New Jersey Comprehensive Waiver Demonstration
Section 1115 Quarterly Report
***Demonstration Year:* 5 (7/1/16-6/30/17)**
***Federal Fiscal Quarter:* 1 (10/1/16-12/31/16)**

I. Introduction

The New Jersey Comprehensive Waiver Demonstration (NJCW) was approved by the Centers for Medicare and Medicaid Services (CMS) on October 2, 2012, and is effective October 1, 2012 through June 30, 2017.

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 and benefits.

III. Enrollment Counts for Quarter

Demonstration Populations by MEG	Total Number of Demonstration participants Quarter Ending – 09/16	Total Number of Demonstration participants Quarter Ending – 12/16	Total Number of Demonstration participants Quarter Ending – MM/YY	Total Number of Demonstration participants Quarter Ending – MM/YY
Title XIX	716,812	715,549		
ABD	266,056	265,056		
LTC				
HCBS - State plan	7,225	8,072		
TBI – SP				
ACCAP – SP				
CRPD – SP				
GO – SP				
HCBS - 217-Like	11,674	12,079		
TBI – 217-Like				
ACCAP – 217-Like				
CRPD – 217-Like				
GO – 217-Like				
SED - 217 Like	35	123		
IDD/MI – (217 Like)	117	85		
NJ Childless Adults				
AWDC	344,286	349,333		
New Adult Group	197,617	197,321		
SED at Risk	3,079	3.304		
MATI at Risk				
Title XXI Exp Child				
NJFAMCAREWAIV-POP 1				

NJFAMCAREWAIV-POP 2	[redacted]
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 over the past year. During this quarter, the Department of Human Services continued meeting with the MLTSS Quality Workgroup that had met during the development of MLTSS to gather information and formulate recommendations to the MLTSS Steering Committee. The goal was to recommend potential nursing facility (NF) quality metrics in support of the state's NF quality improvement (QI) goals under MLTSS. During this quarter, the DHS reached consensus with the MLTSS Stakeholder group as to the seven proposed QI measures. Included was agreement that New Jersey also hopes to use CoreQ as the survey tool to measure NF resident and family satisfaction across all NFs in New Jersey. DHS expects meetings to continue taking place in 2017 as the policies and procedures are crafted around the initiative. The MLTSS Steering Committee met on December 1, 2016 with its representation from stakeholders, consumers, providers, MCOs and state staff members. The agenda included a report to the Committee, including these topics: 1115 Comprehensive Waiver renewal and the most recent program data, including enrolled members, expenditures and services. Stakeholder AARP presented on its new caregiving report: *Family Caregivers and Managed Long-Term Services and Supports Report.* Dr. Nick Castle, a national CoreQ expert and a health policy researcher at the University of Pittsburgh, also attended and presented so the stakeholders could learn firsthand about the proposed NF resident and family satisfaction survey. There was also time at the meeting for a question/answer session with the stakeholders. On December 9, 2016 the DMAHS Deputy Director and Office of Managed Health Care staff presented at the Home Care and Hospice Annual Meeting. Participants received overview of Medicaid Waiver as well as had the opportunity to ask questions about existing policies and procedures. The Office of Managed Health Care (OMHC), with its provider relations unit, 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.
ASD/ID/DD-MI/SED
The Department of Children and Families (DCF), Children's System of Care (CSOC) promotes its program at their many meetings throughout the state and plans to continue to do so at community/stakeholder meetings.
Supports
During this quarter, the Division of Developmental Disabilities (DDD) distributed the timeline for 2017

graduates to enter the DDD system. The vast majority of these individuals will be enrolled into the Supports Program upon exiting the school system.

DDD conducted quarterly Support Coordination Supervisors meetings to provide updates, answer questions, and receive feedback. DDD also met individually with providers within DDD's contract reimbursement system to determine readiness for the shift to the Supports Program and Fee-for-Service and answer questions. In addition, DDD also provided answers to and met with a variety of providers regarding various areas related to the Supports Program.

DDD widely announced the availability of the provider database with instructions on how to utilize it to look up providers and services.

V. Collection and Verification of Encounter Data and Enrollment Data

Summary of Issues, Activities or Findings

New Jersey managed care plans must submit all services provided to MLTSS recipients to the State in HIPAA-compliant formats. These service encounters are edited by New Jersey's fiscal agent, Molina Medicaid Solutions before being considered final. New Jersey implements liquidated damages on its health plans for excessive duplicate encounters and excessive denials by Molina; the total dollar value of encounters accepted by Molina must also equal 98 percent of the medical cost submitted by the plans in their financial statements. Certain acute care encounters (including those for MLTSS enrolled individuals) are subject to monthly minimum utilization benchmarks that must be met. If these benchmarks are not met nine months after the conclusion of a given service month, up to 2 percent of capitation payments to the plans begin to be withheld; if plans meet these thresholds over the subsequent nine months, these withheld capitation payments are returned to the plans. However, if plans do not meet these benchmarks at this point, the withheld capitations are converted to liquidated damages.

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

MLTSS

The Division of Medical Assistance and Health Services (DMAHS) convenes a weekly meeting with state staff from the various Divisions involved in MLTSS to discuss any issues to ensure resolution in a timely manner and in accordance with the rules and laws that govern the Medicaid program. The state also continues to have monthly conference calls with the Managed Care Organizations (MCOs) to review statistics and discuss and create an action plan for any issues that either the state or the MCOs are encountering.

ASD/ID/DD-MI/SED

The Department of Children and Families (DCF), Children's System of Care (CSOC) continues ongoing enrollment of youth in the Intellectual Disabilities/ Development Disabilities co-occurring Mental Illness Pilot (ID/DD-MI) and the Autism Spectrum Disorder (ASD) Pilot. As of December 31, 2016, there were 109 youth identified for the ASD pilot and 134 youth identified for the ID/DD-MI pilot.

CSOC continues to enroll youth into The Serious Emotional Disturbance (SED) Plan A coverage through the SED waiver.

CSOC began to operationalize interpreter services under the ID/DD-MI waiver authority. CSOC expects that services will be implemented and operationalized within the next quarterly reporting period.

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

Technical assistance is ongoing to assist and provide new ASD and ID/DD-MI providers related procedures and expectations. CSOC also provided technical assistance on the Medicaid enrollment process to ensure that providers receive a Medicaid ID for billing and requisite provider enrollment training.

Supports

During this quarter, the Division of Developmental Disabilities (DDD) Reached 1,000 individuals enrolled in the Supports Program. The Department of Human Services awarded funding for Fiscal Services Management to Public Partnerships LLC (PPL). PPL will operate as the fiscal intermediary for participant-directed services and supports for individuals served through the Supports Program. It is anticipated that the FI responsibilities will be fully shifted to PPL by May/June 2017 and enrollment into the Supports Program will increase as individuals using Self-Directed Employees (also commonly referred to as "self-hires") will be able to enroll in the Supports Program at that time.

DDD began notifying every individual/family of his/her tier as a result of completing the NJ Comprehensive Assessment Tool (NJ CAT). This tier leads to the associated individualized budget up-to amount that will be put into effect upon enrollment into the Supports Program.

DDD continues enrollment of individuals into Supports Program + Private Duty Nursing (PDN) and provides options counseling to individuals identified as needing PDN. In addition, DDD also continues to enroll individuals identified through Support Coordination Agencies as meeting the criteria for Supports Program enrollment.

DDD widely released access to the provider database so it can be utilized by the general public as well as Support Coordinators and providers. DDD also provided mechanisms for providers to update/revise information contained in the database through a dedicated email address for the Division's Provider Database Unit.

DDD continues meeting with the trade organizations and individual providers to assist in preparation for the Medicaid-based, Fee-for-Service system. In addition, DDD reached out to Medicaid/DDD approved providers to identify which providers are stating that they are not ready to provide services in the Medicaid based, Fee-for-Service model so we can identify providers in need of technical assistance. In addition, DDD continued to hold regular calls with providers and individuals/families regarding the system reform (including the Supports Program). These calls provide the opportunity for stakeholders to share issues/concerns as they come up, receive updates, and suggest ideas/feedback. Any additional assistance to individuals with Medicaid eligibility is supplied. DDD continues to provide ongoing support and guidance on the application process for provider enrollment.

DDD continues the identification of quality measures for the DDD system, providers, individuals, and services. In addition, DDD continues to participate in Medicaid's Quality Management Unit Comprehensive Audit Review of the Supports Program.

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

IME

During Quarter 1, October 1, 2016 through December 31, 2016, two additional Substance Abuse provider trainings were facilitated by the Interim Management Entity (IME), through the Department of Mental Health and Addiction Services (DMHAS) and DMAHS on the Process of submitting requests for prior authorization. For the coming year, the IME's focus for provider trainings will move toward improved clinical assessment and more accurate level of care determinations based on medical necessity. From Oct. 1, 2016 through Dec. 31, 2016, the IME received and responded to 14,112 calls to the Call Center from individuals or family members. 1,436 individuals were placed in Care Coordination services to facilitate admission to treatment. 692 of the individuals in Care Coordination status were placed there due to provider admission wait lists and 324 or 47 percent of those individuals were on provider wait lists for Detox or Short Term Residential treatment. The IME Utilization Management Service issued 7,603 Prior Authorizations for Medicaid beneficiaries to enter treatment and 2,813 authorizations for extended or continued care for Medicaid beneficiaries during the first Federal Fiscal Quarter. The IME continues to utilize their provider assistance hotline to remain active in the transition of Managed Substance Abuse Services and received 1436 calls.

DSRIP

Quarterly Payment Reports – On January 10, 2017, CMS approved $3,809,552.56 for federal drawdown by New Jersey for Quarter 2, Demonstration Year 5 for payments earned under Stage 1 and Stage 2 measures. This drawdown represents federal share only.

Progress in meeting DSRIP goals - all forty nine hospitals' progress reports were reviewed and approved by NJDOH and sent by November 21st to CMS for review.

Performance – DY4 results: hospitals have begun submitting formal Requests for Information (RFIs) in order to verify MMIS data. Once all RFIs have been answered, the 30-day appeal clock will start. All but one hospital achieved 100% of their Stage 4 measures. Just over half (51.14%) of Stage 3 measures were achieved, resulting in significant forfeitures to the Universal Performance Pool (UPP) totaling $21.8 million. New Jersey received 42 RFIs from hospitals. Three hospitals submitted Chart appeals.

Challenges – On July 26, 2016, CMS approved the Stage 3 substitution measures and remaining ITGs for Quarter 4 only; they would like to discuss the specifics in detail with New Jersey for the future. Specifically, CMS prefers that the state utilize the national benchmark when possible, followed by the New Jersey statewide benchmark. DSRIP measure #45 (Heart Failure Admission Rate) results were rerun due to a measure steward update that impacted comparison to baseline. New Jersey Department of Health (NJDOH) is awaiting a response from CMS regarding a question of possible duplicate funding issue for the CarePoint hospital system.

Mid-course corrections – NJDOH submitted revisions to the DSRIP protocols in May, 2016 to CMS for their review. NJDOH is awaiting feedback. CMS and NJDOH to schedule discussions about extending NJDSRIP under the 1115 Waiver Renewal.

Successes and evaluation – The Learning Collaborative was held on December 8, 2016. The agenda included:
Review DSRIP Program Updates; Guest Speaker - Colette Lamothe-Galette, Director, NJDOH Office of Population Health; Guest Speaker - Presentation by St. Peter's Medical Center "Patient Experience";
And discussion of Patient Identification and Enrollment. It was well attended.

