New Jersey Comprehensive Waiver Demonstration
Section 1115 Quarterly Report
***Demonstration Year:* 6 (7/1/17-6/30/18)**
***Federal Fiscal Quarter:* 2 (1/1/18-3/31/18)**

I. Introduction

The New Jersey Comprehensive Waiver Demonstration (NJCW) was approved by the Centers for Medicare and Medicaid Services (CMS) on August 1, 2017, and is effective August 1, 2017 through June 30, 2022.

This five year demonstration will:

- Maintain Medicaid and CHIP State Plan benefits without change;
- Streamline benefits and eligibility for four existing 1915(c) home and community-based services (HCBS) waivers under one Managed Long Term Services and Supports Program;
- Continue the service delivery system under two previous 1915(b) managed care waiver programs;
- Eliminate the five year look back at time of application for applicants or beneficiaries seeking long term services and supports who have income at or below 100 percent of the Federal Poverty Level (FPL);
- Cover additional home and community-based services to Medicaid and CHIP beneficiaries with serious emotional disturbance, autism spectrum disorder, and intellectual disabilities/developmental disabilities;
- Transform the State's behavioral health system for adults by delivering behavioral health through behavioral health administrative service organizations; and
- Furnish premium assistance options to individuals with access to employer-based coverage.

In this demonstration the State seeks to achieve the following goals:

- Create "no wrong door" access and less complexity in accessing services for integrated health and Long-Term Care (LTC) care services;
- Provide community supports for LTC and mental health and addiction services;
- Provide in-home community supports for an expanded population of individuals with intellectual and developmental disabilities;
- Provide needed services and HCBS supports for an expanded population of youth with severe emotional disabilities; and
- Provide need services and HCBS supports for an expanded population of individuals with co-occurring developmental/mental health disabilities.
- Encourage structural improvements in the health care delivery system through DSRIP funding.

This quarterly report is submitted pursuant to Special Term and Condition (STC) 101 in the New Jersey Comprehensive Waiver; and in the format outlined in Attachment A of the STCs.

II. Enrollment and Benefit Information

Summary of current trends and issues related to eligibility, enrollment, disenrollment, access, and delivery network.

There have been no changes in trends or issues related to eligibility, enrollment, disenrollment, access, and delivery network in the current quarter.

Summary of any changes or anticipated changes in populations served and benefits. Progress on implementing any demonstration amendments related to eligibility or benefits.

There are no anticipated changes in populations served or benefits.

III. Enrollment Counts for Quarter

Demonstration Populations by MEG	Total Number of Demonstration participants Quarter Ending – 09/17	Total Number of Demonstration participants Quarter Ending 12/17	Total Number of Demonstration participants Quarter Ending 03/18	Total Number of Demonstration participants Quarter Ending –
Title XIX	723,461	722,110	699,541	
ABD	267,931	263,748	254,669	
LTC				
HCBS - State plan	10,682	11,266	11,923	
TBI – SP				
ACCAP – SP				
CRPD – SP				
GO – SP				
HCBS - 217-Like	12,925	12,958	13,256	
TBI – 217-Like				
ACCAP – 217-Like				
CRPD – 217-Like				
GO – 217-Like				
SED - 217 Like	284	285	268	
IDD/MI – (217 Like)	492	485	449	
NJ Childless Adults				
AWDC	358,869	367,933	352,654	
New Adult Group	199,908	199,761	194,295	
SED at Risk	3,473	3,752	3,803	
MATI at Risk				
Title XXI Exp Child				

NJFAMCAREWAIV-POP 1	[redacted]
NJFAMCAREWAIV-POP 2	
XIX CHIP Parents	

IV. Outreach/Innovative Activities to Assure Access

MLTSS

The State has continued to maintain its efforts to ensure that consumers, stakeholders, MCOs, providers and other community-based organizations are knowledgeable about MLTSS. The State has depended on its relationships with stakeholder groups to inform consumers about the changes to managed care.

During this quarter, DHS gave MLTSS updates to the following long term care industry providers:

On January 24, 2018, the New Jersey Medical Assistance Advisory Council, a group comprised of medical care and health services professionals who advise the State's Medicaid Director.

On February 22, 2018, the MLTSS Steering Committee its representation from stakeholders, consumers, providers, MCOs and state staff members.

On March 6, 2018, the annual NJ Hospital Association MLTSS/Managed Medicaid Update Seminar. The DHS and the MCOs are participants in this annual seminar which offers providers the opportunity to learn about specific topics as well as network and meet with State and MCO representatives.

The meeting topics included the NJ FamilyCare Data Dashboard Portal, Substance Use Disorder Waiver, Any Willing Qualified Provider (AWQP), the Division of Developmental Disabilities Supports Program, and Medicaid updates including a summary of January 2018 contract changes, NJ FamilyCare enrollment overview, Medicaid-Medicare Alignment, and the Diabetes State Plan Amendment.

The NJ FamilyCare Data Dashboard is a public-facing portal is a result of a 12-month technical assistance grant through CMS Innovative Accelerator Program. Phase 1 of this multi-phase project will launch in the Summer 2018 and will provide public access to CAHPS (Consumer Assessment of Healthcare Providers and Systems), HEDIS and Clinical Measures, Eligibility, and Long Term Care data. The portal will be accessible through a mobile friendly and browser independent platform.

The Medicaid Substance Use Disorder Waiver within the 1115 waiver authority expands Medicaid coverage to provide a full continuum of SUD services that includes case management and peer recovery support services.

The DDD Supports Program funds services and supports for NJ adults with intellectual and developmental disabilities who live in a non-licensed setting. These supports and services include employment/day services, individual/family supports, and supported employment.

The AWQP program is a foundational step in the State's evolving value based purchasing (VBP) strategy. Webinars have been held for the stakeholder community and a webpage has been established to share

data and materials for this initiative. The AWQP initiative launch in January 2018 when the second release of Minimum Data Set (MDS) quality performance data was sent to the Nursing Facilities. (NFs) The multi-year rollout of AWQP is under the purview of DHS in collaboration with a NF Quality Workgroup, which is comprised of long term care industry and consumer stakeholders.

The Office of Managed Health Care (OMHC) has remained committed to its communications efforts to ensure access through its provider networks. Its provider-relations unit has continued to respond to inquiries through its email account on these issues among others: MCO contracting, credentialing, reimbursement, authorizations, appeals and complaint resolution. A comprehensive overview of contract changes effective with the January 2018 contract were provided at all three stakeholder meetings referenced.

Additionally, strategy sessions were presented as a new option for MLTSS Steering Committee members to explore ad-hoc topics that require additional discussion and analysis. Identified committee chairs will plan and lead specific topic areas and report back to the steering committee. These reports will include an analysis of the issue and recommendations.

SED/I-DD/ASD:

The Department of Children and Families (DCF), Children's System of Care (CSOC) promotes their program at their many meetings throughout the state and plans to continue to do so at community meetings.

Supports

The Division of Developmental Disabilities (DDD) is responsible for the daily operations of both the Supports Program (SP) and the Community Care Program (CCP). DDD addresses outreach and activities to address access to both their programs concurrently as both programs have very similar providers, advocacy organizations, and supports and services. The primary difference between the two programs is the required level of care. It is intentional that information about both programs is shared at the same time and to the same audiences. This enables clear and consistent communication to individuals, families, providers, advocacy organizations and State staff.

During this quarter, the Division of Developmental Disabilities (DDD) continues enrollment of individuals into the Supports Program. As of the end of the reporting quarter, DDD enrolled 1,137 individuals in the Supports Program.

DDD began reviewing results of National Core Indicators family surveys in order to begin identifying areas in need of improvement and developing plans to address these areas. DDD is awaiting results from the individual surveys before initiating stakeholder involvement in this process. DDD continued revisions to the Supports Program Policies & Procedures Manual based on input from stakeholders, changes made to improve services, etc.

DDD is continuing enrollment of individuals into Supports Program + Private Duty Nursing (PDN) and provides options counseling to individuals identified as needing PDN.

DDD continues to meet with the trade organizations and individual providers to assist in preparation for the Medicaid-based, Fee-for-Service system. DDD continues to answer provider questions and provide guidance on the application process for provider enrollment. In addition, DDD continues to assist individuals with Medicaid eligibility including assisting individuals in accessing Supports Program only Medicaid.

NJ CAT assessments, supplemental assessments, reassessments as needed and DDD continues to work through the process of Day Habilitation.

CCP

The Division of Developmental Disabilities (DDD) is responsible for the daily operations of both the SP and the CCP. DDD addresses outreach and activities to address access to both their programs concurrently as both programs have very similar providers, advocacy organizations, and supports and services. The primary difference between the two programs is the required level of care. It is intentional that information about both programs is shared at the same time and to the same audiences. This enables clear and consistent communication to individuals, families, providers, advocacy organizations and State staff.

On January 1, 2018, there were 11,114 individuals enrolled on the CCP and on March 31, 2018, there were 11,159 individuals enrolled on the CCP. There were 360 individuals that were enrolled onto the CCP during this quarter despite the growth showing a minimal increase. The reason for the limited increase is that an average of 101 individuals were terminated from the CCP each month, 120 individuals were enrolled on the CCP each month, and 30 applications were pending processing at Medicaid each month. The primary reasons for terminations were due to SSI terminating and the need to apply for Medicaid as a result of the SSI Medicaid terming and death.

In December 2017, DDD began a Council on Quality and Leadership initiative to build quality outcomes into services

1,740 individuals in the CCP were transitioned into FFS/Rate Structure model from the existing cost-reimbursement model and have approved service plans.

Routine meetings with providers and individuals/families regarding the system reform (including both the Supports and CCP Programs). These calls provide the opportunity for stakeholders to share issues/concerns as they come up, receive updates, and suggest ideas/feedback.

DDD provided ongoing guidance to providers on the application process for provider enrollment. In addition, DDD provided guidance to providers and families regarding obtaining and maintaining Medicaid and to providers regarding claiming questions.

DDD continues to meet with the trade organizations and individual providers to assist in preparation for the Medicaid-based, Fee-for-Service/Rate structure system.

NJ CAT assessments, supplemental assessments, reassessments as needed and DDD continues to work through the process for Day Habilitation.

IME

During Demonstration Year 6, Federal Fiscal Quarter 2 (1/1/18-3/31/18) the 24 hour call center at the IME received and responded to 14,055 calls. 2,667 of those calls were referred to treatment and 1,509 were provided Care Coordination services to facilitate treatment. The IME Utilization Management issued 5,766 treatment authorizations for Medicaid recipients and 5,374 clinical extensions of treatment for Medicaid recipients.

The IME maintains a Statewide Capacity Management System (SCMS) and has been working in cooperation with Medicaid, Molina and DOH to upkeep that system with current and newly enrolling providers. They have assisted Medicaid to identify Medicaid providers at each level of care for all the

Residential treatment services and Medicaid will work with the IME to establish a process to keep this system up to date. The DOH Office of Licensing has been working with Medicaid to determine bed availability for each Medicaid provider and the comprehensive list of residential providers is near complete. Currently, Medicaid is verifying the data collected and will begin the same process to establish a comprehensive list of Outpatient providers by level of care and region.

The IME in partnership with the NJ, DOH, DMHAS are planning a statewide provider ASAM training by the Change Companies and the projected dates are to be in September of 2018. This training was originally projected for May but due to budget approval processes and the availability of the trainers the tentative dates have been pushed back.

SUD/OUD

New Jersey submitted the Implementation Plan to CMS on February 9, 2018 and has been working with CMS to edit and finalize the Plan and it is pending approval.

New Jersey submitted the Monitoring Protocol to CMS March 29, 2018 and it is pending approval.

NJ Medicaid has established a multi-agency workgroup to improve access to Medication Assisted Treatment (MAT). A provider survey has been developed and is in process to determine barriers to providing this care, particularly at the residential level. The survey results will allow the State to address the barriers identified and improve access.

NJ Medicaid is preparing provider trainings for Residential treatment services, ASAM placement requirements, coverage, authorization and billing. Training is scheduled for May 25, 2018 and is pending CMS approval of New Jersey's implementation plan.

Surveys were sent to all providers, prevention agencies, and grass roots organizations who peer support services for SUD treatment. The survey period has ended and survey results are currently being compiled by DMHAS.

NJ FamilyCare is working with MCOs to manage Behavioral Health services, including SUD treatment for MLTSS, FIDE-SNP and DDD Medicaid plans. All the SUD services will utilize ASAM placement criteria and this has been included in the MCO contracts under Article 9.9.4.C.

V. Collection and Verification of Encounter Data and Enrollment Data

Summary of Issues, Activities or Findings

No issues or findings.

VI. Operational/Policy/Systems/Fiscal Developments/Issues

MLTSS

DMAHS convenes a bi-weekly meeting with state staff from the various Divisions involved in MLTSS to discuss any issues to ensure that they are resolved timely and in accordance with the rules and laws that govern the Medicaid program. The state also continues to have monthly conference calls with the MCOs

to review statistics and discuss and create an action plan for any issues that either the State or the MCOs are encountering.

SED/I-DD/ASD:

DCF, CSOC continues ongoing enrollment of youth in the Children's Support Service Program (CSSP), Intellectual/ Development Disabilities (CSSP I/DD) and the Autism Spectrum Disorder (ASD) Pilot.
As of March 31, 2018, there were 154 youth identified for the ASD Pilot program and 987 youth identified for the CSSP I/DD Program. As of March 31, 2018, 304 CSSP SED Plan A youth have been enrolled through the Children's Support Services Serious Emotional Disturbance program.

CSOC's Contracted Systems Administrator (CSA), and DMAHS's fiscal agent, Molina, continue to hold implementation meetings as needed.

CSOC continues to build ASD, I/DD-MI and SED provider networks.

Technical assistance continues to be ongoing to assist and provide new ASD, I/DD providers related procedures and expectations. CSOC also provided technical assistance to providers regarding the Medicaid enrollment process; to ensure that providers receive Medicaid ID for billing; and to receive requisite provider enrollment training.

Supports

As previously indicated most operational, policy, systems and fiscal developments/issues for both the SP and CCP are concurrently shared/discussed at meetings and through communications.

During this quarter, the Division of Developmental Disabilities (DDD) attended the Medical Assistance Advisory Council (MAAC) Meeting on January 24, 2018 and provided an update on the Supports Program and answered questions.

DDD attended the quarterly Transition Coordinators Network meeting and provided information about Supports Program eligibility and services available through the Supports Program as well as information regarding becoming DDD eligible prior to exiting the school system.

DDD also attended an event spearheaded by a Support Coordination Supervisor in order to identify areas in need of further training for Support Coordination Agencies. This meeting led to bringing together a workgroup of DDD, Support Coordination, and training entities to develop a curriculum to provide further training to Support Coordinators. In addition, DDD attended the New Jersey Council on Special Transportation (NJ COST) meeting to provide information about transportation options for people enrolled in the Supports Program and give transportation providers information about how they can receive funding for providing transportation to individuals enrolled in the Supports Program.

DDD Held a Q&A session with Support Coordination Agencies connected to the Alliance for the Betterment of Citizens with Disabilities. (one of the trade organizations in NJ) DDD met with representatives from the trade organizations.

DDD met with Support Coordination Leadership – a group of Support Coordination representatives from the 3 trade organizations – to discuss issues, brainstorm solutions, etc. DDD also met with interested potential providers that currently provide services out-of-state or for individuals under 21 to explain the process for becoming a Medicaid/DDD approved provider, identify services available through the Supports Program, answer questions, and provide information/materials.

DDD held the family Advisory Council meeting and Provider Leadership meeting. DDD conducted site visits, meetings, and phone calls with providers in need of technical assistance as they shift to Fee-For-Service (FFS) and begin to serve individuals enrolled in the Supports Program.

CCP

As previously indicated most operational, policy, systems and fiscal developments/issues for both the SP and CCP are concurrently shared/discussed at meetings and through communications.

During this quarter, the Division of Developmental Disabilities (DDD) held the Support Coordination Supervisors meeting. In addition, the Quarterly Provider Leadership meeting was held on April 24, 2018. The March quarterly meeting was moved to April due to NJ State offices being closed for snow. The Quarterly Family meeting was held on April 24, 2018. The March quarterly meeting was moved to April due to NJ State offices being closed for snow.

DDD represented at the Medical Assistance Advisory Committee meeting on January 24, 2018

DDD attended the quarterly Transition Coordinators Network meeting and provided information about Waiver program eligibility and services as well as information regarding becoming DDD eligible prior to exiting the school system.

The Waiver Unit became responsible for responding to questions submitted to a "DDD Medicaid Eligibility Helpdesk" to assist families, providers, advocates, etc. During this quarter there were 385 questions submitted and 385 questions answered. The majority of questions, 45% were regarding the loss of Medicaid and what are the next steps to regain Medicaid, 14% of the questions addressed IT issues such as questions related to Medicaid prior-authorizations, 12% of the questions were related to individuals whose income exceeded 100% of the FPL, and the remainder of questions focused on ABLE account information, Qualified Income Trust information, DDD Intake questions, and generic questions that may not have been Medicaid related.

DDD Conducted site visits, meetings, and phone calls with providers in need of technical assistance as they shift to FFS and begin to serve individuals enrolled in the Supports Program. In addition, Q&A webinars were held on the Waiver Programs and Fee-for-Service. DDD also provided presentations at the Regional Family Support Councils throughout the state.

DSRIP

Quarterly Payment Reports – No payments have been made yet to hospitals for DY6. Semi-Annual 1 Stages 1 and 2 Progress Report payments are being considered for April.

Progress in meeting DSRIP goals – CMS is reviewing Semi-Annual 1 Progress Reports. DY6 Attribution Rosters were provided to hospitals on March 16, 2018. Standard Reporting Workbooks are due from the hospitals on April 30, 2018. Databook 4.0 (first of two updates) released to industry on February 19, 2018.

Performance – 3 hospitals (Hackensack/Mountainside, Cape Regional, and St Luke's Hospital) withdrew the DSRIP program, effective with DY6. New Jersey Department of Health (NJDOH) is received formal letters of withdrawal from these hospitals. Excessive administrative burden of the program was cited as a reason to withdraw. There is no need to recoup funds since no DSRIP funds had yet been distributed. Hospitals will be liable (and have agreed in writing) to accept payment liability for prior year appeals and

audit adjustments. DY5 performance measure results were published on January 9, 2018 and posted to DSRIP website.

Challenges – CMS and NJDOH continue discussions on the design of DY7 and DY8. CMS and NJ agreed that, for DY6 and forward, the state will utilize the national benchmark when possible, followed by the NJ statewide benchmark. CMS is reviewing DY6-8 Planning Protocol submitted by NJDOH on March 29, 2018.

Mid-course corrections – None.

Successes and evaluation – CMS approved the DY6-8 Funding and Mechanics Protocol (FMP) on February 14, 2018. With the approval, NJ is authorized to claim federal financial participation for DY6 payments made to providers, once approved by CMS. CMS and NJ will continue discussing measure specifications, benchmarks, baseline performance thresholds and improvement target goals for DY 7 & 8. The FMP was posted on the NJ DSRIP website.

Other

Managed Care Contracting:

There are no updates for this quarter.

Self-attestations:

There were a total of 150 self-attestations for the time period of January 1, 2018 to March 31, 2018.

MCO Choice and Auto-assignment:

The number of individuals who changes their MCO after auto-assignment is 7,357.

MLR:

MCO Medical Loss Ratios for the 12 month Period July 1, 2016 to June 30, 2017:

	Acute		MLTSS	
	Non Expansion	Expansion	HCBS	NF
Horizon	92.0%	98.8%	85.5%	99.9%
UHC	88.4%	88.3%	92.3%	95.8%
Amerigroup	92.1%	90.4%	94.5%	98.5%
Aetna	74.6%	64.4%	91.1%	94.5%
Wellcare	92.6%	88.0%	97.2%	108.5%

Starting with SFY 2017, New Jersey will begin to report the MLRs required by contract. For SFY 2017 the four MLRs are Acute Non Expansion, Acute Expansion, MLTSS Home and Community Based Services (HCBS) and MLTSS Nursing Facilities (NF).

VII. Action Plan for Addressing Any Issues Identified

Issue Identified	Action Plan for Addressing Issue
No issues identified.	Development:

	Implementation: Administration:

VIII. Financial/Budget Neutrality Development/Issues

Issues Identified:
No issues identified.
Actions Taken to Address Issues:

IX. Member Month Reporting

A. For Use in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Title XIX				
ABD				
LTC (following transition to MLTSS)				
HCBS -State Plan				
TBI – SP				
ACCAP – SP				
CRPD – SP				
GO – SP				
HCBS -217 Like				
TBI – 217-Like				
ACCAP – 217-Like				
CRPD – 217-Like				
GO – 217-Like				
SED -217 Like				
IDD/MI -(217 Like)				
NJ Childless Adults				
New Adult Group				

Title XXI Exp Child				
XIX CHIP Parents				

X. Consumer Issues

Summary of Consumer Issues

Call Centers: Top 5 reasons for calls and %(MLTSS members)

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
1	Eligibility inquiries	Members calling for authorization status.	Member requests to speak to a Care Manager	Medical Benefits	Eligibility Status
2	Request to change PCP	Members calling to contact their Care Manager.	Authorization inquiries	PCP Update	Benefit inquiries
3	Benefit inquiries	Member calling with questions regarding the PPP program.	Requests to change PCP	ID Card request	Authorization status
4			Confirm eligibility	Eligibility Inquiry	Requests for PCP changes
5					Member calling to speak to Care Manager

Call Centers: Top 5 reasons for calls and % (MLTSS providers)

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
1	Provider network inquiries	Providers calling for authorization status.	Authorization inquiries	Eligibility Inquiry	Eligibility Status
2	Coding questions	Claims reprocessing requests due to new coding	Single Case Agreements	One-off claim issues due to discrepancies with authorizations	Claims status
3	Claims Resolution	Patient Pay Liability inquiries	Claims Resolution	One-off claim issues due to processor error.	Authorization status
4			Credentialing Status		Reauthorizations
5					

XI. Quality Assurance/Monitoring Activity

MLTSS:

MLTSS Claims Processing Information by MCO

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
# Claims Received	58,671	133,089	451,325	56,607	203,303
# Claims Paid	42,650	86,277	400,391	50,433	153,195
# Claims Denied	12,751	45,931	46,530	4,417	47,251
# Claims Pending	3,270	881	4,404	1,757	2,834
Average # days for adjudication	15	15	15	15	15

Top 5 Reasons for MLTSS Claims Denial by MCO

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
1	Service denied because payment already made for same/similar procedure within set time frame	NetworX Std Fee Sched	Timely filing	No Authorization on file	No Authorization
2	Exact duplicate claim/service	Capitated Service	Duplicate claim	Benefits Based on Admission Date	No Patient Responsibility
3	Non-covered charge(s	Paid at contracted rate	Provider not eligible for service	Medicare Medicaid 2ndary Carrier	Timely Filing
4		Procedure non-reimbursable	Provider not eligible by contract for payment	Timely filing limit exceeded post process	
5			Submitted procedure is disallowed, incidental to other procedures.		

SED/IDD/ASD:

CSOC has a workgroup that continues to work on streamlining critical incident reporting. CSOC also continues to expand the network of providers to assure timely access to services.

CSOC continues ongoing collaboration with the DMAHS Quality Monitoring team that is providing oversight on quality assurance. Please refer to Attachment C.

Supports:

Similar quality reviews, audits, and monitoring are conducted for both the SP and the CCP. Data is provided for each Program and then reviewed to determine if there are systemic issues occurring in either or both programs. Systemic and individual remediation occurs as required.

The Department of Human Services Quality Management Unit (QMU) conducts an annual audit of the Supports Program. The unit completed their annual audit in December and a draft report of their findings was provided for review.

The Provider Performance & Monitoring Unit is in the process of revising monitoring tools and gathering stakeholder input. These tools will be utilized to monitor Medicaid/DDD approved providers and provide further guidance and technical assistance based on the results/findings.

DDD requires reporting on 86 distinct Unusual Incident Codes. At the end of this quarter there were 6,537 individuals on the Supports Program. From this group, there were 233 unusual incidents reported for 194 individuals (some individuals had more than 1 unusual incident report). Therefore, approximately 97% of individuals on the Supports Program during this quarter did not require an UIR. Some UIR codes, such as abuse, neglect, or exploitation require an investigation. If there were minor or no injuries then the provider agency is responsible to conduct an investigation and submit their findings/action plan for review by the Department of Human Services Critical Incident Management Unit. If there were moderate to major injuries then the Department of Human Services Special Response Unit will conduct an investigation.

Issues regarding implementation of the Fiscal Intermediary – Public Partnerships, LLC continue to come up. Department and Division staff continues to hold regular calls with PPL to resolve ongoing issues regarding payment in particular. In addition, point persons have been identified within the Division and PPL to address specific issues as they occur and an escalation process has been put in place and communicated to stakeholders to address issues that have not been resolved.

CCP:

Similar quality reviews, audits, and monitoring are conducted for both the SP and the CCP. Data is provided for each Program and then reviewed to determine if there are systemic issues occurring in either or both programs. Systemic and individual remediation occurs as required.

