New Jersey Comprehensive Waiver Demonstration
Section 1115 Annual Report
Demonstration Year 3: July 1, 2014 – June 30, 2015

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I. Introduction

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

This five year demonstration will:

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

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

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

This annual report is submitted in accordance with Special Term and Condition (STC) 102 of the NJCW.

II. STC 102(a): Accomplishments, Project Status, Quantitative and Case Study Findings, Interim Evaluation Findings, and Policy and Administrative Difficulties and Solutions in the Operation of the Demonstration.

During Demonstration Year (DY) 3, great progress was made in implementing the NJCW. The Managed Long Term Services and Supports (MLTSS) program went live July 1, 2014, the Department of Children and Families began enrolling individuals into the Autism Spectrum Disorder (ASD) and Individuals with Intellectual Disabilities and Developmental Disabilities with Co-Occurring Mental Illness (ID/DD-MI) Pilots in March of 2015, and the Supports Program went live July 1, 2015.

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 4 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, 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 after July 1.

With the move to MLTSS, the Division of Aging Services (DoAS) has retained its role as 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. During this demonstration year, the State continued to meet and educate its stakeholder groups on MLTSS. During regularly scheduled meetings, the State has met 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.

The DMAHS Office of Managed Health Care, with its provider relations unit, has been at the forefront in spearheading communications efforts to ensure access through its provider networks in these categories—HCBS medical; HCBS non-medical; nursing homes; assisted living providers; community residential providers and long-term care pharmacies. As a resource to stakeholders, the Office of Managed Health Care, 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.

An emphasis has been placed on the DHS website to transmit information as it become available at www.state.nj.us/humanservices/dmahs/home/mltss_resources.html through the posting of materials. The Frequently Asked Questions (FAQs) have been revised several times since July 1 and continues to be modified as necessary. Other documents include copies of presentations to stakeholder provider groups, billing code information, samples of MLTSS claim forms and the MLTSS service dictionary.

A newsletter was mailed to 17,118 providers at the time of the July implementation to reiterate and detail New Jersey's move to MLTSS in order to inform providers and also consumers. An intensive education and outreach program was provided after MLTSS went live. During July, seven educational sessions were held throughout the State to inform providers about their role, and briefing them on topics such as member eligibility confirmation, the MCO provider network, MCO contract parameters, resources and more. Almost 300 providers were trained through these outreach efforts. The presentation was posted so that those who were unable to attend a session could review.

In October 2014, the DHS held three "Feedback Forums" to allow advocates for older adults, people with physical disabilities, caregivers and HCBS providers an opportunity to share their thoughts about the MLTSS rollout with management. The forums were held with the goal of reaching a statewide audience, starting with the central region on October 21 in New Brunswick; the southern region on October 24 in Vineland, and in the north on October 31 in Wayne. Over 300 persons attended the forums. An update was also provided on implementation with a focus on these topics: access to services; the person-centered care approach; the development of plans of care based on care needs and members' rights and responsibilities; provider relations and quality management.

In March 2015 the Division of Medical Assistance and Health Services in cooperation Health Care Association of NJ, Leading Age NJ, and NJ Hospital Association conducted educational session for Assisted Living Providers. Over 100 staff from the Assisted Living provider community attended the training.

The State has had 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 weekly 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 the end of the demonstration year, the state and the MCOs were looking forward to beginning the annual reassessment process.

Supports Program
The Division of Developmental Disabilities (DDD), in implementing the Supports Program, changed their delivery system from a State Contracted to a Fee-for-Service Model. This was a major shift in philosophy that took time for providers, support coordinators and their clients to adjust to. DDD made sure to take their time to engage their stakeholders throughout the process to make the shift as easy as possible, providing many webinars, trainings and materials and allowing for feedback during the entire time period.

The Supports Program went live on July 1, 2015.

Autism Spectrum Disorder Pilot, Intellectual Disability/Developmental Disability with Co-occurring Mental Illness Pilot, Serious Emotional Disturbance Program
Youth eligible for the ASD and ID/DD-MI pilots began in March of 2015. The Department of Children and Families (DCF), Children's System of Care (CSOC) has worked closely with DMAHS to learn as much as they can about the processes involved regarding Medicaid billing, eligibility, enrollment, etc. to ensure their youth are served efficiently and effectively. CSOC has provided and is continuing to provide ongoing support to providers as it relates to procedures and expectations for the new programs. CSOC has also work closely with their stakeholders to ensure that the needs of the community are being heard.

Managed Behavioral Health Organization
The Managed Behavioral Health Organization had begun the demonstration year with a Request for Proposal being drafted and in the approval process. Due to hold-ups at the state level, a new direction was taken.

In January 2015, Governor Chris Christie announced that the Department of Human Services was developing an interim managing entity (IME) for addiction services as the first phase in the overall reform of behavioral health services for adults in NJ. The state identified the University Behavioral Health Care (UBHC) within Rutgers University to develop and implement the IME that was established through a Memorandum of Understanding with the Division of Mental Health and Addiction Services. The IME went live on 7/1/15.

The IME serves as a single point of entry for those seeking treatment for substance use disorder services. The IME will ensure that individuals are receiving the right level of care for the right duration at the right intensity. This will allow the state to manage its resources that include Medicaid and other state funds in the continuum of care. The IME has been designed to provide 24/7 availability for callers; screening for risk and service needs; referral using a bed management system; care coordination to assist individuals to enter care and move through the continuum; utilization management activities which include authorizing and monitoring levels and duration of care for state only funds; verifying eligibility for Medicaid; and referral for the Medicaid member to appropriate Medicaid covered service and Medicaid providers.

Evaluation of the Demonstration
The summary of the progress in the Waiver Evaluation can be found under attachment A of this report.

III. STC 102(d)(i): A Report of Service Use by Program Including Each HCBS Program (encounter data)

Service use data for MLTSS is included in attachment B at the end of this report. Due to the brief time that other HCBS programs have been operating, the State does not have service use data available for those programs at this time.

IV. STC 102(d)(ii): A Summary of the Use of Self-directed Service Delivery Options in the State

Overview of Self-Direction

Self-Direction is a philosophy and service delivery mechanism for home and community based services whereby informed consumers gauge their own needs, determine how and by whom these needs should be met, and monitor the quality of services received. Consumers have both budget authority and employer authority to make choices that work for them. Budget authority allows consumers to choose how they wish to spend their monthly allowance within program guidelines. Employer authority allows consumers to become common law employers so they can choose who they want to hire to provide direct care.

Self- direction may exist in different degrees and span many types of services, ranging on a continuum from an individual making all decisions to an individual using a representative to manage needed services. Research has found that consumers who participate in self-directed service delivery models report increased satisfaction with their homecare services as well as increased quality of 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 under a CMS 1915j authority in 2008. As of August 2015, 5840 consumer were actively participating in Personal Preference. The average monthly budget was $1268.47 which equates to approximately 21.5 hours of PCA services per week.

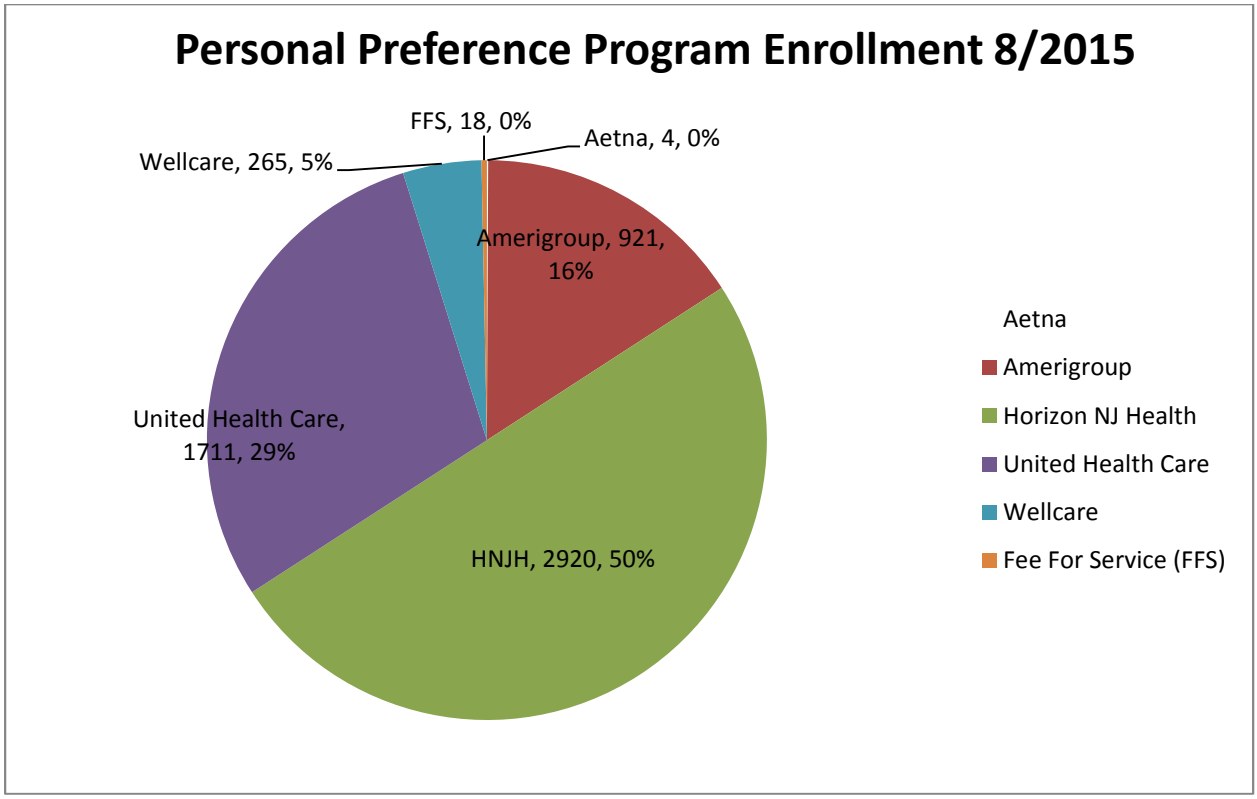
Participants use the majority of their monthly budgets to hire individual workers. Some participants choose to purchase goods and services in lieu of personal care. For example, a consumer may choose to purchase a microwave so he/she can heat up meals when the worker is not present, allowing the consumer to be independent and not relying on the care provider. Participants that purchase goods and services most often purchase small appliances such as microwaves, washer/dryer, toaster ovens, disposable medical supplies including wipes and gloves and other supports such as, transportation and laundry services. Since the inception of

MLTSS in July 2014, consumers have been making fewer purchases of goods and services. We believe this change is most likely caused by the reduction in the PCA rate under managed Care from $15.50/hour to $15.00/hour. Many consumers have revised their monthly budgets and have reduced or removed the purchase of goods and services in order maintain their current worker without having to reduce their salaries or the number of hours they can purchase from the worker to provide care.

From 2008 to July 2011, approximately 30-50 new consumer enrolled each month. There was no marketing for this program so enrollment was fueled by word of mouth. With the inclusion of PCA services, including PPP into Medicaid Managed Care in 2011, enrollment began to increase to about 75-100 new participants each month and has been increasing steadily to date. In the last 12 months, average enrollment has been approximately 182 participants each month. The reason behind increased enrollment is due to the obligation of the Managed Care Organizations to inform their members of the option to self-direct home care services pursuant to CMS regulation.

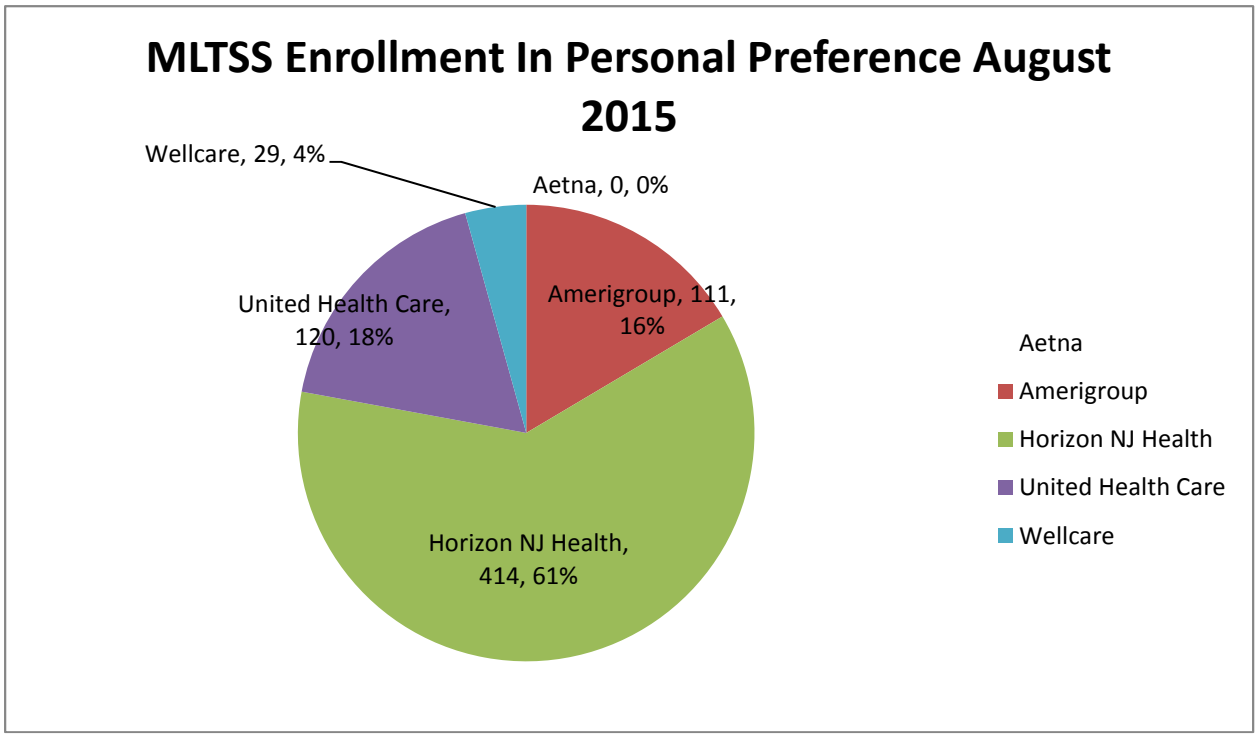
As of August 2015, the total active enrollment for the Personal Preference Program was 5840 consumers. The chart below demonstrates the breakdown of participants by Managed Care Organization.

Chart 1



Of these consumers, 675 were enrolled in Managed Long Term Supports and Services (MLTSS). Chart 2 demonstrates a breakdown of participants by Managed Care Organization.

Chart 2



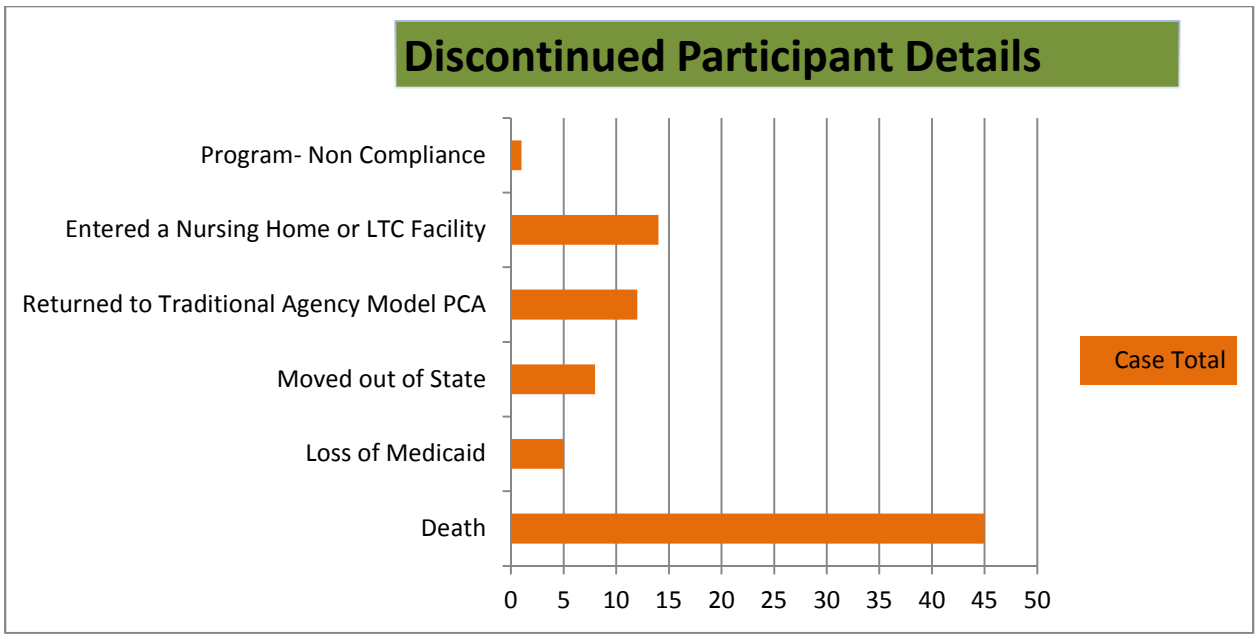
Horizon NJ Health has historically maintained the largest enrollment of its members in the Personal Preference Program. While fifty percent of all active participants in Personal Preference are with Horizon NJ Health, 61% of these consumers are enrolled in MLTSS. Chart #3 demonstrates the proportion of active participation and MLTSS enrollment.

Chart 3

Managed Care Organization	Active Personal Preference Enrollment	Active MLTSS Enrollment
Aetna	**0**	**0**
Amerigroup	**16%**	**16%**
Horizon NJ Health	**50%**	**61%**
United Health Care	**29%**	**18%**
WellCare	**5%**	**4%**

Consumers disenroll from Personal Preference for a variety of reasons. Reasons for disenrollment appear in Chart 4.

Chart 4



In reviewing data, for those consumers who returned to traditional agency model PCA services, the reason is most often due to increased medical need/clinical deterioration and lack of family support to meet the responsibilities of self- direction. Please note that consumers who have disenrolled due to a decline in health or hospitalization, may have subsequently returned to traditional agency model PCA services, entered a LTC facility or may have passed away since their disenrollment from the program. These findings are proportionally similar for all consumers, whether or not they are enrolled in MLTSS.

Chart 5 below indicates the most prevalent disabilities and or diagnosis of self-directed participants;

Chart 5

Alzheimer's/Dementia	Traumatic Brain Injury (TBI)
Chronic Obstructive Pulmonary Disease (COPD)	Cerebral Ventricular Accident (CVA)
Spinal Cord Injury (SCI)	Elderly*
Intellectual Disability	Chronic Pain

*Elderly is a term used to describe the group of multi-system symptoms associated with ageing and the routine deterioration of functional ability.

We speculate that Alzheimer's/Dementia tops the list due to the nature of the disability in that consumer require consistency among caregivers and routine. Self-direction affords a family the ability to self-hire care caregivers of their choice with the requisite consistency and flexibility needed to maintain a loved one in decline in the community. These are not always elements that are available from the traditional home care agency.

Many participants experience co-morbid diagnoses which include: hypertension, diabetes, and depression.

Self-Direction under MLTSS

Based on the success of self-directed PCA services, DHS in its creation of MLTSS developed additional self-directed services to meet the various needs of the MLTSS population in an HCBS environment. One of the purposes of offering these self-directed options was to provide a consumer with the mechanism to purchase unique goods & services previously not available under the Medicaid program. For example, one of the MCOs determined that many of its members were having adverse health effects caused by their homes being excessively hot. In an effort to maintain the individual's health and safety while maintaining them in their home in lieu of an institutional setting, the MCO opted to purchase window air conditioners and were only able to so using the self-directed mechanism which allowed for the purchase of non-routine items.

DDS administers the Self-Directed Service options available to consumers under 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) PEP - 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

Additional training is required for MCO staff. Although MCO staff reports having greater knowledge about self-direction since the implementation of MLTSS and further report seeing the benefits it has on their members both MCO staff and DDS continue to find ways to streamline processes and create a more efficient enrollment process for consumers. DDS will also continue training opportunities to address the noted issues of limited knowledge and MCO staff attrition.