Other
Managed Care Contracting:
There are no updates for this Quarter.
Self-attestations:
There were a total of 232 self-attestations for the time period from October 1, 2016 to December 31, 2016
MCO Choice and Auto-assignment:
The number of individuals who changed their MCO after auto-assignment is 4,682.
MLR:
MCO Medical Loss Ratios for the 12 month Period July 1, 2015 to June 30, 2016: Horizon NJ Health: 91.8% UnitedHealthcare: 87.8% Amerigroup: 83.5% WellCare: 89.4% Aetna: 97.5%

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

This information can be found under Attachment A, Budget Neutrality Monitoring Spreadsheet

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

XI. Quality Assurance/Monitoring Activity

MLTSS:

MLTSS Claims Processing Information by MCO

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
# Claims Received	25,574	6,7196	290,586	44,952	154,886
# Claims Paid	18,733	57,614	214,604	8,494	114,121
# Claims Denied	6,089	7,524	75,982	4,508	35,862
# Claims Pending	752	2,058	15,234	1,950	4,903
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	Invalid combination of HCPCS modifiers	Units exceed UM authorization	No Pre-certification	Service is not contracted	No Authorization
2	Service denied because payment already made for same/similar procedure within set time frame	Paid at contracted rate	No Authorization or referral	No authorization on file	No Patient Responsibility
3	Non-covered charge(s)	State responsibility	Timely filing	Benefits Based on Admission Date	Timely Filing
4	Procedure code incidental to primary procedure.	Non-covered procedure for diagnosis	Duplicate	Dates of service matched	
5		Disallow-not allowed under contract	Not covered on provider's contract	EOB - Medicare 2ndary Carrier	

SED/IDD/ASD:

During this reporting period, the NJ FamilyCare 1115 Comprehensive Waiver Demonstration Application for Renewal was reposted for public review and comment, which included CSOC's waiver components.

The Department of Children and Families (DCF), Children's System of Care (CSOC) has continued to collaborate with the DMAHS Quality Monitoring team that is providing oversight on quality assurance. The Quality strategy reports continue to be finalized.

CSOC does not have quality data available for this quarter. CSOC will provide updated information for the next quarterly report.

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

Supports:

The Division of Developmental Disabilities (DDD) continues to hold quarterly update meetings for families and providers. DDD finalized a draft of the family friendly version of the Supports Program Policies & Procedures Manual. This guide was created with significant input from the Regional Family Support Planning Councils and will be made available publicly next quarter.

During this quarter, some concerns regarding the manner in which respite is set up and lack of providers

available to offer the service has been brought to DDD's attention. The division is working with respite providers to address the concerns and simplify respite standards as appropriate. In addition, individuals provided through businesses that offer attending classes developed specifically for individuals with intellectual/developmental disabilities but similar classes to the general public have expressed concerns about these classes not fitting under "Goods and Services" and the providers not feeling they belong under "Day Habilitation" as previously instructed. The Division is looking further into these classes, meeting with providers, and discussing further options related to these valued services.

Concerns regarding mandated training for Self-Directed Employees have been discussed and some revisions have been made to the training requirements. In addition, feedback was gathered from the Support Coordination Agencies regarding some proposed changes in documentation and developments in iRecord.

Other Quality/Monitoring Issues:

EQR PIP

In December 2013, the MCOs, with the guidance of the EQRO, initiated a collaborative QIP 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 QIP foundation across all MCOs. In September 2015, the plans submitted a report to include a qualitative analysis of their recent activities and, based on the analysis, any revisions to the interventions for the upcoming year. 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 QIP. A routine QIP cycle consists of baseline data followed by two remeasurement years and then a sustainability year. Currently, four MCOs are involved in the collaborative. For three of the MCOs, 2013 is 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 of 2016 started the sustainability year for these plans. The fourth MCO entered into the NJ market in December of 2013, making their baseline year 2014, with results of calendar year 2015 as their first remeasurement year. January of 2016 was the start of remeasurement year 2 for this plan. The MCOs submitted a progress report in September 2016 which was reviewed by the EQRO. In June of 2017, three of the MCOs will be submitting their final report for this QIP. The fourth MCO will be in their sustainability year and will be submitting a progress report in June of 2017.

The MCOs are also involved in a non-collaborative Prenatal QIP 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 of 2016 was the start of remeasurement year 2 for this QIP. The MCO's submitted a progress report in September 2016 which was reviewed by the EQRO. In June of 2017, the plans will submit a progress report which will include results of the remeasurement year 2 data.

Additionally, all MCOs submitted individual QIP proposals in September 2015 on Falls Prevention specific to members receiving managed long term support services. The individual proposals were approved and project activities were initiated by the plans in early 2016. The June reports included the 2015 baseline data. The MCO's submitted a progress report in September 2016, which was reviewed by the EQRO. The plans will submit a progress report in June 2017 which will include the remeasurement year 1 data.

State Sanctions against MCO, ASO, SNP or PACE Organization:
There was two Notice of Deficiency given this quarter. DMAHS issued a notice of deficiency to Amerigroup and UnitedHealthcare.

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.***
	Rutgers Center for State Health Policy's (CSHP) second round of stakeholder interviews regarding MLTSS commenced this quarter. CSHP completed 24 interviews with 66 stakeholders during this quarter, leaving only a small number for the next quarter. CSHP reviewed results of the NCI-AD, which is a quality of life survey administered to those enrolled in MLTSS as well as other long-term services. CSHP incorporated questions about NCI-AD findings into stakeholder discussions. On the quantitative side, CSHP began preparation of 2015 Medicaid fee-for-service claims and managed care encounter data. CSHP identified relevant waiver populations (i.e. those in NFs and those receiving HCBS), compiled demographic characteristics of beneficiaries, began calculating Chronic Illness and Disability Payment System (CDPS) risk scores, cleaned and prepared inpatient and emergency department claims, and started calculating preventable hospitalizations using the latest Agency for Health Care and Research and Quality (AHRQ) Prevention Quality Indicator (PQI) and Pediatric Quality Indicator (PDI) modules which accommodate the change to ICD-10 coding on October 1, 2015. During this quarter, CSHP also arranged to purchase 2014 inpatient and emergency department databases for NJ from AHRQ's Healthcare Cost and Utilization Project. This data will be used along with the existing Uniform Billing datasets for 2011-2013 in creating all-payer comparisons for some of the quality metrics calculated using Medicaid claims. Data for 2015 will be added to this all-payer database when it becomes available. Finally, CSHP requested and received from the State the CAHPS reports for 2015. These data will be part of the evaluation of the impact of MLTSS on the overall Medicaid managed care population which falls under this hypothesis. CSHP continued to stay abreast of developments directly related to MLTSS by attending public and stakeholder meetings. In November, CSHP attended the third meeting of the Nursing Facility Quality workgroup. This group was convened by the State to discuss nursing facility quality requirements for participation in managed care provider networks. In early December, CSHP attended the MLTSS Steering Committee meeting and also held regular meeting with DHS staff. CSHP also attended the October Medical Assistance Advisory Council (MAAC) meeting.
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.***
	During the regular meeting with DHS officials, CSHP met with representatives from the Department of Children and Families in December for updates on Waiver program implementation, their plans for expanding the pilots in the Waiver renewal, and guidance on measuring rates of out-of-home

	treatment using Medicaid claims data. Representatives from DDD were not available for this quarterly meeting. CSHP shared with DDD our plans for Supports interviews beginning next quarter and invited their input. The preparation of the 2015 Medicaid claims analytic dataset and our investigation of the ICD-10 transition, as mentioned in Part A above, are also activities related to our evaluation of this hypothesis.
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.***
	During this quarter, CSHP produced a supplement to the draft interim evaluation report covering the administrative simplifications established under the Waiver. This report drew on statistics from administrative records provided to us by State officials or available in public reports and presentations. It also presented audit data collected by the State's Bureau of Quality Control (BQC) and contextual information on the audit process and findings from direct communications with State officials. This supplement was submitted to the State on October 17, 2016.
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 continued monitoring developments in the DSRIP program. In December, CSHP attended the in-person Learning Collaborative meeting organized by Myers & Stauffer for all DSRIP-participating hospitals and State staff. This was helpful for evaluation purposes not only because formal updates on program status were presented, but also to hear hospitals' questions and comments relating to program rules, performance measurement, and incentive payments. The learning collaborative helps in the design of stakeholder interview and web survey questions which are components of the final evaluation report. CSHP continues to review documents and FAQs posted to the DSRIP website to stay informed about program developments. The preparation of the 2015 Medicaid claims analytic dataset and our investigation of the ICD-10 transition, as mentioned in Part A above, are also activities related to our evaluation of this hypothesis. Finally, CSHP continued work on our comprehensive Medicaid hospital provider ID database for claims years 2011-2015 in anticipation of updating quality metrics for participating and non-participating hospitals.

XIII. Enclosures/Attachments

A. Budget Neutrality Report
B. MLTSS Quality Measures

XIV. State Contact(s)

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XV. Date Submitted to CMS

March 1, 2017

Budget Neutrality Monitoring Spreadsheet

QE Dec 2016 Report

Due to CMS: 02/06/2016

TOTAL COMPUTABLE

Budget Neutrality Test	Authority Citation	Five Year Demonstration Forecasted Expenditures		Difference	
		No Waiver	With Waiver		
Main Test	STC #128	$ 48,003,309,550	$ 38,685,343,094	*$ 9,317,966,455*	a
Supplemental Test #1	STC #129	1,735,621,355	1,756,889,100	*(21,267,745)*	b
Supplemental Test #2	STC #129	11,491,861,820	9,578,562,627	*1,913,299,192*	c
				$ 9,317,966,455	d = a

Savings from Supps Test cannot be used to offset Main Test

FEDERAL SHARE

Budget Neutrality Test	Authority Citation	Five Year Demonstration Forecasted Expenditures		Difference	
		No Waiver	With Waiver		
Main Test	STC #128	$ 24,381,737,610	$ 19,735,600,053	*$ 4,646,137,557*	a
Supplemental Test #1	STC #129	881,946,486	892,683,839	*(10,737,353)*	b
Supplemental Test #2	STC #129	11,399,266,164	9,503,577,722	*1,895,688,442*	c
				$ 4,646,137,557	d = a

Savings from Supps Test cannot be used to offset Main Test

Budget Neutrality Monitoring Spreadsheet

Main Budget Neutrality Test

Budget Neutrality "Without Waiver" Caps as Established in STC #128

TOTAL COMPUTABLE

	DY1	DY2	DY3	DY4	DY5	5-Yr Demo Total
NO WAIVER						
Title XIX	1,888,003,055	2,721,828,868	3,190,622,964	3,440,461,252	3,736,367,586	*14,977,283,725*
ABD	2,303,463,582	3,340,062,527	3,488,247,276	3,554,051,575	3,749,421,753	*16,435,246,712*
LTC	2,434,975,843	3,342,971,496	3,371,660,578	3,445,224,756	3,645,249,242	*16,240,081,916*
HCBS state plan	30,677,444	44,280,262	62,454,144	149,079,040	64,206,305	*350,697,196*
	$ 6,657,119,925	$ 9,449,143,152	$ 10,112,984,962	$ 10,588,816,623	$ 11,195,244,887	$ *48,003,309,550*

	DY1	DY2	DY3	DY4	DY5	*5-Yr Demo Total*
WITH WAIVER						
Title XIX	1,660,509,048	2,399,057,572	2,580,918,481	2,486,484,187	2,700,677,326	*11,827,646,614*
ABD/LTC	3,966,617,892	5,402,994,596	5,116,057,758	5,000,490,646	5,274,527,825	*24,760,688,717*
HCBS state plan	42,985,906	64,819,865	99,350,346	239,959,674	103,362,983	*550,478,774*
HOLD DDD Supports-PDN				-	-	-
Hospital Subsidies	192,443,637	266,607,552	266,600,001	293,872,727	354,600,000	*1,374,123,917*
CNOMS	28,581,139	40,667,507	35,947,427	33,604,500	33,604,500	*172,405,073*
	$ 5,891,137,622	$ 8,174,147,092	$ 8,098,874,013	$ 8,054,411,734	$ 8,466,772,633	$ *38,685,343,094*
Difference	**765,982,303**	**1,274,996,060**	**2,014,110,949**	**2,534,404,889**	**2,728,472,254**	***9,317,966,455***

Notes:

