New Jersey Comprehensive Demonstration
Section 1115 Annual Report
Demonstration Year 8: July 1, 2019 – June 30, 2020

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community settings using industry best practices and guidelines;

XVII. STC 73 (p). Policies for any waiting lists where applicable;

XVIII. STC 73 (q) The state may also provide CMS with any other information it believes pertinent to the provision of the HCBS and their inclusion in the demonstration, including innovative practices, certification activity, provider enrollment and transition to managed care special populations, workforce development, access to services, the intersection between the provision of HCBS and Medicaid behavioral health services, rebalancing goals, cost-effectiveness, and short and long-term outcomes;

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I. Introduction

The New Jersey Comprehensive Demonstration (NJCD) was approved by the Centers for Medicare and Medicaid Services (CMS) on October 2, 2012, and is effective August 1, 2017 through June 30, 2022.

The first five years of the demonstration was initiated to:

- 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;
- Furnish premium assistance options to individuals with access to employer-based coverage.

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

- Maintain its MLTSS program;
- Achieve better care coordination for and the promotion of integrated behavioral and physical health for a more patient centered care experience, and to offer aligned financial incentives and value-based payments;
- Simplify and streamline the administration and oversight of services in order to better monitor the overall health of the Medicaid population; as well as act as the first step to

remove silos of care for I/DD youth transitioning from the children's system into the adult system;

- To provide access to services earlier in life in order to avoid unnecessary out-of-home placements, decrease interaction with the juvenile justice system, and see savings in the adult behavioral health and I/DD systems;
- To build on current processes to further streamline eligibility and enrollment for NJFC beneficiaries;
- To reduce hospitalizations and costs associated with disease and injury;
- Establish an integrated behavioral health delivery system that includes a flexible and comprehensive substance use disorder (SUD) benefit and the New Jersey continuum of care;
- To expedite financial eligibility for Medicaid in a timely manner for individuals placed under the OPG in order to receive needed Medicaid coverage;
- To provide evidence-based home visiting services to low-income families to promote enhanced health outcomes, whole person care, and community-integration.

This annual report is submitted in accordance with Special Term and Condition (STC) 73 of the NJCD.

II. STC 73 (a) Items included in the Quarterly Reports must be summarized to reflect the operation/activities throughout the DY;

The items included in the quarterly report are summarized throughout the annual report to reflect operation/activities throughout DY8.

III. STC 73 (b) Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately

The administrative cost for demonstration year (DY) 8 is $911,378,262. This cost is for the entire Medicaid program and includes salaries and benefits for all employees not only in Medicaid but the county eligibility staff, translation services, the cost of running the fiscal agent contract, Molina, conduent, and all the other vendors, etc.

IV. STC 73 (c) Total contributions, withdrawals, balances, and credits;

Total contributions, withdrawals, balances and credits is included in Attachment F at the end of this report.

V. STC 73 (d) Yearly enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutrality agreement;

Yearly enrollment reports for demonstration enrollees for each DY are included in Attachment F at the end of this report.

VI. STC 73 (e): A Report of Service Use by Program Including Each HCBS Program (encounter data)

Service Use data for the MLTSS, ASD, ID/DD-MI, SED, CCP and Supports Program is included in Attachment A at the end of this report.

VII. STC 73 (f) A Summary of the Use of Self-directed Service Delivery Options in the State

Overview of Self-Direction

Self-Direction is a philosophy and an alternative service delivery mechanism for home and community-based services (HCBS) where informed NJ FamilyCare Plan A beneficiaries gauge their own needs, determine how and by whom these needs should be met, and monitor the quality of services received. Beneficiaries have both budget authority and worker authority to make choices that work for them. Budget authority allows beneficiaries to choose how they wish to spend their monthly budget within the program's guidelines. Employer authority allows beneficiaries to become common law employers so they can choose who they want to hire to provide their direct care. Once a NJ FamilyCare Plan A beneficiary is enrolled in self-direction he/she is referred to as the participant.

Self-direction may exist in different degrees and span many types of services, ranging from a participant making all decisions to a participant utilizing an authorized program representative to manage his/her services. Research has found that participants who utilize self-directed service delivery models report increased satisfaction with their homecare services as well as increased quality of those services.

Self-Directed PCA (Personal Preference)

New Jersey began providing self-directed services as an option to State Plan Medicaid Personal Care Assistance (PCA) Services in 1999 through the Cash and Counseling Demonstration Project, otherwise known as Personal Preference. Personal Preference became a permanent program through CMS 1915j authority in 2008. The 1915j authority was subsumed into the 1115 Comprehensive Waiver in October 2012. In July 2017, the state procured a new Fiscal Intermediary. In April 2018, the Personal Preference Program (PPP) transferred its state operational base from the Division of Disability Services (DDS) to the Division of Medical Assistance and Health Services (DMAHS). This transition allows for improved operational efficiency and oversight given the PPP is largely a function of managed care delivery for the PCA Medicaid State Plan A benefit. The options counseling function was previously conducted by the DDS; however, now the Managed Care Organizations (MCOs) are charged with this responsibility. Upon completion of a participant's PCA assessment the MCO provides options counseling for both PCA agency directed services and the PPP so that he/she can make an informed decision that aligns with person-centered planning and member-driven goal-making.

Participants use the majority of their monthly budgets to hire individual workers to provide assistance with Activities of Daily Living (ADL). Some participants may choose to purchase goods and services in lieu of personal care. For example, a participant may choose to purchase a washer and dryer so he/she can do laundry on his/her own or to allow the worker to spend more time providing service(s) in the home as opposed to being in the laundromat. This allows the participant to potentially be more independent while reducing reliance on the worker. This also potentially frees up the worker to complete additional services once the laundry can be completed in the home. Participants that purchase goods and services most often purchase small appliances such as microwaves, washer/dryer, toaster ovens, as well as other supports such as laundry services.

From 2008 to July 2011, approximately 30-50 new participants enrolled in the PPP each month. During this time, participants only learned about the PPP through word of mouth. There was no formal marketing strategy to enroll participants. With the inclusion of PCA services and the PPP in Medicaid Managed Care in 2011, enrollment began to increase to about 75-100 new participants each month and has been increasing steadily to date. The highest month of enrollment in program history was in June 2020 with a

total of 955 new participants. As of June 2020, 20, 200 participants are actively enrolled in the PPP with an average monthly growth of 409 participants. The reason for the continued increase in enrollment lies with the options counseling provided by the MCOs informing their beneficiaries of the option to self-direct home care services.

Self-Direction under MLTSS

Based on the success of self-directed PCA services, DMAHS in its creation of the MLTSS benefit, developed additional self-directed services to meet the various needs of the MLTSS population in an HCBS environment. One of the purposes of offering self-directed options is to provide a beneficiary with the mechanism to purchase unique goods and services previously not available under the Medicaid program. For example, one of the MCOs determined that a beneficiary was experiencing adverse health effects caused by the excessive heat in the residence. In an effort to manage and support the participant's health and safety, and maintaining services in the home in lieu of an institutional setting, the MCO opted to purchase a window air conditioner by utilizing the self-directed mechanism to facilitate the purchase of this non-routine item.

The DMAHS also administers the Self-Directed Service options available to consumers enrolled in MLTSS which include:

Chore Services – supports designed to help an individual maintain a clean and safe home environment. Chores covered by this service include: cleaning appliances, cleaning carpets and scrubbing floors, washing walls and windows, cleaning attics and basements to remove fire and health hazards, clearing walkways of ice, snow and leaves, replacing fuses, light bulbs, electric plugs, frayed cords, replacing door locks, window catches, faucet washers, installing safety equipment like smoke detectors, fire extinguishers and grab bars and "Spring Cleaning" and weatherization.

Non-Medical Transportation – is a service which helps individuals to gain access to community services, activities and resources which enhance the individual's life. This service is offered in addition to medical transportation. Transportation covered by this service include: shopping, beauty salon, financial institution and religious services.

Home Based Supportive Care (HBSC) - services are designed to assist MLTSS participants with Instrumental Activities of Daily Living (IADL). IADLs are support services such as, but not limited to: grocery shopping, money management, light housekeeping and laundry.

Issues & Trends

The DMAHS has implemented a direct operational relationship between the MCOs and the Fiscal Intermediary (FI). Both the FI and the MCOs exchange enrollment, service authorization and participation data directly, without the intervention of the state. Removing the state from day-to-day operations of the PPP allows the State housed within the DMAHS, to maintain its oversight role to monitor the quality of self-direction, and pursue program enhancements as a valuable component of NJ FamilyCare's home and community-based service options.

The State Program Office (SPO) and the FI are currently collaborating on the implementation of an initiative designed to support new PPP members through the enrollment cycle. The FI created a high-touch enrollment pilot by developing the Orientation and Training Specialist (OTS) role. An OTS supports new PPP participants with a focused one-to-one approach during the initial start-up activities required for

starting a self-directed business such as hiring workers, developing a cash management plan, establishing an Employee Identification Number (EIN) and procuring workers compensation insurance. A dedicated OTS is assigned to the participant and remains with them through their first successful pay period. Once this is completed, the OTS provides the participant with a warm hand-off to their permanent Financial Consultant. The initiative began as a small pilot in New Jersey's southern region; however, due to its success is now in place throughout New Jersey and continues to facilitate a positive enrollment experience for new enrollees in the PPP.

This demonstration year has faced unprecedented challenges due to the COVID -19 pandemic. In March of 2020, the state of New Jersey declared a state of emergency resulting in facility closures, social distancing guidance and Personal Care Assistance (PCA) Agency staffing concerns. The SPO, in collaboration with the FI, replaced all in-person Information and Assistance (I&A) visits with telephonic/online interactions with NJ FamilyCare members. This includes new enrollment, wage updates and quarterly visit activities. The State has also expedited enrollment for prospective participants that require prompt access to the PPP and facilitated faster access to new hires and rate changes for current workers for beneficiaries currently accessing the PPP. The changes assure the health and safety of PPP participants, their families and caregivers and will remain in place during the COVID-19 public health emergency.

VIII. STC 73 (g): A General Update on the Collection, Analysis and Reporting of Data by the Plans at the Aggregate Level

Encounter Data

The main data set that the DMAHS Office of Business Intelligence is responsible for is receiving encounter data from the MCOs. Section 3.9 of the managed care contract requires our plans to "collect, process, format, and submit electronic records for all services delivered to an enrollee." The plans are required to submit encounter records on at least a monthly basis, although there are submissions that generally occur more frequently. DMAHS has a unique set of encounter claim edits to ensure consistency and readability of encounters across the varied MCOs. The Office of Business Intelligence also sets category of service utilization benchmarks in certain areas to ensure completeness of the data submitted by the plans and have contractual requirements related to duplicate encounter submissions and encounter MMIS denial rates. Failure to meet these requirements initially results in the withholding of capitation payments to the MCOs until the failure is resolved; if the contracted standards are not met after a specified period of withholding, the withheld amounts are liquidated and not recoverable by the plans. Plans are also required to submit encounters for payments to subcontractors and the service encounter claim information from these subcontractors.

Shared Data Warehouse

The Division contracts for the operation of a shared data warehouse that includes all nearly all data available from the MMIS and some data from external sources (such as NJ Choice MLTSS assessment data and long term care recipient data from the Division of Aging Services, electronic birth certificate information from the Department of Health). Access to this warehouse is available to all Division staff and to certain select staff in other state departments/agencies (Department of Treasury – Office of Management and Budget, Office of State Comptroller – Medicaid Fraud Division, Department of Law and Public Safety – Division of Criminal Justice for example), with data expertise and consulting available through the Division's Office of Business Intelligence and its shared data warehouse contractor. The

warehouse allows for ad-hoc and production reporting of various data metrics and is also used as the source of data for various interactive data dashboards maintained by the Office of Business Intelligence. The Research and Performance Evaluation functions within the Office of Business Intelligence are the division's "data experts" and are responsible for defining performance metrics from data available from the shared data warehouse and other sources and presenting this information in audience-specific formats, with products ranging from high level slide presentations for senior level Governor's Office staff to detailed claims-based analysis in support of future policy making and fraud detection.

Another way we use data collected from the MCOs is for Performance Improvement Projects (PIPs), which are housed within the Office of Quality Assurance and the Office of Managed Long Term Services and Supports Quality Monitoring. A routine PIP cycle consists of baseline data followed by two remeasurement years where interventions are actively ongoing, and then a sustainability year to ensure that the interventions put into place are sustainable.

Performance Improvement Projects

The Division of Medical and Assistance and Health Services (DMAHS) is actively engaged in three clinical performance improvement projects (PIPs). In January 2017, Amerigroup initiated a non-collaborative Prenatal PIP with the focus on Reduction of Preterm Births. Amerigroup revised their aim statement and performance indicators from their initial project proposal in 2014, resulting in a new PIP cycle. During this annual review, Amerigroup submitted remeasurement and sustainability data, and will submit a final report in August 2020. Regarding the second PIP, in January 2018, Aetna (ABHNJ), Amerigroup (AGNJ), Horizon (HNJH), United (UHC), and WellCare (WCHP) initiated a PIP with the focus on Developmental Screening and Early Intervention. During this annual review, the MCOs submitted 2 years of remeasurement data. For the third PIP, in January 2019, all five MCOs initiated a collaborative PIP with a focus on Risk Behaviors and Depression in the Adolescent Population. During this annual review, the MCOs submitted baseline and remeasurement data.

IX. STC 73 (h): Monitoring of the Quality and Accuracy of Screening and Assessment of Participants who Qualify for HCBS/MLTSS

The NJ Aging and Disability Resource Connection (NJ ADRC) and the NJ Division of Disability Services (DDS) are the lead agencies responsible for screening non-MCO consumers seeking long term services and support. Through an intake process, consumers who trigger as at-risk for nursing home placement are encouraged to complete the Screen for Community Services (SCS) during the telephone call. The SCS identifies service needs, clinical needs, and potential Medicaid financial eligibility. Individuals who do not score as potentially eligible or without identified needs are provided Options Counseling and Information and Assistance (I&A) on all publicly funded long term services and supports. Individuals who score as potentially eligible are encouraged to accept a referral for a comprehensive assessment and to apply at their local County Welfare Agency for financial screening and application.

During the period of July 1, 2019 through June 30, 2020, the below statistical data identifies the number of SCS that resulted in referrals for comprehensive assessments. 54% of screens that identified at risk individuals were referred for comprehensive assessment based on consumer consent. This is a decrease from 71% last year although there was a noted significant increase from FY2017 (52%) to FY2018 (90%) which was attributed to the increased marketing and outreach efforts by the ADRCs as well as the discontinuation of presumptive eligibility for the state funded Jersey Assistance for Community Caregiving (JACC) program which occurred in April 2018. The current percentage is consistent with 2017 trends. The

state will monitor continued trends and continue efforts to identify the potential reasons for the variability.

SCS - I&A/Options Counseling	5,484
SCS – comprehensive assessment recommended	6,725
• SCS referred for comprehensive assessment	3,654
TOTAL	12,209

The NJ Family Care Managed Care Organizations (MCO) are the entities responsible for identifying and screening members who are identified as in need of long term services and supports. Members who screen positively or who request an assessment regardless of outcome are referred for a comprehensive assessment. The SCS has been shared with the MCOs for their programming and use and effective January 1, 2020 is a state mandated tool. Reports are pending development for inclusion of MCO screenings in future reports.

The Department of Human Services (DHS) utilizes a standardized comprehensive assessment to determine clinical eligibility for nursing facility level of care which is required for MLTSS eligibility. The standardized assessment is the interRAI Home Care Assessment, Version 9.1 which is referred to as "NJ Choice HC". The NJ Choice HC is a comprehensive assessment and algorithms which identifies Care Assessment Protocols (CAP) which guide care planning.

Effective March 1, 2020, NJ received a waiver under Section 1135 of the Social Security Act from CMS on the completion of initial and annual level of care assessments as a result of COVID-19 state of emergency. All face to face assessments and visits for MLTSS members were suspended and alternate processes developed for the assessment of individuals newly seeking MLTSS enrollment. As a result of the suspension of assessments from 3/1 to the end of this reporting period of 6/30, there is a significant decrease in the overall assessment submissions, outcomes, and audit results. Therefore, there is no analysis of the change from one demonstration period to another and reporting will be limited to the number of assessments and outcomes.

During the period of July 1, 2019 through June 30, 2020, 48,161 assessments for MLTSS level of care determination were submitted. 47,018 assessments for MLTSS level of care determination (97.63%) were reviewed and a determination provided for existing MCO members.

The final level of care determination was 10,102 Authorized with full review (20.98%), 36,193 authorized without review (75.15%) and 277 Denied (0.58%). 723 assessments (1.50%) were not provided a determination through the review process and are labeled as "Not Authorized". OCCO conducts reassessments for these members. This rate is below 2% which is within the state expected range. There were 1,143 assessment submissions that were unable to be determined; these consisted of duplicate submissions, request that MCO conduct a new assessment, outcome pending more information/screening by another entity (i.e. DDD), or other non-determination outcome. This represents 11.10% of submissions requesting a determination. DoAS distributes these reports to the MCOs annually and reviews overall trends at a care management meeting with a discussion on quality oversight best practices to reduce the percentage of non-determinations.

Effective February 1, 2017, the Department changed its internal policy of reviewing 100 percent of the MCO annual reassessments for existing MLTSS members to an "Authorization without Review" and auditing process. This allows the State to enter continued clinical eligibility upon receipt of the assessment

without a review of the assessment. The State's role in review and determination has been to ensure that assessment and clinical eligibility determinations are completed accurately and in accordance with policy and regulatory requirements. Through ongoing training and quality assurance oversight, the review and determination process has an overall authorization rate of 97.63% and a less than 1% denial rate. The not authorized outcome percentages have stabilized in the 2% of lower range which is well within the initial established benchmark which was dropped from 7% to 5% effective July 1, 2018 based on continual improvement.

Individuals who do not qualify for the Authorization without Review process and require full review and determination by the State are:

1. MLTSS members who no longer appear to meet Nursing Facility Level of Care
2. MLTSS enrolled Youth aged 20 and younger
3. MLTSS members seeking a change in Level of Care Need
4. MLTSS members who require Cost Effectiveness IDT
5. Members seeking MLTSS enrollment including those in nursing facilities or special care nursing facilities
6. Members seeking DDD Demonstration enrollment for Supports Plus PDN
7. MLTSS Members previously Not Authorized or Denied by OCCO who now meet NF LOC as a result of a significant change in condition

The MCO is the responsible entity for identifying the criteria and identifying what level of review is required by the State through the assessment submission process. Various quality processes are in place to ensure authorization without review are appropriate including 1) MLTSS enrollment status is validated prior to entering the continued clinical eligibility, 2) evidence of prior clinical eligibility is validated prior to entering the continued clinical eligibility, 3) Monthly auditing of a sample of submitted records. The State may review any assessment submission at its discretion for any reason.

The State has conducted 3475 random audits - 9.6% of submissions - on assessments not subject to review between July 1, 2019 and June 30, 2020. Statewide, 1.30% of audits were deemed "unsatisfactory" which is a reduction from the prior year rate of 2.35%. Unsatisfactory is defined as an assessment which does not meet one or more of the following criteria: 1) Nursing facility level of care was not able to be validated; 2) Special care nursing facility level of care was not able to be validated; 3) Assessor not registered as certified to conduct assessment in State's database; 4) assessment was not appropriate for the "authorization without review" process. In the event of an unsatisfactory audit, a full review is conducted and appropriate action taken. The State will continue to audit monthly and continue technical assistance and training for the MCOs on identified areas of weakness to improve accuracy and quality of the Authorization without Review process.

NJ Choice HC Recertification

Individuals who conduct assessment utilizing the state's standardized assessment tool are required to undergo recertification and demonstrate competency every three years. The recertification for all stakeholders conducting NJ Choice assessment including the MCOs was held in February 2018. MCO Care Management Supervisors and Master Trainers were the target audience. The MCOs then conduct training for their employees and submit the results to the State. A yearly quality monitoring component was added to the recertification training. All assessors are required to have field supervision conducted by a supervisor or designee which includes 1) observation and oversight of two assessments conducted in the

field which includes feedback on skill level and proficiency and 2) ongoing chart reviews of assessments. The quality monitoring must be conducted yearly and be attested to on the recertification request. The Division of Aging Services (DoAS) has conducted observations of the MCO recertification trainings in 2018 and provided feedback on the MCO training processes.

The DoAS is in the process of developing the 2021 recertification training which is expected to be provided via remote learning due to continued COVID-19 restrictions in NJ.

Supports Program/Community Care Program

DDD's assessment tool, the New Jersey Comprehensive Assessment Tool (NJ CAT), was conducted through an electronic process and was completed by an individual that is knowledgeable about the service recipient. The Division shifted into conducting these assessments in person rather than through an electronic paper process. DDD staff participated in a classroom training by the New Jersey Institute of Technology on May 22, 2019 on how to conduct the NJ CAT which was followed-up with by hands-on mentoring during the months of July and August 2019 to ensure inter-rater reliability. The assessment questions continue to answered by an individual that is knowledgeable about the service recipient, but it is expected that the by completing the assessment in person it will strengthen the validity of the responses. In addition to the clinical assessment being conducted in person, a check is completed by State staff to ensure that all Demonstration Program criteria are met for eligibility. This includes items like: age, Medicaid eligibility, living arrangement, if they are on another waiver program, etc. In addition to verifying the accuracy of screening and assessment of participants at the time of enrollment DDD conducts monthly audits to check the ongoing eligibility criteria. In addition to DDD's internal monitoring, Medicaid conducts an annual audit as well as the external auditors. However, effective mid-March 2020 these assessments were returned to being completed over the phone as a result of COVID-19 and approval by CMS in NJ's Appendix K submission.

ASD Pilot, I/DD-MI Pilot Program, Serious Emotional Disturbance Program:

DCF/CSOC's Contracted System Administrator (CSA) promotes improved outcomes for youth and their family/caregivers through utilization management, care coordination, quality management, and information management processes.

CSOC's CSA provides a 24/7 single point of access to care for youth, families and caregivers living in New Jersey. The CSA performs a broad range of administrative service not limited to the following:

A. Providing a Customer Service Call Center with 24/7 intake and Customer Service capability;

B. Providing a web-based application that interfaces with the CSA's Management Information System (MIS);

C. Utilization management and prior authorization;

D. Coordinating access to services for youth, and;

E. Providing Quality and Outcomes Management, and System Measurement that supports CSOC's goal to promote best practices and providing assistance to the State in assuring compliance with State and federal guidelines.

CSOC collaborates with the State's Medicaid authority, the Department of Human Services, Division of Medial Assistance and Health Services to provide oversight of the Children's Support Services Program Intellectual and or Developmental Disabilities (CSSP I/DD) and the *Autism Spectrum Disorder (ASD) pilot.

To ensure that youth are appropriately identified for demonstration enrollment, an eligibility algorithm was developed in collaboration with the CSA to identify youth. Youth that meet the demonstration criteria are enrolled into either the Autism Spectrum Disorder (ASD) pilot or the Children's Support Program Intellectual Disabilities/Developmental Disabilities (CSSP I/DD) if they meet the criteria for the program. The demonstration algorithm identifies eligible youth and supports CSOC claiming Federal Financial Participation (FFP) for demonstration services.

All demonstration enrolled youth are authorized at a minimum for Care Management Organization (CMO) services. The CMO are independent, community-based organizations that provide service linkage, advocacy, monitoring, individualized service plan development and assessment. Care management provides accountability to ensure services are accessed, coordinated, and delivered in a strength based, individualized, youth focused, family driven, ethnically, culturally, and linguistically relevant manner. CMOs coordinate Child Family Team (CFT) meetings and implement Individual Service Plans (ISP) for each youth and his/her family/caregiver. They coordinate the delivery of services and supports needed to maintain stability and progress towards goals for each youth, utilizing a Wraparound approach to planning.

The CFT is an on-going coordinated process that includes participation from the youth, the youth's family/caregiver, the CMO care manager, and any other individual identified by the youth and family/caregiver to help support the family/caregiver towards sustainable plan of care. The CFT meets, at minimum, every 90 days or as needed. Through the CFT process, strengths and needs are identified, progress and barriers to care, and services to be implemented. Once identified, the request is added to the youth's individual treatment (care) plan, which is reviewed by CSA's clinical staff. Clinically appropriate services are authorized by the CSA. If at any time during the CFT process it is determined that the youth no longer requires a service, that service will end.

On April 1, 2020, the Autism benefit transitioned from the Children's System of Care (CSOC) and from under the Autism Spectrum Disorder (ASD) pilot, and became a state plan benefit implemented through Medicaid's Managed Care Organizations (MCOs). As of this date, CSOC no longer had the authority to receive federal participation on these services and did not enroll any youth in the ASD pilot after March 31, 2020. Please note that CSOC does continue to offer these services to non-Medicaid eligible youth that meet medical necessity at the full cost of the state.

X. STC 73 (i): GEO Access Reports from Each Participating MCO

The Geo Access Report Summary is located under Attachment B.

XI. STC 73 (j) Waiting List(s) Information by Program Including Number of People on the List and the Amount of Time it Takes to Reach the Top of the List Where Applicable

There are currently no waiting lists being used under the demonstration.

XII. STC 73 (k): The Various Service Modalities Employed by the State, Including Updated Service Models, Opportunities for Self-direction in Additional Program, etc.

Along with streamlining administrative inefficiencies, the Comprehensive Demonstration also allowed the State to give different groups of individuals access to more services through MLTSS, and provide more services to children through the ASD, SED, and ID/DD-MI programs. The implementation of the Supports Program in demonstration year 5 is also giving the State the ability to provide home and community based services to developmentally or intellectually disabled individuals who do not meet institutional level of care, however, without these supports would likely deteriorate and would need institutional services.

The services in MLTSS were available prior to implementation; however, these services were only accessible depending on which waiver the individual was in. MLTSS combined four 1915(c) waivers and allowed individuals in those programs access to all available services. For example, private duty nursing services were only accessible in the Global Options (GO) waiver and the Community Resources for Persons with Disabilities (CRPD) waiver prior to implementation of MLTSS. Now individuals who would have been enrolled in the Traumatic Brain Injury (TBI) or AIDS Community Care Alternative Program (ACCAP) waivers can now access private duty nursing services. MLTSS removed the silos of services that were created with the individual 1915(c) waivers.

The Supports Program(SP) is the primary demonstration program that ID/DD young adults enter upon high school graduation. The SP services traditionally replace the educational entitlement with day services such as employment, career planning, day habilitation and pre-vocational services. However, the SP did not offer ID/DD young adults with complex medical needs access to private duty nursing (PDN) which was an entitlement as a youth under early and periodic, screening, diagnostic and treatment (EPSDT). An additional barrier was that EPSDT ends on a young adult's 21st birthday, not upon graduation, and DDD waiver services are not available for a young adult until they are outside of their educational entitlement. However, DDD and Medicaid worked with CMS to allow this smaller sub-population within the SP to access PDN services from the MLTSS program. All other SP services become available upon graduation and enrollment onto the SP. This change has ensured the continuity of care for the individual during the gap months of their 21st birthday, graduation, and enrollment onto the SP program. DDD worked closely with the Division of Children and Families, and the Division of Medical Assistance and Health Services, and the Managed Care Organizations to coordinate these services from one funding steam to another without gaps in service delivery so the transition for the young adults and their families would be seamless. DDD continues to meet regularly with DMAHS and the Managed Care Organizations to review and streamline the process.

Both DDD's Community Care Program and Supports Programs offer opportunities for self-direction. Self-directed options provide a portable budget allowing families to identify not only what services they need, but to also identify how much of each service they need. DDD has conducted some preliminary analysis and it seems that many individuals are choosing to self-direct some services, but are also

electing to purchase some provider managed services. For example, an individual may choose to attend a traditional provider managed day program 3 days a week, but are self-directing the other two days a week by attending classes in the community or seeking employment/volunteering in the community. Another example is where an individual chooses to attend a traditional day services provider during day hours, but hires a self-directed employee to assist them at their home and in the community during early evening and evening hours. DDD will continue to collect data on how individuals choose to use their budgets in the next demonstration year.

XIII. STC 73 (l): Specific Examples of How HCBS Has Been Used to Assist Participants

Managed Long-Term Services and Supports:

Below are specific examples of how HCBS has been used to assist Medicaid beneficiaries in New Jersey.

WellCare:

History: E.E was shot in the back in drive-by gang activity. He was left paralyzed from the waist down and dependent on a wheel chair to get around.

E. E. was referred to WellCare's Housing Specialist, for support as he had nowhere to live and was staying with his mother at her senior building apartment illegally. This living arrangement risked his mother losing her apartment in the building.

The Housing Specialist assisted E.E. with completing multiple housing applications and with getting him on a waiting list for the same apartment complex as his mother. Based on the positive and collaborative relationship between the Housing Specialist and the Property Manager, E.E. was placed as a priority on the waiting list. E.E did eventually move out of his mother's apartment and into a Nursing facility due to sacral wound issues. WellCare housing staff assisted E.E. with obtaining a housing voucher. An IDT was arranged with E.E when his voucher was approved to discuss discharge planning for when he received an apartment.

The Housing Specialist was able to secure a one bedroom unit and E.E. was finally going to have his own apartment where he would be able to have his daughter visit and spend quality time with her.

Another IDT meeting was held with WellCare Housing and care management staff, and E.E in order to ensure there was a safe discharge plan for the transition. The Care Manager ensured all the necessary services and equipment that the member required were in place for his discharge home.

When the COVID pandemic struck, the transition team made further efforts to ensure that E.E. was able to successfully transition to his new apartment. WellCare's discharge team, care management team and housing team all worked together to make sure the apartment was fully furnished and ready for his return home. Safety measures were taken by this team such as wearing gloves, masks, and carrying hand sanitizer at all times throughout the move. E.E. was moved to his new home on 3/23/2020 after residing at the nursing facility for 8 months. Presently, E.E. is still happily residing at the same apartment and continues to have visits with his daughter.

United:

UHC member V.R.'s previous care manager worked with the member on using I Choose Home of NJ program (also known as Money Follows the Person) and participated in the IDT discussions with

member, nursing facility staff, and the nurse from the Office of Community Choice Options - Money Follows the Person. A new care manager took over and assisted the member to continue the process. Through this process, V.R. identified, applied for, and eventually obtained an apartment. V.R. moved home to his new apartment on May 29, 2020. The case manager confirmed that he had furnishings, housewares, and meal service delivery via Mom's Meals. The social worker at the nursing home had ordered skilled services and DME. In addition, the case manager was informed that member recently experienced the death of a close friend from COVID-19 and was experiencing grief issues. In response, the case manager referred V.R. to the UHC Behavioral Health Coordinator to round out member's service and ensure that whole person care is involved. It took teamwork and good care management to successfully transition this member home during the COVID crisis.

