housing strategy as well as housing related policies and procedures and cultivating stakeholder relationship. The manager will coordinate Housing Specialists' duties. The manager will ensure that the Contractor has the structure and systems in place to ensure successful provision of services to Members in the Healthy Homes or MLTSS programs or transitioning to the community for a nursing facility. 24. A New Jersey dedicated Pharmacy Director	
AO7	7.3.C	**7.3.C** **Training** The Contractor shall ensure that all staff has appropriate training, education, experience, and orientation to fulfill the requirements of the positions they hold and shall verify and document that it has met this requirement. The Contractor shall ensure compliance with all mandated training programs as required by DMAHS. The Contractor shall comply with Article 9.5.3 and 9.5.4 regarding MLTSS staff training.	▪ Policies and Procedures addressing the following: ➢ Staff Selection and Placement, Retention, and Background Checks ➢ Examples of Website Training Programs Screen Print ➢ General Orientation Materials ➢ Departmental Orientation Documents ➢ Ongoing Training Documents ➢ Resumes/Bios ➢ Job Descriptions
Sub-heading	B.4.14.VIII Appendix	**B.4.14.VIII** **Delegation of QAPI Activities** The MCO remains accountable for health services management and all QAPI functions, including those pertaining to MLTSS even if certain functions are delegated to other entities.	

AO8	B.4.14.VIII.B Appendix	**B.4.14.VIII.B** The MCO has written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care provided.	▪ Policies and Procedures addressing the following: ➢ Monitoring and Evaluating Delegated Activities ➢ Credentialing Delegation – Scope of Work and Performance Standards ➢ Evidence of monitoring activities
AO9	B.4.14.VIII.C Appendix	**B.4.14.VIII.C** There is evidence of continuous and ongoing evaluation of delegated activities at least annually, including approval of quality improvement plans and regular specified reports.	▪ Delegation Oversight Audits and findings including any corrective action ▪ Entire Year of the most recent committee oversight meeting minutes such as Credentialing Committee and Medical Management
AO10	B.4.14.VIII.D Appendix	**B.4.14.VIII.D** The organization evaluates the entity's ability to perform the delegated activities prior to delegation.	▪ Policies and Procedures addressing the following: ➢ Evaluation Prior to Delegation ➢ Credentialing Delegation – Scope of Work and Performance Standards ➢ Pre-Delegation Evaluation Audit findings
AO11	B.4.14.VIII.E Appendix	**B.4.14.VIII.E** If the organization delegates selection of providers to another entity, the organization retains the right to approve, suspend, or terminate any provider selected by that entity.	▪ Quality Improvement Program Description ▪ Credentialing Program ▪ Policies and Procedures addressing the following: ▪ Delegation Agreement Process and Structure ▪ Credentialing Delegation – Scope of Work and Performance Standards ▪ Credentialing Committee Charter ▪ Delegation Agreements ▪ Entire Year of the most recent Credentialing Committee Meeting Minutes
AO12**	4.8.1.M 4.9.2.E	**4.8.1.M** MLTSS Any Willing Provider and Any Willing Plan. The definition of MLTSS Any Willing Providers refers to any New Jersey-based nursing facility (NF), special care nursing facility (SCNF), assisted living provider (AL), community residential services (CRS) provider that serves residents with traumatic brain injury. The definition also applies to long term care pharmacies that apply to become network providers. These Medicaid Providers must comply with the Contractor's provider network participation requirements and are included in the Contractor's provider network to serve MLTSS Members. In addition, if the Contractor wishes to have any New Jersey-based nursing facility (NF), special care nursing facility (SCNF), assisted living	▪ Evidence of compliance with AWP requirements – procedures relating to contracting for NFs, SCNFs, ALs and CRSs; ▪ Contracts executed to serve MLTSS population ▪ Correspondence with providers requesting participation

		provider (AL), community residential services provider (CRS) join its network, those providers will be instructed to complete the application form which is known as Any Willing Plan. The Contractor must accept all NFs, SCNFs, ALs, CRSs that serve residents with traumatic brain injury, and long term care pharmacies which are Medicaid Provider. Network participation of these provider types cannot be denied based on the application of a subjective standard. 1. MLTSS Any Willing Provider status for NF, SCNF, AL and CRS will be from the date that the service comes into MLTSS, and continue through the end of State Fiscal Year 2024, dependent upon available appropriation in each Fiscal Year. For NF, SCNF, AL and CRS that would mean that Any Willing Provider status expires on June 30, 2024. Thereafter the Contractor may determine the continuing provider network status of these provider types based on Member utilization and access needs. 2. The rates for NF, SCNF, AL and CRS during the Any Willing Provider period will be the higher of: (a) the rate set by the State with the possibility of an increase each fiscal year for inflation, performance on specified quality metrics , or other factors dependent upon available appropriation and (b) the negotiated rate between the Contractor and the facility. This does not preclude volume-based rate negotiations and agreement between the Contractor and these providers. 3. The Any Willing Plan status also expires June 30, 2024. **4.9.2.E** **Contract Submission**: MLTSS provider contracts and subcontracts – The Contractor shall include the MLTSS Any Willing Provider (AWP) and contract term period provisions as necessary and as detailed at 4.8.1M. The Contractor shall contract with all MLTSS provider types listed in the MLTSS Services Dictionary (see Appendix B.9.0) and include all required provider specification requirements. These include, but are not necessarily limited to: 1. Nursing Facility - The Contractor shall include in Custodial and Rehabilitation facility contracts, a notice requirement for the facility/provider to contact the Contractor prior to or within 24 hours of admission for authorization of care. 2. Adult Family Care a. Licensed Adult Family Care Sponsored Agency (AFC) – licensed by HFEL (Health Facilities Evaluation and Licensing) 3. Assisted Living Services (ALR, CPCH) – Assisted Living Facility a. Assisted Living Residences (ALR) b. Comprehensive Personal Care Home (CPCH) 4. Assisted Living Program (ALP) 5. TBI Behavioral Management (Group and Individual) 6. Caregiver/Participant Training	

		7. Cognitive Therapy (Group and Individual) 8. Community Residential Services (CRS) 9. Medical Day Services 10. MLTSS PCA a. The Contractor shall, in any Provider contract for personal care services, require that the increase in hourly rate above the hourly rate paid in state fiscal year 2018 be used solely to increase payments to workers who directly provide personal care services consistent with P.L. 2017, c. 239 1. b. The Contractor shall, in any Provider contract for personal care services, inform the Provider that it will be required to report to DMAHS showing compliance with the requirement to increase payments to direct care workers consistent with P.L. 2017, c. 239 2. 11. Occupational Therapy, Physical Therapy, Speech, Language and Hearing Therapy (Group and Individual) 12. Private Duty Nursing (Adult) 13. Specialized Medical Equipment and Supplies and Evaluation 14. Supported Day Services 15. Non-Traditional Provider Contracts –All model contract forms with Non-Traditional providers shall be submitted on a file and use basis thirty (30) days prior to the effective date, and shall comply with all applicable State and federal laws. Services may include: Chore Services, Community Transition Services, Home Based Supportive Care, Home Delivered Meals, Medication Dispensing Devices and Monthly Monitoring, Non-Medical Transportation; Personal Emergency Response System (PERS) Device, Set Up, and Monitoring, Residential and Vehicle Modifications, Respite, Social Adult Day Care, Structured Day Program.	
AO13*	4.7.4.A	**4.7.4.A** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion. ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.
AO14*	4.7.2.A.11	**4.7.2.A.11** **Report of Accreditation Status** a. Contractor is required to attain NCQA's Health Plan Accreditation and the Health Equity Accreditation by July 1, 2026, and maintain the status throughout the duration of the contract.	▪ Evidence of annual notification to DMAHS of accreditation status, or more frequently if there are any changes in accreditation.

		b. Contractor is required to inform the State, at least annually and upon any change of accreditation, whether it has been accredited by a private independent accrediting entity. c. Contractors that have received accreditation by any private independent accrediting entity must authorize the private independent accrediting entity to provide the State a copy of its most recent accreditation review, including: i. Accreditation entity name ii. Accreditation status, survey type, and level (as applicable) iii. Accreditation results, including recommended actions or improvements, corrective action plans, and summaries of findings, and iv. Expiration date of the accreditation. d. Contractors must make the accreditation status available on their Web sites to include: i. Whether the Contractor has been accredited by a private independent accrediting entity ii. the name of the accrediting entity, accreditation program, and accreditation level (as applicable) iii. Update this information annually or more frequently if that are any changes in accreditation.	

Management Information Systems			
2024 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
Sub-heading	3.1.2.A	**3.1.2.A** **Timely Processing** The Contractor shall provide for timely updates and edits for all transactions on a schedule that allows the Contractor to meet the State's performance requirements. At a minimum, this shall include the following:	
IS1	3.1.2.A.1	**3.1.2.A.1** Enrollee and provider file updates to be daily;	▪ Sample Reports ▪ Daily Updated Enrollee Files Report ▪ Policies and Procedures addressing the following: ➢ Frequency of Enrollee and Provider File Updates
IS2	3.1.2.A.2	**3.1.2.A.2** Reference file updates to be at least weekly or as needed;	▪ Sample Reports

			▪ Policies and Procedures addressing the following: ➢ Frequency of Reference File Updates
IS3	3.1.2.A.3	**3.1.2.A.3** Prior authorizations and referral updates to be daily;	▪ Sample Pre-Service Request Turn-around Time Reports ▪ Sample Pre-Service Request Reports ▪ Policies and Procedures addressing the following: ➢ Frequency of Prior Authorization and Referral Updates
IS4	3.1.2.A.4	**3.1.2.A.4** Claims and encounters to be processed (entered and edited) daily;	▪ Paid, Incurred, and Pended Claims Reports ▪ Policies and Procedures addressing the following: ➢ Frequency of Claims and Encounters Processing
IS5	3.1.2.A.5	**3.1.2.A.5** Claim payments to be at a minimum biweekly except as necessary to meet the requirements in Article 7.16.5	▪ Example of Provider Remittance Inventory with receipt date ▪ Policies and Procedures addressing the following: ➢ Claims Processing
IS6	3.1.2.A.6	**3.1.2.A.6** Capitation payments to be monthly	▪ Policies and Procedures addressing the following: ➢ Capitation Payment Processing ➢ Check Register Lists
IS7	3.1.3.A	**3.1.3.A** **Regular Reporting** The Contractor's system shall provide sufficient reports to meet the requirements of this contract as well as to support the efficient and effective operation of its business functions. The required reports, including time frames and format requirements, are in Section A of the Appendices.	▪ Master Report Schedule ▪ Compliance Tracking Documents
IS8	3.1.3.B	**3.1.3.B** **Ad Hoc Reporting** The Contractor shall have the capability to support ad hoc reporting requests, at no additional cost, in addition to those listed in this contract, both from its own organization and from the State in a reasonable time frame. The time frame for submission of the report will be determined by DMAHS with input from the Contractor based on the nature of the report. DMAHS shall at its option request six (6) to eight (8) reports per year, hardcopy or electronic reports and/or file extracts. This does not preclude or prevent DMAHS from requiring, or the Contractor from	▪ Information System (IS) Data Reporting Request Form ▪ Sample of Ad Hoc Reports ▪ IS Vendor Request Form ▪ Provider Data Reporting Request Form

		providing, additional reports, at no additional cost, that are required by State or federal governmental entities or any court of competent jurisdiction.	
IS9	3.7.1.A 3.7.1.A.3	**3.7.1.A** The system shall provide data to assist in the definition and establishment of Contractor performance measurement standards, norms and service criteria. **3.7.1.A.3** It should maintain data for medical, behavioral, dental and MLTSS assessments and evaluations.	▪ Sample Performance Reports ▪ HEDIS® Reports ▪ MLTSS assessment and evaluation reports
IS10	3.7.1.A.7	**3.7.1.A.7** Reports should facilitate at a minimum monthly tracking and trending of enrollee care issues to monitor and assess Contractor and provider performance and services provided to enrollees.	▪ Policies and Procedures addressing the following: ➢ Tracking and Trending ➢ Monthly Tracking Reports such as: ➢ Quality of Care/Service ➢ Grievances ➢ Utilization of Services ➢ Access and Availability
IS11	3.8	**3.8** The MCMIS shall have a comprehensive reporting capability to support the reporting requirements of this contract and the management needs for all of the Contractor operations.	▪ Grievance Reports ▪ Pended Claims Reports ▪ Quality Reports ▪ Sample of canned reports such as: ▪ Member grievance report ▪ Monthly dashboard reports ▪ Monthly pended claims report
IS12	3.8.1.D	**3.8.1.D** The Contractor shall acquire the capability to receive and transmit data in a secure manner electronically to and from the State's data centers, which are operated by OIT. The standard data transfer software that OIT utilizes for electronic data exchange is Connect: Direct. Both mainframe and PC versions are available. A dedicated line is preferred, but at a minimum connectivity software can be used for the connection.	▪ Flowchart of Network Process ▪ Data Transfer Procedure ▪ A Screen Print of Logins ▪ Confirmation correspondence from DMAHS showing receipt of electronically submitted data
IS13	3.1.2.F	**3.1.2.F** If the Contractor uses different systems or engages in a delegated or sub-contracting arrangement for physical health, behavioral health and/or long-term services and supports, these systems shall be interoperable with non-delegated systems. In addition, the Contractor shall have the capability to integrate data from the different systems and maintain audit trails of all historical documents and electronic record changes.	▪ Flowchart showing integration of data from delegated entities ▪ Demonstration of plan access to delegated services
IS14***	3.1.2.G	**3.1.2.G**	▪ Demonstration of document management for MLTSS

		The Contractor shall ensure that images of documents used by Members and providers to support Care Management processes are indexed and maintain logical relationships to certain key data such as Member identification and provider identification number.	▪ Review of MLTSS CM system
IS15**	3.1.2.I	**3.1.2.I** The Contractor's system shall be able to electronically track, store and share real-time the end- to-end data necessary to complete MLTSS Care Management processes for enrollees receiving long term services and supports including but not limited to, systems alerts for changes related to identification of potential members and the referral date of MLTSS clinical eligibility evaluation, MLTSS status, financial data, clinical eligibility status, NJ Choice assessment system assessment data, and plan of care data. See Article 9.2 for additional detail on the Member's electronic Care Management record.	▪ System documentation regarding tracking of alerts ▪ Integration of new enrollees in MLTSS system ▪ Reporting of potential MLTSS members ▪ Review of MLTSS system onsite
IS16	3.1.2.J	**3.1.2.J** The Contractor's system shall support the standardized collection of data in a consistent format to facilitate easy retrieval for purposes of tracking, trending and reporting information to the State and for internal quality improvement initiatives down to the Member level. If the Contractor's integrated systems include other lines of business, (e.g. Medicare or commercial insurance, or Fully Integrated Dual Eligible (FIDE) SNP) or business in other states, those systems must have the capability to segregate the information by state and product line to allow for direct viewing of all Medicaid/NJ FamilyCare information by the State and/or its vendors.	▪ Documentation relating to capability of separating NJ specific LOBs ▪ Demonstration of electronic access to NJ CM, UM, Claims, Grievances for NJ DMAHS staff and their representatives ▪ Security documents/policies related to access to NJ LOB data
IS17**	3.1.2.K	**3.1.2.K** The Contractor's system shall include a means for the MLTSS Care Manager to ensure that home and community based services were provided as scheduled or the back-up plan was instituted immediately when necessary. This shall include either notification from providers or Service Delivery Verification according to State monitoring protocol to ensure services are delivered per the member's plan of care.	▪ Reports of services rendered to MLTSS members ▪ Flowchart on MLTSS reporting ▪ Demonstration of real time access to service data
IS18*	4.7.4.A	**4.7.4.A** **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** A. The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion. ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.