DDS created two separate Enrollment Packages to help facilitate the enrollment of consumers wishing to enroll in Self-Directed Services one for Personal Preference and one for Self-Directed

MLTSS services. The Personal Preference Packet includes the PCA Assessment Tool used to authorize PCA hours. Early on in the process, there were inconsistencies in the PCA Assessment used amongst the MCOs, which created inconsistencies in the program enrollment process The Division of Medical Assistance and Health Services has adopted a new PCA Assessment Tool which was implemented as of December 2014. This change has significantly decreased inconsistencies in the authorization of PCA hours as well as dissatisfaction amongst consumers.

DDS staff continues to work with MCO staff to keep communication lines open in order to better serve consumers. Working relationships between DDS and MCOs continue to grow in a positive direction.

DHS is in the process of re-procuring the Fiscal Management Services Contract for the Self Directed Services.

V. STC 102(d)(iii): A General Update on the Collection, Analysis and Reporting of Data by the Plans at the Aggregate Level

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." Our plans are required to submit encounter records on at least a monthly basis, though submissions generally occur more frequently. DMAHS has a unique set of encounter claim edits to ensure consistency and readability of encounters across our varied MCOs. We also set 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.

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 certification 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 to senior level Governor's Office staff to detailed claims-based analysis in support of future policy making and fraud detection.

The Division recently established an Office of Business Intelligence that incorporates many of these functions (plus the state's HITECH program) in a single entity. This Office is made up of 10 state employees with additional contractor support and includes the following business units:

- **Office of Research (4 state employees and shared data warehouse contractor)** – This unit is responsible for the day to day management of the shared data warehouse and assists business units throughout the Division (fiscal, quality assurance, medical director, Office of the Director, etc.) with their data needs, report design, and metric definition. This unit also creates data reports requested by the division director, responds to Open Public Records Act inquiries and brings a data perspective to division-wide initiatives and policy discussions.
- **Performance evaluation and Presentations (2 state employees) –** This unit prepares slide presentations, designs and produces interactive data dashboards, coordinates and prepares the NJ FamilyCare Annual Report, and coordinates other policy priority initiatives upon request. This unit is vital in providing a high level understanding of the state's medical assistance programs to various policy makers and stakeholders, from advocacy agencies and provider associations to Department level and Governor's Office officials.
- **Encounter Data Monitoring Unit (3 state employees) –** This unit is responsible for ensuring the MCOs submit their encounter data in a timely manner and within contracted requirements and monitoring the capitation withhold and liquidate damages provisions included in the managed care contract. Their work includes reconciling the various billing methods of each managed care organization to maximize the uniformity of the encounter data set and working with the plans to ensure any new types of billing are able to be accommodated within the general encounter framework. They also work with the State's MMIS vendor to ensure that encounters are able to be accepted and to develop and necessary changes to the encounter claims adjudication business process stemming from billing changes by the MCOs or policy changes within the NJ FamilyCare program.
- **HITECH (1 state employee with 2 part-time staff in other units and contractor support)** – This unit is responsible for the State's HITECH program, including the development and coordination of the State Medicaid Health Information Technology Plan (SMHP) and annual Implementation Advance Planning Document (IAPD) CMS funding requests for the State's HITECH initiatives and day-to-day operation of the state's Medicaid EHR Incentive Program. This unit works with various departments within state government to develop HITECH initiatives that advance health information exchange throughout the state and maximize the meaningful use of EHR systems amongst Medicaid providers. Contractor support provides the EHR Incentive Program attestation system, audits EHR Incentive Program payments, and provider outreach services to encourage the adoption and meaningful use of EHR technology.

Another way we use data collected from the plans is for Quality Improvement Projects (QIPs), which is housed within the Office of Quality Assurance.

In December 2013, the MCOs, with the guidance of the EQRO, initiated a collaborative QIP with a focus on Identification and Management of Obesity in the Adolescent Population. Since inception, the EQRO had held regularly scheduled meetings with the MCOs to ensure a solid and consistent QIP foundation across all MCOs. The MCO's submitted their project update in June 2015 which includes quantitative results for the previous measurement year. In September 2015, the plans will submit a report to include a qualitative analysis of their recent activities and, based on the analysis, any revisions to the interventions for the upcoming year. Starting August 2015, MCOs will meet monthly, independent of the EQRO, for continued collaborative activities. The MCOs are expected to show improvement and sustainability of this collaborative QIP. A routine QIP cycle consists of baseline data followed by two remeasurement years and then a sustainability year. Currently four MCOs are involved in the collaborative. For three of the MCOs, 2013 is their baseline data year for the project; results of calendar year 2014 reflect remeasurement year 1 and results of calendar year 2015 reflect remeasurement year 2. The fourth MCO entered into the NJ market in December of 2013, making their baseline year 2014, with results of calendar year 2015 as their first remeasurement year.

The MCOs are also involved in a non-collaborative Prenatal QIP with the focus on Reduction of Preterm Births. The initial proposals were submitted by the MCOs in October 2014 for review by the EQRO. The individual proposals were approved and project activities were initiated by the plans in early 2015. The June interim reports include the 2014 Baseline Data. The next report submission in September 2015 is expected to include an analysis of plan specific activities. Results of calendar year 2015 measures will represent premeasurement year 1.

Additionally, MCO's will be submitting individual QIP proposals in September 2015 on Falls Prevention specific to members receiving MLTSS.

VI. STC 102(d)(iv): Monitoring of the Quality and Accuracy of Screening and Assessment of Participants who Qualify for HCBS/MLTSS

The NJ FamilyCare 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 are referred for a comprehensive assessment.

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, 2014 through June 30, 2015 the below statistical data identifies the number of SCS that resulted in referrals for comprehensive assessments. 52% of screens that identified at risk individuals were referred for comprehensive assessment based on consumer consent.

SCS - I&A/Options Counseling	4,798
SCS – comprehensive assessment recommended	6,234
SCS referred for comprehensive assessment	3,243
Total	11,032

The Department of Human Services 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.

During the period of July 1, 2014 through June 30, 2015, 26,581 assessments for MLTSS level of care determination were conducted for existing MCO members of which 90% have received a level of care determination. The final level of care determination was 19,903 Authorized/Approved and 209 Denied. The differential of 2,763 is comprised of duplicate submissions, request that MCO conduct new assessment, outcome pending more information/screening by another entity (i.e. DDD), or other non-determination outcome.

In the first several months of MLTSS implementation, the State identified issues with the quality of the comprehensive assessments conducted by the MCOs. This was most apparent through the high rate of Not Authorized review outcomes. Not Authorized is identified as an assessment that is conducted by the MCO and reviewed by the State. The State review is unable to make a determination for level of care eligibility because the clinical criteria is not indicated. The State is responsible for conducting a face to face reassessment for the Not Authorized outcomes. Due to the high percentage (ranged 18-33%) identified, the State implemented an aggressive training strategy. The training outline in attachment C.1 documents the trainings held specifically for the MCOs specific to MLTSS processes and assessment.

Attachment C.2 shows the assessment statistics for Demonstration Year 3 by MCO.

Webinars:

Nine webinars were provided from August 2014 through February 2015. Key webinars related to assessment included:

- Key Areas of NJ Choice – focus on the areas of the assessment tool that are specific to the clinical eligibility criteria as well as those areas that have a direct correlation
- Narratives – focus on the NJ Choice narrative which provides an overall summary of the assessment findings. Correlation between the narrative and the assessment coding is essential to a level of care determination
- SCNF LOC Need – individuals who require a higher level of care need and require medically complex services are identified in the assessment process. These individuals receive a higher cost threshold for community services
- Trends in RFIs; NF LOC overview – focus on reasons why a level of care determination cannot be made; the required information for assessment; the criteria for nursing facility level of care

Care Management Collaboration:

Several Care Management meetings were convened to discuss care management and assessment issues and collaboration on solutions. The following solutions had a direct impact on improving assessment quality.

- Ability of MCO to obtain and utilize assessments conducted by the State that qualified individuals for MLTSS within four months of enrollment.
- Evaluation by MCOs of the outstanding Not Authorized outcomes and strategy to have those that appeared to have errors in the initial assessment were reassessed by the MCO.
- Individual meetings with each MCO to review assessments in which outstanding information was still pending; provide guidance obtaining and submitting the information

NJ Choice HC Annual Recertification

Individuals who conduct assessment utilizing the state's standardized assessment tool are required to undergo annual recertification and demonstrate competency. The annual recertification for the MCOs was held in February 2015 for Care Management Supervisors and Master Trainers. These individuals were responsible for implementing the training internally for their assessment staff between the periods of February through August 2015. The annual recertification for State and ADRC assessors was held in April 2015. The State added a Role Play Module and a Mentoring Module to the training to enhance the skills of the assessors. The Role Play Module focuses on typical scenarios and challenges, skill building for interview skills, and identification of deficits that impact level of care need. The Mentoring Module gives the

assessor the opportunity to strengthen and enhance their skills in real life situations with support, guidance, and feedback.

Mentoring

The Mentoring Module as part of the annual recertification process is the responsibility of the entity that is conducting assessment. In order to prepare these entities for the mentoring module, the State implemented an extensive Mentoring Program for the 5 NJ Family Care MCOs and 3 ADRC counties. This mentoring program paired entity assessors – identified as Lead Mentors based on the strong assessment and interview skills – with State assessors – identified as Master Mentors based on strong assessment, interview, and mentoring skills. The Master Mentor was responsible for modeling assessment skills, observing the Lead Mentor skills, and providing feedback and guidance on areas of weakness.

The collaborative meetings, webinars, enhanced recertification process, and mentoring were all implemented to improve the quality of the screening and assessment of individuals for MLTSS. In the immediate months following the conclusion of the recertification and mentoring process, the MCO Not Authorized rate dropped from an overall average of 25% to 12% (range 8-12%) which was a significant improvement. The Not Authorized rate for the month of August 2015 is 7% overall before factoring in the final State determination. The State has proposed a new quality measure for the Not Authorized rate for the July 2015 contract (pending CMS approval). The measure requires that the Not Authorized rate is to be at or below 7%. This rate is calculated after the State's final determination of nursing facility level of care. Two of the five MCOs are meeting this standard prior to the State's final determination which indicates that their final rate will be within the quality measure parameters. The remaining three MCOs pre-determination rate is 8%, 8% and 13%. The State expects the MCOs with the 8% rate will drop within the parameters. The MCO with the 13% rate is being monitored and will receive additional outreach and support and be required to submit a remediation plan in accordance with the contractual requirements.

VII. STC 102(d)(v): GEO Access Reports from Each Participating MCO

The Geo Access Report Summary is located under Attachment D.

VIII. STC 102(d)(vi): 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 waiver.

IX. STC 102(d)(vii): 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 Waiver 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 IDD/DD-MI programs. The implementation of the Supports Program in demonstration year 4 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.

X. STC 102(d)(viii): Specific Examples of How HCBS Has Been Used to Assist Participants

Since the implementation of MLTSS, the state has been holding regular operations meetings with each MCO. The below describes a specific example from each of the five operating MCOs of how HCBS has been used to assist participants.

Aetna:

Member enrolled with Aetna Better Health of New Jersey (ABHNJ) in the MLTSS program on 1/1/15. The member is diagnosed with schizophrenia, diabetes, and previously had a stroke which left him with right sided weakness. During his initial assessment he preferred to be alone in his rented apartment and was apprehensive to agree to services he is entitled to through the MLTSS program. After options counseling was completed the member agreed to a Personal Emergency Response System (PERS) and home delivered meals. The Care Management Coordinator (CMC) suggested PCA services for the member which he declined at the time. The member's cousin provided informal care for member so the CMC suggested and explained the self-direction program which he also declined. ABHNJ utilized a motivational approach and revisited the PCA and self-direction services during subsequent visits with the member.

The CMC initiated the PERS and home delivered meals for the member. A wireless PERS was installed in his home and he now wears the PERS at all times and has not yet needed to use it.

Home delivered meals were also initiated for the member. The CMC reassured the member that home delivered meals are a part of his benefit with the MLTSS program.

The CMC speaks regularly with the member and his sister, the member's power of attorney. In June, the CMC educated and advised the family once again about PCA and self-direction services. They both were open and interested in the self-direction program.

Once both the member and his sister expressed interest in the program a home visit with the CMC, the Behavior Health Supervisor and Self-direction Coordinator for ABHNJ was scheduled. A detailed overview of the self-direction packet was provided and an application was completed.

The member and family are currently very satisfied with the services being received and plan to utilize the self-direction program. They welcome the ongoing care management involvement and are active in the development of their plan of care. They do not hesitate to call their CMC with questions or concerns.

Amerigroup:

A 52-year-old male member with a history of asthma, COPD, severe rheumatoid arthritis, and lymphoma transitioned in July 2014 to MLTSS from the state's previous long term care waiver program. Three years prior to MLTSS enrollment, while in chemotherapy treatment, he was hit by a car while crossing the street. The impact shattered his hips and knees, and resulted in numerous surgeries, including fusion of wrists and knuckles and an unsuccessful transplant. He cannot turn his head or change positions without assistance.

He has no family residing in the area. He has been challenged to manage his chronic conditions and has been hospitalized more than a dozen times within the previous year. When the Amerigroup care manager arrived in July 2014, the member's mom was staying with him to augment the care that home care aides were providing, but she needed to return to her home in Florida. The care manager increased the home care hours so the member would have the support he needed when his mother returned home.

During his assessment several other concerns were identified that required intervention.

The member explained that his motorized wheel chair was broken, so his care manager arranged for a repairman to come to his home. In addition, his care manager observed that the member appeared frail and malnourished. Through discussion with him it was agreed that meal delivery service was needed and was put into place. To address additional nutritional needs, his care manager contacted the member's primary care doctor who then prescribed Ensure. His care manager also assessed his pain and identified a wound in the sacral area. With wound supplies and weekly RN visits, the member now reports that the wound is healing and no longer causes pain. Lastly, his care manager asked the member about his safety pendant and learned that it was not functioning. She reached out to the vendor, learned the unit was connected to an incorrect phone number, and remedied the situation.

Horizon:

A 64 year old woman with a diagnosis of Hemiplegia affecting her dominant side resides in an Assisted Living Facility. She expressed feelings of depression and reported a desire to see a therapist. She has a Primary Care Physician (PCP) that comes to the facility regularly and prescribed an antidepressant medication; however, the member verbalized she did not want to visit a psychiatrist, unless a therapist deemed it was necessary. She did not verbalize any thoughts of self-harm or harm to others.

The Behavioral Health Administrator contacted the member's PCP, with the permission of the member, and spoke with the PCP regarding the request for an in-home therapist. The PCP identified other residents in the facility that would benefit from a therapist coming to the facility. The member has Medicare as her primary insurance for outpatient therapy services. Through Medicare, the PCP was able to secure a therapist to come to the facility and provide counseling services for this member, as well as other residents. MLTSS care management was the conduit for collaboration. The Behavioral Health Administrator worked with the member's medical team to ensure she was connected to services to improve her overall quality of life.

United HealthCare:

A 61 year old male with a diagnosis of bipolar I disorder was hospitalized in a Psychiatric Hospital for mental health stabilization. The member met the criteria for nursing home level of care (NF LOC) due to an arm injury which made self-care and performing daily tasks difficult. He was living on his own for a number of years and it was becoming increasingly more challenging for him.

Once psychiatrically stable, the member verbalized that he did not want to return to living on his own because he found it frightening due to his physical limitations. While he is able to ambulate with his injured arm, he is unable to get up and down from a sitting or lying down position without assistance. With the MLTSS benefit, he would be discharged home with a Home Health Aide and a Partial Psychiatric Hospitalization Program during the day. The only time he would be on his own would be at night, but he was uncomfortable with this plan and requested placement in a facility with 24 hour care and assistance.

His treatment team discussed living with family for support during the night. The member has a 90 year old mother in the area, and a brother, but he was unable to live with either of them. His sister lives in a neighboring state, but he was unable to move in with her either. The member requested placement in a facility, and the family agreed. The hope was to find a facility near his family.

The member was discharged to a subacute rehabilitation center/nursing facility. He will receive rehabilitative services and transition to their nursing facility for long term care. The member voiced his relief to not be living on his own and the facility is ten minutes from his mother's home. The family expressed appreciation and report that he is happier than he has been in years. His sister stated that her brother is pleased and "where he needs and wants to be."

WellCare:

WellCare successfully completed two MLTSS assessments for members who reside in A+ AMHRs.

The first member is a 75 year old man with a history of schizoaffective disorder who currently resides in an A+ residential program. The second member is a 64 year old man who also has a history of schizoaffective disorder and resides in an A+ AMHR. Both of these members have recently become incontinent. As both group homes have "No Touch" policies, the staff is only permitted to cue and supervise the members with their activities of daily living (ADLs) and cannot provide hands-on assistance with toileting and using diapers. As you can imagine, this was causing ethical dilemmas for the staff and embarrassment and humiliation for the members.

After completing the NJ Choice and PCA Tool, WellCare determined that both members met criteria for MLTSS. Home Health Agencies were contacted the next day to authorize and initiate PCA services and services began three business days after our initial visit.

Without MLTSS, both of these members would have been transferred to a nursing home.

XI. STC 102(d)(ix): 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.)

Money Follows the Person/Nursing Facility Transitions: NJ participates in the federal demonstration project that assists individuals who meet CMS eligibility requirements to transition from institutions to the community, 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 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.

Number of Nursing Facility Transitions and MFP by Quarters

First Quarter

MCO	Number of Transitions
Aetna	0
Amerigroup	5
Horizon	15
United Health Care	3
Wellcare	12
Quarter Total	**35**

Second Quarter

MCO	Number of Transitions
Aetna	0
Amerigroup	14
Horizon	24
United Health Care	13
Wellcare	5
Quarter Total	**56**

Third Quarter

MCO	Number of Transitions
Aetna	**0**
Amerigroup	**9**
Horizon	**38**
United Health Care	**14**
Wellcare	**2**
Quarter total	**63**

Fourth Quarter

MCO	Number of Transitions
Aetna	0
Amerigroup	10
Horizon	60
United Health Care	17
Wellcare	7
Quarter Total	**94**

Grand Totals for DY3

MCO	Number of Transitions
Aetna	0
Amerigroup	38
Horizon	137
United Health Care	47
Wellcare	26
Grand Total	**248**

Balance Incentive Program

New Jersey was awarded $108.5 million from the US Department of Health and Human Services, Centers for Medicare and Medicaid Services, to support the expansion of home and community-based services for New Jersey seniors and people with disabilities. The funds were received for the Balancing Incentive Payment Program (BIP), which is administered through the New Jersey Department of Human Services. To date, NJ has earned $89.0 million and has been granted an extension until September 20, 2017, to reinvest the remaining BIP revenue.

Based on CMS 2009 data, NJ was spending 26 percentage of its LTC budget on home and community based services, which was the second lowest rate in the county. Today NJ's

percentage on HCBS is 45.2% an increase of 19.2%. Below is the chart that shows all states rebalancing efforts.

Percent of Total LTSS Spent on Community LTSS by Quarter: All Participating States

State	2009	2012 Q2	2012 Q3	2012 Q4	2013 Q1	2013 Q2	2013 Q3	2013 Q4	2014 Q1	2014 Q2	2014 Q3	2014 Q4	2015 Q1
NH	41.2%	46.2%	45.6%	53.9%	59.3%	46.2%	53.8%	57.4%	53.3%	40.0%	47.4%	56.0%	54.1%
MD	36.8%		53.6%	52.1%	53.4%	53.0%	50.9%	54.8%	54.4%	60.3%	57.7%	58.9%	60.6%
GA	37.4%			N/A	46.4%	50.0%	49.1%	49.2%	49.1%	49.0%	49.2%	47.5%	48.5%
MO	40.7%			54.8%	51.2%	54.7%	55.6%	55.7%	52.7%	56.6%	56.1%	56.6%	60.6%
IA	39.8%				48.0%	48.2%	50.2%	50.0%	52.0%	48.0%	49.7%	51.1%	52.4%
MS	14.4%				28.7%	30.1%	28.9%	27.4%	28.8%	30.9%	30.3%	30.4%	31.0%
TX	46.9%				59.8%	53.1%	56.4%	59.7%	59.3%	58.6%	56.9%	58.8%	58.5%
IN*	30.6%					32.1%	32.0%	30.5%	31.7%	30.9%	31.2%	30.3%	N/A
AR	29.8%						52.1%	48.7%	48.7%	53.9%	53.8%	49.7%	53.3%
CT	44.1%						45.2%	37.8%	47.3%	53.3%	48.1%	43.6%	49.0%
NJ	26.0%							38.5%	36.4%	42.5%	42.9%	46.1%	45.2%
LA*	36.4%							44.8%	35.8%	38.0%	40.5%	38.8%	N/A
NY	46.7%							54.3%	54.9%	56.3%	56.9%	58.8%	58.7%
IL	27.8%							30.8%	39.7%	43.0%	42.9%	44.4%	48.9%
OH	32.5%							42.7%	49.5%	51.1%	61.9%	60.5%	61.6%
ME	49.1%							53.2%	55.1%	55.8%	54.2%	56.8%	52.5%
KY	31.1%									41.5%	44.6%	49.5%	47.8%
NV	41.6%										48.3%	48.8%	47.5%
MA	44.8%										65.0%	65.1%	64.4%
PA	33.0%											45.1%	45.9%

= Did not participate in the Program long enough to submit a progress report.

