New Jersey Comprehensive Waiver Demonstration
Section 1115 Quarterly Report
***Demonstration Year:* 5 (7/1/16-6/30/17)**
***Federal Fiscal Quarter:* 3 (4/1/17-6/30/17)**

I. Introduction

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

This five year demonstration will:

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

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

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

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

II. Enrollment and Benefit Information

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

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

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

There are no anticipated changes in populations served or benefits.

III. Enrollment Counts for Quarter

Demonstration Populations by MEG	Total Number of Demonstration participants Quarter Ending – 09/16	Total Number of Demonstration participants Quarter Ending – 12/16	Total Number of Demonstration participants Quarter Ending – 03/17	Total Number of Demonstration participants Quarter Ending – 06/17
Title XIX	738,022	736,958	733,911	708,387
ABD	276,205	273,472	269,376	260,844
LTC				
HCBS - State plan	7,250	8,122	8,606	9,922
TBI – SP				
ACCAP – SP				
CRPD – SP				
GO – SP				
HCBS - 217-Like	11,909	12,276	12,359	12,417
TBI – 217-Like				
ACCAP – 217-Like				
CRPD – 217-Like				
GO – 217-Like				
SED - 217 Like	82	153	211	227
IDD/MI – (217 Like)	164	254	374	343
NJ Childless Adults				
AWDC	357,745	369,302	374,239	358,397
New Adult Group	203,905	204,088	203,744	196,433
SED at Risk	3,441	3,675	4,169	3,947
MATI at Risk				
Title XXI Exp Child				
NJFAMCAREWAIV-POP 1				

NJFAMCAREWAIV-POP 2	
XIX CHIP Parents	

IV. Outreach/Innovative Activities to Assure Access

MLTSS

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

The MLTSS Steering Committee met on June 8, 2017 with its representation from stakeholders, consumers, providers, MCOs and state staff members. The June meeting focused on the new National Association of States United for Aging and Disabilities (NASUAD)/Center for Health Care Strategies (CHCS) report, *Demonstrating the Value of the Medicaid MLTSS Program*. A CHCS representative gave an overview of the national MLTSS landscape with a focus on where New Jersey (NJ) ranked. In addition, the State and MCOs presented on family caregiver services, strategies and success stories as well as the NJ Caregiver assessment, which looks for consistent, routine, and normal support that individuals are already receiving from family and friends.

The Department of Human Services (DHS) met with the Nursing Facility (NF) Quality Workgroup on June 20, 2017 to provide an update on the Nursing Home Quality Performance Measures Initiative and its design, policies and project plan, including workflows and key timeframes. Stakeholders were pleased to see the State's progress and framework for moving ahead with the Any Willing Qualified Provider (AWQP) program. DHS is developing a program aimed at improving the quality of care and outcome to MLTSS members living in nursing facilities.This new program is considered to be a foundational step in the State's evolving value based purchasing (VBP) strategy with the goal to reimburse providers based on performance and to encourage consumers to select high value service providers.

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

- May 16, 2017 at the annual assisted living conference sponsored by the Health Care Association of New Jersey, a non-profit trade association representing long term care providers.
- June 15, 2017 at the annual meeting of LeadingAge New Jersey, a statewide association of not-for-profit senior care organizations whose members include adult day programs, assisted living communities, home and community based services, independent living senior housing, life plan communities, and nursing homes; and
- June 22, 2017 at the annual conference of the Home Care and Hospice Association of New Jersey to over 200 professionals from licensed home health agencies, health care service firms, hospices, and organizations that offer services and products that support home care and hospices.

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

ASD/ID/DD-MI/SED

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

Supports

During this quarter, the Division of Developmental Disabilities (DDD) continues enrollment of individuals into the Supports Program. As of the end of the reporting quarter, DDD enrolled 2,500 individuals in the Supports Program.

DDD held weekly meetings with representatives from Public Partnerships LLC (PPL) in order to operationalize their role as the Fiscal Intermediary (FI). Provider payments going through the FI and payment for Self-Directed Employees who have been enrolled in PPL will begin July 1, 2017. Switching the remaining Self-Directed Employees will continue to take place over the next quarter. DDD provided technical assistance and guidance to Medicaid/DDD approved providers who have expressed that they are not yet ready to provide services through the Supports Program. The Division has notified all providers that they need to be ready by July 1, 2017 and has approved some extensions for providers still in need of items to be in place before being ready. No extensions have been provided beyond the end of the next quarter.

DDD notified individuals that have not completed the current version of the NJ Comprehensive Assessment Tool (NJ CAT) that they need to get it completed by the end of July or be in jeopardy of a gap in services.

DDD continues to assist individuals with Medicaid eligibility including assisting individuals in accessing Supports Program Only Medicaid.

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

DDD continues to meet with the trade organizations and individual providers to assist in preparation for the Medicaid-based, Fee-for-Service system. In addition, DDD continues regular calls with providers and individuals/families regarding the system reform (including the Supports Program). These calls provide the opportunity for stakeholders to share issues/concerns as they come up, receive updates, suggest ideas and provide feedback. DDD continues to answer provider questions and provide guidance on the application process for provider enrollment.

DDD continues the identification of quality measures for the DDD system, providers, individuals, and services. In addition, DDD received a final report from the Division of Medical Assistance and Health Service's Quality Management Unit Comprehensive Audit Review of the Supports Program. The final report indicated that the Supports Program was in compliance with all sub-assurances and a Corrective Action Plan was not required for any sub-assurance based on the results of the audit.

NJ CAT assessments, supplemental assessments, reassessments as needed and DDD continues to work through the process for Day Habilitation Certification. During this quarter, DDD released a revised (version 4.0) Supports Program Policies & Procedures Manual.

V. Collection and Verification of Encounter Data and Enrollment Data

Summary of Issues, Activities or Findings

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

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

MLTSS

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

ASD/ID/DD-MI/SED

The Department of Children and Families (DCF), Children's System of Care (CSOC) continues ongoing enrollment of youth in the Intellectual Disabilities/ Development Disabilities co-occurring Mental Illness Pilot (ID/DD-MI) and the Autism Spectrum Disorder (ASD) Pilot. As of 6/30/2017, there were 154 youth identified for the ASD pilot and 808 youth identified for the ID/DD-MI pilot. The SED Plan A coverage process was finalized with the Division of Medical Assistance and Health Services (DMAHS) and has been operationalized. As of 6/30/17, 251 SED Plan A youth have been enrolled through the Serious Emotional Disturbance program.

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

CSOC continues to build ASD, I/DD-MI and SED provider networks and are expected to be poster next quarter.

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

training.

Supports

During this quarter, the Division of Developmental Disabilities (DDD) held the initial Family Advisory Council meeting. This group will meet monthly to provide input and feedback on Division policies. No issues regarding the Supports Program were presented to the Division during this quarter.

DDD conducted quarterly Support Coordination Supervisors meeting to provide updates, answer questions, and receive feedback. DDD also met individually with providers within our contract reimbursement system to determine readiness for the shift to the Supports Program and Fee-for-Service and answer questions. In addition, DDD also provided answers to and met with a variety of providers regarding various areas related to the Supports Program. No issues were raised during these meetings.

DDD provided a webinar entitled "How DDD Services Can Support an Individual with Intellectual and Developmental Disability's Best and Most Meaningful Life." This webinar provided information about how the Supports Program can support individuals in Employment/Work, Education/Learning, Entertainment/Fun, Home Life, Responsibilities, and Health/Well Being. The webinar attendees included providers, Support Coordinators, individuals and families, and DDD staff. This webinar was one of the most highly attended webinars so there are plans to provide it again in the future. DDD conducted webinars for our current qualified providers under the previous system to ensure that they are fully informed about the shift to Fee-for-Service and need to become Medicaid/DDD approved providers in the areas they provide services. DDD also provided training related to Supports Program + PDN for Division staff. Plans are in place to provide similar trainings for Managed Care Organization Care Managers as well as Support Coordinators in the fall of 2017. DDD beneficiaries are notified of upcoming webinars through regular division updates, as well as through the Support Coordinator listserv. These webinars are open to the public and there are plans to archive the webinars in the future.

DDD provided presentations at schools, trade organization membership meetings, conferences, family group/organization meetings and events, self-advocates, the transition coordinators network, etc.

IME

During the DY5 FF3, from April 1, 2017 through June 30, 2017, the IME received and responded to 17,057 calls to the call center from consumers and/or family members. 3,147 of those calls resulted in direct referrals into treatment and 1,485 calls were sent to care coordination services to facilitate admission to treatment. The IME Utilization Management services reviewed and approved clinical medical necessity for 6,007 treatment requests and 3,820 clinical reviews for continued treatment. The IME also continues to maintain the provider hotline for provider assistance and responded to 3,855 calls between April 1 and June 30. The IME in partnership with DMHAS and Medicaid facilitated trainings to providers on the clinical review process and ASAM placement criteria. In addition targeted assistance training was provided to Opioid Treatment Providers who have been struggling during this transition process over the past year.

DSRIP

Quarterly Payment Reports –Federal drawdown by New Jersey for Quarter 3, Demonstration Year 5 for payments earned under Stage 1 and Stage 2 measures is pending CMS approval of Progress Reports.

Progress in meeting DSRIP goals – For DY5 Q3, all progress reports have been submitted to CMS as of May 17, 2017 for review.