Horizon:

A MLTSS member who resided at a LTC facility for many years in Hunterdon County was a loved patient at her facility and quickly became family to many of the staff and other patients around her. In early April, the Horizon MLTSS Care Manager received call from family stating their concerns regarding the Covid-19 pandemic. At the time the member's facility had numerous cases of COVID-19 and despite the facilities' efforts to contain the virus, an outbreak had started to occur. Due to the above the family had requested a leave of absence (LOA) from the facility where the member would be able to return to community without penalty. The Horizon Care Manager provided options counseling with members' family and reviewed services that would be available to the member while she resided in community. In a joint effort with the state of NJ, a 30 day leave of absence was approved starting April 4, 2020. The member was moved successfully from her LTC facility (and second home) to her daughter's home.

After the initial 30 day LOA it was noted by the Horizon Care Manager and the member's family that the member was having success at home in the community. Member's daughter reported that the member was enthused to be with family at this time of crisis in the world and that all member's ADLs were being met by the care of her daughter. An additional 30 day LOA was requested by the family. The Horizon Care Manager discussed with the family the possibility of making the member's transition to community permanent. The Member and family agreed that member is thriving at home. The Horizon Care Manager then set up the MLTSS services of Personal Emergency Response System, Residential Modifications and Home Delivered Meals. The Horizon Care Manager also coordinated access to Durable Medical Equipment available through the State Plan. As of early May the Member is continuing to thrive in the community with the support of MLTSS services and her family.

Amerigroup:

On March 25th, 2020 an Amerigroup care manager received a call from GA's family who indicated that GA has been bedridden for the past few days, appears confused and is no longer verbally communicative. Repeated calls to her PCP by Amerigroup as well as the member's children have not been returned. In addition, repeated calls to emergency services were triaged as the family was instructed to keep GA home as she did not exhibit any signs associated with COVID 19. GA's Amerigroup care manager placed a call to the PCP's office and informed the staff of member's current status and her direct contact information. The care manager then called the local police department and informed them of the member's condition and impressed upon them that GA needed to be transferred to the ER due to unstable health status. The police department dispatched EMS right away and member was taken to the hospital for treatment. The Amerigroup care manager spoke to the PCP and updated the

doctor with the status of the member. GA was experiencing side effects from the many medications she receives and was not tested for COVID-19 at the hospital.

GA returned home and is now stable. She expressed much gratitude to the care manager in intervening to obtain the emergency care she needed. She is now eating, talking and walking. Amerigroup confirmed no additional services were needed at this time, the member resumed her regular schedule of HCBS services; PCA and Personal Emergency Response System. Care manager educated family/caregivers on the importance of medication management and to advise the PCP if member demonstrates any COVID-19 symptoms.

Aetna:

Member is a 46 year-old female who is diagnosed with multiple behavioral health and medical conditions.

Member has been enrolled since January 1, 2018. Member had her own apartment but due to issues with her landlord, she moved into her mother's basement. Member was very distraught over this and stated that she was unable to focus on any of her healthcare concerns until her apartment situation was addressed.

Concerns: Member was very upset about her housing situation. She stated that she did not want to work on her health until her housing situation was addressed. Member was unwilling to find a new PCP in spite of disliking her current PCP. The member was also unwilling to work with a Mental Health Therapist due to her concerns about obtaining a new apartment.

Care Manager Intervention: CM collaborated with Aetna member advocate, Community Caseworker, Housing Authority Representative (HUD) and member's lawyer. The CM also collaborated with Aetna BH team to provide co-case management for the member.

The member's apartment was under a HUD voucher. The member advocate worked with HUD representative and received approval for members voucher to be transferred to the township where the member requested to relocate.

Member was able to find a first-floor apartment in Roselle Park where she desired to relocate. The CM and Member Advocate worked with member's landlord and HUD to ensure member did not incur any fees associated with early termination of lease.

Outcomes: Member has now moved into her new apartment. She is now willing and open to working with Aetna Behavioral Health (BH) team to discuss seeing a therapist, member was provided with a list of primary care providers in her area. Member has not yet selected a BH therapist, however member continues to work with ABHNJ BH team. Member is also now willing to work on other health related goals as her housing issues have been resolved. The member is thankful that she back in an apartment of her own and is looking forward to a positive future.

Children System of Care Programs

The Children's System of Care (CSOC) is pleased to share the following stories received from the Care Management Organizations (CMOs) that detail, in their own words and the words of their family, the impact demonstration services have on the quality of life for the youth and their family or caregiver.

B. S. is a 10-year-old youth enrolled in the I/DD demonstration that was referred to the Care Management Organization (CMO) in March of 2018. At the time of referral, the youth was having a difficult time following his mother's redirection and would often become aggressive by hitting himself, having tantrums, screaming, running around in the home, and being physically aggressive with family members. The youth was difficult to manage given his size and strength.

Individual Support Services (ISS) providers began working with the youth in July 2019. Since this time, the ISS providers were able to teach the parents how to set limits and provide structure so that the youth could better learn independent skills and understand redirection. The youth has made substantial progress due to the ISS technicians' interventions with both the youth and parents. The youth is now engaging with all providers and tantrums have significantly decreased. He is utilizing technology with more restrictions and time frames. As a result, his behaviors have improved, his impulse control is better managed, tantrums have minimized, and he is able to deal with his frustrations. At this time, the youth does not require prompting during shower time as he is now able to do it on his own without being told. Youth is now flushing toilet and washing his hands independently. Additionally, the family continues to be engaged in Intensive in Home -Clinical (IIH-Clinical) services and it is reported by the clinician that youth is engaging during these sessions with the family.

D. T. is an 11-year-old youth that was enrolled in the CMO in May of 2016. During this reporting period, the youth was initially enrolled in the ASD pilot and was later transferred to the I/DD demonstration. The youth's behaviors included self-injurious activities, and aggression. He would attempt to scratch others in the home, scratch himself and or dig his finger onto hard surfaces to the point where he was at risk for breaking or dislocating his fingers. He would also engage in daily tantrums, which included screaming, crying, biting, and more scratching. The family reported that it was difficult for them to redirect the youth, especially when his routine was disrupted.

Upon referral to CMO services, the youth did not have or use an effective communication device. As a non-verbal youth, he would typically express his emotions with smiling, frowning, crying, etc. The family was also not involved in any community activities as the youth was sensitivity to loud noises and would elope in the community when he heard a loud noise (i.e. trucks, motorcycles, etc.).

Over the course of Intensive in Home – Behavioral (IIH-B) services, the youth and his family built a strong rapport with their Board-Certified Behavioral Analysis (BCBA/ABA) and Behavioral Technician (BT). Over the past few years, the intensity and frequency of his tantrums has significantly decreased. The youth now has an iPad and is working on functional communication and expressive language. The family reports that they have seen huge progress using his iPad for communication. The BCBA also keeps in regular contact with the school, to ensure that his program is similar in both environments. IIH-B services continue to work on an activity schedule, independence with ADL's, pre-vocational skills, and community safety/awareness. The BCBA has been incorporating more sensory activities for the youth and states that he seems to really be enjoying them. Additionally, the youth is now able to attend Chuck E Cheese (pizza entertainment center) once a month on Sunday's and began attending SkyZone (indoor trampoline park) once a month on Monday's. He was also able to attend a summer camp last summer for one full week.

Due to the consistency in service providers and the involvement and dedication of the youth and family, his service plan with IIH-B services has been hugely successful and the youth was successfully transitioned out of CMO in June 2020.

K.B. is a 17-year-old youth enrolled in the I/DD demonstration that was referred to CMO services by his mother in February 2019. She was seeking Applied Behavioral Analysis (ABA) services for his physical

aggression in the home. The youth's parent stated that during these aggressive episodes, he caused property damage such as throwing objects or punching holes in the walls. The youth's parent stated that a typical day for him includes daily verbal prompting to wake him up for school and assistance with Activities of Daily Living (ADLs) skills. The youth's parent also had significant concerns about his safety.

During CMO involvement, the CMO successfully linked the family to a provider to secure the necessary ABA supports for the youth to decrease his aggression in the home. The ABA providers have implemented strategies on following a daily schedule (especially in the morning for school), ADL skills (brushing his teeth, washing his face, cleaning thoroughly) and increasing his functional communication with transition cues with an iPad. In addition, providers are incorporating yoga for relaxation for further assistance with decreasing the youth's aggression, which he enjoys. The youth's parent expressed that they are extremely grateful for the services provided by the team and are very optimistic about his future. The youth successfully transitioned out of CMO services in July 2020.

C. W. is a 14-year-old youth that is enrolled in the I/DD demonstration and was referred to the CMO in August of 2016. Upon referral to CMO, his mother's primary concern was his inability to function independent of his caregiver's support for all his Activities of Daily Living (ADLs). The youth was reported to perform well in school and was able to complete toileting functions with support. The challenge for the family was transferring those skills to the home. The youth's mother attempted to support him with development of independent skill, but it was reported the process resulted in him and his mother becoming frustrated.

The Child Family Team (CFT) agreed that the youth would benefit from utilization of Individual Support Services (ISS). The Behavioral Technician (BT) worked closely with parent and youth and over time the youth improved in his ability to communicate, toilet with less physical assistance, brush his teeth and complete simple household tasks. The youth was less reactive in the home and it became easier for his family to manage him in the home and community setting. The youth's mother was pleased with the outcome and decided to transition youth from ISS and CMO services as youth had met the family vision of decreasing his impulsive behaviors and being more independent with his self-care.

The youth was successfully transitioned from CMO services in November 2019. To date, the youth continues to reside at home with his mother and older brother, with whom he has established a bond. The youth's mother reports that the youth responds well to the family and there are no concerns regarding his living environment.

H.J. is a 9-year-old youth that was referred to the CMO in February of 2018. The youth was displaying aggression towards caregivers, not following directions, had limited communication and the caregivers had very few strategies that they were implementing to better address the youth's needs.

Upon implementing Intensive in Home – Clinical (IIH-C), the family was very engaged, and the parents were able to learn strategies. The youth was making small progress with her ability to communicate with sign language and PECS. The youth also was making progress with decreasing her aggression once she was able to better express herself using PECS, gestures and increasing use of sign language, which is also used in the school setting. The team was able to increase her strengths and identified additional strengths of hers such as her enjoyment of going to parks and walking in the neighborhood. The IIH clinician was able to provide parent with strategies and tools to address youth becoming more independent to empower youth and family. IIH has also provided the family with structure and routine chart which benefited youth once she returned from school to ensure consistency with youth.

IIH services have successfully addressed family relationships and ensuring consistency throughout all family members. Youth has been stable with little to no aggression, has been able to express herself, increased her patience level, and is more independent. The team agreed that due to youth's progress, the youth would transition out of the CMO in May of 2020.

C.A. is an 11-year-old youth that was referred to the CMO in November of 2018. The CMO originally opened with the family due to youth's behaviors in the home and in the community. The youth would have temper tantrums, cry, and fall to the ground. Since Intensive in Home – Clinical (IIH-C) was implemented, the family has developed a routine in the home that establishes breaks, time outs, and rewards system. IIH-C also worked with youth on expressing herself when she feels upset or uncomfortable. Due to the goals that have been met, the caregiver feels more confident in redirecting behaviors. The behaviors that existed at the beginning of CMO services are now nonexistent. Caregiver has also implemented a routine in the home that incorporates timed breaks and free time for youth. Youth is still very shy and quiet but understands the importance of talking to an adult when something is upsetting her. The caregiver has also developed a good relationship with the teacher and transportation staff that keep her updated on any changes. Due to the elimination of the youth's behaviors and the strategies that the caregiver has learned, the youth was successfully transitioned from CMO services in January 2020.

C.G. is a 6-year-old male that was referred to the CMO in July of 2017, due to frequent tantrums, limited verbal ability, struggling in school, and needing assistance with Activities of Daily Living (ADLs). The Child Family Team (CFT) first implemented Intensive in Home - Clinical (IIH-C) services for 2 hours per week. The IIH-C clinician worked with the parents to set up and implement a token reward system that helped the youth identify more than one preferred activity (which was using the phone/iPad) and to complete tasks before receiving a reward.

After 9 months of IIH-C services, the team decided to implement Individual Support Services (ISS) for 8 hours per week. The ISS providers have helped this youth and family make great progress in the area of toileting (now able to use verbal prompts instead of physical assistance), has expanded the menu of foods that he will eat, an increased awareness of safety, and increase in verbal skills. The CFT also worked on collaborating with the youth's school district and an out of district school placement was implemented. The new school has been an active part of the team and provided in home support to help the family set up the same token/reward system used successfully in school.

Despite a lapse in services due to COVID-19, the youth continues to make progress with the help of consistent ISS providers. The youth's ISS services (8 hours per week) resumed in person in July, when he started working with a new provider and they are developing a nice rapport. The youth can now dress himself with verbal prompting only, his speech has significantly increased over the last six months and he is able to request his wants and needs very clearly, almost speaking in full sentences. Additionally, the youth can follow multiple step commands and is able to wear a mask for a half hour!

Supports Program/Community Care Program

The addition of a second demonstration program, Supports Program including the Supports Program + PDN, as well as the movement of the Community Care Waiver into the 1115 has resulted in countless stories of how much better service recipients lives are. Examples include how the addition of services such as therapies and behavioral supports have changed the quality of life for individuals. Families have stated that these services, especially the behavioral supports, are instrumental in allowing individuals to

remain in their own homes rather than having to be placed in a provider's residential setting. Families have also stated that therapies have always been available only through the state plan. The issue families of this population faced was that the state plan only allowed for rehabilitative therapy and it was time limited. The addition of habilitative therapies into the demonstration allowed them to receive on-going maintenance therapy which aids in maintaining range of motion, etc. Many individuals have been able to benefit from adaptive equipment and habilitative physical and occupational therapy. Families have also provided positive feedback related to the Goods and Services demonstration service. One individual who was graduating and entering the adult system was no longer going to be able to access an adaptive tricycle that was available to him for use at his school. A request for this item was submitted to the Goods and Services' review team who was able to approve the request once all required paperwork was received. This individual's family sent a photo of him on his tricycle and stated that this adaptive tricycle had changed his life. He was using it to ride around his community allowing him to develop relationships with his neighbors. The family also stated that in addition to the joy he receives from being a little more independent it is offering a great form of exercise for him as well as reducing behaviors due to the ability to go out on his tricycle to calm down. This year many family members also indicated how remote services were working well for their loved ones and afforded them the opportunity to stay connected to their day service programs and enjoy new opportunities for remote classes.

Additional positive feedback has been received from individuals and families around assigning a budget based on need and one that is portable. Individuals need to operate within their assigned budget, but they can purchase the demonstration services that best meet their needs as well as the amount of service needed. Individuals also choose if they want to receive services from a traditional provider or if they want to hire their own employees and self-direct their services. Individuals may also choose to self-direct some services and receive some services in a more traditional provider managed setting.

STC 73 (m) A description of the intersection between demonstration MLTSS and any other state programs or services aimed at assisting high-needs populations and rebalancing institutional expenditures (e.g. New Jersey's Money Follows the Person demonstration, other federal grants, optional Medicaid Health Home benefit, behavioral health programs, etc.);

The NJ Department of Human Services continues to participate in the Money Follows the Person (MFP) demonstration program. The Division of Aging Services (DoAS) is the lead agency for MFP nursing facility transitions and continues to collaborate with the MCOs on these transitions as well as the below identified responsibilities.

- Promote, identify, and facilitate nursing home transitions for individuals that reside in the nursing facility under Medicaid fee for service (grandfathered population; those pending MCO enrollment)
- Train the MCO staff on all aspects of nursing facility transitions
- Serve as subject matter experts at IDT meetings facilitated by MCO care managers
- Train MCO staff on housing resources
- Receive and follow up on Section Q referrals
    - DoAS is the state designated agency for Section Q
- Train nursing facility staff and helping to identify resources for discharge planning.

- Identify eligible individuals, assist in transitions and track inventory of units for the Money Follows the Person Housing Partnership Program which utilizes rebalancing dollars to set aside apartments for nursing home transitions
- Utilize and track NED2 and 811 Mainstream vouchers
    - Identify eligible individuals, identify housing resources and facilitate lease up process other voucher programs, such as 811 Mainstream program

Through CMS approval, the MCO contract was amended in July 2017 requiring the MCO to staff a dedicated Housing Specialist(s) who will be responsible for helping to identify, secure, and maintain community-based housing for MLTSS members. Application fees for apartments are covered under the allowable Community Transition Services. The Housing Specialist must be familiar with relevant public and private housing resources and stakeholders, including but not limited to HUD subsidized housing, all Department of Community Affairs (DCA), New Jersey Housing and Mortgage Finance Agency (NJ HMFA) housing program voucher programs, public housing authorities, realtors, and online housing locator resources.

A standardized quarterly housing report template was developed and implemented on April 1, 2019. This report collects information related to three primary goals: 1) Establish and foster strong relationships with individuals/entities that connect with, provide or maintain housing or housing-related benefits or services; 2) Increase housing capacity and access to housing resources within the MCO for individuals participating in LTSS programs; and 3) MCO leadership will take a proactive approach to increasing affordable and accessible housing stock for individuals participating in LTSS programs. The reports indicate that housing specialists at MCOs have allowed MCOs to more effectively support housing needs of members seeking to obtain and maintain tenancy, develop relationships between MCO and housing developers and develop relationships with non-traditional providers who assist with member housing-related issues. However, they also indicate significant outstanding unmet need, and further opportunities to better address housing needs of beneficiaries.

DoAS is currently the lead for facilitating the assignment and utilization of sixty (60) Non-Elderly Disabled (NED) Category 2 housing vouchers in collaboration with the NJ Department of Community Affairs (DCA). In late 2018 and early 2019, NJ's MFP Program was offered thirty-nine (39) 811 Mainstream vouchers from the DCA for nursing home residents. DoAS receives referrals from the MFP assigned staff through nursing facilities including Section Q referrals, community providers, and NJ FamilyCare MCOs. Individuals are assisted with applications which are then forwarded to DCA for processing. MFP continues to outreach to other local Public Housing Authorities (PHA) for additional 811 mainstream voucher opportunities.

Money Follows the Person/Nursing Facility Transitions

New Jersey participates in the federal MFP demonstration project that assists Medicaid eligible individuals who meet MFP eligibility requirements to transition from institutions to the community in order to improve community based systems of long-term care for low-income seniors and individuals with disabilities. Under MLTSS, Nursing Facility Transition refers to the process applicable to all MLTSS Members who are currently residing in a NF/SCNF facility regardless of the length of time the Member has been in the facility. The managed care organizations (MCOs) are responsible for NF/SCNF transition planning and the cost of all assessed transitional service needs. The State is responsible for identifying FFS members and counseling them on enrolling in MLTSS in order to facilitate transition, providing guidance as needed to the MCOs, and tracking and completing Money Follows the Person (MFP) requirements for

qualified NF/SCNF residents as identified by the MCO or the State for the MFP demonstration. The Office of Community Choice Options or its designee shall participate in all MFP transitions.

First Quarter July 2019- Sept 2019

MCO	# of Transitions
Aetna	10
Amerigroup	21
Horizon	113
United Health Care	9
Wellcare	9
Quarter Total	**162**

Second Quarter Oct 201- Dec 2019

MCO	# of Transitions
Aetna	13
Amerigroup	16
Horizon	106
United Health Care	14
Wellcare	7
2Quarter Total	**156**

Third Quarter Jan 2020- March 2020

MCO	# of Transitions
Aetna	14
Amerigroup	8
Horizon	134
United Health Care	10
Wellcare	6
Quarter Total	**172**

Fourth Quarter April 2020- June 2020

MCO	# of Transitions
Aetna	25
Amerigroup	19
Horizon	100
United Health Care	4
Wellcare	3
Quarter Total	**151**

Grand Totals for DY

MCO	# of Transitions
Aetna	62
Amerigroup	64
Horizon	453
United Health Care	37
Wellcare	25
Grand Total	**641**

PACE

Under the Comprehensive demonstration, individuals who qualify for MLTSS may select NJ FamilyCare Managed Care Organizations (MCOs) for Managed Long Term Services and Supports (MLTSSO) or the Program of All-Inclusive Care for the Elderly (PACE) program. A PACE organization coordinates and provides all Medicare and NJ FamilyCare services, including nursing facility care and prescription drugs. Many participants are transported to a PACE center to receive services in addition to receiving services in the home as needed. To participate in the PACE program, a person must be 55 years of age or older and are able to live safely in the community at the time of enrollment. There are currently six PACE organizations in ten counties.

PACE in New Jersey	
NAME	**COUNTIES**
Trinity Health LIFE -	Camden; parts of Burlington
Lutheran Senior LIFE -	Hudson
LIFE St. Francis -	Mercer; parts of Burlington
Inspira LIFE -	Cumberland, Gloucester, Salem
Beacon of LIFE –	Monmouth
AtlantiCare LIFE Connection	Atlantic; Cape May

	BEACON OF LIFE	TRINITY HEALTH LIFE	LUTHERAN SENIOR LIFE	INSPIRA LIFE	LIFE ST. FRANCIS	ATLANTICARE LIFE	Total State Enrollment

Avg. Monthly Enrollment SFY17	56	224	132	229	305	N/A	946
Avg. Monthly Enrollment SFY18	88	220	130	259	321	25	1043
Avg. Monthly Enrollment SFY19	114	215	128	275	334	65	1161
Avg. Monthly Enrollment SFY20	137	215	126	274	346	93	1191

PACE Initiatives during DY8:

- Six established PACE programs are currently serving approximately 1,167 participants.
- Union, Ocean and Essex Counties have been awarded to applicants. Opening of these county specific sites is expected in 2021 and later.

XV. STC 73 (n) A summary of the outcomes of the state's Quality Strategy for HCBS

Children System of Care

Performance Measures

Please refer to attachment C.1 for summary data on CSOC's performance measures.

Comprehensive Audit

The Comprehensive Audit of Autism Spectrum Disorder (ASD) Program, Children's Support Services Program for youth with Intellectual/Developmental Disabilities (I/DD), and Supports Program was conducted for 2018CY by the Division of Medical Assistance and Health Services' Quality Management Unit (QMU). The QMU monitors adherence of Children's System of Care (CSOC) and Division of Developmental Disabilities (DDD) to their quality management strategies through evaluation of level of

care determinations, responsiveness of plans of care to participants' needs, verification of providers qualifications, health and welfare assessment, and fiscal accountability.

Community Care Program (CCP) administered by DDD was included into the Comprehensive Medicaid Demonstration on November 1, 2017. The audit of this program conducted for calendar year 2018 is not finalized due to public health emergency of COVID-19, however, audit activities are to resume at this time to allow for completion of the previously conducted audits. The CCP audit is expected to conclude by the end of 2020 calendar year.

CSOC Audit

Key Elements Identified:

- Health and Welfare: one sub assurance did not meet the 86% threshold (unusual incident reporting)
- Qualified Providers: two sub assurances did not meet the 86% threshold (monitoring of qualified provider status and required trainings)

CSOC Response:

- Health and Welfare: CSOC provided rationale for each unusual incident identified in QMU's audit. CSOC's process for reporting incidents is currently being revised so that incidents reported to the Screening Central Registry (SCR) and the unusual incident reporting (UIR) system will be monitored more efficiently while other Departmental Divisions conduct investigations and CSOC could enhance the outcome of incidents outside its purview.
- Qualified Providers:
  (1) DCF's contracting unit confirms qualifications as part of their contract renewal. Providers are required to ensure that staff maintain valid license/certification to have a valid DCF contract**.** The provider confirms this information on their renewal application. The DCF contracting unit currently reviews licensure/certification for IIH providers to ensure they are valid. Education and experience qualifications for IIH/ISS staff are submitted to CSOC service line staff and get a one-time review. This occurs whenever the provider adds personnel to their staff complement and during the annual review of the contract documentation, which are reviewed by CSOC staff.

  (2) DCF contracting will include a component in their annual review process that will require providers to attest that they continue to meet the requirements of the Request for Qualification (RFQ)

Recommendations:

- Distribution of a memorandum to all providers outlining the process of unusual incident reporting once the process is finalized – CSOC distributed a memo to providers in May of 2020 outlining compliance with unusual incident reporting.
- Strict compliance to mandatory Unusual Incident Reporting
- Following CSOC's meeting with DMAHS, CSOC is to submit, in collaboration with DMAHS, their current process of credentialing and verification of certifications and required trainings of providers to ensure that regulatory standards are met – currently being developed by CSOC.

Audit Findings (2018 QMU Audit of CSOC's ASD and I/DD Programs)

Quality of Care:

Sub-assurances	Compliance
All youth that meet the clinical criteria for services through the Department of Children and Families will be assessed utilizing the comprehensive Child and Adolescent Needs and Strength (CANS) assessment tool.	100%
80% of the youth show improvement in Child and Adolescent Needs and Strengths composite rating within a year.	97%

Level of Care (LOC) Determination:

Sub-assurances	Compliance
The level of care of enrolled youth is reevaluated at least annually or as specified in its approved demonstration.	98%
The process and instruments described in the approved demonstration are applied appropriately and according to the approved description to determine youth's level of care.	96%

Service Plan:

Sub-assurances	Compliance
Service plans address all youths' assessed needs (including health and safety risk factors) and personal goals, either by demonstration services or through other means.	98%
The state monitors service plan development in accordance with its policies and procedures.	86%

Service plans are updated/revised at least annually or when warranted by changes in the youth's needs.	100%
Services are delivered in accordance with the service plan, including the type, scope, amount, duration, & frequency specified in the service plan.	98%
Youth/Families are afforded choice between/among demonstration services and providers.	98%

Qualified Providers:

Sub-assurances	**Compliance**
The State verifies that providers initially meet required licensure and/or certification standards prior to their furnishing demonstration services. No new providers enrolled during 2018CY	N/A N/A
The state verifies that providers of demonstration services continually meet required qualified status, including any applicable licensure and/or certification standards. No information received – Document currently in development **CAP required*	0%
The State implements its policies and procedures for verifying that applicable certifications/checklists and trainings are provided in accordance with qualification requirements as listed in the demonstration. No information received – Process in development (not implemented in 2018)	0%

**CAP required*	

Health and Welfare:

Assurance: The state demonstrates it has designed and implemented an effective system for assuring demonstration participant health and welfare.	
Sub-assurances	**Compliance**
The state, on an ongoing basis, identifies, addresses, and seeks to prevent the occurrence of abuse, neglect and exploitation and unexplained death.	100%
The State demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible. Incident reporting process is under revision **CAP required*	0%
The State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.	100%
The State establishes overall health care standards and monitors those standards.	100%

Financial Accountability:

Sub-assurances	**Compliance**

The State provides evidence that claims are coded and paid in accordance with the reimbursement methodology specified in the approved demonstration and only for services rendered.	95%
The State provides evidence that rates remain consistent with the approved rate methodology throughout the five-year demonstration cycle.	100%

Division of Developmental Disabilities

Supports Program Audit

Key element identified:

- Service Plans: one sub-assurance did not meet the 86% compliance threshold
- Qualified Providers: data for one sub-assurance was not received from DDD
- Financial Accountability: eighteen identified members may require claims resolution

DDD Response:

- Service Plans: DDD internal auditing identified issues related to service delays and/or no services being identified. DDD has been working with Support Coordinators (SC) to add an ongoing monthly demonstration service or to dis-enroll these individuals from the Supports Program and move to a State Case Manager. Improvement should be seen in the 2019 audit.
- Qualified Providers: DDD's Provider Performance and Monitoring Unit (PPMU) conduct monitoring of all certified and non-licensed/certified businesses providing demonstration services. Monitoring tools were developed and implemented in 2018. PPMU provides each agency with a report that identified the areas that require corrective actions. The agencies are required to develop Corrective Action Plans (CAP). At this time, some databases have been and some are still in need of being built so that the data can be entered and systemic compliance reports and rates can be identified. This should be operational by the next audit.
- Financial Accountability: DDD will reach out to each SC to determine if they did not properly upload the required documentation to iRecord. Documentation will be provided to QMU or claims will be paid back to the federal government for non-compliance.

Recommendations:

- Develop a process to ensure demonstration services are provided as indicated in the plan of care.
- Annual submission of evidentiary data by DDD for Qualified Providers sub-assurances to ensure CMS compliance.

2018 Audit Findings (Supports Program)

Level of Care:

Sub-assurances	Compliance

An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.	100%
The LOC of enrolled members is reevaluated at least annually or as specified in the approved demonstration.	99%
The processes and instruments described in the approved demonstration are applied appropriately and according to the approved description to determine participant level of care.	100%

Service Plan:

Assurance: The State demonstrates it has designed and implemented an effective system for reviewing the adequacy of service plans for demonstration participants.	
Sub-assurances	**Compliance**
Service plans address all members' assessed needs (including health and safety risk factors) and personal goals, either by the provision of demonstration services or through other means.	96%
The state monitors service plan development in accordance with its policies and procedures.	86%
Service plans are updated/revised at least annually or when warranted by changes in the demonstration participant's needs.	96%
Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan. **CAP required*	73%
Participants are afforded choice between/among demonstration services and providers.	100%

Qualified Providers:

Sub-assurances	**Compliance**
The state verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to their furnishing demonstration services.	100%

The state monitors non-licensed/non-certified providers to assure adherence to demonstration requirements. **CAP required*	0%
The state implements its policies and procedures for verifying that trainings provided in accordance with State requirements and the approved demonstration.	86%

Health and Welfare:

Assurance: The state demonstrates it has designed and implemented an effective system for assuring demonstration participant health and welfare.	
Sub-assurance	**Compliance**
The state demonstrates on an ongoing basis that it identifies, addresses, and seeks to prevent instances of abuse, neglect, exploitation and unexplained death.	99%
The state demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.	90%
The state policies and procedures for the use or prohibition of restrictive interventions (including restraints & seclusion) are followed.	100%
The state establishes overall health care standards and monitors those standards.	100%

Financial Accountability:

Sub-assurance	**Compliance**
The state provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved demonstration and only for services rendered.	91%
The state provides evidence that rates remain consistent with the approved rate methodology throughout the five-year demonstration cycle.	100%

Managed Long Term Services and Supports:

Please refer to attachment C.2 for MLTSS performance measures.

XVI. STC 73 (o): Efforts and Outcomes Regarding the Establishment of Cost-effective MLTSS in Community Settings Using Industry Best Practices and Guidelines The state developed and employs a cost effective/cost neutral placement policy in which MLTSS members will most often receive the most cost-neutral placement which will typically be in a community setting. The Contractor is required to evaluate the cost neutrality of the plan of care for all MLTSSS members receiving HCBS in a community setting. Members whose cost of HCBS services exceed 85% or 100% of the state established threshold cost of institutional care are counseled on the cost effectiveness process. An Interdisciplinary Team Meeting is convened to review the plan of care, services needed, and develop a plan of care within the confines of the cost effectiveness threshold or at a higher cost based on an exception. Exceptions are recommended by the interdisciplinary team and approved by the DMAHS Medical Director based on temporary higher care needs or long term complex medical needs typically met through private duty nursing services. The IDT process ensures that members through a collaborative process are provided choice of placement, evaluated for risk, and have a back-up plan implemented as necessary. The cost effective/cost neutral policy which focuses on the individual member needs, choice and safety while maintaining overall program cost neutrality is based on industry best practice ascertained from other state's MLTSS programs.

XIV. STC 73 (p) Policies for Any Waiting Lists Where Applicable

There are currently no waiting lists in use.