Source: Attachment C of Balancing Incentive Program Instruction Manual; Program Progress Reports

* As of 12/31/2014, state is no longer participating in Program.

PACE

Under the Comprehensive Waiver 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, you must be 55 years of age or older and able to live safely in the community at the time of enrollment. There are currently four PACE organizations in seven counties, with a fifth PACE program opening October 1, 2015 serving one county.

Program of All-inclusive Care for the Elderly (PACE)	
NAME	COUNTIES
LIFE at Lourdes -	Most of Camden
Lutheran Senior LIFE -	Parts of Hudson
LIFE St. Francis -	Mercer and parts of northern Burlington
Inspira LIFE -	Parts of Cumberland, parts of Gloucester and parts of Salem
Beacon of LIFE –	Parts of Monmouth County

PACE New Member Enrollments FY2015:

1st Qtr : 65

2nd Qtr: 62

3rd Qtr: 48

4th Qtr: 49

Total New enrollments: 224

PACE Initiatives for 2015:

- During DY3 the NJ PACE Program in conjunction with the Division of Medical Assistance and Health Services Office of MLTSS Quality Assurance established a PACE workgroup to review MLTSS Performance Measures and select/modify those measures for PACE. The workgroup is finalizing the PACE Performance Measures, which when implemented will enable the State Administering Agency (SAA) to evaluate and compare data related to care and services across MLTSS and PACE.
- NJ's fifth PACE program - Beacon of LIFE officially opens October 1, 2015. The site will serve several communities in Monmouth County.
- In late May PACE Programs agreed to partner with DoAS to implement ***The Otago Exercise Program*** which trains physical therapists, assistant physical therapists and nurses to deliver the evidenced based program to PACE members. This 1/1 falls prevention program was created in Australia and is proven effective in reducing falls among participants.

XII. STC 102(d)(x): A Summary of the Outcomes of the State's Quality Strategy for HCBS

The outcomes and analysis for the State's Quality Strategy can be found under Attachment E.

XIII. STC 102(d)(xi): Efforts and Outcomes Regarding the Establishment of Cost-effective MLTSS in Community Settings Using Industry Best Practices and Guidelines

The design incorporated into MLTSS is one where the state requires MCOs to provide service coordination and care management with a holistic perspective. All MLTSS members have an MCO assigned care manager who is responsible to coordinate acute care, long term care (MLTSS) and behavioral health services to ensure the member is as safe and independent in the community as possible. In addition, the state requires the MCOs to ensure linkages to community based services (based on need) that do not necessarily fall into a covered benefit category.

XIV. STC 102(d)(xii): Policies for Any Waiting Lists Where Applicable

There are currently no waiting lists in use.

XV. STC 102(d)(xiii): Other Topics of Mutual Interest Between CMS and the State Related to the HCBS Included in the Demonstration

CMS issuance in January 2014 of the home and community based services (HCBS) settings rule required New Jersey to move forward with the development and submission of a Statewide Transition Plan (STP) during this NJCW reporting period. The STP described how New Jersey will ensure that the NJCW is compliance with the HCBS setting requirements.

DHS, working with the Department of Children and Families and the Department of Health, publicly released New Jersey's draft STP on January 26, 2015. The public comment period closed on February 27, 2015. Over 1,000 public comments were received in the form of letters, emails, phone calls and testimony at the two public input sessions on February 4 and 19, 2015. The draft STP produced strong emotional and operations-based opposition. It opened up an important dialogue and resulted in constructive and useful feedback. Because of the public's commitment to the issues and willingness to engage in the public input process, an important dialogue developed and resulted in constructive and useful feedback that is being incorporated into the revised plan. DHS requested from CMS a 30-day extension to the March 17th submission deadline and a revised version was submitted to CMS on April 17, 2015.

XVI. STC 102(d)(xiv): 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.

MCOs are developing communication links with NJs County Welfare Agencies for the purpose of assisting members with applying for programs such as utility assistance, and SNAP. MCOs are also developing communication links with county based Aging and Disability Resource Connections (ADRCs) to assist members with linking to community based MLTSS services that are covered by the MCO.

One MCO in particular has established a staff position within its requirement for a member advocate, who's function is to not only act as an advocate for the purpose of navigating LTSS and managed care, but also assists members with connections to community based services operated through the above mentioned entities. This appears to be a promising best practice which illustrates how one MCO has taken a required responsibility to the next level in the interest of ensuring member success in the community.

XVII. STC 102(d)(xv): 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 E.

XVIII. STC 102(d)(xvi): 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 at the end of this report.

XIX. Enclosures

A) Waiver Evaluation Summary
B) 1115 Waiver Service Units and Claims
C.1) Care Management Trainings
C.2) Assessment Statistics
D) Geo Access Report by MCO
E) MLTSS Performance Measurement Report
F) Budget Neutrality Analysis

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XXI. Date Submitted to CMS

Report Submitted to CMS on October 22, 2015.

Attachment A
Summary of Waiver Evaluation Activities

A.	***Expanding Medicaid managed care to include long-term care services and supports will result in improved access to care and quality of care and reduced costs, and allow more individuals to live in their communities instead of institutions.***
	Federal Fiscal Quarter 4 (July 1, 2014 to September 30, 2014) During the period ending September 30, 2014, the Rutgers Center for State Health Policy (CSHP) participated in regular meetings and conference calls with the state in order to understand and document key information related to the background and implementation of the managed care expansion that will inform both our quantitative and qualitative evaluations. These included monthly update calls with the State; MLTSS Steering Committee meetings; and meetings with officials from the Office of Managed Care and the Division of Aging Services. Activities related to the quantitative evaluation of the managed care expansion centered on data procurement and preparation in the most recent quarter. There are three data sources for this evaluation component: publicly available uniform billing (UB) hospital discharge data, Medicaid claims and encounter records, and secondary data from MCO performance reports. Activities with these data sources are organized under the two research questions addressing this hypothesis and are detailed below: *Research Question 1a: What is the impact of the managed care expansion on access to care, the quality, efficiency, and coordination of care, and the cost of care for adults and children?* *Research Question 1b: What is the impact of including long-term care services in the capitated managed care benefit on access to care, quality of care, and mix of care settings employed?* Medicaid claims: Processing of the Medicaid claims and encounter data (received at CSHP in March of 2014) occurred in FFQ4 to begin preparation of analytic datasets for calculating AHRQ's Prevention Quality Indicators and Pediatric Quality Indicators, avoidable emergency department visits, and 30-day risk-standardized readmission rates for the baseline period (Jan. 2011-Sept. 2012). CSHP established a dialogue with Molina, the State's Medicaid fiscal agent, to clarify record processing and ask questions about data structure and variable definitions. CSHP has mapped the specifications for all metrics supporting our evaluation of this hypothesis to our claims dataset variables, and reviewed the MMIS data dictionary to identify additional variables that will be necessary and/or helpful in future datasets. CSHP also began adapting the coding for CMS's 30-day risk-standardized Medicare/all-payer readmission measures developed at Yale University for the Medicaid claims data. HEDIS/CAHPS: The performance of Medicaid MCOs on 13 HEDIS measures and 9 CAHPS measures

of consumer satisfaction were collected from secondary data sources for the baseline period. In addition to public reports, such as the 2013 Family Care Annual Report, CSHP requested and received reports from the State containing plan-level and state-level estimates for most of these 22 measures. CSHP will use these measures to evaluate the quality of preventive care, treatment of chronic conditions, and behavioral health care for the Medicaid managed care population. To compare these measures over time, CSHP also requested and received from the State the HEDIS plan-level denominators.

Analysis with UB discharge data to create all-payer comparisons for certain quality measures (e.g., avoidable/preventable hospitalizations that occur from inadequate ambulatory care in the community, preventable ED visits) started in the month of *October 2014* and will be explained in more detail in future quarterly reports.

Background/Institutional/Policy-level information: Identifying and documenting such information is critical for the quantitative analysis described above and also the qualitative part of the evaluation that involves key informant interviews with MLTSS stakeholders. Some specific examples of such activities include: 1) regular calls with State Medicaid officials to discuss progress on waiver activities 2) working with the State to understand and accurately use Medicaid claims and quality metrics based on HEDIS/CAHPS, 3) quarterly meetings with officials from State departments overseeing the managed care expansion (e.g. Division of Aging Services in addition to Division of Medical Assistance and Health Services) to discuss implementation of MLTSS 4) review of metrics from the MLTSS Quality Strategy and MCO Contract and identifying consistency with the metrics set from the original evaluation plan 5) review of other documents such as the Service Dictionary, MAAC meeting presentations and minutes, the Care Management Workbook, communication materials directed to consumers and providers, MLTSS Triage reports and information on related efforts such as the Balancing Incentives Program, and 6) attending and documenting relevant information at Steering Committee meetings and public forums related to the MLTSS expansion.
In the month of *October*, we started work related to the key informant interviews developing a list of potential interviewees and questions.

Federal Fiscal Quarter 1 (October 1, 2014 to December 31, 2014)

During the period ending December 31, 2014, CSHP continued their monitoring of the managed care expansion as it relates to long-term services and supports. These activities yield a great deal of contextual and procedural information that will inform both our quantitative and qualitative evaluations.

Some specific examples of activities this last quarter include: 1) monthly update calls with State Medicaid officials to discuss progress and new developments related to waiver programs and services, 2) attending and documenting relevant information at the October 2014 MLTSS Steering Committee meeting, 3) attendance at one of the public stakeholder forums convened by the State to discuss MLTSS implementation and gather feedback directly from providers, consumers, advocates, etc. 4) review of metrics from the MLTSS Quality Strategy submitted by the State with their progress report for the last quarter, 5) continued review of other documents including the MCO Contract and MLTSS Service Dictionary, MAAC meeting presentations and minutes, and communication materials directed to consumers and providers.

Identifying and documenting information through these activities is critical for the qualitative part

of the evaluation that involves key informant interviews with MLTSS stakeholders. During October-December 2014, CSHP started work related to these key informant interviews. With input from select stakeholders we designed the set of questionnaires and targeted interviewee groups for the stakeholder interviews that are planned during February-April 2015.

Related to the quantitative evaluation of the managed care expansion, CSHP conducted data analysis and preparation of our first report to the State. This initial report (delivered in January 2015) presented a selection of quality measures for the entire Medicaid managed care population in the baseline period (1/2011-9/2012) with estimates for all-payers and other payer types for selected metrics. The report primarily addresses Research Question 1a under this hypothesis.

The data in this report come from two of the three sources of data for our quantitative analysis: publicly available uniform billing (UB) hospital discharge data and secondary data from MCO performance reports provided to us by the State. Analyses generated with these data sources are described briefly below, but greater detail regarding our analyses and findings can be found in the final report provided to the State. :

UB discharge data: CSHP calculated avoidable/preventable hospitalizations that occur from inadequate ambulatory care in the community using the Agency for Healthcare Research & Quality's Prevention Quality Indicators (PQIs) and Pediatric Quality Indicators (PDIs). Population-based rates of PQIs and PDIs for all payers combined and for individual payer types (Medicaid, Duals, Other Medicare, Private, and Uninsured) were calculated using data from the 2010-2012 American Community Survey for population denominators. An analogous set of tables was produced for avoidable/preventable ED visits using the methodology provided by the New York University Center for Health and Public Service Research.

During this quarter, CSHP also procured the UB data files for year 2013 which will be the first post-baseline year included in future analyses. When data for future years become available, rates of avoidable hospitalizations and ED visits from these baseline years will be compared to the demonstration years.

HEDIS/CAHPS: The performance of Medicaid MCOs on 13 HEDIS measures and 9 CAHPS measures of consumer satisfaction were collected from secondary data sources for the baseline period and assembled into tables for our report. CAHPS measures of consumer satisfaction were presented for each MCO in each of the two baseline years, as were the overall plan averages. As in the case of UB-based metrics, findings from the baseline years will ultimately be compared to the demonstration years.

CSHP continued to work with the State and Molina (the State's Medicaid data vendor) to assist in the preparation of Medicaid claims and encounter database that will be used for the calculation of a variety of quality metrics as part of the waiver evaluation. Examples of metrics specific to the managed care expansion hypothesis that will be calculated from Medicaid claims data include avoidable/preventable hospitalizations, avoidable/preventable ED visits, and 30-day risk-standardized readmission measures for Medicaid overall and sub-populations of LTC-eligible beneficiaries.

Federal Fiscal Quarter 2 (January 1, 2015 to March 31, 2015)

During the period ending March 31, 2015, the Rutgers Center for State Health Policy (CSHP) continued our monitoring of the managed care expansion as it relates to long-term services and supports. As mentioned in previous reports, these activities yield a great deal of contextual and procedural information that will inform both our quantitative and qualitative evaluations.

Some specific examples of activities this last quarter include: 1) monthly update calls with State Medicaid officials to discuss progress and new developments related to waiver programs and services, 2) quarterly in-person meetings with the lead staff involved in implementing the waiver across various state departments, 3) attending and documenting relevant information at the January 2015 MLTSS Steering Committee meeting, 4) continued review of other documents including the MCO Contract and MLTSS Service Dictionary, MAAC meeting presentations and minutes, and communication materials directed to consumers and providers.

CSHP finalized the MLTSS interview questions and began outreach and completion of interviews. By the end of the quarter CSHP completed seven interviews with eleven stakeholders. CSHP is planning for about eight additional interviews in the next quarter for our initial stakeholder summary.

Activities to support the quantitative evaluation of the above hypothesis in the last quarter were centered on validating the corrected Medicaid Fee-For-Service Claims and Managed Care Encounter datasets received in February 2015 (more details in section D below), operationalizing metric definitions in the claims data, and calculation of metrics specified in the evaluation plan. Additionally, CSHP continued discussions with representatives from Medicaid familiar with the claims data to specify the best methodology for identifying subpopulations of beneficiaries in the baseline period, specifically, the nursing facility population, former 1915(c) waiver populations, dual eligibles, and an approach for creating general groupings of Medicaid beneficiaries: ABD, children, and adults, in anticipation of the adjustments we will need to do for analyses using data from the post-expansion years.

Federal Fiscal Quarter 3 (April 1, 2015 to June 30, 2015)

During the quarter ending June 30, 2015, the Rutgers Center for State Health Policy (CSHP) continued our meetings/discussions with the state including, among other things, the monitoring of the managed care expansion as it relates to long-term services and supports. As mentioned in previous reports, these activities yield a great deal of contextual and procedural information that inform both our quantitative and qualitative evaluations.

Some specific examples of activities this last quarter include, as in the previous ones: 1) monthly update calls with State Medicaid officials to discuss progress and ongoing developments related to waiver programs and services, 2) quarterly in-person meetings with the lead staff involved in implementing the waiver across various state departments, 3) attending and documenting relevant information at the May 2015 MLTSS Steering Committee meeting, 4) continued review of other documents including the MCO Contract and MLTSS Service Dictionary, MAAC meeting presentations and minutes, and communication materials directed to consumers and providers.

CSHP completed our MLTSS interviews. By the end of the quarter CSHP completed a project total of 16 interviews with 34 stakeholders. CSHP completed their report on the stakeholder interviews and submitted it to the state just after the end of the quarter on July 1, 2015.

	In the quarter ending June 30, 2015, CSHP completed the majority of the data preparation and analysis for the second baseline report in the quantitative evaluation of the above hypothesis. A variety of quality metrics were tabulated for specific subpopulations of Medicaid beneficiaries for years 2011 and 2012: Medicaid overall, the Medicaid managed care population, specific eligibility groups, the long-term care population overall (excluding PACE), the nursing facility and HCBS subpopulations, and cohorts of beneficiaries having behavioral health conditions. Examples of some of the quality metrics calculated were ambulatory visits within 14 days of hospital discharge, avoidable hospital use (both inpatient and ED), and 30-day readmissions for heart failure, pneumonia, acute myocardial infarction, and for all causes. Tables presenting these data were generated and most sections of the report were drafted. This in-depth analytic work and the subsequent organization of this baseline report established the framework for answering the two research questions under this hypothesis in accordance with the evaluation plan.
B.	***Providing home and community-based services to Medicaid and CHIP beneficiaries and others with serious emotional disturbance, opioid addiction, pervasive developmental disabilities, or intellectual disabilities/developmental disabilities will lead to better care outcomes.***
	<u>Federal Fiscal Quarter 4 (July 1, 2014 to September 30, 2014)</u> *<u>Research Question 2a</u>: What is the impact of providing additional home and community-based services to Medicaid and CHIP beneficiaries with serious emotional disturbance, autism spectrum disorder (previously classified as pervasive developmental disabilities), or intellectual disabilities/developmental disabilities?* *<u>Research Question 2b</u>: What is the impact of the program to provide a safe, stable, and therapeutically supportive environment for children from age 5 up to age 21 with serious emotional disturbance who have, or who otherwise be at risk for, institutionalization?* The data preparation work related to the Medicaid claims described under the previous hypothesis also supports our evaluation of this second hypothesis. Subject to sufficient sample size, stratifications of quality measures by waiver populations will include a breakout for the groups receiving targeted home and community-based services. CSHP is examining the variables needed to identify the Medicaid and CHIP beneficiaries with serious emotional disturbance, autism spectrum disorder, or intellectual disabilities/developmental disabilities. CSHP has also mapped other relevant quality/utilization metrics to test this hypothesis to the claims data variables in our dataset and/or detailed in the MMIS data dictionary. State officials also facilitated a meeting for us with key individuals from the Department of Children and Families' Children's System of Care during the most recently completed quarter. During this meeting, CSHP discussed the services, timing, and financing for those services provided to those special populations of children targeted for additional services under the waiver. Regular calls with State Medicaid officials over the quarter also provided us with updates on implementation of the pilot programs related to this hypothesis. **<u>Federal Fiscal Quarter 1 (October 1, 2014 to December 31, 2014)</u>** The data preparation work and planning related to the Medicaid claims described under the

	previous hypothesis also supports our evaluation of this second hypothesis. CSHP plans to identify the Medicaid and CHIP beneficiaries with serious emotional disturbance, autism spectrum disorder, or intellectual disabilities/developmental disabilities, and have confirmed the special program codes for these populations with the State. Many of the quality metrics mentioned above will also be calculated for these populations. **Federal Fiscal Quarter 2 (January 1, 2015 to March 31, 2015)** In January 2015, we met with representatives from DDD and DCF overseeing the reforms in home and community-based services for special populations of children and adults with intellectual/developmental disabilities. CSHP received updates on the status of their initiatives and enrollment in the waiver demonstration programs. **Federal Fiscal Quarter 3 (April 1, 2015 to June 30, 2015)** In April 2015, CSHP met with representatives from DDD and DCF overseeing the reforms in home and community-based services for special populations of children and adults with intellectual/developmental disabilities. CSHP received updates on the status of their initiatives and enrollment in the waiver demonstration programs.
C.	***Utilizing a projected spend-down provision and eliminating the look back period at time of application for transfer of assets for applicants or beneficiaries seeking long term services and supports whose income is at or below 100% of the FPL will simplify Medicaid eligibility and enrollment processes without compromising program integrity.***
	Federal Fiscal Quarter 4 (July 1, 2014 to September 30, 2014) *Research Question 3a: What is the impact of the projected spend-down provision on the Medicaid eligibility and enrollment process? What economies or efficiencies were achieved, and if so, what were they? Was there a change in the number of individuals or on the mix of individuals qualifying for Medicaid due to this provision?* *Research Question 3b: What is the impact of eliminating the transfer of assets look-back period for long term care and home and community based services for individuals who are at or below 100% of the FPL? Was there a change in the number of individuals or on the mix of individuals qualifying for Medicaid due to this provision?* CSHP is assessing related policy changes e.g., qualified income trust and examining availability of relevant metrics (detailed in the evaluation plan). **Federal Fiscal Quarter 1 (October 1, 2014 to December 31, 2014)** In November 2014, State Medicaid officials organized a conference call including the evaluation team and representatives from county operations and Medicaid's Quality Control Unit to discuss the self-attestation process and their internal review of these attestations for individuals <100% FPL. CSHP discussed specific pieces of information they would be able to collect and provide to us to support our evaluation of the error rate for self-attestations and the impact of this policy change on approval times.