Performance – DY4 results: 25 hospitals submitted appeals. All appeals have been submitted to CMS for review as of June 30, 2017. Challenges – CMS approved the Stage 3 substitution measures and remaining ITGs for DY5. CMS and NJ agreed that for DY6 and forward, the state will utilize the national benchmark when possible, followed by the NJ statewide benchmark. New Jersey Department of Health (NJDOH) is awaiting a response from CMS regarding a question of possible duplicate funding issue for the CarePoint hospital system. CMS and NJDOH are working together on revisions to the FMP for DY5. Mid-course corrections – Centers for Medicare and Medicaid (CMS), New Jersey Department of Human Services (NJDHS) and New Jersey Department of Health are holding weekly calls to discuss the 1115 Waiver renewal, including extending NJDSRIP under the 1115 Waiver Renewal. CMS and NJDOH are working together on a final version of the STCs for DY6. Successes and evaluation – The Learning Collaborative was held on June 8, 2017. The agenda included: Partnering with Managed Care Organizations; Stakeholder Engagement; and Next Generation DSRIP. It was well attended.
Other
Managed Care Contracting:
There are no updates for this quarter.
Self-attestations:
There were a total of 167 self-attestations for the time period from April 1, 2017 to June 30, 2017.
MCO Choice and Auto-assignment:
The number of individuals who changed their MCO after auto-assignment is 4,845.
MLR:
MCO Medical Loss Ratios for the 12 month Period July 1, 2015 to June 30, 2016: Horizon NJ Health: 91.8% UnitedHealthcare: 87.8% Amerigroup: 83.5% WellCare: 89.4% Aetna: 97.5%

VII. Action Plan for Addressing Any Issues Identified

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

VIII. Financial/Budget Neutrality Development/Issues

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

IX. Member Month Reporting

A. For Use in Budget Neutrality Calculations

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

X. Consumer Issues

Summary of Consumer Issues

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

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
1	Eligibility	Checking status of authorization	Request to speak with Care Manager	Medical Benefits	Speak to Care Manager
2	Benefits	Checking status of assessment	Request MLTSS assessment	PCP Update	Change PCP because of auto assignment.
3	PCP Change	Member looking to speak with their Care Manager	Member inquiries with questions about their care plan	ID Card	calling to speak to Care Managers
4	Provider Search	Checking on status of authorization request	Returning CM's calls	Eligibility Inquiry	Inquiries on eligibility
5			Requests to speak with Clinical Care Coordinator		Inquiries on benefits

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

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
1	Eligibility	Checking status of authorization	Authorization inquiries from service providers (Requests for authorization)	Claim Status	Authorization requests
2	Authorization inquiries	Checking status of assessment	Eligibility inquiries	Eligibility Inquiry	Inquiries on eligibility
3	Network participation inquires	Facilities seeking new or return authorizations	Requests for MLTSS enrollment	Training inquiries	Claims inquiries
4	Training inquiries	Providers request authorization maintenance – corrections, updates due to change in member status	Inquiries about MLTSS covered benefits	Authorization inquiries	Authorization status inquiries
5	Claims	Checking on	Claims status		

	inquiries	status of authorization request			

XI. Quality Assurance/Monitoring Activity

MLTSS:

MLTSS Claims Processing Information by MCO

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
# Claims Received	Eligibility	Checking status of authorization	Authorization inquiries from service providers (Requests for authorization)	Claim Status	Authorization requests
# Claims Paid	33,785	82,956	310,201	54,639	184,820
# Claims Denied	24,197	71,533	275,910	46,668	137,412
# Claims Pending	7,830	9,414	30,857	4,307	43,820
Average # days for adjudication	1,758	2,009	3,434	3,664	1,412

Top 5 Reasons for MLTSS Claims Denial by MCO

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
1	Service denied because payment already made for same/similar procedure within set time frame	NetworX Std Fee Sched	Duplicate claim	No authorization on file	No Authorization
2	Non-covered	Procedure non-	Timely filing	Medi 2ndary	No Patient

	charge(s)	reimbursable		Carrier	Responsibility
3	Procedure code incidental to primary procedure	Disallow-not allowed under contract	No authorization	Benefits Based on Admission Date	Timely Filing
4		Incorrect billing form/provider	Provider not contracted	iCES Edit overridden	
5					

SED/IDD/ASD:

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

Supports:

DDD continues to hold quarterly update meetings for families, providers, and Support Coordination Agencies.

Other Quality/Monitoring Issues:

EQR PIP

In December 2013, the MCOs, with the guidance of the External Quality Review Organization (EQRO), initiated a collaborative Quality Incentive Program (QIP) with a focus on Identification and Management of Obesity in the Adolescent Population. Since inception, the EQRO had held regularly scheduled meetings with the MCOs to ensure a solid and consistent QIP foundation across all MCOs. In September 2015, the plans submitted a report to include a qualitative analysis of their recent activities and, based on the analysis, any revisions to the interventions for the upcoming year. Starting August 2015, the MCOs met monthly, independent of the EQRO, for continued collaborative activities. The MCOs are expected to show improvement and sustainability of this collaborative QIP. A routine QIP cycle consists of baseline data followed by two remeasurement years and then a sustainability year. Currently, four MCOs are involved in the collaborative. For three of the MCOs, 2013 is their baseline data year for the project; results of calendar year 2014 reflect remeasurement year 1 and results of calendar year 2015 reflect remeasurement year 2. January of 2016 started the sustainability year for these plans. The fourth MCO entered into the NJ market in December of 2013, making their baseline year 2014, with results of calendar year 2015 as their first remeasurement year. January of 2016 was the start of remeasurement year 2 for this plan. The MCOs submitted a progress report in September 2016 which was reviewed by the EQRO. January of 2017 started the sustainability year for the fourth MCO. In June 2017, three of the MCOs submitted their final report for this QIP as the final sustainability data collection was completed in May 2017, and is currently being reviewed by the EQRO. The fourth MCO is currently in their sustainability year and submitted a progress report in June 2017, which is currently being reviewed by the EQRO.

The MCOs are also involved in a non-collaborative Prenatal QIP with the focus on Reduction of Preterm Births. The initial proposals were submitted by the MCOs in October 2014 for review by the EQRO. The individual proposals were approved and project activities were initiated by the plans in early 2015. The

June interim reports included the 2014 baseline data. The September 2015 reports included an analysis of plan specific activities and any revisions for the upcoming year. Results of calendar year 2015 measures represented remeasurement year 1. January of 2016 was the start of remeasurement year 2 for this QIP. The MCO's submitted a progress report in September 2016 which was reviewed by the EQRO. January of 2017 was the start of the sustainability year for these plans. In June 2017, the plans submitted a progress report which included the results of the remeasurement year 2 data and is currently being reviewed by the EQRO. Additionally, all MCOs submitted individual QIP proposals in September 2015 on Falls Prevention specific to members receiving managed long term support services. The individual proposals were approved and project activities were initiated by the plans in early 2016. The June reports included the 2015 baseline data. The MCO's submitted a progress report in September 2016, which was reviewed by the EQRO. January of 2017 was the start of remeasurement year 2 for this QIP. The plans submitted a progress report in June 2017 which included the remeasurement year 1 data and is currently being reviewed by the EQRO.
State Sanctions against MCO, ASO, SNP or PACE Organization:
There are currently no state sanctions against an MCO, ASO, SNP or PACE organization.

XII. Demonstration Evaluation

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

A.	***Expanding Medicaid managed care to include long-term care services and supports will result in improved access to care and quality of care and reduced costs, and allow more individuals to live in their communities instead of institutions.***
	The Center for State Health Policy (CSHP) devoted this quarter to complete all evaluation activities related to this hypothesis. Calculation of all evaluation metrics and population characteristics from Medicaid fee-for-service claims and managed care encounter data were completed, regression analyses were finalized, results were organized into tables or charts, and the narrative of the draft final evaluation report was composed. CSHP also examined CAHPS-HEDIS results, MCO and state-reported quality metrics, and the NCI-AD surveys in New Jersey and other states and summarized relevant results in the draft final evaluation report. Additionally, CSHP completed the MLTSS Stakeholder report summarizing findings from qualitative interviews of individuals and agencies participating in or affected by MLTSS reforms. In June, CSHP attended the MLTSS Steering Committee meeting in person and listened by phone to the Nursing Facility Quality Stakeholders meeting.
B.	***Providing home and community-based services to Medicaid and CHIP beneficiaries and others with serious emotional disturbance, opioid addiction, pervasive developmental disabilities, or intellectual disabilities/developmental disabilities will lead to better care outcomes.***
	The chapter in the draft final evaluation report addressing this hypothesis as it pertains to children with ASD, ID-DD/MI, and SED was completed during this quarter and reviewed by staff from the Division of Children and Families. A draft of the stakeholder report regarding the Supports Program was also completed during this quarter and delivered to the State for review.
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.
	All evaluation activities related to this hypothesis were completed this quarter. The draft report of CSHP's findings was reviewed by the State and the content was finalized after addressing their comments.
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.***
	CSHP continued to monitor developments in the DSRIP program this quarter. CSHP communicated to the DSRIP state official the plans in regard to the second round of key informant interviews and the web survey which will be part of the final evaluation report. CSHP has kept abreast of all materials and announcements posted to the DSRIP website, including another revision of the Databook released in June, and communications with hospitals about the future of DSRIP. In June, CSHP attended the DSRIP Learning Collaborative meeting, and CSHP also requested from the State results of selected Stage 4 metric calculations as required for the final evaluation report due in March 2018.