XVI. STC 73 (q): The State may also provide CMS with any other information it believes pertinent to the provision of the HCBS and their inclusion in the demonstration, including innovative practices, certification activity, provider enrollment and transition to managed care special populations, workforce development, access to services, the intersection between the provision of HCBS and Medicaid behavioral health services, rebalancing goals, cost-effectiveness, and short and long-term outcomes.

Managed Long Term Services and Supports Program

MCOs continue to link with NJ's County Welfare Agencies for the purpose of assisting members with applying for programs such as utility assistance and NJ SNAP. MCOs also continue to connect with county based Aging and Disability Resource Connections (ADRCs) to assist members with linking to community based LTSS services that are not covered by the MCO. During the current public health emergency MCOs and the state are continuing to work collaboratively to ensure eligibility is maintained and services are delivered in alternate methodologies to ensure maximum protection of health and safety.

The state continues to work with the MCOs on the nursing facility to community transition process. As is shown above, the state remains committed to working with MCOs to ensure that members who desire to

transition to more independent living in the community are afforded this opportunity in the safest and most practicable way possible during the public health emergency.

Consumer Issues from July 1, 2019 to June 30, 3020

MLTSS:

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

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
1	Provider Search	Authorization status	Member requests to speak to Care Manager	Benefits-Medical Benefits	Members calling to speak to their care managers
2	Eligibility	Contact their Care Manager	Authorization Inquiries	PCP Inquiry	Benefits inquiries
3	Benefits	Questions regarding the PPP program	Request to change PCP	PCP Update	Eligibility inquiries
4	PCP Change	ID Card Inquiry	Confirm eligibility	ID Card inquiry	New authorization requests
5				Provider Search/ Verification	

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

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
1	Eligibility	Claims status	Authorization Inquiries	Claims status	Eligibility inquiries
2	Claims status	Authorization status.	Confirm eligibility	Network provider inquiries	Claims status
3	Network provider inquiries	Eligibility inquiries	Network provider inquiries	Authorization Inquiries	Status of authorization
4			Claims status	Eligibility inquiries	Status of reauthorization
5					Benefits inquiries

MLTSS Claims Processing Information by MCO

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
Total Submitted	387,187	705,692	2,345,410	271,969	1,125,193
Paid	295,217	648,359	2,164,101	242,277	867,297

Denied	82,188	35,405	149,779	16,396	222,375
Pending	9,782	21,928	31,530	9,887	35,521

Top Reasons for MLTSS Claims Denial by MCO

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
1	Service denied because payment already made for same/similar procedure within set time frame.	Capitated Service	Invalid number of units submitted on claim	No Authorization on file	No Authorization
2	Non-covered charge(s).	claim paid per fee schedule	Duplicate claim	Medicare Medicaid 2ndary Carrier	No Patient Responsibility
3	Exact duplicate claim/service.	Procedure non-reimbursable	Provider not eligible by contract for payment	Benefits Based on Admission Date	Timely Filing
4	Timely Filing	Disallow-not allowed under contract	Invalid Number of Units Submitted on Claim	Claim is a duplicate	
5			Resubmit with EOD from Medicare	Secondary Carrier Insurance	

MLTSS Outreach and Communications to Ensure Access Update

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

During this quarter, outreach and communications heavily focused on the response to COVID-19. The Department has a webpage dedicated to communications related to COVID-19 resources which includes information regarding demonstration flexibilities approved by CMS, policy guidance related to interim processes, and general resources for COVID-19.

DHS gave MLTSS updates to the long term care provider industry. Due to restrictions on public gatherings, this meeting was conducted virtually.

The New Jersey Medical Assistance Advisory Council, a group comprised of medical care and health services professionals as well as advocacy groups who advise the State's Medicaid Director met virtually on April 22, 2020. MLTSS-related meeting topics included Electronic Visit Verification, Autism Benefits, and NJ FamilyCare Actions related to the COVID-19 Emergency.

The Office of Managed Health Care (OMHC) has remained committed to its communications efforts to ensure access through its provider networks. Its provider-relations unit has continued to respond to inquiries through its email account on these issues among others: MCO contracting, credentialing, reimbursement, authorizations, appeals and complaint resolution

ASD Pilot, I/DD-MI Pilot Program, Serious Emotional Disturbance Program:

Provider Enrollment/Access to Services

There are 181 CSOC qualified providers that deliver demonstration services.

Total Number of Agencies Qualified by the CSOC to Deliver Demonstration Services

Demonstration	Demonstration Service	Number of Qualified Agencies
CSSP I/DD Demonstration and ASD Pilot	Individual Supports	30
CSSP I/DD Demonstration and ASD Pilot	Intensive In- Community Services – Habilitation (IIH) (Clinical/ Therapeutic)	37
CSSP I/DD Demonstration and ASD Pilot	Intensive In- Community Services – Habilitation (IIH) (Behavioral)	30
CSSP I/DD Demonstration	Respite	80
CSSP I/DD Demonstration	Interpreter Services	3
CSSP I/DD Demonstration	Non-Medical Transportation	1

Total Number of New Agencies Qualified by the CSOC to Deliver Demonstration Services

Demonstration	Demonstration Service	Number of Qualified Agencies
CSSP I/DD Demonstration and ASD Pilot	Intensive In- Community Services – Habilitation (IIH) (Behavioral)	0
CSSP I/DD Demonstration	Interpreter Services	0
CSSP I/DD Demonstration	Non-Medical Transportation	0

No new demonstration providers were added during this reporting period.

Quality Strategy Measures
The results of the Quality Strategy Measures can be found in Attachment C.1.

XIX. STC 73(r): A Report of the Results of the State's Monitoring Activities of Critical Incident Reports

The results of the State's monitoring activities of critical incidents can be found in Attachment D.

XX. STC 73(s): Medical Loss Ratio (MLR) Reports for each participating MCO

	SFY19 MLR Summary	
	Acute	**MLTSS**
Horizon	91.1%	91.9%
UHC	96.0%	94.3%
Amerigroup	92.4%	98.7%
Aetna	90.3%	93.5%
Wellcare	96.8%	95.4%

XXI. Other Topics of Mutual Interest between CMS and the State

Managed Long Term Services and Supports Program

The launch of MLTSS was a major shift of how services were delivered to individuals who were in need of long term care. The Managed Care Organizations (MCOs) and the Office on Community Choice Options (OCCO) had to complete and validate over 11,000 NJ Choice assessments affirming that individuals who were transitioned from the four former 1915(c) waivers still met nursing facility level of care.

MLTSS also carves-in the behavioral health benefit into the MCO allowing for greater integration for physical, behavioral and long term care benefits.

Following the transition to MLTSS on July 1, 2014, the state has maintained its efforts to ensure that consumers, stakeholders, MCOs, providers and other community-based organizations have learned and are knowledgeable about the move to managed care. The state has depended on its relationships with stakeholder groups to inform consumers about the implementation of MLTSS. In turn, stakeholders have relayed accurate information to consumers. This strategy has continued in the post-implementation phase.

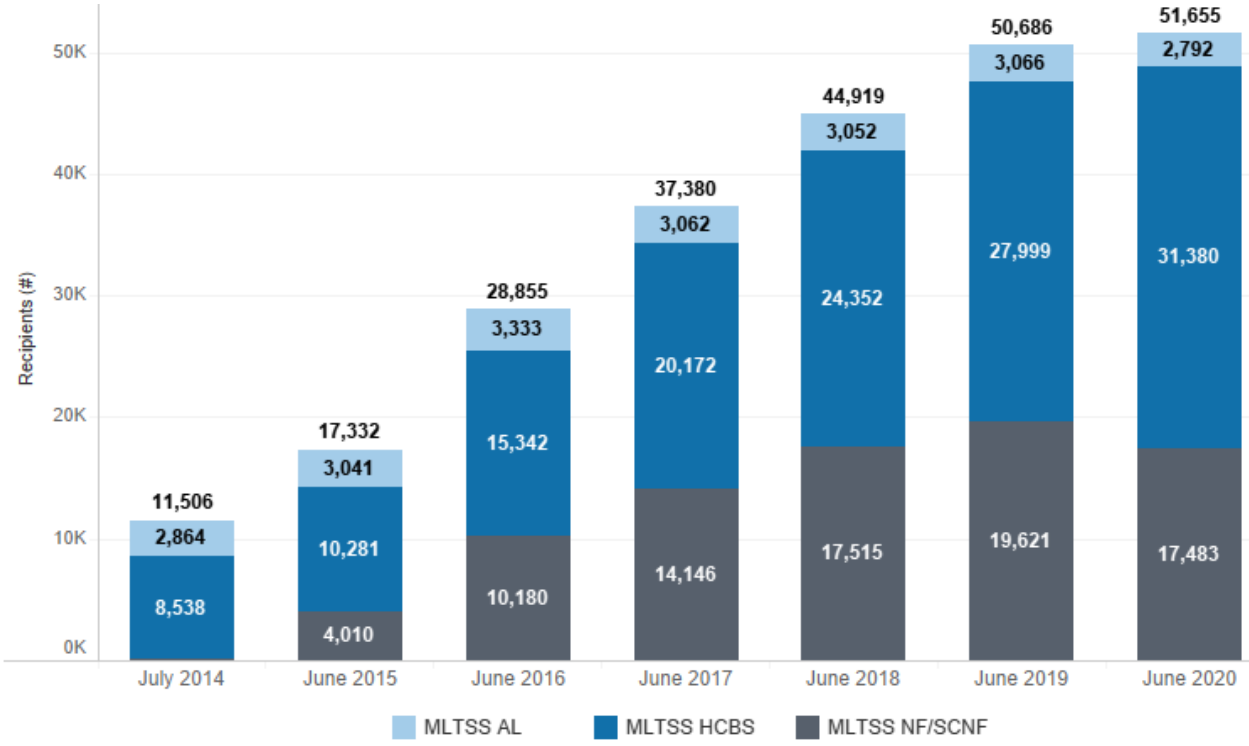
The Division of Aging Services (DoAS) is the primary liaison to the aging and disability networks. The DoAS has oversight of the Aging and Disability Resource Connection (ADRC) partnership as the single entry/no wrong door system for consumers to access MLTSS. The state continues to meet with groups ranging from the Human Services Directors, the 21 Area Agencies on Aging (AAAs), the County Welfare Agencies (CWAs) to the State Health Insurance Assistance Program (SHIP) counselors and Adult Protective Service (APS) providers on a regular basis.

The DMAHS Office of Managed Health Care (OMHC), with its provider relations unit, has been at the forefront in spearheading communications efforts to ensure access through its provider networks in the following categories—HCBS medical; HCBS non-medical; nursing homes; assisted living providers; community residential providers and long-term care pharmacies. As a resource to stakeholders, OMHC addresses provider inquiries on MCO contracting, credentialing, reimbursements, authorizations and appeals. It also handles provider inquiries, complaint resolution and tracking with a dedicated email account for providers to directly contact the Office of Managed Health Care.

The state has had bi-weekly conference calls with the Managed Care Organizations (MCOs) during the demonstration year to review statistics and discuss and create an action plan for any issues that either the State or the MCOs are encountering. Also, state staff from various divisions who are involved in MLTSS meet monthly to discuss any issues to ensure that they are resolved timely and in accordance with the rules and laws that govern the Medicaid program.

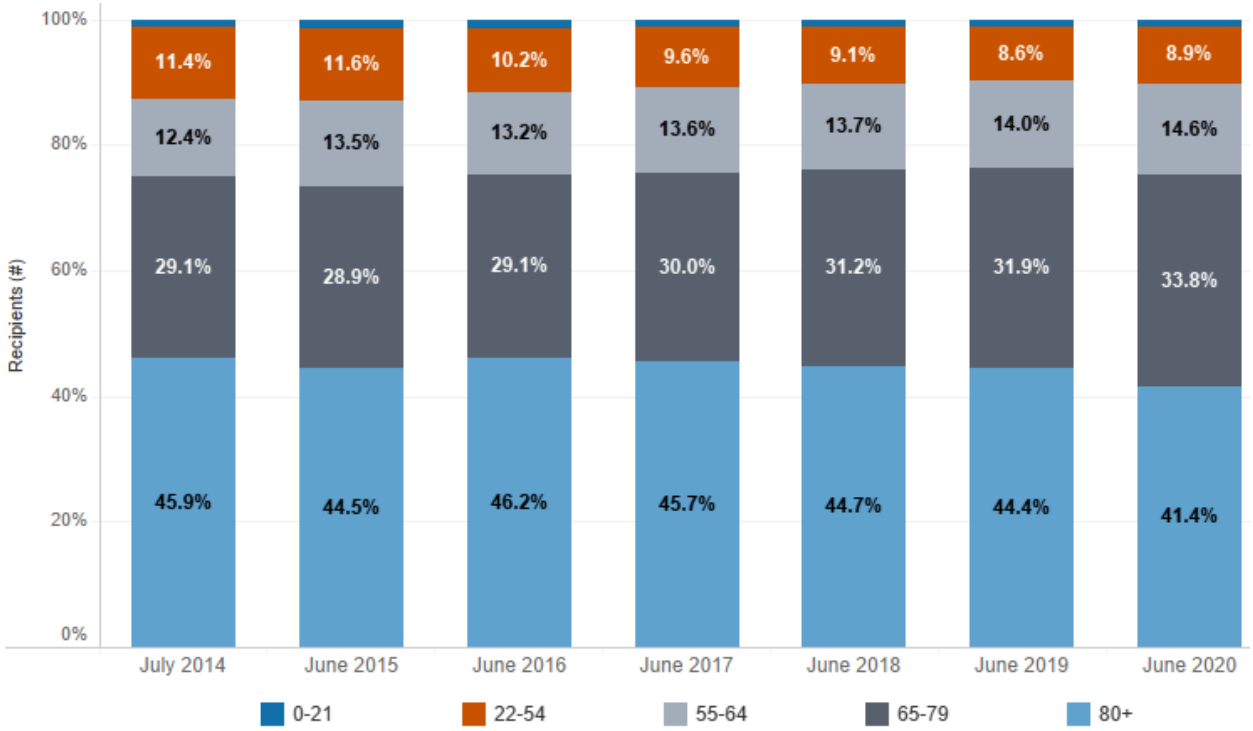
As of June 30, 2020, a total of 51,655 individuals were enrolled in MLTSS. As shown in the chart below, as the program has grown and evolved, more individuals are enrolled in Home and Community-Based (HCBS) settings than Nursing Facilities (NF). Please note that the growth of the NF population since July 1, 2014 is due to new NF enrollees and individuals moving from fee-for-service into MLTSS. The overall NF population has decreased since July 2014 by over 1,000 people.

Total MLTSS Population by Setting



Below is a breakdown of MLTSS participants by age group. The largest segment group of individuals enrolled in MLTSS is 80 years of age and older. Approximately 75 percent of the MLTSS population is ages 65 and older.

MLTSS Population by Age Group



HCBS Settings Requirements

New Jersey is continuing to work toward ensuring all Medicaid beneficiaries receive services in the settings most appropriate for them. All divisions impacted by the final rule have identified, through the CMS crosswalk, those areas needing to come into compliance. The state is currently working on the identified regulatory changes and provider instructions to implement the HCBS final rule.

Rebalancing Long Term Care

Service utilization of HCBS under MLTSS continues to increase. As of June 2020, over 57,000 individuals were enrolled in Medicaid long term care with approximately 34,000 receiving HCBS under MLTSS and approximately 22,000 residing in nursing facilities and special care nursing facilities. Since MLTSS was launched in July 2014, New Jersey has continued to rebalance Medicaid long-term care with 61 percent of individuals receiving HCBS rather than nursing home care. This figure was 50 percent last year and 28.9 percent when MLTSS began. This is due to several factors including the elimination of waitlists, financial eligibility-related administrative changes like the development of the QIT program, and program expansion.

Interim Management Entity Update:

During the annual reporting period from July 1, 2019 to June 30, 2020, the IME received 56,037 calls from individuals seeking information, referral or admission to SUD treatment. There were 6,674 referrals to treatment and 4,780 individuals who received Care Coordination to facilitate treatment admission. The UM staff issued 22,215 clinical reviews for admission to the appropriate level of care, and 17,047 clinical reviews for extended treatment for Medicaid recipients. The IME received and responded to a total of 11,999 calls on the provider assistance call line to support Medicaid SUD treatment providers.

DMHAS provided technical assistance with the IME and Managed Care Organizations to the SUD treatment providers, for long term residential services covered by the contracted MCOs on October 1, 2019 and for the special Medicaid plans for MLTSS, DDD and FIDE-SNP.

IME collaborated with DMHAS to host ASAM provider trainings by the Change Companies in several formats: in person trainings for providers over two days; webinar option which provided educational credits and one day training specific to Long Term Residential providers to support the transition to a Medicaid provider SUD service during October 2019.

As an emergency policy from COVID-19, prior authorization requests were temporarily suspended for all levels of substance use care beginning April 1, 2020. Guidelines for providers were issued in a Medicaid Alert (MA 2020-04, attached). The IME updated the division on provider availability and patient access through the information received during the referral process.

Operational/Policy Updates:

Self-attestations for transfer of assets:
There were a total of 1086 self-attestations for the time period of July 1, 2019 to June 30, 2020.
MCO Choice and Auto-assignment:
The number of individuals who changed their MCO after auto-assignment 29,805.

XXII. An updated budget neutrality analysis, incorporating the most recent actual data on expenditures and member months, with updated projections of expenditures and member months through the end of the demonstration, and proposals for corrective action should the projections show that the demonstration will not be budget neutral on its scheduled end date.

The updated Budget Neutrality analysis is enclosed in Attachment F at the end of this report.

XXIII. Enclosures

A) 1115 Demonstration Service Units and Claims
- a. ASD Pilot, I/DD-MI Pilot Program, SED Program
- b. Managed Long Term Services and Supports
- c. Supports
- d. CCP

B) Geo Access Report by MCO
C.1) ASD and ID/DD-MI Performance Measurement Report
C.2) MLTSS Performance Measurement Report
D) Critical Incident Report
E) Supports/CCP Report Update
F) Budget Neutrality Analysis

XXV. State Contact(s)

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XXI. Date Submitted to CMS

Report Submitted to CMS on January 25, 2021

FEE FOR SERVICE PAYMENTS, SERVICE UNITS, AND CLAIM COUNT FOR JULY 1, 2019 THROUGH MARCH 31, 2020 FOR ASD, IDD-MI, AND SED
FEDERALLY MATCHED WAIVER SERVICES

Row Labels	CLM PROC CDE	CLM PROC MOD CDE	CLM PROC MOD 2 CDE	PROV TYPE CDE	PROV SPECLT CDE	CLAIM PMT AMT	CLAIM SVC UNITS QTY	NET PAID CLAIM COUNT
ASD						**2,560,903**	**190,448**	**14,682**
COMM BASED WRAP AROUND SERV(II HABIL	**T2021**	HA	**HO**			744,027	35,305	3,759
COMM BASED WRAP AROUND(II HABILITATI	**T2021**	HA	**HN**	44	**826**	**229,463**	**12,346**	**1,590**
COMP COMM SUPP SERV(INDIV SUPPORTS)	**H2015**	HA	**HN**	44	**826**	**54,531**	**8,731**	**786**
COMP COMM SUPP SERV(INDIV SUPPORTS)	**H2016**	HA	**HN**	44	**826**	**1,496,919**	**133,541**	**8,452**
IIH-HABILITATION BCBA-D	**96152**	HA		44	**826**	**8,695**	**188**	**16**
MENTAL HEALTH ASSESSMENT(BCBA)	**H0031**	HA	**22**	44	**826**	**25,394**	**312**	**75**
MENTAL HEALTH ASSESSMENT, BY NON-PHY	**H0031**	HA	**HN**	44	**826**	**1,875**	**25**	**4**
IDD/MI						**10,869,170**	**845,713**	**53,634**
COMM BASED WRAP AROUND SERV(II HABIL	**T2021**	52	**HO**			791,032	45,982	3,805
COMM BASED WRAP AROUND SERV(II HABIL	**T2021**	HA	**HO**			1,519,580	72,003	7,315
COMM BASED WRAP AROUND(II HABILITATI	**T2021**	HA	**HN**	44	**826**	**405,562**	**21,898**	**2,561**
COMMUN BASED WRAP AROUND SERV(II HAB	**T2021**	22	**HA**	44	**826**	**724,489**	**25,719**	**3,126**
COMMUN BASED WRAP AROUND SERV(II HAB	**T2021**	HA	**22**	44	**826**	**48,054**	**1,703**	**142**
COMP COMM SUPP SERV(HAB IN HOME)	**H2016**	HA	**HO**			3,149,994	282,130	15,188
COMP COMM SUPP SERV(INDIV SUPPORTS)	**H2015**	HA	**HN**	44	**826**	**118,113**	**18,963**	**1,597**
COMP COMM SUPP SERV(INDIV SUPPORTS)	**H2016**	HA	**HN**	44	**826**	**3,377,588**	**301,690**	**15,131**
COMP COMMUN SUPP SERV(IND SUPPORTS)	**H2015**	HA	**HO**			75,394	12,071	851
HABILITATION RES(DDD OUT OF HOME SER	**T2016**	HA	**U1**	44	**825**	**1,069**	**7**	**7**
HABILITATION RES(DDD OUT OF HOME SER	**T2016**	HA	**U2**	44	**825**	**81,136**	**188**	**158**
IIH-HABILITATION BCBA-D	**96152**	HA		44	**826**	**20,396**	**441**	**37**
MENTAL HEALTH ASSESSMENT(BCBA)	**H0031**	HA	**22**	44	**826**	**156,033**	**2,032**	**385**
MENTAL HEALTH ASSESSMENT, BY NON-PHY	**H0031**	HA	**HN**	44	**826**	**6,225**	**83**	**14**
MENTAL HEALTH ASSESSMENT, BY NON-PHY	**H0031**	HA	**HO**			75	1	1
NON-EMERG TRANSPORT(NON-MED WHEELCHA	**S0215**	HA		44	**838**	-	**4**	**4**
NON-EMERGENCY TRANSPORT(NON-MED TAXI	**A0090**	HA	**22**	44	**838**	**120**	**188**	**20**
RES CARE NOS(DDD OUT OF HOME SERV)	**T2033**	HA	**U2**	44	**825**	**19,469**	**48**	**48**
RESPITE CARE IN HOME (PER 15 MINS)	**S9125**	52	**HA**	44	**865**	**500**	**80**	**4**
RESPITE CARE IN HOME (PER 15 MINS)	**S9125**	HA	**52**	44	**865**	**374,342**	**60,481**	**3,239**
NON-EMERG TRANSPORT(AMBULANCE)	**S0215**	HA	**22**	44	**838**	-	**1**	**1**
SED						**29,705,570**	**478,620**	**83,409**
BEHAV ASSIST SERV BY DYFS PROV/15 MI	**H2019**			44	**903**	**152**	**4**	**1**
BEHAV ASSIST SERV BY DYFS PROV/15 MI	**H2019**	UC		44	**903**	**912**	**24**	**4**
BEHAVIORAL ASSIST SERVICES EA 15 MIN	**H2014**	TJ	**BA**	44	**903**	**7,293**	**799**	**99**
BEHAVIORAL ASSIST SERVICES EA 15 MIN	**H2014**	TJ	**U1**	44	**903**	**4,329**	**444**	**45**
BEHAVIORAL ASSIST SERVICES EA 15 MIN	**H2014**	TJ	**U2**	44	**903**	**332**	**38**	**6**
CSOCI CARE MANAGEMENT (CMO) SERVICES	**Z5008**			44	**901**	**16,874,850**	**21,774**	**21,847**
GRP BEHAV ASSIST SERV 2 CHILDREN	**H2014**	TJ	**UN**	44	**903**	**9,661**	**1,723**	**214**
HOSPITAL LEAVE JCAHO RTC/DYFS	**Y9952**			59	**897**	**8,752**	**16**	**16**
IIC ASSESSMENT-CLIN LICENSED PRACT	**H0018**	TJ	**U1**	44	**902**	**21,018**	**186**	**62**
INDIVID BEHAVIOR ASSIST SERV 15 MIN	**H2014**	TJ		44	**902**	**(488)**	**(50)**	**(5)**
INDIVID BEHAVIOR ASSIST SERV 15 MIN	**H2014**	TJ		44	**903**	**745,295**	**76,635**	**8,883**
INTENS IN-COM GRP CLIN LEV 2 CHILD	**H0036**	UN	**U1**	44	**902**	**33,010**	**1,743**	**217**
INTENS IN-COM GRP CLIN LEV 3 CHILD	**H0036**	UP	**U1**	44	**902**	**382**	**24**	**3**
INTENS IN-COM INDIV CLIN LEVEL SERV	**H0036**	TJ	**U1**	44	**902**	**7,153,107**	**254,540**	**32,129**
INTENS IN-COMM PROF IND SERV MASTERS	**H0036**	TJ	**U2**	44	**902**	**2,380,086**	**112,373**	**14,106**
MEN HLTH REHAB GROUP HOME/DYFS	**Y9935**			44	**897**	**113,695**	**983**	**983**
MEN HLTH REHAB GROUP HOME/DYFS	**Y9935**			44	**899**	**369,137**	**2,142**	**446**
MEN HLTH REHAB JCAHO RTC/DYFS	**Y9948**			59	**896**	**244,750**	**550**	**550**
MEN HLTH REHAB JCAHO RTC/DYFS	**Y9948**			59	**897**	**210,595**	**385**	**466**
MH RHAB NON-RTC COMM PSYCH RESI/DMHS	**Y9933**			44	**896**	**131,830**	**398**	**398**
MH RHAB NON-RTC COMM PSYCH RESI/DMHS	**Y9933**			44	**898**	**91,088**	**275**	**305**
MH RHAB TRANSITIONAL LIVNG HOME/DYFS	**Y9936**			44	**899**	**119,759**	**747**	**617**
MH RHB NON-RTC RESIDENTIAL CARE/DYFS	**Y9943**			44	**896**	**798,372**	**2,041**	**1,389**
MOBILE RESPONSE - INITIAL	**S9485**	TJ		44	**894**	**327,664**	**241**	**241**
MULTISYSTEMIC THERAPY FOR JUVENILES,	**H2033**			44	**902**	**2,088**	**36**	**8**
MULTISYSTEMIC THERAPY FOR JUVENILES,	**H2033**			44	**903**	**11,252**	**194**	**24**
MH RHAB IN TREATMENT HOMES / DMHS	**Y9932**			44	**897**	**46,651**	**355**	**355**
Grand Total						**43,135,643**	**1,514,781**	**151,725**

Notes:
Service from dates for claims span July 1, 2019 through March, 31, 2020 and were paid from July 1, 2019 and August 26, 2020. Only non-voided, paid claims are reflected in the data.
*ASD, IDD-MI, and SED wavier services are defined by CCB295, **Appendix A** "New Services", for procedures marked as **Matchable** for SPC 37 under SED, Matchable for SPC 38 for IDD/MI, and Matchable for SPC 47, 48, 49 under Waiver. Fields to be matched include procedure code, modifiers 1 and 2, provider type, provider specialty code, special program code, and CSOCI enrolled indicator.*
NJMMIS Project Request Report # 14947 incorporating language interpreter services as a IDD/MI matchable waivered services is also used to identify matchable waivered claims.
Report categorizes claims as a ASD, IDD-MI, or SEDS claim only if ALL criteria are satisfied on Appendix A OR NJMMIS Project Request Report 14947.