	Federal Fiscal Quarter 2 (January 1, 2015 to March 31, 2015) There were no specific activities related to evaluation of this hypothesis in the quarter ending March 31, 2015. **Federal Fiscal Quarter 3 (April 1, 2015 to June 30, 2015)** Stakeholder interview feedback on the elimination of the look back period was that not many consumers are affected, but that it does simplify the eligibility and enrollment process for these individuals. Stakeholder interview feedback on the Qualified Income Trusts was that they are positive with respect to allowing consumers to spend down in community settings in addition to nursing facilities, thus improving access to home and community-based services. However, there are questions of access to legal assistance for consumers who have few financial or social resources with respect to both drawing up the trust documents initially and finding someone to administer the trust over time.
D.	***The Delivery System Reform Incentive Payment (DSRIP) Program will result in better care for individuals (including access to care, quality of care, health outcomes), better health for the population, and lower cost through improvement.***
	Federal Fiscal Quarter 4 (July 1, 2014 to September 30, 2014) The DSRIP evaluation has a quantitative and a qualitative evaluation component. Activities relating to the quantitative section are similar to other components of the waiver evaluation e.g.; data management, mapping of variables from metric definition to claims, examining documentation relating to calculation of endorsed/established quality metrics for application on Medicaid claims. The qualitative evaluation comprises key informant interviews (KII) with DSRIP stakeholders and a hospital web survey. For the midpoint evaluation, the KIIs are intended to capture stakeholder perceptions related to program implementation and the program's potential to achieve the triple aims. In the period ending September 2014, CSHP conducted informal interviews with selected stakeholders to understand and identify questions for the KIIs. Subsequently, CSHP created the questions, and started scheduling interviews. At this time (*early November*) CSHP has completed almost all of the KIIs, and are ready to start analysis. Other activities included: Incorporating feedback from CMS into the evaluation plan. This included developing crosswalks between research questions, hypotheses, and metrics and adding them as appendices to our evaluation document CSHP also updated the text to better convey the flow between the conceptual and analytical dimensions of our evaluation plan as well as to reflect DSRIP policy changes (e.g., change in reporting requirements) relating to specific metrics. Attending webinars hosted by Myers and Stauffer and NJ DOH (related to DSRIP training sessions, attribution models, learning collaboratives) to keep abreast of the developments in program

implementation and also individual hospital experiences.

Federal Fiscal Quarter 1 (October 1, 2014 to December 31, 2014)

The DSRIP evaluation has a quantitative and a qualitative evaluation component. For the quantitative section we continued activities related to mapping of variables from metric definition to claims and examining documentation relating to calculation of endorsed/established quality metrics for application to Medicaid claims.

The qualitative evaluation comprises key informant interviews (KII) with DSRIP stakeholders and a hospital web survey. For the midpoint evaluation, the KIIs are intended to capture stakeholder perceptions related to program implementation and the program's potential to achieve the triple aims. In the period ending December 2014, CSHP completed nearly all key informant interviews. CSHP utilized the information gathered in the interviews to design a web survey to be distributed to all New Jersey hospitals. CSHP also worked with NJ DOH staff to identify survey contacts and create letters from NJ DOH to accompany the invitation to participate in the survey.

Other activities included attending webinars hosted by Myers and Stauffer and the NJ DOH (related to DSRIP training sessions, attribution models, learning collaboratives) to keep abreast of the developments in program implementation and also individual hospital experiences.

Federal Fiscal Quarter 2 (January 1, 2015 to March 31, 2015)

Three main activities relating to the evaluation of the DSRIP program, specifically the midpoint evaluation report are the following:

Calculation of metrics from the Medicaid Fee-for-Service and Managed Care Encounter data:
As mentioned previously, validation of the corrected Medicaid claims dataset that CSHP received in February 2015 was conducted. CSHP used uniform billing hospital discharge data to benchmark counts of inpatient and ED visits in the claims data. CSHP spoke to Medicaid representatives as needed to understand claims structure and key variables. CSHP completed the majority of the programming for DSRIP metrics in the most recent quarter. CSHP followed technical specifications for year 2014 from the applicable measure stewards (National Quality Forum, Joint Commission, etc.). Finalizing covariates and DSRIP exposure variables to create analytic datasets is underway, and refinement of the modeling approach continues.

DSRIP Key Informant Interviews: CSHP completed four additional DSRIP stakeholder interviews in this period, bringing our total to twelve. The members of the evaluation team separately identified themes from the interviews and discussed any differences in emphasis. CSHP wrote up our methods and our findings in a summary report that will be a component of the midterm evaluation.

Hospital Web Survey: The hospital midpoint web survey was designed by CSHP staff in January and February, 2015. It was informed by the key informant telephone interviews conducted earlier and also the material discussed at learning collaborative meetings. The final version of the questionnaire was programmed into *Survey Monkey* and pretested by Rutgers CSHP staff. Several minor programming revisions were performed following pretesting.

	On March 3, 2015, an advance endorsement letter from the New Jersey Department of Health was emailed by Rutgers CSHP personnel to the DSRIP contact person for each DSRIP-eligible hospital in New Jersey. The letters were tailored slightly for the hospitals that were participating in DSRIP, non-participating, or withdrawn from the program, and encouraged the hospitals to provide feedback on the program via the survey. In some cases further follow-up was required related to the email contacts. On March 12, 2015, another email was sent to all NJDSRIP-eligible hospitals containing informed consent information and a link to the web survey. On March 23, 2015, a reminder email with the consent information and survey link was sent to all eligible hospitals. On March 31, 2015, a second reminder email with the consent information and survey link was sent to all eligible hospitals. *Around the time of the writing of this report, on April 15, 2015, a final email reminder with the consent information and survey link was sent to those eligible hospitals who had not completed the web survey. The survey field period was completed on April 24, 2015.* **Federal Fiscal Quarter 3 (April 1, 2015 to June 30, 2015)** Quantitative Evaluation: CSHP continued their analysis work in two main areas. The first related to metrics that CSHP would independently calculate to evaluate the DSRIP program based on Medicaid claims data. Second, CSHP utilized all-payer data to create the list of relevant hospitals for each NJ zip code and then create a measure of DSRIP exposure based on the proportion of hospitals that were participating in the DSRIP program.

ENCOUNTER PAYMENTS, SERVICE UNITS, AND CLAIM COUNT FOR JULY 1, 2014 THROUGH MARCH 31, 2015 FOR MLTSS WAIVER RECIPIENTS

Procedure Code Description	Procedure Code	Claim_Payment_Amt	Clm_Service_Units_Qty	Clm_Net_Paid_Claim_Indicator
ADULT DAYCARE SERVICES 15MIN	S5100	9,462	2,743	220
MEDICAL DAY CARE	S5102	7,844,891	100,787	100,239
TEAM EVALUATION & MANAGEMENT	T1024	3,986	13	13
Medical Day Care Total		**7,858,339**	**103,543**	**100,472**
ADULT DAYCARE SERVICES 15MIN	S5100	1,622,621	445,985	29,367
ADULT FOSTER CARE PER DIEM	S5140	191,982	4,025	768
ALCOHOL AND/OR DRUG SERVICES	H0004	72,097	2,415	654
ASSIST LIVING WAIVER/DIEM	T2031	40,045,124	688,935	122,408
CHORE SERVICES PER 15 MIN	S5120	601	256	16
CHORE SERVICES PER DIEM	S5121	1,444	132	13
COMM TRANS WAIVER/SERVICE	T2038	16,062	9	9
DAY HABIL WAIVER PER 15 MIN	T2021	300,684	40,992	3,765
DEVELOP COGNITIVE SKILLS	97532	633,347	19,135	3,763
FAMILY HOMECARE TRAIN/SESSION	S5111	2,680	41	41
HABIL ED WAIVER PER HOUR	T2013	1,279,478	16,807	5,425
HOMAKER SERVICE NOS PER 15M	S5130	25,531,488	6,840,240	378,017
HOME ENVIRONMENT ASSESSMENT	T1028	537	12	12
HOME MEALS PER MEAL	S5170	2,269,645	326,947	47,590
HOME MODIFICATIONS PER MONTH	S5165	105,598	59	53
LPN/LVN SERVICES UP TO 15MIN	T1003	10,291,623	1,050,830	27,397
MED REMINDER SERV PER MONTH	S5185	3,242	79	79
MEDICAL DAY CARE	S5102	192,571	5,822	5,599
P.T. THER PROC,1 OR MORE AREAS	97110	605,583	19,280	6,925
PERS INSTAL & EQUIP	S5160	11,267	234	234
PERS MONTHLY FEE	S5161	509,520	20,193	19,793
PRIVATE DUTY/INDEP NURS SERV	T1000	260,411	27,479	664
RES, NOS WAIVER PER DIEM	T2033	7,999,823	43,739	38,485
RESPITE CARE SERVICE 15 MIN	T1005	77,867	42,109	751
RN SERVICES UP TO 15 MINUTES	T1002	4,128,387	353,357	10,074
SELF CARE MANAGEMENT TRAINING	97535	530,181	16,973	4,744
SPEECH LANGUAGE HEARING THERAP	92507	315,190	6,292	2,799
SPEECH,LANGUAGE/HEARING THERAP	92508	91,920	3,809	1,056
UNSKILLED RESPITECARE /DIEM	S5151	22,378	268	127
VEHICLE MOD WAIVER/SERVICE	T2039	638	1	1
DAILY RESPITE CARE IN NURSING FACILITY	-	128,210	739	86
Managed Long Term Supports and Services Total		**97,242,197**	**9,977,194**	**710,715**
CUSTODIAL NURSING HOME CARE	-	30,562,195	162,944	6,205
Custodial Nursing Facility Total		**30,562,195**	**162,944**	**6,205**
PERSONAL CARE SER PER 15 MIN	T1019	40,810,838	10,958,276	641,181
Personal Care Assistance Total		**40,810,838**	**10,958,276**	**641,181**
ALCOHOL AND/OR DRUG SERVICES	H0019	23,838	166	166
ALCOHOL AND/OR DRUG SERVICES	H0020	640	191	191
E/M OFFICE/OP ESTAB PATIENT	99213	164	5	5
E/M OFFICE/OP ESTAB PT VISIT	99215	63	1	1
E/M OFFICE/OP ESTABLISHED PT	99214	63	1	1
GROUP MEDICAL PSYCHOTHERAPY	90853	22	10	6
GRP PSYCH PARTIAL HOSP 45-50	G0410	-	8	8
HEALTH & BEHAV INTERVEN INDIV	96152	-	5	2
HOSPITAL OUTPT CLINIC VISIT	G0463	224	6	6
MH PARTIAL HOSP TX UNDER 24H	H0035	1,939	93	30
PSYCH DIAG EVAL W/MED SRVCS	90792	347	9	9
PSYCH DIAGNOSTIC EVALUATION	90791	119	4	4
PSYTX PT&/FAM W/E&M 30 MIN	90833	234	7	7
PSYTX PT&/FAMILY 30 MINUTES	90832	1,068	34	34
PSYTX PT&/FAMILY 45 MINUTES	90834	900	28	27
SPECIAL FAMILY THERAPY	90847	91	1	1
OTHER MENTAL HEALTH	various	554,730	54,949	6,574
Behavioral Health Total		**584,441**	**55,518**	**7,072**
Total Long Term Care and Home and Community Based Services for MLTSS Waiver Reci		**177,058,011**	**21,257,475**	**1,465,645**
Grand Total MLTSS or LTC Encounter Services, including Behavioral Health		**177,058,011**	**21,257,475**	**1,465,645**

Notes:

Service from dates for claims span July 1, 2014 through March, 31, 2015 and were paid from July 1, 2014 through September 23, 2015. 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.

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, 2014 THROUGH MARCH 31, 2015 FOR MLTSS WAIVER RECIPIENTS

Clm Proc Curr Layman Name	Clm Proc Code	Claim_Payment_Amt	Clm_Service_Units_Qty	Count__dist__of_Claims_ICN_Idn
CUSTODIAL NURSING FACILITY	-	5,925,933	32,517	1,248
MEDICAL DAY CARE	S5102	20,881	266	266
HHA/CNA PER HR WEEKDAY	S9122	100,766	6,503	1,554
NURSING ASSESSMENT/EVALUATION	T1001	560	16	16
PERSONAL CARE ASSISTANT VISIT	Z1605	176	15	15
PERSONAL CARE ASSISTANT VISIT	Z1616	60	5	5
PERSONAL CARE ASSISTANT VISIT	Z1611	8	1	1
ALP DAILY RATE	Y9634	45,623	869	29
ALR DAILY RATE	Y9633	1,331,985	21,446	771
CPCH DAILY RATE	Y7574	143,869	2,776	97
Total Long term care and Home and Community Based Services for MLTSS Waiver Recip		**7,569,861**	**64,414**	**4,002**
Behavioral Health Total		**469,976**	**2,522**	**1,183**
Grand Total MLTSS or LTC Fee for Service, including Behavioral Health		**8,039,837**	**66,936**	**5,185**

Notes:

Service from dates for claims span July 1, 2014 through March, 31, 2015 and were paid from July 1, 2014 through September 23, 2015. Only non-voided, paid claims are reflected in the data.

Medical Day Care, MLTSS related waiver services, 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.

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.

For claims fitting multiple categories, the hierarchy applied for categorization is as follows: Custodial Nursing Facility, Medical Day Care, Personal Care Assistance, MLTSS related Waiver Services, and Behavioral Health.

Attachment C.1
Training Outreach by OCCO
July 2014 through June 2015

MCO Care Management Meetings:

November 5, 2014

May 8, 2015

MLTSS Webinars for MCOs:

8/6/14: Cost Effectiveness IDTs

8/7/14: Key Areas of NJ Choice

9/18/14: General Care Management issues

10/2/14: Narratives

10/16/14: SCNF LOC Need

10/30/14: Cost Effectiveness processes

11/12/14: Trends in RFIs, NF LOC overview

12/5/14: Transitions/MFP

2/27/15: Cost Effectiveness processes/updates

NJ Choice/Comprehensive Assessment Trainings:

NJ Choice Recertification

MCO NJ Choice Recertification (2 day) – 68 MCO Care Manager Supervisor attendees

February 2-3, 2015

February 9-10, 2015

OCCO/ADRC NJ Choice Recertification (2 day):

March 30-31, 2015 (NRO)

April 1-2, 2015 (SRO)

PACE NJ Choice Recertification (2 day):

May 19 and 21, 2015

MCO Mentoring:

March 9 – 13, 2015 (Wellcare - 4 Assessors; Amerigroup – 4 Assessors)

March 9 – 20, 2015 (United – 9 Assessors)

March 16- 27, 2015 (Horizon – 15 Assessors)

June 15 – 19, 2015 (Aetna – 2 Assessors)

April 8, 2015 – Individual MCO Recap on Mentoring Outcomes

Stakeholder Webinars:

Assisted Living Provider Webinars:

March 24-25, 2015

Nursing Facility Provider Webinars:

June 26 and July 1, 2015

Hospital/NF: EARC

December 17- 18, 2015

Hospital/NF/MCO: PASRR

February 18, 19, 25, and 26, 2015

Attachment C.2 DY3 MCO Assessment Statistics

Aetna	Number	Percentage
Consumer Records	175	
Total Assessments	187	
MDC Only	0	
TOTAL MLTSS ASSESSMENTS	187	100
Level of Care determination outcomes		
Authorized	68	40
Not Authorized (percentage calculated on Authorized/Not Authorized outcomes only)	9	12
Approved	97	55
Denied (percentage based on Not Authorized outcomes)	1	11
TOTAL	**175**	**94**

Amerigroup	Number	Percentage
Consumer Records	4994	
Total Assessments	6080	
MDC Only	1538	
TOTAL MLTSS ASSESSMENTS	4542	75
Level of Care determination outcomes		
Authorized	2787	70
Not Authorized (percentage calculated on Authorized/Not Authorized outcomes only)	501	15
Approved	709	18
Denied (percentage based on Not Authorized outcomes)	12	2
TOTAL	**4009**	**88**

*Total percentages calculated on factors independent to each category and are not directly correlated to each other (i.e. denial rate analyzed on subset of total assessment population).

Due to duplication of assessments and members often having more than one assessment with variable outcomes, the statistics including percentages are not unduplicated MCO members.

Members assessed by the State prior to MCO enrollment were not able to be filtered out of the statistical analysis.

Data Source: TeleSys Clinical Assessment Database; Assessment outcomes effective July 1, 2014 through June 30, 2015

Horizon	Number	Percentage
Consumer Records	14697	
Total Assessments	18714	
MDC Only	4702	
TOTAL MLTSS ASSESSMENTS	14012	75
Level of Care determination outcomes		
Authorized	8765	70
Not Authorized (percentage calculated on Authorized/Not Authorized outcomes only)	1911	18
Approved	1811	14
Denied (percentage based on Not Authorized outcomes)	118	6
TOTAL	**12605**	**90**

United	Number	Percentage
Consumer Records	6454	
Total Assessments	7798	
MDC Only	1782	
TOTAL MLTSS ASSESSMENTS	6016	77
Level of Care determination outcomes		
Authorized	3526	65
Not Authorized (percentage calculated on Authorized/Not Authorized outcomes only)	1095	24
Approved	767	14
Denied (percentage based on Not Authorized outcomes)	67	6
TOTAL	**5455**	**90**

*Total percentages calculated on factors independent to each category and are not directly correlated to each other (i.e. denial rate analyzed on subset of total assessment population).

Due to duplication of assessments and members often having more than one assessment with variable outcomes, the statistics including percentages are not unduplicated MCO members.

Members assessed by the State prior to MCO enrollment were not able to be filtered out of the statistical analysis.

Data Source: TeleSys Clinical Assessment Database; Assessment outcomes effective July 1, 2014 through June 30, 2015

WellCare	Number	Percentage
Consumer Records	3091	
Total Assessments	3462	
MDC Only	1638	
TOTAL MLTSS ASSESSMENTS	1824	53
Level of Care determination outcomes		
Authorized	1225	73
Not Authorized (percentage calculated on Authorized/Not Authorized outcomes only)	304	20
Approved	148	9
Denied (percentage based on Not Authorized outcomes)	11	4
TOTAL	**1688**	**93**

Statewide MCO Totals	Number	Percentage
Consumer Records	29411	
Total Assessments	36241	
MDC Only	9660	27
TOTAL MLTSS ASSESSMENTS	26581	73
Level of Care determination outcomes		
Authorized	16371	81
Not Authorized (percentage calculated on Authorized/Not Authorized outcomes only)	3820	19
Approved	3532	13
Denied (percentage based on Not Authorized outcomes)	209	5
TOTAL	**23932**	**91**

*Total percentages calculated on factors independent to each category and are not directly correlated to each other (i.e. denial rate analyzed on subset of total assessment population).

Due to duplication of assessments and members often having more than one assessment with variable outcomes, the statistics including percentages are not unduplicated MCO members.

Members assessed by the State prior to MCO enrollment were not able to be filtered out of the statistical analysis.