The Department of Human Services Quality Management Unit (QMU) completed its annual audit of the CCP. Audit findings demonstrated substantial compliance (86% or greater) in all sub-assurance so no corrective action plan was required. Despite not requiring a corrective action plan, DDD Wavier Unit staff is ensuring that there are follow-up actions related to each of the individual findings. Any findings that required a return of FMAP are being resolved and a monthly update is forwarded to QMU by the Waiver Unit staff.

Waiver Unit staff have met with the Provider Performance & Monitoring Unit and are taking the lead on developing additional monitoring tools that will generate data related to Waiver and State compliance.

These tools will be utilized to monitor Medicaid/DDD approved providers and provide further guidance and technical assistance based on the results/findings. Tools related to Support Coordination and Day Habilitation are nearly complete.

DDD requires reporting on 86 distinct Unusual Incident Codes. At the end of this quarter there were 11,159 individuals on the Community Care Program. From this group, there were 4,529 unusual incidents reported for 2,160 individuals (some individuals had more than 1 unusual incident report). Therefore, approximately 81% of individuals on the CCP during this quarter did not require an UIR. Some UIR codes, such as abuse, neglect, or exploitation require an investigation by the Office of Investigations. Approximately 1% of the Unusual Incident Reports filed required an investigation by the Office of Investigations. If there were minor or no injuries then the provider agency is responsible to conduct an investigation and submit their findings/action plan for review by the Department of Human Services Critical Incident Management Unit. If there were moderate to major injuries then the Department of Human Services Special Response Unit will conduct an investigation. Danielle's Law is practiced in NJ. This law requires that 911 be called in a potential life-threatening emergency (e.g.: seizures, pain breathing). Approximately 35% of the reported UIRs had a primary code of Danielle's Law. Often Danielle's Law incidents are determined to not be life-threatening; Direct Support Professionals are held to the prudent person standard and failure to report a perceived emergency may result in a $5,000 fine. DDD's Risk Management Unit conducts analysis if someone has more than 2 incidents in a single month summaries are created and sent to Support Coordination/Case Management staff as well as DDD's Provider Performance Monitoring Unit.

As discussed in the previous Quarterly report the Division, along with its partners, is working to develop additional training materials to provide the Support Coordination Agencies additional training in order to understand "how to be a Support Coordinator." Initial meeting were held in the last quarter and additional meetings were held in this quarter. Training topics are being actively discussed.

Issues regarding implementation of the Fiscal Intermediary – Public Partnerships, LLC continue to come up. Department and Division staff continues to hold regular calls with PPL to resolve ongoing issues regarding payment in particular. In addition, point persons have been identified within the Division and PPL to address specific issues as they occur and an escalation process has been put in place and communicated to stakeholders to address issues that have not been resolved.

Other Quality/Monitoring Issues:

EQR PIP

In December 2013, the MCOs, with the guidance of the EQRO, initiated a collaborative PIP with a focus on Identification and Management of Obesity in the Adolescent Population. Since inception, the EQRO had held regularly scheduled meetings with the MCOs to ensure a solid and consistent PIP foundation across all MCOs. Starting August 2015, the MCOs met monthly, independent of the EQRO, for continued collaborative activities. The MCOs are expected to show improvement and sustainability of this collaborative PIP. A routine PIP cycle consists of baseline data followed by two remeasurement years and then a sustainability year. Four MCOs were involved in the collaborative. For three of the MCOs, 2013 was their baseline data year for the project; results of calendar year 2014 reflect remeasurement year 1 and results of calendar year 2015 reflect remeasurement year 2. January 2016 started the sustainability year for these MCOs. The fourth MCO entered into the NJ market in December 2013, making their baseline year 2014, with results of calendar year 2015 as their first remeasurement year. January 2016 was the start of remeasurement year 2 for this MCO. All MCOs submitted a progress report in June 2016 which included remeasurement year 2 data for three MCOs and remeasurement year 1 data for the fourth MCO and were reviewed by the EQRO. All MCOs submitted a progress report

update in September 2016 and were reviewed by the EQRO. January 2017 started the sustainability year for the fourth MCO. In June 2017, three of the MCOs submitted their final report for this PIP as the final sustainability data collection was completed in May 2017, and were reviewed by the EQRO. Three MCOs have now completed their collaborative PIP cycle with a focus on Identification and Management of Obesity in the Adolescent Population. Two of the MCOs showed improvement in their baseline rates to the sustainability rates on the three sub-metrics; BMI percentile, BMI risk categorization, and evaluation of family history. One of the MCOs showed improvement in their baseline rate to the sustainability rate on the sub-metric, BMI risk categorization. The fourth MCO is currently in their sustainability year and submitted a progress report in June 2017 which included the results of remeasurement year 2 data and was reviewed by the EQRO. The fourth MCO submitted a progress report update in September 2017 and was reviewed by the EQRO.

The MCOs are also involved in a non-collaborative Prenatal PIP with the focus on Reduction of Preterm Births. The initial proposals were submitted by the MCOs in October 2014 for review by the EQRO. The individual proposals were approved and project activities were initiated by the plans in early 2015. The June interim reports included the 2014 baseline data. The September 2015 reports included an analysis of plan specific activities and any revisions for the upcoming year. Results of calendar year 2015 measures represented remeasurement year 1. January 2016 was the start of remeasurement year 2 for this PIP. All MCOs submitted a progress report in June 2016 which included remeasurement year 1 data, and were reviewed by the EQRO. All MCOs submitted a progress report update in September 2016 and were reviewed by the EQRO. January 2017 was the start of the sustainability year for the MCOs. In June 2017, all MCOs submitted a progress report which included the results of the remeasurement year 2 data and were reviewed by the EQRO. In the June 2017 report, one of the MCOs revised their Prenatal PIP aim statement and performance indicators, resulting in a new PIP cycle. For this MCO, 2016 is now the baseline data year for the project; results of calendar year 2017 will reflect remeasurement year 1 and results of calendar year 2018 will reflect remeasurement year 2. January 2019 will be the start of the sustainability year for this MCO. All MCOs submitted a progress report update in September 2017 and were reviewed by the EQRO.

Additionally, the MCOs submitted individual PIP proposals with the focus on Developmental Screening and Early Intervention. The initial proposals were submitted by the MCOs in September 2017 and were reviewed by the EQRO. The individual proposals were approved, and the plans have initiated project activities in early 2018.

Lastly, all MCOs submitted individual PIP proposals in September 2015 on Falls Prevention specific to members receiving managed long term services and supports. The individual proposals were approved and project activities were initiated by the MCOs in early 2016. The MCOs submitted a progress report in June 2016 which included the 2015 baseline data. The MCOs submitted a progress report update in September 2016 and were reviewed by the EQRO. January 2017 was the start of remeasurement year 2 for this PIP. The MCOs submitted a progress report in June 2017 which included the results of the remeasurement year 1 data and were reviewed by the EQRO. The MCOs submitted a progress report update in September 2017 and were reviewed by the EQRO. January 2018 was the start of the sustainability year for the MCOs.

State Sanctions against MCO, ASO, SNP or PACE Organization:

NJ provided a Notice of Deficiency to Horizon NJ TotalCare (FIDE SNP) related to a Corrective Action Plan (CAP) needed for denial and appeal notification letters. After reviewing the CAP we found that Horizon took the appropriate action after being notified of the issue by reprocessing the affected denials and appeals, and reissued the corrected corresponding notification letters. We still have concerns related to a corresponding policy of their internal audit process of these notification letters for their "Delegate & Vendor Oversight – Government Programs".

XII. Demonstration Evaluation

The State is testing the following hypotheses in its evaluation of the demonstration:

A.	***Expanding Medicaid managed care to include long-term care services and supports will result in improved access to care and quality of care and reduced costs, and allow more individuals to live in their communities instead of institutions.***
	The Center for State Health Policy (CSHP) draft final evaluation report covering all findings related to this hypothesis was submitted to the State in June 2017. CSHP attended the MAAC Meeting on January 24th and the MLTSS Steering Committee Meeting on February 22nd as part of our general monitoring of ongoing activities related to MLTSS.
B.	***Providing home and community-based services to Medicaid and CHIP beneficiaries and others with serious emotional disturbance, opioid addiction, pervasive developmental disabilities, or intellectual disabilities/developmental disabilities will lead to better care outcomes.***
	The draft final evaluation report covering all findings related to this hypothesis was submitted to the State in June 2017. CSHP attended the MAAC Meeting on January 24, 2018, where updates were provided on the Supports Program. No other activities related to this hypothesis were undertaken this quarter.
C.	***Utilizing a projected spend-down provision and eliminating the look back period at time of application for transfer of assets for applicants or beneficiaries seeking long term services and supports whose income is at or below 100% of the FPL will simplify Medicaid eligibility and enrollment processes without compromising program integrity.***
	Since the draft final evaluation report covering all findings related to this hypothesis was submitted to the State in June 2017, no further activities related to this hypothesis were undertaken this quarter.
D.	***The Delivery System Reform Incentive Payment (DSRIP) Program will result in better care for individuals (including access to care, quality of care, health outcomes), better health for the population, and lower cost through improvement.***
	This quarter CSHP completed several major components of the DSRIP summative evaluation. The final version of the hospital web survey was programmed into Survey Monkey and pretested in early January 2018. Several minor programming revisions were performed following pretesting. All survey materials, including the survey questionnaire and emails/letters described below, were approved by the Rutgers Institutional Review Board. A list of DSRIP contact persons at all 49 DSRIP-participating hospitals in New Jersey was provided to us by the New Jersey Department of Health. On January 23, 2018, an advance endorsement letter from the New Jersey Department of Health was emailed to the DSRIP contact persons at the hospitals. This advance letter described the survey and its purpose, encouraged the hospitals to

	provide feedback on the program via the survey, and indicated that Rutgers Center for State Health Policy researchers would again be conducting the survey. The email accompanying the advance letter requested that the hospitals contact CSHP staff if the survey should be sent to a different hospital representative, and CSHP followed up on these contact person changes. On January 24, 2018, another email was sent containing informed consent information and a link to the web survey. On January 30 and February 6, 2018, reminder emails with the consent information and survey link were sent. The survey field period was closed on February 20, 2018. The survey data was prepared for analysis, low and high Medicaid hospital groups were created, and the data was then analyzed using IBM SPSS Statistics (SPSS). Frequencies or means of all measures were conducted, and then cross-tabulations or ANOVAs of all measures by the Medicaid hospital groups were conducted. Changes over time were noted for those items that were also on the first 2015 survey. A chapter in the report containing a description of these results was prepared, along with charts and a table displaying the findings. Also during this quarter, analysis of the DY2, DY3, and newly-received DY4 and DY5 performance results on selected DSRIP Stage 4 quality metrics was completed. In this analysis, within-subjects' analyses of variance (ANOVAs) were conducted to assess change over time from 2013 to 2016 for each of the metrics across all 50 New Jersey hospitals participating in the DSRIP program (one of these dropped out of the program after 2014). Time trends in the average value of metrics over 2013-2016 were also calculated and plots of the mean values over four years were prepared. Finally, we determined what percentage of hospitals improved for each metric based on performance in the first and last years. A chapter in the report containing a description of these results was prepared, along with charts and a table displaying the findings. The chapter relating to findings from the second round of key informant interviews was also completed this quarter and sent to the State for review. The interviews were completed last quarter. Analysis was completed on the interview data (10 interviews with 29 informants, including participating hospitals, associations, outpatient partners, and state staff. Finally, CSHP made significant progress on the quantitative analyses for the DSRIP summative evaluation this quarter. Analytic datasets for all outcome metrics were finalized, and CSHP conducted the majority of the descriptive analyses and difference-in difference regression modeling. Charts and tables of results were prepared, and CSHP completed significant portions of the chapter containing a description of our methods and results for inclusion in the summative evaluation report.

XIII. Enclosures/Attachments

A. Budget Neutrality Report
B. MLTSS Quality Measures
C. ASD/ ID/DD-MI Performance Measures

XIV. State Contact(s)

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XV. Date Submitted to CMS
May 30, 2018

Deliverables due during MLTSS 2nd quarter (1/1/2018 - 3/31/2018)

The Division of Medical Assistance and Health Services' (DMAHS) Office of Managed Long-Term Services and Supports Quality Monitoring (MLTSS/QM) receives and analyzes the Performance Measure data submitted by the respective data source. The MLTSS-MCO Quality Workgroup continues to meet on a monthly basis to discuss any issues raised by the MCOs, review data submitted, and facilitate resolution. To assist in the refining of the existing data submitted in the MLTSS Performance Measure Reports by the Managed Care Organizations, the State's External Quality Review Organization, IPRO, has developed more refined specifications for the MLTSS PMs effective July 1, 2016. The development of the refined specifications is an ongoing agenda item with the IPRO taking the lead on the discussions during the monthly MLTSS MCO Quality Workgroup meetings. IPRO continues to work with the MCOs to validate their system's coding for each Performance Measure using the refined specifications. The MLTSS Program Year is July 1st of a given year through June 30th of the following year and the MLTSS Performance Measures specifications are for those measurements periods that occur within a particular program year. Prior to the start of a new MLTSS program year, the MLTSS PM specifications are reviewed; revised, suspended, or new ones are added for upcoming Program Year. In addition to the PM Deliverables, this workgroup discusses other MCO contract required MLTSS reporting requirements. Any areas of concern are discussed at a following meeting along with recommendations and resolution.

This quarterly report reflects the performance measures (PM) that were reported by the MCOs and the Division of Aging Services (DoAS) to the Office of MLTSS/QM during the second quarter of MLTSS (1/1/18 – 3/31/18). Each performance measure identifies its measurement period; however, depending on the source for the numerator/denominator the due date for reporting on a particular measure may have a lag time to allow for collection of the information. Several measures rely on claims data; therefore, a lag of 180 days must be built into the due date to allow for the MCO to receive the claims and process the data. This report reflects the performance measures data the Office of MLTSS/QM should have received during the fourth year, second quarter (1/1/18 – 3/31/18) of MLTSS program.

The data for the PMs that DoAS is responsible for reporting is obtained from within their TeleSys database, SAMS database, and/or the Shared Data Warehouse. The PM # 02 was eliminated effective with the July 2017 contract. As previously reported, the State discontinued reporting on PM #02 and PM #06 beginning July 1, 2017. Revisions were made to how the denominator for PM #04a is defined. The OCCO is responsible for conducting the nursing facility level of care determinations for individuals seeking admission to nursing facilities regardless of funding source. The change to the denominator will assist in better focusing the data on the MLTSS population.
Unless otherwise noted, Performance Measure(s) data reports that are not included in this document may be a result of measures involved in review from New Jersey's EQRO or lag time allowing for receipt of claims related data..

Deliverables due during MLTSS 2nd quarter (1/1/2018 - 3/31/2018)

PM # 03	Nursing facility level of care assessments conducted by the MCO determined to be "Not Authorized"
Numerator:	Total number of "Not Authorized" reassessments conducted by OCCO with a determination of "Approved"
Denominator:	Total number of MLTSS level of care assessments that were conducted by MCO with a determination of "Authorized" and "Not Authorized" by OCCO during the measurement month
Data Source:	DoAS
Measurement Period:	Monthly – Due the 15th of the following month

Measurement period	09/2017	10/2017	11/2017
Numerator	1092	995	877
Denominator	1120	1013	898
%	97.5	98.2	97.7

Beginning 7/1/2017, PM #03 was revised and a lag time of three months added to allow for reassessment by OCCO. After review of a level of care assessment conducted by an MCO, OCCO determines an outcome of "Authorized" or "Not Authorized." For those assessments determined to be "Not Authorized," OCCO conducts a reassessment of the member. For these measurement months, DoAS reported that the rate of reassessments by OCCO with a final outcome of "Approved" was consistently high.

PM # 04	Timeliness of nursing facility level of care assessment by MCO
Numerator:	The number of assessments in the denominator where the MCO assessment/ determination date is less than 30 days from the referral date to MLTSS
Denominator:	Number of level of care assessments conducted by MCO in the measurement month
Data Source:	MCO
Measurement Period:	Monthly – Due 15th of the 2nd month (lag report) following reporting period

November 2017	A	B	C	D	E	TOTAL
Numerator	16	61	365	68	124	634
Denominator	23	66	406	75	127	697
%	69.5	92.4	89.9	90.7	97.6	90.9

December 2017	A	B	C	D	E	TOTAL
Numerator	17	55	459	81	195	807
Denominator	20	61	490	82	201	854
%	85.0	90.2	93.7	98.8	97.0	94.5

N = Numerator D = Denominator % = Percentage N/A = Not Available O/D = Over due
A = Aetna B = Amerigroup C = Horizon NJ Health D = United HealthCare E = WellCare

Deliverables due during MLTSS 2nd quarter (1/1/2018 - 3/31/2018)

January 2018	A	B	C	D	E	TOTAL
Numerator	21	55	384	53	105	618
Denominator	22	59	410	67	193	751
%	95.4	93.2	94.0	79.0	54.4	82.3

The MCOs are monitoring the timeliness of level of care (LOC) assessments and have identified that some of the delays include: Care Manager not scheduling the appointment within 30 days, member requested a later appointment or rescheduled the original appointment, member was unable to contact to schedule the appointment, member hospitalization, and members dis-enrolled. MCO E reported for November 2017 there was a slight decrease in the compliance rate in comparison to October 2017. They reported 2 long term custodial care members had inpatient admissions during the referral period and therefore the assessors had to reschedule the assessment and were completed on day 32 and 35 from the original date of referral. The 3rd member that was out of the 30-day compliance timeframe was due to an issue with timely submission of the assessment. MCO A reported for December 2017 that 7 of the valid referrals were for members living in the community (HCBS), and the remaining 13 were members living in the Nursing Facility (NF) setting. There were 13 additional referrals that did not require NJ Choice assessment due to transferring to another MCO, relocation out of the country and 1 member expired. MCO C reported there were 41 untimely assessments, 3 of which are MLTSS FIDE/SNP members. Of the untimely assessments, 30 were late due to the Care Manager not scheduling the appointment within 30 days, 8 at the members request or rescheduled the original appointment, and 3 were unable to contact for initial appointment. Care Managers that were untimely in the completion of the assessment were re-educated on the contractual requirement for timely assessment and Supervisors have been notified to begin remediation. Additionally, MCO C reported ongoing tracking and trending of this measure, has identified decreased results, and has increased oversight on the timeliness of assessments. The MCOs continue improvement procedures such as monitoring the referral and submission process for all completed assessments, ensuring NF residents have custodial authorizations in place, evaluating the performance of the Rapid Assessment model and ongoing monitoring of the plan's referral queues with increased oversight of the referral and assessment process.

PM # 04a	Timeliness of nursing facility level of care assessment
Numerator:	The number of assessments in the denominator where the OCCO/ADRC assessment/determination date is less than 30 days from the referral date
Denominator :	Number of new MLTSS enrollees within the reporting month with an assessment completed by OCCO/ADRC
Data Source:	DoAS
Measurement Period:	Monthly – Due 15th of the 2nd month (lag report) following reporting period

Measurement Period	11/2017	12/2017	01/2018
Numerator	691	697	713
Denominator	1083	1116	1203
%	63.8	62.5	59.3

N = Numerator D = Denominator % = Percentage N/A = Not Available O/D = Over due
A = Aetna B = Amerigroup C = Horizon NJ Health D = United HealthCare E = WellCare

Though the denominator for this measure was revised beginning 7/1/2017 to include only new MLTSS enrollees, OCCO staff continues to assess members referred to them, including those whose outcome is not MLTSS enrollment. DoAS reported that the compliance rate over the last six months ranged from 59 % to 67%.

PM # 05	Timeliness of nursing facility level of care re-determinations
Numerator:	Total number of MLTSS members in the denominator who are confirmed as appropriate for continued MLTSS enrollment who have not had a level of care assessment by report close out.
Denominator:	Total number of MLTSS members with no level of care assessment conducted in the last 16 months
Data Source:	DoAS
Measurement Period:	Beginning 7/1/2017, this is a quarterly report – due 3 months after the 16-month report is run

November 2017	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	1	6	0	14	4	25
Denominator	45	64	116	94	59	378
%	2.2	9.4	0	14.9	6.8	6.6

In March 2017, DoAS finalized a quarterly schedule for the 16 month report, requiring close out by the MCOs within 8 weeks. DoAS provided training for the MCOs regarding streamlined assessment review; disenrollment; 16 month report process and timelines; and requirement for a Corrective Action Plan if all cases are not closed out or an extension requested within 30 days of receipt of report.

As of 7/1/2017, the revised definition for PM #05 is: Timeliness of nursing facility level of care re-determinations. This is the second report using the new guidelines.

The resolution for cases reported include-

Resolutions	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Clinical Assessments Completed	35	37	102	58	42	**274**
Terminations Completed	7	17	12	14	13	**56**
Terminations pending denial/fair hearings	0	3	2	8	0	**13**

The trend continues to be a decrease in the number of outstanding overdue assessments. The number of individuals without a level of care reassessment since MLTSS started on July 1, 2014 has been reduced from 2.5% to 0%. Overall final compliance rate for this reporting month is at 93.4% for follow up on outstanding assessments.

DoAS continues to educate MCO's through MCO Care Manager Meetings in regard to the contractual agreement of annual assessments. MCO compliance for resolving outstanding cases continues to be less than 100%. As a result, DoAS has issued a request for Corrective Action Plans to 4 of the 5 MCO's. The MCO's have until April 1, 2018 to submit their plan to DoAS. DoAS will continue to work

with the MCO's to ensure a 100% compliance rate for the completion of outstanding clinical assessments.

PM # 07	Members offered a choice between institutional and HCBS settings
Numerator:	Number of assessments in the denominator with an indicator showing choice of setting within the IPOC
Denominator:	Number of level of care assessments with a completed Interim Plan of Care (IPOC)
Data Source:	DoAS
Measurement Period:	Monthly – Due the 15th of the following month

Measurement Period	12/2017	01/2018	02/2018
Numerator	849	884	850
Denominator	1045	1054	1037
%	81.2	83.9	82.0

DoAS reported an increase in compliance overall during this reporting period. MCOs are sent individual compliance reports each month and are reminded to continually update assessors on coding requirements as they relate to choice of settings. DoAS reported that they noted an increase in compliance of 4.3 points in December; a 2.6 point increase in October; and although expected to see increased compliance rates, a 1.9 point decrease was noted for February.

PM # 17	Timeliness of Critical Incident (CI) reported to DoAS for measurement month
Numerator:	#CI reported in writing to DoAS within 2 business days
Denominator:	Total # of CI reported to DoAS for measurement month
Data Source:	DoAS
Measurement Period:	Monthly – Due 15th of the following month

Measurement Period	12/2017	01/2018	02/2018
Numerator	316	400	321
Denominator	317	420	336
%	99.7	95.2	95.5

DoAS reports that a high percentage of Critical Incident reports were filed on a timely basis during this reporting period. Four MCOs fell below the 100% threshold during this reporting period. All four MCOs provided Corrective Action Plans to DoAS to address their delays.

PM # 17a	Timeliness of Critical Incident(CI) reporting (verbally within 1 business day) for media and unexpected death incidents
Numerator:	# CI reported to DoAS verbally reported within 1 business day for media and unexpected death incidents
Denominator:	Total # of CI reported verbally to DoAS for measurement month
Data Source:	DoAS
Measurement Period:	Monthly – Due 15th of the following month

Measurement Period	12/2017	01/2018	02/2018
Numerator	6	2	6
Denominator	6	2	6
%	100	100	100

DoAS reported that all Critical Incidents for Media Involvement and Unexpected Death were reported on time for this reporting period.

PM # 19	Timelines for investigation of complaints, appeals, grievances (complete within 30 days)
Numerator:	# of complaints, appeals and grievances investigated within 30 days (unless findings cannot be obtained in that timeframe which must be documented)
Denominator:	Total # of complaints, appeals, and grievances received for measurement period
Data Source:	MCO Table 3A and 3B Reports; DMAHS
Measurement Period:	Quarterly Due: 45 days after reporting period.

Table 3A - Appeals

10/1/17-12/30/17	A	B	C	D	E	TOTAL
Numerator	0	22	56	30	24	132
Denominator	0	22	56	30	24	132
%	0.0	100	100	100	100	100

N = Numerator D = Denominator % = Percentage N/A = Not Available O/D = Over due
A = Aetna B = Amerigroup C = Horizon NJ Health D = United HealthCare E = WellCare

Table 3B - Grievances

10/1/17-12/30/17	A	B	C	D	E	TOTAL
Numerator	0	73	112	21	45	251
Denominator	0	75	117	21	45	258
%	0.0	97.3	95.7	100	100	97.3

MCO B had two cases in Table 3B that took more than 30 days to resolve. As per the MCO B, one delay was 31 days until resolution of MCO payment for services rendered due to timing for provider claims reprocessing and MCO payment. Additionally, MCO B reported 34 days for the resolution of family member dissatisfaction with facility was due to the facility and family members no response/delay to multiple voice messages and email communications from the MCO. MCO C had five cases in Table 3B that took more than 30 days to resolve. MCO C reported three cases involved member dissatisfaction with PCA services. The MCO reported that the delay in one case was due to the late responsiveness by the investigating department while the other two were due to grievance staff error. Additionally, MCO C reported two cases regarding billing issues/unpaid claims. In one case, the provider was reeducated in reference to not billing members and in the other; the member was educated regarding covered benefits and services.