2024 Core Medicaid Care Management Document Submission Guide

Appendix H2

Care Management and Continuity of Care			
2024 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CM1	4.5.1.B.1 4.5.1.B.7	**4.5.1.B.1** Identification and Service Delivery. The Contractor shall have in place all the following to identify and serve Enrollees with special needs: 1. Methods for identifying persons at risk of or having special needs who should be referred for a Comprehensive Needs Assessment. See Care Management Workbook for information on Comprehensive Needs Assessment. https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or https://www.state.nj.us/humanservices/dmahs/news/Care Management_Workbook.pdf This includes review of hospital and pharmacy utilization and policies and procedures for providers or, where applicable, authorized persons, to make referrals of assessment candidates and for Enrollees to self-refer for a Comprehensive Needs Assessment. **4.5.1.B.7** In addition to the standards set forth in this Article, the Contractor shall make all reasonable efforts and accommodations to ensure that services provided to Enrollees with special needs are equal in quality and accessibility to those provided to all other Enrollees.	▪ Policies and Procedures addressing the following: ➢ Enrollee with Special Needs ▪ Special Needs Care Management Referral Process ▪ Adult Complex Needs Assessment Form ▪ Pediatric Complex Needs Assessment Form ▪ New Enrollees Welcome Call Scripts ▪ Special Needs Enrollees Report ▪ Utilization of Services by Membership Category Comparison Analysis ▪ Internal Audits
CM2	4.6.2.J	**4.6.2.J** **Discharge Planning** The Contractor shall have procedures to ensure adequate and appropriate discharge planning, and to include Coordination of Services for Enrollees with special needs.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be included in the determination of the results for this element.** ▪ Policies and Procedures addressing the following: ➢ Discharge Planning ➢ Continuity and Coordination of Care ➢ Utilization Management ▪ Care Management or Utilization Management Program Description

Sub-heading	4.6.5 4.6.5.A	**4.6.5** The Contractor shall develop and implement Care Management as defined in Article 1 with adequate capacity to provide services to all Enrollees who would benefit from Care Management services. For MLTSS Enrollees, the Contractor shall provide Care Management in accordance with Article 9. **4.6.5.A** Care Management Standards. Through Care Management, the Contractor will identify the needs and risks of Enrollees; identify which services Enrollees are currently receiving; identify Enrollees' unmet needs; stratify Enrollees into care levels; serve as coordinators to link Enrollees to services; and ensure Enrollees receive the appropriate care in the appropriate setting by the appropriate providers. As part of the Care Management process, the Contractor will:	
CM3	4.6.5.A	**4.6.5.A** Apply systems, science, and information to identify Enrollees with potential Care Management needs and assist Enrollees in managing their health care more effectively with the goal of improving, maintaining, or slowing the deterioration of their health status.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be included in the determination of the results for this element.** ▪ Policies and Procedures addressing the following: ➢ Care Management of Enrollees with Special Needs ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Utilization Management/Case Management Program Description ▪ Care Management Desk-Top Procedures ▪ Criteria for Determining Level of Care Management ▪ Initial Health Screen (IHS) tool ▪ Comprehensive Needs Assessment (CNA) ▪ Components used for identification of Enrollees with Care Management needs
CM4	4.6.5.A	**4.6.5.A** Design and implement Care Management programs and services that are dynamic and change as Enrollees' needs or circumstances change.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be included in the determination of the results for this element.** ▪ Policies and Procedures addressing the following: ➢ Care Management ➢ Transitions of Care ➢ Care Management Continuity and Coordination ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Comprehensive Needs Assessment (CNA)

			▪ Initial Health Screen (IHS) tool ▪ Care Plan
CM5	4.6.5.A	**4.6.5.A** Use a multi-disciplinary team to manage the care of Enrollees needing Care Management. While Care Management may be performed by one qualified health professional (a nurse, social worker, physician, or other professional), the process will involve coordinating with different types of health services provided by multiple providers in all care settings, including the home, clinic and hospital. Refer to Care Management Workbook at NJMMIS.com https://www.njmmis.com/documentDownload.aspx?document=CareManagementWorkbook.pdf or http://www.state.nj.us/humanservices/dmahs/news/Care_Management_Workbook.pdf for Care Management Framework, Standards, Definitions and Tools.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be included in the determination of the results for this element.** ▪ Policies and Procedures addressing the following: ➢ Care Management Continuity and Coordination of Care ➢ Transitions in Care ▪ Initial Health Screen (IHS) tool ▪ CM Continuity and Coordination of Care Policy ▪ Transitions in Care Policy ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Comprehensive Needs Assessment (CNA) ▪ Organizational chart for Care Management ▪ Resumes for the Care Management team
Sub-heading	4.6.5.B	**4.6.5.B** Components of Care Management. Care Management is a comprehensive, holistic, and dynamic process that encompasses the following seven components:	
CM6	4.6.5.B.1	**4.6.5.B.1** **Identification of Enrollees Who Need Care Management** The MCO must have effective systems, policies, procedures, and practices in place to identify any Enrollee in need of Care Management services. All new Enrollees, including Enrollees who were disenrolled from the MCO for at least six (6) months, (except for DCP&P Enrollees, any Enrollee designated IDD/DD receiving services from DCF or DDD) will be screened using an approved Initial Health Screen tool (IHS) to quickly identify their immediate physical and/or behavioral health care needs, as well as the need for more extensive screening. Any Enrollee identified as having potential Care Management needs will receive a detailed Comprehensive Needs Assessment (if deemed necessary by a healthcare professional), with ongoing care coordination and management as appropriate. All elements of the State approved IHS tool that appear in the Care Management Workbook must be included in the MCOs' screening tool.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be included in the determination of the results for this element.** ▪ Policies and Procedures addressing the following: ➢ Identification of Enrollees in need of Care Management services ➢ Use of approved Initial Health Screen (IHS) ➢ Comprehensive Needs Assessment (CNA) for extensive screening when necessary ➢ Care Management Continuity and Coordination of Care ▪ Transitions of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Referral Process Flowcharts ▪ Provider input as part of care coordination across the multi-disciplinary team ▪ Unable to Reach Process

			▪ Reports documenting outreach efforts and results for completion of the IHS for new Enrollees
CM7	4.6.5.B.2	**4.6.5.B.2** **Comprehensive Needs Assessment (CNA)** The MCO will conduct an approved CNA on new Enrollees, following the evaluation by a healthcare professional of their Initial Health Screen results; any Enrollee identified as having potential Care Management needs; as well as DCP&P Enrollees and any Enrollee designated IDD/DD receiving services from DCF or DDD. The goal of the CNA is to identify an Enrollee's Care Management needs in order to determine an Enrollee's level of care and develop a Care Plan. The CNA will be conducted by a healthcare professional, either telephonically or face-to-face, depending on the Enrollee's needs. All elements of the State approved CNA tool that appears in the Care Management Workbook must be included in the MCOs' assessment tool.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be included in the determination of the results for this element.** ▪ Policies and Procedures addressing the following: ➢ Care Management ➢ Use of the Comprehensive Needs Assessment (CNA) Care Management Continuity and Coordination of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Flowcharts ▪ Unable to Reach Process ▪ Referral Process across multi-disciplinary team Reports showing outreach to Enrollees identified for CNA and completion results
CM8	4.6.5.B.3	**4.6.5.B.3** **Plan of Care to Address Needs Identified** Care Plan: Based on the CNA, the Care Manager will assign Enrollees to a care level, develop a Care Plan and facilitate and coordinate the care of each Enrollee according to his/her needs or circumstances. With input from the Enrollee and/or caregiver and PCP, the Care Manager must jointly create a Care Plan with short/long-term Care Management goals, specific actionable objectives, and measurable quality outcomes. The Care Plan should be culturally appropriate and consistent with the abilities and desires of the Enrollee and/or caregiver. Understanding that Enrollees' care needs and circumstances change, the Care Manager must continually evaluate the Care Plan to update and/or change it to accurately reflect the Enrollee's needs and level of care.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be included in the determination of the results for this element.** ▪ Policies and Procedures addressing the following: ➢ Care Management Continuity and Coordination of Care ➢ Transitions of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Flowchart ▪ Sample Care Plan(s) ▪ Care Management Program Evaluation
CM9	4.6.5.B.4	**4.6.5.B.4** **Implementation of Care Plan** The Care Manager shall be responsible for executing the linkages and monitoring the provision of needed services identified in the Care Plan. This includes making referrals, coordinating care, promoting communication, ensuring Continuity of Care, and conducting follow-up. Care Management activities may be conducted telephonically, electronically or face-to-face, depending on the Enrollee's identified	▪ Policies and Procedures addressing the following: ➢ Mechanisms for Enrollees and/or caregivers, their families and healthcare providers to be actively involved in developing the Care Plan ➢ Care Management Program Guidelines ➢ Care Management Continuity and Coordination of Care ➢ Transitions of Care ▪ Care Management Program Description

		needs and level of care. Implementation of the Enrollee's Care Plan should enhance his/her health literacy while being considerate of the Enrollee's overall capacity to learn and (to the extent possible) assist the Enrollee to become self-directed and compliant with his/her healthcare regimen.	▪ Community Based Care Management Description ▪ Care Management Flowchart Sample Care Plan(s) ▪ Care Management Program Evaluation ▪ Interventions to execute the Care Plan ▪ Care Manager job description ▪ Care Manager training ▪ Evidence of oversight of Care Manager performance
CM10	4.6.5.B.5	**4.6.5.B.5** **Analysis of Care Plan Effectiveness and Appropriateness** Each Enrollee with Care Management needs must have a Care Plan to address his/her individual health related needs that when successfully implemented, assists him/her to reach their optimal level of wellness and self-direction. The MCO will develop a process that is reflected in its policies and procedures to regularly review the Care Plan to analyze its effectiveness in reaching the stated goals and desired outcomes. The Care Manager will provide feedback of the analysis to the Enrollee/caregiver, primary care physician, and other healthcare professionals involved in the Enrollee's care.	▪ Policies and Procedures addressing the following: ➢ Care Plan analysis and evaluation ▪ Care Management ▪ Continuity and Coordination ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Monitoring Process and Reports ▪ Sample of reports to provide feedback to Enrollee/caregiver and healthcare professionals
CM11	4.6.5.B.6	**4.6.5.B.6** **Modify Care Plan Based on Analysis** Following analysis, the Care Manager will modify the strategies outlined in the Care Plan to achieve its stated goals and desired outcomes. The strategies must reflect any new information received, the Enrollee's current circumstances and healthcare status, and remain consistent with the abilities, desires and level of self-direction of the Enrollee and/or caregiver.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be included in the determination of the results for this element.** ▪ Policies and Procedures addressing the following: ➢ Care Plan Analysis, Evaluation and Modification Strategies ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Program Evaluation ▪ Initial Health Screen (IHS) ▪ Comprehensive Needs Assessment (CNA) ▪ Samples of modified Care Plans
CM12	4.6.5.B.7	**4.6.5.B.7** **Monitoring Outcomes of Care/Case Management Process** The effectiveness of the Care and Case Management process will be measured by the review and analysis of Enrollee outcomes. The MCO must develop policies and procedures that describe protocols detailing how they will collect and submit population based data measures to DMAHS annually for review. State approved measures will be used to monitor success based on pre-determined scoring benchmarks.	▪ Policies and Procedures addressing the following: ➢ Protocols to collect and submit population based data measurement ➢ Protocols that evaluate Enrollee needs on a continual basis ▪ Evaluation of Enrollee outcomes ▪ Care Management Monitoring Components ▪ Annual Report Submission ▪ Care Management Program Description ▪ Community Based Care Management Description