XIII. Enclosures/Attachments

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

XIV. State Contact(s)

Meghan Davey
Director
NJ Division of Medical Assistance and Health Services
PO Box 712, Trenton, NJ 08625

Phone: 609-588-2600
Fax: 609-588-3583

Stacy Shanfeld
NJ Division of Medical Assistance and Health Services
PO Box 712, Trenton, NJ 08625

Phone: 609-588-2606
Fax: 609-588-3583

XV. Date Submitted to CMS

Federal Budget Neutrality Summary

SUBJECT TO PUBLIC COMMENT PROCESS

Room Under the Budget Neutrality Cap	**$ 31,477,434,166**

	Total				
State Fiscal Year	Date of Service Budget Neutrality Ceiling*	CMS 64 Waiver Date of Service Expenditures	BN Savings Phase-Down	DSRIP Expenditures	Variance
Initial Waiver Period					
SFY13 Actual	$ 6,657,135,109	$ 5,891,233,244			$ 765,901,865
SFY14 Actual	$ 9,449,402,249	$ 8,174,587,531			$ 1,274,814,718
SFY15 Actual	$ 10,114,682,433	$ 8,104,593,990			$ 2,010,088,443
SFY16 Actual	$ 10,677,824,461	$ 8,152,637,041			$ 2,525,187,420
SFY17 Estimated	$ 11,159,269,155	$ 8,491,505,369			$ 2,667,763,787
SFY13-17	$ 48,058,313,407	$ 38,814,557,175	$ -	$ -	$ 9,243,756,232
First Waiver Extension Period					
SFY18 Projected	$ 11,896,950,170	$ 8,292,583,641			$ 3,604,366,528
SFY19 Projected	$ 12,685,551,420	$ 8,827,479,537			$ 3,858,071,883
SFY20 Projected	$ 13,528,745,933	$ 9,214,995,541			$ 4,313,750,392
SFY21 Projected	$ 14,430,482,800	$ 9,462,849,812			$ 4,967,632,987
SFY22 Projected	$ 15,395,008,680	$ 9,905,152,536			$ 5,489,856,144
SFY18-22	$ 67,936,739,002	$ 45,703,061,068			$ 22,233,677,934
Second Waiver Extension Period					
Total					**$ 31,477,434,166**

Budget Neutrality Monitoring Spreadsheet

Main Budget Neutrality Test

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

TOTAL COMPUTABLE

Waiver Year	1	2	3	4	5	***Demo***	6	7	8	9	10	***Renewal***
State Fiscal Year	2013	2014	2015	2016	2017	***Period 1***	2018	2019	2020	2021	2022	***Period 1***
NO WAIVER												
Title XIX	$ 1,888,003,055	$ 2,721,828,868	$ 3,190,622,964	$ 3,450,426,912	$ 3,605,707,094	**$ 14,856,588,893**	$ 3,916,313,421	$ 4,253,676,301	$ 4,620,100,621	$ 5,018,089,822	$ 5,450,362,995	$ 23,258,543,159
***ABD/LTC/HCBS State Plan**	$ 4,769,132,053	$ 6,727,573,381	$ 6,924,059,470	$ 7,227,397,549	$ 7,553,562,061	**$ 33,201,724,514**	$ 7,980,636,748	$ 8,431,875,120	$ 8,908,645,312	$ 9,412,392,978	$ 9,944,645,685	$ 44,678,195,842
	$ -	$ -	$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	$ -	$ -	$ -
NO WAIVER -TOTAL COMPUTABLE	**$ 6,657,135,109**	**$ 9,449,402,249**	**$ 10,114,682,433**	**$ 10,677,824,461**	**$ 11,159,269,155**	**$ 48,058,313,407**	**$ 11,896,950,170**	**$ 12,685,551,420**	**$ 13,528,745,933**	**$ 14,430,482,800**	**$ 15,395,008,680**	**$ 67,936,739,002**
WITH WAIVER												
Title XIX	$ 1,660,532,120	$ 2,399,180,142	$ 2,582,613,493	$ 2,534,724,200	$ 2,649,124,657	**$ 11,826,174,612**	$ 2,877,328,130	$ 3,125,189,727	$ 3,394,402,860	$ 3,686,806,812	$ 4,004,399,310	$ 17,088,126,839
****ABD/LTC/HCBS State Plan**	$ 4,009,676,348	$ 5,468,130,944	$ 5,219,407,337	$ 5,283,892,825	$ 5,508,360,696	**$ 25,489,468,150**	$ 5,209,108,223	$ 5,496,142,521	$ 5,614,445,392	$ 5,735,895,711	$ 5,860,605,937	$ 27,916,197,784
HCBS state plan	$ -	$ -	$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	$ -	$ -	$ -
DDD Supports-PDN	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	$ -
DSRIP	$ 192,443,637	$ 266,607,552	$ 266,600,001	$ 293,872,727	$ 293,872,727	**$ 1,313,396,644**	$ 166,000,000	$ 166,000,000	$ 166,000,000	$ -	$ -	$ 498,000,000
CNOMS	$ 28,581,139	$ 40,668,893	$ 35,973,159	$ 40,147,289	$ 40,147,289	**$ 185,517,769**	$ 40,147,289	$ 40,147,289	$ 40,147,289	$ 40,147,289	$ 40,147,289	$ 200,736,445
WITH WAIVER - TOTAL COMPUTABLE	**$ 5,891,233,244**	**$ 8,174,587,531**	**$ 8,104,593,990**	**$ 8,152,637,041**	**$ 8,491,505,369**	**$ 38,814,557,175**	**$ 8,292,583,641**	**$ 8,827,479,537**	**$ 9,214,995,541**	**$ 9,462,849,812**	**$ 9,905,152,536**	**$ 45,703,061,068**
Difference	**$ 765,901,865**	**$ 1,274,814,718**	**$ 2,010,088,443**	**$ 2,525,187,420**	**$ 2,667,763,787**	**$ 9,243,756,232**	**$ 3,604,366,528**	**$ 3,858,071,883**	**$ 4,313,750,392**	**$ 4,967,632,987**	**$ 5,489,856,144**	***$ 22,233,677,934***

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

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

FEDERAL SHARE

Waiver Year	1	2	3	4	5	***Demo***	6	7	8	9	10	***Renewal***
State Fiscal Year	2013	2014	2015	2016	2017	***Period 1***	2018	2019	2020	2021	2022	***Period 1***
NO WAIVER												
Title XIX	$ 947,820,714	$ 1,506,619,075	$ 1,750,450,892	$ 1,732,193,224	$ 1,810,147,427	**$ 7,747,231,332**	$ 1,966,078,907	$ 2,135,442,788	$ 2,319,396,177	$ 2,519,195,858	$ 2,736,206,878	**$ 11,676,320,608**
***ABD/LTC/HCBS State Plan**	$ 2,391,860,109	$ 3,385,329,393	$ 3,480,257,450	$ 3,620,527,386	$ 3,784,120,100	**$ 16,662,094,439**	$ 3,997,285,138	$ 4,223,298,360	$ 4,462,099,796	$ 4,714,413,534	$ 4,981,004,694	**$ 22,378,101,523**
	$ -	$ -	$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	$ -	$ -	**$ -**
	$ -	$ -	$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	$ -	$ -	**$ -**
NO WAIVER - FEDERAL SHARE	**$ 3,339,680,823**	**$ 4,891,948,468**	**$ 5,230,708,342**	**$ 5,352,720,610**	**$ 5,594,267,527**	**$ 24,409,325,771**	**$ 5,963,364,045**	**$ 6,358,741,148**	**$ 6,781,495,973**	**$ 7,233,609,393**	**$ 7,717,211,572**	**$ 34,054,422,131**
WITH WAIVER												
Title XIX	$ 833,625,102	$ 1,328,022,716	$ 1,416,882,579	$ 1,272,489,520	$ 1,329,921,166	**$ 6,180,941,082**	$ 1,444,484,528	$ 1,568,916,719	$ 1,704,067,869	$ 1,850,861,340	$ 2,010,300,038	**$ 8,578,630,493**
****ABD/LTC/HCBS State Plan**	$ 2,011,080,838	$ 2,751,940,994	$ 2,624,022,610	$ 2,647,200,206	$ 2,759,984,637	**$ 12,794,229,285**	$ 2,608,866,127	$ 2,752,620,510	$ 2,811,855,451	$ 2,872,665,650	$ 2,935,107,363	**$ 13,981,115,101**
HCBS state plan	$ -	$ -	$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	$ -	$ -	**$ -**
HOLD DDD Supports-PDN	$ -	$ -	$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	$ -	$ -	**$ -**
DSRIP	$ 96,221,820	$ 138,946,278	$ 150,097,502	$ 168,572,730	$ 167,087,881	**$ 720,926,211**	$ 83,000,002	$ 83,000,002	$ 83,000,002	$ -	$ -	**$ 249,000,007**
CNOMS	$ 14,798,341	$ 21,084,004	$ 18,689,916	$ 20,274,381	$ 20,073,645	**$ 94,920,286**	$ 20,073,645	$ 20,073,645	$ 20,073,645	$ 20,073,645	$ 20,073,645	**$ 100,368,223**
WITH WAIVER - FEDERAL SHARE	**$ 2,955,726,101**	**$ 4,239,993,992**	**$ 4,209,692,607**	**$ 4,108,536,836**	**$ 4,277,067,328**	**$ 19,791,016,864**	**$ 4,156,424,302**	**$ 4,424,610,876**	**$ 4,618,996,967**	**$ 4,743,600,635**	**$ 4,965,481,045**	**$ 22,909,113,824**
	$ 2,011,069,653											
Difference	**$ 383,954,722**	**$ 651,954,476**	**$ 1,021,015,735**	**$ 1,244,183,774**	**$ 1,317,200,200**	**$ 4,618,308,907**	**1,806,939,743**	**1,934,130,273**	**2,162,499,006**	**2,490,008,758**	**2,751,730,527**	**11,145,308,307**

Notes:

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

Budget Neutrality Monitoring Spreadsheet

Supplemental Test #1

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

TOTAL COMPUTABLE

Waiver Year	1	2	3	4	5	*Demo*		6	7	8	9	10	*Renewal*
State Fiscal Year	2013	2014	2015	2016	2017	*Period 1*		2018	2019	2020	2021	2022	*Period 1*
NO WAIVER													
HCBS 217-like	$ 217,434,338	$ 299,298,600	$ 296,727,244	$ 333,410,293	$ 381,879,694	**$ 1,528,750,169**		$ 403,278,363	$ 425,876,110	$ 449,740,123	$ 474,941,359	$ 501,554,749	**$ 2,255,390,704**
Adults w/o Depend. Children	$ 1,677,789	$ 798,912	$ -	$ -	$ -	**$ 2,476,701**		$ -	$ -	$ -	$ -	$ -	**$ -**
SED 217-like	$ 253,840	$ 345,267	$ 290,262	$ 256,844	$ 5,104,782	**$ 6,250,995**		$ 5,510,394	$ 5,948,235	$ 6,420,866	$ 6,931,050	$ 7,481,773	**$ 32,292,319**
Former XIX Chip Parents	$ -	$ 140,335,250	$ -	$ -	$ -	**$ 140,335,250**		$ -	$ -	$ -	$ -	$ -	**$ -**
IDD/MI	$ -	$ -	$ 6,423,263	$ 34,851,919	$ 40,495,720	**$ 81,770,902**		$ 43,713,400	$ 47,186,749	$ 50,936,080	$ 54,983,323	$ 59,352,149	**$ 256,171,702**
NO WAIVER -TOTAL COMPUTABLE	**$ 219,365,967**	**$ 440,778,028**	**$ 303,440,769**	**$ 368,519,057**	**$ 427,480,196**	**$ 1,759,584,017**		**$ 452,502,158**	**$ 479,011,094**	**$ 507,097,069**	**$ 536,855,733**	**$ 568,388,671**	**$ 2,543,854,724**
WITH WAIVER													
HCBS 217-like	$ 207,464,369	$ 278,302,398	$ 331,117,748	$ 375,476,571	$ 430,061,851	**$ 1,622,422,937**		$ 454,160,413	$ 479,609,340	$ 506,484,301	$ 534,865,203	$ 564,836,432	**$ 2,539,955,689**
Adults w/o Depend. Children	$ 1,529,772	$ 674,018	$ -	$ -	$ -	**$ 2,203,790**		$ -	$ -	$ -	$ -	$ -	**$ -**
SED 217-like	$ 83	$ 58,922	$ 27,837	$ 96,680	$ 6,135,308	**$ 6,318,830**		$ 6,622,803	$ 7,149,033	$ 7,717,076	$ 8,330,254	$ 8,992,153	**$ 38,811,319**
Former XIX Chip Parents	$ -	$ 126,863,607	$ -	$ -	$ -	**$ 126,863,607**		$ -	$ -	$ -	$ -	$ -	**$ -**
IDD/MI	$ -	$ -	$ 1,186,792	$ 7,795,679	$ 9,058,086	**$ 18,040,557**		$ 9,777,817	$ 10,554,736	$ 11,393,387	$ 12,298,675	$ 13,275,894	**$ 57,300,509**
WITH WAIVER - TOTAL COMPUTABLE	**$ 208,994,224**	**$ 405,898,945**	**$ 332,332,377**	**$ 383,368,930**	**$ 445,255,245**	**$ 1,775,849,721**		**$ 470,561,033**	**$ 497,313,109**	**$ 525,594,764**	**$ 555,494,131**	**$ 587,104,479**	**$ 2,636,067,516**
Difference	**$ 10,371,743**	**$ 34,879,083**	**$ (28,891,608)**	**$ (14,849,873)**	**$ (17,775,049)**	**$ (16,265,704)**		**$ (18,058,875)**	**$ (18,302,016)**	**$ (18,497,695)**	**$ (18,638,399)**	**$ (18,715,808)**	**$ (92,212,792)**

FEDERAL SHARE

Waiver Year	1	2	3	4	5	*Demo*		6	7	8	9	10	*Renewal*
State Fiscal Year	2013	2014	2015	2016	2017	*Period 1*		2018	2019	2020	2021	2022	*Period 1*
NO WAIVER													
HCBS 217-like	$ 110,183,053	$ 154,284,438	$ 152,380,963	$ 167,828,121	$ 192,226,073	**$ 776,902,648**		$ 201,639,182	$ 212,938,055	$ 224,870,062	$ 237,470,680	$ 250,777,374	**$ 1,127,695,352**
Adults w/o Depend. Children	$ 852,857	$ 408,324	$ -	$ -	$ -	**$ 1,261,182**		$ -	$ -	$ -	$ -	$ -	**$ -**
SED 217-like	$ -	$ 172,639	$ 145,397	$ 129,706	$ 2,552,391	**$ 3,000,134**		$ 2,755,197	$ 2,974,118	$ 3,210,433	$ 3,465,525	$ 3,740,886	**$ 16,146,159**
Former XIX Chip Parents	$ -	$ 71,621,870	$ -	$ -	$ -	**$ 71,621,870**		$ -	$ -	$ -	$ -	$ -	**$ -**
IDD/MI	$ -	$ -	$ 3,244,338	$ 17,445,776	$ 20,362,472	**$ 41,052,586**		$ 21,980,419	$ 23,726,924	$ 25,612,201	$ 27,647,277	$ 29,844,055	**$ 128,810,876**
NO WAIVER -TOTAL COMPUTABLE	**$ 111,035,911**	**$ 226,487,272**	**$ 155,770,698**	**$ 185,403,603**	**$ 215,140,936**	**$ 893,838,420**		**$ 226,374,798**	**$ 239,639,096**	**$ 253,692,695**	**$ 268,583,482**	**$ 284,362,316**	**$ 1,272,652,387**
WITH WAIVER													
HCBS 217-like	$ 105,130,854	$ 143,461,176	$ 170,041,822	$ 189,002,945	$ 216,479,436	**$ 824,116,233**		$ 227,080,206	$ 239,804,670	$ 253,242,150	$ 267,432,602	$ 282,418,216	**$ 1,269,977,844**
Adults w/o Depend. Children	$ 777,617	$ 344,491	$ -	$ -	$ -	**$ 1,122,108**		$ -	$ -	$ -	$ -	$ -	**$ -**
SED 217-like	$ -	$ 29,462	$ 13,944	$ 48,823	$ 3,067,654	**$ 3,159,883**		$ 3,311,401	$ 3,574,516	$ 3,858,538	$ 4,165,127	$ 4,496,077	**$ 19,405,659**
Former XIX Chip Parents	$ -	$ 64,746,447	$ -	$ -	$ -	**$ 64,746,447**		$ -	$ -	$ -	$ -	$ -	**$ -**
IDD/MI	$ -	$ -	$ 599,439	$ 3,902,272	$ 4,554,680	**$ 9,056,391**		$ 4,916,582	$ 5,307,240	$ 5,728,939	$ 6,184,145	$ 6,675,521	**$ 28,812,428**
WITH WAIVER - TOTAL COMPUTABLE	**$ 105,908,471**	**$ 208,581,576**	**$ 170,655,205**	**$ 192,954,040**	**$ 224,101,770**	**$ 902,201,062**		**$ 235,308,190**	**$ 248,686,427**	**$ 262,829,628**	**$ 277,781,874**	**$ 293,589,813**	**$ 1,318,195,932**
Difference	**$ 5,127,440**	**$ 17,905,696**	**$ (14,884,507)**	**$ (7,550,437)**	**$ (8,960,833)**	**$ (8,362,642)**		**$ (8,933,392)**	**$ (9,047,331)**	**$ (9,136,932)**	**$ (9,198,392)**	**$ (9,227,497)**	**$ (45,543,544)**

Supplemental Test #2

Budget Neutrality Monitoring Spreadsheet

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

TOTAL COMPUTABLE

Waiver Year	1	2	3	4	5	*Demo*		6	7	8	9	10	*Renewal*
State Fiscal Year	2013	2014	2015	2016	2017	*Period 1*		2018	2019	2020	2021	2022	*Period 1*
NO WAIVER													
New Adult Group	$ -	$ 655,329,429	$ 3,208,229,680	$ 3,490,197,745	$ 3,690,968,615	**$ 11,044,725,469**		$ 3,946,655,795	$ 4,220,055,380	$ 4,512,394,375	$ 4,824,984,784	$ 5,159,229,498	**$ 22,663,319,831**
NO WAIVER -TOTAL COMPUTABLE	**$ -**	**$ 655,329,429**	**$ 3,208,229,680**	**$ 3,490,197,745**	**$ 3,690,968,615**	**$ 11,044,725,469**		**$ 3,946,655,795**	**$ 4,220,055,380**	**$ 4,512,394,375**	**$ 4,824,984,784**	**$ 5,159,229,498**	**$ 22,663,319,831**
WITH WAIVER													
New Adult Group	$ -	$ 862,002,142	$ 2,860,394,406	$ 2,901,491,432	$ 3,068,397,436	**$ 9,692,285,416**		$ 3,280,956,785	$ 3,508,240,914	$ 3,751,269,863	$ 4,011,134,335	$ 4,289,000,589	**$ 18,840,602,486**
WITH WAIVER - TOTAL COMPUTABLE	**$ -**	**$ 862,002,142**	**$ 2,860,394,406**	**$ 2,901,491,432**	**$ 3,068,397,436**	**$ 9,692,285,416**		**$ 3,280,956,785**	**$ 3,508,240,914**	**$ 3,751,269,863**	**$ 4,011,134,335**	**$ 4,289,000,589**	**$ 18,840,602,486**
Difference	**$ -**	**$ (206,672,713)**	**$ 347,835,274**	**$ 588,706,313**	**$ 622,571,179**	**$ 1,352,440,053**		**$ 665,699,009**	**$ 711,814,466**	**$ 761,124,512**	**$ 813,850,449**	**$ 870,228,909**	**$ 3,822,717,345**

FEDERAL SHARE

Waiver Year	1	2	3	4	5	*Demo*		6	7	8	9	10	*Renewal*
State Fiscal Year	2013	2014	2015	2016	2017	*Period 1*		2018	2019	2020	2021	2022	*Period 1*
NO WAIVER													
New Adult Group	$ -	$ 655,316,796	$ 3,208,177,306	$ 3,490,140,767	$ 3,598,694,400	**$ 10,952,329,269**		$ 3,729,589,726	$ 3,945,751,780	$ 4,128,840,853	$ 4,342,486,306	$ 4,643,306,548	**$ 20,789,975,212**
NO WAIVER -TOTAL COMPUTABLE	**$ -**	**$ 655,316,796**	**$ 3,208,177,306**	**$ 3,490,140,767**	**$ 3,598,694,400**	**$ 10,952,329,269**		**$ 3,729,589,726**	**$ 3,945,751,780**	**$ 4,128,840,853**	**$ 4,342,486,306**	**$ 4,643,306,548**	**$ 20,789,975,212**
WITH WAIVER													
New Adult Group	$ -	$ 861,985,526	$ 2,860,347,710	$ 2,901,444,065	$ 2,991,687,500	**$ 9,615,464,801**		$ 3,100,504,162	$ 3,280,205,254	$ 3,432,411,925	$ 3,610,020,901	$ 3,860,100,530	$ 17,283,242,772
WITH WAIVER - TOTAL COMPUTABLE	**$ -**	**$ 861,985,526**	**$ 2,860,347,710**	**$ 2,901,444,065**	**$ 2,991,687,500**	**$ 9,615,464,801**		**$ 3,100,504,162**	**$ 3,280,205,254**	**$ 3,432,411,925**	**$ 3,610,020,901**	**$ 3,860,100,530**	**$ 17,283,242,772**
Difference	**$ -**	**$ (206,668,730)**	**$ 347,829,596**	**$ 588,696,702**	**$ 607,006,899**	**$ 1,336,864,468**		**$ 629,085,564**	**$ 665,546,525**	**$ 696,428,928**	**$ 732,465,404**	**$ 783,206,018**	**$ 3,506,732,440**