1. Federal share is calculated using Composite Federal Share Ratios (source data is CMS 64 Schedule C as reported in QE SEPT 2016 with a run date of Dec 5, 2016). Note that the federal share for LTC "No Waiver" is calculated using the composite federal share ratio applicable to the ABD Meg.
2. "With Waiver" expenditures from CMS 64 Schedule C as reported in QE SEPT 2016 with a run date of Dec 5, 2016
3. Member-months are reported from MMIS with last actual reported as of Sept 30, 2016.
4. "With Waiver" pmpm's calculated using Sch C expenditures and MMIS eligibility actual member-months reported through June 2016 as reported in Sept 2016.
5. CNOMs (costs not otherwise matchable) include Severe Emotionally Disturbed children (SED at risk), MATI population, DDD non-disabled adult children and CCW Supports Equalization
6. Hospital Subsidies Include GME state plan, HRSF & GME, HRSF Transition Payments and DSRIP as reported on the CMS64 Sch C
7. The DDD Supports-PDN population, pending waiver amendment approval, is represented as a separate line item

FEDERAL SHARE

	DY1	DY2	DY3	DY4	DY5	5-Yr Demo Total
NO WAIVER						
Title XIX	947,820,766	1,506,626,507	1,750,551,416	1,727,190,330	1,875,742,085	*7,807,931,104*
ABD	1,155,159,955	1,680,449,004	1,752,965,046	1,780,260,479	1,878,123,382	*8,246,957,866*
LTC	1,221,111,811	1,681,912,561	1,694,376,194	1,725,748,021	1,825,942,315	*8,149,090,902*
HCBS state plan	15,580,857	22,839,271	32,076,731	74,971,625	32,289,254	*177,757,738*
	$ 3,339,673,389	$ 4,891,827,343	$ 5,229,969,387	$ 5,308,170,454	$ 5,612,097,037	$ *24,381,737,610*

	DY1	DY2	DY3	DY4	DY5	*5-Yr Demo Total*
WITH WAIVER						
Title XIX	833,613,565	1,327,961,421	1,416,033,970	1,248,271,998	1,355,801,859	*6,181,682,813*
ABD/LTC	1,989,212,324	2,718,349,376	2,570,996,181	2,504,796,479	2,642,064,481	*12,425,418,841*
HCBS state plan	21,832,238	33,433,371	51,026,787	120,675,359	51,981,088	*278,948,843*
HOLD DDD Supports-PDN				-	-	-
Hospital Subsidies	96,221,820	138,946,278	150,097,502	168,572,730	207,380,003	*761,218,332*
CNOMS	14,798,341	21,083,311	18,677,049	16,970,273	16,802,250	*88,331,224*
	$ 2,955,678,288	$ 4,239,773,757	$ 4,206,831,489	$ 4,059,286,838	$ 4,274,029,681	$ *19,735,600,053*
Difference	**383,995,101**	**652,053,586**	**1,023,137,898**	**1,248,883,616**	**1,338,067,356**	***4,646,137,557***

Budget Neutrality Monitoring Spreadsheet

Supplemental Test #1

Budget Neutrality "Without Waiver" Caps as Established in STC #129

TOTAL COMPUTABLE

	DY1	DY2	DY3	DY4	DY5	5-Yr Demo Total
NO WAIVER						
HCBS 217-like	217,434,338	299,298,600	296,727,244	331,897,834	376,181,457	1,521,539,474
Adults w/o Depend. Children	1,677,789	798,912	-	-	-	2,476,701
SED 217-like	253,840	345,267	290,262	240,791	259,924	1,390,085
Former XIX Chip Parents	-	140,335,250	-	-	-	140,335,250
IDD/MI	-	-	6,423,263	30,515,937	32,940,645	69,879,846
	$ 219,365,967	$ 440,778,028	$ 303,440,769	$ 362,654,563	$ 409,382,027	$ 1,735,621,355

	DY1	DY2	DY3	DY4	DY5	5-Yr Demo Total
WITH WAIVER						
HCBS 217-like	207,462,499	278,158,918	330,934,921	374,767,202	418,936,606	1,610,260,146
Adults w/o Depend. Children-AWDC	1,529,772	674,018	-	-	-	2,203,790
SED 217-like	83	58,922	27,837	88,796	95,851	271,489
Former XIX Chip Parents	-	126,863,607	-	-	-	126,863,607
IDD/MI	-	-	1,186,792	7,743,980	8,359,296	17,290,068
	$ 208,992,354	$ 405,755,465	$ 332,149,550	$ 382,599,978	$ 427,391,753	$ 1,756,889,100
Difference	**10,373,613**	**35,022,563**	**(28,708,781)**	**(19,945,415)**	**(18,009,726)**	**(21,267,745)**

Notes:

1. Federal share is calculated using Composite Federal Share Ratios (source data is CMS 64 Schedule C as reported in QE Sept 2016 with a run date of Dec 5, 2016).

2. "With Waiver" expenditures from CMS 64 Schedule C as reported in QE Sept 2016 with a run date of Dec 5, 2016

3. Member-months are reported from MMIS with last actual reported as of Sept 2016.

4. "With Waiver" pmpm's calculated using Sch C expenditures and MMIS eligibility actual member-months reported through Jun 2016 as reported in Sept 2016.

FEDERAL SHARE

	DY1	DY2	DY3	DY4	DY5	5-Yr Demo Total
NO WAIVER						
HCBS 217-like	110,183,067	154,286,829	152,383,180	167,068,853	189,360,092	773,282,020
Adults w/o Depend. Children - AWDC	852,857	408,324	-	-	-	1,261,182
SED 217-like	128,449	172,639	145,397	121,600	129,962	698,047
Former XIX Chip Parents	-	71,621,870	-	-	-	71,621,870
IDD/MI	-	-	3,244,338	15,275,422	16,563,607	35,083,367
	$ 111,164,373	$ 226,489,663	$ 155,772,915	$ 182,465,874	$ 206,053,661	$ 881,946,486

	DY1	DY2	DY3	DY4	DY5	5-Yr Demo Total
WITH WAIVER						
HCBS 217-like	105,129,919	143,389,436	169,950,406	188,648,192	210,881,937	817,999,890
Adults w/o Depend. Children	777,617	344,491	-	-	-	1,122,108
SED 217-like	42	29,462	13,944	44,842	47,926	136,216
Former XIX Chip Parents	-	64,746,447		-	-	64,746,447
IDD/MI	-	-	599,439	3,876,419	4,203,321	8,679,179
	$ 105,907,578	$ 208,509,836	$ 170,563,789	$ 192,569,453	$ 215,133,183	$ 892,683,839
Difference	**5,256,795**	**17,979,827**	**(14,790,874)**	**(10,103,579)**	**(9,079,521)**	**(10,737,353)**

Budget Neutrality Monitoring Spreadsheet

Supplemental Test #2

Budget Neutrality "Without Waiver" Caps as Established in STC #129

TOTAL COMPUTABLE

	DY1	DY2	DY3	DY4	DY5	5-Yr Demo Total
NO WAIVER						
New Adult Group	$ -	$ 1,115,934,974	$ 3,208,229,680	$ 3,463,870,945	$ 3,703,826,221	$ 11,491,861,820
WITH WAIVER						
New Adult Group	$ -	$ 861,661,360	$ 2,857,959,499	$ 2,859,545,537	$ 2,999,396,231	$ 9,578,562,627
Difference	**-**	**254,273,614**	**350,270,181**	**604,325,408**	**704,429,989**	**1,913,299,192**

Notes:

1. Federal share is calculated using Composite Federal Share Ratios (source data is CMS 64 Schedule C as reported in QE Sept 2016 with a run date of Dec 5, 2016).
2. "With Waiver" expenditures from CMS 64 Schedule C as reported in QE Sept 2016 with a run date of Dec 5, 2016
3. Member-months are reported from MMIS with last actual reported as of Sept 2016.
4. "With Waiver" pmpm's calculated using Sch C expenditures and MMIS eligibility actual member-months reported through June 2016 as reported in Sept 2016.

FEDERAL SHARE

	DY1	DY2	DY3	DY4	DY5	5-Yr Demo Total
NO WAIVER						
New Adult Group	$ -	$ 1,115,934,974	$ 3,208,229,680	$ 3,463,870,945	$ 3,611,230,565	$ 11,399,266,164
WITH WAIVER						
New Adult Group	$ -	$ 861,661,360	$ 2,857,959,499	$ 2,859,545,537	$ 2,924,411,326	$ 9,503,577,722
Difference	**-**	**254,273,614**	**350,270,181**	**604,325,408**	**686,819,240**	**1,895,688,442**

Detail with Waiver TC

		DY1	DY2	DY3	DY4	DY5	Demo Period	
Title XIX	MMs	5,773,180	7,850,901	8,699,959	8,868,311	9,104,210		2.7%
	Pmpm	$287.62	$305.58	$296.66	$280.38	$296.64		5.8%
	Spend	$1,660,509,048	$2,399,057,572	$2,580,918,481	$2,486,484,187	$2,700,677,326	**$11,827,646,614**	
ABD	MMs	2,486,117	3,342,730	3,355,975	3,300,636	3,360,538		1.8%
	Pmpm	$1,595.51	$1,616.34	$1,524.46	$1,515.01	$1,569.55		3.6%
	Spend	$3,966,617,892	$5,402,994,596	$5,116,057,758	$5,000,490,646	$5,274,527,825	**$24,760,688,717**	
LTC	MMs							1.8%
	Pmpm							3.9%
	Spend	$0	$0	$0	$0	$0	**$0**	
HCBS State Plan	MMs	13,594	18,860	25,656	59,066	24,535		1.8%
	Pmpm	$3,162.12	$3,436.90	$3,872.40	$4,062.57	$4,212.88		3.7%
	Spend	$42,985,906	$64,819,865	$99,350,346	$239,959,674	$103,362,983	**$550,478,774**	

		DY1	DY2	DY3	DY4	DY5	Demo Period	
HCBS 217-Like	MMs	96,351	127,895	122,272	131,885	142,169		1.8%
	Pmpm	$2,153.20	$2,174.90	$2,706.55	$2,841.62	$2,946.76		3.7%
	Spend	$207,462,499	$278,158,918	$330,934,921	$374,767,202	$418,936,606	**$1,610,260,146**	
AWDC	MMs	6,057	2,774	0	0	0		
	Pmpm	$252.56	$242.98					
	Spend	$1,529,772	$674,018	$0	$0	$0	**$2,203,790**	
SED 217-Like	MMs	113	145	115	90	92		1.8%
	Pmpm	$0.73	$406.36	$242.06	$986.62	$1,045.82		6.0%
	Spend	$83	$58,922	$27,837	$88,796	$95,851	**$271,489**	
XIX Chip Parents	MMs	0	456,761	0	0	0		
	Pmpm		$277.75					
	Spend	$0	$126,863,607	$0	$0	$0	**$126,863,607**	
IDD/MI - 217-Like	MMs	0	0	581	2,604	2,652		1.8%
	Pmpm	$0.00	$0.00	$2,042.67	$2,973.88	$3,152.31		6.0%
	Spend	$0	$0	$1,186,792	$7,743,980	$8,359,296	**$17,290,068**	
New Adult Group	MMs	0	2,399,241	6,541,000	6,725,963	6,849,424		1.8%
	Pmpm		$359.14	$436.93	$425.15	$437.90		5.0%
	Spend	$0	$861,661,360	$2,857,959,499	$2,859,545,537	$2,999,396,231	**$9,578,562,627**	

		DY1	DY2	DY3	DY4	DY5	Demo Period	
Title XIX	MMs	5,773,180	7,850,901	8,699,959	8,868,311	9,104,210		2.7%
	Pmpm	$327.03	$346.69	$366.74	$387.95	$410.40		5.8%
	Spend	$1,888,003,055	$2,721,828,868	$3,190,622,964	$3,440,461,252	$3,736,367,586	**$14,977,283,725**	
ABD	MMs	2,204,187	2,970,291	2,994,435	2,945,070	2,999,130		1.8%
	Pmpm	$1,045.04	$1,124.49	$1,164.91	$1,206.78	$1,250.17		3.6%
	Spend	$2,303,463,582	$3,340,062,527	$3,488,247,276	$3,554,051,575	$3,749,421,753	**$16,435,246,712**	
LTC	MMs	281,930	372,439	361,540	355,566	362,093		1.8%
	Pmpm	$8,636.81	$8,975.89	$9,325.83	$9,689.41	$10,067.17		3.9%
	Spend	$2,434,975,843	$3,342,971,496	$3,371,660,578	$3,445,224,756	$3,645,249,242	**$16,240,081,916**	
HCBS State Plan	MMs	13,594	18,860	25,656	59,066	24,535		1.8%
	Pmpm	$2,256.69	$2,347.84	$2,434.29	$2,523.94	$2,616.93		3.7%
	Spend	$30,677,444	$44,280,262	$62,454,144	$149,079,040	$64,206,305	**$350,697,196**	