			▪ Care Management Program Evaluation ▪ Monitoring Process and Reports ▪ Actions to address any identified deficiencies
CM13	4.6.5.C	**4.6.5.C** **Referrals** The Contractor shall have policies and procedures to respond to Care Management referrals from network providers, state agencies, private agencies under contract with DDD, self-referrals, or, where applicable, referrals from an authorized person in a timely manner, but not to exceed two (2) business days.	▪ Policies and Procedures addressing the following: ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Desk-Top Procedures ▪ Monitoring Procedures ▪ Audit results and actions taken based on identified deficiencies
CM14	4.6.2.O	**4.6.2.O** **Continuity of Care** The Contractor's Quality Management Plan shall include a continuity of care system including a mechanism for tracking issues over time with an emphasis on improving health outcomes, as well as preventive services and maintenance of function for Enrollees with special needs.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be included in the determination of the results for this element.** ▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ▪ Examples of Care Management Tracking Reports ▪ Improvement Efforts based on findings ▪ Care Management Program Description ▪ QI Program Evaluation
CM15	4.6.5.D.1	**4.6.5.D.1** The Contractor shall establish and operate a system to assure that a comprehensive treatment plan for every Enrollee will progress to completion in a timely manner without unreasonable interruption.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be included in the determination of the results for this element.** ▪ Policies and Procedures addressing the following: ➢ Care Management of Persons with Special Needs ➢ Appointment Scheduling Assistance ➢ Enrollee Notification of Provider's Termination ➢ Provider Termination ▪ Care Management Program Description ▪ Community Based Care Management Description
CM16	4.6.5.D.2	**4.6.5.D.2** The Contractor shall construct and maintain policies and procedures to ensure Continuity of Care by each provider in its network.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be included in the determination of the results for this element.** ▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ➢ Enrollee Notification of Provider's Termination ➢ Provider Termination ▪ Care Management Program Description

			▪ Community Based Care Management Description
CM17	4.6.5.D.3	**4.6.5.D.3** An Enrollee shall not suffer unreasonable interruption of his/her active treatment plan. Any interruptions beyond the control of the provider will not be deemed a violation of this requirement.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be included in the determination of the results for this element.** ▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ➢ Provider Termination ➢ Enrollee Notification of Provider's Termination ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Redacted Enrollee Provider Termination Notification Letters ▪ Monitoring Reports
CM18a	4.6.5.D.4	**4.6.5.D.4** If a change in Contractor or Fee-for-Service enrollment occurs, approved dental services on an active prior authorization will be honored with a new prior authorization for the services given by the Contractor of new enrollment even if the services have not been initiated unless there is a change in the treatment plan by the treating dentist. This prior authorization shall be honored for as long as it is active, or for a period of six months, whichever is longer. If the prior authorization has expired, a new request for prior authorization will be required.	▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ▪ Care Management Program Description ▪ Community Based Care Management Description
CM18c	4.6.5.D.7	**4.6.5.D.7** If a change in Contractor or Fee-for-Service enrollment occurs, approved Behavioral Health services with an active authorization shall be honored for sixty (60) days unless there is a change in treatment plan.	▪ Policies and Procedures addressing the following: ➢ Continuity and Coordination of Care ▪ Care Management Program Description ▪ Behavioral Health Policy ➢ Plan of Care Policy ➢ MCO to MCO Transfer Policy
CM18d	4.6.5.D.8	**4.6.5.D.8** If an Enrollee has already had a medical or dental treatment procedure initiated prior to his/her enrollment in the Contractor's plan, the initiating treating provider must complete that procedure (not the entire treatment plan). See 4.1.1.F for details.	▪ Policies and Procedures addressing the following: ➢ Care Management Policy ▪ Care Management Program Description ▪ Community Based Care Management Description ➢ Plan of Care Policy
CM19	4.6.5.E	**4.6.5.E** **Documentation** The Contractor shall document all contacts and linkages to medical and other services in the Enrollee's case files.	**Findings from the file review will be used to verify compliance. Information from the Chart Audit review will be included in the determination of the results for this element.** ▪ Care Management Program Description ▪ Community Based Care Management Description

			▪ Care Management Program Evaluation ▪ Monitoring Process and audit reports ▪ Samples of modified Care Plans ▪ Evaluation of Enrollee's Outcomes
CM20	4.6.5.F	**4.6.5.F** **Informing Providers** The Contractor shall inform its PCPs and specialists of the availability of Care Management services and must develop protocols describing how providers will coordinate services with the Care Managers.	▪ Policies and Procedures addressing the following: ➢ PCPs Responsibilities ➢ Continuity and Coordination of Care ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Provider Handbook
CM21	4.6.5.G	**4.6.5.G** **Care Managers** The Contractor shall establish a distinct Care Management function within the Contractor's plan. This function shall be overseen by a Care Management Supervisor, as described in Article 7.3. Care Managers shall be dedicated to providing Care Management and may be employees or contracted agents of the Contractor. The Care Manager, in conjunction with and with approval from, the Enrollee's PCP, shall make referrals to needed services.	Policies and Procedures addressing the following: ➢ Care Management Program Description ➢ Community Based Care Management Description ➢ Organizational chart for Care Management ➢ Resumes for the Care Management team
CM22	4.6.5.H	**4.6.5.H** **Notification** The Contractor shall provide written notification and contact information to the Enrollee, or authorized person, of the name of the Care Manager as soon as the Care Plan is completed.	▪ Policies and Procedures addressing the following: ➢ Transitions of Care ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Care Management Flowchart ▪ Sample Care Plan(s) ▪ Care Management Program Evaluation ▪ Sample notification letters
Sub-heading	4.6.5. I	**4.6.5.I** Level of Service	
CM23	4.6.5.I.2 4.6.5. L	**4.6.5.I.2** The Contractor shall have a mechanism to allow for changing levels of Care Management as needs change. **4.6.5.L** Enrollees shall have the right to decline Care Management services; however, such refusal does not preclude the Contractor from managing the Enrollee's care.	▪ Policies and Procedures addressing the following: ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Monitoring Procedures ▪ Sample Care Plan ▪ Audit results and actions taken based on identified deficiencies

CM24	4.6.5.I.3	**4.6.5.I.3** At the time of enrollment, the Contractor shall place all children, who are under DCP&P/DCF, into its Care Management program at a higher level of care initially. The Contractor may manage the Enrollee at a lower level of care, after assessment and coordination of needed services and stability are determined by the Contractor with input from the PCP, Contractor's Care Managers, and medical director, DCP&P/DCF case worker or authorized representative.	▪ Policies and Procedures addressing the following: ➢ Care Management ▪ Care Management Program Description ▪ Community Based Care Management Description ▪ Monitoring Procedures ▪ Audit results and actions taken based on identified deficiencies
CM25	4.6.5.K	**4.6.5.K** Care Management shall also be made available to Enrollees who exhibit inappropriate, disruptive or threatening behaviors in a medical practitioner's office when such behaviors may relate to or result from the existence of the Enrollee's special needs.	▪ Policy and Procedures addressing the following: ➢ Enrollees with Special Needs ▪ Special Needs Care Management Referral Process ▪ Adult Complex Needs Assessment Form ▪ Pediatric Complex Needs Assessment Form ▪ Special Needs Enrollees Report ▪ Internal Audits ▪ Provider Manual
CM26	4.6.5.M	**4.6.5.M** **Hours of Service** The Contractor shall make Care Management services available during normal office hours, Monday through Friday.	▪ Policy and Procedures addressing the following: ➢ Care Management Program Description ➢ Community Based Care Management Description ➢ Plan of Care ➢ Back-up Plans, Risk Assessment and/or Risk Agreement
CM27	4.8.2.A	**4.8.2.A** The Contractor shall offer each Enrollee a choice of two (2) or more primary care physicians within the Enrollee's county of residence or only on request by an Enrollee, a PCP outside of their county of residence. Where applicable, this offer can be made to an authorized person. Subject to any limitations in the benefit package, the PCP shall be responsible for overall clinical direction, supervising, coordinating, managing the Enrollee's health care, providing initial and primary care to each Enrollee, for initiating referrals for specialty care, and other medically necessary services, both in network and out of network, maintaining continuity of each Enrollee's health care and maintaining the Enrollee's comprehensive medical record which includes documentation of all services provided to the Enrollee by the PCP, as well as any specialty or referral services, and serve as a central point of integration and coordination of covered services listed in Article 4.1. The Contractor shall establish policies and procedures to ensure that PCPs are adequately notified of specialty and referral services. PCPs who	▪ Policies and Procedures addressing the following: ➢ PCP Responsibilities ➢ Non-Participating Providers ▪ Provider Manual ▪ PCP Provider Participating Agreement (Contract) ▪ Quality Improvement Program Description

		provide professional inpatient services to the Contractor's Enrollees shall have admitting and treatment privileges in a minimum of one general acute care hospital that is under subcontract with the Contractor and is located within the Contractor's service area. The PCP shall be an individual, not a facility, group or association of persons, although he/she may practice in a facility, group or clinic setting.	
CM37	4.7.4.A	4.7.4.A **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion. ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.

New Jersey Annual Assessment of MCO Operations
Appendix H3

MLTSS HCBS CM
2024 MLTSS CM Audit Submission Guide

Care Management and Continuity of Care			
2024 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CM18b	4.6.5.D.6 4.1.1.F.1 9.3.3 9.3.3.A 9.3.3.B 9.3.3.C 9.3.3.D 9.3.3.E 9.3.3.F 9.6.6.E 4.1.1.E 9.6.6.F	4.6.5.D.6 If a change in Contractor or Fee for Service enrollment occurs, approved Custodial services with an active authorization shall be honored for sixty (60) days unless there is a change in treatment plan. The new Contractor will visit the Member within forty-five (45) calendar days of the Enrollee's enrollment to review existing NJ Choice Assessment (see 4.1.1.F). 4.1.1.F.1 The Contractor shall continue all services authorized under the relinquishing Contractor's plan of care until the new Contractor's Care Manager has conducted a face-to-face assessment and established a new plan of care based on the Member's assessed needs. The new Contractor shall follow the Care Management process outlined in Article 9.6. If a Member resides in a NF, SCNF or community alternative residential setting, the new Contractor shall continue to provide services to the Member in accordance with the level of services approved by the relinquishing Contractor; however, after participating in options counseling the Member may elect to be transitioned to a more integrated community setting, if appropriate.9.3.3	▪ Policies and Procedures addressing the following: ➢ Continuity of Care Policy ➢ MCO to MCO Transfer Policy ▪ Care Management Program Description ▪ Community Based Care Management Description Plan of Care Policy

Care Management and Continuity of Care			
2024 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		The Contractor shall actively assist MLTSS Member transfer from one provider to another. The Contractor shall have policies and procedures for provider transfers that, at a minimum: 9.3.3.A Have a mechanism for allowing a Member to request and be granted a change of provider. 9.3.3.B Notify providers of their role in providing continuity of care for their members in transition. 9.3.3.C Direct the Care Manager to coordinate transfers and ensure a transfer does not create a lapse in services to include NF/SCNF to NF/SCNF Transfer(s); 1.Care Manager shall make telephonic contact with the receiving facility within five (5) business days of placement following a member's transfer, 2.Care Manager shall complete a Face-to-Face visit and update the member's plan of care within forty-five (45) business days of placement. 9.3.3.D Work with the provider that is no longer willing or able to provide services to a Member to cooperate with the Member's Care Manager to facilitate a seamless transition to another provider and continue to provide services to the Member until the Member has been transitioned to the other provider. 9.3.3.E	

Care Management and Continuity of Care			
2024 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		Have a mechanism for information exchange between providers in accordance with termination timeframes outlined in section 4.9.3; and 9.3.3.F. Have a mechanism for ensuring confidentiality as specified in Article 7.38. 9.6.6.E When a Member's enrollment changes to another Contractor, the Care Manager of the relinquishing Contractor shall coordinate the transfer with the receiving Contractor. This includes transferring Care Management records from the prior 12 (twelve) months to the receiving Contractor in accordance with the requirements contained in section 4.1.1.E. 4.1.1.E For full time students attending school and residing out of the country, the Contractor shall not be responsible for health care benefits while the individual is in school. 9.6.6.F The Care Manager shall be responsible for notification to and coordination with all the service providers to assure a thorough discharge planning process including transition to available community services to meet the needs of Members.	

Care Management and Continuity of Care			
2024 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
Sub-heading	4.5.1.A 9.5.1.B	4.5.1.A In addition to the requirements specified in this Article 4.5, for MLTSS Enrollees the Contractor shall comply with the requirements in Article 9. In the event of a conflict between the requirements in this Article 4.5 and Article 9, the requirements in Article 9 shall prevail. New enrollees who have been identified as MLTSS and have received a NJ Choice assessment are exempt from the Comprehensive Needs Assessment requirement. 9.5.1.B MLTSS Care Management Standards General MLTSS Requirements The Contractor shall design its MLTSS Care Management program with the principles of being person-centered, goal-oriented, and culturally relevant to assure that, as a primary goal of the program, Members receive services to meet their identified care needs in a supportive, effective, efficient, timely and cost-neutral manner. The Contractor's Care Management program shall emphasize prevention, health promotion, and continuity and coordination of care which advocates for, and links Members to services as necessary across providers and settings and emphasizes the least restrictive, most integrated setting.	
CM28	9.5.1. D	9.5.1.D Annually, the Contractor shall develop a comprehensive written MLTSS Care Management Program Description and perform an evaluation of the effectiveness of the prior year's MLTSS Care Management program.	▪ Care Management Program Description ▪ Care Management Program Evaluation

Care Management and Continuity of Care			
2024 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CM29	9.5.1.F 9.5.1.G 9.2.2	9.5.1.F The Contractor shall ensure that, upon a Member's entry into the MLTSS program, the Contractor's Care Management activities shall become integrated with MLTSS care coordination processes and functions, and that the Member's assigned MLTSS Care Manager shall assume primary responsibility for coordination of all the Member's physical health, behavioral health, and long-term care needs. 9.5.1.G The Contractor shall have systems in place to facilitate timely communication between internal departments and the Care Manager to ensure that each Care Manager receives all relevant information regarding his/her Members. The Care Manager shall follow up on this information and document as appropriate per the requirements specified in section 9.2.2. 9.2.2 ELECTRONIC CARE MANAGEMENT RECORD STANDARDS A. General Requirements 1. The electronic Member record shall be complete, comprehensive and confidentially maintained in accordance with section 9.2.2B. 2. The Contractor shall maintain the integrity of the electronic Care Management member record documentation and shall ensure the availability of the record through electronic submission and in hard copy. When printed, the Contractor shall ensure each case file page indicates the Member's name and unique identifier; each entry made shall be dated and shall identify the specific Care Manager. 3. The Contractor shall maintain a uniform tracking system for documenting the beginning and end dates and number of units of all	▪ Care Manager job descriptions ▪ Reports to Care Manager ▪ Systems descriptions/diagrams ▪ Electronic MLTSS Care Management record ▪ Evidence that the member is assigned a MLTSS Care Manager who has primary responsibility for the member's physical health, behavioral health, and long-term care needs. ▪ Evidence of the systems that the Contractor has in place to facilitate communication between internal departments and the Care Manager.