ENCOUNTER PAYMENTS, SERVICE UNITS, AND CLAIM COUNT FOR JULY 1, 2019 THROUGH MARCH 31, 2020 FOR MLTSS WAIVER RECIPIENTS

Clm Proc Code	Clm Proc Curr La	Sum of Clm Net Paid Claim Indicat	Sum of Claim Payment Amt	Sum of Clm Service Units Qty
MEDICAL DAY CARE	S5102	1,195,616	92,904,925	1,214,439
TEAM EVALUATION & MANAGEMENT	T1024	1,500	473,398	1,595
ADULT DAYCARE SERVICES 15MIN	S5100	66	4,894	1,341
MDC Total		**1,197,182**	**93,383,217**	**1,217,375**
ASSIST LIVING WAIVER/DIEM	T2031	86,799	48,520,864	895,012
HOME MEALS PER MEAL	S5170	1,039,123	10,177,356	1,510,705
MEDICAL DAY CARE	S5102	11,205	409,292	12,670
GRP THERAPEUTIC PROCEDURE	97150	5,745	540,480	5,772
NURSING FACILITY		1,447	2,774,987	13,184
RES, NOS WAIVER PER DIEM	T2033	56,069	10,471,834	58,082
PERS MONTHLY FEE	S5161	118,998	3,635,780	119,051
P.T. THER PROC,1 OR MORE AREAS	97110	11,118	1,357,417	38,589
ALCOHOL AND/OR DRUG SERVICES	H0004	2,459	189,239	7,698
CHORE SERVICES PER DIEM	S5121	38	23,276	67
COMM TRANS WAIVER/SERVICE	T2038	125	188,431	125
HEALTH & BEHAV INTERVEN GROUP	96153	5,198	540,141	24,423
PRIVATE DUTY/INDEP NURS SERV	T1000	6,627	3,167,562	265,870
MED REMINDER SERV PER MONTH	S5185	613	30,700	613
ADULT FOSTER CARE PER DIEM	S5140	113	153,590	3,040
ADULT DAYCARE SERVICES 15MIN	S5100	44,390	3,095,424	864,964
HOME MODIFICATIONS PER MONTH	S5165	373	959,350	373
UNSKILLED RESPITECARE /DIEM	S5151	6	868	13
COGNITIVE SKILL DEVELOPMENT	G0515	9,455	1,671,798	47,390
LPN/LVN SERVICES UP TO 15MIN	T1003	38,331	14,634,854	1,524,152
SELF CARE MANAGEMENT TRAINING	97535	8,059	1,047,773	29,973
PT OR MANIP FOR MAINT	S8990	3,485	332,658	13,932
SPEECH,LANGUAGE/HEARING THERAP	92508	3,171	299,793	3,205
PERS INSTAL & EQUIP	S5160	1,299	58,115	1,299
RESPITE CARE SERVICE 15 MIN	T1005	2,047	282,570	100,141
SPEECH LANGUAGE HEARING THERAP	92507	4,742	669,499	4,771
HOMAKER SERVICE NOS PER 15M	S5130	4,071	193,891	53,436
RN SERVICES UP TO 15 MINUTES	T1002	14,839	6,255,430	525,290
DAY HABIL WAIVER PER 15 MIN	T2021	77	1,695	230
ELEC MED COMP DEV, NOC	T1505	113	6,972	113
N-ET; PER DIEM	**T2002**	**42**	**4,079**	**42**
VEHICLE MOD WAIVER/SERVICE	T2039	10	90,001	10
HOME ENVIRONMENT ASSESSMENT	**T1028**	**406**	**43,700**	**407**
CHORE SERVICES PER 15 MIN	S5120	23	11,110	3,394
NON-EMERG TRANSP ONE WAY	T2003	15	2,843	15
MLT Total		**1,480,631**	**111,843,372**	**6,128,051**
NURSING FACILITY		180,043	963,529,778	5,085,278
NFC Total		**180,043**	**963,529,778**	**5,085,278**
PERSONAL CARE SER PER 15 MIN	T1019	2,941,673	236,789,186	53,368,386
PCA Total		**2,941,673**	**236,789,186**	**53,368,386**
PSYTX PT&/FAMILY 30 MINUTES	90832	18,743	322,105	18,836
PSYCH DIAG EVAL W/MED SRVCS	90792	1,915	169,893	1,927
SPECIAL FAMILY THERAPY	90847	171	4,678	174
ALCOHOL AND/OR DRUG SERVICES	H0020	2,613	217,939	3,646
ALCOHOL AND/OR DRUG SERVICES	H0019	4,048	1,052,035	5,831
ALCOHOL AND/OR DRUG SERVICES	H0015	168	12,205	168
ALCOHOL AND/OR DRUG SERVICES	H0018	58	8,628	58
ALCOHOL AND/OR DRUG SERVICES	H0010	21	8,570	21
PSYTX PT&/FAMILY 60 MINUTES	90837	2,127	29,576	2,131
PSYCH DIAGNOSTIC EVALUATION	90791	2,383	116,557	2,398
BRIEF EMOTIONAL/BEHAV ASSMT	96127	348	442	386
SMOKING AND TOBACCO USE CESSAT	99406	340	1,602	340
SMOKING AND TOBACCO USE CESSAT	99407	76	520	76
PSYTX PT&/FAMILY 45 MINUTES	90834	9,552	263,513	9,557
NEUROBEHAVIORAL STATUS EXAM	96116	95	1,097	95
E/M OFFICE/OP - ESTABLISHED PT	99212	42	1,464	42
MH PARTIAL CARE	H0035	6,848	557,966	31,963
ALCOHOL AND/OR SUBSTANCE (OTHE	99408	47	316	47
ALCOHOL AND/OR SUBSTANCE (OTHE	99409	2	40	2
HEALTH & BEHAV ASSESS INIT	96150	4	5	5
ELECTROCONVULSIVE THERAPY	90870	133	1,542	133
PSYTX PT&/FAM W/E&M 45 MIN	90836	152	2,304	152
PSYTX CRISIS INITIAL 60 MIN	90839	21	355	21
E/M OFFICE/OP ESTAB PATIENT	99213	725	36,124	726
GROUP MEDICAL PSYCHOTHERAPY...	90853	1,718	24,487	2,053
GRP PSYCH PARTIAL HOSP 45-50	G0410	68	80	158
HEALTH & BEHAV ASSESS RE-ASSES	96151	3	-	3
PSYTX PT&/FAM W/E&M 30 MIN	90833	1,206	25,719	1,210
E/M OFFICE/OP ESTAB PT VISIT	99215	9	987	9
HEALTH & BEHAV INTERVEN INDIV	96152	3	-	6
E/M EST PT MINIMAL PROBLEM(S)	99211	88	2,958	96
E/M OFFICE/OP ESTABLISHED PT	99214	192	16,380	194
ALCOHOL/SUBS INTERV 15-30MN	G0396	15	19	15
ALCOHOL AND/OR DRUG ASSESS	H0003	146	761	191
HOSPITAL OUTPT CLINIC VISIT	G0463	314	1,206	315

ENCOUNTER PAYMENTS, SERVICE UNITS, AND CLAIM COUNT FOR JULY 1, 2019 THROUGH MARCH 31, 2020 FOR MLTSS WAIVER RECIPIENTS

Clm Proc Code	Clm Proc Curr La	Sum of Clm Net Paid Claim Indicat	Sum of Claim Payment Amt	Sum of Clm Service Units Qty
DEVELOPMENTAL SCREEN W/SCORE	96110	16	94	16
FAMILY MEDICAL PSYCHOTH--1 HR.	90846	14	108	14
HEALTH & BEHAV INTERVEN FAMILY	96154	3	152	10
CONSULTATION WITH FAMILY	90887	7	208	7
PSYTX PT&/FAM W/E&M 60 MIN	90838	140	631	140
STANDARDIZED COGNITIVE PERFORM	96125	1	-	1
PSYTX COMPLEX INTERACTIVE	90785	3	146	3
E/M OFFICE/OP NEW PATIENT	99204	2	92	2
E/M OFFICE/OP NEW PATIENT	99201	1	-	1
INTENS IN COMMUN SERV/15 MIN	H0036	1	-	4
DRUG TEST PRSMV CHEM ANLYZR	80307	3	-	3
ASSER COM TX FACE-FACE/15MIN	H0039	7	55	15
COMP COMM SUPP SVC, 15 MIN	H2015	1	-	1
NRPSYC TST EVAL PHYS/QHP 1ST	96132	3	-	3
TCRANIAL MAGN STIM TX DELI	90868	7	-	7
PSYCL/NRPSYC TST PHY/QHP EA	96137	2	-	8
NRPSYC TST EVAL PHYS/QHP EA	96133	3	-	10
PSYCL/NRPSYC TST PHY/QHP 1ST	96136	3	-	3
HLTH BHV IVNTJ INDIV 1ST 30	96158	16	1,269	16
ORAL MED ADM DIRECT OBSERVE	H0033	19	2,900	19
PSYCHI/PSYCHOLO SERV,INDIV THE	OP914	4	-	4
A/D TX PROGRAM, PER DIEM	H2036	139	10,885	139
NUBHVL XM PHY/QHP EA ADDL HR	96121	1	-	1
PSYCL/NRPSYC TST TECH EA	96139	2	77	9
HLTH BHV IVNTJ INDIV EA ADDL	96159	16	1,621	31
PARTIAL HOSP LESS INTENSE	OP912	91	24,752	91
PSYCL/NRPSYC TECH 1ST	96138	2	41	2
TCRANIAL MAGN STIM TX PLAN	90867	1	-	1
ALCOHOL/SUBS INTERV >30 MIN	G0397	2	-	2
OTHER MENTAL HEALTH	various	32,783	4,689,712	4,689,712
Behavioral Health Total		**87,687**	**7,614,818**	**4,773,260**
Total Long Term Care and Home and Community Based Services for MLTSS Waiver Recipients		**5,799,529**	**1,405,545,553**	**65,799,090**
Grand Total MLTSS or LTC Encounter Services, including Behavioral Health		**5,887,216**	**1,413,160,371**	**70,572,350**

Notes:
Service from dates for claims span July 1, 2019 through March, 31, 2020 and were paid from July 1, 2019 and August 26, 2020. Only non-voided, paid claims are reflected in the data.
Medical Day Care, Managed Long Term Supports, Personal Care Assistant Services (not including self-directed Personal Care), and Nursing Facility claims and services are defined using the Encounter Category of Service and a waiver Special Program Code on the claim. Only custodial nursing facility care is reflected.
Behavioral Health claims have been pulled with a combination of primary diagnosis code, procedure code, revenue code, or DRG related to a behavioral health need, with the exclusion of diagnoses which are categorized as altering the mental status of an individual but are of organic origin, as specified by Section 4.1.2b of the current State Managed Care Contract.
For claims fitting multiple categories, the hierarchy applied for categorization is as follows: Managed Long Term Services and Supports, Custodial Nursing Facility, Medical Day Care, Personal Care Assistance, and Behavioral Health.
Existing issues with encounter data submission by the Managed Care Organization (e.g. span dates for services no matching service unit counts) are not corrected in the data provided.

FEE FOR SERVICE PAYMENTS, SERVICE UNITS, AND CLAIM COUNT FOR JULY 1, 2019 THROUGH MARCH 31, 2020 FOR MLTSS WAIVER RECIPIENTS

Clm Proc Code	Clm Proc Curr La	Sum of Claim Payment Amt	Sum of Clm Service Units Qty	Sum of Clm Net Paid Claim Indicat
NURSING HOMES		20,838,391	108,709	3,880
MEDICAL DAY CARE	S5102	68,609	874	874
ASSIST LIVING WAIVER/DIEM	T2031	20,597	377	13
ALR DAILY RATE	Y9633	2,249,636	44,591	1,610
CPCH DAILY RATE	Y7574	330,413	7,223	252
		23,507,645	**161,774**	**6,629**
Behavioral Health Total		**5,801,995**	**92,008**	**30,000**
Grand Total MLTSS or LTC Fee for Service, including Behavioral Health		**29,309,640**	**253,782**	**36,629**

Notes:
Service from dates for claims span July 1, 2019 through March, 31, 2020 and were paid from July 1, 2019 and August 26, 2020. Only non-voided, paid claims are reflected in the data. Medical Day Care, Managed Long Term Supports, Personal Care Assistant Services (not including self-directed Personal Care), and Nursing Facility claims and services are defined using the Fee for Service Category of Service and a waiver Special Program Code on the claim.

DDD Supports Waiver - July 1, 2019 through March 31, 2020

Data run through 8/26/20

Row Labels	Claim Payments	Service Units Quantity	Net Paid Claims
ALCOHOL AND/OR DRUG SERVICES	601,954	52,151	4,518
BEHAV ASSISTANCE SERVICES IND	302,243	22,300	2,886
CAMP OVERNITE WAIVER/SESSION	919,654	4,995	2,695
COM WRAP-AROUND SV, 15 MIN	50,245,131	7,270,729	287,412
COMP COMM SUPP SVC, 15 MIN	1,883,902	420,382	19,022
DAY HABIL WAIVER PER 15 MIN	63,338,176	11,097,269	423,183
FINANCIAL MGT WAIVER/15MIN	2,355,956	32,696	32,441
HABIL PREVOC WAIVER PER HR	4,124,684	683,190	36,487
HABIL SUP EMPL WAIVER 15MIN	3,053,410	372,461	27,810
HOME MODIFICATIONS PER MONTH	205,390	30	29
NOC RETAIL ITEMS ANDSUPPLIES	6,613,233	149,156	43,516
NON-EMERG.TRANSP./MILE VOL.INT	1,932,966	2,612,760	62,462
ONE-ON-ONE THERAPEUTIC INTER	4,417	121	40
PT OR MANIP FOR MAINT	426,745	15,672	2,801
RESPITE CARE SERVICE 15 MIN	2,601,298	452,536	29,568
SELF CARE MANAGEMENT TRAINING	194,832	7,788	2,360
SERV ASMNT/CARE PLAN WAIVER	21,657,442	167,829	91,680
SPECIAL MED EQUIP, NOSWAIVER	1,304	11	3
SPECIAL SUPPLY, NOS WAIVER	170,753	223	190
SPEECH LANGUAGE HEARING THERAP	10,855	1,463	442
VEHICLE MOD WAIVER/SERVICE	170,702	18	17
SIGN LANG/ORAL INTERPRETER	4,527	720	57
SUPPORT BROKER WAIVER/15 MIN	16,309	2,678	59
PERS INSTAL & EQUIP	125	3	3
FAMILY HOMECARE TRAINING 15M	9,740	81	27
PERS MONTHLY FEE	1,708	39	39
Grand Total	**160,847,457**	**23,367,301**	**1,069,747**

Notes:

Service dates for claims span July 1, 2019 through March 31, 2020 and were paid from July 1, 2019 through August 26, 2020.

Only non-voided, paid claims are reflected in the data.

Waiver services are defined as procedures directed toward dedicated appropriation codes '317' or '318' where special program code is '45' or '46'

Community Care Program Report - July 31, 2019 through March 31, 2020

Data run through 08/26/2020

Row Labels	Claim Payments	Service Units Quantity	Net Paid Claims
BEHAVIORAL HLTH COUNSEL/TPY PER 15MN	$507,448.07	69,433	13,325
BEH HLTH COUN & THERAPY/15MINUTES	$910,204.45	46,895	8,375
COMP COM SUP SERV PER 15 MINUTES	$24,417,638.89	1,981,642	29,844
COMPR COMM SUPPORT SERV PER 15 MINS	$535,474.48	100,877	9,635
COMPREHENSIVE COM SUPP SERV PER DIEM	$61,063,846.02	117,381	102,086
COMPREHENSIVE COM SUP SERV/15 MINS	$24,232,146.31	3,306,963	78,482
COMPREHENSIVE COM SUP SERV PER DIEM	$744,162,556.84	4,522,161	1,738,542
DAY CAMP ONLY UP TO 6 HRS PER DAY	$99,867.58	830	388
DAY HABILITATION WAIVER/ 15 MINUTES	$82,063,088.29	14,627,124	586,526
DAY HABILITATION WAIVER/15 MINUTES	$50,714,681.73	6,871,155	285,411
DAY HABILITATION WAIVER PER 15 MINS	$1,494,410.22	590,121	24,117
DAY HABILITATION WAIVER PER/15MINS	$847,090.17	182,059	7,561
DDD FI NONMCD PROVIDER TRANSPORT	$30,473.36	5,136	690
EMERG RESPONSE SYS/MO NO INST/TEST	$967.60	23	23
EMERG RESPONSE SYS/MO W/INST/TESTING	$200.00	4	4
HABILITATION,PREVOC,,WAIVER PER HOUR	$242,840.58	66,688	5,650
HABILITATION,PREVOC,WAIVER PER HOUR	$2,554,385.95	440,752	35,008
HABILITATION,SUP EMPLOY,WAIVER 15MIN	$1,389,446.92	295,206	20,281
HABILITATION,SUP EMPLOY,WAIVER,15MIN	$135,435.04	14,632	1,154
HABILITATION,SUP,EMPLOY WAIVER 15MIN	$964,610.35	205,249	13,561
HABILITATION,SUPEMPLOY,WAIVER,15MIN	$872,297.50	63,822	7,092
HME CARE TRAINING,FAMILY;PER 15 MINS	$7,380.00	95	15
HOME MODIFICATIONS PER SERVICE	$371,023.59	40	39
MAINTENANCE PHYSICAL THERAPY	$470,314.82	17,093	3,800
MISC THER ITEM PURCHASES NOC	$1,446,715.53	38,000	11,469
NON-EMERGENCY TRANSPORT PER MILE	$1,527,946.73	2,090,936	63,177
OCCUPATIONAL THERAPY 15 MINS	$26,904.00	3,602	985
RESPITE CARE SERVICES,UP TO 15 MINS	$888,688.37	179,492	10,504
RESPITE/DAY OOH OVNGT TIER A ACU DIF	$363.84	3	3
RESPITE/DAY OOH OVNGT TIER B	$12,260.37	102	55
RESPITE/DAY OOH OVNGT TIER B AC DI	$6,792.24	28	22
RESPITE/DAY OOH OVNGT TIER C	$69,632.55	348	182
RESPITE/DAY OOH OVNGT TIER D	$55,865.92	218	115
RESPITE/DAY OOH OVNGT TIER D AC DIF	$77,373.92	138	62
RESPITE/DAY OOH OVNGT TIER E	$40,673.76	112	24
RESPITE/DAY OOH OVNGT TIER E AC DIF	$42,817.64	59	21
RESPITE/DAY-OUT OF HME OVNG TIER A	$4,487.52	74	74
RESPITE DAY OVERNIGHT CAMP	$592,921.27	2,496	1,221
RESPITE/DAY OVNGT TIER C AC DIF	$34,109.87	88	52
RESPITE SELF DIRECTED EMPLOYEE	$43,010.19	8,775	471
SELF-CARE/HME HGT TRAINING/15 MINS	$338,470.13	12,821	3,471
SERV ASSESS/POC,DVLP,WAIVER	$21,813,754.87	167,731	92,385
SIGN LGE OR ORAL INTERP SERV/15MINS	$542.01	89	2
SKILLS TRNG & DEVELOPMENT/15MINUTES	$144,182.12	10,477	2,374
SPECIALIZED SUPPLY NOC WAIVER	$152,475.36	203	154
SPEC MED EQUIP NOC WAIVER	$1,356.25	12	5
SPEECH THERAPY IN HOME PER DIEM	$8,663.38	1,218	391
SPEECH THERAPY,IN HOME, PER DIEM	$388,826.72	15,009	4,433
SUPPORTS BROKE,SELF-DIR,WVR,15 MINS	$15,188.46	2,494	108
TRANSPORTATION NON-MEDICAL MFP	$1,016,769.27	583,648	15,675
VEHICLE MOD,WAIVER;PER SERVICE	$84,180.00	6	6
Grand Total	**$1,026,922,801.05**	**36,643,560**	**3,179,050**

Notes:
Service dates for claims span July 1, 2019 through March 31, 2020 and were paid from July 1, 2019 through August 26, 202(
Only non-voided, FFS paid claims are reflected in the data.
Represents those services listed in the Appendix H: CCP Services Quick Reference Guide of the NJ Division of Developmental Disabilities' CCP Policies & Procedures Manual (Version 3.0) March 2019 for NJFC beneficiaries with a SPC = 07.

	Atlantic County 2020 2Q	Bergen County 2020 2Q	Burlington County 2020 2Q	Camden County 2020 2Q	Cape May County 2020 2Q	Cumberland County 2020 2Q	Essex County 2020 2Q	Gloucester County 2020 2Q	Hudson County 2020 2Q
Dentist (PCDs)	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**
Dentist	92.4%	92.4%	91.4%	99.5%	100.0%	91.0%	100.0%	96.4%	100.0%
PCPs	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**
PCP	94.3%	94.3%	96.9%	99.6%	100.0%	91.5%	100.0%	95.7%	100.0%
Pediatric PCPs	91.8%	91.8%	96.9%	100.0%	100.0%	95.2%	100.0%	96.1%	100.0%
Specialist (13 Dobi)	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**
Cardiologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Dermatologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Endocrinologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
ENT	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
General surgeon	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Neurologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Obstetrician/gynecologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Oncologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Ophthalmologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Oral surgeon	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Orthopedist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Psychiatrist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Urologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Hospitals	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**
Hospital	90.1%	90.1%	96.6%	99.9%	97.8%	98.0%	100.0%	99.8%	100.0%

	Hunterdon County 2020 2Q	Mercer County 2020 2Q	Middlesex County 2020 2Q	Monmouth County 2020 2Q	Morris County 2020 2Q	Ocean County 2020 2Q	Passaic County 2020 2Q	Salem County 2020 2Q	Somerset County 2020 2Q
Dentist (PCDs)	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**
Dentist	100.0%	97.0%	98.8%	97.3%	93.2%	98.8%	99.9%	89.4%	98.5%
PCPs	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**
PCP	67.1%	99.8%	99.3%	97.2%	95.4%	98.1%	99.9%	100.0%	94.9%
Pediatric PCPs	94.4%	100.0%	100.0%	99.0%	96.2%	99.2%	99.9%	100.0%	98.6%
Specialist (13 Dobi)	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**
Cardiologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Dermatologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Endocrinologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
ENT	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
General surgeon	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Neurologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Obstetrician/gynecologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Oncologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Ophthalmologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Oral surgeon	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Orthopedist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Psychiatrist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Urologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Hospitals	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**
Hospital	32.8%	100.0%	100.0%	100.0%	99.9%	97.2%	100.0%	100.0%	99.9%

	Sussex County 2020 2Q	Union County 2020 2Q	Warren County 2020 2Q
Dentist (PCDs)	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**
Dentist	100.0%	100.0%	100.0%
PCPs	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**
PCP	96.3%	100.0%	96.4%
Pediatric PCPs	93.8%	100.0%	74.0%
Specialist (13 Dobi)	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**
Cardiologist	100.0%	100.0%	100.0%
Dermatologist	100.0%	100.0%	100.0%
Endocrinologist	100.0%	100.0%	100.0%
ENT	100.0%	100.0%	100.0%
General surgeon	100.0%	100.0%	100.0%
Neurologist	100.0%	100.0%	100.0%
Obstetrician/gynecologist	100.0%	100.0%	100.0%
Oncologist	100.0%	100.0%	100.0%
Ophthalmologist	100.0%	100.0%	100.0%
Oral surgeon	100.0%	100.0%	100.0%
Orthopedist	100.0%	100.0%	100.0%
Psychiatrist	100.0%	100.0%	100.0%
Urologist	100.0%	100.0%	100.0%
Hospitals	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**
Hospital	66.9%	100.0%	53.6%

	Atlantic County 2020 2Q	Bergen County 2020 2Q	Burlington County 2020 2Q	Camden County 2020 2Q	Cape May County 2020 2Q	Cumberland County 2020 2Q	Essex County 2020 2Q	Gloucester County 2020 2Q	Hudson County 2020 2Q
Dentist (PCDs)	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**
Dentist	90.2%	100.0%	94.1%	99.1%	100.0%	93.2%	100.0%	94.4%	100.0%
PCPs	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**
PCP	95.9%	100.0%	98.5%	100.0%	100.0%	92.7%	100.0%	94.5%	100.0%
Pediatric PCPs	92.8%	100.0%	98.6%	100.0%	100.0%	96.3%	100.0%	95.3%	100.0%
Specialist (13 Dobi)	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**
Cardiologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Dermatologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Endocrinologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
ENT	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
General surgeon	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Neurologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Obstetrician/gynecologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Oncologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Ophthalmologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Oral surgeon	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Orthopedist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Psychiatrist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Urologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Hospitals	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**
Hospital	89.7%	100.0%	97.9%	100.0%	98.3%	2.1%	100.0%	95.3%	100.0%

	Hunterdon County 2020 2Q	Mercer County 2020 2Q	Middlesex County 2020 2Q	Monmouth County 2020 2Q	Morris County 2020 2Q	Ocean County 2020 2Q	Passaic County 2020 2Q	Salem County 2020 2Q	Somerset County 2020 2Q
Dentist (PCDs)	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**
Dentist	100.0%	99.3%	100.0%	98.3%	94.0%	98.6%	93.5%	100.0%	93.7%
PCPs	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**
PCP	100.0%	100.0%	100.0%	99.1%	96.6%	99.0%	99.7%	100.0%	99.8%
Pediatric PCPs	100.0%	100.0%	100.0%	98.4%	97.4%	99.4%	97.4%	100.0%	99.9%
Specialist (13 Dobi)	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**
Cardiologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Dermatologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Endocrinologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
ENT	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
General surgeon	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Neurologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Obstetrician/gynecologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Oncologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Ophthalmologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Oral surgeon	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Orthopedist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Psychiatrist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Urologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Hospitals	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**
Hospital	99.1%	100.0%	100.0%	99.7%	100.0%	99.8%	99.0%	94.5%	100.0%

	Sussex County 2020 2Q	Union County 2020 2Q	Warren County 2020 2Q
Dentist (PCDs)	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**
Dentist	100.0%	100.0%	97.2%
PCPs	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**
PCP	96.9%	100.0%	98.3%
Pediatric PCPs	97.5%	100.0%	97.7%
Specialist (13 Dobi)	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**
Cardiologist	100.0%	100.0%	100.0%
Dermatologist	100.0%	100.0%	100.0%
Endocrinologist	100.0%	100.0%	100.0%
ENT	100.0%	100.0%	100.0%
General surgeon	100.0%	100.0%	100.0%
Neurologist	100.0%	100.0%	100.0%
Obstetrician/gynecologist	100.0%	100.0%	100.0%
Oncologist	100.0%	100.0%	100.0%
Ophthalmologist	100.0%	100.0%	100.0%
Oral surgeon	100.0%	100.0%	100.0%
Orthopedist	100.0%	100.0%	100.0%
Psychiatrist	100.0%	100.0%	100.0%
Urologist	100.0%	100.0%	100.0%
Hospitals	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**
Hospital	69.3%	100.0%	97.8%

	Atlantic County 2020 2Q	Bergen County 2020 2Q	Burlington County 2020 2Q	Camden County 2020 2Q	Cape May County 2020 2Q	Cumberland County 2020 2Q	Essex County 2020 2Q	Gloucester County 2020 2Q	Hudson County 2020 2Q
Dentist (PCDs)	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**
Dentist	88.7%	99.9%	94.9%	99.0%	100.0%	92.2%	99.9%	92.0%	100.0%
PCPs	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**
PCP	93.9%	100.0%	97.7%	100.0%	100.0%	92.7%	99.9%	94.9%	100.0%
Pediatric PCPs	96.7%	100.0%	97.1%	100.0%	100.0%	96.8%	100.0%	96.8%	100.0%
Specialist (13 Dobi)	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**
Cardiologist	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	99.9%	100.0%	100.0%
Dermatologist	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	99.9%	100.0%	100.0%
Endocrinologist	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	99.9%	100.0%	100.0%
ENT	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	99.9%	100.0%	100.0%
General surgeon	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	99.9%	100.0%	100.0%
Neurologist	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	99.9%	100.0%	100.0%
Obstetrician/gynecologist	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%
Oncologist	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	99.9%	100.0%	100.0%
Ophthalmologist	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	99.9%	100.0%	100.0%
Oral surgeon	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	99.9%	100.0%	100.0%
Orthopedist	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	99.9%	100.0%	100.0%
Psychiatrist	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	99.9%	100.0%	100.0%
Urologist	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	99.9%	100.0%	100.0%
Hospitals	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**
Hospital	100.0%	100.0%	97.2%	99.9%	98.0%	99.1%	99.9%	99.8%	100.0%

	Hunterdon County 2020 2Q	Mercer County 2020 2Q	Middlesex County 2020 2Q	Monmouth County 2020 2Q	Morris County 2020 2Q	Ocean County 2020 2Q	Passaic County 2020 2Q	Salem County 2020 2Q	Somerset County 2020 2Q
Dentist (PCDs)	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**
Dentist	100.0%	99.7%	99.4%	98.2%	93.7%	93.6%	97.9%	100.0%	99.4%
PCPs	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**
PCP	100.0%	99.9%	99.9%	98.3%	99.9%	98.4%	99.9%	100.0%	99.6%
Pediatric PCPs	100.0%	99.9%	99.9%	99.2%	99.8%	96.4%	99.9%	100.0%	99.7%
Specialist (13 Dobi)	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**
Cardiologist	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Dermatologist	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Endocrinologist	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
ENT	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
General surgeon	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Neurologist	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Obstetrician/gynecologist	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Oncologist	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Ophthalmologist	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Oral surgeon	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Orthopedist	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Psychiatrist	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Urologist	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Hospitals	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**
Hospital	99.8%	100.0%	99.9%	99.9%	100.0%	99.2%	99.6%	100.0%	99.9%

	Sussex County 2020 2Q	Union County 2020 2Q	Warren County 2020 2Q
Dentist (PCDs)	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**
Dentist	95.4%	99.9%	99.9%
PCPs	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**
PCP	99.6%	99.9%	99.9%
Pediatric PCPs	100.0%	99.9%	100.0%
Specialist (13 Dobi)	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**
Cardiologist	99.9%	99.9%	99.9%
Dermatologist	99.9%	99.9%	99.9%
Endocrinologist	99.9%	99.9%	99.9%
ENT	99.9%	99.9%	99.9%
General surgeon	99.9%	99.9%	99.9%
Neurologist	99.9%	99.9%	99.9%
Obstetrician/gynecologist	99.9%	99.9%	99.9%
Oncologist	99.9%	99.9%	99.9%
Ophthalmologist	99.9%	99.9%	99.9%
Oral surgeon	99.9%	99.9%	99.9%
Orthopedist	99.9%	99.9%	99.9%
Psychiatrist	99.9%	99.9%	99.9%
Urologist	99.9%	99.9%	99.9%
Hospitals	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**
Hospital	64.0%	99.9%	97.3%

	Atlantic County 2020 2Q	Bergen County 2020 2Q	Burlington County 2020 2Q	Camden County 2020 2Q	Cape May County 2020 2Q	Cumberland County 2020 2Q	Essex County 2020 2Q	Gloucester County 2020 2Q	Hudson County 2020 2Q
Dentist (PCDs)	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**
Dentist	95.5%	99.9%	87.0%	100.0%	68.4%	90.7%	100.0%	95.5%	100.0%
PCPs	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**
PCP	97.6%	100.0%	95.9%	99.8%	100.0%	91.6%	100.0%	89.4%	100.0%
Pediatric PCPs	94.8%	100.0%	91.6%	99.9%	100.0%	93.5%	100.0%	91.5%	100.0%
Specialist (13 Dobi)	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**
Cardiologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Dermatologist	100.0%	100.0%	100.0%	100.0%	99.7%	100.0%	100.0%	100.0%	100.0%
Endocrinologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
ENT	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
General surgeon	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Neurologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Obstetrician/gynecologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Oncologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Ophthalmologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Oral surgeon	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Orthopedist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Psychiatrist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Urologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Hospitals	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**
Hospital	100.0%	100.0%	100.0%	100.0%	97.9%	98.7%	100.0%	100.0%	100.0%

	Hunterdon County 2020 2Q	Mercer County 2020 2Q	Middlesex County 2020 2Q	Monmouth County 2020 2Q	Morris County 2020 2Q	Ocean County 2020 2Q	Passaic County 2020 2Q	Salem County 2020 2Q	Somerset County 2020 2Q
Dentist (PCDs)	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**
Dentist	84.6%	98.8%	100.0%	98.0%	97.2%	97.1%	100.0%	89.8%	100.0%
PCPs	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**
PCP	90.0%	99.4%	100.0%	98.4%	98.7%	95.5%	99.9%	100.0%	99.3%
Pediatric PCPs	66.7%	99.6%	100.0%	97.6%	96.8%	98.3%	100.0%	100.0%	100.0%
Specialist (13 Dobi)	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**
Cardiologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Dermatologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Endocrinologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
ENT	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
General surgeon	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Neurologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Obstetrician/gynecologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Oncologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Ophthalmologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Oral surgeon	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Orthopedist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Psychiatrist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Urologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Hospitals	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**
Hospital	53.8%	100.0%	100.0%	99.8%	100.0%	92.7%	99.5%	100.0%	100.0%

	Sussex County 2020 2Q	Union County 2020 2Q	Warren County 2020 2Q
Dentist (PCDs)	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**
Dentist	72.3%	100.0%	86.7%
PCPs	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**
PCP	99.8%	100.0%	100.0%
Pediatric PCPs	100.0%	100.0%	100.0%
Specialist (13 Dobi)	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**
Cardiologist	100.0%	100.0%	100.0%
Dermatologist	100.0%	100.0%	100.0%
Endocrinologist	100.0%	100.0%	100.0%
ENT	100.0%	100.0%	100.0%
General surgeon	100.0%	100.0%	100.0%
Neurologist	100.0%	100.0%	100.0%
Obstetrician/gynecologist	100.0%	100.0%	100.0%
Oncologist	100.0%	100.0%	100.0%
Ophthalmologist	100.0%	100.0%	100.0%
Oral surgeon	100.0%	100.0%	100.0%
Orthopedist	100.0%	100.0%	100.0%
Psychiatrist	100.0%	100.0%	100.0%
Urologist	100.0%	100.0%	100.0%
Hospitals	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**
Hospital	65.7%	100.0%	93.8%

	Atlantic County 2020 2Q	Bergen County 2020 2Q	Burlington County 2020 2Q	Camden County 2020 2Q	Cape May County 2020 2Q	Cumberland County 2020 2Q	Essex County 2020 2Q	Gloucester County 2020 2Q	Hudson County 2020 2Q
Dentist (PCDs)	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**
Dentist	93.6%	99.8%	92.1%	99.9%	100.0%	92.4%	100.0%	95.8%	100.0%
PCPs	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**
PCP	95.4%	100.0%	99.5%	100.0%	100.0%	91.7%	100.0%	95.6%	100.0%
Pediatric PCPs	96.0%	100.0%	99.2%	99.9%	100.0%	94.5%	100.0%	96.5%	100.0%
Specialist (13 Dobi)	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**
Cardiologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Dermatologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Endocrinologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
ENT	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
General surgeon	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Neurologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Obstetrician/gynecologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Oncologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Ophthalmologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Oral surgeon	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Orthopedist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Psychiatrist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Urologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Hospitals	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**
Hospital	99.9%	100.0%	100.0%	100.0%	98.2%	98.2%	100.0%	97.5%	100.0%

	Hunterdon County 2020 2Q	Mercer County 2020 2Q	Middlesex County 2020 2Q	Monmouth County 2020 2Q	Morris County 2020 2Q	Ocean County 2020 2Q	Passaic County 2020 2Q	Salem County 2020 2Q	Somerset County 2020 2Q
Dentist (PCDs)	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**
Dentist	100.0%	99.1%	99.9%	97.6%	95.2%	98.1%	99.9%	100.0%	99.5%
PCPs	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**
PCP	100.0%	100.0%	100.0%	99.3%	98.1%	98.8%	99.3%	100.0%	99.8%
Pediatric PCPs	100.0%	100.0%	100.0%	98.4%	96.5%	98.6%	98.9%	100.0%	99.6%
Specialist (13 Dobi)	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**
Cardiologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Dermatologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Endocrinologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
ENT	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
General surgeon	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Neurologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Obstetrician/gynecologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Oncologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Ophthalmologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Oral surgeon	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Orthopedist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Psychiatrist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Urologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Hospitals	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**
Hospital	88.3%	100.0%	100.0%	99.9%	100.0%	99.9%	99.9%	28.7%	100.0%

	Sussex County 2020 2Q	Union County 2020 2Q	Warren County 2020 2Q
Dentist (PCDs)	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**
Dentist	100.0%	100.0%	100.0%
PCPs	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**
PCP	96.1%	100.0%	97.4%
Pediatric PCPs	100.0%	100.0%	99.5%
Specialist (13 Dobi)	**1 in 45 Miles**	**1 in 45 Miles**	**1 in 45 Miles**
Cardiologist	100.0%	100.0%	100.0%
Dermatologist	100.0%	100.0%	100.0%
Endocrinologist	100.0%	100.0%	100.0%
ENT	100.0%	100.0%	100.0%
General surgeon	100.0%	100.0%	100.0%
Neurologist	100.0%	100.0%	100.0%
Obstetrician/gynecologist	100.0%	100.0%	100.0%
Oncologist	100.0%	100.0%	100.0%
Ophthalmologist	100.0%	100.0%	100.0%
Oral surgeon	100.0%	100.0%	100.0%
Orthopedist	100.0%	100.0%	100.0%
Psychiatrist	100.0%	100.0%	100.0%
Urologist	100.0%	100.0%	100.0%
Hospitals	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**
Hospital	98.7%	100.0%	40.3%

New Jersey 1115 Comprehensive Demonstration
Annual Report Demonstration Year 8 (July 1, 2019 – June 30, 2020) Department of Children and Families
Children's System of Care

Quality Strategy Measures

Data reports were created through CSOC's Contracted System Administrator (CSA) to assist CSOC in measuring demonstration outcomes, delivery of service and other required quality strategy assurances.