Data Source: TeleSys Clinical Assessment Database; Assessment outcomes effective July 1, 2014 through June 30, 2015

Attachment D

Aetna Better Health

GeoAccess Report Summary by MCO

*% of members with access as of 6.30.15	Bergen	Camden	Essex	Hudson	Middlesex	Passaic	Somerset	Union
Adult PCP	100.00%	99.90%	100.00%	100.00%	100.00%	97.00%	97.90%	100.00%
Pediatric PCP	96.90%	99.20%	100.00%	100.00%	100.00%	98.20%	94.80%	100.00%
General Dentist	94.40%	94.70%	100.00%	100.00%	94.70%	93.20%	79.80%	100.00%
Hospital	100.00%	100.00%	100.00%	100.00%	99.80%	95.70%	100.00%	100.00%
Cardiologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Dermatologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Endocrinologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Otolaryngologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
General Surgeon	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Neurologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
OB/GYN	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Oncologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Ophthalmologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Oral Surgeon	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Orthopedist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Psychiatrist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Urologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Amerigroup

*% of members with access as of 6.30.15	Atlantic	Bergen	Burlington	Camden	Cape May	Cumberland	Essex	Gloucester	Hudson	Hunterdon	Mercer	Middlesex	Monmouth	Morris
Adult PCP	91.70%	99.90%	97.90%	100.00%	100.00%	91.70%	100.00%	94.90%	100.00%	78.90%	97.00%	100.00%	96.20%	94.00%
Pediatric PCP	91.80%	100.00%	99.00%	100.00%	100.00%	93.40%	100.00%	99.40%	100.00%	91.70%	99.60%	100.00%	99.10%	96.10%
General Dentist	87.80%	97.00%	91.10%	96.70%	93.70%	91.90%	100.00%	87.20%	100.00%	99.60%	96.60%	96.30%	95.30%	95.50%
Hospital	93.20%	100.00%	97.60%	100.00%	98.00%	98.60%	100.00%	97.80%	100.00%	26.30%	99.90%	100.00%	100.00%	100.00%
Cardiologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Dermatologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Endocrinologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Otolaryngologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
General Surgeon	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Neurologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
OB/GYN	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Oncologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Ophthalmologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Oral Surgeon	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Orthopedist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Psychiatrist	100.00%	100.00%	100.00%	100.00%	88.30%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Urologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Amerigroup

Ocean	Passaic	Salem	Somerset	Sussex	Union	Warren
79.40%	99.80%	100.00%	97.00%	87.20%	100.00%	96.70%
91.70%	99.90%	100.00%	99.50%	100.00%	100.00%	97.70%
91.40%	97.70%	100.00%	89.40%	97.40%	100.00%	89.00%
87.90%	99.90%	100.00%	99.90%	85.20%	100.00%	48.50%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Horizon NJ Health

*% of members with access as of 6.30.15	Atlantic	Bergen	Burlington	Camden	Cape May	Cumberland	Essex	Gloucester	Hudson	Hunterdon	Mercer	Middlesex	Monmouth	Morris
Adult PCP	95.10%	100.00%	98.00%	99.90%	100.00%	93.10%	100.00%	93.00%	100.00%	100.00%	100.00%	100.00%	98.10%	98.50%
Pediatric PCP	95%	100.00%	97.60%	100.00%	100.00%	96.20%	100.00%	96.60%	100.00%	100.00%	100.00%	100.00%	99.30%	97.80%
General Dentist	91.60%	99.80%	90.40%	98.70%	100.00%	92.80%	100.00%	91.80%	100.00%	100.00%	97.50%	99.00%	97.80%	91.70%
Hospital	95.80%	100.00%	100.00%	100.00%	98.10%	98.90%	100.00%	97.90%	100.00%	99.80%	100.00%	100.00%	100.00%	100.00%
Cardiologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Dermatologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Endocrinologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Otolaryngologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
General Surgeon	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Neurologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
OB/GYN	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Oncologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Ophthalmologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Oral Surgeon	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Orthopedist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Psychiatrist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Urologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

Horizon NJ Health

Ocean	Passaic	Salem	Somerset	Sussex	Union	Warren
100.00%	100.00%	100.00%	99.90%	100.00%	100.00%	100.00%
94.10%	100.00%	100.00%	99.60%	96.00%	100.00%	100.00%
90.20%	97.80%	100.00%	94.30%	95.90%	100.00%	100.00%
99.90%	99.80%	99.60%	100.00%	99.70%	100.00%	97.10%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

UnitedHealthcare

*% of members with access as of 6.30.15	Atlantic	Bergen	Burlington	Camden	Cape May	Cumberland	Essex	Gloucester	Hudson	Hunterdon	Mercer	Middlesex	Monmouth	Morris
Adult PCP	89.80%	99.90%	98.70%	100.00%	100.00%	91.90%	100.00%	93.90%	100.00%	100.00%	100.00%	100.00%	98.50%	97.20%
Pediatric PCP	90.00%	100.00%	99.00%	100.00%	100.00%	95.70%	100.00%	95.90%	100.00%	100.00%	100.00%	100.00%	98.80%	97.60%
General Dentist	93.80%	99.10%	83.80%	98.70%	100.00%	92.40%	100.00%	89.60%	100.00%	99.90%	99.30%	98.70%	98.60%	82.50%
Hospital	90.70%	100.00%	91.20%	99.90%	98.20%	0.70%	100.00%	97.70%	100.00%	94.90%	100.00%	98.60%	96.70%	99.10%
Cardiologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Dermatologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Endocrinologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Otolaryngologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
General Surgeon	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Neurologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
OB/GYN	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Oncologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Ophthalmologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Oral Surgeon	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Orthopedist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Psychiatrist	100.00%	100.00%	100.00%	100.00%	100.00%	99.70%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Urologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

UnitedHealthcare

Ocean	Passaic	Salem	Somerset	Sussex	Union	Warren
97.80%	100.00%	100.00%	100.00%	99.30%	100.00%	99.80%
99.00%	99.80%	100.00%	99.90%	95.20%	100.00%	98.60%
99.00%	94.50%	100.00%	94.40%	95.50%	100.00%	96.80%
99.80%	94.50%	95.90%	99.60%	67.70%	100.00%	97.70%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
99.00%	100.00%	100.00%	100.00%	100.00%	100.00%	99.90%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

WellCare

*% of members with access as of 6.30.15	Bergen	Essex	Hudson	Mercer	Middlesex	Morris	Passaic	Somerset	Sussex	Union
Adult PCP	100.00%	100.00%	100.00%	88.10%	99.90%	78.70%	99.40%	98.20%	97.60%	100.00%
Pediatric PCP	99.60%	99.90%	100.00%	87.40%	97.40%	79.10%	99.30%	74.80%	94.20%	100.00%
General Dentist	98.00%	99.60%	99.90%	93.00%	93.00%	81.40%	98.90%	85.00%	96.20%	98.80%
Hospital	100.00%	100.00%	100.00%	100.00%	100.00%	98.90%	99.60%	100.00%	26.90%	100.00%
Cardiologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Dermatologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Endocrinologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Otolaryngologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	96.20%	100.00%
General Surgeon	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Neurologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
OB/GYN	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Oncologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Ophthalmologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Oral Surgeon	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Orthopedist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Psychiatrist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Urologist	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%

The Division of Medical Assistance and Health Services' (DMAHS) Office of Managed Long-Term Services and Supports Quality Monitoring (MLTSS/QM) formed a workgroup, "MLTSS-MCO Quality Workgroup", with representation from each of the MCOs, the Division of Aging Services (DoAS), and DMAHS. This workgroup meets on a monthly basis and primarily focuses on the MLTSS Performance Measures (PM) and other contract required reports. The workgroup initial focus was to review each of the PM, define the numerator and denominator, identify acceptable data sources, measurement period, and due dates. These meetings facilitate the discussion of reporting elements that MCOs may present challenges in reporting and developing a consensus on how to address so that the data received from each MCO can be aggregated and representative of the overall MLTSS program. Each month, MLTSS/QM reviews the information received to date, identifies any issues raised by the MCOs, and facilitates resolution. It is understood that this is the first year of MLTSS and that the data received will serve as a baseline moving forward. In addition to the PM deliverables, this workgroup discusses other MCO contract required, MLTSS reporting requirements. Reporting templates are developed and agreed upon along with the reporting timeline. Any areas of concern are discussed at a following meeting along with recommendations and resolution.

Each performance measure identifies its measurement period; however, depending on the source for the numerator/denominator the due date for reporting on a particular measure may have a lag time to allow for collection of the information. Several measures rely on claims data; therefore, a lag of 180 days must be built into the due date to allow for the MCO to receive the claims and process the data. Each of the measures will reflect the measurement period, reporting period, and data source (entity). This report reflects the performance measures (PM) that were reported by the MCOs, DoAS, and the Division of Disability Services (DDS) as submitted to the DMAHS' Office of MLTSS/QM through June 30, 2015. The MCO reported PMs are self-reported and have not yet been validated by New Jersey's External Quality Review Organization (EQRO), IPRO.

All of the data for the PMs that DoAS is responsible for reporting is contained within their TeleSys database except for the measures concerning critical incidents which is housed in their SAMS database. Reporting within the TeleSys database required newly developed queries which required extensive testing and revision to obtain accurate and consistent reporting outcomes. For most of the measures DoAS is responsible for reporting, this development and reporting was completed in late June 2015. This limited the DoAS from analyzing the data, discovering issues needing action and implementing action more timely. Moving forward, DoAS should be able to examine data results and report timely to DMAHS' Office of MLTSS/QM.

The following measures are not included in this report for the stated reason:

- PMs #2 and #5 data resides in the DoAS' TeleSys database along with the data for the other DoAS reporting measures. The new queries for these measures are not yet completed. Anticipated completion is no later than December 2015.
- PMs # 35, 36, 37, 38, 39, and 40 are all annual measurement periods with a lag reporting time. The data for these measures is not available for this annual report but will be included in the submission of the State's quarterly report for the respective lag reporting period.
- New Jersey's EQRO/IPRO is performing various reviews including the Annual Assessment, MLTSS Care Management Reviews, etc. to provide the data for the following measures: 8, 9, 9A, 10, 11,

12, 13, 15*, 15A*, and 16 (*Data will be obtained during the IPRO Annual Assessment). These elements are collected annually but will have a lag reporting time. The Annual Assessments will be conducted during the fall 2015. The MLTSS CM Review is being conducted in two parts; July 1, 2014 – Dec. 31, 2015 and Jan. 1, 2015 – June 30, 2015. The second part will be conducted in Dec/Jan 2016. The combined results should be available approximately March 2016. Moving forward the MLTSS CM review will be conducted late summer early fall following the end of the MLTSS year (7/1 – 6/30).

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

Measurement Period	July 2014	August 2014	Sept 2014	Oct. 2014	Nov. 2014	Dec. 2014	Jan. 2015	Feb. 2015	March 2015	April 2015	May 2015
Numerator	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Denominator	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

To report on this measure, DoAS needed to develop new queries which require extensive testing and revision to obtain accurate and consistent reporting outcomes. This measure's query development process has not been fully completed. Anticipate completion and data production by the end of this calendar year.

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

Measurement Period	July 2014	Aug 2014	Sept 2014	Oct. 2014	Nov. 2014	Dec. 2014	Jan. 2015	Feb. 2015	March 2015	April 2015	May 2015
Numerator	1367	1973	2303	1802	2450	1355	1307	1161	1352	1122	1214
Denominator	1371	1980	2329	1819	2474	1368	1331	1189	1367	1131	1220
%	99	99	98.8	99	99	99	98	97.6	98.9	99	99.5

The average percentage for year one of this measure is 99%. This percentage is determined be consistent with OCCO's historical numbers from prior to implementing MLTSS, but is high for the MCO performance. Prior to June 2015, OCCO denials were primarily located "outside" of the MCO section within TeleSys, the system where this data is maintained. It is anticipated that moving forwarded, there will be a changed in this data.

PM #4	Timeliness of nursing facility level of care assessment by MCO
Numerator:	The number of assessments in the denominator where the MCO assessment/ determination date is less than 30 days from the referral date to MLTSS
Denominator:	Number of level of care assessments conducted by MCO in the measurement month
Data Source:	MCO
Measurement Period:	Monthly – Due 45 days following reporting month

January 2015*	**A**	**B**	**C**	**D**	**E**	**TOTAL**	**February 2015***	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	1	81	84	4	18	188	Numerator	11	67	92	9	33	212
Denominator	1	89	84	73	27	274	Denominator	11	67	94	22	69	263
%	100	91	100	5.4	67	69	%	100	100	98	41	48	80.6

March 2015*	**A**	**B**	**C**	**D**	**E**	**TOTAL**	**April 2015***	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	7	22	116	75	54	274	Numerator	17	63	161	49	133	423
Denominator	7	22	118	124	162	433	Denominator	17	73	163	83	182	518
%	100	100	98	60	33	63.3	%	100	86	99	59	73	81.7

May 2015*	**A**	**B**	**C**	**D**	**E**	**TOTAL**	**June 2015***	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	14	102	169	44	177	506	Numerator	5	128	204	53	112	502
Denominator	17	106	173	68	235	599	Denominator	14	140	211	81	124	570
%	82	96	98	65	75	84.5	%	35	91.4	97	65.4	90.3	88.1

OCCO enacted the following measures in order to improve the timeliness of Nursing Facility Level of Care Assessments (NJ Choice):

- A mentoring project was undertaken between March and June 2015. Each MCO identified Care Managers who were mentored in the field by OCCO assessors.
- The required NJ Choice Annual Recertification Training was offered by OCCO to all entities that perform the assessment between February 2015 through May 2015

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

Measurement Period	July 2014	August 2014	Sept 2014	Oct. 2014	Nov. 2014	Dec. 2014	Jan. 2015	Feb. 2015	March 2015	April 2015	May 2015
Numerator	306	345	473	466	363	470	396	444	571	689	704
Denominator	626	756	870	874	712	898	698	737	973	1094	1094
%	49	46	54	53	51	52	57	60	59	63	64

This percentage has increased steadily each month and is expected to continue. OCCO staffing resources were significantly taxed during the implementation of MLTSS and the extremely high percentage of MCO Not Authorized assessments resulting in the need for OCCO to conduct the assessment. OCCO has retained 30 of the 41 new hires (Jan 2014-April 2015) but have lost experienced staff due to retirement/resignation; staff recruitment continues to be one of their goals.

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

To report on this measure, DoAS needed to develop new queries which require extensive testing and revision to obtain accurate and consistent reporting outcomes. This measure's query development process has not been fully completed. Anticipate completion and data production by the end of this calendar year. MLTSS enrollment began July 1, 2014 so there isn't any data currently due.

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

Measurement Period	July 2014	August 2014	Sept 2014	Oct. 2014	Nov. 2014	Dec. 2014	Jan. 2015	Feb. 2015	March 2015	April 2015	May 2015
Numerator	1371	1980	2329	1819	2474	1368	1331	1189	1367	1131	1220
Denominator	1371	1980	2329	1819	2474	1368	1331	1189	1367	1131	1220
%	100	100	100	100	100	100	100	100	100	100	100

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

PM # 7	Members offered a choice between institutional and HCBS settings
Numerator:	Number of assessments in the denominator with an indicator showing choice of setting within the IPOC
Denominator:	Number of level of care assessments with a completed Interim Plan of Care (IPOC)
Data Source:	DoAS
Measurement Period:	Monthly – Due the 15th of the following month

Measurement Period	July 2014	August 2014	Sept 2014	Oct. 2014	Nov. 2014	Dec. 2014	Jan. 2015	Feb. 2015	March 2015	April 2015	May 2015
Numerator	1372	1916	1923	1518	2266	1148	939	809	1082	967	1204
Denominator	1739	2578	2653	1964	2833	1188	973	819	1094	1053	1257
%	79	74	72	77	80	97	97	99	99	92	96

The first few months of MLTSS the percentages were below 80%. This requirement was reinforced with the MCO and the training appears to have been effective and the rates improved to 90+% from December 2014 moving forward. OCCO continues to monitor the MCOs performance.

PM # 8	Plans of Care established within 30 days of enrollment into MLTSS/HCBS
Numerator:	Number of records in the denominator that have a plan of care developed 30 days or less from the MLTSS/HCBS enrollment date
Denominator:	Total number of MLTSS/HCBS records for members newly enrolled in MLTSS in the Measurement year
Data Source:	IPRO
Measurement Period:	Annually

Data is not currently available due to lag report.

PM # 9	Plans of Care reassessment for MLTSS/HCBS members conducted within 30 days of annual level of care redetermination
Numerator:	Number of records in the denominator that have a plan of care developed 30 days or less from redetermination date
Denominator:	Total number of MLTSS/HCBS records for members receiving an annual level of care redetermination in the measurement year
Data Source:	IPRO
Measurement Period:	Annually

Data is not currently available due to lag report.

PM # 9A	Plans of Care amended based on change of member condition
Numerator:	Number of records in the denominator that had a revised plan of care
Denominator:	Total number of MLTSS/HCBS members' records where there was a significant change in the members' condition in the measurement year
Data Source:	IPRO
Measurement Period:	Annually

Data is not currently available due to lag report.

PM # 10	Plans of Care are aligned with members needs based on the results of the NJ Choice assessment
Numerator:	Number of records in the denominator where the plan of care aligned with member needs based on NJ Choice results, including type, scope, amount, frequency and duration
Denominator:	Total number of MLTSS records selected for review during management year
Data Source:	IPRO
Measurement Period:	Annually

Data is not currently available due to lag report.

PM # 11	Plans of Care developed using "person-centered principles"
Numerator:	Number of records in the denominator that were developed using "person-centered Principles"
Denominator:	Total number of MLTSS records selected for review for the measurement year
Data Source:	IPRO
Measurement Period:	Annually

Data is not currently available due to lag report.

PM # 12	MLTSS Home and Community Based Services (HCBS) Plans of Care that contain a back-up plan
Numerator:	Number of records in the denominator in which the plan of care contained a back-up plan
Denominator:	Total number of MLTSS/HCBS records selected for review for measurement year
Data Source:	IPRO
Measurement Period:	Annually

Data is not currently available due to lag report.

PM # 13	MLTSS/HCBS services are delivered in accordance with the plan of care (POC), including, type, scope, amount, frequency, and duration
Numerator:	Number of records in the denominator in which services and supports were documented as "delivered" in the type, scope, amount, frequency, and duration prescribed by the member's POC
Denominator:	Total number of MLTSS/HCBS records selected for review for measurement year
Data Source:	IPRO
Measurement Period:	Annually

Data is not currently available due to lag report.

PM # 14	Member Access to MLTSS Services
Numerator:	MCO shall comply with contract Article 4.8 for MLTSS Provider network requirements
Denominator:	State reviews MCO provider files data in GeoAccess and determines if plan meets the contractual MLTSS provider network standards.
Data Source:	MCO
Measurement Period:	Quarterly and Annually

The MCOs submit their Provider Network Files on a quarterly basis to DMAHS which includes MLTSS Providers. The files are reviewed to identify any submitted gaps in coverage as well as areas that may require further information from the MCO. In addition to this report, the MCOs report during the bi-weekly conference call with the State any potential gaps in coverage and the action the MCO is taking to mitigate any impact on the MLTSS member. Should there be a service need for a MLTSS member in a deficient county, the MCOs will complete a single case agreement with a non-par provider and/or arrange for transportation to a participating provider in a contiguous county.

PM # 15	MCO MLTSS providers are credentialed in a timely manner
Numerator:	The number of provider records in the denominator credentialed in a "timely manner"
Denominator:	Total number of MLTSS provider records selected for the review for measurement year
Data Source:	IPRO
Measurement Period:	Annual

Data is not currently available due to lag report.

PM # 15A	MCO MLTSS providers are re-credentialed in a timely manner
Numerator:	The number of provider records in the denominator re-credentialed in a "timely manner"
Denominator:	Total number of MLTSS provider records for review for the measurement year
Data Source:	IPRO
Measurement Period:	Annual

Data is not currently available due to lag report.

PM # 16	MCO member training on identifying/reporting critical incidents
Numerator:	Number of records in the denominator where the MLTSS member (or family member/ authorized representative) received information/education on identifying and reporting abuse, neglect, and/or exploitation at least annually
Denominator:	Total number of MLTSS records selected for review for measurement year
Data Source:	IPRO
Measurement Period:	Annual

Data is not currently available due to lag report.

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

Measurement Period	**July 2014**	**Aug. 2014**	**Sept 2014**	**Oct. 2014**	**Nov. 2014**	**Dec. 2014**	**Jan. 2015**	**Feb. 2015**	**March 2015**	**April 2015**	**May 2015**	**June 2015**
Numerator	12	25	22	23	32	40	71	92	95	69	72	84
Denominator	14	26	27	35	38	42	80	93	101	82	82	85
%	85.7	96.1	81.4	65.7	84.2	95.2	88.7	99	94	84	87.8	98.8

DoAS reports that for the first year of MLTSS they are analyzing data to determine trends in the reporting of critical incidents and identify strategies to improve the timeliness of reporting by the MCOs. When examining the trends, DoAS will take into account the variations between MCOs enrollment to ensure comparisons across MCO performance is equitable.