Notes:

1. Federal share is calculated using Composite Federal Share Ratios (source data is CMS 64 Schedule C as reported in QE Sept2015 with a run date of Jan 14, 2016).
2. Member-months based on MMIS report with last actual reported as of December 2015.
3. "With Waiver" pmpm's based on calculations using Sch C expenditures and MMIS eligibility actual member-months reported through Sept 2015

Federal Budget Neutrality - Cap

TOTAL EXPENDITURES IN WAIVER	**$6,876,501,076**	**$10,545,509,706**	**$13,626,352,883**	**$14,536,541,263**	**$15,277,717,966**	**$60,862,622,893**		**$16,296,108,122**	**$17,384,617,893**	**$18,548,237,377**	**$19,792,323,316**	**$21,122,626,849**	**$93,143,913,557**	
														Original STC
Waiver Year	1	2	3	4	5	***Demo***		6	7	8	9	10	***Renewal***	Growth %'s
State Fiscal Year	2013	2014	2015	2016	2017	***Period 1***		2018	2019	2020	2021	2022	***Period 1***	used for
Member Months	*actual*	*actual*	*actual*	*actual*	*estimated*			*projected*	*projected*	*projected*	*projected*	*projected*		BN
Title XIX	5,773,180	7,850,901	8,699,959	8,893,999	8,785,836			9,019,541	9,259,462	9,505,765	9,758,620	10,018,201		2.7%
***ABD/LTC/HCBS State Plan**	2,499,711	3,361,590	3,381,631	3,401,925	3,357,056			3,418,678	3,481,431	3,545,336	3,610,414	3,676,686		1.8%
														1.8%
														1.8%
Total Waiver Member Months	**8,272,891**	**11,212,491**	**12,081,590**	**12,295,924**	**12,142,892**			**12,438,219**	**12,740,893**	**13,051,101**	**13,369,034**	**13,694,887**		
Per Member Per Month														
Title XIX	$327.03	$346.69	$366.74	$387.95	$410.40			$434.20	$459.39	$486.03	$514.22	$544.05		5.8%
***ABD/LTC/HCBS State Plan**	$1,907.87	$2,001.31	$2,047.55	$2,124.50	$2,250.06			$2,334.42	$2,421.96	$2,512.78	$2,607.01	$2,704.78		3.75%
Total Expenditures (Member Months x PMPM)														
Title XIX	$1,888,003,055	$2,721,828,868	$3,190,622,964	$3,450,426,912	$3,605,707,094	**$14,856,588,893**		**$3,916,313,421**	**$4,253,676,301**	**$4,620,100,621**	**$5,018,089,822**	**$5,450,362,995**	**$23,258,543,159**	
***ABD/LTC/HCBS State Plan**	$4,769,132,053	$6,727,573,381	$6,924,059,470	$7,227,397,549	$7,553,562,061	**$33,201,724,514**		**$7,980,636,748**	**$8,431,875,120**	**$8,908,645,312**	**$9,412,392,978**	**$9,944,645,685**	**$44,678,195,842**	
Total Base Expenditures	**$6,657,135,109**	**$9,449,402,249**	**$10,114,682,433**	**$10,677,824,461**	**$11,159,269,155**	**$48,058,313,407**		**$11,896,950,170**	**$12,685,551,420**	**$13,528,745,933**	**$14,430,482,800**	**$15,395,008,680**	**$67,936,739,002**	
** ABD, LTC, and HCBS State Plan Member Months, PMPM, and Total Expenditures are combined in the WOW Cap Consolidated Calculation*														
Hypothetical Population Expenditures														
HCBS 217-Like	$217,434,338	$299,298,600	$296,727,244	$333,410,293	$381,879,694	**$1,528,750,169**		**$403,278,363**	**$425,876,110**	**$449,740,123**	**$474,941,359**	**$501,554,749**	**$2,255,390,704**	
***Adults w/o Dependent Children**	$1,677,789	$798,912	$0	$0	$0	**$2,476,701**		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	
SED 217-Like	$253,840	$345,267	$290,262	$256,844	$5,104,782	**$6,250,995**		**$5,510,394**	**$5,948,235**	**$6,420,866**	**$6,931,050**	**$7,481,773**	**$32,292,319**	
***XIX CHIP Parents**	$0	$140,335,250	$0	$0	$0	**$140,335,250**		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	
IDD/MI	$0	$0	$6,423,263	$34,851,919	$40,495,720	**$81,770,902**		**$43,713,400**	**$47,186,749**	**$50,936,080**	**$54,983,323**	**$59,352,149**	**$256,171,702**	
New Adult Group	$0	$655,329,429	$3,208,229,680	$3,490,197,745	$3,690,968,615	**$11,044,725,469**		**$3,946,655,795**	**$4,220,055,380**	**$4,512,394,375**	**$4,824,984,784**	**$5,159,229,498**	**$22,663,319,831**	
Total Hypothetical Expenditures	**$219,365,967**	**$1,096,107,457**	**$3,511,670,449**	**$3,858,716,802**	**$4,118,448,811**	**$12,804,309,486**		**$4,399,157,952**	**$4,699,066,473**	**$5,019,491,444**	**$5,361,840,517**	**$5,727,618,169**	**$25,207,174,555**	
** Adults w/o Dependent Chidren and Title XIX CHIP Parents are now in New Adult Group as of 1/1/14.*														

With Waiver - Expenditures														
TOTAL EXPENDITURES IN WAIVER	**$6,100,227,468**	**$9,442,488,618**	**$11,297,320,773**	**$11,437,497,403**	**$12,005,158,050**	**$50,282,692,312**		**$12,044,101,459**	**$12,833,033,560**	**$13,491,860,168**	**$14,029,478,279**	**$14,781,257,604**	**$67,179,731,070**	
														Original STC
Waiver Year	1	2	3	4	5	***Demo***		6	7	8	9	10	***Renewal***	Growth %'s
State Fiscal Year	2013	2014	2015	2016	2017	***Period 1***		2018	2019	2020	2021	2022	***Period 1***	used for
Member Months	*actual*	*actual*	*actual*	*actual*	*estimated*			*projected*	*projected*	*projected*	*projected*	*projected*		BN
Title XIX	5,773,180	7,850,901	8,699,959	8,893,999	8,785,836			9,019,541	9,259,462	9,505,765	9,758,620	10,018,201		2.7%
***ABD/LTC/HCBS State Plan**	2,499,711	3,361,590	3,381,631	3,401,925	3,357,056			3,046,489	3,102,410	3,159,358	3,217,351	3,276,409		1.8%
														1.8%
														1.8%
Total Waiver Member Months	**8,272,891**	**11,212,491**	**12,081,590**	**12,295,924**	**12,142,892**			**12,066,029**	**12,361,872**	**12,665,123**	**12,975,971**	**13,294,610**		
Per Member Per Month														
Title XIX	$287.63	$305.59	$296.85	$284.99	$301.52			$319.01	$337.51	$357.09	$377.80	$399.71		5.8%
***ABD/LTC/HCBS State Plan**	$1,604.06	$1,626.65	$1,543.46	$1,553.21	$1,609.12			$1,667.05	$1,727.06	$1,727.06	$1,727.06	$1,727.06		3.6%
														3.9%
														3.7%
Total Expenditures (Member Months x PMPM)														
Title XIX	$1,660,532,120	$2,399,180,142	$2,582,613,493	$2,534,724,200	$2,649,124,657	**$11,826,174,612**		$2,877,328,130	$3,125,189,727	$3,394,402,860	$3,686,806,812	$4,004,399,310	**$17,088,126,839**	
***ABD/LTC/HCBS State Plan**	$4,009,676,348	$5,468,130,944	$5,219,407,337	$5,283,892,825	$5,508,360,696	**$25,489,468,150**		$5,209,108,223	$5,496,142,521	$5,614,445,392	$5,735,895,711	$5,860,605,937	**$27,916,197,784**	
Total Base Actual Expenditures	**$5,670,208,468**	**$7,867,311,086**	**$7,802,020,830**	**$7,818,617,025**	**$8,157,485,353**	**$37,315,642,762**		**$8,086,436,352**	**$8,621,332,248**	**$9,008,848,252**	**$9,422,702,523**	**$9,865,005,247**	**$45,004,324,623**	
** ABD, LTC, and HCBS State Plan Member Months, PMPM, and Total Expenditures are combined in the Actuals Consolidated Calculation*														
Hypothetical Population Expenditures														
HCBS 217-Like	$207,464,369	$278,302,398	$331,117,748	$375,476,571	$430,061,851	**$1,622,422,937**		$454,160,413	$479,609,340	$506,484,301	$534,865,203	$564,836,432	**$2,539,955,689**	
****Adults w/o Dependent Children**	$1,529,772	$674,018	$0	$0	$0	**$2,203,790**		$0	$0	$0	$0	$0	**$0**	
SED 217-Like	$83	$58,922	$27,837	$96,680	$6,135,308	**$6,318,830**		$6,622,803	$7,149,033	$7,717,076	$8,330,254	$8,992,153	**$38,811,319**	
****XIX CHIP Parents**	$0	$126,863,607	$0	$0	$0	**$126,863,607**		$0	$0	$0	$0	$0	**$0**	
IDD/MI - 217-Like	$0	$0	$1,186,792	$7,795,679	$9,058,086	**$18,040,557**		$9,777,817	$10,554,736	$11,393,387	$12,298,675	$13,275,894	**$57,300,509**	
New Adult Group	$0	$862,002,142	$2,860,394,406	$2,901,491,432	$3,068,397,436	**$9,692,285,416**		$3,280,956,785	$3,508,240,914	$3,751,269,863	$4,011,134,335	$4,289,000,589	**$18,840,602,486**	
Total Hypothetical Expenditures	**$208,994,224**	**$1,267,901,087**	**$3,192,726,783**	**$3,284,860,362**	**$3,513,652,681**	**$11,468,135,137**		**$3,751,517,818**	**$4,005,554,023**	**$4,276,864,626**	**$4,566,628,466**	**$4,876,105,068**	**$21,476,670,002**	
*** Adults w/o Dependent Chidren and Title XIX CHIP Parents are now in New Adult Group as of 1/1/14.*														
Supports Program	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	
Hospital Subsidies														
HRSF & GME	$ 192,443,637	$ -	$ -	$ -	$ -	**$192,443,637**		$ -	$ -	$ -	$ -	$ -	**$0**	
HRSF Transition Payments	-	83,302,681	-	-	-	**$83,302,681**							**$0**	
GME State Plan	-	100,000,001	100,000,000	127,272,727	127,272,727	**$454,545,455**		-	-	-	-	-	**$0**	
DSRIP	-	83,304,870	166,600,001	166,600,000	166,600,000	**$583,104,871**		166,000,000	166,000,000	166,000,000	-	-	**$498,000,000**	
Hospital Subsidies Expenditures	**$ 192,443,637**	**$ 266,607,552**	**$ 266,600,001**	**$ 293,872,727**	**$ 293,872,727**	**$1,313,396,644**		**$ 166,000,000**	**$ 166,000,000**	**$ 166,000,000**	**$ -**	**$ -**	**$498,000,000**	
Costs Otherwise Not Matchable (CNOMs)														
SED at Risk	$ 24,511,364	$ 37,239,735	$ 35,973,159	$ 40,147,289	$ 40,147,289	**$178,018,836**		$ 40,147,289	$ 40,147,289	$ 40,147,289	$ 40,147,289	$ 40,147,289	**$200,736,445**	
MATI at Risk	4,069,775	3,429,158	-	-	-	**$7,498,933**		-					**$0**	
DDD non-Disabled Adult Children	-	-	-											
DDD Community / Supports Equalization	-	-	-											
CNOM Expenditures	***$ 28,581,139***	***$ 40,668,893***	***$ 35,973,159***	***$ 40,147,289***	***$ 40,147,289***	**$185,517,769**		***$ 40,147,289***	***$ 40,147,289***	***$ 40,147,289***	***$ 40,147,289***	***$ 40,147,289***	**$200,736,445**	