Care Management and Continuity of Care			
2024 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		authorized services, as applicable, in each Member's electronic Care Management record.	
CM30	9.5.1.I 9.5.1. J	9.5.1.I The Contractor shall have policies and procedures to address a potentially unsafe environment for Members, providers, and Care Managers, including steps and actions to mitigate the risk of potential harm, while continuing to meet the care needs of the member. 9.5.1.J The Contractor shall have policies and procedures to address urgent or emergent medical and behavioral health conditions that pose a risk to Members, providers, and Care Managers.	▪ Policies and procedures addressing ➢ Identification of risk ➢ Safety ➢ Urgent/Emergent conditions ➢ Procedures to mitigate risk
CM31	9.5.2.A 9.5.2. B	9.5.2.A Individuals hired as Care Managers shall be either: 1. Licensed clinical or licensed certified social worker, N.J.S.A. 45:1-15 or 2. Licensed, registered nurse, N.J.S.A. 45:11-26, or 3. Graduate from an accredited college or university with a bachelor's degree, or higher, in a health related or behavioral science field, with a minimum of one year paid professional experience working directly with the elderly or physically disabled in an institutional or community setting. 9.5.2.B Care Managers shall have knowledge or experience in: 1. Interviewing and assessing Members. 2. Caseload management and casework practices. 3. Human services principles for determining eligibility for benefits and services.	▪ MLTSS Care Management job descriptions used in recruitment. ▪ Organization Chart with CM names ▪ MLTSS CM Staff Qualifications ▪ CM resumes

Care Management and Continuity of Care			
2024 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		4. Ability to effectively solve problems and locate community resources; and 5. The needs and service delivery system for all populations in the Care Manager's caseload.	
CM32	9.5.3.A 9.5.4.A 9.5.4.B	9.5.3.A Training of Care Management Staff A. The Contractor shall develop standardized initial and ongoing quarterly and annual training and education which includes the following components: 1.Training curriculum including topic, goals of training, length, format, materials, prerequisites, and competency standards for each training area 2.Training records for each employee documenting trainings completed, date, competency and remediation actions 3.Quality Assurance program to identify inter/intra-rater reliability and core standards 4.Continuous Quality Assurance monitoring and standards to ensure standards are being met 5.Remediation training plan for employees who do not meet the standards. 9.5.4.A A. Care Managers shall be provided with adequate orientation and ongoing training on subjects relevant to the population served by the Contractor. Documentation of training dates and staff attendance as well as copies of materials used shall be maintained by the Contractor and be made available to DMAHS, or its designee, upon request. 9.5.4.B All MLTSS Care Managers must be NJ Choice certified and able to conduct the NJ Choice Assessment System for initial and re-evaluations.	▪ Curriculum ▪ Training Manuals ▪ Dates of training ▪ Roster of CMs with dates of training and type of training received or report from LMS ▪ Evidence of compliance with all elements under 9.5.3 and 9.5.4

Care Management and Continuity of Care			
2024 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		The Contractor shall submit to DoAS a complete listing of Care Management Training and Education activities scheduled for each calendar month. Reports are due by the 20th day of the month prior to the scheduled training month. The listing shall include the training title, description, instructor, date and time, target audience, and location or mode of delivery.	
CM34	9.5.5. K	9.5.5.K Accessibility of Assigned Care Manager 1. The Contractor shall have written protocols to ensure newly enrolled MLTSS Members are assigned to a Care Manager immediately upon enrollment. 2.Upon enrollment into the MLTSS program the Member shall receive written communication from the Contractor which identifies the assigned Care Manager and provides direct contact information for the Member's assigned Care Manager and direct access to the Care Management department without need to call through the Member Services line. 3. Members and/or Member representatives shall be provided adequate information in an easy to find and easy to read format in order to be able to contact their assigned Care Managers or Contractor office for assistance, including what to do in cases of emergencies and/or after hours. 4. A system of back-up Care Managers shall be in place and any Member who contacts the Contractor when the Member's primary Care Manager is unavailable shall be given the opportunity to be referred to a back-up for assistance.	▪ Samples of information provided to members ▪ Procedures for referral to back-up CMs ▪ Rosters/reports for back-up CMs of upcoming site visits

Care Management and Continuity of Care			
2024 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
		5. There shall be a mechanism to ensure Members, representatives and providers receive a return call within one business day when messages are left for the Care Manager. 6. After Hours: There shall be a mechanism to ensure Members, representative and providers have access to a registered nurse or other qualified and licensed health professional that can review the Member's plan of care and back-up plan and can authorize services to ensure the health and welfare of the Member during times when the Contractor's business office is closed (e.g., holidays, weekends, and overnights).	
CM36	4.6.2.R.2.f.iv 9.10.2. A	4.6.2.R.2.f.iv Reporting of MLTSS-related critical incidents in accordance with Article 9. 9.10.2.A The Contractor shall identify, track, review, and analyze critical incidents to identify and address potential and actual quality of care and or health and safety issues. The Contractor shall regularly review the number and types of incidents (including, for example, the number and type of incidents across settings, providers, and provider types) and findings from investigations; identify trends and patterns; identify opportunities for improvement; and develop and implement strategies to reduce the occurrence of incidents and improve the quality of MLTSS delivery.	▪ Monitoring reports ▪ Policies and procedures addressing ➢ Critical incidents ➢ Quality of care ➢ MLTSS Policies and Procedures ➢ Sample Critical Incident Report ➢ Critical Incident Policy ➢ CI training and educational materials provided to CM Staff and Providers including attendance sheet of all participants
CM37	4.7.4. A	4.7.4. A **INDEPENDENT EXTERNAL QUALITY REVIEW ORGANIZATION REVIEWS** The Contractor shall cooperate with the External Quality Review Organization (EQRO) audits and provide the information requested in the time frames specified, generally within thirty (30) days or as indicated in the notice, including, but not limited to medical and dental records, QAPI reports and documents, and financial information.	▪ Narratives and supporting documentation should be filed within each review element as appropriate. ▪ Documentation should reflect the review period. ▪ Prior CAPs should be addressed to show progress/completion ▪ Supporting documentation should be limited and respond to the specific review element and explanation should be given related to compliance.

Care Management and Continuity of Care			
2024 Element	**Contract Reference**	**Contract Requirement Language**	**Documentation Examples**
CM38	9.4.1.A.4 9.5.1. E	9.4.1.A.4 The process for contacting and changing the Member's Care Manager, including, but not limited to, how and when the Member will be notified of the newly assigned Care Manager is, and the procedure for making changes to the assigned Care Manager, whether initiated by the Contractor or requested by the Member. 9.5.1.E The Contractor shall ensure that assignment of an MLTSS Care Manager to a Member has minimal disruption and re-assignment is limited to ensure continuity of the Member/Care Manager relationship. MLTSS members shall have no more than one change in their assigned primary Care Manager within a calendar year unless the change is due to member relocation, change in Care Manager employment (i.e. termination or leave), requested by member, or any other reason approved by DMAHS. The Contractor shall submit to the state for approval, their initial policy and all revisions that ensures MLTSS member's continuity of care management between care managers and with transition to a new Contractor.	▪ MLTSS Policies and Procedures ▪ Care Management Program ▪ Community Based Care Management Description ▪ Gap in Care Policy ▪ Back –up Plan ▪ Verification of Service Policy ▪ Documentation of back-up Care Manager ▪ Member notification of the back-up Care Manager ▪ Care Manager Assignment Policy

Information System Capabilities Assessment (ISCA) Survey 2024

Information Systems Capabilities Assessment (ISCA) for NJ

Thank you for participating in ISCA survey. Pursuant to the release of the updated EQRO Protocols by CMS in 2023, DMAHS requested IPRO to conduct an Information Systems Capabilities Assessment (ISCA) review in 2024 for all New Jersey MCOs.

MCO's are requested to complete the below ISCA questionnaire.

Please provide details and information if your MCO has different processes, policies and procedures for any product line.

Please complete the entire survey using the unique link shared in email to access. Please complete the ISCA tool no later than March 18, 2024.

At the bottom of the tool, there is an option to 'Save and Return Later'. Please select this option to save all responses during data entry. Do NOT close out the window without saving, as all the data entered will be lost if it is not saved.When 'Save and Return Later' is selected, Redcap will generate a return code. If you do not select "Save and Return Later" your responses will NOT be saved. Please save this return code to revisit the partially filled ISCA tool.The unique link and return code can be shared with staff working on the ISCA tool to access the data in the tool and for data entry. However, it is recommended that no more than one member of staff enter data into the tool simultaneously.To re-open a saved ISCA tool, open the unique link in your web browser and enter the return code.Once all responses have been completed, click on 'Submit'.If you need any help accessing or completing the survey, please send an email to Mdramitinos@ipro.org and TAneja@ipro.org,

MCO Contact Information

Worksheet A.1 Information System Capabilities Assessment (ISCA) Tool Instructions

[Attachment: "ISCA Tool Instructions.docx"]

Worksheet A.1 Information System Capabilities Assessment (ISCA) Tool Acronyms

[Attachment: "Information System Capabilities Assessment - Acronyms.docx"]

MCO Name _____

MCO Contact Name _____

Title _____

Mailing Address _____

Phone Number _____

Email Address _____

Interview Date _____

Type of delivery system (check all that apply)

- ☐ MCO
- ☐ PIHP
- ☐ PAHP
- ☐ Other

Other, Please Specify:

_____
(If Other was selected above)

Programs (please check)

- ☐ Medicaid (Title XIX Only)
- ☐ CHIP (Title XXI only)
- ☐ Medicaid and CHIP
- ☐ FIDE SNP
- ☐ MLTSS
- ☐ Medicaid Expansion
- ☐ Other

Other, Please Specify:

_____
(If Other was selected above)

Requested Documentation

(Provide processes, policies and procedures for all product lines)

Check box if document is attached Requested Document Details
_____ _____ Previous Medicaid Performance Measure Audit Reports If applicable, attach the information system analysis report completed as a part of the MCO's most recent accreditation review or its most recent third party performance measure validation process
_____ _____ Organizational Chart Attach an organizational chart for your MCO. The chart should make clear the relationship among key Individuals/departments responsible for information management, including performance measure reporting.
_____ _____ Data Integration Flow Chart Attach a flowchart that gives an overview of the structure of your management information system. See the example provided in Section II-D. "Integration and Control of Data for Performance Measure Reporting." Be sure to show how all claims, encounter, membership, provider, EHR, and vendor data are integrated for performance measure reporting.
_____ _____ Performance Measure Repository File Structure (if applicable) Attach a complete file structure, file format, and field definitions for the performance measure repository.
_____ _____ Program/Query Language for Performance Measure Repository Reporting (if applicable) Attach full documentation on the software programs or codes used to convert performance measure repository data to performance measures.
_____ _____ Continuous Enrollment Source Code Attach a copy of the source code that you use to calculate continuous enrollment for Medicaid or CHIP enrollees. If no source code is use, then provide the computer program used
_____ _____ Medicaid Member Months Source Code Attach a copy of the source code/computer programs that you use to calculate member months, member years for Medicaid or CHIP enrollees.
_____ _____ Medicaid or CHIP Claims Edits Attach a list of specific edits performed on claims as they are adjudicated with notation of performance timing (pre- or post-payment) and whether they are manual or automated functions.
_____ _____ Statistics on Medicaid or CHIP claims/encounters and other administrative data Attach documentation that explains statistics reported in the ISCA.

Section 1: Background Information

1. Please select your Managed Care Model.

◯ MCO
◯ PIHP
◯ PAHP

2. What year was the MCO incorporated?

_____

3. Enter your average unduplicated member enrollment for the last three years. For each column enter the reference year.

INSURER YEAR 1: 2021 YEAR 2: 2022 YEAR 3: 2023
Privately Insured _____ _____ _____
Medicare _____ _____

_____

Medicaid _____ _____ _____
CHIP _____ _____ _____
FIDE SNP _____ _____ _____
MLTSS _____ _____ _____
Others (specify) _____ _____ _____

4. Has your organization ever undergone a formal information system capability assessment?

◯ Yes
◯ No (GO TO SECTION 2)

4 a. Who performed the assessment?

_____

4 b. When was the assessment completed?

_____

4 c. Please provide a copy of the results of each assessment performed within the past 2 years.

Section 2. Information Systems: Data Processing Procedures & Personnel

These questions attempt to determine the stability and expertise of the information system department. Responses can provide additional insight into the development cycle responses. Outsourcing means using non-employees to get the work done, sometimes off-site, in which case project specification, management, coordination, and acceptance become key success factors. Enter an educated guess if the turnover rate is unknown.

1. What type of system or repository does your organization use to store Medicaid and CHIP claims and encounter data?

_____

2. Is this data system or repository located on-site or located in the cloud?

◯ Onsite (GO TO QUESTION 3)
◯ In the cloud

2a. If in the cloud, which cloud provider hosts the data?

_____

3. How would you characterize this system or repository? Mark all that apply.

- ☐ Relational database management system (DBMS)
- ☐ Network
- ☐ Hierarchical DBMS
- ☐ Flat file
- ☐ Indexed
- ☐ Proprietary
- ☐ Don't know
- ☐ Other

3a. Please specify

_____

4. Into what repository or DBMS(s), if any, do you extract relevant Medicaid or CHIP encounter/claim/enrollment detail for analytic reporting purposes?

_____

5. How would you characterize the repository/DBMS(s)? Mark all that apply.

- ☐ Relational database management system (DBMS)
- ☐ Network
- ☐ Hierarchical DBMS
- ☐ Flat file
- ☐ Indexed
- ☐ Proprietary
- ☐ Don't know
- ☐ Other

5a. Please specify

_____

6. What programming language(s) do you use to create Medicaid/CHIP data extracts or analytic reports?

_____

6a. How many staff are trained and capable of modifying these programs?

_____

7. Do you calculate defect rates for programs?

- ◯ Yes
- ◯ No (GO TO QUESTION 8)

7a. If yes, what methods do you use to calculate the defect rate?