- CSA NJ1218 New Enrollees, Quarterly Count and IOS Completed
- CSA NJ1219 Follow – Up Treatment Plan and Associated SNA
- CSA NJ1220 Demonstration Services Provided
- CSA NJ1225 Strengths & Needs Assessment – Post SPC Start
- CSA NJ1289 Demonstration ISP Aggregate Report All Youth
- CSA NJ2021 CANS Demonstration Outcome
- CSA NJ1384 Demonstration Sub Assurance

A summary of the outcomes of the State's Quality Strategy for HCBS as outlined above - CSSP I/DD Demonstration and ASD Pilot

#1 Administrative Authority Sub Assurance	The New Jersey State Medicaid Agency, Division of Medical Assistance and Health Services (DMAHS) retains the ultimate administrative authority and responsibility for the operation of the Demonstration program by exercising oversight of the performance of the Demonstration functions by other state and contracted agencies.
Data Source	DMAHS reports on this sub assurance
Sampling Methodology	DMAHS reports on this sub assurance
Numerator: Number of sub assurances that are substantially compliant (86 % or greater)	DMAHS reports on this sub assurance
Denominator: **T**otal number of sub assurances audited	DMAHS reports on this sub assurance
Percentage	DMAHS reports on this sub assurance

#2 Quality of Life Sub Assurance	All youth that meet the clinical criteria for services through the Department of Children and Families (DCF), Division of Children' s System of Care (CSOC) will be assessed utilizing the comprehensive

	Child and Adolescent Needs and Strengths (CANS) assessment tool	
Data Source	Review of Child and Adolescent Needs and Strengths scores Contracted System Administrator (CSA) Data Data report: CSA NJ1225 Strengths & Needs Assessment – Post SPC Start	
Sampling Methodology	100% New youth enrolled in the demonstration	
Demonstration	**I/DD**	**ASD**
Numerator: Number of youth receiving Child and Adolescent Needs and Strengths (CANS) assessment	943	125
Denominator: Total number of new enrollees	946	125
Percentage	99.7%	100%

CSOC conducted a review of the data for all the youth enrolled during the reporting period under the CSSP I/DD demonstration and ASD pilot. Two youth were enrolled in the demonstration at the end of the quarter and are in the process of having their assessments done. One youth was involved with Mobile Response and Stabilization Services (MRSS) and had the required crisis assessment completed (CAT). The existing demonstration enrollment report does not capture MRSS assessments and therefore this youth was not counted correctly. CSOC is working to modify this report to include MRSS's assessment.

#3 Quality of Life Sub Assurance	80% of youth should show improvement in Child and Adolescent Needs and Strengths composite rating within a year	
Data Source	CSA Data on CANS Initial and Subsequent Assessments Data report: CSA NJ2021CANS Demonstration Outcome	
Sampling Methodology	Number of youth enrolled in the demonstration for at least 1 year	
Demonstration	**I/DD**	**ASD**
Numerator: Number of youth who improved within one year of admission	1459	402
Denominator: Number of youth with Child and Adolescent Needs and Strengths assessments conducted 1 year from admission or last CANS conducted	1582	410
Percentage	92%	98%

#4 Level of Care	CSOC's Contracted System's Administrator (CSA), conducts an initial

Sub Assurance	Level of Care assessments (aka Intensity of Services (IOS) prior to enrollment for all youth	
Data Source	CSA Data report: CSA NJ1218 New Enrollees, Quarterly Count and IOS Completed	
Sampling Methodology	100% new youth enrolled in the demonstration	
Demonstration	**I/DD**	**ASD**
Numerator: Number of youth receiving initial level of care determination prior to enrollment	946	125
Denominator: Number of new enrollees	946	125
Percentage	100%	100%

#5 Plan of Care Sub Assurance	The Plan of Care (aka Individual Service Plan (ISP)) is developed based on the needs identified in the Child and Adolescent Needs and Strengths assessment tool and according to CSOC policies	
Data Source	CSA Data on Plans of Care completions, Record Review Data report: CSA NJ1219 Follow – Up Treatment Plan and Associated SNA	
Sampling Methodology	100% of youth enrolled during the measurement period	
Demonstration	**I/DD**	**ASD**
Numerator: Number of Plans of Care that address youth's assessed needs	943	125
Denominator: Number of Plans of Care reviewed	946	125
Percentage	97.7%	100%

CSOC conducted a review of the data for all the youth enrolled during the reporting period under the CSSP I/DD demonstration and ASD pilot. It was found that two youth included in the sample had been enrolled in the demonstration at the end of the quarter and are in the process of having their assessments done. One youth was involved with Mobile Response and Stabilization Services (MRSS) and had the required crisis assessment completed. The existing demonstration enrollment report does not capture MRSS assessments and therefore this youth was not counted correctly. CSOC is working to modify this report to include MRSS's assessment.

CSOC is working to modify this report to include MRSS assessment.

#6 Plan of Care Sub Assurance	Plan of Care (ISP) is updated at least annually or as the needs of the youth changes	
Data Source	CSA Data Report: CSA NJ1289 Demonstration ISP Aggregate Report All Youth	
Sampling Methodology	100% of youth enrolled during the measurement period	
Demonstration	**I/DD**	**ASD**
Numerator: Number of current Plans of Care updated at least annually	448	87
Denominator: Number of Plans of Care reviewed	448	87
Percentage	100%	100%

#7 Plan of Care Sub Assurance	Services are authorized in accordance with the approved plan of care Data Report: CSA NJ1220 Demonstration Services Provided	
Data Source	CSA Data Report of Authorizations Record Review	
Sampling Methodology	100% of youth enrolled during the measurement period	
Demonstration	**I/DD**	**ASD**
Numerator: Number of Plans of Care that had services authorized based on the Plan of Care	946	125
Denominator: Number of Plans of Care reviewed	946	125
Percentage	100%	100%

#8 Plan of Care Sub Assurance	Services are delivered in accordance with the approved plan of care	
Data Source	CSA Data Report of Authorizations Claims paid on authorized services through MMIS Record Review	
Sampling Methodology	Random sample representing a 95% confidence level	
Demonstration	**I/DD**	**ASD**

Numerator: Number of services that were delivered	In Development	In Development
Denominator: Number of services that were authorized	In Development	In Development
Percentage	In Development	In Development

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

#9 Plan of Care Sub Assurance	Youth/families are provided a choice of providers, based on the available qualified provider network	
Data Source	Record review Statewide CSA Data Report: NJ1384 Provider List - CSA Data Report	
Sampling Methodology	Random sample representing a 95% confidence level	
Waiver	I/DD	ASD
Numerator: Number of youth/families given a choice of providers as indicated in progress notes	2710	604
Denominator: Number of records reviewed	3698	671
Percentage	73%	90%

The record review found evidence of choice being offered during the Child and Family Team (CFT) meeting. However, the form documenting choice was not consistently captured at every 90-day CFT meeting and uploaded in the youth's electronic record. CSOC will reinforce the need to correctly upload the documentation of choice.

#10 Qualified Providers Sub Assurance	Children's System of Care verifies that providers of waiver services initially meet required qualified status, including any applicable licensure and/or certification standards prior to their furnishing waiver services	
Data Source	Record review	
Sampling Methodology	100% Agency	
Waiver	**I/DD**	**ASD**
Numerator: Number of new providers that met the	0	0

qualifying standards prior to furnishing waiver services		
Denominator: Total number of new providers	0	0
Percentage	0%	0%

No new waiver providers were enrolled during this reporting period.

# 11 Qualified Providers Sub Assurance	Children's System of Care verifies that providers of waiver services continually meet required qualified status, including any applicable licensure and/or certification standards	
Data Source	Provider Certification	
Sampling Methodology	100% Agency	
Waiver	**I/DD**	**ASD**
Numerator: Number of providers that meet the qualifying standards applicable-licensures/certification	181	181
Denominator: **Total** number of providers that initially met the qualified status	148	148
Percentage	81.7%	81.7%

The provider pool overlaps both the I/DD and ASD programs. As a result, the numbers above are duplicated between the two programs.

As the verification of provider qualifications was implemented within this reporting period, and the information is obtained based on the provider's contracted renewal date, the data only includes provider information for those providers that had a contracted renewal date that fell between the date of implementation and the end the reporting period. It would not include any provider that had a contracted date outside of this time period. It is anticipated that all contracted providers will be counted and reported on in the next annual report.

# 12 Qualified Providers Sub Assurance	CSOC implements its policies and procedures for verifying that applicable certifications/checklists and training are provided in accordance with qualification requirements as listed in the waiver	
Data Source	Record Review	
Sampling Methodology	100% Community Provider Agencies	
Waiver	**I/DD**	**ASD**

Numerator: Number of providers that have been trained and are qualified to provide waiver services	In Development	In Development
Denominator: Total number of providers that provide waiver services	In Development	In Development
Percentage	In Development	In Development

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

# 13 Health and Welfare Sub Assurance	The State demonstrates on an on-going basis, that it identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation	
Data Source	Review of UIRMS database and Administrative policies & procedures	
Sampling Methodology	100% of youth enrolled for the reporting period	
Waiver	**I/DD**	**ASD**
Numerator: Total number of UIRs submitted timely according to State policies	128	30
Denominator: Number of UIRs submitted involving enrolled youth	128	30
Percentage	100%	100%

Three reported incidents involving youth served under the I/DD waiver were not reported timely as required by CSOC's administrative order.

# 14 Health and Welfare Sub Assurance	The State incorporates an unusual incident management reporting system (UIRMS), as articulated in Administrative Order 2:05, which reviews incidents and develops polices to prevent further similar incidents (i.e., abuse, neglect and runaways)	
Data Source	Review of UIRMS database and Administrative policies & procedures	
Sampling Methodology	100% of youth enrolled for the reporting period	
Waiver	**I/DD**	**ASD**
Numerator:	128	30

The number of incidents that were reported through UIRMS and had required follow up		
Denominator: Total number of incidents reported that required follow up	128	30
Percentage	100%	100%

# 15 Health and Welfare Sub Assurance	The State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed	
Data Source	Review of UIRMS	
Sampling Methodology	100% of all allegations of restrictive interventions reported	
Waiver	**I/DD**	**ASD**
Numerator: Number of unusual incidents reported involving restrictive interventions that were remediated in accordance to policies and procedures	2	N/A
Denominator: Total number of unusual incidents reported involving restrictive interventions	1	N/A
Percentage	50%	N/A

In review of the one incident in which proper restrain procedure was not followed, it was reported in the UIR that the youth was engaging in dropping behaviors (dropping to the floor) while being transitioned to his afternoon class. Staff attempted to implement an escort in the form of an improper carry for approximately 10 seconds. Carries are not an approved technique. As a result, the corrective action was that the staff involved received re-training on approved techniques.
No injuries were sustained.

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

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

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

Deliverables due during MLTSS Year 6 (7/1/2019 - 6/30/2020)

The Office of Managed Long-Term Services and Supports Quality Monitoring (MLTSS QM) is involved in multiple activities associated with the quality oversight of the Managed Care Organizations (MCOs) and their relation to the MLTSS population. IPRO, the External Quality Review Organization (EQRO) for the State, on behalf of the State of New Jersey, conducts the mandatory CMS activities of: Review of Compliance with Medicaid and CHIP Managed Care Regulations, Validation of Performance Measures, and Validation of Performance Improvement Projects (PIPs).

The Annual Assessment of MCO Operations conducted by the EQRO reviews compliance for contractual Federal and State operational and quality requirements. MCOs demonstrating compliance at or above eighty five percent (85%) receive a partial review every other year for those elements that are "Not Met" or "N/A" during the comprehensive review. MLTSS elements are subject to review each year regardless of their compliance determination in the prior year. The 2019 review included partial reviews for four MCOs and a full review for one MCO for Core/MLTSS. Corrective Action Plans (CAPs) were requested from the MCOs for any elements that received recommendations for deficiencies. For the audit period of January –December 2018 an assessment was conducted in early 2019 for FIDE SNP/MLTSS.

The NJ FamilyCare Managed Care Contract article 9.11.E requires NJ FamilyCare MCOs to report Performance Measures for the MLTSS program. The EQRO, in collaboration with the Office of Managed Long-Term Services and Supports Quality Monitoring, annually review and refine Performance Measure specifications to assure consistent approaches to data collection across the five MCOs. Each year, the MCOs are required to submit source code and sample files to the EQRO for the first measurement period for each Performance Measure as part of the validation process. The EQRO assesses each MCO's process for calculating Performance Measures including whether the process adhered to each measure's specifications, and the accuracy of the Performance Measure rates as calculated and reported by the MCOs. The EQRO works with the State to monitor the submission of Performance Measures throughout the year and produces quarterly validation reports as well as an annual Performance Measure validation report for the Office of MLTSS QM.

All five MCOs submitted a progress report update in August 2019 on the topic of Decreasing Gaps in Care that included the 2018 baseline data which was reviewed by the EQRO. January 2020 was the start of remeasurement Year 2 for this PIP. Recommendations for performance improvement provided to the MCOs regarding this new topic were to target preventative services for MLTSS members and/or to target services related to chronic disease. One MCO was required to submit a new Falls PIP as a result of incongruent and inconclusive data in a previous Falls PIP. The MCO submitted their first new Falls PIP update in August of 2019. Four MCOs provided Project status updates for Gaps in Care through March 2020 which were submitted in April 2020. One MCO submitted a Project Status and Baseline Update for Year 1 for both their Gaps in Care and Falls PIPs in April 2020. All of the PIP submissions were reviewed by the EQRO in collaboration with DMAHS. Recommendations for improvement were provided to all of the MCOs. Due to the onset of COVID 19 in early 2020, many of the MCOs have identified challenges with the implementation of planned interventions for their PIPs. In August 2020 all five MCOs are expected to submit PIP project updates.

The EQRO also performs voluntary CMS activities inclusive of conducting MLTSS Care Management audits and the Calculation of Performance Measures. Two separate MLTSS Care Management audits, one for members receiving Home and Community Based Services (HCBS), and one for members receiving services in a Nursing Facility/Special Care Nursing Facility, were conducted by the EQRO to evaluate the effectiveness of each MCO's contractually-required MLTSS Care Management program. Audit activities included an evaluation of the following metrics: Assessment, Outreach, Face-to-Face Visits, Initial Plan of Care, Ongoing Care Management, and Gaps in Care. Based on the findings, the MCOs were required to submit work plans to the State addressing the EQRO's recommendations. (Reports available on request)

The EQRO uses the data from the annual assessment, focus studies, and MLTSS Care Management (CM) audits to calculate certain MLTSS Performance Measures for each MCO. The results of the MLTSS Performance Measures calculated by the EQRO are included in each specific report.

For the third year, the EQRO conducted a focus study on behalf of the State for Performance Measure #13 to assess if MLTSS HCBS Services were delivered in accordance with the Plan of Care (POC), including the type, scope, amount, frequency, and duration. The EQRO calculated PM #13 for each of the five MCOs through review of care management records and claims history. Where appropriate, planned service discontinuations and black-out periods were removed from this analysis. Black-out periods are periods of time when MLTSS HCBS services are stopped temporarily due to hospitalizations, extended family visits, non-custodial inpatient rehabilitations, and other reasonable circumstances. MCOs were responsible for providing details of such events to the EQRO. MCOs were given a template for reporting pertinent information for black-out periods, including start and end dates, and the reason why the black-out period or service discontinuation occurred. If no reason was documented, the black-out period was not removed from this analysis. The EQRO continues to work with the MCOs for consistency and standardization in their submissions of Performance Measure #13 data.

The Office of MLTSS Quality Monitoring is also involved in multiple initiatives consisting of workgroups, meetings, and surveys with the goal of evaluating and improving the health, safety, and quality of life of the members enrolled in MLTSS. These initiatives include but are not limited to: the MLTSS MCO Quality Workgroup, National Core Indicators – Aging and Disabilities (NCI-AD) Survey, Interdivisional Quality Workgroup, monthly MCO Conference calls, and Annual MLTSS/MCO Quality Status Meetings.

The MLTSS MCO Quality Workgroup consists of representatives from each of the MCOs, Division of Aging Services (DoAS), the EQRO, MLTSS QM, and other DMAHS units. The monthly meetings have a primary focus on the MLTSS Performance Measures as well as other contract required reports. These meetings facilitate the discussion of reporting elements that may present challenges to the MCOs in reporting and a consensus is developed on how to address these issues so that the data received from each MCO can be aggregated and representative of the overall MLTSS program.

National Core Indicators – Aging and Disabilities

The National Core Indicators for Aging and Disabilities© (NCI-AD) are standard measures used across participating states to assess the quality of life and outcomes of seniors and adults with physical disabilities—including traumatic or acquired brain injury—who are accessing publicly-funded services. The program is coordinated by Advancing States (formerly the National Association of States United for Aging and Disabilities (NASUAD)) and Human Services Research Institute (HSRI). New Jersey voluntarily participates in this extensive, confidential, face to face consumer survey, the purpose of which is to procure feedback directly from service recipients regarding service satisfaction and quality of life issues. The NCI-AD survey is important to NJ because data gleaned from survey participants can be used to support New Jersey's efforts to strengthen LTSS policy, inform quality assurance activities, and improve the quality of life of LTSS consumers regardless of funding source. The Medical Assistance Customers Centers (MACCs), Program of All-inclusive Care for the Elderly (PACE) organizations, NJ Hospital Association, American Association of Retired Persons (AARP), and the Managed Care Organizations (MCOs) all have a vested interest in the continued completion and outcomes of this survey. In 2018-2019, over 750 members were surveyed, including MLTSS members, both in the community and in nursing facilities, and PACE members. New Jersey included eleven questions unique to the State that addressed specific concerns relevant to NJ and its residents and also participated in the optional NCI-AD Person-Centered Planning Module, which consisted of ten questions addressing how involved the member is during the development of their Plan of Care and whether their goals and choices were reflected in the POC. All NCI-AD reports along

with additional information regarding the NCI-AD Survey process can be found on the NCI-AD website, www.nci-ad.org.

MLTSS Performance Measure Data Report

Each year, the Office of MLTSS QM works with the EQRO in the selection and development of MLTSS Performance Measures to meet the reporting requirements of the Special Terms and Conditions (STC) of the 1115 Comprehensive Medicaid Waiver and to evaluate MCO performance in areas not specifically required in the STC. The MCOs, DoAS, and the DMAHS PPP State Program Office submit the required Performance Measure reports to the Office of MLTSS QM. All corrections/reconciliations received by the respective specified data source (MCOs, DoAS, EQRO or the DMAHS PPP State Program Office) are reported to CMS quarterly.

Annual Performance Measure Validation Reporting Monitoring

The EQRO has been working with the MCOs on their MLTSS Annual Performance Measure Validation during the July 1, 2019 – June 30, 2020 period. The EQRO conferred individually with each MCO to review their data sources and reporting systems for each Performance Measure. Data sources included claims data, eligibility data, care management systems, and living arrangement files. MCOs submitted source code, member level files and preliminary rates for the first reporting cycle for each measure for review and approval. MCOs were provided with feedback on initial submissions and were given an opportunity to correct source code and or processes used to produce the Performance Measures. Upon completion of the review process and receiving approval from the EQRO, MCOs submitted their rates to DMAHS Office of MLTSS QM.

Quarterly Performance Measure Validation Reporting Monitoring

The EQRO has been actively working with the MCOs to obtain for their Performance Measures their source codes, sample files, preliminary rates, preliminary data, flow charts, and tools the MCOs have developed that will describe how the measures are being produced. As multiple sources of data are being utilized (systems, claims, complaints/grievances), the EQRO sought consistency across all MCOs and arranged calls with each MCO to discuss. As Performance Measure source codes are validated by the EQRO, the MCOs simultaneously submit their Performance Measures to the State and to the EQRO's FTP site. This enables the EQRO to capture the MCO Performance Measure data in real time and perform real time quarterly monitoring. The MCOs must resubmit to the State and to the EQRO all Performance Measures not accepted by either the State or the EQRO. All Performance Measure reports, including corrections, are to be submitted to both the State and to the EQRO.

Monthly MCO Conference Calls

The DMAHS Office of Managed Health Care conducts monthly operational meetings with each of the five MCOs. In those meetings, operational areas such as Member utilization of MLTSS services, care management ratios, and critical incident trends are reviewed. These areas among others are used as a method to allow MCOs to self-examine their operational effectiveness, report issues to the state where guidance or partnership would be needed and work to resolution.

The DMAHS and its sister agencies operating MLTSS also meet monthly to discuss new and trending issues needing resolution.

Beginning in March 2020, challenges related to the COVID-19 pandemic have mandated changes to the MLTSS program, including the suspension of face-to-face assessments and in-person care management visits. The Office of MLTSS QM is working closely with DMAHS administration to assure that MLTSS members maintain continuity of care amid the rapid changes to available services, including the mandated closure of Medical Day Care Centers. The Office of MLTSS QM anticipates that these changes will be reflected in many of the Performance Measures and other monitoring

activities reported for the measurement periods covering the COVID-19 pandemic time period. The Nursing Facility/Special Care Nursing Facility MLTSS Care Management Audit which was scheduled to begin in May 2020 was postponed due to Pandemic related concerns and will be re-evaluated in early 2021. For reporting impacted by COVID-19, data analysis will identify how the data was affected.

Monitoring activities of critical incident reports:

Performance Measure #17

Performance Measure 17 is the timeliness of Critical Incidents (CI) written reporting within two business days in the SAMS critical incident reporting system from July 1, 2019 to June 30, 2020. This measurement is determined by the number of CIs reported in writing to the Division of Aging Services (DoAS) within two business days divided by the total number of critical incidents reported to DoAS for the measurement period.

Based on the first and second year of reporting, the DoAS established that the minimum percentage accepted is 100%. Anything less requires a response from the MCO stating what actions will be taken to improve timeliness. As per the COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers, issued by CMS on March 30, 2020 with a retroactive effective date of March 1, 2020, 1135 waivers can be used to implement a range of flexibilities. These flexibilities include, but are not limiting to, 1135 waiver reporting and oversight. As such, the one-day and two-day reporting time requirement for critical incident reporting has been waived during the COVID-19 emergency declaration.

For this measurement period, a total of 12,720 CIs were reported in two business days within the reporting year. The efficiency was 97.42% reported from July 1, 2019 till March 31, 2020 for the program requirements. Due to the CMS Waiver, April, May, and June months were not required to report within the determined timeframe.

While the timeliness requirement for reporting critical incidents was waived, DoAS still tracked the number of days from when the MCO was made aware of the incidents to when they were reported to the state. The average number of days between those two benchmarks for April was 10 days, May 22 days, and June 6 days.

Performance Measure #17a

Performance Measure #17a is the measurement of Critical Incidents (CI) reported to DoAS verbally reported within one business day for media and unexpected death incidents from July 1, 2019 - June 30, 2020. This measurement is determined by the number of Critical Incidents (CI) reported to DoAS verbally reported within one business day for media and unexpected death incidents divided by the total number of CI reported verbally to DoAS for the measurement period.

Based on the first and second year of reporting, the DoAS has established that the minimum percentage accepted is 100%. Anything less will require a response from the MCO stating what actions they will take to improve timeliness. As per the COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers, issued by CMS on March 30, 2020 with a retroactive effective date of March 1, 2020, 1135 waivers can be used to implement a range of flexibilities. These flexibilities include, but are not limiting to, 1135 waiver reporting and oversight. As such, the one-day and two-day reporting time requirement for critical incident reporting has been waived during the COVID-19 emergency declaration.

For this measurement period, a total of 2407 CI were reported to DoAS verbally within one business day for media and unexpected death incidents. This resulted in a 100% efficiency score from July 1, 2019 to March 31, 2020 for the program requirements. Due to the CMS Waiver, April, May, and June months were not required to report within the determined timeframe.

While the timeliness requirement for reporting unexpected deaths and potential media events was waived, DoAS still tracked the number of days from when the MCO was made aware of the incidents to when they were reported to the state. For April the average number of days between those two benchmarks was 11 days, for May 24 days, and for June 8 days.

Supports Program and Community Care Program Updates

Outreach/Innovative Activities to Ensure Success:

Division of Developmental Disabilities (DDD) is responsible for the daily operations of both the Supports Program (SP) and the Community Care Program (CCP). DDD addresses outreach and activities to address access to both their programs concurrently as the same providers and advocacy organizations are affiliated with both program and the supports and the majority of services are identical in both programs. The primary difference between the two programs is the required level of care. Therefore the below represents data elements that is representative of both DDD programs.

4th Quarter Supports Program (SP) and Community Care Program (CCP)

The Demonstration Unit established a "DDD Medicaid Eligibility Helpdesk" to assist families, providers, advocates, etc. with questions related to Medicaid and demonstration operations. During this quarter, there were 1,923 questions submitted and answered. Three domains compose approximately 75% of the emails received. These areas are Medicaid troubleshooting (31%), voucher payments (38%), and transitioning between demonstration programs (i.e.: From MLTSS to Supports Program + Private Duty Nursing, SP to CCP, CCP to MLTSS, etc.) (26%). This quarter represented a substantial increase in questions and transitions from one demonstration program to another demonstration program while the other two areas (Medicaid troubleshooting questions and voucher payment questions remained within the historical percentages). The remainder of the questions focus on citizenship issues, wavier admission questions, follow-up emails that resulted in an immediate resolution, and emails that need to be routed to a different helpdesk or Unit. The helpdesk is involved in assisting children who are losing their EPSDT PDN services on their 21st birthday as well as individuals who want to change demonstration programs. Examples include children losing their educational entitlement and needing SP+PDN services, specifically the PDN or individuals wanting to transfer from MLTSS to a DDD demonstration program. During this quarter state staff worked remotely and congregate day facilities remained closed the entire quarter. This quarter represented the first decrease in the number of questions submitted to the helpdesk since its inception. There was a decrease of approximately 300 questions over the quarter with the majority of the decrease occurring during the months of May and June. Anecdotally, the decrease may be due to the decrease in individuals losing Medicaid due to the approved 1135 modifications and the bi-weekly Communication Update webinars conducted by DDD's Assistant Commissioner.

Annual

During this DY the Division developed a Medicaid Eligibility Helpdesk (MEH). Prior to moving to a FFS model individuals and provider agencies would receive services even when their Medicaid was terminated. These services were paid for with State dollars and a Federal match was not received. With the shift to FFS the providers would only receive payment for services rendered to individuals with Medicaid and individuals who lost Medicaid would either lose services or the provider would not be reimbursed for continuing to render services. The MEH was developed out of a need to offer guidance to individuals, guardians, payees, and providers on how to maintain and re-establish Medicaid once lost. The helpdesk received 7,273 questions this DY. The Division has received many compliments regarding the helpdesk's customer service, timely responses, and helpful information. The majority of the questions received focus on trouble shooting Medicaid questions such as what to do when someone is notified that their Medicaid is terming, a parent is planning to retire-how will SSDI impact my child's Medicaid, and Medicaid has been terminated-what do I do now. Initial data showed that 90% of helpdesk questions

came from Support Coordination Agencies, however current data shows that the questions are coming from a broader group of stakeholders including provider agencies, families, and advocacy organizations.

In addition to the helpdesk, a Medicaid 101 Webinar was provided for families and individuals, Support Coordinators, and Providers. This Webinar is available on the Division's website. The Demonstration Unit staff also presented information related to maintaining and/or reinstating Medicaid at provider meetings, family meetings, and Support Coordination meetings. The Demonstration Unit operates the helpdesk and meets with Medicaid staff, routinely, to ensure that the information is current and accurate.

Operational/Policy/Systems/Fiscal Developments/Issues

As previously indicated most operational, policy, systems and fiscal developments/issues for both the SP and CCP are concurrently shared/discussed at meetings and through communications. Therefore the below is representative of both DDD programs.