Federal Budget Neutrality - Cap

TOTAL EXPENDITURES IN WAIVER	**$6,876,501,076**	**$10,545,509,706**	**$13,626,352,883**	**$14,536,541,263**	**$15,277,717,966**	**$60,862,622,893**		**$16,296,108,122**	**$17,384,617,893**	**$18,548,237,377**	**$19,792,323,316**	**$21,122,626,849**	**$93,143,913,557**	
														Original STC
Waiver Year	1	2	3	4	5	***Demo***		6	7	8	9	10	***Renewal***	Growth %'s
State Fiscal Year	2013	2014	2015	2016	2017	***Period 1***		2018	2019	2020	2021	2022	***Period 1***	used for
Member Months	*actual*	*actual*	*actual*	*actual*	*estimated*			*projected*	*projected*	*projected*	*projected*	*projected*		BN
Title XIX	5,773,180	7,850,901	8,699,959	8,893,999	8,785,836			9,019,541	9,259,462	9,505,765	9,758,620	10,018,201		2.7%
ABD	2,204,185	2,970,258	2,994,227	2,984,002	2,893,300			2,946,410	3,000,494	3,055,571	3,111,658	3,168,776		1.8%
LTC	281,932	372,472	361,748	358,881	365,469			372,177	379,009	385,966	393,051	400,265		1.8%
HCBS State Plan	13,594	18,860	25,656	59,042	98,287			100,091	101,928	103,799	105,705	107,645		1.8%
Total Waiver Member Months	**8,272,891**	**11,212,491**	**12,081,590**	**12,295,924**	**12,142,892**			**12,438,219**	**12,740,893**	**13,051,101**	**13,369,034**	**13,694,887**		
Per Member Per Month														
Title XIX	$327.03	$346.69	$366.74	$387.95	$410.40			$434.20	$459.39	$486.03	$514.22	$544.05		5.8%
ABD	$1,045.04	$1,124.49	$1,164.91	$1,206.78	$1,250.17			$1,295.18	$1,341.80	$1,390.11	$1,440.15	$1,492.00		3.6%
LTC	$8,636.81	$8,975.89	$9,325.83	$9,689.41	$10,067.17			$10,459.79	$10,867.72	$11,291.56	$11,731.93	$12,189.48		3.9%
HCBS State Plan	$2,256.69	$2,347.84	$2,434.29	$2,523.94	$2,616.93			$2,713.76	$2,814.17	$2,918.29	$3,026.27	$3,138.24		3.7%
Total Expenditures (Member Months x PMPM)														
Title XIX	$1,888,003,055	$2,721,828,868	$3,190,622,964	$3,450,426,912	$3,605,707,094	**$14,856,588,893**		**$3,916,313,421**	**$4,253,676,301**	**$4,620,100,621**	**$5,018,089,822**	**$5,450,362,995**	**$23,258,543,159**	
ABD	$2,303,461,492	$3,340,025,418	$3,488,004,975	$3,601,033,934	$3,617,117,365	**$16,349,643,184**		**$3,816,119,411**	**$4,026,069,903**	**$4,247,571,189**	**$4,481,258,757**	**$4,727,803,055**	**$21,298,822,314**	
LTC	$2,434,993,117	$3,343,267,700	$3,373,600,351	$3,477,345,150	$3,679,234,498	**$16,308,440,816**		**$3,892,894,337**	**$4,118,961,793**	**$4,358,157,397**	**$4,611,243,524**	**$4,879,026,824**	**$21,860,283,875**	
HCBS State Plan	$30,677,444	$44,280,262	$62,454,144	$149,018,465	$257,210,199	**$543,640,515**		**$271,623,000**	**$286,843,424**	**$302,916,726**	**$319,890,697**	**$337,815,807**	**$1,519,089,653**	
Total Base Expenditures	**$6,657,135,109**	**$9,449,402,249**	**$10,114,682,433**	**$10,677,824,461**	**$11,159,269,155**	**$48,058,313,407**		**$11,896,950,170**	**$12,685,551,420**	**$13,528,745,933**	**$14,430,482,800**	**$15,395,008,680**	**$67,936,739,002**	
Hypothetical Population Expenditures														
HCBS 217-Like	$217,434,338	$299,298,600	$296,727,244	$333,410,293	$381,879,694	**$1,528,750,169**		**$403,278,363**	**$425,876,110**	**$449,740,123**	**$474,941,359**	**$501,554,749**	**$2,255,390,704**	
***Adults w/o Dependent Children**	$1,677,789	$798,912	$0	$0	$0	**$2,476,701**		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	
SED 217-Like	$253,840	$345,267	$290,262	$256,844	$5,104,782	**$6,250,995**		**$5,510,394**	**$5,948,235**	**$6,420,866**	**$6,931,050**	**$7,481,773**	**$32,292,319**	
***XIX CHIP Parents**	$0	$140,335,250	$0	$0	$0	**$140,335,250**		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	
IDD/MI	$0	$0	$6,423,263	$34,851,919	$40,495,720	**$81,770,902**		**$43,713,400**	**$47,186,749**	**$50,936,080**	**$54,983,323**	**$59,352,149**	**$256,171,702**	
New Adult Group	$0	$655,329,429	$3,208,229,680	$3,490,197,745	$3,690,968,615	**$11,044,725,469**		**$3,946,655,795**	**$4,220,055,380**	**$4,512,394,375**	**$4,824,984,784**	**$5,159,229,498**	**$22,663,319,831**	
Total Hypothetical Expenditures	**$219,365,967**	**$1,096,107,457**	**$3,511,670,449**	**$3,858,716,802**	**$4,118,448,811**	**$12,804,309,486**		**$4,399,157,952**	**$4,699,066,473**	**$5,019,491,444**	**$5,361,840,517**	**$5,727,618,169**	**$25,207,174,555**	