PM # 20	Total # of MLTSS members receiving MLTSS services.
Numerator:	Unique count of members with at least one claim for MLTSS services during the measurement period. (Excluding: CM, PCA, Medical Day, and Behavioral Health services).
Denominator:	Unique count of members meeting eligibility criteria at any time during the measurement period. (Quarter or Annual).
Data Source:	MCO paid claims data, adjusted claims (excluding denied claims); according to the list of MLTSS/HCBS service procedure codes and the logic for the MCO Encounter Categories of Service (copy of list provided). Based on the premise: member must use services monthly *Total may include duplication if member switches MCO during the reporting period.
Measurement Period:	Quarterly/Annually – Due: 180 day lag for claims + 30 days after quarter and year

1/1/17 – 3/31/17	A	B	C	D	E	TOTAL
Numerator	1000	4073	12457	5749	3209	26488
Denominator	1301	4933	16326	7169	5198	34927
%	76.9	82.6	76.3	80.2	61.7	75.8

Deliverables due during MLTSS 2nd quarter (1/1/2018 - 3/31/2018)

4/1/17 – 6/30/17	A	B	C	D	E	TOTAL
Numerator	1223	5436	13011	6021	3595	29286
Denominator	1551	6854	16777	7362	5784	38328
%	78.9	79.3	77.6	81.8	62.2	76.4

7/1/16 – 6/30/17	A	B	C	D	E	TOTAL
Numerator	1517	6698	16255	8118	4329	36917
Denominator	1888	8213	20070	9063	6596	45830
%	80.3	81.6	81.0	89.6	65.6	80.6

The MCOs continue to claim under reporting for this measure. MCOs report that there are members receiving services but the MCO had not yet received a claim as some providers are not submitting, and or delaying the submission of claims for services. MCO A did not have reportable data for this measure during the first quarter of MLTSS (10/1/17 – 12/31/17) report and is included in this quarterly report which reflects the data reported by MCO A during the measurement period of 1/1/2017 – 3/31/2017. MCO A requested extensions for this deliverable until the claims were successfully resubmitted and claims based data was re-run for the reporting period. MCO A reported that of the 1301 members, 794 were receiving custodial services in a Nursing Facility, and another 59 were residing in Assisted Living facilities. Indication of those identified not receiving MLTSS services were noted for PERS or HDM before or after the measurement period. MCO A determined that coding errors were the source of denied PERS claims and began collaborating with their PERS vendors to rectify the coding issue. PERS vendors were required to resubmit claims from the previous measurement period reflected in this report. MCO A reported they will closely monitor PERS claims in order to ensure ongoing accuracy. Additionally, MCO A reported that MLTSS Care Managers undergo quarterly refresher training on options counseling and the importance of increasing use of MLTSS-specific services in the HCBS membership. MCO B reported that 828 of the members that were reported during the quarterly period as not utilizing an MLTSS service are receiving PCA/PPP or Medical Day. Reasons for the 497 without services account for members no longer eligible, inpatient/rehab and enrollment during last month of measurement quarter and the member requested a visit after 30 days of enrollment. Additionally, MCO B reported that they developed a member activity report to review monthly claim data to identify high/low utilization for care management intervention including invoice confirmation from the new PPP fiscal intermediary. MCO B reports that effective February 2018, they are conducting monthly HCBS phone calls to improve member experience, capture potential gaps in care, and include review of authorized services with the member

PM # 21	MLTSS members transitioned from NF to Community.
Numerator:	Cases in the denominator who transitioned to HCBS during the measurement period. (Cases should be counted only once).
Denominator:	Unique count of members continuously enrolled with the MCO in MLTSS for the measurement period. (Quarter or Annual).
Data Source:	MCO – living arrangement file and client tracking system
Measurement Period:	Quarterly/Annually – Due: 30 days after the quarter and year

10/1/17-12/31/17	A	B	C	D	E	TOTAL
Numerator	N/A	19	87	28	4	N/A
Denominator	N/A	2657	5805	6641	1368	N/A
%	N/A	0.7	1.5	0.4	0.3	N/A

The MCOs continue to report that as they continue to work with approved programs such as Money Follows the Person to identify appropriate NF transitions to the community, there have been increases in the number of MLTSS members transitioning from the NF to the community. MCO E reported there were a total of 1368 continuously enrolled nursing facility members in the plan, 4 members transitioned to the community and there were no MLTSS FIDE/SNP members among those transitioning during this quarter. Additionally, MCO E reported that all members who transitioned are still currently active in the plan and remain in an HCBS setting. One transition was identified as member transferring from NF to ALF setting and the other 3 have transitioned to their private residence. MCO C reported 74 transitioned to a private residence and 13 transitioned into an ALR/ALP/CPCH. The age range was from 24 to 95 with the average age at 65 and there were 2 MLTSS FIDE/SNP members who transitioned to the community during this measurement period. Additionally, MCO C reported they will continue to track and trend members that are transitioned to the community to ensure they are safely transitioned and adapt well to their new environment. MCO A is still working with the State's EQRO on their coding for this performance measure and has an extension to submit this report next quarter. This data will be included in the third quarter report.

PM # 23	MLTSS NF to HCBS transitions who returned to NF within 90 days.
Numerator:	Cases in the denominator with an NF living arrangement status within 90 days of initial HCBS transition date.
Denominator:	Unique count of members in NF MLTSS that are continuously enrolled with the MCO from beginning of Measurement period (Quarter or Annual) or from date of initial enrollment in NF MLTSS, whichever is later, through 90 days post HCBS transition date.
Data Source:	MCO – Living arrangement file, CM tracking, and prior auth. System (r/o respite/rehab). MCO to identify how the dates were calculated.
Measurement Period:	Quarterly/ Annually Lag Report Due: 120 days after reporting quarter or year.

Deliverables due during MLTSS 2nd quarter (1/1/2018 - 3/31/2018)

7/1/17-9/30/17	A	B	C	D	E	TOTAL
Numerator	N/A	1	5	3	0	N/A
Denominator	N/A	20	63	47	7	N/A
%	N/A	5.0	7.9	6.4	0.0	N/A

The MCO's are continuing to track and trend members returning to the NF within 90 days. MCO E reported that 5 of the 7 NF to HCBS transitions were 65 years of age or older, there were no MLTSS FIDE/SNP members and all members remained in a community setting after their initial transition for 90 days or greater. Additionally, MCO E reported that 6 were facilitated through MFP and they ensure all the transitions occurring from an NF to HCBS setting have adequate supports in place prior to discharge as well as providing immediate follow up with the member post discharge. MCO B reported that 1 member remained in the HCBS setting for 76 days prior to returning to the NF and during the CM follow-up visit, it was identified that the member's preferred setting was the NF as he did not feel he had adequate care in the community setting. Additionally, MCO B reviews reasons for return to NF and has identified that the top reasons include hospitalizations and increased ADL deficits. MCO D reported they identified 3 members who transitioned back to the NF and none were enrolled in the MLTSS FIDE/SNP. MCO D also reported that this report criterion delinks the results PM 21 and the new ability to make retroactive living arrangement file adjustments also impacts this report. Additionally, MCO D reported the results this quarter are in line with previous data submissions and while the change to the code was one component, reeducation is being conducted to ensure proper use of the Placement value for each care manager. MCO A is working with the State's EQRO on their coding for this performance measure and has an extension to submit this report next quarter. This data will be included in the third quarter report.

PM # 24	MLTSS HCBS members transitioned from the community to NF for more than 180 days.
Numerator:	Cases in the denominator with NF living arrangement status for 181 days or more after the date of transition to NF.
Denominator:	Unique count of members in HCBS MLTSS that are continuously enrolled with the MCO from the beginning of measurement period (Quarter or Annual) or from date of initial enrollment in HCBS MLTSS, whichever is later, through 181 days post NF transition date.
Data Source:	MCO -Living arrangement file, CM tracking, and prior authorization system (r/o respite/rehab). MCO to identify how the dates were calculated
Measurement Period:	Quarterly/Annually Lag Report Due: 210 day lag after quarter and year

4/1/17 – 6/30/17	A	B	C	D	E	TOTAL
Numerator	11	35	124	59	11	240
Denominator	13	38	137	64	14	266
%	84.6	92.1	90.5	92.2	78.6	90.2

N = Numerator D = Denominator % = Percentage N/A = Not Available O/D = Over due
A = Aetna B = Amerigroup C = Horizon NJ Health D = United HealthCare E = WellCare

Deliverables due during MLTSS 2nd quarter (1/1/2018 - 3/31/2018)

7/1/16 – 6/30/17	A	B	C	D	E	TOTAL
Numerator	28	104	459	246	61	898
Denominator	30	110	498	269	68	975
%	93.3	94.6	92.2	91.4	89.7	92.1

The MCO's are continuing to track and trend members returning to the NF for greater than 180 days. MCO A reported during the quarter of the 13 members placed into long term care, 3 were men and 10 were women. It was reported that the 2 members who did not remain for 6 months or more were both women at a skilled nursing facility for rehabilitation following inpatient hospital stays. They did not wish to remain for the long term but were not prepared to discharge home at the end of their skilled nursing facility stay. Additionally, MCO A reports the 11 members who remained for long term care were from a home setting with maximized services prior to placement and each of them agreed with NF placement. MCO E reported during the quarter of the 14 members identified with HCBS to NF transitions, 11 members remained in the NF for more than 180 days of which 10 remain actively enrolled in the plan. Additionally, MCO E reported that the implementation of a NF team and on-going monitoring identifies members for potential transition during the initial period 180 day period. MCOs will continue to monitor.

PM # 25	MLTSS HCBS members transitioned from the community to NF for 180 days or less.
Numerator:	Cases in the denominator with NF living arrangement status for 180 days or less after the date of transition to NF.
Denominator:	Unique count of members in HCBS MLTSS that are continuously enrolled with the MCO from the beginning of measurement period (Quarter or Annual) or from date of initial enrollment in HCBS MLTSS, whichever is later, through 180 days post NF transition date.
Data Source:	MCO - Living arrangement file, CM tracking, and prior authorization system (r/o respite/rehab). MCO to identify how the dates were calculated.
Measurement Period:	Quarterly/Annually Lag Report Due: 210 day lag after quarter and year

4/1/17 – 6/30/17	A	B	C	D	E	TOTAL
Numerator	2	3	13	5	3	26
Denominator	13	38	137	64	14	266
%	15.4	7.9	9.5	7.8	21.4	9.8

7/1/16 – 6/30/17	A	B	C	D	E	TOTAL
Numerator	2	6	39	23	7	77
Denominator	30	110	498	269	68	975
%	6.7	5.5	7.8	8.6	10.3	7.9

N = Numerator D = Denominator % = Percentage N/A = Not Available O/D = Over due
A = Aetna B = Amerigroup C = Horizon NJ Health D = United HealthCare E = WellCare

MCOs report they are continuing to monitor and work with community and family supports to prevent hospitalizations and institutionalization. MCO E reported during the annual measure there were 68 members identified in the denominator as having had a transition event from an HCBS setting into a NF setting and of those 7 members experienced a short NF stay of less than 180 days. MCO E reported during the annual measure that 5 out of 7 members were age 65 or older, there were no members identified as MLTSS FIDE/SNP, and the average number of days for the short stays is sixty two. Additionally, MCO E reported that one of their NF team focus is coordinating services for members with an initial NF transition to increase the number of short stays and decreasing long term institutionalization where avoidable. In addition, as a Plan, there has been a greater focus in decreasing the number of members admitted to a NF setting by adding services for community members where needed and addressing issues that may influence these transitions such as caregiver support.

PM # 26	Acute inpatient utilization by MLTSS HCBS members.
Numerator:	The sum of visits to an acute inpatient facility, regardless of the intensity or duration of the visit, using identified value sets and exclusions during measurement period. Count IP visits based on member's enrollment in HCBS on date of discharge. (Report monthly values in data analysis).
Denominator:	Sum of member months (# of members enrolled in HCBS per month) for measurement period. (Report monthly values in data analysis).
Data Source:	MCO paid and denied (excluding duplicate claims) claims according to logic for the MCO encounter Categories of Services (separate file)
Measurement Period:	Monthly data reported Quarterly/Annually (180 day lag for claims + 30 days after quarter and year)

4/1/17 – 6/30/17	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	81	661	1472	361	607	3182
Denominator	1594	11037	29824	11361	12445	66261
%	5.1	6.0	4.9	3.2	4.9	4.8

7/1/16 – 6/30/17	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	288	2248	5620	1394	2160	11710
Denominator	5301	38362	113024	43962	43344	243993
%	5.4	5.9	5.0	3.2	5.0	4.8

Data for this measure is captured on a monthly basis and the numerators are added together and the denominators are added together to report quarterly data reflecting the number of hospitalizations that occurred per member month. It is based on hospital events and not unduplicated members. The top diagnosis for hospital admission include: Sepsis, unspecified organism, urinary tract infection, chronic obstructive pulmonary disease, type 2 diabetes with hypoglycemia, anemia, schizophrenia, GI bleed, C. difficile, atrial fibrillation, non ST- Segment

elevated myocardial infarction, pneumonia unspecified organism, acute kidney enterocolitis due to clostridia, gastritis, CHF, CKD, pneumonitis, and genitourinary tract disease. MCO B reported trends in top diagnoses with sepsis, unspecified organism (49 instances) and urinary tract infection (24 instances) and population trends with 175 instances amongst the MLTSS FIDE/SNP population and 486 amongst the MLTSS Medicaid population. Additionally, MCO B reported amongst the MLTSS FIDE/SNP population, the top diagnosis was chronic obstructive pulmonary disease with acute exacerbation. MCO C reported that the top three diagnoses for acute inpatient utilization for HCBS members remained sepsis, urinary tract infection, and chronic obstructive pulmonary disease. Additionally, MCO C reported that conference calls are conducted weekly to review actions that can be taken to prevent readmissions. MCO E reported 487 unique members were identified as having events in the numerator. Review of admissions by member showed a total of 91 members having more than 1 admission during the measurement period as there were 2 members with 5 admissions related to CHF and sepsis in one case and the other member had admissions related to CHF and diabetes. There were 6 members with 4 admissions, 11 members with 3 admissions and 72 members had 2 admissions. Additionally, MCO E reported review of diagnoses showed the majority of multiple admissions were related to chronic conditions such as CHF, renal failure, hepatic failure, and complications including sepsis and pneumonia. The top diagnoses categories reported during this quarter continue to be circulatory disease with 130 events, of which 48 correspond to CHF, followed by respiratory tract diseases with 76 events (36 of those events related to COPD), and infectious disease were reported in 72 events (with 62 related to Sepsis). GI tract disorders were reported with a total of 53 events (6 events of non-infective gastroenteritis and no other trends identified). Finally, genitourinary tract disease was reported in 47 events, with 20 of those events reported as being renal failure and 17 events with UTI reported. To identify trends and target an inpatient admission reduction plan, MCO E reportedly conduct an in-depth review on all members with multiple admissions and continue using their newly developed discharge planning report to improve timely outreach, appropriate discharge planning including follow up appointments and medication reconciliation.

PM # 27	Acute inpatient utilization by MLTSS NF members.
Numerator:	The sum of visits to an acute inpatient facility, regardless of the intensity or duration of the visit, using identified value sets and exclusions. Count IP visits based on member's enrollment in NF on date of discharge. (Report monthly values in data analysis).
Denominator:	Sum of member months (# of members enrolled in NF per month) for measurement period. (Report monthly values in data analysis).
Data Source:	MCO paid claims and denied claims (excluding duplicate claims) according to logic for the MCO encounter Categories of Services (separate file)
Measurement Period:	Monthly data reported Quarterly/Annually (180 day lag for claims + 30 days after quarter and year)

4/1/17 – 6/30/17	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	98	437	684	103	198	1520
Denominator	2394	7752	17030	9129	3716	40021
%	4.1	5.6	4.0	1.1	5.3	3.8

N = Numerator D = Denominator % = Percentage N/A = Not Available O/D = Over due
A = Aetna B = Amerigroup C = Horizon NJ Health D = United HealthCare E = WellCare

7/1/16 – 6/30/17	A	B	C	D	E	TOTAL
Numerator	354	1574	2518	388	688	5522
Denominator	7808	28096	61808	33365	12878	143955
%	4.5	5.6	4.1	1.2	5.3	3.8

Data for this measure is captured on a monthly basis and the numerators are added together and the denominators are added together to report quarterly data reflecting the number of hospitalizations that occurred per member month. It is based on hospital events and not unduplicated members. MCO E reported during the measurement year there were 12878 member months identified with 688 acute inpatient events reported. There were a total of 423 unique members accounting for 688 events and 344 out of 423 unique members were age 65 or older. Review of admissions by member showed a total of 146 members having more than 1 admission during the measurement period with 1 member accounting for 9 events. Additionally, MCO E reported as they continue to implement a nursing facility care management team, the utilization rates overall have continued to decline for this population. MCO D reported during the measurement year the most common hospitalization primary diagnosis was essential primary hypertension followed by sepsis unspecified organism and muscle weakness, generalized. 52 percent of members hospitalized were 65 years of age or older. Additionally, MCO D reported of the 388 unique inpatient hospitalizations, 44 unique members had multiple admissions with the top 3 diagnoses identified as dementia unspecified, followed by cerebral palsy unspecified and pneumonia unspecified organism. MCO C reported during the measurement year that of the 2518 inpatient hospitalizations, there were 5 MLTSS FIDE/SNP NF members that had a hospital admission during the measurement period and the top 3 diagnoses remained consistent throughout the fiscal year, as sepsis 14.61%, urinary tract infection (UTI) 3.61% and acute kidney failure 3.53%.

PM # 28	Readmissions of MLTSS HCBS members to the hospital within 30 days.
Numerator:	Sum of all HCBS members acute readmission for any diagnosis within 30 days of an index discharge date during the first and last date of the measurement period (Quarter or Annual). Using the administrative specification, assign each acute inpatient stay to a reporting month based on index discharge date. (Report monthly value in data analysis).
Denominator:	Sum of all acute inpatient discharges on or between the first and last day of the measurement period (Quarter or Annual) using the administrative specification to identify acute inpatient discharges and HCBS members. (Report monthly values in data analysis).
Data Source:	MCO paid and denied claims (exclude denials for duplicate submissions) for numerator and 834 file for denominator.
Measurement Period:	Monthly data reported Quarterly/Annually Lag Report Due: 240 days after quarter and year.

Deliverables due during MLTSS 2nd quarter (1/1/2018 - 3/31/2018)

4/1/17 – 6/30/17	A	B	C	D	E	TOTAL
Numerator	13	135	158	48	116	470
Denominator	68	597	1374	361	528	2928
%	19.1	22.6	11.5	13.3	22.0	16.1

7/1/16 – 6/30/17	A	B	C	D	E	TOTAL
Numerator	62	394	633	126	419	1634
Denominator	242	1858	5079	1394	1869	10442
%	25.6	21.2	12.5	9.0	22.4	15.6

Data for this measure is captured on a monthly basis and the numerators are added together and the denominators are added together to report quarterly data reflecting the number of hospitalizations that occurred per member month. It is based on hospital events and not unduplicated members. Some of the reported diagnoses include ; paranoid schizophrenia, type 2 diabetes, hereditary hemorrhagic telangiectasia, COPD, osteomyelitis, sepsis-unspecified, urinary tract infection, epilepsy, ESRD, CHF, acute & chronic respiratory failure, cellulitis, pneumonia. MCO C reported that of the 158 readmissions a total of 34 MLTSS FIDE/SNP HCBS members had an acute-inpatient readmission and the top 3 diagnoses were sepsis-unspecified organism, urinary tract infection, and chronic obstructive pulmonary disease with acute exacerbation. Additionally, MCO C reported that as readmissions are tracked and monitored, weekly inpatient conference calls are conducted to review reasons for readmissions and discuss implementations to prevent or reduce readmissions. MCO E reported in the annual measure there are 419 readmissions that identified a total of 235 unique members, of which 182 were age 65 or older. There were 78 MLTSS FIDE/SNP members identified and 16 of those presented with an acute readmission for any diagnosis within 30 days of an index discharge date. MCO E reported the top 5 disease categories were: diseases of the circulatory system at 113 events, with CHF accounting for 44 events, followed by infectious and parasitic diseases at 59 events with 48 events related to sepsis. Diseases of the respiratory system were reported in 45 events where 19 corresponded to COPD and 13 to pneumonia. Endocrine, nutritional, and metabolic diseases reported 35 events for which 28 were related to diabetes. Diseases of the digestive system was reported with 35 events without significant trends identified and disorders of the genitourinary system was reported in 32 events, 19 of the events were related to renal failure and 9 were related to UTI and cystitis. MCO E reports 83 of the 235 members were identified as having more than one readmission event with the highest utilization reported as 1 member with 24 readmission events due to multiple co-morbidities, including congestive heart failure and diabetes. Another high utilization member was identified with 14 readmission events related to COPD, system lupus erythematosus and pulmonary embolism. Additionally, MCO E reported interventions for high utilization members include changing assigned PCP, in order to address preventative services, referrals to providers specializing with the disease process specific to the member, referrals to support groups in the community, and on-going follow up by the care manager to track utilization after care management intervention. MCOs will continue to monitor.

Deliverables due during MLTSS 2nd quarter (1/1/2018 - 3/31/2018)

PM # 29	Readmissions of MLTSS NF members to the hospital within 30 days.
Numerator:	Sum of all NF members acute readmission for any diagnosis within 30 days of an index discharge date during the first and last date of the measurement period (Quarter or Annual). Using the administrative specification, assign each acute inpatient stay to a reporting month based on index discharge date. (Report monthly value in data analysis).
Denominator:	Sum of all acute inpatient discharges on or between the first and last day of the measurement period (Quarter or Annual) using the administrative specification to identify acute inpatient discharges and NF members. (Report monthly values in data analysis).
Data Source:	MCO paid claims and denied claims (exclude denials for duplicate submissions) for numerator and 834 file for denominator.
Measurement Period:	Monthly data reported Quarterly/Annually Lag Report Due: 240 days after quarter and year.

4/1/17 – 6/30/17	A	B	C	D	E	TOTAL
Numerator	16	37	96	19	27	195
Denominator	77	349	619	103	120	1268
%	21.0	10.6	15.5	18.4	22.5	15.4

7/1/16 – 6/30/17	A	B	C	D	E	TOTAL
Numerator	73	158	342	44	117	734
Denominator	280	1171	2552	388	520	4911
%	26.0	13.5	13.4	11.3	22.5	14.9

Data for this measure is captured on a monthly basis and the numerators are added together and the denominators are added together to report quarterly data reflecting the number of hospitalizations that occurred per member month. It is based on hospital events and not unduplicated members. MCO A reported during the quarter they had 12 unique members that accounted for the 16 readmissions and one member had 3 readmissions during the reporting period. Additionally, MCO A reported that they utilize a NF Contact Sheet on the custodial members' charts and has educated the NF to notify the CM directly with any admission, critical incident or change in condition to improve care manager awareness of inpatient stays and needs upon discharge. MCO B reported that the 37 readmissions consisted of 37 unique members and the average days between discharge and readmission was 10.9 days. Additionally, MCO B reported refinement of current reports with adding additional data elements to trend reasons for readmissions and discharging facilities to develop interventions targeting specific populations or providers and identify trends in primary setting. MCO D reported 44 readmissions for the annual measurement period and 1 readmission was identified as MLTSS FIDE/SNP. The three leading primary diagnosis for the overall readmission were Unspecified Dementia, Alcohol induced acute pancreatitis, and Cerebral palsy unspecified. The 44 readmissions consisted of 26 unique members, of which 5 had more than 2 readmissions with 1 member having 6 readmissions for the diagnoses of Unspecified Dementia.

Deliverables due during MLTSS 2nd quarter (1/1/2018 - 3/31/2018)

PM # 30	ER utilization by MLTSS HCBS members.
Numerator:	Sum of ER visits of HCBS members that did not result in an inpatient encounter, regardless of intensity or duration of visit, using identified value sets and exclusions during the measurement period. (Report monthly values in data analysis).
Denominator:	Sum of member months (Number of members enrolled in HCBS on last day of month) for measurement period. (Report monthly values in data analysis).
Data Source:	MCO paid claims and denied claims (exclude denials for duplicate submissions) for numerator and 834 file for denominator.
Measurement Period:	Monthly data reported Quarterly/Annually (180 day lag for claims + 30 days after quarter and year)

4/1/17 – 6/30/17	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	201	121	2684	822	961	4789
Denominator	1591	11037	29824	11361	12451	66264
%	12.6	1.1	9.0	7.2	7.7	7.2

7/1/16 – 6/30/17	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	560	635	10312	3037	3462	18006
Denominator	4328	38362	113024	43962	43442	243118
%	12.9	1.7	9.1	6.9	8.0	7.4

Data for this measure is captured on a monthly basis and the numerators are added together and the denominators are added together to report quarterly data reflecting the number of ER utilizations that occurred per member month. It is based on ER utilization events and not unduplicated members. MCO A reported during the annual measure there were 560 episodes of ER utilization and the three most frequent reasons for visits to the ER were Urinary Tract Infection, Chest Pain, and Head Injury. Furthermore, 207 members accounted for the 560 ER visits and 104 members had 2 or more ER visits during this time frame. One member was reported with 31 ER visits related to COPD. Additionally, MCO A reported that as they continue to track ER utilization for identified patterns the Care Managers work with members to resolve any barriers to care to avoid multiple trips to the ER. MCO C reported during the annual measure the top three diagnoses identified for ER utilization was Other Chest Pain, Unspecified, Urinary Tract Infection, and Chest Pain Unspecified. Additionally, MCO C reported they continue to track and trend the ER Utilization for MLTSS members, and are in the process of identifying diagnostic groupings.