		DY1	DY2	DY3	DY4	DY5	Demo Period	
HCBS 217-Like	MMs	96,351	127,895	122,272	131,885	144,149		1.8%
	Pmpm	$2,256.69	$2,340.19	$2,426.78	$2,516.57	$2,609.68		3.7%
	Spend	$217,434,338	$299,298,600	$296,727,244	$331,897,834	$376,181,457	**$1,521,539,474**	
AWDC	MMs	6,057	2,774	0	0	0		
	Pmpm	$277.00	$288.00					
	Spend	$1,677,789	$798,912	$0	$0	$0	**$2,476,701**	
SED 217-Like	MMs	113	145	115	90	92		1.8%
	Pmpm	$2,246.37	$2,381.15	$2,524.02	$2,675.46	$2,835.99		6.0%
	Spend	$253,840	$345,267	$290,262	$240,791	$259,924	**$1,390,085**	
XIX Chip Parents	MMs	0	456,761	0	0	0		
	Pmpm		$307.24					
	Spend	$0	$140,335,250	$0	$0	$0	**$140,335,250**	
IDD/MI	MMs	0	0	581	2,604	2,652		1.8%
	Pmpm	$9,839.39	$10,429.75	$11,055.53	$11,718.87	$12,422.00		6.0%
	Spend	$0	$0	$6,423,263	$30,515,937	$32,940,645	**$69,879,846**	
New Adult Group	MMs	0	2,399,241	6,541,000	6,725,963	6,849,424		1.8%
	Pmpm		$465.12	$490.48	$515.00	$540.75		5.0%
	Spend	$0	$1,115,934,974	$3,208,229,680	$3,463,870,945	$3,703,826,221	**$11,491,861,820**	

ORIGINAL STC APPROVED GROWTH PERCENTAGES FOR BUDGET NEUTRALITY

Hospital Subsidy Summary

Total Computable					
Program	DY1	DY2	DY3	DY4	DY5
HRSF & GME	$ 192,443,637	$ -	$ -	$ -	$ -
HRSF Transition Payments	-	83,302,681	-	-	-
GME State Plan	-	100,000,001	100,000,000	127,272,727	188,000,000
DSRIP	-	83,304,870	166,600,001	166,600,000	166,600,000
	$ 192,443,637	*$ 266,607,552*	*$ 266,600,001*	*$ 293,872,727*	*$ 354,600,000*

Composite Federal Share Percentage

Program	DY1	DY2	DY3	DY4	DY5
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%
GME State Plan	0.00%	55.64%	66.80%	67.00%	66.00%
DSRIP	0.00%	50.00%	50.00%	50.00%	50.00%

Federal Share					
Program	DY1	DY2	DY3	DY4	DY5
HRSF & GME	$ 96,221,820	$ -	$ -	$ -	$ -
HRSF Transition Payments	-	41,651,341	-	-	-
GME State Plan	-	55,642,502	66,797,499	85,272,727	124,080,000
DSRIP	-	41,652,435	83,300,003	83,300,003	83,300,003
	$ 96,221,820	*$ 138,946,278*	*$ 150,097,502*	*$ 168,572,730*	*$ 207,380,003*

DY1-3: Total Comuputable, Federal Share and Composite Federal Share Percentage tie to CMS64 Sch C for QE SEPT 16 with a run date of DEC 5, 2016.
DY4 & DY5: Total Computable amounts tie to the amounts budgeted in SFY2016.
DY4 & DY5: Federal Share amounts = Total Computable amounts multiplied by the Federal Composite Share Percentage (estimate for DY4/DY5)

Costs Otherwise Not Matchable (CNOM) Summary

Total Computable

Program	DY1	DY2	DY3	DY4	DY5
SED at Risk	$ 24,511,364	$ 37,238,349	$ 35,947,427	$ 33,604,500	$ 33,604,500
MATI at Risk	4,069,775	3,429,158	-	-	-
DDD non-Disabled Adult Children	-	-	-	-	-
DDD Community / Supports Equalization	-	-	-	-	-
	$ 28,581,139	*$ 40,667,507*	*$ 35,947,427*	*$ 33,604,500*	*$ 33,604,500*

Composite Federal Share Percentage

Program	DY1	DY2	DY3	DY4	DY5
SED at Risk	51.99%	51.83%	51.96%	50.50%	50.00%
MATI at Risk	50.50%	52.00%	0.00%	0.00%	0.00%
DDD non-Disabled Adult Children				50.00%	50.00%
DDD Community / Supports Equalization				50.00%	50.00%

Federal Share

Program	DY1	DY2	DY3	DY4	DY5
SED at Risk	$ 12,743,019	$ 19,300,149	$ 18,677,049	$ 16,970,273	$ 16,802,250
MATI at Risk	2,055,322	1,783,162	-	-	-
DDD non-Disabled Adult Children	-	-	-	-	-
DDD Community / Supports Equalization	-	-	-	-	-
	$ 14,798,341	*$ 21,083,311*	*$ 18,677,049*	*$ 16,970,273*	*$ 16,802,250*

Notes: SED at Risk and MATI at Risk

DY1-3: Total Comuputable, Federal Share and Composite Federal Share Percentage tie to CMS64 Sch C for QE SEPT 16 with a run date of Dec 5, 2016.

DY4: Total Computable amounts tie to CMS64 Sch for QE SEPT 16 annualized assuming only 2 months' worth spending has occured (1 month lag)

DY5: Total Computable = DY4 estimate

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

Notes: DDD programs

DY1-3: No spending

DY4: Total Computable assumes the programs are operational for 9 months

DY5: Total Computable assumes the programs are operational for 12 months

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

DDD Waiver Ammendment Annual Cost Estimate

DY4 = 0 months

DY5 = 12 months

		People	Cost PMPM	Gross Cost		Fed Share		
				DY4	DY5	DY4	DY5	
#1 non-DAC	Supports	182	$ 1,891	$ -	$ -	$ -	$ -	CNOM
	State Plan	182	$ 1,312	$ -	$ -	$ -	$ -	
				$ -	$ -	$ -	$ -	
#2 CCW/Supports Equalization	Supports	59	$ 1,891	$ -	$ -	$ -	$ -	CNOM
	State Plan	59	$ 1,312	$ -	$ -	$ -	$ -	
				$ -	$ -	$ -	$ -	
TOTAL				$ -	$ -	$ -	$ -	
				$ -	$ -	$ -	$ -	
				$ -	$ -	$ -	$ -	

#3 DDD Supports - PDN Group

	DY4	DY5
Projected Monthly Clients	195	222
Months	0	0
Projected MMs	*0*	*0*
Monthly cost of DD Supports	$1,890.83	$1,947.56
Hcbs Non-dual cap rate	$8,230.66	$8,477.58
Total PMPM Cost	*$10,121.49*	*$10,425.14*
Total Annual Cost	**$0**	**$0**
Federal Share	***$0***	***$0***

Member-months removed from following MEGs beginning DY4:
without waiver

	DY4	DY5
ABD	0	52
HCBS 217-Like	0	165
LTC	0	5

Notes:

For non-DAC and CCW Supports, the state plan service cost PMPM = ABD Non-dual cap rate

For non-DAC and CCW Supports, the DDD Supports cost PMPM was provided by DDD.

For non-DAC and CCW Supports,the estimated clients were provided by DDD

For DD Supports-PDN Group, the HCBS Non-dual cap rate is used for medical/LTC costs

For DD Supports-PDN Group, the DDD Supports cost PMPM was provided by DDD.

For DD Supports-PDN Group, the estimated clients were found using DMAHS Office of Managed Health Care analysis

NJ Comprehensive Waiver: 1115 Demonstration

Demonstration Year 3 (SFY15): Major Medicaid Eligibility Group

Expenditure Completion Percentage through 9/30/2016

	CMS64 Sch C: Total Computable Expenditures							
	QE Sept 14	QE Dec 14	QE Mar 15	QE Jun 15	QE Sept 15	QE Dec 15	QE Mar 16	QE JUNE 16
Title XIX	$434,928,859	$1,123,432,957	$1,776,674,891	$2,421,649,657	$2,553,436,009	$2,568,462,904	$2,575,538,654	$2,579,610,169
ABD (w/ LTC)	$959,799,916	$2,238,665,986	$3,502,700,629	$4,800,030,515	$5,061,934,434	$5,089,988,884	$5,104,002,307	$5,113,595,990
HCBS state plan	$17,444,346	$40,534,851	$67,115,872	$98,437,031	$98,879,627	$98,966,602	$99,129,814	$99,310,816
HCBS 217-like	$79,660,649	$164,047,547	$247,004,147	$327,788,341	$328,690,304	$329,600,356	$330,361,606	$330,820,508
New Adult Group	$544,696,512	$1,223,823,248	$1,853,884,815	$2,660,505,457	$2,751,130,881	$2,841,374,347	$2,850,881,400	$2,856,835,610

	CMS64 Sch C: Percent Completion							
	QE Sept 14	QE Dec 14	QE Mar 15	QE Jun 15	QE Sept 15	QE Dec 15	QE Mar 16	QE JUNE 16
Title XIX	17.49%	45.18%	71.45%	97.39%	102.69%	103.30%	103.58%	103.75%
ABD (w/ LTC)	19.19%	44.77%	70.05%	95.99%	101.23%	101.79%	102.07%	102.26%
HCBS state plan	7.27%	16.89%	27.97%	41.02%	41.21%	41.24%	41.31%	41.39%
HCBS 217-like	21.26%	43.77%	65.91%	87.46%	87.71%	87.95%	88.15%	88.27%
New Adult Group	19.05%	42.80%	64.83%	93.04%	96.21%	99.36%	99.70%	99.91%

Budgent Neutrality Monitoring Sheet Notes

Generally, Budget Neutrality demonstration lags by 1 quarter. Therefore, the QE Sept 2016 NJ Comp Waiver quarterly report represents CMS 64 Sch C as of the QE September 30, 2016

Enrollment Trends

DY1-DY3 Actual as reported in Sept 2016 with the exception of ABD and LTC meg. The LTC Meg member-months are estimated in accordance with STC#108 for the purposes of establishing budget neutrality caps. In the current report, all estimated LTC member-months are presumed to be a subset of the ABD Meg, as this Meg contains most nursing facility expenditures. The State of NJ is currently working to better estimate these subsets. Therefore, the ABD Meg = member-months as reported in Sept 2016 less LTC estimates.

DY4

Title XIX	Sum of Jul-Mar actuals (as reported Jun'16) multiplied by 4/3 then multiplied 0.51%
ABD	Sum of Jul-Mar actuals (as reported Jun'16) multiplied by 4/3 then multiplied 0.45% for "**No Waiver**." **WITH Waiver** = No waiver total *less* *3* months of projected DD Supports clients that are current ABD/LTC clients *plus* LTC clients
LTC	Sum of Jul-Mar actuals (as reported Jun'16) multiplied by 4/3 then multiplied 0.45%
HCBS state plan	Ties to MLTSS (Mar'16 actuals) capitation projection; split between percentage of state plan vs. 217-like using MEG Enrollment report. Ties to MLTSS (Mar'16 actuals) capitation projection; split between percentage of state plan vs. 217-like using MEG Enrollment report for "**No Waiver**."
HCBS 217-Like	**WITH Waiver** = NO Waiver total *less* 9 months of projected DD Supports clients that are current HCBS 217-like clients
SED At-Risk	Sum of Jul-Sept actuals (as reported Dec'15) multiplied by 4 then multiplied 1.35%
SED 217-Like	Sum of Jul-Sept actuals (as reported Dec'15) multiplied by 4 then multiplied 1.35%
New Adult Group	Sum of Jul-Sept actuals (as reported Dec'15) multiplied by 4 then multiplied 1.35%

DY5 Except for exceptions below, Prior DY projected member-months increased by CMS-approved Budget Neutrality growth factors

ABD	Prior DY projected member-months increased by CMS-approved Budget Neutrality growth factors for "**No Waiver**." **WITH Waiver** = No waiver total *less* 12 months of projected DD Supports clients that are current ABD/LTC clients *plus* LTC clients
HCBS state plan	DY5 based on MLTSS (Dec 15 actuals) capitation projection; split between percentage of state plan vs. 217-like using MEG Enrollment report. Ties to MLTSS (Dec 15 actuals) capitation projection; split between percentage of state plan vs. 217-like using MEG Enrollment report for "**No Waiver**."
HCBS 217-like	**WITH Waiver** = NO Waiver total *less* 12 months of projected DD Supports clients that are current HCBS 217-like clients

No Waiver Spending

DY1-DY5 Total Computable = MM's multplied by PMPM caps per STCs #128 and #129. .