_____

7b. If yes, What was the most recent time period?

_____

7c. If yes, What were the results?

_____

8. Approximately what percentage of your organization's programming work is outsourced?

_____
(Enter %)

9. What is the average years of experience among those staff who perform programming and data analysis in your organization?

_____

10. Approximately how many resources (time, money, etc.) are spent on training per programmer and analysis staff per year?

Number of hours: _____

Dollars spent: $ _____

Other resources (specify): _____

10a. What type of training for programmers is provided?

_____

11. What is the turnover rate for your programming and analysis staff for each of the last 3 years (new staff per year/total staff)?

Year 1 (2021): _____

Year 2 (2022): _____

Year 3 (2023): _____

12. Does your organization follow a standard software development methodology (SDLCM - Software Development Life Cycle Model)?

◯ Yes
◯ No (GO TO QUESTION 13)

12a. Outline the steps of the maintenance cycle for your state's mandated Medicaid and CHIP reporting requirement(s). Include any tasks related to documentation, debugging, roll out, training, etc. The level of detail should result in 10-25 steps in the outline.

_____

13. Does your organization use version control software for change management and deployment to the production environment?

◯ Yes
◯ No (GO TO QUESTION 14)

13a. If YES, which Product is used?

_____
(Note: The information system department should follow a standardized process when updating and revising code. This process should include safeguards that ensure that the correct version of a program is in use)

13b. Do all programmer and analysis staff and of your systems use this product for development and deployment?

◯ Yes
◯ No

14. How does your organization know if changes to the claims/encounter/enrollment tracking system affect required reporting to the state Medicaid or CHIP program (i.e., what prompts your organization to change these systems)?

_____
(Note: A specific individual within the organization should be responsible for determining the impact of any changes made to the MCO's claims/encounter/enrollment tracking systems. The MCO should have in place a system for triggering information system staff to update the programs.)

15. Who is responsible for your organization meeting the state Medicaid and CHIP reporting requirements? Mark all that apply.

☐ CEO
☐ CFO
☐ COO
☐ CCO
☐ Other

Please specify:

_____

16. Do you have a separate repository for Encounter Data to be submitted to the state?
◯ Yes
◯ No

16a. Please specify.
_____

17. How would you characterize the repository/DBMS(s)? Mark all that apply.
☐ Relational database management system (DBMS)
☐ Network
☐ Hierarchical DBMS
☐ Flat file
☐ Indexed
☐ Proprietary
☐ Don't know
☐ Other

If Other, please specify :
_____

18. HEDIS Repository

18a. Describe your HEDIS Repository
_____

18b. Is your HEDIS repository developed and maintained in-house or by a certified vendor? Please specify NCQA certified vendor if used. What data is stored in-house vs certified vendor repository? Please Describe.
_____

19. For the HEDIS Electronic Clinical Data Systems (ECDS),
The below hierarchy indicates in which order data sources should be extracted for compliance with the measure specifications when quality data elements to support the measure are identified in multiple data sources.

Acceptable sources (in hierarchical order):
1. Electronic health record (EHR)/personal health record (PHR)
2. Health information exchange (HIE)/clinical registry
3. Case management registry
4. Administrative (i.e. claims)

In the below table please check the data sources used and specify the hierarchy order (number 1 to 4) that you use for ECDS measure.

Data Sources Check for Data element Enter Order
Electronic health record (EHR)/personal health record (PHR) _____ _____
Health information exchange (HIE)/clinical registry _____ _____
Case management registry _____ _____
Administrative (i.e. claims) _____ _____

20. For the Race and Ethnicity values and required categories below reported to NCQA, Please specify which data sources (Direct data/Indirect data/Other) are used?

Race Reported to NCQA As reported to NCQA: Category Reported Direct/Indirect/Other Data Sources
'1' - White _____ _____
'2' - Black or African American _____ _____
'3' - American Indian and Alaska Native _____ _____
'4' - Asian _____ _____
'5' - Native Hawaiian and Other Pacific Islander _____ _____
'6' - Some Other Race _____ _____
'7' - Two or More Races _____ _____
'8' - Asked but No Answer _____ _____
'9' - Unknown _____ _____
Ethnicity Reported to NCQA As reported to NCQA: Category Reported Direct/Indirect/Other Data Sources
'1' - Hispanic/Latino _____ _____
'2' - Not Hispanic/Latino _____ _____
'3' - Asked but No Answer _____ _____
'4' - Unknown _____ _____

21. What methods did your MCO use in HEDIS MY2022 to stratify race and ethnicity data?

_____

22. What methods does your MCO intend to use in HEDIS MY2023 to stratify race and ethnicity data?

_____

Section 3. Staffing

1. Describe the Medicaid or CHIP data processing organization in terms of staffing and the expected productivity goals. What is the overall daily, monthly, and annual productivity of the overall department and by processor?

_____

(Note: Unusually high productivity goals can affect the accuracy and quality of a processor's work.)

2. Describe processor training from new hire to refresher courses for seasoned processors.

_____

(Note: New hires should be provided with on-the-job training and supervision. Supervisors should closely audit the work of new hires before concluding the training process. Seasoned processors should have occasional refresher courses and training concerning any system modifications.)

Section 4. Security

1. Does your organization have a disaster recovery (DR) plan and DR system?

◯ Yes
◯ No (GO TO QUESTION 3a)

2. Where is the DR system located?

_____

3. Does it provide failover capability?

_____

3a. Please provide Vendor DR site details, if applicable

_____

4. How long does it take to switch over to the DR system when the primary system fails?

5. How often is the DR system tested?

_____

6. How frequently are system backups performed?

_____

7. Where are backup data stored?

8. How and how often are the backups tested to make sure that the backup procedure is functioning properly?

9. How is Medicaid or CHIP data corruption prevented due to system failure or program error?
(Note: A back-up procedure will protect the data from destruction due to system failure and program error. MCOs can also institute additional safeguards to protect data from being written over during these processes.)

10. Describe the controls used to assure that all Medicaid and CHIP claims data entered into the system are fully accounted for (i.e., batch control sheets).
(Note: MCO should have a process in place that ensures that all claims/encounters that have been logged as received are entered into the system and processed.)

11. Describe the provisions in place for physical security of the computer system and manual files:

Premises:

Documents:

Computer facilities:

Desktops, laptops and mobile devices:
(Note: The system should be protected from both unauthorized usage and accidental damage. Paper based claims/encounters should be in locked storage facilities when not in use. The computer system and terminals should be protected from unauthorized access using a password system and security screens. Passwords should be changed frequently and should be re-set whenever an employee terminates.)

12. Describe the steps taken to verify that the MCO's information system processes for protecting PHI, including its encryption methods, are compliant with Federal Information Processing Standards Publication (FIPS) 140-2.

(for more information on the FIPS 140-2 process and validation list, please review the FIPS 140-2 related documents at https://www.hhs.gov/sites/default/files/ocr/privacy/hipaa/administrative/securityrule/fips1402.pdf?language=es)

12a. Provide the results of the most recent FIPS 140-2 tests completed on the MCO's information system.

13. Describe the procedures in place to determine which system users may access levels of the system that include PII. Please identify the job titles and responsibilities of each system user with access to systems that include PII.

14. Describe the methods in place to allow those with access to PII to only access the minimum amount of information necessary to perform their job.

15. Identify training and awareness provided to personnel (system owners, managers, operators, contractors and/or program managers) using the system to make them aware of their responsibilities for protecting the information being collected and maintained.

16. Describe the process and guidelines in place with regard to the retention and destruction of PII.

17. Describe, briefly but with specificity, how the PII will be secured in the system using administrative, technical, and physical controls.

18. If you employ cloud-based technology, describe the provisions in place to secure the virtual system.

19. If you utilize remote network access to connect users with the MCO's secure networks via the internet, describe the provisions in place to secure the network against unauthorized access.

20. Which staff position(s) is responsible for the security and user administration task that grants access to the system?

21. Which staff positions have access to what levels of the system?

22. Can your programming and analysis staff access the production system or only the development system?

◯ Production System Only
◯ Development System Only

23. How often must passwords be changed?

_____

24. How quickly are logons deactivated after employee terminations and resignations?

_____

25. Describe your patch management protocols and processes.

26. What other individuals have access to the computer system? Customers? Providers? Describe their access and the security that is maintained restricting or controlling such access.
(Note: Both members and providers should have their access limited to read-only so that they cannot alter any files. They should be given access to only those files containing their own patients or members. Customers should be prevented from accessing highly confidential patient information by being given "blinded" patient names and "scrambled" ID numbers, or restricted access to particular files.)

Section 5. Data Acquisition Capabilities

The purpose of this section is to obtain a high-level understanding of how you collect and maintain administrative data (claims and encounter data), enrollment information, data on ancillary services such as prescription drugs.

5A. Administrative Data (Claims and Encounter Data)

These questions request information on input data sources (i.e., electronic claims and paper) and on the transaction system(s) you use.

1. How are data submitted (i.e. electronically, on paper or both)?

◯ Submitted Electronically
◯ Submitted on paper
◯ Submitted both on paper and electronically

1a. What percent of data are submitted electronically?

_____
(Provide % value)

1b. What formats are used?

_____

1c. Is there a front-end web portal available for data submissions?

◯ No
◯ Yes

2. Do you use standard claims or encounter forms for the following? Mark yes or no for each data source. If yes, please specify (e.g., CMS1500, UB 94).

Data Source	Yes/No	If Yes, please specify
Hospital	_____	_____
Physician	_____	_____
Drug	_____	_____
Nursing Home	_____	_____
Home Health	_____	_____
Mental Health	_____	_____
Dental	_____	_____

Note: MCOs that do not use either CMS 1500 or UB 92 forms may be using forms they developed themselves. If a MCO is using its own forms, these forms should be reviewed to ensure they are capturing the following key data elements: patient identification information (Medicaid ID, name, date of birth, gender), provider identifying information (national provider identifier (NPI), Tax ID, name), date of service, place of service and diagnoses and procedure codes. An evaluation of their forms to ascertain adequacy and completeness of data collection may be necessary.

3. We would like to understand how claims or encounters are submitted to your MCO. We are also interested in an estimate on an annual basis of what percentage (if any) of services provided to your enrollees by all providers serving your Medicaid and CHIP enrollees are NOT submitted as claims or encounters, and therefore, are not represented in your administrative data. Please fill in the following table with the appropriate percentages:

Claims or Encounter Types

	Medium	Hospital	PCP	Specialist Physician	Dental	Mental health/ substance abuse	Drug	Other
Claims/Encounters submitted electronically	_____	_____	_____	_____	_____	_____	_____	
Claims/Encounters submitted on paper	_____	_____	_____	_____	_____	_____	_____	
Services not submitted as claims or encounters	_____	_____	_____	_____	_____	_____	_____	

Note : Please provide the percentage of claims received electronically, on paper and via the portal.

Since paper forms need to be entered into a MCO's system, processing paper forms is prone to error. If a MCO is receiving more that 50 percent of its data on paper forms, verify the data checks the MCO uses to test processor accuracy. Electronic data submission should also undergo data edits and validity checks. MCOs with a high percentage of unavailable data for a particular category will have difficulty reporting measures that use that category. For example, MCO receiving no drug data from its vendor would not be able to report the HEDIS® measures for Outpatient Drug Utilization.

Please advise what the numbers associated with the Services Not Submitted as claims or encounters indicate._____

3a. For each type of claims or encounter type for which some percentage are not represented in your administrative data, please explain why such activity is not reported.

_____

4. In the following table, please enter an "R" in appropriate cell if the following data elements (data fields) are required by you for providers, for each of the types of Medicaid claims/encounters identified below. Note that each of these elements is required by T-MSIS, and that the MCO's data elements should align with T-MSIS requirements:

Claims or Encounter Types

Medium Hospital PCP Specialist Physician

Dental Mental health/ substance abuse Drug Other
Patient gender _____ _____ _____ _____ _____ _____ _____
Patient date of birth and age

_____ _____ _____ _____ _____ _____ _____
ICD9/10 Diagnosis codes _____ _____ _____ _____ _____ _____ _____
Procedure Code Types:
CPT-4/HCPCS _____ _____ _____ _____ _____ _____ _____
National Drug Code (NDC) _____ _____ _____ _____ _____ _____ _____
Universal Product Code (UPC) _____ _____ _____ _____ _____ _____ _____
Manufacturer Part Number (MPN) _____ _____ _____ _____ _____ _____ _____
First date of service _____ _____ _____ _____ _____ _____ _____
Last date of service _____ _____ _____ _____ _____ _____ _____
Quantity of service _____ _____ _____ _____ _____ _____ _____
Revenue Code _____ _____ _____ _____ _____ _____ _____
Provider NPI _____ _____ _____ _____ _____ _____ _____
Provider Specialty _____ _____ _____ _____ _____ _____ _____

UN, M, or F (UN = the gender of a person could not be uniquely defined as male or female; M = Male; F = Female). Please see AHRQ's Administrative Gender Value Set document at https://ushik.ahrq.gov/ViewItemDetails?&system=mu&itemKey=86667000 for more information.

Standard measures of MCO performance such as Medicaid HEDIS® are dependent upon the availability of the fields listed above. If procedure codes or diagnosis codes are not available, the data will not include the necessary level of detail to report performance measures.

5. In the following table, please enter how many diagnoses (include primary, secondary and all tertiary) and procedures captured on each claim and on each encounter:

	Claim		Encounter	
	Diagnoses	Procedures	Diagnoses	Procedures
Institutional Data	_____	_____	_____	_____
Provider/Provider group data	_____	_____	_____	_____

Note: All diagnosis codes types should be standard, nationally recognized codes, rather than MCO-specific codes. Diagnosis code fields should include all diagnosis codes needed to identify the reason for the encounter, and all relevant comorbidities and complications should be included. Each service rendered or product dispensed should be identified with the appropriate identifier.

6. Can you distinguish between principal and secondary diagnoses?

◯ Yes
◯ No

(Note: Some MCOs will consider the first diagnosis on the claim to be principal. Other MCOs determine the principal diagnosis by selecting the most expensive condition represented.)

6a. If "Yes" to 6, above, How do you distinguish between principal and secondary diagnoses?