PM # 31	ER utilization by MLTSS NF members.
Numerator:	Sum of ER visits of NF members that did not result in an inpatient encounter, regardless of intensity or duration of visit, using identified value sets and exclusions during the measurement period. (Report monthly values in data analysis).
Denominator:	Sum of member months (Number of members enrolled in NF on last day of month) for measurement period. (Report monthly values in data analysis).
Data Source:	MCO paid claims and denied claims (exclude denials for duplicate submissions) for numerator and 834 file for denominator.
Measurement Period:	Monthly data reported Quarterly/Annually (180 day lag for claims + 30 days after quarter and year)

4/1/17 – 6/30/17	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	95	77	605	305	128	1210
Denominator	2382	7752	17030	9134	3713	40011
%	4.0	1.0	3.6	3.3	3.4	3.0

7/1/16 – 6/30/17	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	394	384	2351	1201	549	4879
Denominator	6769	28096	61808	33374	12878	142925
%	5.8	1.4	3.8	3.6	4.3	3.4

MCOs are monitoring their respective data to identify patterns, trends, and frequency. MCO B reported for the quarterly measure that the top diagnosis identified is Sepsis, unspecified organism and the 77 visits consisted of 35 unique members with 1 member experiencing 8 ER visits during the quarter. Additionally, MCO B reported modifying performance measures for ER utilization to include facility/provider names, admitting and discharge diagnosis and CPT codes. MCO D reported during the quarterly measure the top 4 diagnoses identified were UTI, Injury, Cardiac and Gastrostomy related. Additionally, MCO D reported one member was identified having 12 visits related to Opioids and altered mental status and one member had 10 visits with multiple diagnosis related to Schizophrenia, depression and Diabetes. Furthermore, MCO D reported that there were 199 members that were over the age of 65 and five members under the age of 18 that utilized the Emergency Room. MCO E reported during the annual measurement period there were a total of 331 unique members accounting for the 549 ER utilization events and 269 of the 331 unique members were age 65 or older. MCO E reported analysis of the top three identified diagnoses showed the highest number of events as Injuries/poisoning due to external causes most of which were contusions, sprains, and lacerations. This was followed by General Signs and Symptoms with the majority attributed to chest pain, altered mental status, syncope, and collapse. The third most common category identified was Mental, Behavioral, and Neurodevelopmental disorders, where alcohol dependence/abuse had the highest number of events. Additionally MCO E reported other identified diagnosis related to CHF, cardiac arrest, UTI, GI bleeding, Endocrine, Nutritional, and Metabolic disorders. Furthermore, MCO E reported reviews will be conducted on all members with multiple ER visits help further develop a targeted ER utilization reduction plan.

PM # 33	MLTSS services used by HCBS members: PCA services only.
Numerator:	Unique count of members with at least one claim for PCA services during the measurement period. Exclude members with a claim for any other MLTSS service or for claims for Medical Day services during the measurement period.
Denominator:	Unique count of members enrolled in MLTSS HCBS at any time during the measurement period.
Data Source:	MCO – claims data
Measurement Period:	Quarterly (Lag Report Due: 210 day lag after quarter)

4/1/17 – 6/30/17	A	B	C	D	E	TOTAL
Numerator	78	488	2044	813	518	3941
Denominator	737	4076	10767	4085	4401	24066
%	10.6	12.0	19.0	19.9	11.8	16.4

The MCOs will continue to monitor this data for trends, etc.

PM # 34	MLTSS services used by HCBS members: Medical Day services only.
Numerator:	Unique count of members with at least one claim for Medical Day services during the measurement period. Exclude members with a claim for any other MLTSS service or for PCA services during the measurement period.
Denominator:	Unique count of members enrolled in MLTSS HCBS at any time during the measurement period.
Data Source:	MCO claims data
Measurement Period:	Quarterly (Lag Report Due: 210 day lag after quarter)

4/1/17 – 6/30/17	A	B	C	D	E	TOTAL
Numerator	22	158	173	52	620	1025
Denominator	737	4076	10767	4085	4401	24066
%	3.0	3.9	1.6	1.3	14.1	4.3

The MCOs will continue to monitor this data for trends, etc.

Deliverables due during MLTSS 2nd quarter (1/1/2018 - 3/31/2018)

PM # 35	Follow-up after mental health hospitalization for HCBS MLTSS members: 7 day follow-up.
Numerator:	Per Administrative Specifications, the unique count of visits (Not unique members) who received face-to-face follow up with a mental health professional within seven days of hospitalization following an acute inpatient discharge with a principal diagnosis of mental Illness.
Denominator:	Using administrative specifications, the unique count of acute inpatient discharges (Not unique members) of eligible MLTSS HCBS members with a principal diagnosis of mental illness during measurement year. The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges
Data Source:	MCO – paid claims
Measurement Period:	Quarterly and Annually

4/1/17 – 6/30/17	A	B	C	D	E	TOTAL
Numerator	0	1	8	0	2	11
Denominator	2	3	31	5	7	48
%	0.0	33.3	25.8	0.0	28.6	22.9

7/1/16 – 6/30/17	A	B	C	D	E	TOTAL
Numerator	0	4	20	0	7	31
Denominator	5	18	89	12	27	151
%	0.0	22.2	22.5	0.0	25.9	20.5

MCOs are reporting some challenges in obtaining this data due to dual eligible members and limited access to Medicare claims. MCO A reports that for the quarterly measure, of the two acute inpatient discharges, none had a 7 day face to face follow up with mental health professional. Additionally, MCO A reported that they provided reeducation to their Care Management team in that any inpatient psychiatric care must be followed up within timeframe for outpatient visit to Behavioral Health provider and have educated their providers to submit claims for BH services regardless of payer source. MCO B reports that for the quarterly measure, of the 3 members with a mental health hospitalization, 1 was identified as having a 7-day face to face follow up visit with a mental health professional. Additionally, MCO B reported barriers identified with follow up included provider availability affecting timeliness of follow up appointments. Furthermore, MCO B reported they expect improved compliance while continuing to integrate BH interventions into Care Management. MCO C reported for the annual measurement period there were a total of 89 acute inpatient discharges for mental health hospitalization and of the 89 hospitalizations, 20 members received a face-to-face follow up within seven days that included 1 identified HCBS MLTSS FIDE/SNP member. Additionally, it was reported that 51 of the 69 members that did not have a follow up visit within seven days, did receive follow up within thirty days. MCO C reported one member received a follow up within thirty days according to documentation however the plan does not have a claim as the member was Medicare Prime. Additionally, MCO C reported the top three diagnoses for acute inpatient utilization for MLTSS HBSC members to be Schizoaffective Disorder, Bipolar Type, Major Depressive Disorder, Recurrent Severe without Psychotic Features and Paranoid Schizophrenia.

MCO C reported they have developed a workgroup to manage follow up visits for Behavioral health admissions and created tracking reports that will be monitored daily. MCOs report they are continuing to monitor.

PM # 36	Follow-up after mental health hospitalization for HCBS MLTSS members: 30 day follow-up.
Numerator:	Per Administrative Specifications, the unique count of visits (Not unique members) who received face-to-face follow up with a mental health professional within thirty days of hospitalization following an acute inpatient discharge with a principal diagnosis of mental illness.
Denominator:	Using administrative specifications, the unique count of acute inpatient discharges (Not unique members) of eligible MLTSS HCBS members with a principal diagnosis of mental illness during measurement year. The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges.
Data Source:	MCO – paid claims
Measurement Period:	Quarterly and Annually

4/1/17 – 6/30/17	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	1	2	23	0	2	28
Denominator	2	3	31	5	7	48
%	50.0	66.7	74.2	0.0	28.6	58.3

7/1/16 – 6/30/17	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	3	10	71	2	11	97
Denominator	5	18	89	12	27	151
%	60.0	55.6	79.8	16.7	40.7	64.2

MCOs are reporting some challenges in obtaining this data due to dual eligible members and limited access to Medicare claims. MCO E reported for the annual measurement period there were a total of 27 acute inpatient discharges for mental health hospitalization and of the 27 hospitalizations, 11 received a face-to-face follow up visit within 30 days. MCO E identified 23 unique members where 11 were 65 years of age or older and included 1 identified HCBS MLTSS FIDE/SNP member. Additionally, MCO E identified follow up events diagnosis as Major Depressive Order (6) Schizophrenia (4), and Bipolar Disorder (1). MCO E also reported the BH administrator will continue to collaborate with the network team to educate providers on the authorization process for MLTSS members so that the plan is aware of the admission in real time to help facilitate timely follow up. MCO D reported for the annual measurement period there were a total of 12 acute inpatient discharges for mental health hospitalization and of the 12 hospitalizations, 2 members received a face-to-face follow up within 30 days. Additionally, MCO D reported 6 of the 10 discharges that did not have follow up their BHA was not notified of the members' inpatient admissions to ensure after care planning and follow appointments are scheduled. Furthermore,

MCO D reported that reasons for no follow up for members who did have scheduled appointments included nonappearance with or without cancelation due to disinterest in the behavioral health program or transportation issues. MCO C reports for the quarterly measure, of the 31 acute inpatient discharges for mental health hospitalization there were 23 follow up visits with a mental health professional within thirty days. MCO C identified members with scheduled appointments but no evidence of follow up and readmission to acute inpatient stay within 4 days post-acute discharge within those that did not receive a face-to-face follow up visit within 30 days. MCOs report they are continuing to monitor and some are working with their behavior health administrator and staff to track hospital admissions and to ensure follow-up care.

PM # 37	Follow-up after mental health hospitalization for NF MLTSS members: 7 day follow up.
Numerator:	Per Administrative Specifications, the unique count of visits (Not unique members) who received face-to-face follow up with a mental health professional within seven days of hospitalization following an acute inpatient discharge with a principal diagnosis of mental illness.
Denominator:	Using administrative specifications, the unique count of acute inpatient discharges (Not unique members) of eligible MLTSS NF members with a principal diagnosis of mental illness during measurement year. The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges.
Data Source:	MCO – paid claims
Measurement Period:	Quarterly and Annually

4/1/17 – 6/30/17	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	0	0	0	0	0	0
Denominator	0	0	1	4	0	5
%	0.0	0.0	0.0	0.0	0.0	0.0

7/1/16 – 6/30/17	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	1	0	2	4	0	7
Denominator	2	1	15	16	4	38
%	50.0	0.0	13.3	25.0	0.0	18.4

MCOs are reporting some challenges in obtaining this data are due to dual eligible members and limited access to Medicare claims. MCO A reported for the annual measurement period there were a total of 2 acute inpatient discharges for mental health hospitalization and of the 2 hospitalizations, 1 received a face-to-face follow up visit within 7 days. Additionally MCO A reported that they provided reeducation to their Care Management team in that any inpatient psychiatric care must be followed up within timeframe for outpatient visit to Behavioral Health provider and have educated their providers to submit claims for BH services regardless of payer source. MCO C reports for the quarterly measure there was a total of 1 acute inpatient psychiatric

discharge for mental health hospitalization and the 1 hospitalization did not result in a face-to-face follow up visit within 7 days. Additionally, MCO C reported the diagnoses for this member was identified as Schizoaffective Disorder, Depressive Type. MCO E reported for the annual measurement period there were a total of 4 acute inpatient discharges for mental health hospitalization and of the 4 hospitalizations, none received a face-to-face follow up visit within 7 days. Of the 4 events MCO E reported that there were 3 unique members identified, 2 of the 3 were 65 years old or older, and none were identified as MLTSS FIDE/SNP members. Additionally, MCO E reported they added a Behavioral Health Care Manager with a substance abuse specialty to provide additional professional support to address the needs of this population and will continue to add staffing as needed to assist with the management of members who are identified to have higher behavioral health concerns.

PM # 38	Follow-up after mental health hospitalization for NF MLTSS members: 30 day follow up.
Numerator:	Per Administrative Specifications, the unique count of visits (Not unique members) who received face-to-face follow up with a mental health professional within thirty days of hospitalization following an acute inpatient discharge with a principal diagnosis of mental illness.
Denominator:	Using administrative specifications, the unique count of acute inpatient discharges (Not unique members) of eligible MLTSS NF members with a principal diagnosis of mental illness during measurement year. The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges.
Data Source:	MCO – paid claims
Measurement Period:	Quarterly and Annually

4/1/17 – 6/30/17	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	0	0	1	1	0	2
Denominator	0	0	1	4	0	5
%	0.0	0.0	100	25.0	0.0	40.0

7/1/16 – 6/30/17	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	1	0	12	10	1	24
Denominator	2	1	15	16	4	38
%	50.0	0.0	80.0	62.5	25.0	63.2

MCOs are reporting some challenges in obtaining this data due to dual eligible members and limited access to Medicare claims. MCO A reported for the annual measurement period there were a total of 2 acute inpatient discharges for mental health hospitalization and of the 2 hospitalizations, 1 received a face-to-face follow up visit within 30 days. Additionally, MCO A reported that they provided reeducation to their Care Management team in that any inpatient psychiatric care must be followed up within timeframe for outpatient visit to Behavioral Health provider and have educated their providers to submit claims for BH services regardless of payer source. MCO B reported for the

annual measurement period there was 1 acute inpatient discharge for mental health hospitalization and the member did not receive a face-to-face follow up visit within 30 days. Additionally, MCO B reported barriers identified with follow up included provider availability affecting timeliness of follow up appointments. Furthermore, MCO B reported they expect improved compliance while continuing to integrate BH interventions into Care Management.

PM # 39	Total MLTSS HCBS members with select behavioral health diagnoses.
Numerator:	Cases in the denominator with at least one claim during the measurement period with a primary or secondary diagnosis of mental illness (HEDIS 2016 Mental Illness Value Set) or substance abuse (HEDIS 2016 AOD Dependence Value Set). (In data analysis stratify numerator).
Denominator:	Unique count of MLTSS HCBS members meeting eligibility criteria that is assigned to HCBS based on the last date of enrollment in MLTSS with the MCO during the measurement period.
Data Source:	MCO – paid claims
Measurement Period:	Quarterly and Annually

4/1/17 – 6/30/17	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	161	1433	1764	686	554	4598
Denominator	636	4059	10559	3953	4418	23625
%	25.3	35.3	16.7	17.4	12.5	19.5

7/1/16 – 6/30/17	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	250	1652	3392	1337	956	7587
Denominator	787	4905	12228	4736	4965	27621
%	31.8	33.7	27.7	28.2	19.3	27.5

MCOs report they used claims payment systems based on the claims submitted/received by the MCO. MCO B reports for the annual measure there were a total of 1652 members with at least one claim with a select BH diagnosis. Additionally, MCO B reported that the top diagnosis identified for this population is major depressive disorder and this diagnosis has consistently been the top diagnosis in this performance measure over the year. MCO E reported for the annual measure there were a total of 4965 unique count of MLTSS HCBS members meeting eligibility criteria and 397 were identified as MLTSS FIDE/SNP members. Additionally, MCO E reported of the 956 members in the numerator 596 members were 65 years of age or older, 802 were identified with mental illness (16.15%), 86 were identified with substance abuse and mental illness (1.73%) and those with substance abuse only were 68 (1.37%). Furthermore, MCO E reported that the top 4 diagnosis

identified were Major depressive disorder, adjustment disorder with anxiety, dysthymic disorder, and bipolar disorder. The MCOs will continue to monitor the data for trends.

PM # 39a	Total MLTSS HCBS members with Substance Abuse Only (SA).
Numerator:	Members in the denominator of the Substance Abuse Only (SA) population, with at least one claim during the measurement period with a primary or secondary diagnosis of substance abuse only (HEDIS 2016 AOD Dependence Value Set).
Denominator:	Unique count of MLTSS HCBS members meeting eligibility criteria that is assigned to HCBS based on the last date of enrollment in MLTSS with the MCO during the measurement period.
Data Source:	MCO – paid claims
Measurement Period:	Quarterly and Annually

4/1/17 – 6/30/17	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	8	83	161	47	42	341
Denominator	636	4059	10559	3953	4418	23625
%	1.3	2.0	1.5	1.2	1.0	1.4

7/1/16 – 6/30/17	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	12	99	306	82	68	567
Denominator	787	4905	12228	4736	4965	27621
%	1.5	2.0	2.5	1.7	1.4	2.1

The MCOs will continue to monitor this data stratification for trends.

PM # 39b	Total MLTSS HCBS members with Mental Illness Only (MI).
Numerator:	Members in the denominator of the Mental Illness Only (MI) population, with at least one claim during the measurement period with a primary or secondary diagnosis of mental illness only (HEDIS 2016 Mental Illness Value Set).
Denominator:	Unique count of MLTSS HCBS members meeting eligibility criteria that is assigned to HCBS based on the last date of enrollment in MLTSS with the MCO during the measurement period.
Data Source:	MCO – paid claims
Measurement Period:	Quarterly and Annually

Deliverables due during MLTSS 2nd quarter (1/1/2018 - 3/31/2018)

4/1/17 – 6/30/17	A	B	C	D	E	TOTAL
Numerator	141	1212	1449	599	485	3886
Denominator	636	4059	10559	3953	4418	23625
%	22.2	29.9	13.7	15.2	11.0	16.4

7/1/16 – 6/30/17	A	B	C	D	E	TOTAL
Numerator	214	1386	2629	1120	802	6151
Denominator	787	4905	12228	4736	4965	27621
%	27.2	28.3	21.5	23.7	16.2	22.3

The MCOs will continue to monitor this data stratification for trends.

PM # 39c	Total MLTSS HCBS members with Substance Abuse and Mental Illness (SA/MI).
Numerator:	Members in the denominator of the Substance Abuse/Mental Illness (SA/MI) population, with at least one claim during the measurement period with a primary or secondary diagnosis of substance abuse AND mental illness (HEDIS 2016 Mental Illness Value Set) AND (HEDIS 2016 AOD Dependence Value Set).
Denominator:	Unique count of MLTSS HCBS members meeting eligibility criteria that is assigned to HCBS based on the last date of enrollment in MLTSS with the MCO during the measurement period.
Data Source:	MCO – paid claims
Measurement Period:	Quarterly and Annually

4/1/17 – 6/30/17	A	B	C	D	E	TOTAL
Numerator	12	138	154	40	27	371
Denominator	636	4059	10559	3953	4418	23625
%	1.9	3.4	1.5	1.0	0.6	1.6

7/1/16 – 6/30/17	A	B	C	D	E	TOTAL
Numerator	24	167	457	135	86	869
Denominator	787	4905	12228	4736	4965	27621
%	3.0	3.4	3.7	2.9	1.7	3.1

The MCOs will continue to monitor this data stratification for trends.

N = Numerator D = Denominator % = Percentage N/A = Not Available O/D = Over due
A = Aetna B = Amerigroup C = Horizon NJ Health D = United HealthCare E = WellCare

PM # 40	Total MLTSS NF members with selective behavioral health diagnoses.
Numerator:	Cases in the denominator with at least one claim during the measurement period with a primary or secondary diagnosis of mental illness (HEDIS 2016 Mental Illness Value Set) or substance abuse (HEDIS 2016 AOD Dependence Value Set). (In data analysis stratify numerator).
Denominator:	Unique count of MLTSS NF members meeting eligibility criteria that is assigned to NF based on the last date of enrollment in MLTSS with the MCO during the measurement period.
Data Source:	MCO – paid claims
Measurement Period:	Quarterly and Annually

4/1/17 – 6/30/17	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	467	1460	1919	1256	442	5544
Denominator	915	2912	6218	3330	1366	14741
%	52.0	50.1	30.9	37.7	32.4	37.6

7/1/16 – 6/30/17	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	669	1754	3296	2120	471	8310
Denominator	1101	3654	7842	4247	1631	18475
%	60.8	48.0	42.0	49.9	45.4	45.0

MCOs report they used claims payment system based on the claims submitted/received by the MCO. MCO C reported during the annual measure they identified 3,296 of the MLTSS members residing in a Nursing Facility have a primary or secondary diagnosis of behavioral health (HEDIS 2016 Mental Illness Value Set and HEDIS 2016 AOD Dependence Value Set). Additionally MCO C reported of the 3,296 members, there were 2,839 identified with a Mental Illness diagnosis, 124 had a Substance Abuse diagnosis and 333 had both Mental Illness and Substance Abuse diagnoses. Also 8 MLTSS FIDE/SNP members were identified with a Mental Illness diagnosis. MCO D reported during the quarterly measure there were 3,330 MLTSS NF members who were continuously enrolled and 1,256 of those had at least one claim for a select behavioral diagnosis. MCO D reported that the top three behavioral health disorders during the measurement period were Major depressive disorder, single episode, and Bipolar disorder, unspecified and major depressive disorder, recurrent, unspecified. Additionally MCO D reported their Behavioral Health Administrator works collaboratively with an interdisciplinary team to ensure that MLTSS NF members diagnosed with a select behavioral health diagnosis are connected to appropriate behavioral health services. MCOs will continue to monitor.

PM # 40a	Total MLTSS NF members with Substance Abuse Only (SA).
Numerator:	Members in the denominator of the Substance Abuse Only (SA) population, with at least one claim during the measurement period with a primary or secondary diagnosis of substance abuse only (HEDIS 2016 AOD Dependence Value Set).
Denominator:	Unique count of MLTSS NF members meeting eligibility criteria that is assigned to NF based on the last date of enrollment in MLTSS with the MCO during the measurement period.
Data Source:	MCO – paid claims
Measurement Period:	Quarterly and Annually

4/1/17 – 6/30/17	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	4	29	90	28	6	157
Denominator	915	2912	6218	3330	1366	14741
%	0.4	1.0	1.4	0.8	0.4	1.1

7/1/16 – 6/30/17	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	8	37	124	49	11	229
Denominator	1101	3654	7842	4247	1631	18475
%	0.7	1.0	1.6	1.2	0.7	1.2

The MCOs will continue to monitor this data stratification for trends.

PM # 40b	Total MLTSS NF members with Mental Illness Only (MI).
Numerator:	Members in the denominator of the Mental Illness Only (MI) population, with at least one claim during the measurement period with a primary or secondary diagnosis of mental illness only (HEDIS 2016 Mental Illness Value Set).
Denominator:	Unique count of MLTSS NF members meeting eligibility criteria that is assigned to NF based on the last date of enrollment in MLTSS with the MCO during the measurement period.
Data Source:	MCO – paid claims
Measurement Period:	Quarterly and Annually

4/1/17 – 6/30/17	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	459	1351	1730	1181	421	5142
Denominator	915	2912	6218	3330	1366	14741
%	50.2	46.4	27.8	35.5	30.8	34.9

7/1/16 – 6/30/17	A	B	C	D	E	TOTAL
Numerator	634	1627	2839	1939	692	7731
Denominator	1101	3654	7842	4247	1631	18475
%	57.6	44.5	36.2	45.7	42.4	41.8

The MCOs will continue to monitor this data stratification for trends.

PM # 40c	Total MLTSS NF members with Substance Abuse and Mental Illness (SA/MI).
Numerator:	Members in the denominator of the Substance Abuse/Mental Illness (SA/MI) population, with at least one claim during the measurement period with a primary or secondary diagnosis of substance abuse AND mental illness (HEDIS 2016 Mental Illness Value Set) AND (HEDIS 2016 AOD Dependence Value Set).
Denominator:	Unique count of MLTSS NF members meeting eligibility criteria that is assigned to NF based on the last date of enrollment in MLTSS with the MCO during the measurement period.
Data Source:	MCO – paid claims
Measurement Period:	Quarterly and Annually

4/1/17 – 6/30/17	A	B	C	D	E	TOTAL
Numerator	13	80	99	47	15	254
Denominator	915	2912	6218	3330	1366	14741
%	1.4	2.7	1.6	1.4	1.1	1.7

7/1/16 – 6/30/17	A	B	C	D	E	TOTAL
Numerator	27	90	333	132	38	620
Denominator	1101	3654	7842	4247	1631	18475
%	2.5	2.5	4.2	3.1	2.3	3.4

The MCOs will continue to monitor this data stratification for trends.

PM # 41	MLTSS services used by HCBS members: PCA services and Medical Day services only.
Numerator:	Unique count of members with at least one claim for Medical Day services AND at least one claim for PCA services during the measurement period. Exclude members with a claim for any other MLTSS service during the measurement period.
Denominator:	Unique count of members enrolled in MLTSS HCBS at any time during the measurement period.
Data Source:	MCO claims data
Measurement Period:	Quarterly (Lag Report Due: 210 day lag after quarter)

4/1/17 – 6/30/17	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	23	248	465	124	616	1476
%	3.1	6.1	4.3	3.0	14.0	6.1

MCO A reported there were 23 members who were receiving only PCA and MDC services during the measurement period. MCO A reports random case file sampling identified several members began MLTSS-specific services following the measurement period, such as PERS and HDM and have also identified nine members who enrolled with MLTSS during the measurement period. Additionally, MCO A reported they conduct monthly reeducation with Care Management regarding the importance of options counseling, providing MLTSS-specific services, and evaluation if appropriate for discharge assessment. MCO E reported there were 616 members who were receiving only PCA and MDC services during the measurement period. MCO E reported they identified 412 unique MLTSS FIDE/SNP members enrolled in MLTSS HCBS at any time during the measurement period but none of those members were found to be utilizing PCA services and Medical Day services only. Additionally, MCO E reported their Care Management team continues to provide options counseling on MLTSS-specific services but have found cultural values can affect the services members are comfortable accepting and may be a factor for this measure. All MCOs report they will continue to monitor these members to verify that their needs are being met and continue to monitor this data for trends, etc.