** Adults w/o Dependent Chidren and Title XIX CHIP Parents are now in New Adult Group as of 1/1/14.*

With Waiver - Expenditures

TOTAL EXPENDITURES IN WAIVER	**$6,100,227,468**	**$9,442,488,618**	**$11,297,320,773**	**$11,437,497,403**	**$12,005,158,050**	**$50,282,692,312**		**$12,044,101,459**	**$12,833,033,560**	**$13,491,860,168**	**$14,029,478,279**	**$14,781,257,604**	**$67,179,731,070**	
														Original STC
Waiver Year	1	2	3	4	5	***Demo***		6	7	8	9	10	***Renewal***	Growth %'s
State Fiscal Year	2013	2014	2015	2016	2017	***Period 1***		2018	2019	2020	2021	2022	***Period 1***	used for
Member Months	*actual*	*actual*	*actual*	*actual*	*estimated*			*projected*	*projected*	*projected*	*projected*	*projected*		BN
Title XIX	5,773,180	7,850,901	8,699,959	8,893,999	8,785,836			9,019,541	9,259,462	9,505,765	9,758,620	10,018,201		2.7%
***ABD**	2,486,117	3,342,730	3,355,975	3,342,883	3,258,769			2,946,398	3,000,482	3,055,559	3,111,646	3,168,764		1.8%
***LTC**														1.8%
HCBS State Plan	13,594	18,860	25,656	59,042	98,287			100,091	101,928	103,799	105,705	107,645		1.8%
Total Waiver Member Months	**8,272,891**	**11,212,491**	**12,081,590**	**12,295,924**	**12,142,892**			**12,066,029**	**12,361,872**	**12,665,123**	**12,975,971**	**13,294,610**		
Per Member Per Month														
Title XIX	$287.63	$305.59	$296.85	$284.99	$301.52			$319.01	$337.51	$357.09	$377.80	$399.71		5.8%
***ABD**	$1,595.54	$1,616.41	$1,525.65	$1,508.82	$1,563.14			$1,619.41	$1,677.71	$1,677.71	$1,677.71	$1,677.71		3.6%
***LTC**														3.9%
HCBS State Plan	$3,162.12	$3,441.37	$3,872.47	$4,066.37	$4,216.83			$4,372.85	$4,534.64	$4,702.43	$4,876.42	$5,056.84		3.7%
Total Expenditures (Member Months x PMPM)														
Title XIX	$1,660,532,120	$2,399,180,142	$2,582,613,493	$2,534,724,200	$2,649,124,657	**$11,826,174,612**		$2,877,328,130	$3,125,189,727	$3,394,402,860	$3,686,806,812	$4,004,399,310	**$17,088,126,839**	
***ABD**	$3,966,690,442	$5,403,226,627	$5,120,055,291	$5,043,806,205	$5,093,901,545	**$24,627,680,110**		$4,771,424,809	$5,033,933,470	$5,126,336,408	$5,220,435,488	$5,316,261,845	**$25,468,392,019**	
***LTC**	$0	$0	$0	$0	$0	**$0**		$0	$0	$0	$0	$0	**$0**	
HCBS State Plan	$42,985,906	$64,904,317	$99,352,046	$240,086,620	$414,459,151	**$861,788,040**		$437,683,414	$462,209,051	$488,108,984	$515,460,224	$544,344,093	**$2,447,805,765**	
Total Base Actual Expenditures	**$5,670,208,468**	**$7,867,311,086**	**$7,802,020,830**	**$7,818,617,025**	**$8,157,485,353**	**$37,315,642,762**		**$8,086,436,352**	**$8,621,332,248**	**$9,008,848,252**	**$9,422,702,523**	**$9,865,005,247**	**$45,004,324,623**	
** ABD and LTC Member Months, PMPM, and Total Expenditures are combined in the Actual Detail Calculation*														
Hypothetical Population Expenditures														
HCBS 217-Like	$207,464,369	$278,302,398	$331,117,748	$375,476,571	$430,061,851	**$1,622,422,937**		$454,160,413	$479,609,340	$506,484,301	$534,865,203	$564,836,432	**$2,539,955,689**	
****Adults w/o Dependent Children**	$1,529,772	$674,018	$0	$0	$0	**$2,203,790**		$0	$0	$0	$0	$0	**$0**	
SED 217-Like	$83	$58,922	$27,837	$96,680	$6,135,308	**$6,318,830**		$6,622,803	$7,149,033	$7,717,076	$8,330,254	$8,992,153	**$38,811,319**	
****XIX CHIP Parents**	$0	$126,863,607	$0	$0	$0	**$126,863,607**		$0	$0	$0	$0	$0	**$0**	
IDD/MI - 217-Like	$0	$0	$1,186,792	$7,795,679	$9,058,086	**$18,040,557**		$9,777,817	$10,554,736	$11,393,387	$12,298,675	$13,275,894	**$57,300,509**	
New Adult Group	$0	$862,002,142	$2,860,394,406	$2,901,491,432	$3,068,397,436	**$9,692,285,416**		$3,280,956,785	$3,508,240,914	$3,751,269,863	$4,011,134,335	$4,289,000,589	**$18,840,602,486**	
Total Hypothetical Expenditures	**$208,994,224**	**$1,267,901,087**	**$3,192,726,783**	**$3,284,860,362**	**$3,513,652,681**	**$11,468,135,137**		**$3,751,517,818**	**$4,005,554,023**	**$4,276,864,626**	**$4,566,628,466**	**$4,876,105,068**	**$21,476,670,002**	
*** Adults w/o Dependent Chidren and Title XIX CHIP Parents are now in New Adult Group as of 1/1/14.*														
Supports Program	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	
Hospital Subsidies														
HRSF & GME	$ 192,443,637	$ -	$ -	$ -	$ -	**$192,443,637**		$ -	$ -	$ -	$ -	$ -	**$0**	
HRSF Transition Payments	-	83,302,681	-	-	-	**$83,302,681**							**$0**	
GME State Plan	-	100,000,001	100,000,000	127,272,727	127,272,727	**$454,545,455**		-	-	-	-	-	**$0**	
DSRIP	-	83,304,870	166,600,001	166,600,000	166,600,000	**$583,104,871**		166,000,000	166,000,000	166,000,000	-	-	**$498,000,000**	
Hospital Subsidies Expenditures	**$ 192,443,637**	**$ 266,607,552**	**$ 266,600,001**	**$ 293,872,727**	**$ 293,872,727**	**$1,313,396,644**		**$ 166,000,000**	**$ 166,000,000**	**$ 166,000,000**	**$ -**	**$ -**	**$498,000,000**	
Costs Otherwise Not Matchable (CNOMs)														
SED at Risk	$ 24,511,364	$ 37,239,735	$ 35,973,159	$ 40,147,289	$ 40,147,289	**$178,018,836**		$ 40,147,289	$ 40,147,289	$ 40,147,289	$ 40,147,289	$ 40,147,289	**$200,736,445**	
MATI at Risk	4,069,775	3,429,158	-	-	-	**$7,498,933**		-					**$0**	
DDD non-Disabled Adult Children	-	-	-											
DDD Community / Supports Equalization	-	-	-											
CNOM Expenditures	***$ 28,581,139***	***$ 40,668,893***	***$ 35,973,159***	***$ 40,147,289***	***$ 40,147,289***	**$185,517,769**		***$ 40,147,289***	***$ 40,147,289***	***$ 40,147,289***	***$ 40,147,289***	***$ 40,147,289***	**$200,736,445**	

Hypotheticals: Enrollment and PMPM's															
Waiver Year		1	2	3	4	5	***Demo***		6	7	8	9	10	***Renewal***	Growth %'s
State Fiscal Year		2013	2014	2015	2016	2017	***Period 1***		2018	2019	2020	2021	2022	***Period 1***	
WOW-CAP															
HCBS 217-Like	Enrollment	96,351	127,895	122,272	132,486	146,332			149,018	151,753	154,539	157,376	160,264		1.8%
	PMPM	$2,256.69	$2,340.19	$2,426.78	$2,516.57	$2,609.68			$2,706.24	$2,806.37	$2,910.20	$3,017.88	$3,129.54		3.7%
Adults w/o DC	Enrollment	6,057	2,774	3,870,426	4,240,834	4,389,071			4,389,071	4,389,071	4,389,071	4,389,071	4,389,071		
	PMPM	$277.00	$288.00						$0.00	$0.00	$0.00	$0.00	$0.00		
SED 217-Like	Enrollment	113	145	115	96	1,800			1,833	1,867	1,901	1,936	1,971		1.8%
	PMPM	$2,246.37	$2,381.15	$2,524.02	$2,675.46	$2,835.99			$3,006.15	$3,186.52	$3,377.71	$3,580.37	$3,795.19		6.0%
XIX Chip Parents	Enrollment	0	456,761	0	0	0			0	0	0	0	0		
	PMPM		$307.24						$0.00	$0.00	$0.00	$0.00	$0.00		
IDD/MI	Enrollment	0	0	581	2,974	3,260			3,320	3,381	3,443	3,506	3,570		1.8%
	PMPM	$9,839.39	$10,429.75	$11,055.53	$11,718.87	$12,422.00			$13,167.32	$13,957.36	$14,794.80	$15,682.49	$16,623.44		6.0%
New Adult Group	Enrollment	0	1,408,947	6,541,000	6,777,083	6,825,647			6,950,938	7,078,529	7,208,462	7,340,780	7,475,527		1.8%
	PMPM		$465.12	$490.48	$515.00	$540.75			$567.79	$596.18	$625.99	$657.29	$690.15		5.0%
ACTUALS															
HCBS 217-Like	Enrollment	96,351	127,895	122,272	132,486	146,332			149,018	151,753	154,539	157,376	160,264		1.8%
	PMPM	$2,153.21	$2,176.02	$2,708.04	$2,834.08	$2,938.95			$3,047.69	$3,160.45	$3,277.39	$3,398.65	$3,524.40		3.7%
Adults w/o DC	Enrollment	6,057	2,774	3,870,426	4,240,834	4,389,071			4,389,071	4,389,071	4,389,071	4,389,071	4,389,071		
	PMPM	$252.56	$242.98						$0.00	$0.00	$0.00	$0.00	$0.00		
SED 217-Like	Enrollment	113	145	115	96	1,800			1,833	1,867	1,901	1,936	1,971		1.8%
	PMPM	$0.73	$406.36	$242.06	$1,007.08	$3,408.50			$3,613.01	$3,829.80	$4,059.58	$4,303.16	$4,561.35		6.0%
***XIX CHIP Parents**	Enrollment	0	456,761	0	0	0									
	PMPM		$277.75												
IDD/MI - 217-Like	Enrollment	0	0	581	2,974	3,260			3,320	3,381	3,443	3,506	3,570		1.8%
	PMPM	$0.00	$0.00	$2,042.67	$2,621.28	$2,778.55			$2,945.27	$3,121.98	$3,309.30	$3,507.86	$3,718.33		6.0%
New Adult Group	Enrollment	0	1,186,513	6,541,000	6,777,083	6,825,647			6,950,938	7,078,529	7,208,462	7,340,780	7,475,527		1.8%
	PMPM		$726.50	$437.30	$428.13	$449.54			$472.02	$495.62	$520.40	$546.42	$573.74		5.0%