DY1-DY5 Federal Share = Total Computable multiplied by composite federal share ratio in accordance with STC #130

With Waiver Spending

DY1-DY3 Total Computable and Federal Share tie to CMS64 Sch C as reported by Meg on QE Mar'16

DY4

Title XIX	Projected MM's multiplied by PMPM based on DY4 spend on QE Mar 16 Sch C (with DY3 Title XIX Meg Completion % applied))
ABD	Projected MM's multiplied by PMPM based on DY4 spend on QE Mar 16 Sch C (with DY3 Title XIX Meg Completion % applied))
LTC	No spending reported (presumably rolled into ABD spending)
HCBS state plan	Projected MM's multiplied by PMPM based on DY4 spend on QE Mar 16 Sch C (with DY3 HCBS 217 like Meg Completion % applied))
HCBS 217-like	Projected MM's multiplied by PMPM based on DY4 spend on QE Mar 16 Sch C (with DY3 Title XIX Meg Completion % applied))
SED 217-like	Projected MM's multiplied by PMPM based on DY4 spend on QE Mar 16 Sch C (assumes 8 months worth of expenditures (1 month lag)
New Adult Group	Projected MM's multiplied by PMPM based on DY4 spend on QE Mar 16 Sch C (with DY3 Title XIX Meg Completion % applied))

DY5 = projected MM's multiplied by PMPMs, generally are 3% increase over DY4 PMPM (projected MCO rate increase)

DY4-DY5 Federal Share = Total Computable multiplied by composite federal share ratio in accordance with STC #130

Schedule C

CMS 64 Waiver Expenditure Report

Cumulative Data Ending Quarter/Year : 4/2016

State: New Jersey

Summary of Expenditures by Waiver Year

Waiver: 11W00279

MAP Waivers

Total Computable

Waiver Name	A	01	02	03	04	05
ABD	0	3,966,617,892	5,402,994,596	5,116,057,758	5,000,490,646	1,049,760,262
ACCAP – 217 Like	0	630,539	880,454	0	0	0
ACCAP – SP	0	900,000	966,297	0	0	0
AWDC	0	1,529,772	674,018	0	0	0
Childless Adults	0	27,844,394	48,216,389	0	0	0
CRPD – 217 Like	0	11,803,536	16,894,842	0	0	0
CRPD –SP	0	10,672,842	15,247,535	0	0	0
DSRIP	0	0	83,304,870	166,600,001	166,600,000	7,619,105
GME State Plan	0	0	100,000,001	100,000,000	127,291,443	46,999,989
GO – 217 Like	0	181,068,236	221,682,839	0	0	0
GO – SP	0	23,869,092	33,606,671	0	0	0
HCBS – 217 Like	0	286,256	21,262,532	330,934,921	374,767,202	95,262,436
HCBS – State Plan	0	86,858	5,634,434	99,350,346	239,959,674	79,627,592
HRSF & GME	0	192,443,637	0	0	0	0
HRSF Transition Paym	0	0	83,302,681	0	0	0
IDD/MI – 217 Like	0	0	0	1,186,792	7,743,980	1,043,495
MATI at Risk	0	4,069,775	3,429,158	0	0	0
New Adult Group	0	7,911,919	861,661,360	2,857,959,499	2,859,545,537	659,922,291
SED – 217 Like	0	83	58,922	27,837	88,796	122,423
SED at Risk	0	24,511,364	37,238,349	35,947,427	38,833,896	5,600,750
TBI – 217 Like	0	13,673,932	17,438,251	0	0	0
TBI – SP	0	7,457,114	9,364,928	0	0	0
Title XIX	0	1,660,509,048	2,399,057,572	2,580,918,481	2,486,484,187	498,605,582
XIX CHIP Parents	0	0	126,863,607	0	0	0
Total	**0**	**6,135,886,289**	**9,489,780,306**	**11,288,983,062**	**11,301,805,361**	**2,444,563,925**

Federal Share

Waiver Name	A	01	02	03	04	05
ABD	0	1,989,212,324	2,718,349,376	2,570,996,181	2,504,796,479	525,214,137
ACCAP – 217 Like	0	319,151	446,869	0	0	0
ACCAP – SP	0	454,312	489,362	0	0	0
AWDC	0	777,617	344,491	0	0	0
Childless Adults	0	14,715,147	24,778,164	0	0	0
CRPD – 217 Like	0	6,026,151	8,740,654	0	0	0
CRPD –SP	0	5,447,877	7,899,121	0	0	0
DSRIP	0	0	41,652,435	83,300,003	83,300,002	3,809,553
GME State Plan	0	0	55,642,502	66,797,499	84,588,472	31,334,893
GO – 217 Like	0	91,709,982	114,209,771	0	0	0
GO – SP	0	12,108,906	17,304,835	0	0	0
HCBS – 217 Like	0	146,141	11,005,082	169,950,406	188,648,192	47,632,917
HCBS – State Plan	0	44,439	2,920,775	51,026,787	120,675,359	39,823,460
HRSF & GME	0	96,221,820	0	0	0	0
HRSF Transition Paym	0	0	41,651,341	0	0	0
IDD/MI – 217 Like	0	0	0	599,439	3,876,419	521,751
MATI at Risk	0	2,055,322	1,783,162	0	0	0
New Adult Group	0	7,911,919	861,661,360	2,857,959,499	2,859,545,537	659,922,291
SED – 217 Like	0	42	29,462	13,944	44,411	61,213
SED at Risk	0	12,743,019	19,300,149	18,677,049	19,908,823	2,800,375
TBI – 217 Like	0	6,928,494	8,987,060	0	0	0
TBI – SP	0	3,776,704	4,819,278	0	0	0
Title XIX	0	833,613,565	1,327,961,421	1,416,033,970	1,262,119,529	249,570,787
XIX CHIP Parents	0	0	64,746,447	2,148	0	0
Total	**0**	**3,084,212,932**	**5,334,723,117**	**7,235,356,925**	**7,127,503,223**	**1,560,691,377**

Composite Federal Share %

Waiver Name	01	02	03	04	05
ABD	50.15%	50.31%	50.25%	50.09%	50.09%
AWDC	50.83%	51.11%			
Childless Adults	52.85%	51.39%			
DSRIP		50.00%	50.00%	50.00%	50.00%
GME State Plan		55.64%	66.80%	*67.00%*	*66.00%*
HCBS – 217 Like	50.67%	51.55%	51.35%	50.34%	50.34%
HCBS – State Plan	50.79%	51.58%	51.36%	50.29%	50.29%
HRSF & GME	50.00%				
HRSF Transition Payments		50.00%			
IDD/MI – 217 Like			50.51%	50.06%	50.28%
MATI at Risk	50.50%	52.00%			
New Adult Group	100.00%	100.00%	100.00%	*100.00%*	97.50%
SED – 217 Like	50.60%	50.00%	50.09%	50.50%	50.00%
SED at Risk	51.99%	51.83%	51.96%	50.50%	50.00%
Title XIX	50.20%	55.35%	54.87%	*50.20%*	50.20%
XIX CHIP Parents		51.04%			

DY1 & DY2 HCBS expenditures

	DY1	DY2
	total computable	
HCBS – 217 Like	207,462,499	278,158,918
HCBS – State Plan	42,985,906	64,819,865
	Federal share	
HCBS – 217 Like	105,129,919	143,389,436
HCBS – State Plan	21,832,238	33,433,371

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CMS 64 - MEDICAID ELIGIBILITY GROUPS AS OF JUNE 2014

		Actuals through 6/30/2016 (as of 9/30/2016)				
	DEFINITIONS:	DY1	DY2	DY3	DY4	DY5
1	TITLE XIX	5,773,180	7,850,901	8,699,959	8,868,311	4,358,266
2	ABD (Excluding HCBS and LTC SPC 61)	2,486,117	3,342,730	3,355,975	3,300,636	1612339
3	Childless Adults	385,740	225,208			
4	Adults W/O Dependent Children	6,057	2,774			
5	SED	26,729	43,160	38,453	43,042	20,455
6	HCBS (State Plan)	13,594	18,860	25,656	59,066	44,280
7	HCBS (217 Like)	96,351	127,895	122,272	131,885	70,949
8	LTC					
9	SED (217 Like)	113	145	115	90	421
10	IDD/MI (217 Like)	0	0	581	2,604	718
11	XIX CHIP Parents *(10/01/2013 - 12/31/2013 Only)*		456,761	0	0	0
12	New Adult Group *(01/01/2014 Onwards)*		2,399,241	6,541,000	6,725,963	3,319,833

	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
1	643,208	641,115	641,945	643,840	643,718	645,054	645,116	635,183	634,001	633,251	632,536	631,012	628,743	625,874	623,702	661,241	667,292	678,653	683,673	689,180	693,744	698,873	705,756	712,044	716,443	718,070	721,307	726,830	732,111	736,730	740,261	744,442	746,892
2	274,854	274,540	274,471	275,897	276,304	276,808	277,259	277,750	278,234	278,390	278,697	279,521	279,906	279,461	278,818	276,842	277,127	278,134	278,326	278,535	278,973	280,262	280,382	280,535	280,359	280,294	276,829	279,154	279,165	279,205	279,364	279,287	279,139
3	45,455	44,363	43,494	43,024	42,618	42,563	41,976	41,588	40,659	39,738	39,242	38,278	37,737	34,678	35,535																		
4	772	750	713	682	670	663	644	610	553	503	491	460	453	442	425	145,207	160,725	203,473	221,698	235,947	248,452	261,467	275,824	285,009	293,647	303,733	320,267	332,291	348,973	355,792	362,664	364,468	366,291
5	2,560	2,618	2,677	2,907	3,029	3,110	3,181	3,313	3,334	3,271	3,291	3,154	3,364	3,566	3,531	3,769	3,856	4,162	4,191	3,551	3,454	3,185	3,028	2,810	2,886	2,923	3,039	3,164	3,262	3,413	3,522	3,637	3,584
6	1,518	1,520	1,504	1,467	1,474	1,493	1,511	1,543	1,564	1,553	1,555	1,540	1,567	1,586	1,586	1,596	1,583	1,580	1,576	1,573	1,565	1,492	1,546	1,624	1,821	2,011	2,162	2,163	2,265	2,349	2,496	2,703	3,024
7	11,219	11,225	11,221	10,428	10,396	10,420	10,456	10,480	10,506	10,556	10,577	10,645	10,726	10,752	10,751	10,758	10,742	10,606	10,604	10,577	10,601	9,863	9,920	9,994	10,300	10,490	10,467	10,246	10,156	10,149	10,181	10,224	10,282
8																0	0	0	0	0	0	24,537	24,150	23,794	23,313	22,974	22,725						
9	15	13	14	15	15	10	7	9	15	14	11	15	15	16	13	9	9	11	15	10	7	14	18	11	6	8	9	9	5	7	9	11	8
10																		0	0	0	0	0	0	0	0	0	0	0	0	113	133	145	190
11													152,428	152,087	152,246																		
12																181,112	186,389	198,362	203,220	205,870	208,786	211,485	214,061	216,647	218,794	220,090	225,796	225,810	228,275	228,919	**227,858**	**226,725**	**226,114**

Source = CMS64 MEG report from Sept 2016

BN caps should be as of 3-27-14

Meg =	Title XIX		as appears on march 27 2014 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

MMX Member Mo	Count(dist) Recip Idn
10/1/2012	29,433.
11/1/2012	29,367.
12/1/2012	29,283.
1/1/2013	29,181.
2/1/2013	28,845.
3/1/2013	28,866.
4/1/2013	28,799.
5/1/2013	28,697.
6/1/2013	28,751.
7/1/2013	28,866.
8/1/2013	29,043.
9/1/2013	29,078.
10/1/2013	29,123.
11/1/2013	29,162.
12/1/2013	29,211.
1/1/2014	29,086.
2/1/2014	28,860.
3/1/2014	28,892.
4/1/2014	28,823.
5/1/2014	28,805.
6/1/2014	28,774.
7/1/2014	29,240.
8/1/2014	29,139.
9/1/2014	28,994.
10/1/2014	28,803.
11/1/2014	28,529.
12/1/2014	28,357.
1/1/2015	28,343.
2/1/2015	28,043.
3/1/2015	27,839.
4/1/2015	27,756.
5/1/2015	27,701.
6/1/2015	27,889.
7/1/2015	27,916.