_____

7. Please explain what happens if a Medicaid or CHIP claim or encounter is submitted and one or more required fields are missing, incomplete, or invalid. For example, if diagnosis is not coded, is the claims examiner required by the system to use an on-line software product like AutoCoder to determine the correct ICD-10 code?

Institutional Data: _____
Professional Data: _____

_____

8. How is the MCO able to distinguish backend-system-assigned data versus data submitted by the service provider?

_____

9. What steps do you take to verify the accuracy of submitted information (i.e., procedure code, diagnosis edits, gender-diagnosis edits, gender-procedure code edits)?

Institutional Data: _____
Professional Data: _____

_____
(Note: MCOs will often verify that the information in procedure code and diagnosis code fields are valid codes. MCOs may also verify that diagnosis and procedure codes are appropriate for age and gender. For example, a claim with a procedure of hysterectomy should be for a female patient.)

10. Under what circumstances can claims processors change Medicaid or CHIP claims/encounter information?

_____
(Note: If processors are given the ability to modify claims/encounter information, the accuracy of that information could be affected either negatively or positively. Processors may simply correct data that was submitted incorrectly, which would increase the quality of the data. However, processors may also change diagnosis and procedure codes which could result in a loss of coding specificity. Does the MCO check processed data against paper claims?)

11. Identify any instance where the content of a field is intentionally different from the description or intended use of the field. For example, if the dependent's SSN is unknown, do you enter the member's SSN instead?

_____
(Note: Changing the content of a field can create data processing issues. For example, if the enrollee's SSN is used as an ID for a number of dependents, the claim may be given the age and sex of the member rather than the actual patient. The use of the enrollee's SSN would make it difficult to track the dependent's experience over time.)

12. How are Medicaid or CHIP claims/encounters received from each of the following sources? Please mark one column per source:

Note: Intermediaries that are processing the data, such as a pharmacy benefit firm, could modify the data, creating a data set that is inconsistent with the MCO's data. The intermediary may define field content differently or may not be using the same fields as the MCO, making it difficult to integrate the intermediary's data into the MCO's systems. All data submitted through an intermediary should be monitored for quality by the MCO.

	Received directly from Provider	Received through an intermediary
Hospital	◯	◯
Physician	◯	◯
Pharmacy	◯	◯
Nursing Home	◯	◯
Home Health	◯	◯
Mental Health	◯	◯
Dental	◯	◯
Other	◯	◯

12a. If the data are received through an intermediary, what changes, if any, are made to the data? Please answer for each source received through an intermediary in the table above. _____

13. In the following table, please estimate the percentage of Medicaid or CHIP claims/encounters that are coded using the following coding schemes:

Coding Scheme	Inpatient Diagnosis	Inpatient Procedure	Ambulatory/ Outpatient Diagnosis	Ambulatory/ Outpatient Procedure	Drug
ICD - 10 CM	_____	_____	_____	_____	_____
CPT - 4	_____	_____	_____	_____	_____
HCPCS	_____	_____	_____	_____	_____
DSM - IV	_____	_____	_____	_____	_____
National Drug Code	_____	_____	_____	_____	_____
Internally Developed	_____	_____	_____	_____	_____
Other: Specify	_____	_____	_____	_____	_____
Not Required	_____	_____	_____	_____	_____
TOTAL (can be greater than 100% if a claims type is subject to more than one coding system)	_____	_____	_____	_____	_____

Note: If a MCO is using internally-developed coding schemes, the state should verify whether this coding can be mapped to standard coding such as ICD-10 or CPT-4. If the coding can be translated for reporting purposes (Medicaid HEDIS® requires diagnosis and procedure codes), the MCO should provide information on the level of specificity with which the coding maps to standard coding (i.e., three-digit specificity or five-digit specificity). If the mapping has a low level of specificity, information on co-morbidities and complications may not be retained during translation.

14. Please list all information systems through which service and utilization data for the Medicaid or CHIP population is processed. _____

15. Please describe any major systems changes or updates that have taken place in the last three years in your Medicaid or CHIP claims or encounter system (be sure to provide specific dates on which changes were implemented). Check all that apply.

- ☐ New system installed to replace old system
- ☐ New system purchased and installed to replace most of old system; old system still used
- ☐ Major enhancement to old system. If enhancements were made to the old system, please summarize below what enhancements were made and whether (and if so, how) the enhancements have impacted historical data.
- ☐ New product line adjudicated on old system
- ☐ Conversion of a product line from one system to another

(Note: Each upgrade or consolidation of the MCO's information system has the potential to damage the quality of the data. For example, data could be lost or corrupted during a system conversion, or a new system could limit a MCO's access to historical data. Changes in data quality and access will affect the MCO's ability to report performance measures and utilization. The MCO should have a fallback option, such as parallel operations.
When a MCO undertakes any major system changes such as conversion to a new system, the system changes could affect data quality. Data quality problems include corruption of data, loss of data, and loss of the level of detail within the data.
The implementation of a new system can also affect the accessibility of historical data.)

15a. Please summarize what enhancements were made and whether (and if so, how) the enhancements have impacted historical data:

_____

16. How many years of Medicaid or CHIP data are retained on-line?

_____

16a. How is historical Medicaid or CHIP data accessed when needed?

_____

(Note: Due to system constraints, MCO may remove historical data and place it in off-line storage.
The MCO's ability to report on experience spanning several years of data could be affected by the accessibility of the data stored off-line.)

17. What percent of your Medicaid or CHIP data is processed on-line vs. batch? If batch, how often are batch jobs run?

_____

18. Describe your policy regarding Medicaid or CHIP claim/encounter audits.

_____

18a. Are Medicaid or CHIP encounters audited regularly or randomly?

- ◯ Regularly
- ◯ Randomly

18b. What are the standards regarding timeliness of processing in 2023?

_____

(Note: MCOs should be performing random periodic audits of their encounter data to determine the quality of data processing. MCOs that do not perform audits at least annually are not closely monitoring the quality of data processing. MCO standards regarding timeliness of processing will influence the lag time for encounter data processing.)

19. Please describe system edits that are targeted to field content and consistency. Are diagnostic and procedure codes edited for validity?

_____

(Note: MCOs should have an established, standard set of edits that verify field content and consistency. For example, a field content data edit would verify that a valid date is entered into the date of service field. Key fields which should be edited include patient identifying information (Medicaid ID, name, date of birth, sex), provider identifying information (name, tax ID, type), date and place of service, and diagnosis and procedure codes. The quality of diagnosis and procedure coding will affect the validity of reports and performance measures submitted by the MCO/PIHP.)

20. Please complete the following table for Medicaid and CHIP claims and encounter data and other Medicaid and CHIP administrative data.

Item	Claims	Encounters	Other administrative data
Percent of total service volume	_____	_____	_____
Percent Complete	_____	_____	_____

Item	Claims	Encounters	Other administrative data
How are the above statistics quantified?	_____	_____	_____
Incentives for data submission	_____	_____	_____

Note: MCOs with claims data comprising more than 50 percent of their total service volume are likely to have a more complete representation of total MCO experience than MCOs that rely heavily on encounter data. While providers have an incentive to submit claims in order to receive payment for services, they do not always have incentives to submit encounter information. If an MCO does not offer providers an incentive, or does not require the submission of encounter data, the MCO may not receive data for every encounter. Other administrative data collected by an MCO could include data from pharmacy or laboratory vendors.

20. (Ctd.) Attach any documentation that should be reviewed to explain the data that is being submitted.

21. Describe the Medicaid or CHIP claims/encounter suspend ("pend") process including timeliness of reconciling pended services. What percentage of claims are suspended or pended?

_____

(Note: Pended claims/encounters are those claims/encounters that have been suspended during processing because they failed data quality edits or violated provider payment parameters. Information on these claims and encounters will not be available for reporting until they have been reconciled and processed into the system.)

22. Describe how Medicaid or CHIP claims are suspended/pended for medical review, for non-approval due to missing authorization code(s) or for other reasons. What triggers a processor to follow up on "pended" claims? How frequent are these triggers?

_____

(Note: Review and processing should not be handled by the same employee. A system should be in place which encourages the processor to follow-up on the status of claims in review that have not yet been approved to ensure they are resolved.)

23. Are any of your Medicaid or CHIP services/providers capitated?

◯ No
◯ Yes

23a. If yes, have you conducted studies on the completeness of the information collected on capitated services?

_____

23b. If yes, what were the results?

_____

(Note: Because provider payment for capitated services is not determined by the encounter data submitted, providers do not have an incentive to submit complete and accurate information on every service provided. Data on capitated services often does not include the same level of detail as fee-for-service claims information. Per service pricing information may not be available when providers are paid on a capitated basis but at least the amount of the capitation payment should be available. MCOs should be aware that capitated data is less complete and should audit the data at least annually to monitor its quality.)

24. In the following table, enter the claim/encounter system(s) for each product line offered to Medicaid or CHIP enrollees.

	Medicaid Systems Used to Process
Product Line (1)	
Product Line (2)	
Product Line (3)	

Fee-for-service (indemnity) claims _____ _____ _____
Capitated service encounters _____ _____ _____
Clinic patient registrations _____ _____ _____
Pharmacy claims _____ _____ _____
Other (describe) _____ _____ _____

CHIP (if applicable)
Systems used to Process

_____

Product Line (1)

_____

Product Line (2)

_____

Product Line (3)

_____

Fee-for-service (indemnity) _____ _____ _____
Capitated Service Encounters _____ _____ _____
Clinic patient registrations _____ _____ _____
Pharmacy Claims _____ _____ _____
Other (describe) _____ _____ _____

Note: Typically, there is just one product line offered to Medicaid or CHIP enrollees, but there may be some circumstances in which an MCO offers additional product lines to the state (e.g., partial risk products, premium assistance programs).

---

25. Beginning with receipt of a Medicaid or CHIP claim in-house, describe the claim handling, logging, and processes that precede adjudication. Describe the following: When are claims assigned a document control number and logged or scanned into the system? When are claims stored using document imaging? If there is a delay in document imaging, how do processors access a claim that is logged into the system, but is not yet filmed?

_____

25a. Please describe each system or process that is involved in adjudicating:

- A professional encounter(s) for a capitated service (e.g., child immunizations that arrive separately from the office visit)
- A hospital claim for a delivery or for a newborn that exceeds its mother's stay

_____

(Note: Professional encounters arriving separately from an office visit may not be processed as quickly as the actual office visits. If these encounters are treated as "non-standard" events, the MCO may not be able to easily link these encounters with the related office visit. For example, newborns exceeding a mother's stay may have their hospital stay split into two parts. The part of the stay which coincides with the mother's hospitalization may be processed on the mother's claim and the remainder of the stay could be processed separately. Processing the newborn's stay as two separate claims could affect the MCO's ability to report accurately on newborn hospital utilization.)

25b. Discuss which decisions in processing a Medicaid or CHIP claim/encounter are automated, which are prompted by automated messages appearing on the screen, and which are manual. Document the opportunities a processor has for overriding the system manually. Is there a report documenting overrides or "exceptions" generated on each processor and reviewed by the claim supervisor? If so, please describe this report.

_____

25c. Are any outside parties or contractors used to complete adjudication, including but not limited to:

(i). Bill auditors (hospital claims, claims over a certain dollar amount) _____ If yes,please specify: _____
(ii). Peer or Medical reviewers _____ If yes,please specify: _____
(iii). Sources for additional charge data (usual and customary) _____ If yes,please specify: _____
(iv). Bill "re-pricing" for carved out benefits (mental health, substance abuse) _____ If yes,please specify: _____
(v). Other (If yes, please provide additional information) _____ If yes,please specify: _____

25d. How are these data incorporated into your organization's data?

_____

(Note: If outside parties are used, the MCO should be incorporating data generated by those parties into the system. The data should first be run through the MCO's data quality checks to verify its accuracy and completeness.)

25e. Describe the system's editing capabilities that assure that Medicaid and CHIP claims are correctly adjudicated.

- Attach a list of the specific edits that are performed on claims as they are adjudicated, and note (1) whether the edits are performed pre- or post-payment, and (2) which are manual functions and which are automated functions.

_____

(Note: When reviewing MCO adjudication edits, the state should concentrate on edits which affect the data fields that are used to generate MCO performance measures and reports. Are outliers for length of stay and charges edited? Utilizing an automated editing process provides more consistent results that do not require processor judgment. Edits that are performed pre- payment can prevent invalid data from being incorporated into the system.)

25f. Discuss the routine and non-routine (ad hoc or special) audits that are performed on claims/encounters to assure the quality and accuracy and timeliness of processing. In your response, note which audits are performed per processor, which rely on targeted samples, and which use random sampling techniques. What is the total percentage of claims on-hand that are audited through these QA processes? How frequently do these audits occur?

_____

(Note: This item is not relevant in instances where the EQRO is performing encounter data validation. When reviewing edits that are used to determine processor accuracy, consider that these edits will not provide information on the quality of the initial provider data submission. The audit MCO should include random sampling techniques to provide an overall picture of quality. MCOs will often concentrate on auditing complicated or aberrant claims/encounters rather than using a random sample. The MCO should have instituted a process for sharing audit results with the processor to facilitate quality improvement.)

25g. Please describe how Medicaid and CHIP eligibility files are updated, how frequently and who has "change" authority. How and when does Medicaid and CHIP eligibility verification take place?

_____

25h. How are encounters for capitated services handled by payment functions? What message appears to notify processors that they are handling a capitated service?

_____

25i. Describe how your systems and procedures handle validation and payment of Medicaid claims when procedure codes are not provided.

_____

(Note: MCOs requiring valid procedure coding for all claims/encounters will have more detailed data available for reporting and analysis. However, these MCOs may allow processors to supply missing codes using a code book or override the system using an unspecified code. A number of MCOs use programs such as the GMIS AutoCoder product to fill in missing codes. When a MCO supplies missing codes, the coding can be less accurate than codes supplied directly by the provider of service.)

26. Describe all performance monitoring standards for Medicaid and CHIP claims/encounters processing. Provide the results of a recent performance monitoring activity.