Deliverables due during MLTSS 2nd quarter (1/1/2018 - 3/31/2018)

PM # 18	**Quarterly and Annual Critical Incident reporting for abuse, neglect and exploitation**
Numerator:	# of critical incidents per category
Denominator:	Total # of critical incidents reported for measurement period (quarter or annual)
Data Source:	MCO
Measurement Period:	October 2017 – December 2017

PM	MCO	MCO A		MCO B		MCO C		MCO D		MCO E		TOTAL	
18	**Critical Incident (CI) reporting types:**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
a	Unexpected death of a member	0	0	0	0	5	0.8	2	2.0	2	4.2	**9**	**0.9**
b	Media involvement or the potential for media involvement	0	0	3	1.6	1	0.2	0	0	3	6.3	**7**	**0.7**
c	Physical abuse (incl. seclusion and restraints both physical and chemical)	1	4.3	9	4.7	10	1.6	3	2.9	1	2.1	**24**	**2.4**
d	Psychological / Verbal abuse	0	0	2	1.0	1	0.2	1	1.0	0	0	**4**	**0.4**
e	Sexual abuse and/or suspected sexual abuse	0	0	1	0.5	2	0.3	0	0	1	2.1	**4**	**0.4**
f	Fall resulting in the need of medical treatment	10	43.5	70	36.5	209	33.2	44	43.1	22	45.8	**355**	**35.7**
g	Medical emergency resulting in need for medical treatment	3	13.0	8	4.2	306	48.6	9	8.8	1	2.1	**327**	**32.9**
h	Medication error resulting in serious consequences	0	0	1	0.5	0	0	0	0	0	0	**1**	**0.1**
i	Psychiatric emergency resulting in need for medical treatment	2	8.7	0	0	15	2.4	4	3.9	1	2.1	**22**	**2.2**
j	Severe injury resulting in the need of medical treatment	0	0	3	1.6	10	1.6	0	0	2	4.2	**15**	**1.5**
k	Suicide attempt resulting in the need for medical attention	0	0	0	0	2	0.3	1	1.0	0	0	**3**	**0.3**
l	Neglect/Mistreatment, caregiver (paid or unpaid)	1	4.3	3	1.6	4	0.6	5	4.9	2	4.2	**15**	**1.5**
m	Neglect/Mistreatment, self	1	4.3	0	0	4	0.6	1	1.0	0	0	**6**	**0.6**
n	Neglect/Mistreatment, other	1	4.3	0	0	0	0	0	0	1	2.1	**2**	**0.2**
o	Exploitation, financial	0	0	2	1.0	2	0.3	1	1.0	0	0	**5**	**0.5**
p	Exploitation, theft	0	0	2	1.0	1	0.2	0	0	0	0	**3**	**0.3**
q	Exploitation, destruction of property	0	0	0	0	0	0	0	0	0	0	**0**	**0**
r	Exploitation, other	0	0	0	0	0	0	1	1.0	2	4.2	**3**	**0.3**
s	Theft with law enforcement involvement	1	4.3	0	0	1	0.2	0	0	2	4.2	**4**	**0.4**
t	Failure of member's Back-up Plan	1	4.3	0	0	1	0.2	0	0	0	0	**2**	**0.2**
u	Elopement/Wandering from home or facility	0	0	2	1.0	2	0.3	0	0	0	0	**4**	**0.4**
v	Inaccessible for initial/on-site meeting	2	8.7	17	8.9	5	0.8	12	11.8	0	0	**36**	**3.6**
w	Unable to Contact	0	0	14	7.3	19	3.0	7	6.9	1	2.1	**41**	**4.1**
x	Inappropriate or unprofessional conduct by a provider involving member	0	0	1	0.5	21	3.3	2	2.0	1	2.1	**25**	**2.5**
y	Cancellation of utilities	0	0	1	0.5	0	0	1	1.0	0	0	**2**	**0.2**
z	Eviction/loss of home	0	0	1	0.5	8	1.3	0	0	1	2.1	**10**	**1.0**
aa	Facility closure, with direct impact to member's health and welfare	0	0	0	0	0	0	0	0	0	0	**0**	**0**
ab	Natural disaster, with direct impact to member's health and welfare	0	0	0	0	0	0	0	0	0	0	**0**	**0**
ac	Operational Breakdown	0	0	42	21.9	0	0	1	1.0	0	0	**43**	**4.3**
ad	Other	0	0	10	5.2	0	0	7	6.9	5	10.4	**22**	**2.2**
TOTAL # of Critical Incidents Reported for 10/1/2017 - 12/31/2017		**23**	**A**	**192**	**B**	**629**	**C**	**102**	**D**	**48**	**E**	**994**	**TOTAL**

N = Numerator D = Denominator % = Percentage N/A = Not Available O/D = Over due

A = Aetna B = Amerigroup C = Horizon NJ Health D = United HealthCare E = WellCare

Deliverables due during MLTSS 2nd quarter (1/1/2018 - 3/31/2018)

There were a total of 994 Critical Incidents reported by the five MCOs during the October 1st, 2017 to December 31st 2017 measurement period. These are reported events not unduplicated members. The top two categories account for 68.6% of the overall CIs. The five most common CIs were:

1. Fall resulting in the need for medical treatment at (355 reported CIs – 35.7% overall)
2. Medical emergency resulting in the need for medical treatment (327 reported CIs – 32.9% overall)
3. Operational Breakdown (43 reported CIs – 4.3% overall)
4. Unable to Contact (41 reported CIs – 4.1% overall)
5. Inaccessible for initial/on-site meeting (36 reported CIs – 3.6% overall)

MCO A discussed the ongoing education given to providers on the process and form to be used for critical incident reporting. Starting October 2017, this MCO is providing refrigerator magnets to HCBS members so that they can easily locate their CM's contact information for CI reporting or for any other needs.

MCO B reported 42 critical incidents in the category of Operational Breakdown due to a facility closing to admissions by the Board of Health. The MCO stated that their affected members reported quality of care concerns. They worked closely with the members to offer options counseling to transfer members to a new setting/facility and they provided their findings and updates on their members to the State.

MCO C identified in their report the data regarding age groups for members who experienced a critical incident along with where the CI took place. They report that they are consistently finding the majority of falls occur for members in their own home. This MCO reported that these members have been re-assessed for fall risk and that some environmental risks have been addressed through appropriate furniture placement, installing grab bars, etc.

As part of their Discovery, MCO D noted trends in CIs from three different facilities/providers. The MCO reached out to those providers and they shared the response from one provider detailing the interventions used to reduce the risk for falls, including utilizing PT to address unsteady gait, assessing apartment for lighting, and review for appropriate footwear.

In cooperation with the EQRO and the MCOs, the Office of MLTSS Quality Monitoring and DoAS have revised PM #18. Effective 1/1/2018, the MCOs will be reporting not only the number of CIs per category, but how many CIs have a known date of occurrence, and the average time it takes for the MCO to be notified of a CI. The MCOs have been given a 30-day extension for the revised PM #18, measurement period 1/1/18 – 3/31/18, to allow the EQRO time to review and validate the data from the MCOs. The first revised report is due to DMAHS on 5/30/18.

Federal Budget Neutrality Summary

SUBJECT TO PUBLIC COMMENT PROCESS

Room Under the Budget Neutrality Cap	**$ 32,151,601,736**

	Total				
State Fiscal Year	Date of Service Budget Neutrality Ceiling*	CMS 64 Waiver Date of Service Expenditures	BN Savings Phase-Down	DSRIP Expenditures	Variance
Initial Waiver Period					
SFY13 Actual	$ 6,644,069,672	$ 5,849,718,345			$ 794,351,327
SFY14 Actual	$ 9,534,820,053	$ 8,122,701,250			$ 1,412,118,803
SFY15 Actual	$ 10,084,234,041	$ 8,108,287,456			$ 1,975,946,585
SFY16 Actual	$ 10,710,269,302	$ 8,191,128,112			$ 2,519,141,190
SFY17 Actual	$ 11,141,262,792	$ 8,347,772,030			$ 2,793,490,762
SFY13-17	$ 48,114,655,860	$ 38,619,607,193	$ -	$ -	$ 9,495,048,667
First Waiver Extension Period					
SFY18 Projected	$ 11,877,988,726	$ 8,212,488,638			$ 3,665,500,088
SFY19 Projected	$ 12,665,594,019	$ 8,742,999,297			$ 3,922,594,721
SFY20 Projected	$ 13,507,750,952	$ 9,112,966,318			$ 4,394,784,634
SFY21 Projected	$ 14,408,407,992	$ 9,342,100,110			$ 5,066,307,882
SFY22 Projected	$ 15,371,811,311	$ 9,764,445,568			$ 5,607,365,743
SFY18-22	$ 67,831,553,000	$ 45,174,999,931			$ 22,656,553,069
Second Waiver Extension Period					
Total					**$ 32,151,601,736**

Budget Neutrality Monitoring Spreadsheet

Main Budget Neutrality Test

Budget Neutrality "Without Waiver" Caps based on Current Demo caps Established in STC #128

TOTAL COMPUTABLE

Waiver Year	1	2	3	4	5	*Demo*		6	7	8	9	10	*Renewal*
State Fiscal Year	2013	2014	2015	2016	2017	*Period 1*		2018	2019	2020	2021	2022	*Period 1*
NO WAIVER													
Title XIX	$ 1,888,003,055	$ 2,721,828,868	$ 3,190,622,964	$ 3,450,278,327	$ 3,616,697,196	**$ 14,867,430,410**		$ 3,928,250,243	$ 4,266,641,395	$ 4,634,182,568	$ 5,033,384,829	$ 5,466,975,560	$ 23,329,434,595
***ABD/LTC/HCBS State Plan**	$ 4,756,066,617	$ 6,812,991,185	$ 6,893,611,077	$ 7,259,990,975	$ 7,524,565,596	**$ 33,247,225,450**		$ 7,949,738,483	$ 8,398,952,623	$ 8,873,568,385	$ 9,375,023,163	$ 9,904,835,751	$ 44,502,118,405
	$ -	$ -	$ -	$ -	$ -	**$ -**		$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	**$ -**		$ -	$ -	$ -	$ -	$ -	$ -
NO WAIVER -TOTAL COMPUTABLE	**$ 6,644,069,672**	**$ 9,534,820,053**	**$ 10,084,234,041**	**$ 10,710,269,302**	**$ 11,141,262,792**	**$ 48,114,655,860**		**$ 11,877,988,726**	**$ 12,665,594,019**	**$ 13,507,750,952**	**$ 14,408,407,992**	**$ 15,371,811,311**	**$ 67,831,553,000**
WITH WAIVER													
Title XIX	$ 1,660,533,500	$ 2,401,466,400	$ 2,585,362,512	$ 2,544,431,853	$ 2,580,901,601	**$ 11,772,695,866**		$ 2,897,276,284	$ 3,146,856,275	$ 3,417,935,828	$ 3,712,366,980	$ 4,032,161,307	$ 17,206,596,674
****ABD/LTC/HCBS State Plan**	$ 3,968,160,069	$ 5,413,958,405	$ 5,220,351,024	$ 5,312,626,189	$ 5,557,326,252	**$ 25,472,421,939**		$ 5,106,268,177	$ 5,387,198,846	$ 5,486,086,313	$ 5,586,788,953	$ 5,689,340,084	$ 27,255,682,373
HCBS state plan	$ -	$ -	$ -	$ -	$ -	**$ -**		$ -	$ -	$ -	$ -	$ -	$ -
DDD Supports-PDN	$ -	$ -	$ -	$ -	$ -			$ -	$ -	$ -	$ -	$ -	$ -
DSRIP	$ 192,443,637	$ 266,607,552	$ 266,600,001	$ 293,872,727	$ 166,600,000	**$ 1,374,123,917**		$ 166,000,000	$ 166,000,000	$ 166,000,000			$ 498,000,000
CNOMS	$ 28,581,139	$ 40,668,893	$ 35,973,919	$ 40,197,343	$ 42,944,177	**$ 188,365,471**		$ 42,944,177	$ 42,944,177	$ 42,944,177	$ 42,944,177	$ 42,944,177	$ 214,720,885
WITH WAIVER - TOTAL COMPUTABLE	**$ 5,849,718,345**	**$ 8,122,701,250**	**$ 8,108,287,456**	**$ 8,191,128,112**	**$ 8,347,772,030**	**$ 38,807,607,193**		**$ 8,212,488,638**	**$ 8,742,999,297**	**$ 9,112,966,318**	**$ 9,342,100,110**	**$ 9,764,445,568**	**$ 45,174,999,931**
Difference	**$ 794,351,327**	**$ 1,412,118,803**	**$ 1,975,946,585**	**$ 2,519,141,190**	**$ 2,793,490,762**	**$ 9,307,048,667**		**$ 3,665,500,088**	**$ 3,922,594,721**	**$ 4,394,784,634**	**$ 5,066,307,882**	**$ 5,607,365,743**	***$ 22,656,553,069***

** ABD, LTC, and HCBS State Plan Member Months, PMPM, and Total Expenditures are combined in the WOW Cap Consolidated Calculation*

*** ABD, LTC, and HCBS State Plan Member Months, PMPM, and Total Expenditures are combined in the Actuals Consolidated Calculation*

FEDERAL SHARE

Waiver Year	1	2	3	4	5	*Demo*		6	7	8	9	10	*Renewal*
State Fiscal Year	2013	2014	2015	2016	2017	*Period 1*		2018	2019	2020	2021	2022	*Period 1*
NO WAIVER													
Title XIX	$ 947,820,711	$ 1,506,480,875	$ 1,750,292,980	$ 1,750,842,567	$ 1,817,054,161	**$ 7,772,491,293**		$ 1,967,919,130	$ 2,137,441,533	$ 2,321,567,100	$ 2,521,553,791	$ 2,738,767,930	**$ 11,687,249,483**
***ABD/LTC/HCBS State Plan**	$ 2,385,270,183	$ 3,428,272,661	$ 3,464,950,873	$ 3,636,888,973	$ 3,765,208,223	**$ 16,680,590,913**		$ 3,978,460,670	$ 4,203,270,731	$ 4,440,793,084	$ 4,691,747,076	$ 4,956,892,792	**$ 22,271,164,353**
	$ -	$ -	$ -	$ -	$ -	**$ -**		$ -	$ -	$ -	$ -	$ -	**$ -**
	$ -	$ -	$ -	$ -	$ -	**$ -**		$ -	$ -	$ -	$ -	$ -	**$ -**
NO WAIVER - FEDERAL SHARE	**$ 3,333,090,893**	**$ 4,934,753,536**	**$ 5,215,243,853**	**$ 5,387,731,540**	**$ 5,582,262,384**	**$ 24,453,082,206**		**$ 5,946,379,800**	**$ 6,340,712,264**	**$ 6,762,360,184**	**$ 7,213,300,867**	**$ 7,695,660,722**	**$ 33,958,413,837**
WITH WAIVER													
Title XIX	$ 833,625,792	$ 1,329,166,299	$ 1,418,262,799	$ 1,291,171,081	$ 1,296,663,154	**$ 6,168,889,125**		$ 1,451,436,408	$ 1,576,467,455	$ 1,712,269,047	$ 1,859,768,992	$ 2,019,975,022	**$ 8,619,916,924**
****ABD/LTC/HCBS State Plan**	$ 2,011,078,783	$ 2,751,925,375	$ 2,624,021,712	$ 2,647,175,688	$ 2,756,305,142	**$ 12,790,506,700**		$ 2,606,805,437	$ 2,750,446,480	$ 2,809,642,777	$ 2,870,413,692	$ 2,932,815,475	**$ 13,970,123,861**
HCBS state plan	$ -	$ -	$ -	$ -	$ -	**$ -**		$ -	$ -	$ -	$ -	$ -	**$ -**
HOLD DDD Supports-PDN	$ -	$ -	$ -	$ -	$ -	**$ -**		$ -	$ -	$ -	$ -	$ -	**$ -**
DSRIP	$ 96,221,820	$ 138,946,279	$ 150,097,502	$ 167,888,474	$ 83,300,002	**$ 636,454,077**		$ 83,000,002	$ 83,000,002	$ 83,000,002			**$ 249,000,006**
CNOMS	$ 14,798,341	$ 21,084,004	$ 18,690,296	$ 20,590,547	$ 21,966,901	**$ 97,130,089**		$ 21,966,901	$ 21,966,901	$ 21,966,901	$ 21,966,901	$ 21,966,901	**$ 109,834,505**
WITH WAIVER - FEDERAL SHARE	**$ 2,955,724,736**	**$ 4,241,121,957**	**$ 4,211,072,308**	**$ 4,126,825,790**	**$ 4,158,235,199**	**$ 19,692,979,990**		**$ 4,163,208,748**	**$ 4,431,880,837**	**$ 4,626,878,727**	**$ 4,752,149,586**	**$ 4,974,757,398**	**$ 22,948,875,296**
	$ 2,011,069,653												
Difference	**$ 377,366,157**	**$ 693,631,579**	**$ 1,004,171,545**	**$ 1,260,905,750**	**$ 1,424,027,185**	**$ 4,760,102,216**		**1,783,171,052**	**1,908,831,427**	**2,135,481,457**	**2,461,151,282**	**2,720,903,324**	**11,009,538,541**

Notes:

1. Member-months based on MMIS report with last actual reported as of Dec 30, 2017.
2. "With Waiver" pmpm's based on calculations using Sch C expenditures and MMIS eligibility actual member-months reported through Dec 2017
3. CNOMs (costs not otherwise matchable) include Severe Emotionally Disturbed children (SED at risk), MATI population, DDD non-disabled adult children and CCW Supports Equalization

Budget Neutrality Monitoring Spreadsheet

Supplemental Test #1

Budget Neutrality "Without Waiver" Caps based on Current Demo caps Established in STC #129

TOTAL COMPUTABLE

Waiver Year	1	2	3	4	5	*Demo*	6	7	8	9	10	*Renewal*
State Fiscal Year	2013	2014	2015	2016	2017	*Period 1*	2018	2019	2020	2021	2022	*Period 1*
NO WAIVER												
HCBS 217-like	$ 217,434,338	$ 299,298,600	$ 296,727,244	$ 333,440,492	$ 384,643,345	**$ 1,531,544,019**	$ 406,196,876	$ 428,958,161	$ 452,994,878	$ 478,378,494	$ 505,184,485	**$ 2,271,712,894**
Adults w/o Depend. Children	$ 1,677,789	$ 798,912	$ -	$ -	$ -	**$ 2,476,701**	$ -	$ -	$ -	$ -	$ -	**$ -**
SED 217-like	$ 253,840	$ 345,267	$ 290,262	$ 256,844	$ 5,238,074	**$ 6,384,287**	$ 5,654,277	$ 6,103,550	$ 6,588,522	$ 7,112,028	$ 7,677,130	**$ 33,135,507**
Former XIX Chip Parents	$ -	$ 140,335,250	$ -	$ -	$ -	**$ 140,335,250**	$ -	$ -	$ -	$ -	$ -	**$ -**
IDD/MI	$ -	$ -	$ 6,423,263	$ 34,933,951	$ 48,520,332	**$ 89,877,546**	$ 52,375,626	$ 56,537,252	$ 61,029,549	$ 65,878,792	$ 71,113,342	**$ 306,934,561**
NO WAIVER -TOTAL COMPUTABLE	**$ 219,365,967**	**$ 440,778,028**	**$ 303,440,769**	**$ 368,631,287**	**$ 438,401,750**	**$ 1,770,617,803**	**$ 464,226,779**	**$ 491,598,963**	**$ 520,612,949**	**$ 551,369,314**	**$ 583,974,957**	**$ 2,611,782,962**
WITH WAIVER												
HCBS 217-like	$ 207,465,132	$ 278,302,398	$ 331,284,723	$ 375,780,962	$ 403,596,079	**$ 1,596,429,294**	$ 457,776,537	$ 483,428,094	$ 510,517,039	$ 539,123,916	$ 569,333,782	**$ 2,560,179,368**
Adults w/o Depend. Children	$ 1,529,772	$ 674,018	$ -	$ -	$ -	**$ 2,203,790**	$ -	$ -	$ -	$ -	$ -	**$ -**
SED 217-like	$ 83	$ 58,922	$ 27,837	$ 96,680	$ 12,227,868	**$ 12,411,390**	$ 13,199,461	$ 14,248,255	$ 15,380,383	$ 16,602,466	$ 17,921,653	**$ 77,352,218**
Former XIX Chip Parents	$ -	$ 126,863,607	$ -	$ -	$ -	**$ 126,863,607**	$ -	$ -	$ -	$ -	$ -	**$ -**
IDD/MI	$ -	$ -	$ 1,186,792	$ 7,798,525	$ 10,976,749	**$ 19,962,066**	$ 11,692,141	$ 12,621,167	$ 13,624,011	$ 14,706,538	$ 15,875,080	**$ 68,518,938**
WITH WAIVER - TOTAL COMPUTABLE	**$ 208,994,987**	**$ 405,898,945**	**$ 332,499,352**	**$ 383,676,167**	**$ 426,800,696**	**$ 1,757,870,147**	**$ 482,668,139**	**$ 510,297,516**	**$ 539,521,433**	**$ 570,432,920**	**$ 603,130,515**	**$ 2,706,050,524**
Difference	**$ 10,370,980**	**$ 34,879,083**	**$ (29,058,583)**	**$ (15,044,880)**	**$ 11,601,054**	**$ 12,747,656**	**$ (18,441,361)**	**$ (18,698,553)**	**$ (18,908,484)**	**$ (19,063,606)**	**$ (19,155,558)**	**$ (94,267,562)**

FEDERAL SHARE

Waiver Year	1	2	3	4	5	*Demo*	6	7	8	9	10	*Renewal*
State Fiscal Year	2013	2014	2015	2016	2017	*Period 1*	2018	2019	2020	2021	2022	*Period 1*
NO WAIVER												
HCBS 217-like	$ 110,183,049	$ 154,284,438	$ 152,378,938	$ 167,842,416	$ 192,343,787	**$ 777,032,629**	$ 203,106,351	$ 214,487,437	$ 226,506,264	$ 239,198,567	$ 252,602,084	**$ 1,135,900,704**
Adults w/o Depend. Children	$ 852,857	$ 408,324	$ -	$ -	$ -	**$ 1,261,182**	$ -	$ -	$ -	$ -	$ -	**$ -**
SED 217-like	$ -	$ 172,639	$ 145,397	$ 129,706	$ 2,619,037	**$ 3,066,779**	$ 2,827,138	$ 3,051,775	$ 3,294,261	$ 3,556,014	$ 3,838,565	**$ 16,567,753**
Former XIX Chip Parents	$ -	$ 71,621,870	$ -	$ -	$ -	**$ 71,621,870**	$ -	$ -	$ -	$ -	$ -	**$ -**
IDD/MI	$ -	$ -	$ 3,244,338	$ 17,467,004	$ 24,383,715	**$ 45,095,057**	$ 26,321,179	$ 28,412,589	$ 30,670,176	$ 33,107,146	$ 35,737,750	**$ 154,248,840**
NO WAIVER -TOTAL COMPUTABLE	**$ 111,035,906**	**$ 226,487,272**	**$ 155,768,673**	**$ 185,439,126**	**$ 219,346,539**	**$ 898,077,517**	**$ 232,254,669**	**$ 245,951,801**	**$ 260,470,701**	**$ 275,861,726**	**$ 292,178,399**	**$ 1,306,717,297**
WITH WAIVER												
HCBS 217-like	$ 105,131,236	$ 143,461,176	$ 170,125,310	$ 189,155,145	$ 201,821,244	**$ 809,694,111**	$ 228,897,186	$ 241,723,465	$ 255,268,465	$ 269,572,461	$ 284,677,983	**$ 1,280,139,560**
Adults w/o Depend. Children	$ 777,617	$ 344,491	$ -	$ -	$ -	**$ 1,122,108**	$ -	$ -	$ -	$ -	$ -	**$ -**
SED 217-like	$ -	$ 29,462	$ 13,944	$ 48,823	$ 6,113,934	**$ 6,206,163**	$ 6,599,731	$ 7,124,127	$ 7,690,191	$ 8,301,233	$ 8,960,827	**$ 38,676,109**
Former XIX Chip Parents	$ -	$ 64,746,447	$ -	$ -	$ -	**$ 64,746,447**	$ -	$ -	$ -	$ -	$ -	**$ -**
IDD/MI	$ -	$ -	$ 599,439	$ 3,899,269	$ 5,516,325	**$ 10,015,033**	$ 5,875,843	$ 6,342,721	$ 6,846,697	$ 7,390,717	$ 7,977,963	**$ 34,433,942**
WITH WAIVER - TOTAL COMPUTABLE	**$ 105,908,853**	**$ 208,581,576**	**$ 170,738,693**	**$ 193,103,237**	**$ 213,451,503**	**$ 891,783,862**	**$ 241,372,760**	**$ 255,190,314**	**$ 269,805,353**	**$ 285,264,411**	**$ 301,616,773**	**$ 1,353,249,611**
Difference	**$ 5,127,053**	**$ 17,905,696**	**$ (14,970,020)**	**$ (7,664,111)**	**$ 5,895,036**	**$ 6,293,655**	**$ (9,118,091)**	**$ (9,238,512)**	**$ (9,334,652)**	**$ (9,402,685)**	**$ (9,438,374)**	**$ (46,532,314)**