4th Quarter Supports Program (SP) and Community Care Program (CCP)
At the close of this quarter the SP enrollment was approximately 10,950 and the CCP enrollment was approximately 11,730. Despite significantly higher enrollment averages per month the actual number of individuals at the end of the quarter for each program is far less. This is due to a variety of reasons including a similar amount of individuals being terminated each month and re-establishing Medicaid in subsequent months. DDD has been working on strategies with both Medicaid and their stakeholders to decrease the number of people who are terminated each month due to failure to respond to Medicaid notices.

Despite working remotely this quarter DDD administration continued to participate in or facilitate meetings with the provider community, families, advocacy organizations, councils, and disability rights leaders through bi-weekly webinars which provided operational updates and guidance. DDD also participated in the quarterly MAAC meeting which held its first virtual meeting. In addition to the bi-weekly webinars the Department of Human Services created a COVID-19 webpage that provides ongoing guidance in addition to a dashboard related to DDD operations and individuals served. NJ also submitted and received approvals from CMS for an Appendix K and 1135 that included requests for temporary modifications as a result of the COVID-19 health crisis.

Currently congregate day settings remain closed, however a Congregate Day Services re-opening committee was established to begin discussing the requirements needed to re-open congregate day settings. Support Coordination continued to be provided remotely as well as other demonstration services.

Much work was conducted to ensure safe practices among providers serving individuals. This included guidance documents, dashboard data, and delivering PPE to providers and families.

Annual
At the beginning of the DY the SP enrollment was approximately 9,300 and at the end of the DY the SP enrollment was approximately 10,900. At the beginning of the DY the CCP enrollment was approximately 11,300 and at the end of the DY the CCP enrollment was approximately 11,700. Despite significantly higher

enrollment averages per month the actual number of individuals at the end of the DY for each program is far less.
This is due to a variety of reasons including a similar amount of individuals being terminated each month and re-establishing Medicaid in subsequent months. DDD has been working on strategies with both Medicaid and their stakeholders to decrease the number of people who are terminated each month due to failure to respond to Medicaid notices. At the end of the DY 100% of individuals on the SP are in the FFS/Rate Structure model and 93% of individuals on the CCP have converted to FFS.

Quality Assurance/Monitoring Activity
4th Quarter and Annual Report
Similar quality reviews, audits, and monitoring are conducted for both the SP and the CCP. Data is provided for each Program and then reviewed to determine if there are systemic issues occurring in either or both programs. Systemic and individual remediation occurs as required.

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

DDD requires reporting on approximately 80 Incident Reporting (IR) codes. The IR codes are the same for both DDD demonstration programs. During this quarter there were 350 incidents reported for 323 individuals on the Supports Program. Approximately 97% of individuals on the Supports Program during this quarter did not require an IR. For the CCP, there were 2,778 incidents reported for 2,503 individuals this quarter. Over 9,000 individuals did not experience any incidents. The majority of individuals with incident reports filed in both programs experienced a single incident this quarter. Approximately 80% of individuals on the CCP during this quarter did not require an IR, which is consistent with the previous data. During this quarter 1,343 incidents with a COVID-19 code were filed. Due to the March 2020 State of Emergency and anticipated health crisis 2 new Incident Codes were developed for COVID. One was for a medically related COVID incident and the other was for an operational breakdown. For example, insufficient staffing. These codes already existed, but a modifier of COVID was added for trending and tracking. The 1,343 incidents include staff and family related COVID incidents as well, but the initial IR numbers are only for service recipients. The COVID incidents include negative results, positive results, universal testing, and deaths. Some IR codes, such as abuse, neglect, or exploitation require an investigation by the Office of Investigations. Less than 1% of the Incident Reports filed required an investigation by the Office of Investigations. If there were minor or no injuries, then the provider agency is responsible to conduct an investigation and submit their findings/action plan for review by the Department of Human Services Critical Incident Management Unit. If there were moderate to major injuries, then the Department of Human Services Special Response Unit will conduct an investigation.

During the previous quarter the Office of Risk Management developed findings reports on both choking and walkaway IRs based upon data demonstrating an increase in these areas. Meetings with the Support Coordination Unit occurred and preventative protocols were implemented in this quarter. Protocols included training and additional questions highlighted and incorporated into the service plan. The ORM will continue to conduct quarterly analysis around these two areas and provide updates to supporting units (Support Coordination Unit/Provider Performance and Monitoring Unit).

A Risk Council meets to look at IR from a system perspective. This committee meets quarterly and develops action items based on the data. The Risk Management Unit also conducts systemic and individual remediation activities because of IR analysis.

Annual

During this DY there were approximately 1,350 incident reports generated averaging 113 per month and representing less than 1% of individuals on the SP. This data is consistent with the findings for the last DY. For the CCP there were approximately 12,743 incident reports generated. Of these incident reports filed less than 1% required an investigation from the Office of Investigations. This is the second DY that the number of incident reports filed decreased, although the decrease was not significant.

A Risk Council meets to look at IR from a system perspective. This committee meets quarterly and develops action items based on the data. The Risk Management Unit also conducts systemic and individual remediation activities because of IR analysis. The data metrics were reviewed during this DY and minor changes are currently being vetted by the administration.

Demonstration Unit staff met with the Provider Performance & Monitoring Unit to discuss monitoring activities related to the monitoring tools that had been developed. These tools are utilized to monitor Medicaid/DDD approved providers for both DDD programs and provides further guidance technical assistance based on the results/findings. Data is entered into the databases and reports continue to be developed. Databases were/are being built so that data may be analyzed more efficiently and systemic issues can be identified and corrected. However, the Provider Performance and Monitoring Unit has conducted reviews of Day Services and Individual and Community Based Supports and has been providing exit interviews, findings reports, and technical assistance to a variety of providers. Providers are required to submit a plan of correction to PPMU. The PPMU and Demonstration Unit are conducting monthly meetings to ensure demonstration compliance and improvement activities when needed. The PPMU conducted outreach to providers as a result of day facilities closing and to residential providers and families who might be in need of personal protective equipment and is participating on the congregate day services re-opening committee. A web page dedicated to COVID-19 communications and guidance documents was developed and weekly webinars are conducted for the DDD community to get updates.

During this DY, three surveys were developed around the demonstration service: support coordination. Specifically, the surveys were: 1) Providers to complete on various questions related to their overall experiences with support coordination agencies, 2) Support Coordinators are to complete various questions related to their caseload size, salary, overall experiences with provider agencies, 3) Support Coordination Supervisors to complete various questions related to their role and tasks. Because of feedback from the advocacy community, a fourth survey was created for families to complete including a Spanish version. All surveys were released and closed the end of July, but were re-opened for an additional few weeks to allow for additional respondents. The survey results have been placed into 3 different Power Point presentations and was shared with Division Leadership. The data was scheduled to be shared at the March 2020 quarterly Provider and Family meetings, however due to the State of Emergency and work from home order this did not occur. The quarterly meetings did occur, but they were focused on the new work climate and COVID. The intent remains to share the results of the survey, receive feedback from the provider and family community, and implement quality improvement initiatives.

A committee was developed to create a guidebook for Support Coordinators related to the Person Centered Planning Tool that is used to develop Outcomes in the service plan. The guidebook was completed and multiple trainings throughout the state occurred in the fourth quarter. Both state staff and support coordinators participated in the face-to-face training sessions. The guidebook was

developed as a quality improvement activity to increase the person-centered philosophy when completing the PCPT and NJ ISP (DDD's service plan). DDD is working on developing a review sheet to determine if the guidebook is having an influence of the service plan development.

Audits were conducted by internal and external entities and the draft findings have been received. DDD is drafted their response to the draft reports, which will include individual and systemic remediation activities.

One external audit, conducted by Medicaid Quality Management Unit staff, for both DDD programs, looks at 5 Assurances (Service Plan, Level of Care, Qualified Providers, Financial Accountability, and Health and Welfare) with a total of 17 sub-assurances with those 5 assurances. The Division responds to the audit findings addressing each individual finding as well as addressing systemic findings. Over the years there has been significant improvements noted with a minimum compliance rate of 86% in almost all sub-assurances. This is the first year that the CCP audit consisted entirely of service recipients that have transitioned into the FFS model that has a new service plan, new wavier services, and new rules and requirements. The DRAFT report showed a decrease in compliance. The Demonstration staff were beginning to analyze the data when there was a need to work remotely. This analysis will continue, but was halted due to COVID activities taking precedence.

DDD participates in the National Core Indicators. This DY DDD conducted over 400 face-to-face interviews with adults receiving services in both programs as well as the NCI Staff Stability Survey. DDD hosted NCI staff/consultants to provide DDD provider leadership with a summary of NJs data. This meeting served as an initial meeting related to staff retention. DDD is participating in NCI again this DY. This DY NCI surveys include questions related to COVID-19 which is new and DDD is looking forward to being able to analyze this data.

DDD worked with the Council on Quality and Leadership and is developing a quality initiative to embed some of the person centered philosophies into service planning.

Federal Budget Neutrality Summary

SUBJECT TO PUBLIC COMMENT PROCESS

Room Under the Budget Neutrality Cap					**$ 28,873,147,345**
	Total				
State Fiscal Year	Date of Service Budget Neutrality Ceiling*	CMS 64 Waiver Date of Service Expenditures	BN Savings Phase-Down	DSRIP Expenditures	Variance
Initial Waiver Period					
SFY13 Actual	$ 6,871,898,690	$ 5,839,998,519			$ 1,031,900,171
SFY14 Actual	$ 9,431,708,430	$ 8,123,145,328			$ 1,308,563,102
SFY15 Actual	$ 10,102,033,007	$ 8,124,498,013			$ 1,977,534,994
SFY16 Actual	$ 10,699,606,636	$ 8,202,224,406			$ 2,497,382,230
SFY17 Actual	$ 11,144,593,493	$ 8,387,448,667			$ 2,757,144,826
SFY13-17	$ 48,249,840,256	$ 38,677,314,933	$ -	$ -	$ 9,572,525,323
First Waiver Extension Period					
SFY18 Actual	$ 11,627,746,895	$ 8,275,479,152			$ 3,352,267,743
SFY19 Actual	$ 11,704,628,853	$ 8,318,115,251			$ 3,386,513,602
SFY20 Actual	$ 12,258,052,481	$ 8,398,881,641			$ 3,859,170,840
SFY21 Projected	$ 13,074,965,813	$ 8,965,912,801			$ 4,109,053,012
SFY22 Projected	$ 13,948,718,652	$ 9,355,101,827			$ 4,593,616,825
SFY18-22	$ 62,614,112,693	$ 43,313,490,671			$ 19,300,622,022
Second Waiver Extension Period					
Total					**$ 28,873,147,345**

Budget Neutrality Monitoring Spreadsheet

Main Budget Neutrality Test

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

TOTAL COMPUTABLE

Waiver Year	1	2	3	4	5	*Demo*	6	7	8	9	10	*Renewal*
State Fiscal Year	2013	2014	2015	2016	2017	*Period 1*	2018	2019	2020	2021	2022	*Period 1*
NO WAIVER												
Title XIX	$ 1,888,003,055	$ 2,721,828,868	$ 3,190,622,964	$ 3,450,278,327	$ 3,615,572,700	**$ 14,866,305,914**	$ 3,754,912,420	$ 3,815,179,055	$ 4,143,829,920	$ 4,500,791,746	$ 4,888,503,326	$ 21,103,216,466
***ABD/LTC/HCBS State Plan**	$ 4,983,895,635	$ 6,709,879,563	$ 6,911,410,044	$ 7,249,328,309	$ 7,529,020,793	**$ 33,383,534,342**	$ 7,872,834,475	$ 7,889,449,798	$ 8,114,222,561	$ 8,574,174,066	$ 9,060,215,326	$ 41,510,896,227
	$ -	$ -	$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	$ -	$ -	$ -
NO WAIVER -TOTAL COMPUTABLE	**$ 6,871,898,690**	**$ 9,431,708,430**	**$ 10,102,033,007**	**$ 10,699,606,636**	**$ 11,144,593,493**	**$ 48,249,840,256**	**$ 11,627,746,895**	**$ 11,704,628,853**	**$ 12,258,052,481**	**$ 13,074,965,813**	**$ 13,948,718,652**	**$ 62,614,112,693**
WITH WAIVER												
Title XIX	$ 1,660,533,500	$ 2,401,753,394	$ 2,588,414,484	$ 2,549,675,884	$ 2,591,767,989	**$ 11,792,145,251**	$ 2,628,154,865	$ 2,761,270,528	$ 3,062,575,752	$ 3,326,395,131	$ 3,612,940,695	$ 15,391,336,970
****ABD/LTC/HCBS State Plan**	$ 3,968,224,421	$ 5,414,534,418	$ 5,233,912,050	$ 5,318,687,934	$ 5,586,271,992	**$ 25,521,630,815**	$ 5,433,625,572	$ 5,343,146,008	$ 5,122,607,174	$ 5,591,818,955	$ 5,694,462,417	$ 27,185,660,126
HCBS state plan	$ -	$ -	$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	$ -	$ -	$ -
DDD Supports-PDN	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	$ -
DSRIP	$ 182,909,773	$ 266,607,552	$ 266,600,001	$ 293,872,727	$ 166,600,000	**$ 1,364,590,053**	$ 166,000,000	$ 166,000,000	$ 166,000,000			$ 498,000,000
CNOMS	$ 28,330,825	$ 40,249,964	$ 35,571,478	$ 39,987,861	$ 42,808,686	**$ 186,948,814**	$ 47,698,715	$ 47,698,715	$ 47,698,715	$ 47,698,715	$ 47,698,715	$ 238,493,575
WITH WAIVER - TOTAL COMPUTABLE	**$ 5,839,998,519**	**$ 8,123,145,328**	**$ 8,124,498,013**	**$ 8,202,224,406**	**$ 8,387,448,667**	**$ 38,865,314,933**	**$ 8,275,479,152**	**$ 8,318,115,251**	**$ 8,398,881,641**	**$ 8,965,912,801**	**$ 9,355,101,827**	**$ 43,313,490,671**
Difference	**$ 1,031,900,171**	**$ 1,308,563,102**	**$ 1,977,534,994**	**$ 2,497,382,230**	**$ 2,757,144,826**	**$ 9,384,525,323**	**$ 3,352,267,743**	**$ 3,386,513,602**	**$ 3,859,170,840**	**$ 4,109,053,012**	**$ 4,593,616,825**	***$ 19,300,622,022***

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

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

FEDERAL SHARE

Waiver Year	1	2	3	4	5	*Demo*	6	7	8	9	10	*Renewal*
State Fiscal Year	2013	2014	2015	2016	2017	*Period 1*	2018	2019	2020	2021	2022	*Period 1*
NO WAIVER												
Title XIX	$ 947,820,711	$ 1,506,469,241	$ 1,750,151,802	$ 1,750,830,336	$ 1,816,515,118	**$ 7,771,787,207**	$ 1,888,423,385	$ 1,918,732,727	$ 2,084,018,067	$ 2,263,541,578	$ 2,458,529,778	**$ 10,613,245,534**
***ABD/LTC/HCBS State Plan**	$ 2,499,524,558	$ 3,376,403,772	$ 3,473,912,853	$ 3,631,623,584	$ 3,767,547,946	**$ 16,749,012,714**	$ 3,942,108,721	$ 3,950,368,950	$ 4,062,865,509	$ 4,293,167,650	$ 4,536,533,195	**$ 20,785,044,025**
	$ -	$ -	$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	$ -	$ -	**$ -**
	$ -	$ -	$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	$ -	$ -	**$ -**
NO WAIVER - FEDERAL SHARE	**$ 3,447,345,268**	**$ 4,882,873,013**	**$ 5,224,064,655**	**$ 5,382,453,920**	**$ 5,584,063,064**	**$ 24,520,799,920**	**$ 5,830,532,106**	**$ 5,869,101,676**	**$ 6,146,883,576**	**$ 6,556,709,228**	**$ 6,995,062,973**	**$ 31,398,289,559**
WITH WAIVER												
Title XIX	$ 833,625,792	$ 1,329,314,879	$ 1,419,822,500	$ 1,293,823,124	$ 1,302,141,078	**$ 6,178,727,373**	$ 1,321,753,626	$ 1,388,700,256	$ 1,540,232,906	$ 1,672,913,147	$ 1,817,022,858	**$ 7,740,622,792**
****ABD/LTC/HCBS State Plan**	$ 2,011,079,520	$ 2,751,932,037	$ 2,624,034,877	$ 2,647,846,587	$ 2,796,259,621	**$ 12,831,152,643**	$ 2,919,435,876	$ 2,825,799,420	$ 2,773,061,210	$ 2,871,952,461	$ 2,934,384,543	**$ 14,324,633,510**
HCBS state plan	$ -	$ -	$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	$ -	$ -	**$ -**
DDD Supports-PDN	$ -	$ -	$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	$ -	$ -	**$ -**
DSRIP	$ 96,221,820	$ 138,946,279	$ 150,097,502	$ 167,888,474	$ 83,300,002	**$ 636,454,077**	$ 83,000,002	$ 83,000,002	$ 83,000,002			**$ 249,000,006**
CNOMS	$ 14,673,183	$ 20,874,539	$ 18,489,075	$ 20,485,806	$ 21,899,156	**$ 96,421,759**	$ 24,099,950	$ 23,865,369	$ 23,865,369	$ 23,865,369	$ 23,865,369	**$ 119,561,427**
WITH WAIVER - FEDERAL SHARE	**$ 2,955,600,315**	**$ 4,241,067,734**	**$ 4,212,443,954**	**$ 4,130,043,991**	**$ 4,203,599,857**	**$ 19,742,755,851**	**$ 4,348,289,454**	**$ 4,321,365,047**	**$ 4,420,159,487**	**$ 4,568,730,977**	**$ 4,775,272,771**	**$ 22,433,817,736**
	$ 2,011,069,653											
Difference	**$ 491,744,954**	**$ 641,805,279**	**$ 1,011,620,701**	**$ 1,252,409,929**	**$ 1,380,463,206**	**$ 4,778,044,069**	**1,482,242,652**	**1,547,736,629**	**1,726,724,089**	**1,987,978,251**	**2,219,790,202**	**8,964,471,824**

Notes:

1. Member-months based on MMIS report with last actual reported as of Jun 30, 2020.
2. "With Waiver" pmpm's based on calculations using Sch C expenditures and MMIS eligibility actual member-months reported through Jun 2020
3. CNOMs (costs not otherwise matchable) include Severe Emotionally Disturbed children (SED at risk), MATI population, DDD non-disabled adult children and CCW Supports Equalization

Budget Neutrality Monitoring Spreadsheet

Supplemental Test #1

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

TOTAL COMPUTABLE

Waiver Year	1	2	3	4	5	*Demo*	6	7	8	9	10	*Renewal*
State Fiscal Year	2013	2014	2015	2016	2017	*Period 1*	2018	2019	2020	2021	2022	*Period 1*
NO WAIVER												
HCBS 217-like	$ 217,434,338	$ 299,298,600	$ 296,727,244	$ 333,440,492	$ 384,875,606	**$ 1,531,776,281**	$ 431,355,419	$ 491,681,457	$ 565,967,865	$ 597,681,935	$ 631,173,106	**$ 2,717,859,781**
Adults w/o Depend. Children	$ 1,677,789	$ 798,912	$ -	$ -	$ -	**$ 2,476,701**	$ -	$ -	$ -	$ -	$ -	**$ -**
SED 217-like	$ 253,840	$ 345,267	$ 290,262	$ 256,844	$ 5,238,074	**$ 6,384,287**	$ 10,413,302	$ 12,175,687	$ 13,922,918	$ 15,029,196	$ 16,223,375	**$ 67,764,478**
Former XIX Chip Parents	$ -	$ 140,335,250	$ -	$ -	$ -	**$ 140,335,250**	$ -	$ -	$ -	$ -	$ -	**$ -**
IDD/MI	$ -	$ -	$ 6,423,263	$ 34,933,951	$ 49,886,752	**$ 91,243,966**	$ 97,925,359	$ 113,473,330	$ 116,657,004	$ 125,926,254	$ 135,932,013	**$ 589,913,960**
NO WAIVER -TOTAL COMPUTABLE	**$ 219,365,967**	**$ 440,778,028**	**$ 303,440,769**	**$ 368,631,287**	**$ 440,000,432**	**$ 1,772,216,484**	**$ 539,694,079**	**$ 617,330,474**	**$ 696,547,787**	**$ 738,637,384**	**$ 783,328,494**	**$ 3,375,538,218**
WITH WAIVER												
HCBS 217-like	$ 207,465,133	$ 278,455,290	$ 331,749,289	$ 376,403,813	$ 404,760,537	**$ 1,598,834,062**	$ 664,076,315	$ 742,879,798	$ 638,892,755	$ 674,693,179	$ 712,499,684	**$ 3,433,041,731**
Adults w/o Depend. Children	$ 1,529,772	$ 674,018	$ -	$ -	$ -	**$ 2,203,790**	$ -	$ -	$ -	$ -	$ -	**$ -**
SED 217-like	$ 83	$ 58,922	$ 27,837	$ 96,680	$ 12,236,369	**$ 12,419,891**	$ 22,824,203	$ 22,105,801	$ 32,524,547	$ 35,108,859	$ 37,898,514	**$ 150,461,924**
Former XIX Chip Parents	$ -	$ 126,863,607	$ -	$ -	$ -	**$ 126,863,607**	$ -	$ -	$ -	$ -	$ -	**$ -**
IDD/MI	$ -	$ -	$ 1,186,792	$ 7,798,525	$ 10,984,729	**$ 19,970,046**	$ 21,760,260	$ 22,834,194	$ 26,042,079	$ 28,111,312	$ 30,344,961	**$ 129,092,806**
WITH WAIVER - TOTAL COMPUTABLE	**$ 208,994,988**	**$ 406,051,837**	**$ 332,963,918**	**$ 384,299,018**	**$ 427,981,635**	**$ 1,760,291,396**	**$ 708,660,778**	**$ 787,819,793**	**$ 697,459,381**	**$ 737,913,350**	**$ 780,743,159**	**$ 3,712,596,461**
Difference	**$ 10,370,979**	**$ 34,726,191**	**$ (29,523,149)**	**$ (15,667,731)**	**$ 12,018,797**	**$ 11,925,088**	**$ (168,966,699)**	**$ (170,489,319)**	**$ (911,594)**	**$ 724,034**	**$ 2,585,335**	**$ (337,058,243)**

FEDERAL SHARE

Waiver Year	1	2	3	4	5	*Demo*	6	7	8	9	10	*Renewal*
State Fiscal Year	2013	2014	2015	2016	2017	*Period 1*	2018	2019	2020	2021	2022	*Period 1*
NO WAIVER												
HCBS 217-like	$ 110,183,049	$ 154,283,535	$ 152,376,942	$ 167,846,262	$ 192,469,758	**$ 777,159,546**	$ 215,740,697	$ 245,912,525	$ 283,066,577	$ 298,928,243	$ 315,678,719	**$ 1,359,326,761**
Adults w/o Depend. Children	$ 852,857	$ 408,324	$ -	$ -	$ -	**$ 1,261,182**	$ -	$ -	$ -	$ -	$ -	**$ -**
SED 217-like	$ -	$ 172,639	$ 145,397	$ 128,459	$ 2,619,467	**$ 3,065,962**	$ 5,207,455	$ 6,089,799	$ 6,963,695	$ 7,517,012	$ 8,114,293	**$ 33,892,255**
Former XIX Chip Parents	$ -	$ 71,621,870	$ -	$ -	$ -	**$ 71,621,870**	$ -	$ -	$ -	$ -	$ -	**$ -**
IDD/MI	$ -	$ -	$ 3,244,338	$ 17,486,831	$ 24,943,792	**$ 45,674,961**	$ 48,963,107	$ 56,754,600	$ 58,346,940	$ 62,983,030	$ 67,987,491	**$ 295,035,167**
NO WAIVER -TOTAL COMPUTABLE	**$ 111,035,906**	**$ 226,486,368**	**$ 155,766,677**	**$ 185,461,553**	**$ 220,033,016**	**$ 898,783,521**	**$ 269,911,260**	**$ 308,756,924**	**$ 348,377,212**	**$ 369,428,284**	**$ 391,780,503**	**$ 1,688,254,183**
WITH WAIVER												
HCBS 217-like	$ 105,131,237	$ 143,539,149	$ 170,361,648	$ 189,473,008	$ 202,413,874	**$ 810,918,916**	$ 332,135,128	$ 371,548,377	$ 319,539,671	$ 337,445,110	$ 356,353,883	**$ 1,717,022,169**
Adults w/o Depend. Children	$ 777,617	$ 344,491	$ -	$ -	$ -	**$ 1,122,108**	$ -	$ -	$ -	$ -	$ -	**$ -**
SED 217-like	$ -	$ 29,462	$ 13,944	$ 48,354	$ 6,119,189	**$ 6,210,949**	$ 11,413,865	$ 11,056,451	$ 16,267,497	$ 17,560,069	$ 18,955,344	**$ 75,253,226**
Former XIX Chip Parents	$ -	$ 64,746,447	$ -	$ -	$ -	**$ 64,746,447**	$ -	$ -	$ -	$ -	$ -	**$ -**
IDD/MI	$ -	$ -	$ 599,439	$ 3,903,695	$ 5,492,456	**$ 9,995,590**	$ 10,880,225	$ 11,420,706	$ 13,025,155	$ 14,060,099	$ 15,177,277	**$ 64,563,462**
WITH WAIVER - TOTAL COMPUTABLE	**$ 105,908,854**	**$ 208,659,549**	**$ 170,975,031**	**$ 193,425,057**	**$ 214,025,519**	**$ 892,994,010**	**$ 354,429,218**	**$ 394,025,534**	**$ 348,832,323**	**$ 369,065,278**	**$ 390,486,504**	**$ 1,856,838,857**
Difference	**$ 5,127,052**	**$ 17,826,819**	**$ (15,208,354)**	**$ (7,963,504)**	**$ 6,007,497**	**$ 5,789,511**	**$ (84,517,958)**	**$ (85,268,610)**	**$ (455,111)**	**$ 363,006**	**$ 1,293,999**	**$ (168,584,674)**

Budget Neutrality Monitoring Spreadsheet

Supplemental Test #2

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

TOTAL COMPUTABLE

Waiver Year	1	2	3	4	5	*Demo*	6	7	8	9	10	*Renewal*
State Fiscal Year	2013	2014	2015	2016	2017	*Period 1*	2018	2019	2020	2021	2022	*Period 1*
NO WAIVER												
New Adult Group	$ -	$ 655,329,429	$ 3,208,229,680	$ 3,490,111,740	$ 3,707,793,511	**$ 11,061,464,359**	$ 3,853,307,470	$ 3,923,065,615	$ 4,019,150,697	$ 4,297,572,275	$ 4,595,281,155	**$ 20,688,377,212**
NO WAIVER -TOTAL COMPUTABLE	**$ -**	**$ 655,329,429**	**$ 3,208,229,680**	**$ 3,490,111,740**	**$ 3,707,793,511**	**$ 11,061,464,359**	**$ 3,853,307,470**	**$ 3,923,065,615**	**$ 4,019,150,697**	**$ 4,297,572,275**	**$ 4,595,281,155**	**$ 20,688,377,212**
WITH WAIVER												
New Adult Group	$ -	$ 849,408,487	$ 2,862,968,161	$ 2,915,531,800	$ 3,146,291,973	**$ 9,774,200,421**	$ 3,169,829,362	$ 3,184,729,250	$ 3,357,474,642	$ 3,590,059,449	$ 3,838,756,273	**$ 17,140,848,976**
WITH WAIVER - TOTAL COMPUTABLE	**$ -**	**$ 849,408,487**	**$ 2,862,968,161**	**$ 2,915,531,800**	**$ 3,146,291,973**	**$ 9,774,200,421**	**$ 3,169,829,362**	**$ 3,184,729,250**	**$ 3,357,474,642**	**$ 3,590,059,449**	**$ 3,838,756,273**	**$ 17,140,848,976**
Difference	**$ -**	**$ (194,079,058)**	**$ 345,261,519**	**$ 574,579,940**	**$ 561,501,538**	**$ 1,287,263,938**	**$ 683,478,108**	**$ 738,336,365**	**$ 661,676,055**	**$ 707,512,826**	**$ 756,524,881**	**$ 3,547,528,235**

FEDERAL SHARE

Waiver Year	1	2	3	4	5	*Demo*	6	7	8	9	10	*Renewal*
State Fiscal Year	2013	2014	2015	2016	2017	*Period 1*	2018	2019	2020	2021	2022	*Period 1*
NO WAIVER												
New Adult Group	$ -	$ 655,305,931	$ 3,207,138,686	$ 3,487,155,931	$ 3,606,361,234	**$ 10,955,961,783**	$ 3,640,753,941	$ 3,667,072,654	$ 3,677,522,888	$ 3,867,815,047	$ 4,135,753,039	**$ 18,988,917,569**
NO WAIVER -TOTAL COMPUTABLE	**$ -**	**$ 655,305,931**	**$ 3,207,138,686**	**$ 3,487,155,931**	**$ 3,606,361,234**	**$ 10,955,961,783**	**$ 3,640,753,941**	**$ 3,667,072,654**	**$ 3,677,522,888**	**$ 3,867,815,047**	**$ 4,135,753,039**	**$ 18,988,917,569**
WITH WAIVER												
New Adult Group	$ -	$ 849,378,031	$ 2,861,994,577	$ 2,913,062,608	$ 3,060,220,417	**$ 9,684,655,633**	$ 2,994,977,388	$ 2,976,915,170	$ 3,072,089,298	$ 3,231,053,504	$ 3,454,880,646	$ 15,729,916,006
WITH WAIVER - TOTAL COMPUTABLE	**$ -**	**$ 849,378,031**	**$ 2,861,994,577**	**$ 2,913,062,608**	**$ 3,060,220,417**	**$ 9,684,655,633**	**$ 2,994,977,388**	**$ 2,976,915,170**	**$ 3,072,089,298**	**$ 3,231,053,504**	**$ 3,454,880,646**	**$ 15,729,916,006**
Difference	**$ -**	**$ (194,072,100)**	**$ 345,144,109**	**$ 574,093,323**	**$ 546,140,817**	**$ 1,271,306,150**	**$ 645,776,553**	**$ 690,157,484**	**$ 605,433,590**	**$ 636,761,543**	**$ 680,872,393**	**$ 3,259,001,564**

Notes:

1. Federal share is calculated using Composite Federal Share Ratios (source data is CMS 64 Schedule C as reported in QE Jun 2020 with a run date of 08 18, 2020).
2. Member-months based on MMIS report with last actual reported as of Dec 2019.
3. "With Waiver" pmpm's based on calculations using Sch C expenditures and MMIS eligibility actual member-months reported through Sept 2018 as