	MMs
DY1	261,222.
DY2	347,723.
DY3	340,633.
DY4	336,757.
DY5	103,084.

8/1/2015	28,088.
9/1/2015	28,092.
10/1/2015	28,173.
11/1/2015	28,321.
12/1/2015	28,327.
1/1/2016	28,219.
2/1/2016	28,107.
3/1/2016	28,083.
4/1/2016	27,897.
5/1/2016	27,870.
6/1/2016	27,664.
7/1/2016	27,277.
8/1/2016	27,015.
9/1/2016	24,420.
10/1/2016	24,372.

MMX Member Month Date	Count(dist) Recip Idn
10/1/2012	2,376.
11/1/2012	2,353.
12/1/2012	2,332.
1/1/2013	2,322.
2/1/2013	2,302.
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	2,047.
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	1,678.
5/1/2015	1,665.
6/1/2015	1,650.
7/1/2015	1,638.

	MMs
DY1	20,708.
DY2	24,716.
DY3	20,907.
DY4	18,809.
DY5	2,002.

8/1/2015	1,631.
9/1/2015	1,611.
10/1/2015	1,583.
11/1/2015	1,583.
12/1/2015	1,572.
1/1/2016	1,560.
2/1/2016	1,548.
3/1/2016	1,538.
4/1/2016	1,532.
5/1/2016	1,511.
6/1/2016	1,502.
7/1/2016	1,006.
8/1/2016	996.

	Duals	Non-duals	Combo								
	79399	89399									
SFY15	*$ 2,545.11*	*$ 7,627.91*	***$ 2,926.37***	*wt avg, net of patient liability*							
SFY16	$ 2,622.65	$ 8,251.51	$ 3,196.95								
SFY17	$ 2,516.08	$ 7,774.91	$ 3,292.86								
	93.4%	6.6%			33.2%	66.8%		**As Reported on the MEG Report Jun'16**			
	Duals	Non-duals	Total		HCBS-SP	HCBS-217		HCBS-SP	HCBS-217		
Jul-14	10,344	721	**11,065**	*actual*	1,492	9,863		*1,492*	*9,863*		
Aug-14	10,367	733	**11,100**	*actual*	1,546	9,920		*1,546*	*9,920*		
Sep-14	10,493	755	**11,248**	*actual*	1,624	9,994		*1,624*	*9,994*		
Oct-14	10,777	822	**11,599**	*actual*	1,821	10,300		*1,821*	*10,300*		
Nov-14	*10,943*	*872*	**11,815**	*actual*	2,011	10,490		*2,011*	*10,490*		
Dec-14	11,186	*925*	**12,111**	*actual*	2,162	10,467		*2,162*	*10,467*		
Jan-15	11,046	*893*	**11,939**	*actual*	2,163	10,246		2,163	10,246		
Feb-15	10,990	*899*	**11,889**	*actual*	2,265	10,156		2,265	10,156		
Mar-15	11,021	*952*	**11,973**	*actual*	2,349	10,149		2,349	10,149		
Apr-15	10,925	*929*	**11,854**	*actual*	2,496	10,181		2,496	10,181		
May-15	11,369	*1,015*	**12,384**	*actual*	2,703	10,224		2,703	10,224		
Jun-15	*11,648*	*1,116*	**12,764**	*actual*	3,024	10,282		3,024	10,282		
Jul-15	*12,141*	*1,199*	13,340	*actual*	3,360	10,517		3,360	10,517		
Aug-15	*12,443*	*1,278*	13,721	*actual*	3,715	10,584		3,715	10,584		
Sep-15	*12,746*	*1,357*	14,103	*actual*	3,972	10,701		3,972	10,701		
Oct-15	*12,982*	*1,396*	14,378	*actual*	4,158	10,734		4,158	10,734		
Nov-15	*13,242*	*1,496*	14,738	*actual*	4,528	10,837		4,528	10,837		
Dec-15	*13,635*	*1,552*	**15,187**	*actual*	4,766	11,037		4,766	11,037		
Jan-16	*14,050*	*1,624*	**15,674**	*actual*	5,086	11,078		5,086	11,078		
Feb-16	*14,343*	*1,668*	16,011	*actual*	5,320	11,163		5,320	11,163		
Mar-16	*14,563*	*1,713*	16,276	*actual*	5,541	11,171		5,541	11,171		
Apr-16	*14,913*	*1,783*	16,696	*actual*	5,797	11,270		5,797	11,270		
May-16	*15,354*	*1,859*	17,213	*actual*	6,259	11,312		6,259	11,312		
Jun-16	*15,755*	*1,955*	17,710	*actual*	6,564	11,481		6,564	11,481		
Jul-16	*16,107*	*2,017*	18,124		6,009	11,563		6840	11657		
Aug-16	16,322	2,074	**18,396**		6,099	11,645		7072	11696		
Sep-16	*16,529*	*2,102*	**18,631**		6,177	11,726		7225	11674		
Oct-16	*16,699*	*2,149*	**18,848**		6,249	11,808					
					0	11,890					
					0	11,972					
					0	12,053					
					0	12,135					
					0	12,217					
					0	12,299					
					0	12,380					
					0	12,462	ties to the DMAHS Budget Office capitation projection using Jun 16 actu				

al enroll as emailed to Ketna on 11/9/16			

Deliverables due during MLTSS 2nd quarter (10/1/2016 - 12/31/2016)

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 (PM) 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 MLTSS Performance Measure data reported by the Managed Care Organizations, the State's External Quality Review Organization, IPRO, has developed more refined specifications for the current PMs. The development of the refined specifications has been an ongoing agenda item with the IPRO taking the lead on the discussions during the monthly meetings. IPRO has encouraged the MCOs to begin revising their system coding for the measures and make available for IPRO review during the development phase so that 'technical assistance' may be provided. The refined specifications are effective with measurement period beginning July 1, 2016; however, due to the lag time in reporting the majority of the refined measures will not be submitted until April 2017. 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 (10/1/16 – 12/31/16). 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 with a reporting period for the third year, second quarter (10/1/16 -12/31/16) of MLTSS.

The data for the PMs that DoAS is responsible for reporting is obtained from within their TeleSys database, or the intent is to extract from the Shared Data Warehouse (PM#2, PM#5), and the measures concerning critical incidents is housed within their SAMS database. After reviewing the query results and data source available, the DoAS has discovered that they are unable to report the numerator/denominator for PM#2 as initially defined. Due to the MLTSS systemic enrollment process, MLTSS services are not provided to an individual's enrollment into MLTSS. DoAS is currently reviewing the results of queries that examine the number of new MLTSS enrolled members in the denominator during the reporting month and then examining the number of member in the denominator that received MLTSS services as identified through encounters after enrollment. This review has a nine month lag in reporting to allow for encounter submission. Results of this query will be provided in the next quarterly report submission. It was also discovered that DoAS is unable to track the numerator and denominator as initially defined for PM#5. However, DoAS is monitoring the timeliness of the MCOs conducting the nursing facility level of care re-determinations. A query is run and provided to each MCO identifying the MLTSS members that have not had a level of care (LOC) re-determination within the past 16-months. The MCOs are required to submit within a month the status of each member. Moving forward the DoAS is proposing to provide the MCO specific data identifying the total number of members for which DoAS does not have data identifying a LOC re-determination within the past 16-months; the number of assessments that were conducted and received by the State since report was developed; number of determinations that MCO reported were conducted but State did not received the date; number of members recommended for disenrollment due to inability to contact/voluntary disenrollment; and members who either expired or eligibility was termed. Results of this query will be provided in the next quarterly report submission.

Measures that are not included in this report may be a result of queries that are still under development, 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 (10/1/2016 - 12/31/2016)

PM: #2	#2 – Nursing Facility Level of Care assessment conducted prior to enrollment into MLTSS
Numerator:	# of members in the denominator that started receiving MLTSS services after the LOC approved/authorized date
Denominator:	All MLTSS level of care assessments with "approved" or "authorized" date within the measurement month
Data Source:	DoAS
Measurement Period:	Monthly with a three month lag report – Due 15th of the month following the 3 month lag

Not available at this time, this measure is being re-developed. Revised measure and data results will be provided in the next quarterly report.

PM #3	Nursing Facility level of care authorized by Office of Community Choice Options (OCCO) for MCO referred members
Numerator:	# of MLTSS level of care assessment outcomes in the denominator that were "authorized" or "approved" by OCCO
Denominator:	Total number of MLTSS level of care assessments that were "authorized", "approved" or "denied" by OCCO during the measurement month
Data Source:	DoAS
Measurement Period:	Monthly – Due the 15th of the following month

Measurement period	09/2016	10/2016	11/2016
Numerator	1952	1262	1348
Denominator	2047	1272	1356
%	95.4	99.2	99.4

The average percentage for reporting quarter is 98%.

PM #4	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

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 (10/1/2016 - 12/31/2016)

August 2016	A	B	C	D	E	TOTAL
Numerator	10	132	133	95	356	726
Denominator	10	133	134	100	433	810
%	**100**	**99.2**	**99.3**	**95.0**	**82.2**	**89.6**

September 2016	A	B	C	D	E	TOTAL
Numerator	18	120	87	65	233	523
Denominator	18	122	87	68	248	543
%	**100**	**98.4**	**100**	**95.6**	**94.0**	**96.3**

October 2016	A	B	C	D	E	TOTAL
Numerator	18	136	87	57	297	595
Denominator	19	136	88	60	316	619
%	**94.7**	**100**	**98.9**	**95.0**	**94.0**	**96.1**

The MCOs are monitoring the timeliness of level of care (LOC) assessments and have identified that some of the delays include: unable to contact until after the 30 day deadline, external departments creating duplicate referrals creating two different referral dates, unable to contact member due to hospitalization or NJ choice not submitted to OCCO timely, and member receiving therapies in an inpatient setting. In one reporting period a MCO reported that they had an untimely assessment due to the member switching nursing facilities during the referral process. Another MCO reported that two referrals were inappropriately made by newer ICM staff and were identified and reeducated on the workflow. Another MCO reported that two untimely assessments were actually seen within the 30 days but a systems issue prevented the assessment from being submitted to OCCO timely. Another MCO reports continued improvements as the number of assessments assigned to their preferable vendor has increased and reported that this vendor is continuing to staff in order to meet compliance timeframes and maintain a completion rate of over 90%.

PM # 4a	Timeliness of nursing facility level of care assessment
Numerator:	The number of assessments in the denominator where the OCCO assessment/ determination date is less than 30 days from the referral date to OCCO
Denominator:	Number of level of care assessments conducted by OCCO in the measurement month
Data Source:	DoAS
Measurement Period:	Monthly – Due 15th of the 2nd month (lag report) following reporting period

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 (10/1/2016 - 12/31/2016)

Measurement Period	08/2016	09/2016	10/2016
Numerator	239	752	757
Denominator	443	1312	1204
%	**54.0**	**57.3**	**62.9**

The average percentage for this reporting period is 58%. The criteria are based on the number of level of care assessments conducted by OCCO in the measurement period. OCCO is responsible for conducting assessment for individuals who are newly seeking Medicaid enrollment in order to access long term services and supports in institutional and community settings. These referrals are generated by various provider sources including hospitals, nursing facilities, assisted living, and county offices. OCCO is unable to track referral sources at this time and because of this, analysis and action planning is difficult. OCCO reports during the month of August there was a volume decrease due to a data system upgrade. The workload includes non-MLTSS individuals and individuals who are not Medicaid eligible. Due to the large population of non-Medicaid eligible individuals OCCO is recommending the measure be taken under advisement for changes and has submitted to a QA workgroup for consideration. Additionally, the DoAS will continue to evaluate methods to improve the data reporting for this measure.