Supplemental Test #2

Budget Neutrality Monitoring Spreadsheet

Budget Neutrality "Without Waiver" Caps based on Current Demo caps Established in STC #129

TOTAL COMPUTABLE													
Waiver Year	1	2	3	4	5	***Demo***		6	7	8	9	10	***Renewal***
State Fiscal Year	2013	2014	2015	2016	2017	***Period 1***		2018	2019	2020	2021	2022	***Period 1***
NO WAIVER													
New Adult Group	$ -	$ 655,329,429	$ 3,208,229,680	$ 3,490,111,740	$ 3,707,697,798	**$ 11,061,368,647**		$ 3,964,543,870	$ 4,239,182,629	$ 4,532,846,640	$ 4,846,853,854	$ 5,182,613,521	**$ 22,766,040,514**
NO WAIVER -TOTAL COMPUTABLE	**$ -**	**$ 655,329,429**	**$ 3,208,229,680**	**$ 3,490,111,740**	**$ 3,707,697,798**	**$ 11,061,368,647**		**$ 3,964,543,870**	**$ 4,239,182,629**	**$ 4,532,846,640**	**$ 4,846,853,854**	**$ 5,182,613,521**	**$ 22,766,040,514**
WITH WAIVER													
New Adult Group	$ -	$ 849,334,482	$ 2,859,427,782	$ 2,913,955,687	$ 3,130,785,731	**$ 9,753,503,682**		$ 3,310,067,418	$ 3,539,368,149	$ 3,784,553,398	$ 4,046,723,545	$ 4,327,055,197	**$ 19,007,767,708**
WITH WAIVER - TOTAL COMPUTABLE	**$ -**	**$ 849,334,482**	**$ 2,859,427,782**	**$ 2,913,955,687**	**$ 3,130,785,731**	**$ 9,753,503,682**		**$ 3,310,067,418**	**$ 3,539,368,149**	**$ 3,784,553,398**	**$ 4,046,723,545**	**$ 4,327,055,197**	**$ 19,007,767,708**
Difference	**$ -**	**$ (194,005,053)**	**$ 348,801,898**	**$ 576,156,053**	**$ 576,912,067**	**$ 1,307,864,965**		**$ 654,476,452**	**$ 699,814,480**	**$ 748,293,242**	**$ 800,130,309**	**$ 855,558,324**	**$ 3,758,272,807**

FEDERAL SHARE													
Waiver Year	1	2	3	4	5	***Demo***		6	7	8	9	10	***Renewal***
State Fiscal Year	2013	2014	2015	2016	2017	***Period 1***		2018	2019	2020	2021	2022	***Period 1***
NO WAIVER													
New Adult Group	$ -	$ 655,310,788	$ 3,207,962,300	$ 3,487,453,246	$ 3,615,005,353	**$ 10,965,731,688**		$ 3,746,493,957	$ 3,963,635,758	$ 4,147,554,676	$ 4,362,168,469	$ 4,664,352,168	**$ 20,884,205,029**
NO WAIVER -TOTAL COMPUTABLE	**$ -**	**$ 655,310,788**	**$ 3,207,962,300**	**$ 3,487,453,246**	**$ 3,615,005,353**	**$ 10,965,731,688**		**$ 3,746,493,957**	**$ 3,963,635,758**	**$ 4,147,554,676**	**$ 4,362,168,469**	**$ 4,664,352,168**	**$ 20,884,205,029**
WITH WAIVER													
New Adult Group	$ -	$ 849,310,323	$ 2,859,189,472	$ 2,911,736,064	$ 3,052,516,088	**$ 9,672,751,947**		$ 3,128,013,710	$ 3,309,309,220	$ 3,462,866,359	$ 3,642,051,190	$ 3,894,349,677	$ 17,436,590,157
WITH WAIVER - TOTAL COMPUTABLE	**$ -**	**$ 849,310,323**	**$ 2,859,189,472**	**$ 2,911,736,064**	**$ 3,052,516,088**	**$ 9,672,751,947**		**$ 3,128,013,710**	**$ 3,309,309,220**	**$ 3,462,866,359**	**$ 3,642,051,190**	**$ 3,894,349,677**	**$ 17,436,590,157**
Difference	**$ -**	**$ (193,999,535)**	**$ 348,772,828**	**$ 575,717,182**	**$ 562,489,265**	**$ 1,292,979,741**		**$ 618,480,247**	**$ 654,326,539**	**$ 684,688,317**	**$ 720,117,278**	**$ 770,002,491**	**$ 3,447,614,872**

Notes:

1. Federal share is calculated using Composite Federal Share Ratios (source data is CMS 64 Schedule C as reported in QE Dec 2017 with a run date of Jan 30, 2018).
2. Member-months based on MMIS report with last actual reported as of Dec 2017.
3. "With Waiver" pmpm's based on calculations using Sch C expenditures and MMIS eligibility actual member-months reported through Sept 2015

Federal Budget Neutrality - Cap

TOTAL EXPENDITURES IN WAIVER	**$6,863,435,639**	**$10,630,927,510**	**$13,595,904,490**	**$14,569,012,329**	**$15,287,362,340**	**$60,946,642,309**		**$16,306,759,375**	**$17,396,375,611**	**$18,561,210,541**	**$19,806,631,160**	**$21,138,399,789**	**$93,209,376,476**	
														Original STC
Waiver Year	1	2	3	4	5	***Demo***		6	7	8	9	10	***Renewal***	Growth %'s
State Fiscal Year	2013	2014	2015	2016	2017	***Period 1***		2018	2019	2020	2021	2022	***Period 1***	used for
Member Months	*actual*	*actual*	*actual*	*actual*	*actual*			*projected*	*projected*	*projected*	*projected*	*projected*		BN
Title XIX	5,773,180	7,850,901	8,699,959	8,893,616	8,812,615			9,047,032	9,287,685	9,534,738	9,788,364	10,048,736		2.7%
***ABD/LTC/HCBS State Plan**	2,499,711	3,451,809	3,381,631	3,402,743	3,404,138			3,466,624	3,530,257	3,595,058	3,661,049	3,728,251		1.8%
														1.8%
														1.8%
Total Waiver Member Months	**8,272,891**	**11,302,710**	**12,081,590**	**12,296,359**	**12,216,753**			**12,513,656**	**12,817,942**	**13,129,797**	**13,449,413**	**13,776,987**		
Per Member Per Month														
Title XIX	$327.03	$346.69	$366.74	$387.95	$410.40			$434.20	$459.39	$486.03	$514.22	$544.05		5.8%
***ABD/LTC/HCBS State Plan**	$1,902.65	$1,973.75	$2,038.55	$2,133.57	$2,210.42			$2,293.22	$2,379.13	$2,468.27	$2,560.75	$2,656.70		3.75%
Total Expenditures (Member Months x PMPM)														
Title XIX	$1,888,003,055	$2,721,828,868	$3,190,622,964	$3,450,278,327	$3,616,697,196	**$14,867,430,410**		**$3,928,250,243**	**$4,266,641,395**	**$4,634,182,568**	**$5,033,384,829**	**$5,466,975,560**	**$23,329,434,595**	
***ABD/LTC/HCBS State Plan**	$4,756,066,617	$6,812,991,185	$6,893,611,077	$7,259,990,975	$7,524,565,596	**$33,247,225,450**		**$7,949,738,483**	**$8,398,952,623**	**$8,873,568,385**	**$9,375,023,163**	**$9,904,835,751**	**$44,502,118,405**	
Total Base Expenditures	**$6,644,069,672**	**$9,534,820,053**	**$10,084,234,041**	**$10,710,269,302**	**$11,141,262,792**	**$48,114,655,860**		**$11,877,988,726**	**$12,665,594,019**	**$13,507,750,952**	**$14,408,407,992**	**$15,371,811,311**	**$67,831,553,000**	
** ABD, LTC, and HCBS State Plan Member Months, PMPM, and Total Expenditures are combined in the WOW Cap Consolidated Calculation*														
Hypothetical Population Expenditures														
HCBS 217-Like	$217,434,338	$299,298,600	$296,727,244	$333,440,492	$384,643,345	**$1,531,544,019**		**$406,196,876**	**$428,958,161**	**$452,994,878**	**$478,378,494**	**$505,184,485**	**$2,271,712,894**	
***Adults w/o Dependent Children**	$1,677,789	$798,912	$0	$0	$0	**$2,476,701**		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	
SED 217-Like	$253,840	$345,267	$290,262	$256,844	$5,238,074	**$6,384,287**		**$5,654,277**	**$6,103,550**	**$6,588,522**	**$7,112,028**	**$7,677,130**	**$33,135,507**	
***XIX CHIP Parents**	$0	$140,335,250	$0	$0	$0	**$140,335,250**		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	
IDD/MI	$0	$0	$6,423,263	$34,933,951	$48,520,332	**$89,877,546**		**$52,375,626**	**$56,537,252**	**$61,029,549**	**$65,878,792**	**$71,113,342**	**$306,934,561**	
New Adult Group	$0	$655,329,429	$3,208,229,680	$3,490,111,740	$3,707,697,798	**$11,061,368,647**		**$3,964,543,870**	**$4,239,182,629**	**$4,532,846,640**	**$4,846,853,854**	**$5,182,613,521**	**$22,766,040,514**	
Total Hypothetical Expenditures	**$219,365,967**	**$1,096,107,457**	**$3,511,670,449**	**$3,858,743,027**	**$4,146,099,548**	**$12,831,986,449**		**$4,428,770,649**	**$4,730,781,592**	**$5,053,459,589**	**$5,398,223,168**	**$5,766,588,478**	**$25,377,823,476**	
** Adults w/o Dependent Chidren and Title XIX CHIP Parents are now in New Adult Group as of 1/1/14.*														

With Waiver - Expenditures													
TOTAL EXPENDITURES IN WAIVER	**$6,058,713,332**	**$9,377,934,677**	**$11,300,214,590**	**$11,488,759,966**	**$12,093,358,457**	**$50,318,981,022**		**$12,005,224,196**	**$12,792,664,963**	**$13,437,041,149**	**$13,959,256,575**	**$14,694,631,280**	**$66,888,818,163**	
														Original STC
Waiver Year	1	2	3	4	5	***Demo***		6	7	8	9	10	***Renewal***	Growth %'s
State Fiscal Year	2013	2014	2015	2016	2017	***Period 1***		2018	2019	2020	2021	2022	***Period 1***	used for
Member Months	*actual*	*actual*	*actual*	*actual*	*estimated*			*projected*	*projected*	*projected*	*projected*	*projected*		BN
Title XIX	5,773,180	7,850,901	8,699,959	8,893,616	8,812,615			9,047,032	9,287,685	9,534,738	9,788,364	10,048,736		2.7%
***ABD/LTC/HCBS State Plan**	2,499,711	3,361,590	3,381,631	3,401,925	3,357,056			3,046,489	3,102,410	3,159,358	3,217,351	3,276,409		1.8%
														1.8%
														1.8%
Total Waiver Member Months	**8,272,891**	**11,212,491**	**12,081,590**	**12,295,541**	**12,169,671**			**12,093,521**	**12,390,095**	**12,694,096**	**13,005,715**	**13,325,145**		
Per Member Per Month														
Title XIX	$287.63	$305.88	$297.17	$286.10	$302.69			$320.25	$338.82	$358.47	$379.26	$401.26		5.8%
***ABD/LTC/HCBS State Plan**	$1,587.45	$1,610.54	$1,543.74	$1,561.65	$1,617.87			$1,676.12	$1,736.46	$1,736.46	$1,736.46	$1,736.46		3.6%
														3.9%
														3.7%
Total Expenditures (Member Months x PMPM)														
Title XIX	$1,660,533,500	$2,401,466,400	$2,585,362,512	$2,544,431,853	$2,580,901,601	**$11,772,695,866**		$2,897,276,284	$3,146,856,275	$3,417,935,828	$3,712,366,980	$4,032,161,307	**$17,206,596,674**	
***ABD/LTC/HCBS State Plan**	$3,968,160,069	$5,413,958,405	$5,220,351,024	$5,312,626,189	$5,557,326,252	**$25,472,421,939**		$5,106,268,177	$5,387,198,846	$5,486,086,313	$5,586,788,953	$5,689,340,084	**$27,255,682,373**	
Total Base Actual Expenditures	**$5,628,693,569**	**$7,815,424,805**	**$7,805,713,536**	**$7,857,058,042**	**$8,138,227,853**	**$37,245,117,805**		**$8,003,544,461**	**$8,534,055,120**	**$8,904,022,141**	**$9,299,155,933**	**$9,721,501,391**	**$44,462,279,046**	
** ABD, LTC, and HCBS State Plan Member Months, PMPM, and Total Expenditures are combined in the Actuals Consolidated Calculation*														
Hypothetical Population Expenditures														
HCBS 217-Like	$207,465,132	$278,302,398	$331,284,723	$375,780,962	$403,596,079	**$1,596,429,294**		$457,776,537	$483,428,094	$510,517,039	$539,123,916	$569,333,782	**$2,560,179,368**	
****Adults w/o Dependent Children**	$1,529,772	$674,018	$0	$0	$0	**$2,203,790**		$0	$0	$0	$0	$0	**$0**	
SED 217-Like	$83	$58,922	$27,837	$96,680	$12,227,868	**$12,411,390**		$13,199,461	$14,248,255	$15,380,383	$16,602,466	$17,921,653	**$77,352,218**	
****XIX CHIP Parents**	$0	$126,863,607	$0	$0	$0	**$126,863,607**		$0	$0	$0	$0	$0	**$0**	
IDD/MI - 217-Like	$0	$0	$1,186,792	$7,798,525	$10,976,749	**$19,962,066**		$11,692,141	$12,621,167	$13,624,011	$14,706,538	$15,875,080	**$68,518,938**	
New Adult Group	$0	$849,334,482	$2,859,427,782	$2,913,955,687	$3,130,785,731	**$9,753,503,682**		$3,310,067,418	$3,539,368,149	$3,784,553,398	$4,046,723,545	$4,327,055,197	**$19,007,767,708**	
Total Hypothetical Expenditures	**$208,994,987**	**$1,255,233,427**	**$3,191,927,134**	**$3,297,631,854**	**$3,557,586,427**	**$11,511,373,829**		**$3,792,735,558**	**$4,049,665,665**	**$4,324,074,831**	**$4,617,156,465**	**$4,930,185,712**	**$21,713,818,232**	
*** Adults w/o Dependent Chidren and Title XIX CHIP Parents are now in New Adult Group as of 1/1/14.*														
Supports Program	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	
Hospital Subsidies														
HRSF & GME	$ 192,443,637	$ -	$ -	$ -	$ -	**$192,443,637**		$ -	$ -	$ -	$ -	$ -	**$0**	
HRSF Transition Payments	$ -	$ 83,302,681	$ -	$ -	$ -	**$83,302,681**							**$0**	
GME State Plan	-	100,000,001	100,000,000	127,272,727	188,000,000	**$515,272,728**							**$0**	
DSRIP	-	83,304,870	166,600,001	166,600,000	166,600,000	**$583,104,871**		166,000,000	166,000,000	166,000,000	-	-	**$498,000,000**	
Hospital Subsidies Expenditures	**$ 192,443,637**	**$ 266,607,552**	**$ 266,600,001**	**$ 293,872,727**	**$ 354,600,000**	**$1,374,123,917**		**$ 166,000,000**	**$ 166,000,000**	**$ 166,000,000**	**$ -**	**$ -**	**$498,000,000**	
Costs Otherwise Not Matchable (CNOMs)														
SED at Risk	$ 24,511,364	$ 37,239,735	$ 35,973,919	$ 40,197,343	$ 42,944,177	**$180,866,538**		$ 42,944,177	$ 42,944,177	$ 42,944,177	$ 42,944,177	$ 42,944,177	**$214,720,885**	
MATI at Risk	4,069,775	3,429,158	-	-	-	**$7,498,933**		-					**$0**	
DDD non-Disabled Adult Children	-	-	-											
DDD Community / Supports Equalization	-	-	-											
CNOM Expenditures	***$ 28,581,139***	***$ 40,668,893***	***$ 35,973,919***	***$ 40,197,343***	***$ 42,944,177***	**$188,365,471**		***$ 42,944,177***	***$ 42,944,177***	***$ 42,944,177***	***$ 42,944,177***	***$ 42,944,177***	**$214,720,885**	

Federal Budget Neutrality - Cap

TOTAL EXPENDITURES IN WAIVER	**$6,863,435,639**	**$10,630,927,510**	**$13,595,904,490**	**$14,569,012,329**	**$15,287,362,340**	**$60,946,642,309**		**$16,306,759,375**	**$17,396,375,611**	**$18,561,210,541**	**$19,806,631,160**	**$21,138,399,789**	**$93,209,376,476**	
														Original STC
Waiver Year	1	2	3	4	5	***Demo***		6	7	8	9	10	***Renewal***	Growth %'s
State Fiscal Year	2013	2014	2015	2016	2017	***Period 1***		2018	2019	2020	2021	2022	***Period 1***	used for
Member Months	*actual*	*actual*	*actual*	*actual*	*actual*			*projected*	*projected*	*projected*	*projected*	*projected*		BN
Title XIX	5,773,180	7,850,901	8,699,959	8,893,616	8,812,615			9,047,032	9,287,685	9,534,738	9,788,364	10,048,736		2.7%
ABD	2,205,906	3,062,519	2,997,958	2,981,094	2,950,330			3,004,486	3,059,636	3,115,799	3,172,992	3,231,235		1.8%
LTC	280,211	370,430	358,017	362,607	355,501			362,027	368,672	375,439	382,331	389,349		1.8%
HCBS State Plan	13,594	18,860	25,656	59,042	98,307			100,112	101,949	103,821	105,726	107,667		1.8%
Total Waiver Member Months	**8,272,891**	**11,302,710**	**12,081,590**	**12,296,359**	**12,216,753**			**12,513,656**	**12,817,942**	**13,129,797**	**13,449,413**	**13,776,987**		
Per Member Per Month														
Title XIX	$327.03	$346.69	$366.74	$387.95	$410.40			$434.20	$459.39	$486.03	$514.22	$544.05		5.8%
ABD	$1,045.04	$1,124.49	$1,164.91	$1,206.78	$1,250.17			$1,295.18	$1,341.80	$1,390.11	$1,440.15	$1,492.00		3.6%
LTC	$8,636.81	$8,975.89	$9,325.83	$9,689.41	$10,067.17			$10,459.79	$10,867.72	$11,291.56	$11,731.93	$12,189.48		3.9%
HCBS State Plan	$2,256.69	$2,347.84	$2,434.29	$2,523.94	$2,616.93			$2,713.76	$2,814.17	$2,918.29	$3,026.27	$3,138.24		3.7%
Total Expenditures (Member Months x PMPM)														
Title XIX	$1,888,003,055	$2,721,828,868	$3,190,622,964	$3,450,278,327	$3,616,697,196	**$14,867,430,410**		**$3,928,250,243**	**$4,266,641,395**	**$4,634,182,568**	**$5,033,384,829**	**$5,466,975,560**	**$23,329,434,595**	
ABD	$2,305,260,006	$3,443,771,990	$3,492,351,254	$3,597,524,617	$3,688,414,056	**$16,527,321,924**		**$3,891,338,615**	**$4,105,427,423**	**$4,331,294,702**	**$4,569,588,465**	**$4,820,992,377**	**$21,718,641,582**	
LTC	$2,420,129,167	$3,324,938,933	$3,338,805,679	$3,513,447,892	$3,578,889,002	**$16,176,210,673**		**$3,786,721,597**	**$4,006,623,408**	**$4,239,295,317**	**$4,485,478,908**	**$4,745,958,827**	**$21,264,078,057**	
HCBS State Plan	$30,677,444	$44,280,262	$62,454,144	$149,018,465	$257,262,538	**$543,692,853**		**$271,678,271**	**$286,901,792**	**$302,978,365**	**$319,955,790**	**$337,884,547**	**$1,519,398,766**	
Total Base Expenditures	**$6,644,069,672**	**$9,534,820,053**	**$10,084,234,041**	**$10,710,269,302**	**$11,141,262,792**	**$48,114,655,860**		**$11,877,988,726**	**$12,665,594,019**	**$13,507,750,952**	**$14,408,407,992**	**$15,371,811,311**	**$67,831,553,000**	
Hypothetical Population Expenditures														
HCBS 217-Like	$217,434,338	$299,298,600	$296,727,244	$333,440,492	$384,643,345	**$1,531,544,019**		**$406,196,876**	**$428,958,161**	**$452,994,878**	**$478,378,494**	**$505,184,485**	**$2,271,712,894**	
***Adults w/o Dependent Children**	$1,677,789	$798,912	$0	$0	$0	**$2,476,701**		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	
SED 217-Like	$253,840	$345,267	$290,262	$256,844	$5,238,074	**$6,384,287**		**$5,654,277**	**$6,103,550**	**$6,588,522**	**$7,112,028**	**$7,677,130**	**$33,135,507**	
***XIX CHIP Parents**	$0	$140,335,250	$0	$0	$0	**$140,335,250**		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	
IDD/MI	$0	$0	$6,423,263	$34,933,951	$48,520,332	**$89,877,546**		**$52,375,626**	**$56,537,252**	**$61,029,549**	**$65,878,792**	**$71,113,342**	**$306,934,561**	
New Adult Group	$0	$655,329,429	$3,208,229,680	$3,490,111,740	$3,707,697,798	**$11,061,368,647**		**$3,964,543,870**	**$4,239,182,629**	**$4,532,846,640**	**$4,846,853,854**	**$5,182,613,521**	**$22,766,040,514**	
Total Hypothetical Expenditures	**$219,365,967**	**$1,096,107,457**	**$3,511,670,449**	**$3,858,743,027**	**$4,146,099,548**	**$12,831,986,449**		**$4,428,770,649**	**$4,730,781,592**	**$5,053,459,589**	**$5,398,223,168**	**$5,766,588,478**	**$25,377,823,476**	
** Adults w/o Dependent Chidren and Title XIX CHIP Parents are now in New Adult Group as of 1/1/14.*														