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

Measurement Period	July 2014	Aug. 2014	Sept 2014	Oct. 2014	Nov. 2014	Dec. 2014	Jan. 2015	Feb. 2015	March 2015	April 2015	May 2015	June 2015
Numerator	0	1	2	1	1	2	5	1	1	1	2	4
Denominator	0	1	2	1	1	2	5	1	1	1	2	4
%	0	100	100	100	100	100	100	100	100	100	100	100

DoAS reports that for the first year of MLTSS they are analyzing data to determine trends in the reporting of critical incidents and identify strategies to improve the timeliness of reporting by the MCOs. When examining the trends, DoAS will take into account the variations between MCOs enrollment to ensure comparisons across MCO performance is equitable.

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

Appeals and Grievances (Table 3A)

Appeals and Grievances (Table 3A)

1/1/15 – 3/31/15	A	B	C	D	E	TOTAL	4/1/15 – 6/30/15	A	B	C	D	E	TOTAL
Numerator	0	1	46	68	5	120	Numerator	0	3	19	36	5	63
Denominator	0	1	46	68	5	120	Denominator	0	3	19	36	5	63
%	0	100	100	100	100	100	%	0	100	100	100	100	100

Complaints (Table 3B)

1/1/15 – 3/31/15	A	B	C	D	E	TOTAL	4/1/15 – 6/30/15	A	B	C	D	E	TOTAL
Numerator	0	0	43	10	4	57	Numerator	0	1	96	7	3	107
Denominator	0	0	43	10	4	57	Denominator	0	1	97	7	3	108
%	0	0	100	100	100	100	%	0	100	99	100	100	99

This data is not available for the first six months (7/1/14 – 12/31/14) of MLTSS as it was co-mingled with the Core Medicaid (State Plan) data. Beginning January 1, 2015, the MCOs were required to report MLTSS members' complaints, grievances, and appeals separate from the Core Medicaid members.

One MCO reported that a complaint took 33 days to address, three days longer than the allowable thirty days for resolution. The complaint pertained to member experiencing difficulty obtaining access to a provider. The MCO reported there was a delay in their Utilization Department in authorizing a service. This was due to staff error and the MCO reported staff was counseled concerning the need for timely resolution to complaints.

PM # 20	Total # of MLTSS members receiving MLTSS services
Numerator:	Total # of unique MLTSS members receiving HCBS and/or NF services during the measurement period (does not include care management)
Denominator:	Total # of unique MLTSS members eligible anytime during the measurement period (quarter or annual)
Data Source:	MCO paid claims data, adjusted claims (excluding denied claims); according to the list of MLTSS/HCBS service procedure codes and the logic for the MCO Encounter Categories of Service (copy of list provided). Based on the premise: member must use services monthly *Total may include duplication if member switches MCO during the reporting period.
Measurement Period:	Quarterly/Annually – Due: 180 day lag for claims + 30 days after quarter and year

7/1/14-9/30/14	A	B	C	D	E	TOTAL	10/1/14 – 12/31/14	A	B	C	D	E	TOTAL
Numerator	0	1394	4946	2817	687	9844	Numerator	0	1575	5160	3066	721	10522
Denominator	0	1822	5364	3073	694	10953	Denominator	0	2227	8451	3314	731	14723
%	0	76.5	92.2	91.7	98.9	89.9	%	0	70.7	61	92.5	98.6	71.5

MCOs report that they discovered some providers were submitting claims with incorrect codes and modifiers. Their respective provider relations staff worked with the respective providers to re-educate on the appropriate MLTSS service codes. In analyzing their data, MCOs also discovered that there members receiving services but the MCO had not yet received a claim. There were also individuals who were not using services and had disenrolled during the reporting period. They appear in the denominator but would have used services and therefore would not be in the numerator.

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

7/1/14-9/30/14	**A**	**B**	**C**	**D**	**E**	**TOTAL**	**10/1/14 – 12/31/14**	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	0	0	0	0	0	0	Numerator	0	3	0	9	0	12
Denominator	0	16	31	16	2	65	Denominator	0	92	293	201	11	597
%	0	0	0	0	0	0	%	0	3	0	4.5	0	2.0

1/1/15 – 3/31/15	**A**	**B**	**C**	**D**	**E**	**TOTAL**	**4/1/15 – 6/30/15**	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	0	9	23	5	2	39	Numerator	0	6	222	10	11	249
Denominator	0	384	1017	249	76	1726	Denominator	51	209	1512	450	179	2401
%	0	2	2.3	2	2.6	2.3	%	0	3	15	2.2	6.14	10.4

7/1/14 – 6/30/15	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	0	23	177	36	13	249
Denominator	81	535	523	199	179	1517
%	0	4	34	18.1	7.3	16.4

The number of MLTSS NF transitions to the community is relatively low for the first three quarters of the year as individuals who were residing in a nursing home prior to July 1 2014 were not enrolled in MLTSS but remained in fee-for-service (FFS). The MCOs report that they have transitioned more individuals; however, they were FFS and therefore do not appear in this measure. Also, the MCOs are continuing to refine their capturing and reporting of this data.

PM # 22	New NF admissions for MLTSS members (excluding previous fee for service residents defined SPC 60 with living arrangement of Nursing Home)
Numerator:	Of the # in the denominator, how many were in a NF living arrangement at any time (excluding previous fee-for-service residents defined SPC 60 with living arrangement of Nursing Home) for the measurement year
Denominator:	Total # of unique MLTSS (NF and HCBS) members with an eligibility start date at any point during the measurement year (excluding previous fee-for-service residents defined SPC 60 with living arrangement of Nursing Home)
Data Source:	MCO – living arrangement file, prior auth. and/or client tracking system.
Measurement Period:	Annually – Due 30 days after year

7/1/14 - 6/30/15	A	B	C	D	E	TOTAL
Numerator	0	506	1739	537	262	3044
Denominator	113	3165	10297	4329	1419	19323
%	0	16	17	12.4	18.4	15.8

The number of MLTSS members that are residing in a nursing facility has gradually increased over the past year. Any new admissions to a nursing facility for custodial care must be enrolled in MLTSS; therefore it is expected that this number will continue to grow. Reportedly, the majority of new MLTSS NF members are individuals who have transitioned following a hospital or short term rehab. stay at the NF.

PM # 23	MLTSS members transitioned from NF to the community at any point during the preceding quarter who returned to the NF within 90 days
Numerator:	# of MLTSS members in the denominator who transitioned from NF to the community who then returned to the NF within 90 days or less from transition during the measurement period
Denominator:	Quarterly: Total # of unique MLTSS members who transitioned from NF to the community during the measurement quarter Annually: Total # of unique MLTSS members who transitioned from NF to the community during state fiscal year 7/1-6/30
Data Source:	MCO – Living arrangement file, CM tracking and prior auth. System (r/o respite/rehab). MCO to identify how the dates were calculated.
Measurement Period:	Quarterly/ Annually Lag Report Due: 120 days after reporting quarter or year

7/1/14-9/30/14	A	B	C	D	E	TOTAL	10/1/14 – 12/31/14	A	B	C	D	E	TOTAL
Numerator	0	0	0	0	0	0	Numerator	0	0	6	0	0	6
Denominator	0	0	0	0	0	0	Denominator	0	10	23	9	0	42
%	0	0	0	0	0	0	%	0	0	26	0	0	14.3

1/1/15 – 3/31/15	A	B	C	D	E	TOTAL
Numerator	0	0	1	1	0	2
Denominator	0	10	37	54	0	101
%	0	0	2.7	1.9	0	2

MCOs are examining the reasons for the MLTSS members' readmission to the NF. In addition, they are reviewing with staff on assessing the preparation for a MLTSS NF member's transition to the community. The State is implementing a MLTSS NF transition incentive payment initiative that will require a minimum of 120 calendar days residing in the community post transition for consideration of the incentive payment.

PM # 24	# of MLTSS HCBS members transitioned from the community to NF for greater than 180 days
Numerator:	# of unique MLTSS HCBS members in the denominator who were still in the NF greater than 180 days during the measurement period
Denominator:	Quarterly: # of unique MLTSS HCBS members that transitioned from the community to NF during the measurement quarter Annually: Total # of unique MLTSS HCBS members that transitioned from the community to NF during the state fiscal year 7/1-6/30
Data Source:	MCO -Living arrangement file, CM tracking and prior auth system (r/o respite/rehab). MCO to identify how the dates were calculated
Measurement Period:	Quarterly/Annually Lag Report Due: 210 day lag after quarter and year

7/1/14-9/30/14	A	B	C	D	E	TOTAL	10/1/14 – 12/31/14	A	B	C	D	E	TOTAL
Numerator	0	10	10	47	0	67	Numerator	0	11	115	68	5	199
Denominator	0	15	12	63	0	90	Denominator	0	11	306	105	7	429
%	0	66	83	75	0	74.4	%	0	100	38	64.8	71.4	46.4

The MCOs continue to monitor the MLTSS members who are transitioned to the NF to determine if that is the least restrictive environment for the members.

PM # 25	# of MLTSS HCBS members transitioned from the community to NF for less than or equal to 180 days (short stay)
Numerator:	# of MLTSS members in the denominator who were in the NF for 180 days or less during the measurement period
Denominator:	Quarterly: Total # of unique MLTSS HCBS members that transitioned from community to NF in a given quarter Annually: Total # of unique MLTSS members that transitioned from the community to NF during the state fiscal year 7/1-6/30
Data Source:	MCO - Living arrangement file, CM tracking and prior auth system (r/o respite/rehab). MCO to identify how the dates were calculated.
Measurement Period:	Quarterly/Annually Lag Report Due: 210 day lag after quarter and year

7/1/14-9/30/14	A	B	C	D	E	TOTAL	10/1/14 – 12/31/14	A	B	C	D	E	TOTAL
Numerator	0	5	2	16	0	23	Numerator	0	0	191	37	2	230
Denominator	0	15	12	63	0	90	Denominator	0	11	306	105	7	429
%	0	33	16	25.4	0	25.6	%	0	0	62	35.2	28.5	53.6

MCO analysis of their data indicated that some of the members that were included in their report had disenrolled from their plan during this period so they may have remained longer than 180 days but not as a member of that MCO. Also captured in some of this data were some members who expired while in the NF and less than 180 days. MCOs are continuing to monitor the NF transitions and refine their reporting.

PM # 26	# of hospitalizations per MLTSS HCBS members
Numerator:	# of hospitalizations (unique combination of member-provider-admission date) of MLTSS HCBS members (not unique members) during the measurement period.
Denominator:	Total # of unique MLTSS HCBS members that were continuously enrolled in your MCO during the measurement period
Data Source:	MCO paid and denied (excluding duplicate claims) claims according to logic for the MCO encounter Categories of Services (separate file)
Measurement Period:	Monthly data reported Quarterly/Annually (180 day lag for claims + 30 days after quarter and year)

7/1/14-9/30/14	A	B	C	D	E	TOTAL	10/1/14 – 12/31/14	A	B	C	D	E	TOTAL
Numerator	0	379	341	150	110	980	Numerator	0	212	442	145	147	946
Denominator	0	5000	5364	9234	1893	21491	Denominator	0	5703	18535	9417	1974	35629
%	0	8	6.4	1.6	5.8	4.6	%	0	3.7	2.4	1.5	7.4	2.7

The data for this measure is captured on a monthly basis and the numerators are added together and the denominators are added together to report quarterly data reflecting the number of hospitalizations that occurred per member month. The MCOs are reviewing the data for patterns and trends.

PM # 27	# of hospitalizations of NF members (not unique members)
Numerator:	# of hospitalizations (unique combination of member-provider-admission date) of MLTSS NF members (not unique members) during the measurement period
Denominator:	Total # of unique MLTSS NF members (SPC 61, 63, 64) that were continuously enrolled in your MCO and in a NF during the measurement period
Data Source:	MCO paid claims and denied claims (excluding duplicate claims) according to logic for the MCO encounter Categories of Services (separate file)
Measurement Period:	Monthly data reported Quarterly/Annually (180 day lag for claims + 30 days after quarter and year)

7/1/14-9/30/14	A	B	C	D	E	TOTAL	10/1/14 – 12/31/14	A	B	C	D	E	TOTAL
Numerator	0	4	0	0	1	5	Numerator	0	14	25	17	2	58
Denominator	0	18	12	19	2	51	Denominator	0	172	662	342	17	1193
%	0	22.2	0	0	50	9.8	%	0	8.1	3.8	5.0	11.8	4.9

There are a low number of MLTSS NF members during the first two quarters of MLTSS as individuals residing in a NF prior to 7/1/14 remained in FFS. The hospitalizations for this population were primarily for septicemia, respiratory distress, altered mental status, and urinary tract infections. The MCO continue to monitor the data for patterns and trends.

PM # 28	# of readmissions of MLTSS HCBS members (not unique members) to the hospital within 30 days
Numerator:	# of readmissions of MLTSS HCBS members (not unique members) to the hospital within 30 days from date of discharge (service through date and new service start date) during the measurement period
Denominator:	# of hospitalizations (unique combination of member-provider-service date) of MLTSS HCBS members (not unique members) during the measurement period
Data Source:	MCO paid and denied claims (exclude denials for duplicate submissions) for numerator and 834 file for denominator.
Measurement Period:	Monthly data reported Quarterly/Annually Lag Report Due: 240 days after quarter and year.

7/1/14-9/30/14	A	B	C	D	E	TOTAL	10/1/14 – 12/31/14	A	B	C	D	E	TOTAL
Numerator	0	5	15	64	29	113	Numerator	0	9	31	93	26	159
Denominator	0	160	315	155	108	738	Denominator	0	212	442	147	147	948
%	0	3.1	4.8	41	26.8	15.3	%	0	4.3	7	63.2	17.7	16.8

The MCOs are monitoring this data to determine patterns and trends and for training opportunities with respective Care Managers on assessing and identifying appropriate supports for members to reduce the risk of readmissions.

PM # 29	# of readmissions of MLTSS NF members (not unique members) to the hospital within 30 days
Numerator:	# of readmissions of MLTSS NF members (not unique members) to the hospital within 30 days from date of discharge (service through date and new service start date) during the measurement period
Denominator:	# of hospitalizations (unique combination of member-provider-service date) of MLTSS NF members (not unique members) during the measurement period
Data Source:	MCO paid claims and denied claims (exclude denials for duplicate submissions) for numerator and 834 file for denominator.
Measurement Period:	Monthly data reported Quarterly/Annually Lag Report Due: 240 days after quarter and year.

7/1/14-9/30/14	A	B	C	D	E	TOTAL	10/1/14 – 12/31/14	A	B	C	D	E	TOTAL
Numerator	0	0	1	0	1	2	Numerator	0	2	5	7	0	14
Denominator	0	0	4	0	1	5	Denominator	0	14	25	17	2	58
%	0	0	25	0	100	40	%	0	14.3	20	41.2	0	24.1

The MCOs are monitoring this data to determine patterns and trends and for training opportunities with respective Care Managers on assessing and identifying appropriate supports for members to reduce the risk of readmissions.

PM # 30	# of ER utilization by MLTSS HCBS members (not unique members)
Numerator:	# of ER utilization (unique combination of member-provider-service date,(not admitted) by MLTSS HCBS members (not unique members) during the measurement period
Denominator:	Total # of unique MLTSS HCBS members that were continuously enrolled in your MCO during measurement period
Data Source:	MCO paid claims and denied claims (exclude denials for duplicate submissions) for numerator and 834 file for denominator.
Measurement Period:	Monthly data reported Quarterly/Annually (180 day lag for claims + 30 days after quarter and year)

7/1/14-9/30/14	A	B	C	D	E	TOTAL	10/1/14 – 12/31/14	A	B	C	D	E	TOTAL
Numerator	0	302	655	388	116	1461	Numerator	0	368	751	306	162	1587
Denominator	0	5000	17078	9234	1893	33205	Denominator	0	5698	18525	9417	1974	35614
%	0	6	3.8	4.2	6.1	4.4	%	0	6.5	4.1	3.2	8.2	4.5

MCOs are monitoring their respective data to identify patterns, trends and frequency. Frequent ER utilization is monitored and shared with CM for appropriate intervention. One MCO reported that a single member had 16 episodes of ER utilization during this measurement period, primarily for alcohol abuse. Another MCO reported urinary tract infections as the primary diagnosis for ER utilization.

PM # 31	# of ER utilization by MLTSS NF members (not unique members)
Numerator:	# of ER utilization (unique combination of member-provider-service date(not admitted) by MLTSS NF members (not unique members) during the measurement period
Denominator:	Total # of unique MLTSS NF members (SPC 61, 63, 64) that were continuously enrolled in your MCO and in a NF during the measurement period
Data Source:	MCO paid claims and denied claims (exclude denials for duplicate submissions) for numerator and 834 file for denominator.
Measurement Period:	Monthly data reported Quarterly/Annually (180 day lag for claims + 30 days after quarter and year)

7/1/14-9/30/14	A	B	C	D	E	TOTAL	10/1/14 – 12/31/14	A	B	C	D	E	TOTAL
Numerator	0	2	0	1	0	3	Numerator	0	10	27	5	2	44
Denominator	0	18	12	19	2	51	Denominator	0	172	664	342	17	1195
%	0	11.1	0	5	0	5.9	%	0	5.8	4.1	1.5	11.8	3.7

MCOs are monitoring their respective data to identify patterns, trends, and frequency. There are relatively small numbers at this time. Urinary tract infections were reported by one MCO as the primary diagnosis for ER utilization for their members.

PM # 32	# of MLTSS HCBS members using unduplicated Self Directed Services
Numerator:	Total # of MLTSS HCBS members using a least one self-directed service during the measurement period
Denominator:	Total # of MLTSS HCBS members eligible anytime during the measurement period
Data Source:	Division of Disability Services
Measurement Period:	Annual – Due 30 days after end of measurement year

7/1/14 – 6/30/15	A	B	C	D	E	TOTAL
Numerator	1	107	437	121	26	692
Denominator	7	1052	3377	2075	311	6822
%	14.3	10.2	12.9	5.8	8.4	10.1

The above data reflects the number of MLTSS members per MCO who are or have self-directed at least one service during the measurement period of July 1, 2014 through June 30, 2015 (numerator) in comparison to the number of MCO members per MCO who are enrolled in self direction for the measurement period (denominator). The above data does NOT reflect total number of MLTSS HCBS enrolled members. As of the end of the reporting period, there continue to be a total of 580 MLTSS members self-directing at least one service.

PM # 33	MLTSS HCBS members receiving only PCA services (out of all of the possible MLTSS services available to them)
Numerator:	# of MLTSS HCBS members receiving only PCA services (out of all of the possible MLTSS services available to them) during the measurement period
Denominator:	Total # of MLTSS HCBS members (60,62) eligible anytime during the measurement period
Data Source:	MCO – claims data
Measurement Period:	Semi-Annually Due: 210 day Lag Report after end of reporting period

7/1/14 – 12/31/14	A	B	C	D	E	TOTAL
Numerator	0	270	18	195	91	574
Denominator	0	2345	7690	3786	812	14633
%	0	11.5	0.2	5.2	11.2	3.9

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

PM # 34	MLTSS HCBS members receiving only Medical Day services (out of all of the possible MLTSS services available to them)
Numerator:	# of MLTSS HCBS members receiving only Medical Day services (out of all of the possible MLTSS services available to them) during the measurement period
Denominator:	Total # of MLTSS HCBS members (60, 62) eligible anytime during the measurement period
Data Source:	MCO claims data (?)
Measurement Period:	Semi-Annually Due:210 day Lag Report after end of reporting period

7/1/14 – 12/31/14	A	B	C	D	E	TOTAL
Numerator	0	105	15	41	8	169
Denominator	0	2345	7690	3786	812	14633
%	0	4.5	0.2	1.1	1.0	1.2

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

PM # 35	# of MLTSS HCBS members who received face to face follow up with a mental health professional within 7 days of hospitalization for mental illness (for selected DSM V Diagnoses: 295,296,297,298,299,300,301,302,307,308,309,311,312,313,314) (and all sub-codes)
Numerator:	Total # of unique hospitalizations defined as unique combination of provider/HCBS patient/service date during measurement year with one of the mental illness diagnoses listed above and followed by a face to face visit with a mental health professional within 7 days of discharge date.
Denominator:	Total # of unique hospitalizations defined as unique combination of provider/HCBS patient/service date during measurement period with one of the mental illness diagnoses listed above.
Data Source:	MCO – paid claims
Measurement Period:	Annually Due: 240 day Lag Report after end of reporting period

Data is not currently available due to lag report.