PM # 5	Timeliness of nursing facility level of care re-determinations
Numerator:	Number of reassessments in the denominator conducted greater than 395 days from the previous OCCO assessment authorization date.
Denominator:	Total number of MLTSS level of care reassessments completed by the MCOs and submitted to OCCO in the measurement month.
Data Source:	DoAS
Measurement Period:	Monthly – Due the 15th of the following month (Initial report due 8/15/15)

Not available at this time, this measure is being re-developed. Revised measure and data results will be provided in the next quarterly report.

PM # 6	Interim Plan of Care (IPOC) Completed (Options Counseling)
Numerator:	Number of assessments in the denominator with an Interim Plan of Care (IPOC) completed
Denominator:	Total number of NJ Choice assessments tagged as “authorized”, “approved” or “denied” within the measurement month
Data Source:	DoAS
Measurement Period:	Monthly – Due the 15th of the following month

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 (10/1/2016 - 12/31/2016)

Measurement Period	09/2016	10/2016	11/2016
Numerator	1943	1245	1424
Denominator	1943	1245	1424
%	**100**	**100**	**100**

The completion of the IPOC is included in the electronic data exchange with the NJ Choice Assessment, the tool used to determine NF LOC eligibility. The IPOC completion should always be 100% since the data exchange will not accept an incomplete record.

PM # 7	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	09/2016	10/2016	11/2016
Numerator	1011	670	833
Denominator	1943	1245	1363
%	**52.0**	**53.8**	**61.1**

The average percentage for this reporting period is 56%. DoAS reports that this data is identified on the Interim Plan of Care (IPOC) form which is utilized to identify options counseling for individuals seeking MLTSS. DoAS has developed and implemented a training module on documenting member choice on the IPOC. The training materials were distributed to OCCO and the MCO's in September. All staff required training compliance by November 1st. Additionally, in the first month following implementation, an improvement of 9% displays expected advancement of measure compliance.

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

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 (10/1/2016 - 12/31/2016)

Measurement Period	09/2016	10/2016	11/2016
Numerator	275	229	214
Denominator	275	233	217
%	**100**	**98.3**	**98.6**

DoAS reports that the reporting from the MCO's is uniform for this measure. Established monitoring of the timeliness of CI reporting has revealed that current analysis doesn't support any significant impact in reporting based on plan enrollment. They have established the minimum percentage accepted is 100% and require the MCO's provide a corrective action plan to improve timeliness. Two MCOs fell below this threshold during this reporting period and they have provided DoAS with an acceptable action plan to address.

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	09/2016	10/2016	11/2016
Numerator	3	3	9
Denominator	3	3	9
%	**100**	**100**	**100**

DoAS reported that established procedures for reporting suggest being acceptable and all critical incidents for Media Involvement and Unexpected Death were reported on time.

PM # 19	Timeliness 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.

Deliverables due during MLTSS 2nd quarter (10/1/2016 - 12/31/2016)

Appeals and Grievances (Table 3A)

7/1/2016 – 9/30/2016	A	B	C	D	E	TOTAL
Numerator	0	14	55	60	14	143
Denominator	0	14	55	60	14	143
%	**0**	**100**	**100**	**100**	**100**	**100**

Complaints (Table 3B)

7/1/2016 – 9/30/2016	A	B	C	D	E	TOTAL
Numerator	2	14	107	9	3	135
Denominator	4	14	107	9	4	138
%	**50.0**	**100**	**100**	**100**	**75.0**	**97.8**

MCO A reported that two complaints took 31 days to resolve, one day longer than required.
MCO E reported that one complaint took 54 days to resolve, 24 days longer than required.

PM # 20	Total # of MLTSS members receiving MLTSS services
Numerator:	Total # of unique MLTSS members receiving HCBS and/or NF services during the measurement period (does not include care management)
Denominator:	Total # of unique MLTSS members eligible anytime 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

1/1/2016 – 3/31/2016	A	B	C	D	E	TOTAL
Numerator	471	3346	11832	5077	3011	23737
Denominator	594	4393	12752	5575	3130	26444
%	**79.3**	**76.2**	**92.8**	**91.1**	**96.2**	**89.8**

In analyzing their data, MCOs discovered that there were members with authorizations for MLTSS services but no claims to determine if needed services are being provided. There were also individuals who the MCOs were unable to contact, that were refusing services, or were enrolled and disenrolled within the same quarter. Although they still appeared in the denominator, they did not utilize these services therefore, would not be captured within the numerator. Also, one MCO reported that some members were initiating delay in the initial face to face visits, thus potentially delaying services and also members having the option of only choosing care management as a service. Additionally, MCO's report that they will continue to provide a member-centric focus during options counseling and will continue to encourage the use of MLTSS services as part of the care planning process.

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 (10/1/2016 - 12/31/2016)

PM # 21	MLTSS members transitioned from NF to Community
Numerator:	# of MLTSS NF (SPC 61, 63, 64) members identified in the denominator who transitioned from a NF to the community (SPC 60, 62) at any time during the measurement period
Denominator:	# of MLTSS members with the living arrangement of NF (SPC 61, 63, 64) at any time during the measurement period (quarter or annual) and continuously enrolled in MCO.
Data Source:	MCO – living arrangement file and client tracking system
Measurement Period:	Quarterly/Annually – Due: 30 days after the quarter and year

7/1/2016-9/30/2016	A	B	C	D	E	TOTAL
Numerator	N/A	N/A	N/A	N/A	N/A	N/A
Denominator	N/A	N/A	N/A	N/A	N/A	N/A
%	N/A	N/A	N/A	N/A	N/A	N/A

Due to the refinement of the PM specifications, some of the MCOs requested an extension in reporting this measure. The data will be reported in the next quarterly report.

PM # 23	MLTSS members transitioned from NF to the community at any point during the preceding quarter who returned to the NF within 90 days
Numerator:	# of MLTSS members in the denominator who transitioned from NF to the community who then returned to the NF within 90 days or less from transition during the measurement period
Denominator:	Quarterly: Total # of unique MLTSS members who transitioned from NF to the community during the measurement quarter Annually: Total # of unique MLTSS members who transitioned from NF to the community during state fiscal year 7/1-6/30
Data Source:	MCO – Living arrangement file, CM tracking and prior auth. System (r/o respite/rehab).
Measurement Period:	Quarterly Lag Report/ Annually; each report is a unique run

4/1/2016-6/30/2016	A	B	C	D	E	TOTAL
Numerator	0	0	10	1	3	14
Denominator	6	18	118	44	9	195
%	**0**	**0**	**8.5**	**2.3**	**33.3**	**7.2**

7/1/2015-6/30/2016 (Year)	A	B	C	D	E	TOTAL
Numerator	0	2	11	1	3	17
Denominator	15	56	122	149	29	371
%	**0**	**3.6**	**9.0**	**0.7**	**10.3**	**4.6**

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 are monitoring the reasons for MLTSS members' readmission to the NF. The MCO's have identified individuals readmitted per members' request and members whose needs could no longer be met in the community, as members had functional declines or lacked formal supports. Additionally, they also continue to track and trend elements that are successful to transition such as care manager accessibility, transportation and proximity of community services. One MCO implemented re-education efforts that aim toward improving Care Manager identification of member needs at time of transition and post transition to decrease unsuccessful transitions.

PM # 24	# of MLTSS HCBS members transitioned from the community to NF for greater than 180 days
Numerator:	# of unique MLTSS HCBS members in the denominator who were still in the NF greater than 180 days during the measurement period
Denominator:	Quarterly: # of unique MLTSS HCBS members that transitioned from the community to NF during the measurement quarter Annually: Total # of unique MLTSS HCBS members that transitioned from the community to NF during the state fiscal year 7/1-6/30
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: 210 day lag after quarter and year

1/1/2016 – 3/31/2016	A	B	C	D	E	TOTAL
Numerator	3	41	112	65	25	246
Denominator	3	44	164	73	60	344
%	**100**	**93.2**	**68.3**	**89.0**	**41.7**	**71.5**

The MCO's have identified causes of members with a length of stay greater than 180 days as members with a decline in functional status and deterioration in health such as complications related to dementia, chronic obstructive pulmonary disease, diabetes and hypertension. MCO A reported that a member acquired a fracture that required multiple surgeries which resulted in chronic debilitation. MCO D reported that the percentage of members returning to the NF for greater than 180 days remained fairly consistent over the course of the year and this quarter's percentage was very similar to prior reports. Another MCO reports that there was a decrease in percentage and overall number from the prior quarter and their process of record review will continue to curtail the length of stay and aim to prevent permanent institutionalization.

PM # 25	# of MLTSS HCBS members transitioned from the community to NF for less than or equal to 180 days (short stay)
Numerator:	# of MLTSS members in the denominator who were in the NF for 180 days or less during the measurement period
Denominator:	Quarterly: Total # of unique MLTSS HCBS members that transitioned from community to NF in a given quarter Annually: Total # of unique MLTSS members that transitioned from the community to NF during the state fiscal year 7/1-6/30
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: 210 day lag after quarter and year

1/1/2016 – 3/31/2016	A	B	C	D	E	TOTAL
Numerator	0	3	52	8	35	98
Denominator	3	44	164	73	60	344
%	**0**	**6.8**	**31.7**	**11.0**	**58.3**	**28.5**

MCOs report they are continuing to track and trend transitions into the NF to confirm that appropriate community to NF transitions are occurring. MCO E reported a significant increase in the number of NF admissions for HCBS members from previous quarter 25% to 58%. MCO E also reports this is an indication of their successful implementing strategies to improve functional and health status to prevent increased length of stay and permanent institutionalization. MCO B reports that they have tracked a subset of the FIDE-SNP population for this measure and 0% was transitioned from community to NF in this quarter specifically.

PM # 26	# of hospitalizations per MLTSS HCBS members
Numerator:	# of hospitalizations (unique combination of member-provider-admission date) of MLTSS HCBS members (not unique members) during the measurement period.
Denominator:	Total # of unique MLTSS HCBS members that were continuously enrolled in your MCO during the measurement period
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)

1/1/2016 – 3/31/2016	A	B	C	D	E	TOTAL
Numerator	11	328	700	198	341	1578
Denominator	500	7422	24562	9969	6432	48885
%	**2.2**	**4.4**	**2.8**	**2.0**	**5.3**	**3.2**

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: pneumonia, sepsis, unspecified asthma, acute kidney failure, cerebral infarction, CHF, COPD, and UTI. MCO D reported a slight increase in the hospitalization rate from the previous quarter of 0.35% whereas MCO E reports a noted overall decline in the hospitalization rate as compared to the previous quarter with a rate change of 12.25%. One MCO reports they support continuity of care by following up with members post discharge to confirm required services are in place and make changes to the care plan when necessary. Another MCO reports they monitor triggers from daily inpatient reports to address timely discharge planning and allow opportunities for interventions in preventing future hospital admissions particularly for chronic conditions.

PM # 27	# of hospitalizations of NF members (not unique members)
Numerator:	# of hospitalizations (unique combination of member-provider-admission date) of MLTSS NF members (not unique members) during the measurement period
Denominator:	Total # of unique MLTSS NF members (SPC 61, 63, 64) that were continuously enrolled in your MCO and in a NF during the measurement period
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)

1/1/2016 – 3/31/2016	A	B	C	D	E	TOTAL
Numerator	18	163	278	137	93	689
Denominator	1016	4421	10880	5313	1909	23539
%	**1.8**	**3.7**	**2.6**	**2.6**	**4.9**	**2.9**

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. Some of the reported diagnoses were related to sepsis, UTI, gastrointestinal disorders, renal failure, pneumonia, encephalopathy, fracture of left pubis, kidney failure, syncope, abscess due to vascular disease, and cardiovascular disorders. MCO E reports that of the74 total numbers of unique members hospitalized during the measurement period 56 were over 65 years of age and there were 16 members with more than one admission.