With Waiver - Expenditures

TOTAL EXPENDITURES IN WAIVER	**$6,100,227,468**	**$9,442,488,618**	**$11,297,320,773**	**$11,437,497,403**	**$12,065,885,323**	**$50,343,419,585**		**$12,044,101,459**	**$12,833,033,560**	**$13,491,860,168**	**$14,029,478,279**	**$14,781,257,604**	**$67,179,731,070**	
														Original STC
Waiver Year	1	2	3	4	5	***Demo***		6	7	8	9	10	***Renewal***	Growth %'s
State Fiscal Year	2013	2014	2015	2016	2017	***Period 1***		2018	2019	2020	2021	2022	***Period 1***	used for
Member Months	*actual*	*actual*	*actual*	*actual*	*estimated*			*projected*	*projected*	*projected*	*projected*	*projected*		BN
Title XIX	5,773,180	7,850,901	8,699,959	8,893,999	8,785,836			9,019,541	9,259,462	9,505,765	9,758,620	10,018,201		2.7%
***ABD**	2,486,117	3,342,730	3,355,975	3,342,883	3,258,769			2,946,398	3,000,482	3,055,559	3,111,646	3,168,764		1.8%
***LTC**														1.8%
HCBS State Plan	13,594	18,860	25,656	59,042	98,287			100,091	101,928	103,799	105,705	107,645		1.8%
Total Waiver Member Months	**8,272,891**	**11,212,491**	**12,081,590**	**12,295,924**	**12,142,892**			**12,066,029**	**12,361,872**	**12,665,123**	**12,975,971**	**13,294,610**		
Per Member Per Month														
Title XIX	$287.63	$305.59	$296.85	$284.99	$301.52			$319.01	$337.51	$357.09	$377.80	$399.71		5.8%
***ABD**	$1,595.54	$1,616.41	$1,525.65	$1,508.82	$1,563.14			$1,619.41	$1,677.71	$1,677.71	$1,677.71	$1,677.71		3.6%
***LTC**														3.9%
HCBS State Plan	$3,162.12	$3,441.37	$3,872.47	$4,066.37	$4,216.83			$4,372.85	$4,534.64	$4,702.43	$4,876.42	$5,056.84		3.7%
Total Expenditures (Member Months x PMPM)														
Title XIX	$1,660,532,120	$2,399,180,142	$2,582,613,493	$2,534,724,200	$2,649,124,657	**$11,826,174,612**		$2,877,328,130	$3,125,189,727	$3,394,402,860	$3,686,806,812	$4,004,399,310	**$17,088,126,839**	
***ABD**	$3,966,690,442	$5,403,226,627	$5,120,055,291	$5,043,806,205	$5,093,901,545	**$24,627,680,110**		$4,771,424,809	$5,033,933,470	$5,126,336,408	$5,220,435,488	$5,316,261,845	**$25,468,392,019**	
***LTC**	$0	$0	$0	$0	$0	**$0**		$0	$0	$0	$0	$0	**$0**	
HCBS State Plan	$42,985,906	$64,904,317	$99,352,046	$240,086,620	$414,459,151	**$861,788,040**		$437,683,414	$462,209,051	$488,108,984	$515,460,224	$544,344,093	**$2,447,805,765**	
Total Base Actual Expenditures	**$5,670,208,468**	**$7,867,311,086**	**$7,802,020,830**	**$7,818,617,025**	**$8,157,485,353**	**$37,315,642,762**		**$8,086,436,352**	**$8,621,332,248**	**$9,008,848,252**	**$9,422,702,523**	**$9,865,005,247**	**$45,004,324,623**	
** ABD and LTC Member Months, PMPM, and Total Expenditures are combined in the Actual Detail Calculation*														
Hypothetical Population Expenditures														
HCBS 217-Like	$207,464,369	$278,302,398	$331,117,748	$375,476,571	$430,061,851	**$1,622,422,937**		$454,160,413	$479,609,340	$506,484,301	$534,865,203	$564,836,432	**$2,539,955,689**	
****Adults w/o Dependent Children**	$1,529,772	$674,018	$0	$0	$0	**$2,203,790**		$0	$0	$0	$0	$0	**$0**	
SED 217-Like	$83	$58,922	$27,837	$96,680	$6,135,308	**$6,318,830**		$6,622,803	$7,149,033	$7,717,076	$8,330,254	$8,992,153	**$38,811,319**	
****XIX CHIP Parents**	$0	$126,863,607	$0	$0	$0	**$126,863,607**		$0	$0	$0	$0	$0	**$0**	
IDD/MI - 217-Like	$0	$0	$1,186,792	$7,795,679	$9,058,086	**$18,040,557**		$9,777,817	$10,554,736	$11,393,387	$12,298,675	$13,275,894	**$57,300,509**	
New Adult Group	$0	$862,002,142	$2,860,394,406	$2,901,491,432	$3,068,397,436	**$9,692,285,416**		$3,280,956,785	$3,508,240,914	$3,751,269,863	$4,011,134,335	$4,289,000,589	**$18,840,602,486**	
Total Hypothetical Expenditures	**$208,994,224**	**$1,267,901,087**	**$3,192,726,783**	**$3,284,860,362**	**$3,513,652,681**	**$11,468,135,137**		**$3,751,517,818**	**$4,005,554,023**	**$4,276,864,626**	**$4,566,628,466**	**$4,876,105,068**	**$21,476,670,002**	
*** Adults w/o Dependent Chidren and Title XIX CHIP Parents are now in New Adult Group as of 1/1/14.*														
Supports Program	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	
Hospital Subsidies														
HRSF & GME	$ 192,443,637	$ -	$ -	$ -	$ -	**$192,443,637**		$ -	$ -	$ -	$ -	$ -	**$0**	
HRSF Transition Payments	-	83,302,681	-	-	-	**$83,302,681**							**$0**	
GME State Plan	-	100,000,001	100,000,000	127,272,727	188,000,000	**$515,272,728**							**$0**	
DSRIP	-	83,304,870	166,600,001	166,600,000	166,600,000	**$583,104,871**		166,000,000	166,000,000	166,000,000	-	-	**$498,000,000**	
Hospital Subsidies Expenditures	**$ 192,443,637**	**$ 266,607,552**	**$ 266,600,001**	**$ 293,872,727**	**$ 354,600,000**	**$1,374,123,917**		**$ 166,000,000**	**$ 166,000,000**	**$ 166,000,000**	**$ -**	**$ -**	**$498,000,000**	
Costs Otherwise Not Matchable (CNOMs)														
SED at Risk	$ 24,511,364	$ 37,239,735	$ 35,973,159	$ 40,147,289	$ 40,147,289	**$178,018,836**		$ 40,147,289	$ 40,147,289	$ 40,147,289	$ 40,147,289	$ 40,147,289	**$200,736,445**	
MATI at Risk	4,069,775	3,429,158	-	-	-	**$7,498,933**		-					**$0**	
DDD non-Disabled Adult Children	-	-	-											
DDD Community / Supports Equalization	-	-	-											
CNOM Expenditures	***$ 28,581,139***	***$ 40,668,893***	***$ 35,973,159***	***$ 40,147,289***	***$ 40,147,289***	**$185,517,769**		***$ 40,147,289***	***$ 40,147,289***	***$ 40,147,289***	***$ 40,147,289***	***$ 40,147,289***	**$200,736,445**	

Hypotheticals: Enrollment and PMPM's															
Waiver Year		1	2	3	4	5	***Demo***		6	7	8	9	10	***Renewal***	Growth %'s
State Fiscal Year		2013	2014	2015	2016	2017	***Period 1***		2018	2019	2020	2021	2022	***Period 1***	
WOW-CAP															
HCBS 217-Like	Enrollment	96,351	127,895	122,272	132,498	147,391			150,096	152,852	155,657	158,515	161,424		1.8%
	PMPM	$2,256.69	$2,340.19	$2,426.78	$2,516.57	$2,609.68			$2,706.24	$2,806.37	$2,910.20	$3,017.88	$3,129.54		3.7%
Adults w/o DC	Enrollment	6,057	2,774	3,870,426	4,240,639	4,405,373			4,405,373	4,405,373	4,405,373	4,405,373	4,405,373		
	PMPM	$277.00	$288.00						$0.00	$0.00	$0.00	$0.00	$0.00		
SED 217-Like	Enrollment	113	145	115	96	1,847			1,881	1,915	1,951	1,986	2,023		1.8%
	PMPM	$2,246.37	$2,381.15	$2,524.02	$2,675.46	$2,835.99			$3,006.15	$3,186.52	$3,377.71	$3,580.37	$3,795.19		6.0%
XIX Chip Parents	Enrollment	0	456,761	0	0	0			0	0	0	0	0		
	PMPM		$307.24						$0.00	$0.00	$0.00	$0.00	$0.00		
IDD/MI	Enrollment	0	0	581	2,981	3,906			3,978	4,051	4,125	4,201	4,278		1.8%
	PMPM	$9,839.39	$10,429.75	$11,055.53	$11,718.87	$12,422.00			$13,167.32	$13,957.36	$14,794.80	$15,682.49	$16,623.44		6.0%
New Adult Group	Enrollment	0	1,408,947	6,541,000	6,776,916	6,856,584			6,982,443	7,110,612	7,241,134	7,374,052	7,509,410		1.8%
	PMPM		$465.12	$490.48	$515.00	$540.75			$567.79	$596.18	$625.99	$657.29	$690.15		5.0%
ACTUALS															
HCBS 217-Like	Enrollment	96,351	127,895	122,272	132,498	147,391			150,096	152,852	155,657	158,515	161,424		1.8%
	PMPM	$2,153.22	$2,176.02	$2,709.41	$2,836.13	$2,941.06			$3,049.88	$3,162.73	$3,279.75	$3,401.10	$3,526.94		3.7%
Adults w/o DC	Enrollment	6,057	2,774	3,870,426	4,240,639	4,405,373			4,405,373	4,405,373	4,405,373	4,405,373	4,405,373		
	PMPM	$252.56	$242.98						$0.00	$0.00	$0.00	$0.00	$0.00		
SED 217-Like	Enrollment	113	145	115	96	1,847			1,881	1,915	1,951	1,986	2,023		1.8%
	PMPM	$0.73	$406.36	$242.06	$1,007.08	$6,620.39			$7,017.62	$7,438.67	$7,885.00	$8,358.10	$8,859.58		6.0%
***XIX CHIP Parents**	Enrollment	0	456,761	0	0	0									
	PMPM		$277.75												
IDD/MI - 217-Like	Enrollment	0	0	581	2,981	3,906			3,978	4,051	4,125	4,201	4,278		1.8%
	PMPM	$0.00	$0.00	$2,042.67	$2,616.08	$2,773.04			$2,939.42	$3,115.79	$3,302.74	$3,500.90	$3,710.95		6.0%
New Adult Group	Enrollment	0	1,186,513	6,541,000	6,776,916	6,856,584			6,982,443	7,110,612	7,241,134	7,374,052	7,509,410		1.8%
	PMPM		$715.82	$437.15	$429.98	$451.48			$474.06	$497.76	$522.65	$548.78	$576.22		5.0%

Hospital Subsidy Summary

Waiver Year	1	2	3	4	5	*Demo*		6	7	8	9	10	*Renewal*
State Fiscal Year	2013	2014	2015	2016	2017	*Period 1*		2018	2019	2020	2021	2022	*Period 1*
TOTAL COMPUTABLE													
HRSF & GME	$ 192,443,637	$ -	$ -	$ -	$ -	**$ 192,443,637**		$ -	$ -	$ -	$ -	$ -	**$ -**
HRSF Transition Payments	-	83,302,681	-	-	-	**$ 83,302,681**							**$ -**
GME State Plan	-	100,000,001	100,000,000	127,291,443	188,000,000	**$ 515,291,444**		218,000,000	218,000,000	218,000,000	218,000,000	218,000,000	**$ 1,090,000,000**
DSRIP	-	83,304,870	166,600,001	166,600,000	166,600,000	**$ 583,104,871**		166,000,000	166,000,000	166,000,000	-	-	**$ 498,000,000**
TOTAL COMPUTABLE	**$ 192,443,637**	**$ 266,607,552**	**$ 266,600,001**	**$ 293,891,443**	**$ 354,600,000**	**$ 1,374,142,633**		**$ 384,000,000**	**$ 384,000,000**	**$ 384,000,000**	**$ 218,000,000**	**$ 218,000,000**	**$ 1,588,000,000**
Composite Federal Share Percentage													
HRSF & GME	50.00%	0.00%	0.00%	0.00%	0.00%								
HRSF Transition Payments	0.00%	50.00%	0.00%	0.00%	0.00%			0.00%	0.00%	0.00%	0.00%	0.00%	
GME State Plan	0.00%	55.64%	66.80%	66.45%	65.08%			65.08%	65.08%	65.08%	65.08%	65.08%	
DSRIP	0.00%	50.00%	50.00%	50.00%	50.00%			50.00%	50.00%	50.00%	50.00%	50.00%	
FEDERAL SHARE													
HRSF & GME	$ 96,221,820	$ -	$ -	$ -	$ -	**$ 96,221,820**		$ -	$ -	$ -	$ -	$ -	**$ -**
HRSF Transition Payments	$ -	$ 41,651,341	$ -	$ -	$ -	**$ 41,651,341**		-	-	-	-	-	**$ -**
GME State Plan	$ -	$ 55,642,502	$ 66,797,499	$ 84,588,472	$ 122,350,400	**$ 329,378,873**		141,874,400	141,874,400	141,874,400	141,874,400	141,874,400	**$ 709,372,000**
DSRIP	$ -	$ 41,652,436	$ 83,300,003	$ 83,300,002	$ 83,300,002	**$ 291,552,443**		83,000,002	83,000,002	83,000,002	-	-	**$ 249,000,006**
FEDERAL SHARE	**$ 96,221,820**	**$ 138,946,279**	**$ 150,097,502**	**$ 167,888,474**	**$ 205,650,402**	**$ 758,804,477**		**$ 224,874,402**	**$ 224,874,402**	**$ 224,874,402**	**$ 141,874,400**	**$ 141,874,400**	**$ 958,372,006**

DY6-10: Total Computable amounts tie to the amounts budgeted in SFY2016.

DY6-10: Federal Share amounts = Total Computable amounts multiplied by the Federal Composite Share Percentage (estimate for DY4/DY5)

Costs Otherwise Not Matchable (CNOM) Summary

Waiver Year	1	2	3	4	5	*Demo*		6	7	8	9	10	*Renewal*	Growth %
State Fiscal Year	2013	2014	2015	2016	2017	*Period 1*		2018	2019	2020	2021	2022	*Period 1*	
TOTAL COMPUTABLE														
SED at Risk	$ 24,511,364	$ 37,239,735	$ 35,973,919	$ 40,197,343	$ 42,944,177	$ 180,866,538		$ 42,944,177	$ 42,944,177	$ 42,944,177	$ 42,944,177	$ 42,944,177	$ 214,720,885	
MATI at Risk	$ 4,069,775	$ 3,429,158	$ -	$ -	$ -	$ 7,498,933		$ -	$ -	$ -	$ -	$ -	$ -	
DDD non-Disabled Adult Children	$ -	$ -	$ -			$ -		$ -	$ -	$ -	$ -	$ -	$ -	3.00%
DDD Community / Supports Equalization	$ -	$ -	$ -			$ -								3.00%
TOTAL COMPUTABLE	**$ 28,581,139.00**	**$ 40,668,893.00**	**$ 35,973,919.00**	**$ 40,197,343.00**	**$ 42,944,177.00**	**$ 188,365,471**		**$ 42,944,177**	**$ 42,944,177**	**$ 42,944,177**	**$ 42,944,177**	**$ 42,944,177**	**$ 214,720,885**	
Composite Federal Share Percentage														
SED at Risk	51.99%	51.83%	51.96%	51.22%	51.15%			51.15%	51.15%	51.15%	51.15%	51.15%		
MATI at Risk	50.50%	52.00%	0.00%	0.00%	0.00%			0.00%	0.00%	0.00%	0.00%	0.00%		
DDD non-Disabled Adult Children				50.00%	50.00%			50.00%	50.00%	50.00%	50.00%	50.00%		
DDD Community / Supports Equalization				50.00%	50.00%			50.00%	50.00%	50.00%	50.00%	50.00%		
FEDERAL SHARE														
SED at Risk	$ 12,743,019	$ 19,300,842	$ 18,690,296	$ 20,590,547	$ 21,966,901	$ 93,291,605		$ 21,966,901	$ 21,966,901	$ 21,966,901	$ 21,966,901	$ 21,966,901	$ 109,834,505	
MATI at Risk	$ 2,055,322	$ 1,783,162	$ -	$ -	$ -	$ 3,838,484		$ -	$ -	$ -	$ -	$ -	$ -	
DDD non-Disabled Adult Children	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	$ -	
DDD Community / Supports Equalization	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	$ -	
FEDERAL SHARE	**$ 14,798,341**	**$ 21,084,004**	**$ 18,690,296**	**$ 20,590,547**	**$ 21,966,901**	**$ 97,130,089**		*$ 21,966,901*	*$ 21,966,901*	*$ 21,966,901*	*$ 21,966,901*	*$ 21,966,901*	**$ 109,834,505**	

Notes: SED at Risk and MATI at Risk

DY6-10: Total Computable = DY5 estimate in the QE Dec 15 Report for current demonstration

DY6-10 Federal Share amounts = Total Computable amounts multiplied by the Federal Composite Share Percentage in accordance with current STC #130.

Notes: DDD programs

DY6-10: Total Computable = DY5 estimate in the QE Dec 15 Report for current demonstration increased by 3% annually

DY6-10: Federal Share amounts = Total Computable amounts multiplied by the Federal Composite Share Percentage (estimate for DY4/DY5)

Budgent Neutrality Monitoring Sheet Notes

Enrollment Trends

No Waiver Spending

DY6-10 Total Computable = MM's multplied by DY5 PMPM caps per STCs #128 and #129 (increased annually by CMS approved growth factors in current STC #128).

DY6-10 Federal Share = Total Computable multiplied by composite federal share ratio in accordance with current Demo's STC #130

With Waiver Spending

DY6-10 = projected MM's multiplied by PMPMs. PMPM calculated by using the DY5 PMPMs from the QE Dec 15 Report and increasing them annually by CMS approved growth factors in current STC #128 and #129

DY6-10 Federal Share = Total Computable multiplied by composite federal share ratio in accordance with STC #130

BN caps should be as of 3-27-14

Meg =	Title XIX		as appears on march 27 2014 STCs PMPM	Should appear on 3/27/14 STCs PMPM
		DY2	$346.00	$346.69
		DY3	$366.07	$366.74
		DY4	$387.30	$387.95
		DY5	$409.76	$410.40

Meg =	ABD		original PMPM	after CMS approve $10m addl GME PMPM
		DY2	$1,123.36	$1,124.49
		DY3	$1,163.80	$1,164.91
		DY4	$1,205.69	$1,206.78
		DY5	$1,249.10	$1,250.17

Meg =	LTC		original PMPM	after CMS approve $10m addl GME PMPM
		DY2	$8,973.64	$8,975.89
		DY3	$9,323.62	$9,325.83
		DY4	$9,687.24	$9,689.41
		DY5	$10,065.04	$10,067.17

Meg =	HCBS State Plan		original PMPM	after CMS approve $10m addl GME PMPM
		DY2	$2,340.19	$2,347.84
		DY3	$2,426.78	$2,434.29
		DY4	$2,516.57	$2,523.94
		DY5	$2,609.68	$2,616.93

Schedule C

CMS 64 Waiver Expenditure Report

Cumulative Data Ending Quarter/Year : 2/2018

State: New Jersey

Summary of Expenditures by Waiver Year

Waiver: 11W00279

MAP Waivers

Total Computable

Waiver Name	A	01	02	03	04	05	06
ABD	0	3,968,073,211	5,408,239,519	5,120,974,328	5,072,480,475	5,192,243,943	3,405,565,293
ACCAP – 217 Like	0	630,539	880,454	0	0	0	0
ACCAP – SP	0	900,000	966,297	0	0	0	0
AWDC	0	1,529,772	674,018	0	0	0	0
Childless Adults	0	27,844,394	48,216,389	0	0	0	0
CRPD – 217 Like	0	11,803,536	16,894,842	0	0	0	0
CRPD –SP	0	10,672,842	15,247,535	0	0	0	0
DSRIP	0	0	83,304,870	166,600,001	166,600,000	166,600,000	0
GME State Plan	0	0	100,000,001	100,000,000	127,291,443	188,000,000	163,499,976
GO – 217 Like	0	181,068,236	221,682,839	0	0	0	0
GO – SP	0	23,869,092	33,606,671	0	0	0	0
HCBS – 217 Like	0	288,889	21,406,012	331,284,723	375,780,962	403,596,079	487,899,108
HCBS – State Plan	0	86,858	5,718,886	99,376,696	240,145,714	365,082,309	482,182,675
HRSF & GME	0	192,443,637	0	0	0	0	0
HRSF Transition Payments	0	0	83,302,681	0	0	0	0
IDD/MI – 217 Like	0	0	0	1,186,792	7,798,525	10,976,749	13,103,439
MATI at Risk	0	4,069,775	3,429,158	0	0	0	0
New Adult Group	0	7,940,104	849,334,482	2,859,427,782	2,913,955,687	3,130,785,731	2,305,275,716
SED – 217 Like	0	83	58,922	27,837	96,680	12,227,868	14,902,776
SED at Risk	0	24,511,364	37,239,735	35,973,919	40,197,343	42,944,177	29,562,020
TBI – 217 Like	0	13,673,932	17,438,251	0	0	0	0
TBI – SP	0	7,457,114	9,364,928	0	0	0	0
Title XIX	0	1,660,533,500	2,401,466,400	2,585,362,512	2,544,431,853	2,580,901,601	1,778,123,227
XIX CHIP Parents	0	0	126,863,607	0	0	0	0
Total	**0**	**6,137,396,878**	**9,485,336,497**	**11,300,214,590**	**11,488,778,682**	**12,093,358,457**	**8,680,114,230**

Federal Share

Waiver Name	A	01	02	03	04	05	06
ABD	0	1,989,939,987	2,720,971,843	2,573,456,256	2,540,799,834	2,598,201,522	1,704,366,875
ACCAP – 217 Like	0	319,151	446,869	0	0	0	0

Composite Federal Share Percentages

Waiver Name	01	02	03	04	05	06	07	08	09	10
ABD	50.15%	50.31%	50.25%	50.09%	50.04%	50.05%	50.05%	50.05%	50.05%	50.05%

ACCAP – SP	0	454,312	489,362	0	0	0	0													
AWDC	0	777,617	344,491	0	0	0	0		AWDC	50.83%	51.11%									
Childless Adults	0	14,715,147	24,778,164	0	0	0	0		Childless Adult	52.85%	51.39%									
CRPD – 217 Like	0	6,026,151	8,740,654	0	0	0	0													
CRPD –SP	0	5,447,877	7,899,121	0	0	0	0													
DSRIP	0	0	41,652,435	83,300,003	83,300,002	83,300,002	0		DSRIP		50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%
GME State Plan	0	0	55,642,502	66,797,499	84,588,472	122,350,400	104,471,035		GME State Pla		55.64%	66.80%	66.45%	65.08%	*65.08%*	*65.08%*	*65.08%*	*65.08%*	*65.08%*
GO – 217 Like	0	91,709,982	114,209,771	0	0	0	0													
GO – SP	0	12,108,906	17,304,835	0	0	0	0													
HCBS – 217 Like	0	147,458	11,076,822	170,125,310	189,155,145	201,821,244	243,959,059		HCBS – 217 Lik	50.67%	51.55%	51.35%	50.34%	50.01%	50.00%	50.00%	50.00%	50.00%	50.00%
HCBS – State Plan	0	44,439	2,963,002	51,039,962	120,768,482	182,615,703	241,126,278		HCBS – State P	50.79%	51.58%	51.36%	50.29%	50.02%	50.01%	50.01%	50.01%	50.01%	50.01%
HRSF & GME	0	96,221,820	0	0	0	0	0		HRSF & GME	50.00%									
HRSF Transition Payments	0	0	41,651,341	0	0	0	0		HRSF Transitio		50.00%								
IDD/MI – 217 Like	0	0	0	599,439	3,903,695	5,488,458	6,551,730		IDD/MI – 217			50.51%	50.00%	50.25%	50.25%	50.25%	50.25%	50.25%	50.25%
MATI at Risk	0	2,055,322	1,783,162	0	0	0	0		MATI at Risk	50.50%	52.00%								
New Adult Group	0	7,938,698	849,310,323	2,859,189,472	2,911,736,064	3,046,573,154	2,182,473,670		New Adult Gro	99.98%	100.00%	99.99%	99.92%	97.50%	94.50%	93.50%	91.50%	90.00%	90.00%
SED – 217 Like	0	42	29,462	13,944	48,354	6,114,934	7,452,850		SED – 217 Like		50.00%	50.09%	50.50%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%
SED at Risk	0	12,743,019	19,300,842	18,690,296	20,590,547	21,966,901	14,781,011		SED at Risk	51.99%	51.83%	51.96%	51.22%	51.15%	51.15%	51.15%	51.15%	51.15%	51.15%
TBI – 217 Like	0	6,928,494	8,987,060	0	0	0	0													
TBI – SP	0	3,776,704	4,819,278	0	0	0	0													
Title XIX	0	833,625,792	1,329,166,299	1,418,262,799	1,291,171,081	1,296,663,154	890,778,972		Title XIX	50.20%	55.35%	54.86%	50.74%	50.24%	50.10%	50.10%	50.10%	50.10%	50.10%
XIX CHIP Parents	0	0	64,746,447	2,148	0	0	0		XIX CHIP Parer		51.04%								
Total	**0**	**3,084,980,918**	**5,326,314,085**	**7,241,477,128**	**7,246,061,676**	**7,565,095,472**	**5,395,961,480**												
Created On: Thursday, April 26, 2018 9:27 AM																			
DY1 & DY2 HCBS expenditures		DY1	DY2																
		total computable																	
HCBS – 217 Like		207,465,132	278,302,398																
HCBS – State Plan		42,985,906	64,904,317																
		Federal share																	
HCBS – 217 Like		105,131,236	143,461,176																
HCBS – State Plan		21,832,238	33,475,598																

CMS 64 - MEDICAID ELIGIBILITY GROUPS AS OF JUNE 2014

Actuals through 9/30/2015 (as of 12/31/2015)

	DEFINITIONS:	DY1	DY2	DY3	DY4	DY5	DY6
1	TITLE XIX	5,773,180	7,850,901	8,699,959	8,893,616	8,812,615	7,211,309
2	ABD (Excluding HCBS and LTC SPC 61)	2,486,117	3,342,730	3,355,975	3,343,701	3,305,831	2,648,227
3	Childless Adults	385,740	225,208	-	-	-	-
4	Adults W/O Dependent Children	6,057	2,774	3,870,426	4,240,639	4,405,373	3,623,102
5	SED	26,729	43,160	38,453	43,795	47,103	38,120
6	HCBS (State Plan)	13,594	18,860	25,656	59,042	98,307	110,124
7	HCBS (217 Like)	96,351	127,895	122,272	132,498	147,391	129,755
8	LTC						
9	SED (217 Like)	113	145	115	96	1,847	2,771
10	IDD/MI (217 Like)	-	-	581	2,981	3,906	4,823
11	XIX CHIP Parents *(10/01/2013 - 12/31/2013 Only)*		456,761	-	-	-	
12	New Adult Group (01/01/2014 Onwards)		1,183,739	2,670,574	2,536,277	2,451,211	1,995,929