_____

26a. How is performance against targets figured into the official performance appraisal process? Into processor and supervisor compensation? _____

27. List all vendors that process claims/encounters and the services covered by a vendor.

Services Covered Vendor Name Contract begin date
Dental _____ _____
Vision _____ _____
Pharmacy _____ _____
Behavioral Health _____ _____
Lab _____ _____
Transportation _____ _____
Other (specify) (1) _____ _____
Other (specify) (2) _____ _____

28. Does your organization submit encounter data directly to CMS T-MSIS?
◯ No
◯ Yes

28a. Describe the encounter data submission process: _____

28b. Which system(s) are used to capture information necessary for T-MSIS reporting? _____

28c. Do you use a vendor to submit data to CMS T-MSIS? _____

28d. How do you ensure that the information is accurate, complete and timely? _____

28e. How do you reconcile the denied encounters and resubmit the corrected encounters? _____

28f. Do you retain records documenting that the T-MSIS reports were submitted? _____

29. Please check all data elements received from providers or from vendors and stored in your MCO's data repository.

	Institutional	Professional	Dental	Pharmacy
CPT	☐	☐	☐	☐
HCPCS	☐	☐	☐	☐

CPT Category II	☐	☐	☐	☐
CDT Codes	☐	☐	☐	☐
Revenue Codes	☐	☐	☐	☐
POS	☐	☐	☐	☐
UB Type of Bill	☐	☐	☐	☐
LOINC Codes	☐	☐	☐	☐
SNOMED Codes	☐	☐	☐	☐
Provider Taxonomy Codes	☐	☐	☐	☐
NDC Codes	☐	☐	☐	☐
ICD-10 CM diagnosis Codes	☐	☐	☐	☐
ICD-10 CM procedure Codes	☐	☐	☐	☐

30. Please provide the max number of codes that are received from providers or vendors and stored in your MCO's data repository .

Type of Codes	Institutional	Professional	Dental	Pharmacy
ICD-10 CM diagnosis Codes	Max codes from providers:_____	Max codes from providers:_____	Max codes from providers:_____	Max codes from providers:_____
ICD-10 CM procedure Codes	Max codes from providers:_____	Max codes from providers:_____	Max codes from providers:_____	Max codes from providers:_____

SECTION 5: B. Enrollment System

1. Please describe any major changes/updates that have taken place in the last three years in your Medicaid or CHIP enrollment data system. Include the specific dates on which changes were implemented. For example:

- New enrollment system purchased and installed to replace old system
- New enrollment system purchased and installed to replace most of old system; is the old system still used?
- Major enhancements to old system; what kinds of enhancements, and what impact on your historical data?
- New product line members stored on old system

_____

(Note: Changes to a MCO's enrollment system requiring data conversion and data integration can create data quality problems. Implementing a new enrollment system could lead to a loss of access to data on the old system, or the assignment of new member numbers for all enrollees. Data conversion and integration can also limit a MCO's ability to track an enrollee's enrollment history. When a new product line is added to an existing system, a MCO may need to make the new data fit the older process, therefore modifying the system to "handle" new information. Implementing such modifications can be difficult for a MCO that has been using the same system for a number of years. The level of enrollment detail retained can be affected by such modifications.)

1a. Enrollment Data: What is the typical volume of records included on the daily exception reports that need to be reviewed and entered manually?

_____

1b. Enrollment Data: Are race and ethnicity values received on the daily 834 file submitted to certified HEDIS vendor for HEDIS reporting?

_____

1c. Enrollment Data: Please describe Vendor's role in processing of Enrollment daily 834 roster files and monthly roster files.	_____
2. In your opinion, have any of these changes influenced, even temporarily, the quality and/or completeness of the Medicaid or CHIP data that are collected? If so, how and when?	_____ (Note: Consider whether changes in data quality will affect the validity of the data submitted to the state.)
3. How does your MCO uniquely identify enrollees?	_____ (Note: Major changes to an MCO's enrollment system could involve the conversion of membership data to a new system. When MCO's convert members, they may change the enrollee's ID number, making it difficult to track the enrollee's enrollment pattern across time. Changes to the enrollment system could also lead to a loss of data for specific patients.)
4. How do you handle enrollee disenrollment and re-enrollment in the Medicaid or CHIP product line? Does the member retain the same ID?	_____ (Note: Enrollees should have a single ID number to facilitate tracking their experience. However, some MCOs change an enrollee's ID number when the enrollee re-enrolls. Experience for enrollees who have switched ID numbers will be more difficult to track. Dependents using an enrollee's ID are also difficult to identify for reporting purposes. For example, children without a unique ID could affect the ability of the MCO to report on low birth-weight babies, childhood immunizations, and asthma inpatient admissions. This is an important point. EQROs should give higher "grades" to MCOs that use strong methods of identifying enrollees.)
5. Can your systems track enrollees who switch from one product line (e.g., Medicaid, commercial, Medicare) to another?	◯ No ◯ Yes
5a. Can you track an enrollee's initial enrollment date with your MCO?	◯ Yes (GO TO QUESTION 5C) ◯ NO
5b. If not, is a new enrollment date assigned when a member enrolls in a new product line?	◯ Yes ◯ No
5c. Can you track and link previous claim/encounter data across product lines?	◯ Yes ◯ No
6. Under what circumstances, if any, can a Medicaid or CHIP member exist under more than one identification number within your MCO's information management systems? Under what circumstances, if any, can a member's identification number change?	_____

7. How does your MCO enroll and track newborns born to an existing Medicaid or CHIP enrollee?

_____

7a. If your MCO has a Medicare product line, describe how your enrollment systems link individuals simultaneously enrolled in both your Medicare product line and the Medicaid product line.

_____

8. Is claim/encounter data linked for Medicare/Medicaid dual eligibles so that all encounter data can be identified for the purposes of performance measure reporting?

◯ Yes
◯ No

8a. Is claim/encounter data linked for individuals enrolled in both a Medicare Advantage Plan and a Medicaid Plan so that all encounter data can be identified for the purposes of performance measure reporting?

◯ Yes
◯ No

9. How often is Medicaid and CHIP enrollment information updated?

_____

(Note: Enrollment information should be updated real-time, daily, or weekly.)

10. How is Medicaid and CHIP continuous enrollment being defined? In particular, does your system have any limitations that preclude you from fully implementing continuous enrollment requirements exactly as specified in the state performance measure requirements?

_____

11. Please attach a copy of the source code that you use to calculate Medicaid/ CHIP continuous enrollment.

12. How do you handle breaks in Medicaid or CHIP enrollment, e.g., situations where a Medicaid enrollee is disenrolled one day and re-enrolled the next simply for administrative reasons? Does this affect your continuous enrollment calculations?

_____

13. Do you have restrictions on when Medicaid or CHIP enrollees can enroll or disenroll? Please describe.

_____

14. How do you identify and count the following:

Medicaid member months?
Medicaid member years?

_____

15. Please list all data from which claims/encounters for the Medicaid or CHIP product line are verified.	_____ (Note: Eligibility of the patient should be verified before claims and encounters are processed. Dates of enrollment and disenrollment are key reporting fields for Medicaid HEDIS® measures. Eligibility status is dynamic for Medicaid beneficiaries and should be updated frequently. Eligibility status should also be verified before data is submitted to the state.)
16. Does the MCO offer vision or pharmacy benefits to its Medicaid or CHIP members that are different from the vision or pharmacy benefits offered to its commercial enrollees (within a given contract or market area)?	◯ Yes ◯ No (GO to SECTION C, ANCILLARY SYSTEMS)
16a. If vision benefits vary by benefit package, outline the different options available. How are enrollees tracked?	_____
16b. If pharmacy benefits vary by benefit package, outline the different options available. How are enrollees tracked?	_____

SECTION 5: C. Ancillary Systems

Use this section to record information on stand-alone systems or benefits provided through subcontracts, such as pharmacy or mental health/substance abuse.

1. For MY2023, does your MCO incorporate data from one or more third-parties to calculate any of the following Medicaid and CHIP quality measures? If so, which measures require third-party data?

Table A.

Measure Measure Submitted Third-Party Data Source
Well-Child Visits in the First 30 Months of Life (W30-CH) _____ _____
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH) _____ _____
Child and Adolescent Well-Care Visits (WCV-CH) _____ _____
Childhood Immunization Status (CIS-CH) _____ _____
Immunizations for Adolescents (IMA-CH) _____ _____
Developmental Screening in the First Three Years of Life (DEV-CH) _____ _____
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH) _____ _____
Chlamydia Screening in Women (CHL-CH) and (CHL-AD) _____ _____
Lead Screening in Children (LSC-CH) _____ _____
Prenatal and Postpartum Care: Timeliness of Prenatal Care and Postpartum Care (PPC-CH) and (PPC-AD) _____ _____
Contraceptive Care - Postpartum Women (CCP-CH) and (CCP-AD) _____ _____
Contraceptive Care - All Women (CCW-CH) and (CCW-AD) _____ _____
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB-CH) and (AAB-AD) _____ _____
Asthma Medication Ratio (AMR-CH) and (AMR-AD) _____ _____
Ambulatory Care: Emergency Department (ED) Visits (AMB-CH) _____ _____
Screening for Depression and Follow-Up Plan: (CDF-CH) and (CDF-AD) _____ _____
Follow-Up After Hospitalization for Mental Illness (FUH-CH) and (FUH-AD) _____ _____
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH) _____ _____
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH) _____ _____
Follow-Up After Emergency Department Visit for Substance Use (FUA-CH) and (FUA-AD) _____ _____
Follow-Up After Emergency Department Visit for Mental Illness (FUM-CH) and (FUM-AD) _____ _____
Oral Evaluation, Dental Services (OEV-CH) _____ _____
Topical Fluoride for Children (TFL-CH) _____ _____
Sealant Receipt on Permanent First Molars (SFM-CH) _____ _____
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD) _____ _____
Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD) _____ _____
Antidepressant Medication Management (AMM-AD) _____ _____
Diabetes Short-Term Complications Admission Rate (PQI01-AD) _____ _____
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD) _____ _____
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (Less Than 9.0%) (HPCMI-AD) _____ _____
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD) _____ _____
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA-AD) _____ _____
Breast Cancer Screening (BCS-AD) _____ _____
Cervical Cancer Screening (CCS-AD) _____ _____
Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD) _____ _____
Concurrent Use of Opioids and Benzodiazepines (COB-AD) _____ _____
Long -Term Services and Supports Comprehensive Care Plan and Update (CPU-AD) _____ _____

Table B. NJ Specific Measures

Measure Measure Sumitted Third-Party Data Source
NJ Preventive Dental Visit (NJD) _____ _____
Multiple Lead Testing in Children through 26 Months of Age (MLT) _____ _____

Table C. FIDE SNP Measures

Measure Measure Sumitted Third-Party Data Source
Colorectal Cancer Screening (COL)

_____ _____
Care for Older Adults (COA)

_____ _____
Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)

_____ _____
Pharmacotherapy Management of COPD Exacerbation (PCE)

_____ _____
Controlling Blood Pressure (CBP)

_____ _____
Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)

_____ _____
Osteoporosis Management in Women Who Had a Fracture (OMW)

_____ _____
Antidepressant Medication Management (AMM)

_____ _____
Follow-Up After Hospitalization for Mental Illness (FUH)

_____ _____
Potentially Harmful Drug-Disease Interactions in the Elderly (DDE)

_____ _____
Transitions of Care (TRC)

_____ _____
Use of High-Risk Medications in the Elderly (DAE)

_____ _____
Plan All-Cause Readmissions (PCR)

_____ _____

1a. Does your MCO utilize a certified NCQA software vendor for the development of the above CMS Core Set measures? Please specify.

_____

---

2. Describe any concerns you may have about the quality or completeness of any third-party data.

_____

(Note: If a MCO is using third-party data, the MCO should have a formal process in place to validate that data before incorporating it into their information system. The MCO needs to check the third-party data for reliability, completeness and timeliness of submission.)

---

3. Please list subcontracted Medicaid or CHIP benefits that are adjudicated through a separate system that belongs to a third-party.

_____

(Note: Many MCOs contract out services for pharmacy benefits management, mental health/substance abuse, laboratory and radiology services. If the data are processed on the third- party's system, it may not be forwarded to the MCO in a complete form or on a timely basis. Such entities may also use a different method of processing resulting in data that will not merge with or complement MCO data.)

---

4. Describe the kinds of information sources available to the MCO from the vendor (e.g., monthly hard copy reports, full claims data).

_____

5. Do you evaluate the quality of this information?
◯ Yes
◯ No (GO TO QUESTION 6a)

5a. If yes, how?

_____

(Note: All of the third-party information should be verified for accuracy before MCO loads it into their information system. The MCO and the third-party data source may not define variables consistently or use the same reporting format.)

6. Did you incorporate these vendor data into the creation of Medicaid or CHIP-related studies?
◯ Yes (GO TO SECTION D)
◯ No

6a. If no, why?

_____

Section 5: D. Additional Data Sources that Support Quality Reporting

This section requests any data sources beyond third party collection of claim/encounter data that support quality reporting.

1. Does the MCO use any other data sources beyond claim/encounter data (such as, beneficiary provided data, HIE, registry data source, vital statistics, care management records, etc.)?
◯ No
◯ Yes

If yes, please list additional data sources.
Please describe how the MCO verifies the accuracy of the data and data exchange process for each data source listed above.

_____

SECTION 5: E. Integration and Control of Data for Performance Measure Reporting

This section requests information on how your MCO integrates Medicaid and CHIP claims, encounter, membership, provider, third-party, and other data to calculate performance rates. All questions relate to your current systems and processes, unless indicated otherwise.

1a. Please attach a flowchart outlining the structure of your management information systems, indicating data integration (e.g., claims files, encounter files, etc.) at the most granular level you have it.