Budget Neutrality Monitoring Spreadsheet

Supplemental Test #3

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

TOTAL COMPUTABLE

Waiver Year	1	2	3	4	5	*Demo*	6	7	8	9	10	*Renewal*
State Fiscal Year	2013	2014	2015	2016	2017	*Period 1*	2018	2019	2020	2021	2022	*Period 1*
With Estimate												
SUD IMD MEG 1 - Long Term Treatment	$ -	$ -	$ -	$ -	$ -	**$ -**	$ -	$ 32,023,920	$ 35,242,573	$ 38,784,170	$ 42,676,767	**$ 148,727,431**
SUD IMD MEG 2 - Short Term Treatment							$ -	$ 54,235,500	$ 59,681,785	$ 65,683,376	$ 72,274,578	**$ 251,875,239**
SUD IMD MEG 3 - Detox Treatment							$ -	$ 53,641,344	$ 55,925,060	$ 61,540,974	$ 67,735,536	**$ 238,842,913**
TOTAL COMPUTABLE	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 139,900,764**	**$ 150,849,418**	**$ 166,008,520**	**$ 182,686,881**	**$ 639,445,583**
With ACTUALS												
SUD IMD MEG 1 - Long Term Treatment	$ -	$ -	$ -	$ -	$ -	**$ -**	$ -	$ 12,033,822	$ 24,067,644	$ 24,067,644	$ 24,067,644	**$ 84,236,754**
SUD IMD MEG 2 - Short Term Treatment							$ 81,536	$ 11,207,122	$ 22,414,244	$ 22,414,244	$ 22,414,244	**$ 78,531,390**
SUD IMD MEG 3 - Detox Treatment							$ 9,608	$ 14,300,736	$ 28,601,472	$ 28,601,472	$ 28,601,472	**$ 100,114,760**
TOTAL COMPUTABLE	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 91,144**	**$ 37,541,680**	**$ 75,083,360**	**$ 75,083,360**	**$ 75,083,360**	**$ 262,882,904**
Difference	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**		**$ 102,359,084**	**$ 75,766,058**	**$ 90,925,160**	**$ 107,603,521**	**$ 376,562,679**

FEDERAL SHARE

Waiver Year	1	2	3	4	5	*Demo*	6	7	8	9	10	*Renewal*
State Fiscal Year	2013	2014	2015	2016	2017	*Period 1*	2018	2019	2020	2021	2022	*Period 1*
With Estimate												
SUD IMD MEG 1 - Long Term Treatment	$ -	$ -	$ -	$ -	$ -	**$ -**	$ -	$ 28,181,050	$ 31,013,464	$ 34,130,070	$ 37,555,555	**$ 130,880,139**
SUD IMD MEG 2 - Short Term Treatment							$ -	$ 43,930,755	$ 48,342,246	$ 53,203,534	$ 58,542,409	**$ 204,018,944**
SUD IMD MEG 3 - Detox Treatment							$ -	$ 44,522,316	$ 46,417,800	$ 51,079,008	$ 56,220,495	**$ 198,239,618**
TOTAL COMPUTABLE	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 116,634,120**	**$ 125,773,510**	**$ 138,412,612**	**$ 152,318,458**	**$ 533,138,701**
With ACTUALS												
SUD IMD MEG 1 - Long Term Treatment	$ -	$ -	$ -	$ -	$ -	**$ -**	$ -	$ 10,610,644	$ 21,221,288	$ 21,221,288	$ 21,221,288	$ 74,274,508
SUD IMD MEG 2 - Short Term Treatment							$ 76,620	$ 9,051,466	$ 18,102,932	$ 18,102,932	$ 18,102,932	**$ 63,436,882**
SUD IMD MEG 3 - Detox Treatment							$ 8,904	$ 11,841,064	$ 23,682,128	$ 23,682,128	$ 23,682,128	**$ 82,896,352**
TOTAL COMPUTABLE	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 85,524**	**$ 31,503,174**	**$ 63,006,348**	**$ 63,006,348**	**$ 63,006,348**	**$ 220,607,742**
Difference	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ -**	**$ 85,130,946**	**$ 62,767,162**	**$ 75,406,264**	**$ 89,312,110**	**$ 312,530,959**

Federal Budget Neutrality - Cap

TOTAL EXPENDITURES IN WAIVER	**$7,091,264,657**	**$10,527,815,887**	**$13,613,703,457**	**$14,558,349,663**	**$15,292,387,435**	**$61,083,521,100**		**$16,020,748,444**	**$16,245,024,942**	**$16,973,750,965**	**$18,111,175,471**	**$19,327,328,300**	**$86,678,028,123**	
														Original STC
Waiver Year	1	2	3	4	5	***Demo***		6	7	8	9	10	***Renewal***	Growth %'s
State Fiscal Year	2013	2014	2015	2016	2017	***Period 1***		2018	2019	2020	2021	2022	***Period 1***	used for
Member Months	*actual*	*actual*	*actual*	*actual*	*actual*			*actual*	*actual*	*projected*	*projected*	*projected*		BN
Title XIX	5,773,180	7,850,901	8,699,959	8,893,616	8,809,875			8,647,823	8,304,935	8,525,848	8,752,637	8,985,458		2.7%
***ABD/LTC/HCBS State Plan**	2,499,711	3,414,071	3,381,631	3,402,743	3,408,042			3,366,318	3,079,054	2,947,382	3,001,484	3,056,579		1.8%
														1.8%
														1.8%
Total Waiver Member Months	**8,272,891**	**11,264,972**	**12,081,590**	**12,296,359**	**12,217,917**			**12,014,141**	**11,383,989**	**11,473,230**	**11,754,121**	**12,042,037**		
Per Member Per Month														
Title XIX	$327.03	$346.69	$366.74	$387.95	$410.40			$434.20	$459.39	$486.03	$514.22	$544.05		5.8%
***ABD/LTC/HCBS State Plan**	$1,993.79	$1,965.36	$2,043.81	$2,130.44	$2,209.19			$2,338.71	$2,562.30	$2,753.03	$2,856.64	$2,964.17		9.56%
Total Expenditures (Member Months x PMPM)														
Title XIX	$1,888,003,055	$2,721,828,868	$3,190,622,964	$3,450,278,327	$3,615,572,700	**$14,866,305,914**		**$3,754,912,420**	**$3,815,179,055**	**$4,143,829,920**	**$4,500,791,746**	**$4,888,503,326**	**$21,103,216,466**	
***ABD/LTC/HCBS State Plan**	$4,983,895,635	$6,709,879,563	$6,911,410,044	$7,249,328,309	$7,529,020,793	**$33,383,534,342**		**$7,872,834,475**	**$7,889,449,798**	**$8,114,222,561**	**$8,574,174,066**	**$9,060,215,326**	**$41,510,896,227**	
Total Base Expenditures	**$6,871,898,690**	**$9,431,708,430**	**$10,102,033,007**	**$10,699,606,636**	**$11,144,593,493**	**$48,249,840,256**		**$11,627,746,895**	**$11,704,628,853**	**$12,258,052,481**	**$13,074,965,813**	**$13,948,718,652**	**$62,614,112,693**	
** ABD, LTC, and HCBS State Plan Member Months, PMPM, and Total Expenditures are combined in the WOW Cap Consolidated Calculation*														
Hypothetical Population Expenditures														
HCBS 217-Like	$217,434,338	$299,298,600	$296,727,244	$333,440,492	$384,875,606	**$1,531,776,281**		**$431,355,419**	**$491,681,457**	**$565,967,865**	**$597,681,935**	**$631,173,106**	**$2,717,859,781**	
***Adults w/o Dependent Children**	$1,677,789	$798,912	$0	$0	$0	**$2,476,701**		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	
SED 217-Like	$253,840	$345,267	$290,262	$256,844	$5,238,074	**$6,384,287**		**$10,413,302**	**$12,175,687**	**$13,922,918**	**$15,029,196**	**$16,223,375**	**$67,764,478**	
***XIX CHIP Parents**	$0	$140,335,250	$0	$0	$0	**$140,335,250**		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	
IDD/MI	$0	$0	$6,423,263	$34,933,951	$49,886,752	**$91,243,966**		**$97,925,359**	**$113,473,330**	**$116,657,004**	**$125,926,254**	**$135,932,013**	**$589,913,960**	
New Adult Group	$0	$655,329,429	$3,208,229,680	$3,490,111,740	$3,707,793,511	**$11,061,464,359**		**$3,853,307,470**	**$3,923,065,615**	**$4,019,150,697**	**$4,297,572,275**	**$4,595,281,155**	**$20,688,377,212**	
Total Hypothetical Expenditures	**$219,365,967**	**$1,096,107,457**	**$3,511,670,449**	**$3,858,743,027**	**$4,147,793,943**	**$12,833,680,844**		**$4,393,001,550**	**$4,540,396,089**	**$4,715,698,484**	**$5,036,209,659**	**$5,378,609,649**	**$24,063,915,430**	
** Adults w/o Dependent Chidren and Title XIX CHIP Parents are now in New Adult Group as of 1/1/14.*														

With Waiver - Expenditures														
TOTAL EXPENDITURES IN WAIVER	**$6,048,993,507**	**$9,378,605,652**	**$11,320,430,092**	**$11,502,055,224**	**$12,149,722,275**	**$50,399,806,750**		**$12,438,785,687**	**$12,810,941,031**	**$12,974,092,401**	**$13,814,162,337**	**$14,494,877,996**	**$66,532,859,452**	
													Original STC	
Waiver Year	1	2	3	4	5	***Demo***		6	7	8	9	10	***Renewal***	Growth %'s	
State Fiscal Year	2013	2014	2015	2016	2017	***Period 1***		2018	2019	2020	2021	2022	***Period 1***	used for	
Member Months	*actual*	*actual*	*actual*	*actual*	*actual*			*actual*	*actual*	*actual*	*projected*	*projected*		BN	
Title XIX	5,773,180	7,850,901	8,699,959	8,893,616	8,809,875			8,647,823	8,304,935	8,525,848	8,752,637	8,985,458		2.7%	
***ABD/LTC/HCBS State Plan**	2,499,711	3,361,590	3,381,631	3,402,743	3,408,042			3,366,318	3,079,054	2,947,382	3,217,351	3,276,409		1.8%	
														1.8%	
														1.8%	
Total Waiver Member Months	**8,272,891**	**11,212,491**	**12,081,590**	**12,296,359**	**12,217,917**			**12,014,141**	**11,383,989**	**11,473,230**	**11,969,988**	**12,261,867**			
Per Member Per Month														
Title XIX	$287.63	$305.92	$297.52	$286.69	$303.31			$320.91	$339.52	$359.21	$380.04	$402.09		5.8%	
***ABD/LTC/HCBS State Plan**	$1,587.47	$1,610.71	$1,547.75	$1,563.06	$1,619.33			$1,677.62	$1,738.02	$1,738.02	$1,738.02	$1,738.02		3.6%	
														3.9%	
														3.7%	
Total Expenditures (Member Months x PMPM)														
Title XIX	$1,660,533,500	$2,401,753,394	$2,588,414,484	$2,549,675,884	$2,591,767,989	**$11,792,145,251**		$2,628,154,865	$2,761,270,528	$3,062,575,752	$3,326,395,131	$3,612,940,695	**$15,391,336,970**		
***ABD/LTC/HCBS State Plan**	$3,968,224,421	$5,414,534,418	$5,233,912,050	$5,318,687,934	$5,586,271,992	**$25,521,630,815**		$5,433,625,572	$5,343,146,008	$5,122,607,174	$5,591,818,955	$5,694,462,417	**$27,185,660,126**		
Total Base Actual Expenditures	**$5,628,757,921**	**$7,816,287,812**	**$7,822,326,534**	**$7,868,363,818**	**$8,178,039,981**	**$37,313,776,066**		**$8,061,780,437**	**$8,104,416,536**	**$8,185,182,926**	**$8,918,214,086**	**$9,307,403,112**	**$42,576,997,096**		
** ABD, LTC, and HCBS State Plan Member Months, PMPM, and Total Expenditures are combined in the Actuals Consolidated Calculation*														
Hypothetical Population Expenditures														
HCBS 217-Like	$207,465,133	$278,455,290	$331,749,289	$376,403,813	$404,760,537	**$1,598,834,062**		$664,076,315	$742,879,798	$638,892,755	$674,693,179	$712,499,684	**$3,433,041,731**		
****Adults w/o Dependent Children**	$1,529,772	$674,018	$0	$0	$0	**$2,203,790**		$0	$0	$0	$0	$0	**$0**		
SED 217-Like	$83	$58,922	$27,837	$96,680	$12,236,369	**$12,419,891**		$22,824,203	$22,105,801	$32,524,547	$35,108,859	$37,898,514	**$150,461,924**		66.5
****XIX CHIP Parents**	$0	$126,863,607	$0	$0	$0	**$126,863,607**		$0	$0	$0	$0	$0	**$0**		
IDD/MI - 217-Like	$0	$0	$1,186,792	$7,798,525	$10,984,729	**$19,970,046**		$21,760,260	$22,834,194	$26,042,079	$28,111,312	$30,344,961	**$129,092,806**		
New Adult Group	$0	$849,408,487	$2,862,968,161	$2,915,531,800	$3,146,291,973	**$9,774,200,421**		$3,169,829,362	$3,184,729,250	$3,357,474,642	$3,590,059,449	$3,838,756,273	**$17,140,848,976**		
Total Hypothetical Expenditures	**$208,994,988**	**$1,255,460,324**	**$3,195,932,079**	**$3,299,830,818**	**$3,574,273,608**	**$11,534,491,817**		**$3,878,490,140**	**$3,972,549,043**	**$4,054,934,023**	**$4,327,972,799**	**$4,619,499,432**	**$20,853,445,438**		
*** Adults w/o Dependent Chidren and Title XIX CHIP Parents are now in New Adult Group as of 1/1/14.*														
Supports Program	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**		**$66,816,395**	**$278,276,737**	**$278,276,737**	**$278,276,737**	**$278,276,737**	**$1,179,923,343**		
Hospital Subsidies														
HRSF & GME	$ 192,443,637	$ -	$ -	$ -	$ -	**$192,443,637**		$ -	$ -	$ -	$ -	$ -	**$0**		
HRSF Transition Payments	$ -	$ 83,302,681	$ -	$ -	$ -	**$83,302,681**							**$0**		
GME State Plan	(9,533,864)	100,000,001	100,000,000	127,272,727	188,000,000	**$505,738,864**		218,000,000	242,000,000	242,000,000	242,000,000	242,000,000	**$1,186,000,000**		
DSRIP	-	83,304,870	166,600,001	166,600,000	166,600,000	**$583,104,871**		166,000,000	166,000,000	166,000,000	-	-	**$498,000,000**		
Hospital Subsidies Expenditures	**$ 182,909,773**	**$ 266,607,552**	**$ 266,600,001**	**$ 293,872,727**	**$ 354,600,000**	**$1,364,590,053**		**$ 384,000,000**	**$ 408,000,000**	**$ 408,000,000**	**$ 242,000,000**	**$ 242,000,000**	**$1,684,000,000**		
Costs Otherwise Not Matchable (CNOMs)														
SED at Risk	$ 24,261,050	$ 36,820,806	$ 35,571,478	$ 39,987,861	$ 42,808,686	**$179,449,881**		$ 47,698,715	$ 47,698,715	$ 47,698,715	$ 47,698,715	$ 47,698,715	**$238,493,575**		
MATI at Risk	4,069,775	3,429,158	-	-	-	**$7,498,933**		-					**$0**		
DDD non-Disabled Adult Children	-	-	-												
DDD Community / Supports Equalization	-	-	-												
Expedited Financial Eligibility													**$0**		
Home Visiting													**$0**		
SUD PIP										$0	$0	$0	**$0**		
CNOM Expenditures	***$ 28,330,825***	***$ 40,249,964***	***$ 35,571,478***	***$ 39,987,861***	***$ 42,808,686***	**$186,948,814**		***$ 47,698,715***	***$ 47,698,715***	***$ 47,698,715***	***$ 47,698,715***	***$ 47,698,715***	***$ 238,493,575***		

Federal Budget Neutrality - Cap

TOTAL EXPENDITURES IN WAIVER	**$7,091,264,657**	**$10,527,815,887**	**$13,613,703,457**	**$14,558,349,663**	**$15,292,387,435**	**$61,083,521,100**		**$16,020,748,444**	**$16,245,024,942**	**$16,682,099,724**	**$17,794,400,526**	**$18,983,265,420**	**$85,725,539,057**	
														Original STC
Waiver Year	1	2	3	4	5	***Demo***		6	7	8	9	10	***Renewal***	Growth %'s
State Fiscal Year	2013	2014	2015	2016	2017	***Period 1***		2018	2019	2020	2021	2022	***Period 1***	used for
Member Months	*actual*	*actual*	*actual*	*actual*	*actual*			*actual*	*actual*	*actual*	*projected*	*projected*		BN
Title XIX	5,773,180	7,850,901	8,699,959	8,893,616	8,809,875			8,647,823	8,304,935	7,925,781	8,136,608	8,353,043		2.7%
ABD	2,175,896	3,032,509	2,995,777	2,982,351	2,954,300			2,866,561	2,543,029	2,375,599	2,419,206	2,463,612		1.8%
LTC	310,221	362,702	360,198	361,350	355,456			361,981	368,625	375,392	382,282	389,300		1.8%
HCBS State Plan	13,594	18,860	25,656	59,042	98,286			137,776	167,400	196,391	199,996	203,667		1.8%
Total Waiver Member Months	**8,272,891**	**11,264,972**	**12,081,590**	**12,296,359**	**12,217,917**			**12,014,141**	**11,383,989**	**10,873,163**	**11,138,092**	**11,409,622**		
Per Member Per Month														
Title XIX	$327.03	$346.69	$366.74	$387.95	$410.40			$434.20	$459.39	$486.03	$514.22	$544.05		5.8%
ABD	$1,045.04	$1,124.49	$1,164.91	$1,206.78	$1,250.17			$1,295.18	$1,341.80	$1,390.11	$1,440.15	$1,492.00		3.6%
LTC	$8,636.81	$8,975.89	$9,325.83	$9,689.41	$10,067.17			$10,459.79	$10,867.72	$11,291.56	$11,731.93	$12,189.48		3.9%
HCBS State Plan	$2,256.69	$2,347.84	$2,434.29	$2,523.94	$2,616.93			$2,713.76	$2,814.17	$2,918.29	$3,026.27	$3,138.24		3.7%
Total Expenditures (Member Months x PMPM)														
Title XIX	$1,888,003,055	$2,721,828,868	$3,190,622,964	$3,450,278,327	$3,615,572,700	**$14,866,305,914**		**$3,754,912,420**	**$3,815,179,055**	**$3,852,178,679**	**$4,184,016,801**	**$4,544,440,445**	**$20,150,727,401**	
ABD	$2,273,898,356	$3,410,026,045	$3,489,810,585	$3,599,041,540	$3,693,377,231	**$16,466,153,757**		**$3,712,701,706**	**$3,412,242,269**	**$3,302,338,065**	**$3,484,021,977**	**$3,675,701,548**	**$17,587,005,565**	
LTC	$2,679,319,835	$3,255,573,255	$3,359,145,314	$3,501,268,304	$3,578,435,980	**$16,373,742,687**		**$3,786,242,266**	**$4,006,116,242**	**$4,238,758,699**	**$4,484,911,127**	**$4,745,358,075**	**$21,261,386,409**	
HCBS State Plan	$30,677,444	$44,280,262	$62,454,144	$149,018,465	$257,207,582	**$543,637,898**		**$373,890,503**	**$471,091,287**	**$573,125,797**	**$605,240,962**	**$639,155,704**	**$2,662,504,253**	
Total Base Expenditures	**$6,871,898,690**	**$9,431,708,430**	**$10,102,033,007**	**$10,699,606,636**	**$11,144,593,493**	**$48,249,840,256**		**$11,627,746,895**	**$11,704,628,853**	**$11,966,401,240**	**$12,758,190,868**	**$13,604,655,771**	**$61,661,623,627**	
Hypothetical Population Expenditures														
HCBS 217-Like	$217,434,338	$299,298,600	$296,727,244	$333,440,492	$384,875,606	**$1,531,776,281**		**$431,355,419**	**$491,681,457**	**$565,967,865**	**$597,681,935**	**$631,173,106**	**$2,717,859,781**	
***Adults w/o Dependent Children**	$1,677,789	$798,912	$0	$0	$0	**$2,476,701**		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	
SED 217-Like	$253,840	$345,267	$290,262	$256,844	$5,238,074	**$6,384,287**		**$10,413,302**	**$12,175,687**	**$13,922,918**	**$15,029,196**	**$16,223,375**	**$67,764,478**	
***XIX CHIP Parents**	$0	$140,335,250	$0	$0	$0	**$140,335,250**		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	
IDD/MI	$0	$0	$6,423,263	$34,933,951	$49,886,752	**$91,243,966**		**$97,925,359**	**$113,473,330**	**$116,657,004**	**$125,926,254**	**$135,932,013**	**$589,913,960**	
New Adult Group	$0	$655,329,429	$3,208,229,680	$3,490,111,740	$3,707,793,511	**$11,061,464,359**		**$3,853,307,470**	**$3,923,065,615**	**$4,019,150,697**	**$4,297,572,275**	**$4,595,281,155**	**$20,688,377,212**	
Total Hypothetical Expenditures	**$219,365,967**	**$1,096,107,457**	**$3,511,670,449**	**$3,858,743,027**	**$4,147,793,943**	**$12,833,680,844**		**$4,393,001,550**	**$4,540,396,089**	**$4,715,698,484**	**$5,036,209,659**	**$5,378,609,649**	**$24,063,915,430**	
** Adults w/o Dependent Chidren and Title XIX CHIP Parents are now in New Adult Group as of 1/1/14.*														

With Waiver - Expenditures														
TOTAL EXPENDITURES IN WAIVER	**$6,100,227,468**	**$9,442,488,618**	**$11,297,320,773**	**$11,437,497,403**	**$12,068,697,523**	**$50,346,231,785**	**$0**	**$12,336,469,280**	**$13,352,348,294**	**$14,005,875,545**	**$14,543,493,656**	**$15,295,272,981**	**$69,533,459,756**	
														Original STC
Waiver Year	1	2	3	4	5	***Demo***		6	7	8	9	10	***Renewal***	Growth %'s
State Fiscal Year	2013	2014	2015	2016	2017	***Period 1***		2018	2019	2020	2021	2022	***Period 1***	used for
Member Months	*actual*	*actual*	*actual*	*actual*	*actual*			*actual*	*actual*	*actual*	*projected*	*projected*		BN
Title XIX	5,773,180	7,850,901	8,699,959	8,893,616	8,809,875			8,647,823	8,304,935	7,925,781	9,361,528	9,610,546		2.7%
***ABD**	2,486,117	3,342,730	3,355,975	3,343,701	3,309,756			3,228,542	2,911,654	2,750,991	3,111,646	3,168,764		1.8%
***LTC**														1.8%
HCBS State Plan	13,594	18,860	25,656	59,042	98,286			137,776	167,400	196,391	105,705	107,645		1.8%
Total Waiver Member Months	**8,272,891**	**11,212,491**	**12,081,590**	**12,296,359**	**12,217,917**			**12,014,141**	**11,383,989**	**10,873,163**	**12,578,879**	**12,886,955**		
Per Member Per Month														
Title XIX	$287.63	$305.88	$297.18	$286.16	$302.73			$320.32	$338.90	$358.55	$379.35	$401.35		5.8%
***ABD**	$1,595.54	$1,616.41	$1,525.65	$1,508.82	$1,563.14			$1,619.41	$1,677.71	$1,677.71	$1,677.71	$1,677.71		3.6%
***LTC**														3.9%
HCBS State Plan	$3,162.12	$3,441.37	$3,872.47	$4,066.37	$4,216.83			$4,372.85	$4,534.64	$4,702.43	$4,876.42	$5,056.84		3.7%
Total Expenditures (Member Months x PMPM)														
Title XIX	$1,660,532,120	$2,401,433,598	$2,585,453,816	$2,544,997,155	$2,667,013,459	**$11,859,430,147**		$2,770,070,663	$2,814,542,472	$2,841,788,778	$3,551,295,647	$3,857,192,637	**$15,834,890,196**	
***ABD**	$3,966,690,442	$5,403,226,627	$5,120,055,291	$5,045,040,419	$5,173,601,198	**$24,708,613,977**		$5,228,332,105	$4,884,906,398	$4,615,360,732	$5,220,435,488	$5,316,261,845	**$25,265,296,567**	
***LTC**	$0	$0	$0	$0	$0	**$0**		$0	$0	$0	$0	$0	**$0**	
HCBS State Plan	$42,985,906	$64,904,317	$99,352,046	$240,086,620	$414,454,934	**$861,783,823**		$602,473,545	$759,099,351	$923,514,044	$515,460,224	$544,344,093	**$3,344,891,256**	
Total Base Actual Expenditures	**$5,670,208,468**	**$7,867,311,086**	**$7,802,020,830**	**$7,818,617,025**	**$8,157,485,353**	**$37,315,642,762**		**$8,086,436,352**	**$8,621,332,248**	**$9,008,848,252**	**$9,422,702,523**	**$9,865,005,247**	**$45,004,324,623**	
** ABD and LTC Member Months, PMPM, and Total Expenditures are combined in the Actual Detail Calculation*														
Hypothetical Population Expenditures														
HCBS 217-Like	$207,465,132	$278,302,608	$331,749,289	$376,403,813	$404,760,537	**$1,598,681,379**		$664,076,315	$742,879,798	$872,597,515	$872,597,515	$872,597,515	**$4,024,748,658**	
****Adults w/o Dependent Children**	$1,529,772	$674,018	$0	$0	$0	**$2,203,790**		$0	$0	$0	$0	$0	**$0**	
SED 217-Like	$83	$58,922	$27,837	$96,680	$12,236,117	**$12,419,639**		$22,824,203	$22,105,801	$21,901,710	$21,901,710	$21,901,710	**$110,635,134**	
****XIX CHIP Parents**	$0	$126,863,607	$0	$0	$0	**$126,863,607**		$0	$0	$0	$0	$0	**$0**	
IDD/MI - 217-Like	$0	$0	$1,186,792	$7,798,525	$10,983,884	**$19,969,201**		$21,760,260	$22,834,194	$20,553,647	$20,553,647	$20,553,647	**$106,255,395**	
New Adult Group	$0	$849,408,487	$2,862,968,161	$2,915,531,800	$3,146,291,973	**$9,774,200,421**		$3,169,829,362	$3,184,729,250	$3,181,002,249	$3,181,002,249	$3,181,002,249	**$15,897,565,359**	
Total Hypothetical Expenditures	**$208,994,224**	**$1,267,901,087**	**$3,192,726,783**	**$3,284,860,362**	**$3,513,652,681**	**$11,468,135,137**		**$3,751,517,818**	**$4,005,554,023**	**$4,276,864,626**	**$4,566,628,466**	**$4,876,105,068**	**$21,476,670,002**	
*** Adults w/o Dependent Chidren and Title XIX CHIP Parents are now in New Adult Group as of 1/1/14.*													**$0**	
													$0	
Supports Program	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**		**$66,816,395**	**$278,276,737**	**$278,276,737**	**$278,276,737**	**$278,276,737**	**$1,179,923,343**	
Hospital Subsidies														
HRSF & GME	$ 192,443,637	$ -	$ -	$ -	$ -	**$192,443,637**		$ -	$ -	$ -	$ -	$ -	**$0**	
HRSF Transition Payments	-	83,302,681	-	-	-	**$83,302,681**							**$0**	
GME State Plan	-	100,000,001	100,000,000	127,272,727	188,000,000	**$515,272,728**		218,000,000	242,000,000	242,000,000	242,000,000	242,000,000	**$1,186,000,000**	
DSRIP	-	83,304,870	166,600,001	166,600,000	166,600,000	**$583,104,871**		166,000,000	166,000,000	166,000,000	-	-	**$498,000,000**	
Hospital Subsidies Expenditures	**$ 192,443,637**	**$ 266,607,552**	**$ 266,600,001**	**$ 293,872,727**	**$ 354,600,000**	**$1,374,123,917**		**$ 384,000,000**	**$ 408,000,000**	**$ 408,000,000**	**$ 242,000,000**	**$ 242,000,000**	**$1,684,000,000**	
Costs Otherwise Not Matchable (CNOMs)														
SED at Risk	$ 24,511,364	$ 37,239,735	$ 35,973,159	$ 40,147,289	$ 42,959,489	**$180,831,036**		$ 47,698,715	$ 39,185,286	$ 33,885,929	$ 33,885,929	$ 33,885,929	**$188,541,788**	
MATI at Risk	4,069,775	3,429,158	-	-	-	**$7,498,933**		-					**$0**	
DDD non-Disabled Adult Children	-	-	-											
DDD Community / Supports Equalization														
Expedited Financial Eligibility													**$0**	
Home Visiting													**$0**	
SUD PIP											$0	$0	$0	**$0**
CNOM Expenditures	***$ 28,581,139***	***$ 40,668,893***	***$ 35,973,159***	***$ 40,147,289***	***$ 42,959,489***	***$ 188,329,969***		***$ 47,698,715***	***$ 39,185,286***	***$ 33,885,929***	***$ 33,885,929***	***$ 33,885,929***	***$ 188,541,788***	

Hypotheticals: Enrollment and PMPM's															
Waiver Year		1	2	3	4	5	***Demo***		6	7	8	9	10	***Renewal***	Growth %'s
State Fiscal Year		2013	2014	2015	2016	2017	***Period 1***		2018	2019	2020	2021	2022	***Period 1***	
WOW-CAP															
HCBS 217-Like	Enrollment	96,351	127,895	122,272	132,498	147,480			159,393	175,202	194,477	198,047	201,682		1.8%
	PMPM	$2,256.69	$2,340.19	$2,426.78	$2,516.57	$2,609.68			$2,706.24	$2,806.37	$2,910.20	$3,017.88	$3,129.54		3.7%
Adults w/o DC	Enrollment	6,057	2,774	3,870,426	4,240,639	4,404,948			4,374,491	4,221,181	4,163,546	4,163,546	4,163,546		
	PMPM	$277.00	$288.00						$0.00	$0.00	$0.00	$0.00	$0.00		
SED 217-Like	Enrollment	113	145	115	96	1,847			3,464	3,821	4,122	4,198	4,275		1.8%
	PMPM	$2,246.37	$2,381.15	$2,524.02	$2,675.46	$2,835.99			$3,006.15	$3,186.52	$3,377.71	$3,580.37	$3,795.19		6.0%
XIX Chip Parents	Enrollment	0	456,761	0	0	0			0	0	0	0	0		
	PMPM		$307.24						$0.00	$0.00	$0.00	$0.00	$0.00		
IDD/MI	Enrollment	0	0	581	2,981	4,016			7,437	8,130	7,885	8,030	8,177		1.8%
	PMPM	$9,839.39	$10,429.75	$11,055.53	$11,718.87	$12,422.00			$13,167.32	$13,957.36	$14,794.80	$15,682.49	$16,623.44		6.0%
New Adult Group	Enrollment	0	1,408,947	6,541,000	6,776,916	6,856,761			6,786,531	6,580,372	6,420,515	6,538,370	6,658,387		1.8%
	PMPM		$465.12	$490.48	$515.00	$540.75			$567.79	$596.18	$625.99	$657.29	$690.15		5.0%
ACTUALS															
HCBS 217-Like	Enrollment	96,351	127,895	122,272	132,498	147,480			159,393	175,202	194,477	198,047	201,682		1.8%
	PMPM	$2,153.22	$2,177.22	$2,713.21	$2,840.83	$2,945.94			$3,054.94	$3,167.97	$3,285.18	$3,406.74	$3,532.79		3.7%
Adults w/o DC	Enrollment	6,057	2,774	3,870,426	4,240,639	4,404,948			4,374,491	4,221,181	4,163,546	4,163,546	4,163,546		
	PMPM	$252.56	$242.98						$0.00	$0.00	$0.00	$0.00	$0.00		
SED 217-Like	Enrollment	113	145	115	96	1,847			3,464	3,821	4,122	4,198	4,275		1.8%
	PMPM	$0.73	$406.36	$242.06	$1,007.08	$6,625.00			$7,022.50	$7,443.85	$7,890.48	$8,363.91	$8,865.74		6.0%
***XIX CHIP Parents**	Enrollment	0	456,761	0	0	0									
	PMPM		$277.75												
IDD/MI - 217-Like	Enrollment	0	0	581	2,981	4,016			7,437	8,130	7,885	8,030	8,177		1.8%
	PMPM	$0.00	$0.00	$2,042.67	$2,616.08	$2,773.04			$2,939.42	$3,115.79	$3,302.74	$3,500.90	$3,710.95		6.0%
New Adult Group	Enrollment	0	1,186,513	6,541,000	6,776,916	6,856,761			6,786,531	6,580,372	6,420,515	6,538,370	6,658,387		1.8%
	PMPM		$715.89	$437.70	$430.22	$451.73			$474.31	$498.03	$522.93	$549.08	$576.53		5.0%