PM # 28	# of readmissions of MLTSS HCBS members (not unique members) to the hospital within 30 days
Numerator:	# of readmissions of MLTSS HCBS members (not unique members) to the hospital within 30 days from date of discharge (service through date and new service start date) during the measurement period
Denominator:	# of hospitalizations (unique combination of member-provider-service date) of MLTSS HCBS members (not unique members) during the measurement period
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)

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

1/1/2016 - 3/31/2016	A	B	C	D	E	TOTAL
Numerator	0	24	79	91	48	242
Denominator	11	328	700	198	341	1578
%	**0**	**7.3**	**11.3**	**46.0**	**14.1**	**15.3**

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 epilepsy, acute kidney failure, fasciolopsiasis, COPD, sepsis, and pneumonia. MCO B reported that 24 readmissions consisted of 16 unique members. MCO E reports that 36 readmissions were members 65 years of age or older and were a total of 38 unique members for which 8 members had more than one admission. Additionally, MCO E reports they are in development of readmission prevention strategies for sepsis which has been the top leading diagnosis for readmissions in the past three measurement periods.

PM # 29	# of readmissions of MLTSS NF members (not unique members) to the hospital within 30 days
Numerator:	# of readmissions of MLTSS NF members (not unique members) to the hospital within 30 days from date of discharge (service through date and new service start date) during the measurement period
Denominator:	# of hospitalizations (unique combination of member-provider-service date) of MLTSS NF members (not unique members) during the measurement period
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)

1/1/2016 - 3/31/2016	A	B	C	D	E	TOTAL
Numerator	0	11	36	31	13	91
Denominator	18	163	278	137	93	689
%	**0**	**6.7**	**12.9**	**22.6**	**14.0**	**13.2**

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 C reports that the overall readmission rate was slightly higher related to latent flu season and the leading diagnoses for readmissions in this measure are sepsis and COPD. MCO C also reports as they identified trends for readmissions they discovered that one member was admitted four times as a result of exacerbation of COPD. MCO A reports that 61% were admitted with an infection process and they continue to trend and implement interventions as needed. MCO B reported that 11 readmissions consisted of 11 different primary diagnoses and that none of the members experienced a reported critical incident related to their readmissions.

PM # 30	# of ER utilization by MLTSS HCBS members (not unique members)
Numerator:	# of ER utilization (unique combination of member-provider-service date,(not admitted) by MLTSS HCBS members (not unique members) during the measurement period
Denominator:	Total # of unique MLTSS HCBS members that were continuously enrolled in your MCO during measurement period
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)

01/1/2016–03/31/2016	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	29	546	1218	425	402	2620
Denominator	500	7422	24562	9969	6432	48885
%	**5.8**	**7.4**	**5.0**	**4.3**	**6.3**	**5.4**

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. The diagnoses across all MCOs include essential hypertension, UTI, chest pain, epistaxis, dizziness, head injury, COPD exacerbation, abdominal pain, seizures, asthma exacerbation, and contusions. MCO A reports that one member had five ER utilizations. MCO E reports that one member with Lupus had 26 ER visits. Furthermore, MCO E reports that utilization data for ER visits revealed that 62, out of the total unique 282 members had more than 1 ER visit. At this time, ER utilization is not excluded if it leads to a hospital admission. Therefore, there is the potential that this utilization may be lower. The data elements are currently under review for further refinement.

PM # 31	# of ER utilization by MLTSS NF members (not unique members)
Numerator:	# of ER utilization (unique combination of member-provider-service date(not admitted) by MLTSS NF members (not unique members) during the measurement period
Denominator:	Total # of unique MLTSS NF members (SPC 61, 63, 64) that were continuously enrolled in your MCO and in a NF during the measurement period
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)

01/1/16 – 03/31/16	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	35	147	270	136	72	660
Denominator	1016	4421	10880	5313	1909	23539
%	**3.4**	**3.3**	**2.5**	**2.6**	**3.8**	**2.8**

MCOs are monitoring their respective data to determine trends by facility and develop ongoing prevention strategies especially those with multiple ER visits. MCO D reports that they did not note any prevailing trends in the primary diagnosis although; they noted that head injury was the most common diagnosis for the second consecutive measurement period. In addition, MCO D reports that their Quality Improvement Project relates to falls and they continue to monitor progress in that extent.

Deliverables due during MLTSS 2nd quarter (10/1/2016 - 12/31/2016)

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:	July-Sept 2016

	MCO	A			B			C			D			E			Quarter - TOTAL		
	Participant Safeguards:	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
18	Critical Incident (CI) reporting Types:																		
a	Unexpected death of a member	0	2	**0**	1	102	**1.0**	5	626	**0.8**	1	75	**1.3**	1	47	**2.1**	8	852	**0.9**
b	Media involvement or the potential for media involvement	0	2	**0**	3	102	**2.9**	2	626	**0.3**	2	75	**2.7**	2	47	**4.3**	9	852	**1.1**
c	Physical abuse (including seclusion and restraints both physical and chemical)	0	2	**0**	2	102	**2.0**	10	626	**1.6**	4	75	**5.3**	1	47	**2.1**	17	852	**2.0**
d	Psychological / Verbal abuse	0	2	**0**	0	102	**0**	1	626	**0.2**	0	75	**0**	0	47	**0**	1	852	**0.1**
e	Sexual abuse and/or suspected sexual abuse	0	2	**0**	0	102	**0**	1	626	**0.2**	1	75	**1.3**	0	47	**0**	2	852	**0.2**
f	Fall resulting in the need for medical treatment	0	2	**0**	0	102	**0**	186	626	**29.7**	22	75	**29.3**	30	47	**63.8**	238	852	**27.9**
g	Medical emergency resulting in need for medical treatment	1	2	**50.0**	0	102	**0**	288	626	**46.0**	12	75	**16.0**	3	47	**6.4**	304	852	**35.7**
h	Medication error resulting in serious consequences	0	2	**0**	0	102	**0**	0	626	**0**	0	75	**0**	0	47	**0**	0	852	**0**
i	Psychiatric emergency resulting in need for medical treatment	0	2	**0**	13	102	**12.7**	24	626	**3.8**	1	75	**1.3**	0	47	**0**	38	852	**4.5**

N = Numerator D = Denominator % = Percentage

Deliverables due during MLTSS 2nd quarter (10/1/2016 - 12/31/2016)

j	Severe injury resulting in the need for medical treatment	0	2	**0**	45	102	**44.1**	14	626	**2.2**	0	75	**0**	3	47	**6.4**	62	852	**7.3**
k	Suicide attempt resulting in the need for medical attention	0	2	**0**	0	102	**0**	3	626	**0.5**	0	75	**0**	0	47	**0**	3	852	**0.4**
l	Neglect/Mistreatment, caregiver (paid or unpaid)	0	2	**0**	4	102	**3.9**	9	626	**1.4**	4	75	**5.3**	2	47	**4.3**	19	852	**2.2**
m	Neglect/Mistreatment, self	0	2	**0**	0	102	**0**	4	626	**0.6**	1	75	**1.3**	0	47	**0**	5	852	**0.6**
n	Neglect/Mistreatment, other	0	2	**0**	0	102	**0**	5	626	**0.8**	2	75	**2.7**	0	47	**0**	7	852	**0.8**
o	Exploitation, financial	1	2	**50.0**	1	102	**1.0**	4	626	**0.6**	0	75	**0**	0	47	**0**	6	852	**0.7**
p	Exploitation, theft	0	2	**0**	1	102	**1.0**	5	626	**0.8**	0	75	**0**	0	47	**0**	6	852	**0.7**
q	Exploitation, destruction of property	0	2	**0**	0	102	**0**	0	626	**0**	0	75	**0**	0	47	**0**	0	852	**0**
r	Exploitation, other	0	2	**0**	1	102	**1.0**	0	626	**0**	0	75	**0**	0	47	**0**	1	852	**0.1**
s	Theft with law enforcement involvement	0	2	**0**	3	102	**2.9**	7	626	**1.1**	0	75	**0**	1	47	**2.1**	11	852	**1.3**
t	Failure of member's Back-up Plan	0	2	**0**	0	102	**0**	4	626	**0.6**	0	75	**0**	1	47	**2.1**	5	852	**0.6**
u	Elopement/Wandering from home or facility	0	2	**0**	3	102	**2.9**	6	626	**1.0**	0	75	**0**	0	47	**0**	9	852	**1.1**
v	Inaccessible for initial/on-site meeting	0	2	**0**	5	102	**4.9**	2	626	**0.3**	9	75	**12.0**	0	47	**0**	16	852	**1.9**
w	Unable to Contact	0	2	**0**	2	102	**2.0**	19	626	**3.0**	11	75	**14.7**	1	47	**2.1**	33	852	**3.9**
x	Inappropriate or unprofessional conduct by a provider involving member	0	2	**0**	3	102	**2.9**	18	626	**2.9**	1	75	**1.3**	1	47	**2.1**	23	852	**2.7**
y	Cancellation of utilities	0	2	**0**	1	102	**1.0**	3	626	**0.5**	0	75	**0**	1	47	**2.1**	5	852	**0.6**
z	Eviction/loss of home	0	2	**0**	0	102	**0**	6	626	**1.0**	0	75	**0**	0	47	**0**	6	852	**0**
aa	Facility closure, with direct impact to member's health and welfare	0	2	**0**	0	102	**0**	0	626	**0**	0	75	**0**	0	47	**0**	0	852	**0**

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

Deliverables due during MLTSS 2nd quarter (10/1/2016 - 12/31/2016)

ab	Natural disaster, with direct impact to member's health and welfare	0	2	**0**	0	102	**0**	0	626	**0**	0	75	**0**	0	47	**0**	0	852	**0**
ac	Operational Breakdown	0	2	**0**	0	102	**0**	0	626	**0**	1	75	**1.3**	0	47	**0**	1	852	**0.1**
ad	Other	0	2	**0**	14	102	**13.7**	0	626	**0**	3	75	**4.0**	0	47	**0**	17	852	**2.0**

The Office of Managed Long-Term Services and Supports Quality Monitoring (MLTSS/QM) and the Division of Aging Services (DoAS) coordinated the adjustment of the categories within the diagram for reporting critical incidents. The new template, effective July 1, 2016, provides additional subsets integrating a seamless standard and consistent approach between the DoAS and MCO's when reporting critical incident outcomes. Additionally, MLTSS QM aimed at decreasing the number of critical incidents that elected in the (Other) category identifying more key elements to improve the effectiveness of this measure.

There were a total of 852 Critical Incidents reported by the five MCOs during the July 1-September 30, 2016 measurement period. These are reported events not unduplicated members. Overall the three most common incidents were: medical emergency resulting in the need for medical treatment (36%); fall resulting in the need for medical treatment (28%); and severe injury resulting in the need for medical treatment (7.3%). One of the MCOs reported only two incidents, but both were for the same member. The MCO's MLTSS CM made a referral to Adult Protective Services (APS) and provided emergency funds for additional food. In addition to contacting APS, the CM provided the member with her own cell phone with the MLTSS CM telephone's number programmed into speed. The MCO reports the CM continues to have open communication with the member for monitoring purposes.

Another MCO note that of the 288 medical emergencies reported, that three members each had two emergencies during this quarter. The MCO's response was to upgrade the observation status of these members to a more frequent schedule. They also increased the frequency of member observation for three members in the fall category. Each of these members had two falls. The MCO further confirmed that there wasn't duplication between these two categories.

MCO D reported that 22 of their 75 reported incidents were for falls. Two members fell more than once. The MCO responded by reassessing the members and updating their respective plan of care. MCO E indicated that 30 of their reported 47 incidents were for falls. They noted that 29 of the 30 falls were for members 65 or older. Overall, they found that 41 of the 47 incidents (87%) were for members 65 years of age or older.

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