PM # 36	# of MLTSS HCBS members who received face to face follow up with a mental health professional within 30 days of hospitalization for mental illness (for selected DSM V Diagnoses: 295,296,297,298,299,300,301,302,307,308,309,311,312,313,314) (and all sub-codes)
Numerator:	Total # of unique hospitalizations defined as unique combination of provider/HCBS patient/service date during measurement year with one of the mental illness diagnoses listed above and followed by a face to face visit with a mental health professional within 30 days of discharge date.
Denominator:	Total # of unique hospitalizations defined as unique combination of provider/HCBS patient/service date during measurement year with one of the mental illness diagnoses listed above.
Data Source:	MCO – paid claims
Measurement Period:	Annually Due: 240 day Lag Report after end of reporting period

Data is not currently available due to lag report.

PM # 37	# of MLTSS NF members who received face to face follow up with a mental health professional within 7 days of hospitalization for mental illness (for selected DSM V Diagnoses: 295,296,297,298,299,300,301,302,307,308,309,311,312,313,314) (and all sub-codes)
Numerator:	Total # of unique hospitalizations defined as unique combination of provider/NF patient/service date during measurement year with one of the mental illness diagnoses listed above and followed by a face to face visit with a mental health professional within 7 days of discharge date.
Denominator:	Total # of unique hospitalizations defined as unique combination of provider/NF patient/service date during measurement period with one of the mental illness diagnoses listed above.
Data Source:	MCO – paid claims
Measurement Period:	Annually Due: 240 day Lag Report after end of reporting period

Data is not currently available due to lag report.

PM # 38	# of MLTSS NF members who received face to face follow up with a mental health professional within 30 days of hospitalization for mental illness (for selected DSM V Diagnoses: 295,296,297,298,299,300,301,302,307,308,309,311,312,313,314) (and all sub-codes)
Numerator:	Total # of unique hospitalizations defined as unique combination of provider/NF patient/service date during measurement year with one of the mental illness diagnoses listed above and followed by a face to face visit with a mental health professional within 30 days of discharge date.
Denominator:	Total # of unique hospitalizations defined as unique combination of provider/NF patient/service date during measurement year with one of the mental illness diagnoses listed above.
Data Source:	MCO – paid claims
Measurement Period:	Annually Due: 240 day Lag Report after end of reporting period

Data is not currently available due to lag report.

PM # 39	# of MLTSS HCBS members with selective behavioral health diagnoses (DSM V Diagnoses: 292,295,296,297,298,299,300,301,302,303,304,305,307,308,309,311,312,313,314) (and all sub-codes)
Numerator:	# of MLTSS unique HCBS members with selective behavioral health diagnoses during the measurement year (for select DSM V Diagnoses listed in definition)
Denominator:	Total # of unique MLTSS HCBS members eligible anytime during the measurement year (HCBS living arrangement on date of service)
Data Source:	MCO – paid claims
Measurement Period:	Annually Due: 240 day Lag Report after end of reporting period

Data is not currently available due to lag report.

PM # 40	# of MLTSS NF members with selective behavioral health diagnoses (DSM V Diagnoses: 292,295,296,297,298,299,300,301,302,303,304,305,307,308,309,311,312,313,314) (and all sub-codes)
Numerator:	# of unique MLTSS NF members with selective behavioral health diagnoses during the measurement period(for select DSM V Diagnoses listed in definition)
Denominator:	Total # of unique MLTSS NF members eligible anytime during the measurement period(NF living arrangement on date of service)
Data Source:	MCO – paid claims
Measurement Period:	Annually Due: 240 day Lag Report after end of reporting period

Data is not currently available due to lag report.

PM # 41	MLTSS HCBS members receiving only PCA services and Medical Day services (out of all of the possible services available to them)
Numerator:	# of MLTSS HCBS members receiving only PCA services and Medical Day services (out of all of the possible MLTSS services available to them) during the measurement period
Denominator:	Total # of MLTSS HCBS members (60, 62) eligible anytime during the measurement period
Data Source:	MCO claims data
Measurement Period:	Semi-Annually Due: 210 days from end of measurement period.

7/1/14 – 12/31/14	A	B	C	D	E	TOTAL
Numerator	0	58	0	252	56	366
Denominator	0	2345	7690	3786	812	14633
%	0	2.5	0	6.7	6.9	2.5

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

The MCOs have implemented an MLTSS self-monitoring program that includes case file audits and reviews of the consistency of the MLTSS member assessments/service authorizations with an analysis of the data and a description of their continuous improvement strategies taken to resolve any identified issues. These reports are submitted to the Office of MLTSS/QM on a quarterly basis. The Office of MLTSS/QM has reviewed each of the MCOs' auditing tool used for this self-audit and has provided the MCOs with a reporting guidelines and format. These reports are reviewed and any issues are discussed with the respective MCO. To date most of the issues identified were addressed by staff re-training.

Through the MLTSS MCO Quality Workgroup we are working with the MCOs on a reporting template to identify all reductions in MLTSS services. Data was received mid-August for the last quarter of MLTSS, year one (4/1/15 – 6/30/15) and based on the initial submission, further revisions are required on the reporting template.

MLTSS Performance Measure Report

Deliverables due during MLTSS Year One (7/1/14 – 6/30/15)

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

	MCO	A			B			C			D			E			Annual - TOTAL		
	Participant Safeguards:	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
18	Critical Incident (CI) reporting Types:																		
a	Unexpected death a member	2	6	33%	2	80	3%	7	450	2%	3	171	2%	0	8	0%	13	715	1.8%
b	Missing person of Unable to Contact	1	6	17%	2	80	3%	11	450	2%	47	171	27%	0	8	0%	61	715	8.5%
c	Theft with law enforcement involvement	0	6	0%	3	80	4%	8	450	2%	3	171	2%	0	8	0%	14	715	2.0%
d	Severe injury or fall resulting in the need of medical treatment	2	6	33%	16	80	20%	204	450	45%	39	171	23%	1	8	13%	262	715	36.6%
e	Medical or psychiatric emergency, including suicide attempt	1	6	17%	3	80	4%	71	450	16%	43	171	25%	4	8	50%	122	715	17.1%
f	Medication error resulting in serious consequences	0	6	0%	1	80	1%	1	450	0%	0	171	0%	1	8	13%	3	715	0.4%
g	Inappropriate or unprofessional conduct by a provider involving member	0	6	0%	6	80	8%	25	450	6%	6	171	4%	0	8	0%	37	715	5.2%
h	Suspected or evidenced physical or mental abuse (including seclusion and restraints)	0	6	0%	3	80	4%	22	450	5%	5	171	3%	0	8	0%	30	715	4.2%
i	Sexual abuse and/or suspected sexual abuse	0	6	0%	1	80	1%	1	450	0%	2	171	1%	0	8	0%	4	715	0.6%
j	Neglect/Mistreatment, including self-neglect, caregiver overwhelmed, environmental	0	6	0%	4	80	5%	27	450	6%	4	171	2%	0	8	0%	35	715	4.9%

k	Exploitation, including financial, theft, destruction of property	0	6	0%	3	80	4%	17	450	4%	1	171	1%	0	8	0%	21	715	2.9%
l	Failure of member's Back-up Plan	0	6	0%	0	80	0%	29	450	6%	0	171	0%	1	8	13%	30	715	4.2%
m	Elopement/Wandering from home or facility	0	6	0%	1	80	1%	3	450	1%	5	171	3%	0	8	0%	9	715	1.3%
n	Eviction /loss of home	0	6	0%	1	80	1%	12	450	3%	0	171	0%	0	8	0%	13	715	1.8%
o	Facility closure, with direct impact to member's health and welfare	0	6	0%	0	80	0%	0	450	0%	0	171	0%	0	8	0%	0	715	0%
p	Media involvement or the potential for media involvement	0	6	0%	2	80	3%	4	450	1%	2	171	1%	0	8	0%	8	715	1.1%
q	Cancellation of utilities	0	6	0%	0	80	0%	3	450	1%	0	171	0%	1	8	13%	4	715	0.6%
r	Natural disaster, with direct impact to member's health and welfare	0	6	0%	0	80	0%	0	450	0%	0	171	0%	0	8	0%	0	715	0%
s	Other	0	6	0%	32	80	40%	5	450	1%	11	171	6%	0	8	0%	48	715	6.7%

The IPRO, New Jersey's External Quality Review Organization conducted a focus study to evaluate the effectiveness of the contractually required MLTSS CM program. This focus study examined the first six months of MLTSS and included the members who met the eligibility requirements for MLTSS and were receiving 1915(c) Home and Community-Based Services by residing in the community or Community Alternative Residential Setting (CARS) within the review period from 7/1/14 through 12/31/14. The results of this study were shared with each respective MCO and a request for a work plan to address any concerns identified. The State had decided to examine the MCOs to assess how well they were meeting the established MLTSS CM to requirements to ensure that the services provided to members who met MLTSS eligibility requirements were consistent with professionally recognized standards of care. Moving forward, the IPRO will conduct another six-month review the end of this year and then move to an annual assessment beginning late summer in 2016. This annual assessment will provide the State with data for the Performance Measures where IPRO is identified as the data source. A summary of the focus study findings is as follows along with the report's structure.

Report Structure
Audit results are presented in four sections:

- Process Description-Summary of contract requirements for key elements in the MLTSS CM process and MCO internal processes.
- File Review-Detailed description of findings of the file review of the four groups evaluated.
    1. Group A- Members converted to MLTSS 7/1/14 (Without High-risk)
    2. Group B-Members converted to MLTSS 7/1/14 (With High-risk)
    3. Group C- Members new to Managed Care and new to MLTSS enrolled after 7/1/14
    4. Group D- Members previously enrolled in MCO and enrolled in MLTSS after 7/1/14
- System Review- Describes the system used by the MCO to document and track CM activities.
- Performance Measures- Summary of file review of the MCO's performance as compared to MLTSS performance measures:
    - PM#8-Initial Plan of Care established within 30 calendar days of enrollment into MLTSS HCBS or from the date of the initial face-to-face visit for Group A&B.
    - PM#10-Plans of Care were aligned with member needs based on the results of the NJ Choice Assessment.
    - PM#11-Plans of Care developed using "person-centered principles".
    - PM#12 MLTSS HCBS Plans of Care contain a Back-Up Plan if required.

Findings
The MCOs demonstrated a commitment to the MLTSS membership by applying CM principles and specific requirements to this vulnerable population.

The CM file audit revealed above average findings in the following areas:

- MCOs demonstrated timely outreach for Groups A&B
- Evidence that NJ Choice Assessments were completed
- Evidence that the Initial Plan of Care completed
- Evidence that Options Counseling was performed
- Plans of Care aligned with Member's needs
- Evidence that Participant Direction Option was offered to Member
- Consistency between NJ Choice Assessment and PCA Assessment Tool
- All but one MCO showed evidence that Member's Rights and Responsibilities were reviewed with the Member

- All but one MCO proved that new services were put in place within 30 days of Member's MLTSS enrollment
- Two MCOs clearly documented that the Cost Effective Analysis (CEA) was completed and documented

The CM File audit revealed issues in the following areas:

- Two MCOs did not meet the timeframes for Member outreach and initial face to face visits.
- No MCO could provide evidence that Members received a copy of the Initial Plan of Care
- Member goals were often not documented, lacked Member input and were not Member centric
- Back-up Plans often not in file, and lacked pertinent information such as, CM's telephone number, provider's 24/7 contact information; and information about actions Member should take to report gaps in care.
- Risk Assessments were not always found and when completed, did not always identify risks or trigger a Risk Management Agreement.
- Two MCOs had problems meeting the standards for completing the Cost Effective Analysis and did not document that the CEA was measured against the Cost Threshold.
- MCOs often lacked documentation to prove that Members were consistently offered PPP. When PPP was offered and accepted, the MCOs did not submit the PPP application to the State timely.

Recommendations for Continued Improvement

Outreach and Face-to-Face Visits

- Review the MCO's process to clearly define timeframes for conducting Member outreach, face-to-face visits and complete the Initial Plan of Care
- Consistently document dates for the following:
    - Date of outreach to set up face-to-face visit
    - Date of face-to-face visit to complete the NJ Choice Assessment
    - Date of face-to-face to complete the Initial Plan of Care

- Document the date the NJ Choice Assessment was completed, submitted, and approved by OCCO to the clinical CM System.
- Document the date a previously completed NJ Choice Assessment is requested from OCCO to the CM system
- At the time of the initial assessment ensure that all components of Options Counseling are offered including Participant Direction Option
- Internally review the process for completing and submitting PPP Packets to the State to ensure timeliness

Initial Plans of Care

- Ensure Member goals are discussed at every face-to-face visit, goals are Member specific, measurable, and POC delineates what interventions will be taken to meet the set goals
- Document communication with the PCP and ensure PCP's input during the development of the Initial Plan of Care
- Document when an Initial Plan of Care is provided to the Member/Member Representative
- Ensure Risk Assessment is completed and if a risk is identified a Risk Management Agreement is completed, and signed by Member/Member Representative
- Complete Back up Plans on all members living in a private home and recommend adding the CM's telephone number and a statement identifying 24-hour/7 day access to a CM

- Initiate a comprehensive Cost Effectiveness reporting mechanism to include all appropriate cost tracking and cost thresholds, and documentation to show the steps to be taken if CEA exceeds Cost Threshold

Ongoing Case Management

- Track the completion date of the Initial Plan of Care to schedule timely follow-up visits
- Track facility discharge dates for timely follow-up face-to-face visit
- Add documentation that a discussion had taken place with the Member/Member Representative regarding how to report unplanned gaps in service delivery.

Budget Neutrality Monitoring Spreadsheet

QE June 2015 Report

Due to CMS: **9/1/2015**

TOTAL COMPUTABLE

Budget Neutrality Test	Authority Citation	Five Year Demonstration Forecasted Expenditures		Difference	
		No Waiver	With Waiver		
Main Test	STC #128	$ 47,883,913,195	$ 40,371,319,656	*$ 7,512,593,539*	a
Supplemental Test #1	STC #129	1,825,524,409	1,892,518,257	*(66,993,848)*	b
Supplemental Test #2	STC #129	11,090,379,567	9,099,244,877	*1,991,134,691*	c
				$ 7,445,599,691	d = a + b

Savings from Supp Test #2 cannot be used to offset Main Test

FEDERAL SHARE

Budget Neutrality Test	Authority Citation	Five Year Demonstration Forecasted Expenditures		Difference	
		No Waiver	With Waiver		
Main Test	STC #128	$ 24,682,310,658	$ 20,850,396,259	*$ 3,831,914,400*	a
Supplemental Test #1	STC #129	934,731,800	969,092,491	*(34,360,691)*	b
Supplemental Test #2	STC #129	11,001,613,042	9,027,257,106	*1,974,355,936*	c
				$ 3,797,553,709	d = a + b

Savings from Supp Test #2 cannot be used to offset Main Test

Budget Neutrality Monitoring Spreadsheet

Main Budget Neutrality Test

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

TOTAL COMPUTABLE

	DY1	DY2	DY3	DY4	DY5	5-Yr Demo Total
NO WAIVER						
Title XIX	1,888,003,055	2,721,798,359	3,180,728,190	3,454,183,159	3,751,269,683	*14,995,982,446*
ABD	2,303,770,824	3,339,472,169	3,493,430,312	3,685,423,618	3,888,015,464	*16,710,112,389*
LTC	2,432,436,621	3,333,367,293	3,164,934,248	3,348,683,718	3,543,103,179	*15,822,525,059*
HCBS state plan	30,677,444	44,273,219	57,678,284	82,346,590	85,772,311	*300,747,848*
Add'l DY4 GME				*27,272,727*	*27,272,727*	*54,545,454*
	$ 6,654,887,945	$ 9,438,911,041	$ 9,896,771,034	$ 10,597,909,812	$ 11,295,433,364	$ *47,883,913,195*

	DY1	DY2	DY3	DY4	DY5	*5-Yr Demo Total*
WITH WAIVER						
Title XIX	1,659,840,020	2,381,142,090	2,665,012,337	2,817,979,162	2,979,726,003	*12,503,699,612*
ABD/LTC	3,960,040,462	5,378,167,015	5,254,050,944	5,510,347,382	5,779,391,479	*25,881,997,282*
HCBS state plan	42,959,719	64,721,553	89,487,829	127,781,891	133,117,907	*458,068,899*
HOLD DDD Supports-PDN				23,684,294	27,772,568	*51,456,862*
Hospital Subsidies	192,443,637	266,607,552	266,600,000	293,872,727	293,872,727	*1,313,396,643*
CNOMS	28,436,213	27,079,508	29,552,610	38,816,014	38,816,014	*162,700,359*
	$ 5,883,720,051	$ 8,117,717,718	$ 8,304,703,719	$ 8,812,481,470	$ 9,252,696,698	$ *40,371,319,656*
Difference	**771,167,894**	**1,321,193,323**	**1,592,067,315**	**1,785,428,342**	**2,042,736,666**	***7,512,593,539***

Notes:

1. Federal share is calculated using Composite Federal Share Ratios (source data is CMS 64 Schedule C as reported in QE Mar 2015 with a run date of June 8, 2015).
2. "With Waiver" expenditures from CMS 64 Schedule C as reported in QE Mar 2015 with a run date of June 8, 2015
3. Member-months are reported from MMIS with last actual reported as of March 30, 2015.
4. "With Waiver" pmpm's calculated using Sch C expenditures and MMIS eligibility actual member-months reported through March 2015 as reported in June 2015.
5. CNOMs (costs not otherwise matchable) include Severe Emotionally Disturbed children (SED at risk), MATI population, DDD non-disabled adult children and CCW Supports Equalization
6. Additional GME (increase of $27.3m) is currently not included in PMPM caps per STC #128. On "With Waiver," $27.3M is included in the Hospital Subsidy line item
7. The DDD Supports-PDN population, pending waiver amendment approval, is represented as a separate line item

FEDERAL SHARE

	DY1	DY2	DY3	DY4	DY5	5-Yr Demo Total
NO WAIVER						
Title XIX	947,821,008	1,507,616,068	1,789,447,974	1,863,552,631	2,023,832,602	*8,132,270,283*
ABD	1,155,317,847	1,680,171,312	1,755,987,120	1,851,641,404	1,953,428,197	*8,396,545,881*
LTC	1,219,842,447	1,677,099,798	1,590,867,222	1,682,455,550	1,780,136,349	*7,950,401,366*
HCBS state plan	15,580,961	22,836,074	29,620,511	42,195,551	43,950,939	*154,184,037*
Add'l DY4 GME				*13,636,364*	*13,636,364*	*27,272,728*
Enhanced GME Revenue			22,250,000	21,636,364	21,636,364	*65,522,727*
	$ 3,338,562,264	$ 4,887,723,252	$ 5,165,922,828	$ 5,453,481,501	$ 5,836,620,814	$ *24,682,310,658*

	DY1	DY2	DY3	DY4	DY5	*5-Yr Demo Total*
WITH WAIVER						
Title XIX	833,277,910	1,318,925,064	1,499,311,052	1,520,316,741	1,607,580,137	*6,779,410,903*
ABD/LTC	1,985,920,376	2,705,889,276	2,640,970,325	2,768,524,984	2,903,698,913	*13,005,003,873*
HCBS state plan	21,819,084	33,383,301	45,956,209	65,477,238	68,211,488	*234,847,320*
HOLD DDD Supports-PDN				11,842,147	13,886,284	*25,728,431*
Hospital Subsidies	96,221,820	133,303,778	133,300,005	146,936,369	146,936,369	*656,698,341*
CNOMS	14,725,869	14,081,343	15,367,358	19,602,086	19,408,007	*83,184,663*
Enhanced GME Revenue	-	-	22,250,000	21,636,364	21,636,364	*65,522,727*
	$ 2,951,965,059	$ 4,205,582,762	$ 4,357,154,948	$ 4,554,335,929	$ 4,781,357,561	$ *20,850,396,259*
Difference	**386,597,205**	**682,140,490**	**808,767,880**	**899,145,572**	**1,055,263,254**	***3,831,914,400***

Notes:

8. Beginning DY3 (June'15), the State began claiming enhanced FFP on GME, which is the federal share % equivalent of MCO payments on the CMS64. GME is technically a Managed Care payment, originally certified in all capitation rate cells, including the Medicaid Expansion population.