Hospital Subsidy Summary

Waiver Year	1	2	3	4	5	***Demo***		6	7	8	9	10	***Renewal***
State Fiscal Year	2013	2014	2015	2016	2017	***Period 1***		2018	2019	2020	2021	2022	***Period 1***
TOTAL COMPUTABLE													
HRSF & GME	$ 192,443,637	$ -	$ -	$ -	$ -	**$ 192,443,637**		$ -	$ -	$ -	$ -	$ -	**$ -**
HRSF Transition Payments	-	83,302,681	-	-	-	**$ 83,302,681**							**$ -**
GME State Plan	(9,533,864)	100,000,001	100,000,000	127,291,443	188,000,000	**$ 505,757,580**		199,833,304	242,285,714	242,000,000	242,000,000	242,000,000	**$ 1,168,119,018**
DSRIP	-	83,304,870	166,600,001	166,600,000	166,600,000	**$ 583,104,871**		166,000,000	166,000,000	166,000,000	-	-	**$ 498,000,000**
TOTAL COMPUTABLE	**$ 182,909,773**	**$ 266,607,552**	**$ 266,600,001**	**$ 293,891,443**	**$ 354,600,000**	**$ 1,364,608,769**		**$ 365,833,304**	**$ 408,285,714**	**$ 408,000,000**	**$ 242,000,000**	**$ 242,000,000**	**$ 1,666,119,018**
Composite Federal Share Percentage													
HRSF & GME	50.00%	0.00%	0.00%	0.00%	0.00%								
HRSF Transition Payments	0.00%	50.00%	0.00%	0.00%	0.00%			0.00%	0.00%	0.00%	0.00%	0.00%	
GME State Plan	0.00%	55.64%	66.80%	66.45%	65.08%			63.59%	63.59%	63.59%	63.59%	63.59%	
DSRIP	0.00%	50.00%	50.00%	50.00%	50.00%			50.00%	50.00%	50.00%	50.00%	50.00%	
FEDERAL SHARE													
HRSF & GME	$ 96,221,820	$ -	$ -	$ -	$ -	**$ 96,221,820**		$ -	$ -	$ -	$ -	$ -	**$ -**
HRSF Transition Payments	$ -	$ 41,651,341	$ -	$ -	$ -	**$ 41,651,341**		-	-	-	-	-	**$ -**
GME State Plan	$ -	$ 55,642,502	$ 66,797,499	$ 84,588,472	$ 122,350,400	**$ 329,378,873**		127,079,448	154,076,093	153,894,400	153,894,400	153,894,400	**$ 742,838,741**
DSRIP	$ -	$ 41,652,436	$ 83,300,003	$ 83,300,002	$ 83,300,002	**$ 291,552,443**		83,000,002	83,000,002	83,000,002	-	-	**$ 249,000,006**
FEDERAL SHARE	**$ 96,221,820**	**$ 138,946,279**	**$ 150,097,502**	**$ 167,888,474**	**$ 205,650,402**	**$ 758,804,477**		**$ 210,079,450**	**$ 237,076,095**	**$ 236,894,402**	**$ 153,894,400**	**$ 153,894,400**	**$ 991,838,747**

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

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

Costs Otherwise Not Matchable (CNOM) Summary

Waiver Year	1	2	3	4	5	*Demo*	6	7	8	9	10	*Renewal*	Growth %
State Fiscal Year	2013	2014	2015	2016	2017	*Period 1*	2018	2019	2020	2021	2022	*Period 1*	
TOTAL COMPUTABLE													
SED at Risk	$ 24,261,050	$ 36,820,806	$ 35,571,478	$ 39,987,861	$ 42,808,686	$ 179,449,881	$ 47,698,715	$ 47,698,715	$ 47,698,715	$ 47,698,715	$ 47,698,715	$ 238,493,575	
MATI at Risk	$ 4,069,775	$ 3,429,158	$ -	$ -	$ -	$ 7,498,933	$ -	$ -	$ -	$ -	$ -	$ -	
DDD non-Disabled Adult Children	$ -	$ -	$ -			$ -	$ -	$ -	$ -	$ -	$ -	$ -	3.00%
DDD Community / Supports Equalization													
Expedited Financial Eligibility												$ -	
Home Visiting	$ -	$ -	$ -			$ -						$ -	3.00%
SUD PIP									$ -	$ -	$ -		
TOTAL COMPUTABLE	**$ 28,330,825.00**	**$ 40,249,964.00**	**$ 35,571,478.00**	**$ 39,987,861.00**	**$ 42,808,686.00**	**$ 186,948,814**	**$ 47,698,715**	**$ 47,698,715**	**$ 47,698,715**	**$ 47,698,715**	**$ 47,698,715**	**$ 238,493,575**	
Composite Federal Share Percentage													
SED at Risk	52.01%	51.85%	51.98%	51.23%	51.16%		50.53%	50.03%	50.03%	50.03%	50.03%		
MATI at Risk	50.50%	52.00%	0.00%	0.00%	0.00%		0.00%	0.00%	0.00%	0.00%	0.00%		
Supports Program							0.00%	0.00%	0.00%	0.00%	0.00%		
DDD non-Disabled Adult Children				50.00%	50.00%		50.00%	50.00%	50.00%	50.00%	50.00%		
DDD Community / Supports Equalization				50.00%	50.00%		50.00%	50.00%	50.00%	50.00%	50.00%		
Expedited Financial Eligibility									50.00%	50.00%	50.00%		
Home Visiting									50.00%	50.00%	50.00%		
SUD PIP									50.00%	50.00%	50.00%		
FEDERAL SHARE													
SED at Risk	$ 12,617,861	$ 19,091,377	$ 18,489,075	$ 20,485,806	$ 21,899,156	$ 92,583,275	$ 24,099,950	$ 23,865,369	$ 23,865,369	$ 23,865,369	$ 23,865,369	$ 119,561,427	
MATI at Risk	$ 2,055,322	$ 1,783,162	$ -	$ -	$ -	$ 3,838,484	$ -	$ -	$ -	$ -	$ -	$ -	
DDD non-Disabled Adult Children	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
DDD Community / Supports Equalization													
Expedited Financial Eligibility									$ -	$ -	$ -	$ -	
Home Visiting	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
SUD PIP									$ -	$ -	$ -	$ -	
FEDERAL SHARE	**$ 14,673,183**	**$ 20,874,539**	**$ 18,489,075**	**$ 20,485,806**	**$ 21,899,156**	**$ 96,421,759**	***$ 24,099,950***	***$ 23,865,369***	***$ 23,865,369***	***$ 23,865,369***	***$ 23,865,369***	***$ 119,561,427***	

Notes: SED at Risk and MATI at Risk

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

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

Notes: DDD programs

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

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

Extension of Pregnant Women Eligibility to 180 Days - Cost Estimate

CY 2018 Data:	Total NJ FamilyCare Births	38,139
	Less Births Covered by Other (Non-Pregnant Women) Eligibility Categories	11,430
	Less Births Covered by Emergency Medicaid	6,712
	Less those estimated to remain enrolled in Medicaid 60 days after birth, absent demonstration amendment	11,280
	Estimated Annual Population Receiving Coverage Extension under Proposed Amendment	**8,717**

Eligibles	8,717
Monthly MCO Capitation Payment	$370.00
Monthly NEMT Capitation Payment	$8.75
Additional of Months of Coverage	4
Total Annual Additional Expenditures	**$13,206,255**
Federal Share @ 50% FFP	**$6,603,128**

To Title XIX year 9 and 10

A

B
C

D

E=A-B-C-D

E
F
G
H

I=E×(F+G)×H

J=I×50%

Total Proposed Budget				
Milestones	**Incentive Payment Per Provider**	**Estimated # of Providers Funded by State-Only Dollars**	**Estimated # of Providers Funded by Federal Dollars**	**Projected State-Only Investment**
Milestone 1	$5,500	120	70	$660,000
Milestone 2 (Tier 1)	$21,000	75	43	$1,575,000
Milestone 2 (Tier 2)	$8,250	45	27	$371,250
Milestone 3	$8,500	120	70	$1,020,000
Milestone 4	$6,000	120	70	$720,000
Milestone 5	$5,500	120	70	$660,000
Milestone 6	$5,500	0	190	$0
Milestone 7	$5,500	0	190	$0
				$5,006,250

DY8 (Jul 2019 - Jun 2020) Estimated Budget by Milestone Achieved*				
Milestones	**Incentive Payment Per Provider**	**Estimated # of Providers Funded by State-Only Dollars**	**Estimated # of Providers Funded by Federal Dollars**	**Projected State-Only Investment**
Milestone 1	$5,500	60	0	$330,000
Milestone 2 (Tier 1)	$21,000	25	0	$525,000
Milestone 2 (Tier 2)	$8,250	20	0	$165,000
Milestone 3	$8,500	20	0	$170,000
Milestone 4	$6,000	0	0	$0
Milestone 5	$5,500	0	0	$0
Milestone 6	$5,500	0	0	$0
Milestone 7	$5,500	0	0	$0
				$1,190,000
*Estimated numbers are based on ability of particpating SUD providers to meet/achieve program milesto				

DY9 (Jul 2020 - Jun 2021) Estimated Budget by Milestone Achieved*				
Milestones	**Incentive Payment Per Provider**	**Estimated # of Providers Funded by State-Only Dollars**	**Estimated # of Providers Funded by Federal Dollars**	**Projected State-Only Investment**
Milestone 1	$5,500	60	35	$330,000
Milestone 2 (Tier 1)	$21,000	50	20	$1,050,000
Milestone 2 (Tier 2)	$8,250	25	20	$206,250
Milestone 3	$8,500	100	35	$850,000
Milestone 4	$6,000	120	30	$720,000
Milestone 5	$5,500	120	0	$660,000

Milestone 6	$5,500	0	0	$0
Milestone 7	$5,500	0	0	$0
				$3,816,250

*Estimated numbers are based on ability of particpating SUD providers to meet/achieve program milesto

DY10 (Jul 2021 - Jun 2022) Estimated Budget by Milestone Achieved*				
Milestones	**Incentive Payment Per Provider**	**Estimated # of Providers Funded by State-Only Dollars**	**Estimated # of Providers Funded by Federal Dollars**	**Projected State-Only Investment**
Milestone 1	$5,500	0	35	$0
Milestone 2 (Tier 1)	$21,000	0	23	$0
Milestone 2 (Tier 2)	$8,250	0	7	$0
Milestone 3	$8,500	0	35	$0
Milestone 4	$6,000	0	40	$0
Milestone 5	$5,500	0	70	$0
Milestone 6	$5,500	0	190	$0
Milestone 7	$5,500	0	190	$0
				$0

*Estimated numbers are based on ability of particpating SUD providers to meet/achieve program milesto

Requested Federal Investment
$385,000
$903,000
$222,750
$595,000
$420,000
$385,000
$1,045,000
$1,045,000
$5,000,750

Requested Federal Investment
$0
$0
$0
$0
$0
$0
$0
$0
$0

nes

Requested Federal Investment
$192,500
$420,000
$165,000
$297,500
$180,000
$0

$0
$0
$1,255,000

nes

Requested Federal Investment
$192,500
$483,000
$57,750
$297,500
$240,000
$385,000
$1,045,000
$1,045,000
$3,745,750

nes

SUD waiver with estimate														Original STC
Waiver Year	1	2	3	4	5	***Demo***	6	7	8	9	10	***Renewal***	**Trend Growth %'s**
State Fiscal Year	2013	2014	2015	2016	2017	***Period 1***	2018	2019	2020	2021	2022	***Period 1***	**used for**
Member Months	*actual*	*actual*	*actual*	*actual*	*actual*		*actual*	*projected*	*projected*	*projected*	*projected*		BN
SUD IMD MEG 1 - Long Term Treatment	0	0	0	0	0		0	799	838	879	922		**4.9%**
SUD IMD MEG 2 - Short Term Treatment							0	1,045	1,096	1,150	1,206		**4.9%**
SUD IMD MEG 3 - Detox Treatment							0	1,304	1,368	1,435	1,505		**4.9%**
Total Waiver Member Months	**0**	**0**	**0**	**0**	**0**		**0**	**3,148**	**3,302**	**3,464**	**3,634**		
Per Member Per Month													
SUD IMD MEG 1 - Long Term Treatment	$0.00	$0.00	$0.00	$0.00	$0.00		$3,184	$3,340	$3,504	$3,676	$3,856		
SUD IMD MEG 2 - Short Term Treatment	$0.00	$0.00	$0.00	$0.00	$0.00		$4,123	$4,325	$4,537	$4,760	$4,993		
SUD IMD MEG 3 - Detox Treatment	$0.00	$0.00	$0.00	$0.00	$0.00		$3,097	$3,428	$3,407	$3,574	$3,750		
Total Expenditures (Member Months x PMPM)													
SUD IMD MEG 1 - Long Term Treatment	$0	$0	$0	$0	$0	**$0**	$0	$32,023,920	$35,242,573	$38,784,170	$42,676,767	**$148,727,431**	
SUD IMD MEG 2 - Short Term Treatment			$0	$0	$0	**$0**	$0	$54,235,500	$59,681,785	$65,683,376	$72,274,578	**$251,875,239**	
SUD IMD MEG 3 - Detox Treatment							$0	$53,641,344	$55,925,060	$61,540,974	$67,735,536	**$238,842,913**	
Total Base Expenditures	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$139,900,764**	**$150,849,418**	**$166,008,520**	**$182,686,881**	**$639,445,583**	
SUD with Actual claim													
SUD IMD MEG 1 - Long Term Treatment							$0	$12,033,822	$24,067,644	$24,067,644	$24,067,644	**$84,236,754**	
SUD IMD MEG 2 - Short Term Treatment							$81,536	$11,207,122	$22,414,244	$22,414,244	$22,414,244	**$78,531,390**	
SUD IMD MEG 3 - Detox Treatment							$9,608	$14,300,736	$28,601,472	$28,601,472	$28,601,472	**$100,114,760**	
Total Expenditures	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$91,144**	**$37,541,680**	**$75,083,360**	**$75,083,360**	**$75,083,360**	**$262,882,904**	
SUD IMD MEG 1 - Long Term Treatment							$0	$10,610,644	$21,221,288	$21,221,288	$21,221,288	**$74,274,508**	
SUD IMD MEG 2 - Short Term Treatment							$76,620	$9,051,466	$18,102,932	$18,102,932	$18,102,932	**$63,436,882**	
SUD IMD MEG 3 - Detox Treatment							$8,904	$11,841,064	$23,682,128	$23,682,128	$23,682,128	**$82,896,352**	
Total FFP Expenditures	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$85,524**	**$31,503,174**	**$63,006,348**	**$63,006,348**	**$63,006,348**	**$220,607,742**	
Difference	$0	$0	$0	$0	$0	$0	**$0**	**$102,359,084**	**$75,766,058**	**$90,925,160**	**$107,603,521**	**$376,562,679**	

Schedule C

CMS 64 Waiver Expenditure Report

Cumulative Data Ending Quarter/Year : 3/2020

State: New Jersey

MAP Waivers

Total Computable

Waiver Name	01	02	03	04	05	06	07	08	Total
ABD	3,968,137,483	5,408,797,475	5,134,487,719	5,078,477,740	5,220,980,634	4,770,046,010	4,551,166,742	4,165,801,540	38,297,895,343
ACCAP – 217 Like	630,539	880,454	0	0	0	0	0	0	1,510,993
ACCAP – SP	900,000	966,297	0	0	0	0	0	0	1,866,297
AWDC	1,529,772	674,018	0	0	0	0	0	0	2,203,790
CCP MEG	0	0	0	0	0	27,109,657	849,878,384	1,419,497,696	2,296,485,737
Childless Adults	27,844,394	48,216,389	0	0	0	0	0	0	76,060,783
CRPD – 217 Like	11,803,536	16,894,842	0	0	0	0	0	0	28,698,378
CRPD –SP	10,672,842	15,247,535	0	0	0	0	0	0	25,920,377
DSRIP	0	83,304,870	166,600,001	166,600,000	166,600,000	166,599,999	166,600,000	0	916,304,870
GME State Plan	(9,533,864)	100,000,001	100,000,000	127,291,443	188,000,000	199,833,304	260,452,409	60,500,000	1,026,543,293
GO – 217 Like	181,068,236	221,682,839	0	0	0	0	0	0	402,751,075
GO – SP	23,869,092	33,606,671	0	0	0	0	0	0	57,475,763
HCBS – 217 Like	288,890	21,558,904	331,749,289	376,403,813	404,760,537	664,076,315	742,879,798	872,597,515	3,414,315,061
HCBS – State Plan	86,938	5,736,943	99,424,331	240,210,194	365,291,358	663,579,562	791,979,266	951,747,589	3,118,056,181
HRSF & GME	192,443,637	0	0	0	0	0	0	0	192,443,637
HRSF Transition Payments	0	83,302,681	0	0	0	0	0	0	83,302,681
IDD/MI – 217 Like	0	0	1,186,792	7,798,525	10,984,729	21,760,260	22,834,194	20,553,647	85,118,147
MATI at Risk	4,069,775	3,429,158	0	0	0	0	0	0	7,498,933
New Adult Group	7,940,104	849,408,487	2,862,968,161	2,915,531,800	3,146,291,973	3,169,829,362	3,184,729,250	3,181,002,249	19,317,701,386
NJCW	0	0	0	0	0	467,444,238	552,620,639	0	1,020,064,877
SED – 217 Like	83	58,922	27,837	96,680	12,236,369	22,824,203	22,105,801	21,901,710	79,251,605
SED at Risk	24,261,050	36,820,806	35,571,478	39,987,861	42,808,686	47,698,715	39,185,286	33,885,929	300,219,811
SUD-Detox	0	0	0	0	0	2,588	15,988,625	22,053,695	38,044,908
SUD-Long Term	0	0	0	0	0	0	15,864,974	26,356,457	42,221,431
SUD-Short Term	0	0	0	0	0	20,536	11,579,794	15,250,990	26,851,320
Supports Program	0	0	0	0	0	66,816,395	278,276,737	306,168,174	651,261,306
TBI – 217 Like	13,673,932	17,438,251	0	0	0	0	0	0	31,112,183
TBI – SP	7,457,114	9,364,928	0	0	0	0	0	0	16,822,042
Title XIX	1,660,533,500	2,401,753,394	2,588,414,484	2,549,675,884	2,591,767,989	2,628,154,865	2,761,270,528	2,569,367,336	19,750,937,980
XIX CHIP Parents	0	126,863,607	0	0	0	0	0	0	126,863,607
Total	**6,127,677,053**	**9,486,007,472**	**11,320,430,092**	**11,502,073,940**	**12,149,722,275**	**12,915,796,009**	**14,267,412,427**	**13,666,684,527**	**91,435,803,795**

	Federal Share										Composit										
Waiver Name	**01**	**02**	**03**	**04**	**05**	**06**	**07**	**08**	**Total**		**Waiver**	**01**	**02**	**03**	**04**	**05**	**06**	**07**	**08**	**09**	**10**
ABD	1,989,972,956	2,721,259,337	2,580,260,549	2,543,856,650	2,612,655,870	2,388,598,176	2,279,381,392	2,217,395,536	19,333,380,466		ABD	50.15%	50.31%	50.25%	50.09%	50.04%	50.07%	50.07%	50.07%	50.07%	50.07%
ACCAP – 217 Like	319,151	446,869	0	0	0	0	0	0	766,020												
ACCAP – SP	454,312	489,362	0	0	0	0	0	0	943,674												
AWDC	777,617	344,491	0	0	0	0	0	0	1,122,108		AWDC	50.83%	51.11%								
CCP MEG	0	0	0	0	0	13,564,047	425,971,120	758,046,254	1,197,581,421												
Childless Adults	14,715,147	24,778,164	0	0	0	0	0	0	39,493,311		Childless Adult	52.85%	51.39%								
CRPD – 217 Like	6,026,151	8,740,654	0	0	0	0	0	0	14,766,805												
CRPD –SP	5,447,877	7,899,121	0	0	0	0	0	0	13,346,998												
DSRIP	0	41,652,435	83,300,003	83,300,002	83,300,002	83,300,000	83,300,000	0	458,152,442		DSRIP		50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%
GME State Plan	(4,766,932)	55,642,502	66,797,499	84,588,472	122,350,400	127,079,448	168,957,117	41,505,794	662,154,300		GME State Plar		55.64%	66.80%	66.45%	65.08%	63.59%	*63.59%*	*63.59%*	*63.59%*	*63.59%*
GO – 217 Like	91,709,982	114,209,771	0	0	0	0	0	0	205,919,753												
GO – SP	12,108,906	17,304,835	0	0	0	0	0	0	29,413,741												
HCBS – 217 Like	147,459	11,154,795	170,361,648	189,473,008	202,413,874	332,135,128	371,553,829	464,282,441	1,741,522,182		HCBS – 217 Like	50.67%	51.55%	51.35%	50.34%	50.01%	50.01%	50.01%	50.01%	50.01%	50.01%
HCBS – State Plan	44,479	2,972,207	51,064,256	120,801,147	182,721,173	331,915,776	396,130,779	506,358,155	1,592,007,972		HCBS – State Pl	50.79%	51.58%	51.36%	50.29%	50.02%	50.02%	50.02%	50.02%	50.02%	50.02%
HRSF & GME	96,221,820	0	0	0	0	0	0	0	96,221,820		HRSF & GME	50.00%									
HRSF Transition Payments	0	41,651,341	0	0	0	0	0	0	41,651,341		HRSF Transitior		50.00%								
IDD/MI – 217 Like	0	0	599,439	3,903,695	5,492,456	10,880,225	11,420,706	10,962,732	43,259,253		IDD/MI – 217 L			50.51%	50.06%	50.00%	50.00%	50.02%	50.02%	50.02%	50.02%
MATI at Risk	2,055,322	1,783,162	0	0	0	0	0	0	3,838,484		MATI at Risk	50.50%	52.00%								
New Adult Group	7,938,698	849,378,031	2,861,994,577	2,913,062,608	3,060,220,417	2,994,977,388	2,976,915,170	2,910,267,830	18,574,754,719		New Adult Gro	99.98%	100.00%	99.97%	99.92%	97.26%	94.48%	93.47%	91.50%	90.00%	90.00%
NJCW	0	0	0	0	0	233,727,049	276,315,164	0	510,042,213												
SED – 217 Like	42	29,462	13,944	48,354	6,119,189	11,413,865	11,056,451	11,701,756	40,383,063		SED – 217 Like		50.00%	50.09%	50.01%	50.01%	50.01%	50.02%	50.02%	50.02%	50.02%
SED at Risk	12,617,861	19,091,377	18,489,075	20,485,806	21,899,156	24,099,950	19,605,797	18,208,294	154,497,316		SED at Risk	52.01%	51.85%	51.98%	51.23%	51.16%	50.53%	50.03%	50.03%	50.03%	50.03%
SUD-Detox	0	0	0	0	0	2,399	13,356,092	18,370,201	31,728,692												
SUD-Long Term	0	0	0	0	0	0	13,983,380	22,943,482	36,926,862												
SUD-Short Term	0	0	0	0	0	19,296	9,456,688	12,678,099	22,154,083												
Supports Program	0	0	0	0	0	33,410,851	139,219,453	162,894,197	335,524,501												
TBI – 217 Like	6,928,494	8,987,060	0	0	0	0	0	0	15,915,554												
TBI – SP	3,776,704	4,819,278	0	0	0	0	0	0	8,595,982												
Title XIX	833,625,792	1,329,314,879	1,419,822,500	1,293,823,124	1,302,141,078	1,321,753,626	1,389,208,939	1,378,651,998	10,268,341,936		Title XIX	50.20%	55.35%	54.85%	50.74%	50.24%	50.29%	50.29%	50.29%	50.29%	50.29%
XIX CHIP Parents	0	64,746,447	2,148	0	0	0	0	0	64,748,595		XIX CHIP Paren		51.04%								
Total	**3,080,121,838**	**5,326,695,580**	**7,252,705,638**	**7,253,342,866**	**7,599,313,615**	**7,906,877,224**	**8,585,832,077**	**8,534,266,769**	**55,539,155,607**												
Created On: Tuesday, August 18, 2020 8:54 AM																					
DY1 & DY2 HCBS expenditures	DY1	DY2																			
	total computable																				
HCBS – 217 Like	207,465,133	278,455,290																			
HCBS – State Plan	42,985,986	64,922,374																			
	Federal share																				
HCBS – 217 Like	105,131,237	143,539,149																			
HCBS – State Plan	21,832,278	33,484,803																			

CMS 64 - MEDICAID ELIGIBILITY GROUPS AS OF DEC 2019

	DEFINITIONS:	DY1	DY2	DY3	DY4	DY5	DY6	DY7	DY8	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
1	TITLE XIX	5,773,180	7,850,901	8,699,959	8,893,616	8,809,875	8,647,823	8,304,935	7,925,781	705,663	702,807	696,900	691,974	689,147	684,862	682,569	679,135	676,136	672,909	670,505	665,329	663,842	662,129	659,299	654,632	653,735	652,372	650,200	658,663	665,493	669,582
2	ABD (Excluding HCBS and LTC SPC 61)	2,486,117	3,342,730	3,355,975	3,343,701	3,309,756	3,228,542	2,911,654	2,750,991	239,789	239,603	239,295	239,093	238,386	237,575	237,755	237,021	236,724	235,701	235,174	234,598	233,665	233,323	232,094	230,432	229,372	227,824	226,156	224,606	222,611	221,136
3	Childless Adults	385,740	225,208	-	-	-	-		-																						
4	Adults W/O Dependent Children	6,057	2,774	3,870,426	4,240,639	4,404,948	4,374,491	4,221,181	4,163,546	356,912	354,145	353,382	353,583	352,885	348,828	346,622	344,203	342,600	342,382	341,621	341,238	340,889	340,291	344,805	345,036	344,893	342,652	342,713	353,381	361,597	364,430
5	SED	26,729	43,160	38,453	43,795	47,122	46,851	32,869	31,799	2,802	2,684	2,694	2,773	2,722	2,641	2,597	2,527	2,524	2,551	2,545	2,574	2,513	2,599	2,654	2,667	2,727	2,822	2,854	2,738	2,635	2,471
6	HCBS (State Plan)	13,594	18,860	25,656	59,042	98,286	137,776	167,400	196,391	13,557	13,680	13,784	13,964	14,097	14,023	14,022	14,263	14,478	14,990	15,259	15,525	15,858	15,996	16,223	16,639	16,822	16,820	16,824	16,975	16,832	16,618
7	HCBS (217 Like)	96,351	127,895	122,272	132,498	147,480	159,393	175,202	194,477	14,373	14,429	14,468	14,552	14,669	14,659	14,753	14,867	15,027	15,247	15,399	15,498	15,761	15,932	16,136	16,371	16,430	16,535	16,657	16,780	16,461	16,517
8	LTC								290,834	25,351	25,351	25,324	25,298	25,128	24,898	24,742	24,704	24,847	24,958	25,019	24,973	25,039	25,077	25,077	25,116	24,947	24,824	24,826	24,465	21,279	20,192
9	SED (217 Like)	113	145	115	96	1,847	3,464	3,821	4,122	307	300	304	315	324	325	327	334	339	339	351	352	352	364	364	357	351	331	328	326	325	321
10	IDD/MI (217 Like)	-	-	581	2,981	4,016	7,437	8,130	7,885	677	667	646	659	645	640	692	710	700	705	697	701	709	714	690	650	627	645	641	702	602	507
11	DDD Support		-	-	-	-	62,004	108,648	125,876	8,561	8,730	8,880	8,977	9,108	9,239	9,375	9,538	9,719	9,903	10,021	10,129	10,230	10,327	10,409	10,477	10,572	10,648	10,674	10,752	10,818	10,819
12	XIX CHIP Parents (10/01/2013 - 12/31/2013 Only)		456,761	-	-	-																									
13	Expansion Parents (01/01/2014 Onwards)		1,183,739	2,670,574	2,536,277	2,451,813	2,412,040	2,359,191	2,256,969	197,800	197,039	197,463	197,485	197,467	195,992	195,458	194,873	193,743	192,792	191,288	189,472	187,889	187,022	187,362	187,402	186,676	185,621	184,954	188,527	190,319	190,437
14	CCW (Community Care Waiver) *(10/01/2013 Onwards)*							115,198	140,718	11,448	11,464	11,483	11,507	11,512	11,512	11,531	11,553	11,571	11,617	11,649	11,680	11,690	11,698	11,715	11,729	11,750	11,767	11,783	11,789	11,753	11,715
15	Substance Use Disorder(SUD*) *(1/1/19 Onwards)*							10,577	16,115			1176	1087	1328	1298	1427	1488	1498	1275						6,712			5,636			3,767
	SUD IMD MEG1 - Long Term Treatment - H0019HF							3,130	4,662			*272*	*277*	*410*	*402*	*431*	*498*	*479*	*361*						*1,732*			*1,530*			*1,400*
	SUD IMD MEG2 - Short Term Treatment - H0018HF							3,137	4,679			*370*	*376*	*397*	*425*	*424*	*418*	*387*	*340*						*1,941*			*1,736*			*1,002*
	SUD IMD MEG3 - Detox Treatment - H0010HF							4,310	6,774			*534*	*434*	*521*	*471*	*572*	*572*	*632*	*574*						*3,039*			*2,370*			*1,365*

Budgent Neutrality Monitoring Sheet Notes

Enrollment Trends

No Waiver Spending

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

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

With Waiver Spending

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

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

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