		Final dec 13 rpt	Final feb 14 rpt	Final mar 14 rpt	Final apr14 rpt	Final may 14 rpt	Final jun 14 rpt	Final Jul 14 rpt	Final aug 14 rpt	Final sept 14 rpt	Final oct 14 rpt	Final nov 14 rpt	Final dec 14 rpt
	DEFINITIONS:	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13
1	TITLE XIX	643,208	641,115	641,945	643,840	643,718	645,054	645,116	635,183	634,001	633,251	632,536	631,012
2	ABD (Excluding HCBS and LTC SPC 61)	274,854	274,540	274,471	275,897	276,304	276,808	277,259	277,750	278,234	278,390	278,697	279,521
3	Childless Adults	45,455	44,363	43,494	43,024	42,618	42,563	41,976	41,588	40,659	39,738	39,242	38,278
4	Adults W/O Dependent Children	772	750	713	682	670	663	644	610	553	503	491	460
5	SED	2,560	2,618	2,677	2,907	3,029	3,110	3,181	3,313	3,334	3,271	3,291	3,154
6	HCBS (State Plan)	1,518	1,520	1,504	1,467	1,474	1,493	1,511	1,543	1,564	1,553	1,555	1,540
7	HCBS (217 Like)	11,219	11,225	11,221	10,428	10,396	10,420	10,456	10,480	10,506	10,556	10,577	10,645
8	LTC												
9	SED (217 Like)	15	13	14	15	15	10	7	9	15	14	11	15
10	IDD/MI (217 Like)												
11	XIX CHIP Parents *(10/01/2013 - 12/31/2013 Only)*												
12	New Adult Group (01/01/2014 Onwards)												

		Final jan 15 rpt	Final feb 15 rpt	Final mar 15 rpt	Final apr 15 rpt	Final may 15 rpt	Final jun 15 rpt	Final jul 15 rpt	Final aug 15 rpt	Final sept 15 rpt	Final Oct 15 rpt	Final Nov 15 rpt	Final Dec 15 rpt
	DEFINITIONS:	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
1	TITLE XIX	628,743	625,874	623,702	663,241	667,292	678,653	683,673	689,180	693,744	698,873	705,756	712,044
2	ABD (Excluding HCBS and LTC SPC 61)	279,906	279,461	278,818	276,842	277,127	278,134	278,326	278,535	278,973	280,262	280,382	280,535
3	Childless Adults	37,737	34,678	35,535									
4	Adults W/O Dependent Children	453	442	425	145,207	160,725	203,473	221,698	235,947	248,452	261,467	275,824	285,009
5	SED	3,364	3,566	3,531	3,769	3,856	4,162	4,191	3,551	3,454	3,185	3,028	2,810
6	HCBS (State Plan)	1,567	1,586	1,586	1,596	1,583	1,580	1,576	1,573	1,565	1,492	1,546	1,624
7	HCBS (217 Like)	10,726	10,752	10,751	10,758	10,742	10,606	10,604	10,577	10,601	9,863	9,920	9,994
8	LTC				0	0	0	0	0	0	24,537	24,150	23,794
9	SED (217 Like)	15	16	13	9	9	11	15	10	7	14	18	11
10	IDD/MI (217 Like)						0	0	0	0	0	0	0
11	XIX CHIP Parents *(10/01/2013 - 12/31/2013 Only)*	152,428	152,087	152,246									
12	New Adult Group (01/01/2014 Onwards)				181,112	186,389	198,362	203,220	205,870	208,786	211,485	214,061	216,647

	DEFINITIONS:	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
1	TITLE XIX	716,443	718,070	721,307	726,830	732,311	736,730	740,261	744,442	746,892	744,994	744,692	744,034	744,176	741,195	739,809
2	ABD (Excluding HCBS and LTC SPC 61)	280,359	280,294	278,829	279,154	279,165	279,205	279,364	279,287	279,139	279,313	279,789	278,996	278,966	278,024	279,820
3	Childless Adults															
4	Adults W/O Dependent Children	293,647	303,733	320,267	332,291	348,973	355,792	362,664	364,468	366,291	362,228	357,424	350,616	345,857	342,309	345,701
5	SED	2,886	2,923	3,039	3,164	3,262	3,413	3,522	3,637	3,584	3,438	3,182	3,107	3,201	3,431	3,581
6	HCBS (State Plan)	1,821	2,011	2,162	2,163	2,265	2,349	2,496	2,703	3,024	3,360	3,715	3,972	4,158	4,528	4,751
7	HCBS (217 Like)	10,300	10,490	10,467	10,246	10,156	10,149	10,181	10,224	10,282	10,517	10,584	10,701	10,734	10,837	11,028
8	LTC	23,313	22,974	22,725												
9	SED (217 Like)	6	8	9	9	5	7	9	11	8	11	8	7	8	9	7
10	IDD/MI (217 Like)	0	0	0	0	0	113	133	145	190	205	220	244	271	275	285
11	XIX CHIP Parents *(10/01/2013 - 12/31/2013 Only)*															
12	New Adult Group (01/01/2014 Onwards)	218,794	220,090	225,796	225,810	228,275	228,919	227,858	226,725	226,114	223,139	219,467	215,942	213,041	209,178	207,478

	DEFINITIONS:	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
1	TITLE XIX	741,320	741,240	740,227	739,262	737,369	735,298	734,757	736,857	737,189	735,578	735,602	735,799
2	ABD (Excluding HCBS and LTC SPC 61)	278,974	278,024	278,259	278,098	277,601	277,837	277,679	277,578	277,969	277,957	276,991	276,449
3	Childless Adults												
4	Adults W/O Dependent Children	353,211	354,296	355,355	357,219	357,319	359,104	358,260	359,657	357,358	355,904	363,152	368,779
5	SED	3,756	3,875	3,959	4,033	4,148	4,084	3,854	3,608	3,449	3,469	3,609	3,694
6	HCBS (State Plan)	5,067	5,310	5,531	5,797	6,263	6,590	6,848	7,074	7,242	7,426	7,673	8,114
7	HCBS (217 Like)	11,081	11,205	11,255	11,380	11,474	11,702	11,818	11,872	11,923	12,054	12,190	12,328
8	LTC												
9	SED (217 Like)	9	4	7	12	9	5	1	50	82	116	132	153
10	IDD/MI (217 Like)	262	269	274	230	222	224	207	194	177	157	137	298
11	XIX CHIP Parents *(10/01/2013 - 12/31/2013 Only)*												
12	New Adult Group (01/01/2014 Onwards)	207,706	208,078	208,765	208,497	207,899	207,087	205,668	205,206	203,996	203,087	203,539	204,364

	DEFINITIONS:	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
1	TITLE XIX	735,541	734,304	734,224	731,318	731,295	730,151	727,630	727,049	723,461	724,126	723,669	722,110	719,329	714,243	699,541
2	ABD (Excluding HCBS and LTC SPC 61)	275,620	274,885	274,211	273,155	272,254	271,083	270,043	269,245	267,931	266,853	265,440	263,748	261,014	258,201	254,669
3	Childless Adults															
4	Adults W/O Dependent Children	374,891	374,231	374,764	374,166	373,879	370,332	364,204	361,387	358,869	357,846	365,165	367,933	363,413	361,299	352,654
5	SED	3,909	4,006	4,245	4,367	4,509	4,384	4,022	3,655	3,473	3,510	3,629	3,752	3,924	3,968	3,803
6	HCBS (State Plan)	8,309	8,419	8,606	9,087	9,538	9,971	10,327	10,498	10,682	10,969	11,123	11,266	11,614	11,751	11,923
7	HCBS (217 Like)	12,484	12,427	12,471	12,555	12,601	12,668	12,825	12,836	12,925	12,927	12,948	12,958	13,238	13,174	13,256
8	LTC															
9	SED (217 Like)	178	196	211	225	245	258	270	278	284	285	276	285	286	281	268
10	IDD/MI (217 Like)	433	452	446	461	469	475	478	486	492	528	498	485	474	458	449
11	XIX CHIP Parents *(10/01/2013 - 12/31/2013 Only)*															
12	New Adult Group (01/01/2014 Onwards)	205,072	204,576	204,686	204,107	203,774	203,136	202,046	200,904	199,908	199,577	200,069	199,761	198,665	197,568	194,295

Source = CMS64 MEG report from Dec 2015

RUN DATE: 3/31/18

MMX Member Mo	Count(dist) Recip Idn
3/1/2013	28,870.
4/1/2013	28,803.
5/1/2013	28,701.
6/1/2013	28,754.
7/1/2013	28,869.
8/1/2013	29,047.
9/1/2013	29,082.
10/1/2013	29,126.
11/1/2013	29,168.
12/1/2013	29,217.
1/1/2014	29,089.
2/1/2014	28,868.
3/1/2014	28,900.
4/1/2014	28,830.
5/1/2014	28,813.
6/1/2014	28,782.
7/1/2014	29,260.
8/1/2014	29,165.
9/1/2014	29,026.
10/1/2014	28,862.
11/1/2014	28,630.
12/1/2014	28,481.
1/1/2015	28,469.
2/1/2015	28,178.
3/1/2015	27,965.
4/1/2015	27,883.
5/1/2015	27,833.
6/1/2015	27,997.
7/1/2015	28,002.
8/1/2015	28,179.
9/1/2015	28,237.
10/1/2015	28,343.
11/1/2015	28,524.
12/1/2015	28,553.
1/1/2016	28,529.
2/1/2016	28,462.
3/1/2016	28,535.
4/1/2016	28,485.
5/1/2016	28,656.
6/1/2016	28,715.
7/1/2016	28,759.
8/1/2016	28,899.
9/1/2016	28,851.
10/1/2016	29,004.
11/1/2016	28,831.
12/1/2016	28,703.
1/1/2017	28,610.
2/1/2017	28,375.
3/1/2017	28,255.
4/1/2017	28,270.
5/1/2017	28,212.
6/1/2017	28,222.
7/1/2017	28,140.
8/1/2017	28,003.
9/1/2017	27,776.
10/1/2017	27,807.
11/1/2017	27,770.
12/1/2017	27,457.
1/1/2018	27,448.
2/1/2018	26,718.
3/1/2018	24,849.
4/1/2018	24,726.

	MMs
DY1	260,420.
DY2	347,442.
DY3	338,091.
DY4	344,279.
DY5	338,143.
DY6	131,198.

MMX Member Month Date	Count(dist) Recip Idn
3/1/2013	2,291.
4/1/2013	2,270.
5/1/2013	2,242.
6/1/2013	2,220.
7/1/2013	2,195.
8/1/2013	2,177.
9/1/2013	2,157.
10/1/2013	2,130.
11/1/2013	2,109.
12/1/2013	2,076.
1/1/2014	2,048.
2/1/2014	2,032.
3/1/2014	2,017.
4/1/2014	1,970.
5/1/2014	1,930.
6/1/2014	1,876.
7/1/2014	1,845.
8/1/2014	1,823.
9/1/2014	1,811.
10/1/2014	1,791.
11/1/2014	1,769.
12/1/2014	1,744.
1/1/2015	1,724.
2/1/2015	1,712.
3/1/2015	1,695.
4/1/2015	1,679.
5/1/2015	1,666.
6/1/2015	1,651.
7/1/2015	1,639.
8/1/2015	1,632.
9/1/2015	1,612.
10/1/2015	1,585.
11/1/2015	1,587.
12/1/2015	1,578.
1/1/2016	1,571.
2/1/2016	1,557.
3/1/2016	1,548.
4/1/2016	1,541.
5/1/2016	1,525.
6/1/2016	1,515.
7/1/2016	1,507.
8/1/2016	1,505.
9/1/2016	1,501.
10/1/2016	1,495.
11/1/2016	1,485.
12/1/2016	1,482.
1/1/2017	1,469.
2/1/2017	1,465.
3/1/2017	1,462.
4/1/2017	1,458.
5/1/2017	1,449.
6/1/2017	1,442.
7/1/2017	1,437.
8/1/2017	1,429.
9/1/2017	1,426.
10/1/2017	1,424.
11/1/2017	1,415.
12/1/2017	1,412.
1/1/2018	1,401.
2/1/2018	1,387.

	MMs
DY1	19,791.
DY2	22,988.
DY3	19,926.
DY4	18,328.
DY5	17,358.

1115 Comprehensive Waiver Quarterly Report
Demonstration Year: 6
Federal Fiscal Quarter: 2 (1/1/18-03/31/18)
Department of Children and Families (DCF), Children's System of Care (CSOC)

Quality Assurance Activities:

STC 103(d)(x) A summary of the outcomes of the State's Quality Strategy for HCBS as outlined above

- **I/DD and ASD Pilot**

#1 Administrative Authority Sub Assurance	The New Jersey State Medicaid Agency (DMAHS) retains the ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of the waiver functions by other state and contracted agencies.
Data Source	Record Review and or CSA data
Sampling Methodology	Random sample of case files representing a 95% confidence level
Numerator: Number of sub assurances that are substantially compliant (86 % or greater)	In Development
Denominator: Total number of sub assurances audited	In Development
Percentage	In Development

The reporting of this quality strategy is in development and will be addressed later.

STC 103(d)(x) A summary of the outcomes of the State's Quality Strategy for HCBS as outlined above

- **I/DD and ASD Pilot**
- **Measurement period 1/1/2018 - 3/31/2018**

#2 Quality of Life Sub Assurance	All youth that meet the clinical criteria for services through the Department of Children and Families(DCF), Division of Children' s System of Care (CSOC) will be assessed utilizing the comprehensive Child and Adolescent Needs and Strengths (CANS) assessment tool.	
Data Source	Review of Child and Adolescent Needs and Strengths scores Contracted System Administrator (CSA) Data. Data report: CSA NJ1225 Strengths & Needs Assessment – Post SPC Start	
Sampling Methodology	100% New youth enrolled in the waiver	
Waiver	**I/DD**	**ASD**
Numerator: Number of youth receiving Child and Adolescent Needs and	179	34

Strengths (CANS) assessment		
Denominator: Total number of new enrollees	180	34
Percentage	99%	100%

One youth was admitted to the waiver on 3/27/18 at the end of the reporting period. The assessment was not due and therefore should not have been captured during this reporting period.

STC 103(d)(x) A summary of the outcomes of the State's Quality Strategy for HCBS as outlined above

- **I/DD and ASD Pilot**
- **Measurement period 1/1/2018 - 3/31/2018**

#3 Quality of Life Sub Assurance	80% of youth should show improvement in Child and Adolescent Needs and Strengths composite rating within a year	
Data Source	CSA Data on CANS Initial and Subsequent Assessments. Data report: CSA NJ2021CANS Waiver Outcome	
Sampling Methodology	Number of youth enrolled in the waiver for at least 1 year.	
Waiver	**I/DD**	**ASD**
Numerator: Number of youth who improved within one year of admission	898	197
Denominator: Number of youth with Child and Adolescent Needs and Strengths assessments conducted 1 year from admission or last CANS conducted	985	205
Percentage	91%	96%

CSOC conducted a review of the Care and Associated Needs Assessment (CANS) for all youth during the reporting period served under the ID/DD – MI and ASD waivers. Both waiver programs achieved greater outcomes than the 80% threshold of improvement for the youth. CSOC will continue to monitor this area to make sure that we maintain an 80% or higher outcome for this indicator.

STC 103(d)(x) A summary of the outcomes of the State's Quality Strategy for HCBS as outlined above

- **I/DD and ASD Pilot**
- **Measurement period 1/1/2018 - 3/31/2018**

#4 Level of Care Sub Assurance	CSOC's Contracted System's Administrator (CSA), conducts an initial Level of Care assessment (aka Intensity of Services (IOS) prior to enrollment for all youth.
Data Source	CSA Data. Data report: CSA NJ1218 New Enrollees, Quarterly Count and IOS Completed

Sampling Methodology	100% new youth enrolled in the waiver	
Waiver	**I/DD**	**ASD**
Numerator: Number of youth receiving initial level of care determination prior to enrollment	180	34
Denominator: Number of new enrollees	180	34
Percentage	100%	100%

CSOC reviewed all new enrollees for the ID/DD and ASD waivers. All youth meet the criteria during the reporting period.

STC 103(d)(x) A summary of the outcomes of the State's Quality Strategy for HCBS as outlined above

- **I/DD and ASD Pilot**
- **Measurement period 1/1/2018 - 3/31/2018**

#5 Plan of Care Sub Assurance	The Plan of Care (aka Individual Service Plan (ISP)) is developed based on the needs identified in the Child and Adolescent Needs and Strengths assessment tool and according to CSOC policies	
Data Source	CSA Data on Plans of Care completions, Record Review. Data report: CSA NJ1219 Follow – Up Treatment Plan and Associated SNA	
Sampling Methodology	100% of youth enrolled during the measurement period.	
Waiver	**I/DD**	**ASD**
Numerator: Number of Plans of Care that address youth's assessed needs	179	34
Denominator: Number of Plans of Care reviewed	180	34
Percentage	99%	100%

One youth was admitted to the waiver on 3/27/18 at the end of the reporting period. The assessment was not due and therefore should not have been captured during this reporting period.
CSCO will continue to monitor this item.

STC 103(d)(x) A summary of the outcomes of the State's Quality Strategy for HCBS as outlined above

- **I/DD and ASD Pilot**
- **Measurement period 1/1/2018 - 3/31/2018**

#6 Plan of Care Sub Assurance	Plan of Care (ISP) is updated at least annually or as the needs of the youth changes	
Data Source	CSA Data Report: CSA NJ1289 Waiver ISP Aggregate Report All Youth	
Sampling Methodology	100% of youth enrolled during the measurement period.	
Waiver	**I/DD**	**ASD**
Numerator: Number of current Plans of Care updated at least annually	359	55
Denominator: Number of Plans of Care reviewed	359	55
Percentage	100%	100%

All waivered youth enrolled during the reporting period had a documented annual review.

STC 103(d)(x) A summary of the outcomes of the State's Quality Strategy for HCBS as outlined above

- **I/DD and ASD Pilot**
- **Measurement period 1/1/2018 - 3/31/2018**

#7 Plan of Care Sub Assurance	Services are authorized in accordance with the approved plan of care (ISP). Data Report: CSA NJ1220 Waiver Services Provided	
Data Source	CSA Data Report of Authorizations Record Review	
Sampling Methodology	100% of youth enrolled during the measurement period.	
Waiver	**I/DD**	**ASD**
Numerator: Number of plans of care that had services authorized based on the plan of care	178	34
Denominator: Number of plans of care	180	34

reviewed		
Percentage	99%	100%

These two youths should not have been counted as part of the report as they did not receive a waiver service.

STC 102(d)(x) A summary of the outcomes of the State's Quality Strategy for HCBS as outlined above

- **I/DD and ASD Pilot**
- **Measurement period 1/1/2018 - 3/31/2018**

#8 Plan of Care Sub Assurance	Services are delivered in accordance with the approved plan of care (ISP).	
Data Source	CSA Data Report of Authorizations Claims paid on authorized services through MMIS Record Review	
Sampling Methodology	Random sample representing a 95% confidence level	
Waiver	**I/DD**	**ASD**
Numerator: Number of Services that were delivered	In Development	In Development
Denominator: Number of services that were authorized	In Development	In Development
Percentage	In Development	In Development

The reporting of this quality strategy is in development and will be addressed at a later date.

STC 103(d)(x) A summary of the outcomes of the State's Quality Strategy for HCBS as outlined above

- **I/DD and ASD Pilot**
- **Measurement period 1/1/2018 - 3/31/2018**

#9 Plan of Care Sub Assurance	Youth/Families are provided a choice of providers, based on the available qualified provider network.	
Data Source	Record review Statewide Provider List -CSA Data Report	
Sampling Methodology	Random sample representing a 95% confidence level	
Waiver	**I/DD**	**ASD**

Numerator: Number of youth/families given a choice of providers as indicated in progress notes	N/A*	N/A*
Denominator: Number of records reviewed	N/A*	N/A*
Percentage	N/A*	N/A*

*CSOC does not have data available for this, our Electronic Health Record recently incorporated a way to document family choice and CSOC is working on a method on how to report this data.

STC 103(d)(x) A summary of the outcomes of the State's Quality Strategy for HCBS as outlined above

- **I/DD and ASD Pilot**
- **Measurement period 1/1/2018 - 3/31/2018**

#10 Qualified Providers Sub Assurance	Children's System of Care verifies that providers of waiver services initially meet required qualified status, including any applicable licensure and/or certification standards prior to their furnishing waiver services.	
Data Source	Record review	
Sampling Methodology	100% Agency	
Waiver	**I/DD**	**ASD**
Numerator: Number of new providers that met the qualifying standards prior to furnishing waiver services	3	
Denominator: Total number of new providers	3	
Percentage	100%	

STC 103(d)(x) A summary of the outcomes of the State's Quality Strategy for HCBS as outlined above

- **I/DD and ASD Pilot**
- **Measurement period 1/1/2018 - 3/31/2018**

# 11 Qualified Providers Sub Assurance	Children's System of Care verifies that providers of waiver services continually meet required qualified status, including any applicable licensure and/or certification standards.
Data Source	Provider HR Record Review
Sampling Methodology	100% Agency

Waiver	**I/DD**	**ASD**
Numerator: Number of providers that meet the qualifying standards – applicable Licensures/certification	In Development	In Development
Denominator: Total number of providers that initially met the qualified status	In Development	In Development
Percentage	In Development	In Development

All providers are qualified at the RFQ stage, so any certifications/qualifications of providers added during the reporting period were confirmed. The reporting of this for established providers is in development.

STC 103(d)(x) A summary of the outcomes of the State's Quality Strategy for HCBS as outlined above

- **I/DD and ASD Pilot**
- **Measurement period 1/1/2018 - 3/31/2018**

# 12 Qualified Providers Sub Assurance	CSOC implements its policies and procedures for verifying that applicable certifications/checklists and training are provided in accordance with qualification requirements as listed in the waiver.	
Data Source	Record Review	
Sampling Methodology	100% Community Provider Agencies	
Waiver	**I/DD**	**ASD**
Numerator: Number of providers that have been trained and are qualified to provide waiver services	3	
Denominator: Total number of providers that provide waiver services	3	
Percentage	100%	

All providers are qualified at the RFQ stage, so any certifications and trainings of providers added during the reporting period were verified.

# 13 Health and Welfare Sub Assurance	The State, demonstrates on an on-going basis, that it identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation.	
Data Source	Review of UIRMS database and Administrative policies & procedures	
Sampling Methodology	100% of youth enrolled for the reporting period	
Waiver	**I/DD**	**ASD**
Numerator: Total number of UIRs submitted timely according to State policies	1	0
Denominator: Number of UIRs submitted involving enrolled youth	11	0
Percentage	9%	n/a

The majority of incidents were reported late, a few days after the incident, and not within the timeframes as required by the procedure. CSOC will send a memo to providers reiterating the need to report UIRs as required by the procedure (next business day or immediately) into our incident database system.

# 14 Health and Welfare Sub Assurance	The State incorporates an unusual incident management reporting system (UIRMS), as articulated in administrative order 205, which reviews incidents and develops policies to prevent further similar incidents (i.e., abuse, neglect and runaways).	
Data Source	Review of UIRMS database and Administrative policies & procedures	
Sampling Methodology	100% of youth enrolled for the reporting period	
Waiver	**I/DD**	**ASD**
Numerator: The number of incidents that were reported through UIRMS and had required follow up	8	0
Denominator: Total number of incidents reported that required follow up	11	0
Percentage	73%	n/a

There are two incidents (one event – two individuals) that were reported to the Department of Human Services (DHS) and one incident to the Division of Permanency and Protection (DCPP) and not into the

incident database maintained by CSOC. Those three unusual incident reports to be completed are awaiting follow-up. As stated above a memo will be sent to providers about the process and CSOC will reach out to the other State entities to gather their findings when follow-up is completed.

# 15 Health and Welfare Sub Assurance	The State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.	
Data Source	Review of UIRMS	
Sampling Methodology	100% of all allegations of restrictive interventions reported	
Waiver	**I/DD**	**ASD**
Numerator: Number of unusual incidents reported involving restrictive interventions that were remediated in accordance to policies and procedures	In Development	In Development
Denominator: Total number of unusual incidents reported involving restrictive interventions	In Development	In Development
Percentage	In Development	In Development

The reporting of this quality strategy is in development and CSOC plans to be able to address this with a future update in the Electronic Health Record.

# 16 Health and Welfare Sub Assurance	The State establishes overall healthcare standards and monitors those standards based on the NJ established EPSDT periodicity schedule for well visits.	
Data Source	MMIS Claims/Encounter Data	
Sampling Methodology	100% of youth enrolled for the reporting period	
Waiver	**I/DD**	**ASD**
Numerator: Number of youth enrolled that received a well visit	In Development	In Development
Denominator: Total number of youth enrolled	In Development	In Development
Percentage	In Development	In Development

The reporting of this quality strategy is in development and will be addressed with a future update in the Electronic Health Record.

# 17 Financial Accountability Sub Assurance	The State provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved waiver and only for services rendered.	
Data Source	Claims Data, Plans of Care, Authorizations	
Sampling Methodology	100% of youth enrolled for the reporting period	
Waiver	**I/DD**	**ASD**
Numerator: The number of claims there were paid according to code within youth's centered plan authorization	In Development	In Development
Denominator: Total number of claims submitted	In Development	In Development
Percentage	In Development	In Development

The reporting of this quality strategy is in development and will be addressed at a later date.