1b. Please attach a diagram of how your claim system interacts with your clinical reivew, provider database and recipient information

2. In consolidating data for Medicaid and CHIP performance measurement, how are the data sets for each measure collected:
◯ By querying the processing system online
◯ By using extract files created for analytical purposes
◯ By using a separate relational database or data warehouse (e.g., a performance measure repository)

If extract files are used, how frequently are the files updated? How do they account for claim and encounter submission and processing lags? How is the file creation process checked for accuracy?	_____
If using a separate relational database or data warehouse, please specify is this the same system from which all other reporting is produced?	_____
3. Describe the procedure for consolidating Medicaid or CHIP claims/encounter, member, and provider data for performance measure reporting (whether it is into a relational database or file extracts on a measure-by-measure basis).	_____
3a. How many different sources of data are merged together to create reports?	_____
3b. What control processes are in place to ensure that data merges are accurate and complete?	_____
3c. What control processes are in place to ensure that no extraneous data are captured (e.g., lack of specificity in patient identifiers may lead to inclusion of non-eligible members or to double counting)?	_____
4. Describe both the files accessed to create Medicaid or CHIP performance measures and the fields from those files used for linking or analysis. Use either a schematic or text to respond.	_____
5. Are any algorithms used to check the reasonableness of data integrated to report Medicaid or CHIP performance measures?	_____
6. Are Medicaid or CHIP reports created from a third-party software product?	◯ Yes ◯ No (GO TO QUESTION 7)
6a. If yes selected above, please specify third party software product used and NCQA certified vendor used.	_____
6b. If yes, how frequently are the files updated? How are reports checked for accuracy?	_____
7. Are the data files used to report Medicaid or CHIP performance measures archived and labeled with the performance period in question?	◯ Yes ◯ No

8. Information on several types of external encounter sources is requested. In the following table, please indicate the following for each type of delegated service:

- Column 2. Indicate the number of third-parties contracted (or subcontracted) to provide the Medicaid or CHIP service. Count the entities that offer all or some of the portion of the service indicated.

- Column 3. Indicate whether your MCO receives member-level data for any Medicaid or CHIP performance measure reporting from the vendor(s). Only answer "Yes" if all data received from contracted third-parties(s) are at the member level. If any encounter-related data is received in aggregate form, you should answer "No". If type of service is not a covered benefit, indicate "N/A".

- Column 4. Indicate whether all data needed for Medicaid or CHIP performance measure reporting are integrated, at the member-level, with MCO administrative data.

- Columns 5 and 6. Rank the completeness and quality of the Medicaid or CHIP data provided by the third party(s). Consider data received from all sources when using the following data quality grades:

A. Data are complete or of high quality

B. Data are generally complete or of good quality

C. Data are incomplete or of poor quality

- Column 7. Describe any concerns you have in ensuring completeness and quality of Medicaid or CHIP data received from contracted third-parties. If the measure is not being calculated because there are no eligible members, please indicate "N/A".

Medicaid or CHIP Claim/Encounter Data from Third Parties

Type of delegated service | Number of contracted third-parties | Always receive member-level data from all third party(s) (Y or N) | Integrate third- party data with MCO administrative data? (Y or N) | Data completeness (A, B, or C) | Data quality (A, B, or C) | Describe rating concerns with data collection

Behavioral health _____ _____ _____ _____ _____ _____
Family Planning _____ _____ _____ _____ _____ _____
Home health Care _____ _____ _____ _____ _____ _____
Hospital _____ _____ _____ _____ _____ _____
Laboratory _____ _____ _____ _____ _____ _____
Pharmacy _____ _____ _____ _____ _____ _____
Primary Care _____ _____ _____ _____ _____ _____
Radiology _____ _____ _____ _____ _____ _____
Specialty Care _____ _____ _____ _____ _____ _____
Vision Care _____ _____ _____ _____ _____ _____
Dental for children _____ _____ _____ _____ _____ _____

9. Does your MCO use a performance measure repository?

◯ Yes
◯ No (GO TO QUESTION 10)

9a. If your MCO uses a performance measure repository for Medicaid or CHIP performance measures, review the repository structure. Does it contain all the key information necessary for Medicaid or CHIP performance measure reporting?

_____

10. Please describe your Medicaid or CHIP report production logs and run controls.

_____

10a. Please describe your Medicaid or CHIP performance measure report generation process.

_____

11. How are Medicaid or CHIP report generation programs documented?

_____

12. How does your MCO test the process used to create Medicaid and CHIP performance measure reports?

_____

13. Are Medicaid and CHIP performance measure reporting programs reviewed by supervisory staff?

◯ No
◯ Yes

14. The purpose of these questions is to evaluate the Medicaid and CHIP provider compensation structure and reporting of certain types of compensation, as this may influence the quality and completeness of data. Please identify the percentage of member months in your MCO contributed by Medicaid members whose primary care providers and specialists are compensated through each of the following payment mechanisms:

Payment Mechanism Primary Care Physician Specialist Physician
Salaried _____ _____
Fee-for-Service, no withhold or bonus _____ _____
Fee-for-Service, with withhold

Please specify % withhold: _____

_____ _____
Fee-for-service with bonus

Bonus Range:

_____

_____ _____
Capitated - no withhold or bonus _____ _____
Capitated with withhold

Please specify % withhold:

_____

_____ _____
Capitated with bonus

Bonus range:

_____

_____ _____
Global/bundled payments _____ _____
Other (Specify):

_____

_____ _____
TOTAL 100% 100%

Note: Timeliness and completeness of provider data submissions often varies by contracting arrangement. Salaried providers work directly for the MCO and will submit data on a timely basis if data submission is a parameter in their contract with the MCO. Fee-for-service providers have the largest incentive to submit accurate and complete data since their payment depends upon it. Capitated providers will need incentives to submit accurate and complete data. Their compensation should be linked to data submission, which can be done through the use of bonuses and withholds. For example, lag times may differ by compensation arrangement as follows: Capitation/Salaried no lag,

Fee-for-Service - 60 day lag, Hospital - 45 day lag

15. How are bonuses and penalties captured within your system? Is this information part of your standardized reporting?	_____
15a. Is the underlying data that determines whether and the extent of bonuses and penalties captured in your system? Is this information part of your standard reporting?	_____
15b. For bundled/global payments, how does your system capture information about the individual services provided for this bundled/global payment? Is this information part of your standardized reporting?	_____
15c. Does your system capture clinical data for quality measurement purposes for providers who receive bundled/global payments? Is this information part of your standardized reporting?	_____
16. Please describe how Medicaid or provider directories are updated, how frequently, and who has "change" authority.	_____
16a. Does your MCO maintain provider profiles on its website?	◯ Yes ◯ No (GO TO QUESTION 17)
16b. If yes to "16a," what provider information is maintained in on the website (e.g., languages spoken, special accessibility for individuals with special health care needs). Other? Please describe:	_____
16c. If yes to "16a," Do you have a different provider directory for FIDE SNP on your website?. Please describe:	_____
17. Does your MCO maintain provider profiles on its information system?	◯ Yes ◯ No (GO TO QUESTION 18) (Note: Provider directories should be updated to reflect changes in provider status to prevent members from selecting providers no longer under contract with the MCO. The MCO should have adequate security procedures in place to restrict the number of individuals who can access confidential provider information and institute changes in status.)
17a. If yes to "17", What provider information is maintained in the provider profile database (e.g., languages spoken, special accessibility for individuals with special health care needs). Other? Please describe.	_____
17b. If yes to "17", What provider information is maintained in the provider profile database for FIDE SNP?. Please describe.	_____

18. How are Medicaid or CHIP fee schedules and provider compensation rules maintained? Who has updating authority?

_____

(Note: Since providers consider fee schedule and compensation information to be confidential, access to this information should be restricted by the MCO. The MCO should have standardized process for updating and maintaining this information.)

19. Are Medicaid or CHIP fee schedules and contractual payment terms automated? Is payment against the schedules automated for all types of participating providers?

_____

(Note: Manual payment processes are more prone to error and reduce processing speed.)

20. Do you conduct GeoAccess or similar analyses software or process to assess network adequacy?

◯ No
◯ Yes

20a. Do you have an alternate method of assessing network adequacy? If yes, how is this information used?

_____

20b. If yes, identify the software or process:

_____

21. Describe any alternate payment arrangements:

_____

22. Are fee schedules and contractual payment terms automated? Is payment against the schedules automated for all types of participating providers?

_____

Section 6. Network Adequacy

1. List or specify Data Source

_____

2. What system is used to collect network adequacy data?

_____

((i.e eligibility & provider data))

3. What system is used to store network adequacy data?

_____

4. How frequently are the data collected and updated?

_____

5. What software systems and/or programming languages are used to analyze network adequacy data?

_____

6. Which staff are involved in collecting and storing network adequacy data and what is their level of training?	_____
7. Are there adequate staffing resources to collect and analyze network adequacy data? Specifically, does the MCO employ enough data analysis and do they have adequate time to perform necessary analytics?	_____
8. Which staff are involved in analyzing and reporting network adequacy data, and what is their level of training?	_____
9. What errors may occur in the process of collecting, storing, and analyzing network adequacy data?	_____
10. What systems are in place to prevent and fix errors that occur in the process of collecting, storing, and analyzing network adequacy data?	_____
11. What proportion of network adequacy data are missing or incomplete on key data elements?	_____
12. What systems are in place to prevent missing or incomplete data?	_____
13. Data concerns relevant to network adequacy validation?	_____
14. Potential solutions or workarounds to address network adequacy data concerns.	_____
15. Describe how provider directories are updated.	_____
16. How frequently are provider directories updated?	_____
17. Does your organization maintain provider profiles in a database?	_____
18. Which staff have the ability to make 'changes' to the provider directory?	_____
19. Who has publishing authority for the provider directory?	_____
20. Describe how you identify provider supply and what methods and tools are currently being used to compare and match enrollee needs to the providers available to serve them currently and in the future.	_____

21.To establish network standards,how do you define eligible providers for each service category based on following:

a. Time and distance standards _____ Please describe _____

If yes, please upload _____

b. Timely access standards, such as appointment wait times; _____ Please describe _____

If yes, please upload _____

c. Providerto-Enrollee ratios; _____ Please describe _____

If yes, please upload _____

d. Other standards, such as those related to physical and cultural accessibility,out-of -network access,telemedicine, e-visits etc to ensure that all services will be accessible _____ Please describe _____

If yes, please upload _____

22. Do you analyze data from complaints and appeals to determine if there are issues concerning geographic distribution or types of practitioners in its network? •How do you make improvements in network from information received from analysis of access and availability?	_____
23. What Strategies do you apply to increase provider participation and access particularly but not exclusively rural areas. For example,Use telehealth to expand access in provider shortage areas?	_____
24. How do you evaluate network adequacy for Managed long-term services and supports (MLTSS) providers-Nurses, Personal care aides and Home Health Aides?	_____
25. How are availability and access of Essential community providers (ECP) and Indian health care providers (IHCPs) maintained?	_____
26. Describe the network adequacy standards maintained by you as per state requirement? (For example, a state may set a network adequacy standard that all enrollees have access to a primary care provider (PCP) within 30 miles or 30 minutes).	_____
27. Have you monitored Network adequacy in previous years? If so, do you have past EQR network adequacy validation reports? Please share, if applicable.	_____

28. What are the methods and calculations you use for calculating each network adequacy indicator? Please explain how they align with the state's expectations and network adequacy standards in compliance with the Network Adequacy Validation protocol. (Network adequacy standards are quantitative parameters that states establish to set expectations for contracted MCOs' provider networks. Network adequacy indicators are metrics used to measure adherence to network adequacy standards and to determine MCO compliance with state network adequacy standards).

_____

29. Please provide network adequacy data from previous years and current year with details on network adequacy standards used. Please provide calculations for network adequacy indicators.

_____

Encounter Data Submissions to State

1. Does your organization submit encounter data directly to CMS T-MSIS?

◯ Yes
◯ No

1a. If yes, please specify.

_____

1b. If No, please explain how encounter data is submitted.

_____

2. What is the Encounter Data acceptance percentage for encounter submitted to the state (Please provide breakouts by Inst and Prof, Dental and Pharmacy if available).

Please enter encounter submission percentage as of date: _____

Institutional

Professional

Dental Pharmacy

_____ _____ _____ _____

3. Do you comply to any timeliness standards regarding the submission of encounters?

◯ Yes
◯ No

3a. If yes, please provide state timeliness standards.

_____

3b. If yes. please provide your organizations timeliness rates and acceptance standards for the past year.

Please provide date you submit to state: _____

Table A: Timeliness Rates by Encounter Type:

Institutional	Professional	Dental	Pharmacy
_____	_____	_____	_____

Table B: State acceptance rates by encounter type:

Institutional	Professional	Dental	Pharmacy
_____	_____	_____	_____

4.What is the frequency of the submission of encounters to the state? _____

4a. Is there a set date you submit data to State. Please specify. _____

4b. Frequency by Encounter Type:

Institutional: _____ Professional: _____ Dental: _____ Pharmacy: _____

Counts of encounters submitted last month:_____

Counts of encounters submitted to state last month:_____

5. What are top 3 encounter data submission denial reason codes for the last month? (provide by encounter type if applicable) _____

6. Are MCO denied claims/encounters submitted to the State?
◯ Yes
◯ No

6a. If yes, please provide type of denials that are submitted.

_____

7. Please select checkbox for data elements sent to State on 837 and NCPDP files.

	Institutional (837I)	Professional (837P)	Dental (837D)	Pharmacy (NCPDP)
CPT	☐	☐	☐	☐
HCPCS	☐	☐	☐	☐
CPT Category II	☐	☐	☐	☐
CDT Codes	☐	☐	☐	☐
Revenue Codes	☐	☐	☐	☐
POS	☐	☐	☐	☐
UB Type of Bill	☐	☐	☐	☐
LOINC Codes	☐	☐	☐	☐
SNOMED Codes	☐	☐	☐	☐
Provider Taxonomy Codes	☐	☐	☐	☐
NDC Codes	☐	☐	☐	☐
ICD-10 CM diagnosis Codes	☐	☐	☐	☐
ICD-10 CM procedure Codes	☐	☐	☐	☐

8. Please provide the max number of codes that are submitted to the State.

Type of Codes Institutional Professional Dental Pharmacy
ICD-10 CM diagnosis Codes Max codes submitted to state:_____ Max codes submitted to state:_____ Max codes submitted to state:_____ Max codes submitted to state:_____
ICD-10 CM procedure Codes Max codes submitted to state:_____ Max codes submitted to state:_____ Max codes submitted to state:_____ Max codes submitted to state:_____