Budget Neutrality Monitoring Spreadsheet

Supplemental Test #1

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

TOTAL COMPUTABLE

	DY1	DY2	DY3	DY4	DY5	5-Yr Demo Total
NO WAIVER						
HCBS 217-like	217,434,338	299,270,518	297,462,343	424,753,712	442,490,384	1,681,411,294
Adults w/o Depend. Children	1,677,789	798,912	-	-	-	2,476,701
SED 217-like	253,840	345,267	216,371	233,564	252,122	1,301,164
Former XIX Chip Parents	-	140,335,250	-	-	-	140,335,250
IDD/MI	-	-	-	-	-	-
	$ 219,365,967	$ 440,749,946	$ 297,678,714	$ 424,987,276	$ 442,742,506	$ 1,825,524,409

	DY1	DY2	DY3	DY4	DY5	5-Yr Demo Total
WITH WAIVER						
HCBS 217-like	207,393,155	277,666,552	329,338,863	464,888,095	484,188,181	1,763,474,846
Adults w/o Depend. Children	1,529,772	674,018	-	-	-	2,203,790
SED 217-like	-	-	-	-	-	-
Former XIX Chip Parents	-	126,839,621	-	-	-	126,839,621
IDD/MI	-	-	-	-	-	-
	$ 208,922,927	$ 405,180,191	$ 329,338,863	$ 464,888,095	$ 484,188,181	$ 1,892,518,257
Difference	**10,443,040**	**35,569,755**	**(31,660,148)**	**(39,900,819)**	**(41,445,675)**	**(66,993,848)**

Notes:

1. Federal share is calculated using Composite Federal Share Ratios (source data is CMS 64 Schedule C as reported in QE March 2015 with a run date of
2. "With Waiver" expenditures from CMS 64 Schedule C as reported in QE March 2015 with a run date of June 8, 2015
3. Member-months are reported from MMIS with last actual reported as of June 2015.
4. "With Waiver" pmpm's calculated using Sch C expenditures and MMIS eligibility actual member-months reported through March 2015 as reported in June 2015.

FEDERAL SHARE

	DY1	DY2	DY3	DY4	DY5	5-Yr Demo Total
NO WAIVER						
HCBS 217-like	110,182,650	154,277,034	152,764,519	217,446,909	226,526,958	861,198,070
Adults w/o Depend. Children	852,857	408,324	-	-	-	1,261,182
SED 217-like	126,920	172,633	108,186	116,782	126,061	650,582
Former XIX Chip Parents	-	71,621,966	-	-	-	71,621,966
IDD/MI	-	-	-	-	-	-
	$ 979,777	$ 72,202,924	$ 108,186	$ 116,782	$ 126,061	$ 934,731,800

	DY1	DY2	DY3	DY4	DY5	5-Yr Demo Total
WITH WAIVER						
HCBS 217-like	105,094,382	143,139,967	169,134,999	237,993,163	247,873,581	903,236,091
Adults w/o Depend. Children	777,617	344,491	-	-	-	1,122,108
SED 217-like	-	-	-	-	-	-
Former XIX Chip Parents	-	64,734,292	-	-	-	64,734,292
IDD/MI	-	-	-	-	-	-
	$ 105,871,999	$ 208,218,750	$ 169,134,999	$ 237,993,163	$ 247,873,581	$ 969,092,491
Difference	**(104,892,222)**	**(136,015,826)**	**(169,026,813)**	**(237,876,381)**	**(247,747,520)**	**(34,360,691)**

Budget Neutrality Monitoring Spreadsheet

Supplemental Test #2

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

TOTAL COMPUTABLE

	DY1	DY2	DY3	DY4	DY5	5-Yr Demo Total
NO WAIVER						
New Adult Group	$ -	$ 1,113,566,583	$ 3,105,523,276	$ 3,320,628,680	$ 3,550,661,029	$ 11,090,379,567
WITH WAIVER						
New Adult Group	$ -	$ 857,234,945	$ 2,617,249,151	$ 2,745,249,949	$ 2,879,510,833	$ 9,099,244,877
Difference	**-**	**256,331,638**	**488,274,126**	**575,378,731**	**671,150,196**	**1,991,134,691**

Notes:

1. Federal share is calculated using Composite Federal Share Ratios (source data is CMS 64 Schedule C as reported in QE Sept 2014 with a run date of Oct 30, 2014).
2. "With Waiver" expenditures from CMS 64 Schedule C as reported in QE June 2014 with a run date of Oct 30, 2014
3. Member-months are reported from MMIS with last actual reported as of September 2014.
4. "With Waiver" pmpm's calculated using Sch C expenditures and MMIS eligibility actual member-months reported through June 2014 as reported in September 2014.

FEDERAL SHARE

	DY1	DY2	DY3	DY4	DY5	5-Yr Demo Total
NO WAIVER						
New Adult Group	$ -	$ 1,113,566,583	$ 3,105,523,276	$ 3,320,628,680	$ 3,461,894,503	$ 11,001,613,042
WITH WAIVER						
New Adult Group	$ -	$ 857,234,945	$ 2,617,249,151	$ 2,745,249,949	$ 2,807,523,062	$ 9,027,257,106
Difference	**-**	**256,331,638**	**488,274,126**	**575,378,731**	**654,371,441**	**1,974,355,936**

		DY1	DY2	DY3	DY4	DY5	Demo Period			
Title XIX	MMs	5,773,180	7,850,813	8,672,979	8,903,681	9,140,521		2.7%		
	Pmpm	$287.51	$303.30	$307.28	$316.50	$325.99		5.8%		
	Spend	$1,659,840,020	$2,381,142,090	$2,665,012,337	$2,817,979,162	$2,979,726,003	**$12,503,699,612**			
ABD	MMs	2,486,117	3,341,135	3,338,257	3,399,126	3,461,252		1.8%	11546743	
	Pmpm	$1,592.86	$1,609.68	$1,573.89	$1,621.11	$1,669.74		3.6%	-2.02%	
	Spend	$3,960,040,462	$5,378,167,015	$5,254,050,944	$5,510,347,382	$5,779,391,479	**$25,881,997,282**		-233244.2	6874696
										6,860,378
LTC	MMs	0	0					1.8%		
	Pmpm	$0.00	$0.00		$0.00	$0.00		3.9%	-0.21%	
	Spend	$0	$0	$0	$0	$0	**$0**		-24048.89	
HCBS State Plan	MMs	13,594	18,857	23,694	32,626	32,776		1.8%		
	Pmpm	$3,160.20	$3,432.23	$3,776.80	$3,916.54	$4,061.45		3.7%		
	Spend	$42,959,719	$64,721,553	$89,487,829	$127,781,891	$133,117,907	**$458,068,899**			

		DY1	DY2	DY3	DY4	DY5	Demo Period	
HCBS 217-Like	MMs	96,351	127,883	122,575	166,851	167,577		1.8%
	Pmpm	$2,152.48	$2,171.25	$2,686.84	$2,786.25	$2,889.34		3.7%
	Spend	$207,393,155	$277,666,552	$329,338,863	$464,888,095	$484,188,181	**$1,763,474,846**	
AWDC	MMs	6,057	2,774	0	0	0		
	Pmpm	$252.56	$242.98					
	Spend	$1,529,772	$674,018	$0	$0	$0	**$2,203,790**	
SED 217-Like	MMs	113	145	86	87	89		1.8%
	Pmpm	$0.00	$0.00					6.0%
	Spend	$0	$0	$0	$0	$0	**$0**	
XIX Chip Parents	MMs	0	456,761	0	0	0		
	Pmpm		$277.69					
	Spend	$0	$126,839,621	$0	$0	$0	**$126,839,621**	
IDD/MI	MMs	0	0	508	0	0		1.8%
	Pmpm	$0.00	$0.00	$0.00	$0.00	$0.00		6.0%
	Spend	$0	$0	$0	$0	$0	**$0**	
New Adult Group	MMs	0	2,394,149	6,331,600	6,447,823	6,566,179		1.8%
	Pmpm		$358.05	$413.36	$425.76	$438.54		5.0%
	Spend	$0	$857,234,945	$2,617,249,151	$2,745,249,949	$2,879,510,833	**$9,099,244,877**	

		DY1	DY2	DY3	DY4	DY5	Demo Period	
Title XIX	MMs	5,773,180	7,850,813	8,672,979	8,903,681	9,140,521		2.7%
	Pmpm	$327.03	$346.69	$366.74	$387.95	$410.40		5.8%
	Spend	$1,888,003,055	$2,721,798,359	$3,180,728,190	$3,454,183,159	$3,751,269,683	**$14,995,982,446**	
ABD	MMs	2,204,481	2,969,766	2,998,884	3,053,932	3,109,989		1.8%
	Pmpm	$1,045.04	$1,124.49	$1,164.91	$1,206.78	$1,250.17		3.6%
	Spend	$2,303,770,824	$3,339,472,169	$3,493,430,312	$3,685,423,618	$3,888,015,464	**$16,710,112,389**	
LTC	MMs	281,636	371,369	339,373	345,602	351,946		1.8%
	Pmpm	$8,636.81	$8,975.89	$9,325.83	$9,689.41	$10,067.17		3.9%
	Spend	$2,432,436,621	$3,333,367,293	$3,164,934,248	$3,348,683,718	$3,543,103,179	**$15,822,525,059**	
HCBS State Plan	MMs	13,594	18,857	23,694	32,626	32,776		1.8%
	Pmpm	$2,256.69	$2,347.84	$2,434.29	$2,523.94	$2,616.93		3.7%
	Spend	$30,677,444	$44,273,219	$57,678,284	$82,346,590	$85,772,311	**$300,747,848**	

		DY1	DY2	DY3	DY4	DY5	Demo Period	
HCBS 217-Like	MMs	96,351	127,883	122,575	168,783	169,557		1.8%
	Pmpm	$2,256.69	$2,340.19	$2,426.78	$2,516.57	$2,609.68		3.7%
	Spend	$217,434,338	$299,270,518	$297,462,343	$424,753,712	$442,490,384	**$1,681,411,294**	
AWDC	MMs	6,057	2,774	0	0	0		
	Pmpm	$277.00	$288.00					
	Spend	$1,677,789	$798,912	$0	$0	$0	**$2,476,701**	
SED 217-Like	MMs	113	145	86	87	89		1.8%
	Pmpm	$2,246.37	$2,381.15	$2,524.02	$2,675.46	$2,835.99		6.0%
	Spend	$253,840	$345,267	$216,371	$233,564	$252,122	**$1,301,164**	
XIX Chip Parents	MMs	0	456,761	0	0	0		
	Pmpm		$307.24					
	Spend	$0	$140,335,250	$0	$0	$0	**$140,335,250**	
IDD/MI	MMs	0	0	0	0	0		1.8%
	Pmpm	$9,839.39	$10,429.75	$11,055.53	$11,718.87	$12,422.00		6.0%
	Spend	$0	$0	$0	$0	$0	**$0**	
New Adult Group	MMs	0	2,394,149	6,331,600	6,447,823	6,566,179		1.8%
	Pmpm		$465.12	$490.48	$515.00	$540.75		5.0%
	Spend	$0	$1,113,566,583	$3,105,523,276	$3,320,628,680	$3,550,661,029	**$11,090,379,567**	

ORIGINAL STC APPROVED GROWTH PERCENTAGES FOR BUDGET NEUTRALITY

Schedule C
CMS 64 Waiver Expenditure Report
Cumulative Data Ending Quarter/Year : 2/2015

State: New Jersey

Summary of Expenditures by Waiver Year
Summary of Expenditures by Waiver Year
Waiver: 11W00279

MAP Waivers

Total Computable

Waiver Name	A	01	02	03
ABD	0	3,960,040,462	5,378,167,015	3,502,700,629
ACCAP – 217 Like	0	630,539	880,454	0
ACCAP – SP	0	900,000	966,297	0
AWDC	0	1,529,772	674,018	0
Childless Adults	0	27,844,394	48,216,389	0
CRPD – 217 Like	0	11,803,536	16,894,842	0
CRPD –SP	0	10,672,842	15,247,535	0
DSRIP	0	0	83,304,870	54,606,972
GME State Plan	0	0	100,000,001	75,000,015
GO – 217 Like	0	181,068,236	221,682,839	0
GO – SP	0	23,869,092	33,606,671	0
HCBS – 217 Like	0	216,912	20,770,166	247,004,147
HCBS – State Plan	0	60,671	5,536,122	67,115,872
HRSF & GME	0	192,443,637	0	0
HRSF Transition Payments	0	0	83,302,681	0
MATI at Risk	0	4,069,775	3,429,158	0
New Adult Group	0	7,171,980	857,234,945	1,853,884,815
SED at Risk	0	24,366,438	23,650,350	19,701,740
TBI – 217 Like	0	13,673,932	17,438,251	0
TBI – SP	0	7,457,114	9,364,928	0
Title XIX	0	1,659,840,020	2,381,142,090	1,776,674,891
XIX CHIP Parents	0	0	126,839,621	0
Total	**0**	**6,127,659,352**	**9,428,349,243**	**7,596,689,081**

Federal Share

Schedule C

CMS 64 Waiver Expenditure Report

Cumulative Data Ending Quarter/Year : 2/2015

Waiver Name	A	01	02	03
ABD	0	1,985,920,376	2,705,889,276	1,760,646,883
ACCAP – 217 Like	0	319,151	446,869	0
ACCAP – SP	0	454,312	489,362	0
AWDC	0	777,617	344,491	0
Childless Adults	0	14,715,147	24,778,164	0
CRPD – 217 Like	0	6,026,151	8,740,654	0
CRPD –SP	0	5,447,877	7,899,121	0
DSRIP	0	0	41,652,435	27,303,487
GME State Plan	0	0	50,000,002	37,500,009
GO – 217 Like	0	91,709,982	114,209,771	0
GO – SP	0	12,108,906	17,304,835	0
HCBS – 217 Like	0	110,604	10,755,613	126,851,249
HCBS – State Plan	0	31,285	2,870,705	34,467,157
HRSF & GME	0	96,221,820	0	0
HRSF Transition Payments	0	0	41,651,341	0
MATI at Risk	0	2,055,322	1,783,162	0
New Adult Group	0	7,171,980	857,234,945	1,853,884,815
SED at Risk	0	12,670,547	12,298,181	10,244,905
TBI – 217 Like	0	6,928,494	8,987,060	0
TBI – SP	0	3,776,704	4,819,278	0
Title XIX	0	833,277,910	1,318,925,064	999,540,701
XIX CHIP Parents	0	0	64,734,292	0
Total	**0**	**3,079,724,185**	**5,295,814,621**	**4,850,439,206**

CMS 64 - MEDICAID ELIGIBILITY GROUPS AS OF JUNE, 2014

	DEFINITIONS:	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
1	TITLE XIX	699,149	705,108	711,606	716,105	717,767	720,818	726,122	730,903	734,185	734,074	732,115	720,094
2	ABD (Excluding HCBS and LTC SPC 61)	279,229	279,081	278,904	278,346	277,844	275,683	275,365	274,503	273,301	272,091	270,198	266,861
3	Childless Adults												
4	Adults W/O Dependent Children	259,190	273,441	282,660	291,343	301,228	317,432	329,043	344,923	350,143	354,275	353,356	346,724
5	SED	3,184	3,027	2,806	2,878	2,911	3,026	3,157	3,248	3,390	3,485	3,532	3,248
6	HCBS (State Plan)	1,485	1,535	1,616	1,823	2,014	2,215	2,204	2,323	2,415	2,575	2,778	3,127
7	HCBS (217 Like)	9,827	9,877	9,938	10,261	10,433	10,467	10,196	10,123	10,082	10,089	10,122	10,217
8	LTC	24,537	24,150	23,794	23,313	22,974	22,725						
9	SED (217 Like)	14	18	11	5	7	9	9	4	6	5	2	1
10	IDD/MI (217 Like)	0	0	0	0	0	0	0	0	111	126	136	135
11	XIX CHIP Parents *(10/01/2013 - 12/31/2013 Only)*												
12	New Adult Group *(01/01/2014 Onwards)*	211,055	213,447	215,953	218,051	219,257	222,467	224,515	226,437	226,423	224,255	221,480	217,377

Source = CMS64 MEG report from Jun 2015

CMS 64 - MEDICAID ELIGIBILITY GROUPS

	DEFINITIONS:	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
1	TITLE XIX	678,653	683,857	688,976	693,676	699,149	705,108	711,606	716,105	717,767	720,818	726,122	730,903	734,185	734,074	732,115	720,094
2	ABD (Excluding HCBS)	278,134	278,007	278,027	278,205	279,229	279,081	278,904	278,346	277,844	275,683	275,365	274,503	273,301	272,091	270,198	266,861
3	Childless Adults																
4	Adults W/O Dependent Children	203,473	221,762	233,724	246,197	259,190	273,441	282,660	291,343	301,228	317,432	329,043	344,923	350,143	354,275	353,356	346,724
5	SED	4,162	4,190	3,549	3,451	3,184	3,027	2,806	2,878	2,911	3,026	3,157	3,248	3,390	3,485	3,532	3,248
6	HCBS (State Plan)	1,580	1,575	1,572	1,564	1,485	1,535	1,616	1,823	2,014	2,215	2,204	2,323	2,415	2,575	2,778	3,127
7	HCBS (217 Like)	10,606	10,604	10,576	10,590	9,827	9,877	9,938	10,261	10,433	10,467	10,196	10,123	10,082	10,089	10,122	10,217
9	SED (217 Like)	11	15	10	7	14	18	11	5	7	9	9	4	6	5	2	1
10	IDD/MI (217 Like)	0	0	0	0	0	0	0	0	0	0	0	0	111	126	136	135
11	XIX CHIP Parents (10/01/2013 - 12/31/2013 Only)																
12	Expansion Parents (01/01/2014 Onwards)	198,362	203,175	205,594	208,429	211,055	213,447	215,953	218,051	219,257	222,467	224,515	226,437	226,423	224,255	221,480	217,377

HCBS (State Plan) BY SPC	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
03 - CRPD - Private Duty Nursing(PDN)	130	129	130	131	0	0	0	0	0	0	0	0	0	0	0	0
05 - ACCAP Waiver	30	29	29	29	0	0	0	0	0	0	0	0	0	0	0	0
06 - CRPD - No PDN	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
17 - TBI Waiver	102	104	103	105	0	0	0	0	0	0	0	0	0	0	0	0
32 - Global Option	1,318	1,313	1,310	1,299	0	0	0	0	0	0	0	0	0	0	0	0
60 - Home & Community	0	0	0	0	946	1,005	1,097	1,315	1,510	1,708	1,692	1,783	1,853	2,006	2,208	2,543
62 - Assisted Living	0	0	0	0	539	530	519	508	504	507	512	540	562	569	570	584
TOTAL	***1,580***	***1,575***	***1,572***	***1,564***	***1,485***	***1,535***	***1,616***	***1,823***	***2,014***	***2,215***	***2,204***	***2,323***	***2,415***	***2,575***	***2,778***	***3,127***

HCBS (217 Like) BY SPC	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
03 - CRPD - Private Duty Nursing(PDN)	164	163	161	161	0	0	0	0	0	0	0	0	0	0	0	0
05 - ACCAP Waiver	113	113	113	112	0	0	0	0	0	0	0	0	0	0	0	0
06 - CRPD - No PDN	41	40	39	39	0	0	0	0	0	0	0	0	0	0	0	0
17 - TBI Waiver	209	210	212	214	0	0	0	0	0	0	0	0	0	0	0	0
32 - Global Option	10,079	10,078	10,051	10,064	0	0	0	0	0	0	0	0	0	0	0	0
60 - Home & Community	0	0	0	0	7,300	7,382	7,519	7,806	8,030	8,041	7,779	7,699	7,579	7,616	7,731	7,765
62 - Assisted Living	0	0	0	0	2,527	2,495	2,419	2,455	2,403	2,426	2,417	2,424	2,503	2,473	2,391	2,452
TOTAL	***10,606***	***10,604***	***10,576***	***10,590***	***9,827***	***9,877***	***9,938***	***10,261***	***10,433***	***10,467***	***10,196***	***10,123***	***10,082***	***10,089***	***10,122***	***10,217***