Hospital Subsidy Summary													
Waiver Year	1	2	3	4	5	***Demo***		6	7	8	9	10	***Renewal***
State Fiscal Year	2013	2014	2015	2016	2017	***Period 1***		2018	2019	2020	2021	2022	***Period 1***
TOTAL COMPUTABLE													
HRSF & GME	$ 192,443,637	$ -	$ -	$ -	$ -	**$ 192,443,637**		$ -	$ -	$ -	$ -	$ -	**$ -**
HRSF Transition Payments	-	83,302,681	-	-	-	**$ 83,302,681**							**$ -**
GME State Plan	-	100,000,001	100,000,000	127,291,443	140,999,967	**$ 468,291,411**		-	-	-	-	-	**$ -**
DSRIP	-	83,304,870	166,600,001	166,600,000	15,238,210	**$ 431,743,081**		166,000,000	166,000,000	166,000,000	-	-	**$ 498,000,000**
TOTAL COMPUTABLE	**$ 192,443,637**	**$ 266,607,552**	**$ 266,600,001**	**$ 293,891,443**	**$ 156,238,177**	**$ 1,175,780,810**		**$ 166,000,000**	**$ 166,000,000**	**$ 166,000,000**	**$ -**	**$ -**	**$ 498,000,000**
Composite Federal Share Percentage													
HRSF & GME	50.00%	0.00%	0.00%	0.00%	0.00%								
HRSF Transition Payments	0.00%	50.00%	0.00%	0.00%	0.00%			0.00%	0.00%	0.00%	0.00%	0.00%	
GME State Plan	0.00%	55.64%	66.80%	67.00%	65.83%			64.83%	64.50%	63.83%	63.33%	63.33%	
DSRIP	0.00%	50.00%	50.00%	50.00%	50.00%			50.00%	50.00%	50.00%	50.00%	50.00%	
FEDERAL SHARE													
HRSF & GME	$ 96,221,820	$ -	$ -	$ -	$ -	**$ 96,221,820**		$ -	$ -	$ -	$ -	$ -	**$ -**
HRSF Transition Payments	-	41,651,341	-	-	-	**$ 41,651,341**		-	-	-	-	-	**$ -**
GME State Plan	-	55,642,502	66,797,499	85,272,727	83,787,879	**$ 291,500,607**		-	-	-	-	-	**$ -**
DSRIP	-	41,652,435	83,300,003	83,300,003	83,300,003	**$ 291,552,443**		83,000,002	83,000,002	83,000,002	-	-	**$ 249,000,007**
FEDERAL SHARE	**$ 96,221,820**	**$ 138,946,278**	**$ 150,097,502**	**$ 168,572,730**	**$ 167,087,881**	**$ 720,926,211**		**$ 83,000,002**	**$ 83,000,002**	**$ 83,000,002**	**$ -**	**$ -**	**$ 249,000,007**
DY6-10: Total Computable amounts tie to the amounts budgeted in SFY2016.													
DY6-10: Federal Share amounts = Total Computable amounts multiplied by the Federal Composite Share Percentage (estimate for DY4/DY5)													

Costs Otherwise Not Matchable (CNOM) Summary

Waiver Year	1	2	3	4	5	*Demo*		6	7	8	9	10	*Renewal*	Growth %
State Fiscal Year	2013	2014	2015	2016	2017	*Period 1*		2018	2019	2020	2021	2022	*Period 1*	
TOTAL COMPUTABLE														
SED at Risk	$ 24,511,364	$ 37,239,735	$ 35,973,159	$ 40,147,289	$ 40,147,289	$ 178,018,836		$ 40,147,289	$ 40,147,289	$ 40,147,289	$ 40,147,289	$ 40,147,289	$ 200,736,445	
MATI at Risk	$ 4,069,775	$ 3,429,158	$ -	$ -	$ -	$ 7,498,933		$ -	$ -	$ -	$ -	$ -	$ -	
DDD non-Disabled Adult Children	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	$ -	3.00%
DDD Community / Supports Equalization	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	$ -	3.00%
TOTAL COMPUTABLE	**$ 28,581,139.00**	**$ 40,668,893.00**	**$ 35,973,159.00**	**$ 40,147,289.00**	**$ 40,147,289.00**	**$ 185,517,769**		**$ 40,147,289**	**$ 40,147,289**	**$ 40,147,289**	**$ 40,147,289**	**$ 40,147,289**	**$ 200,736,445**	
Composite Federal Share Percentage														
SED at Risk	51.99%	51.83%	51.96%	50.50%	50.00%			50.00%	50.00%	50.00%	50.00%	50.00%		
MATI at Risk	50.50%	52.00%	0.00%	0.00%	0.00%			0.00%	0.00%	0.00%	0.00%	0.00%		
DDD non-Disabled Adult Children				50.00%	50.00%			50.00%	50.00%	50.00%	50.00%	50.00%		
DDD Community / Supports Equalization				50.00%	50.00%			50.00%	50.00%	50.00%	50.00%	50.00%		
FEDERAL SHARE														
SED at Risk	$ 12,743,019	$ 19,300,842	$ 18,689,916	$ 20,274,381	$ 20,073,645	$ 91,081,802		$ 20,073,645	$ 20,073,645	$ 20,073,645	$ 20,073,645	$ 20,073,645	$ 100,368,223	
MATI at Risk	$ 2,055,322	$ 1,783,162	$ -	$ -	$ -	$ 3,838,484		$ -	$ -	$ -	$ -	$ -	$ -	
DDD non-Disabled Adult Children	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	$ -	
DDD Community / Supports Equalization	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	$ -	
FEDERAL SHARE	**$ 14,798,341**	**$ 21,084,004**	**$ 18,689,916**	**$ 20,274,381**	**$ 20,073,645**	**$ 94,920,286**		*$ 20,073,645*	*$ 20,073,645*	*$ 20,073,645*	*$ 20,073,645*	*$ 20,073,645*	**$ 100,368,223**	

Notes: SED at Risk and MATI at Risk

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

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

Notes: DDD programs

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

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

Budgent Neutrality Monitoring Sheet Notes

Enrollment Trends

No Waiver Spending

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

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

With Waiver Spending

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

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

BN caps should be as of 3-27-14

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

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

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

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

Schedule C

CMS 64 Waiver Expenditure Report

Cumulative Data Ending Quarter/Year : 2/2017 (QE 3/17)

State: New Jersey

Summary of Expenditures by Waiver Year

Waiver: 11W00118

MAP Waivers

Total Computable

Waiver Name	A	01	02	03	04	05
ABD	0	3,966,690,442	5,403,226,627	5,120,055,291	5,043,806,205	3,636,073,614
ACCAP – 217 Like	0	630,539	880,454	0	0	0
ACCAP – SP	0	900,000	966,297	0	0	0
AWDC	0	1,529,772	674,018	0	0	0
Childless Adults	0	27,844,394	48,216,389	0	0	0
CRPD – 217 Like	0	11,803,536	16,894,842	0	0	0
CRPD –SP	0	10,672,842	15,247,535	0	0	0
DSRIP	0	0	83,304,870	166,600,001	166,600,000	15,238,210
GME State Plan	0	0	100,000,001	100,000,000	127,291,443	140,999,967
GO – 217 Like	0	181,068,236	221,682,839	0	0	0
GO – SP	0	23,869,092	33,606,671	0	0	0
HCBS – 217 Like	0	288,126	21,406,012	331,117,748	375,476,571	296,482,723
HCBS – State Plan	0	86,858	5,718,886	99,352,046	240,086,620	260,071,514
HRSF & GME	0	192,443,637	0	0	0	0
HRSF Transition Paym	0	0	83,302,681	0	0	0
IDD/MI – 217 Like	0	0	0	1,186,792	7,795,679	4,741,149
MATI at Risk	0	4,069,775	3,429,158	0	0	0
New Adult Group	0	7,940,104	862,002,142	2,860,394,406	2,901,491,432	2,218,672,613
SED – 217 Like	0	83	58,922	27,837	96,680	6,135,308
SED at Risk	0	24,511,364	37,239,735	35,973,159	40,147,289	26,165,967
TBI – 217 Like	0	13,673,932	17,438,251	0	0	0
TBI – SP	0	7,457,114	9,364,928	0	0	0
Title XIX	0	1,660,532,120	2,399,180,142	2,582,613,493	2,534,724,200	1,688,400,858
XIX CHIP Parents	0	0	126,863,607	0	0	0
Total	**0**	**6,136,011,966**	**9,490,705,007**	**11,297,320,773**	**11,437,516,119**	**8,292,981,923**

Federal Share

Waiver Name	A	01	02	03	04	05
ABD	0	1,989,248,600	2,718,465,396	2,572,994,973	2,526,461,274	1,819,158,599
ACCAP – 217 Like	0	319,151	446,869	0	0	0
ACCAP – SP	0	454,312	489,362	0	0	0
AWDC	0	777,617	344,491	0	0	0
Childless Adults	0	14,715,147	24,778,164	0	0	0
CRPD – 217 Like	0	6,026,151	8,740,654	0	0	0
CRPD –SP	0	5,447,877	7,899,121	0	0	0
DSRIP	0	0	41,652,435	83,300,003	83,300,002	7,619,106
GME State Plan	0	0	55,642,502	66,797,499	84,588,472	93,036,479
GO – 217 Like	0	91,709,982	114,209,771	0	0	0
GO – SP	0	12,108,906	17,304,835	0	0	0
HCBS – 217 Like	0	147,076	11,076,822	170,041,822	189,002,945	148,246,759
HCBS – State Plan	0	44,439	2,963,002	51,027,637	120,738,932	130,060,006
HRSF & GME	0	96,221,820	0	0	0	0
HRSF Transition Paym	0	0	41,651,341	0	0	0
IDD/MI – 217 Like	0	0	0	599,439	3,902,272	2,370,585
MATI at Risk	0	2,055,322	1,783,162	0	0	0
New Adult Group	0	7,938,698	861,985,526	2,860,347,710	2,900,760,178	2,180,114,481
SED – 217 Like	0	42	29,462	13,944	48,354	3,068,231
SED at Risk	0	12,743,019	19,300,842	18,689,916	20,565,520	13,082,984
TBI – 217 Like	0	6,928,494	8,987,060	0	0	0
TBI – SP	0	3,776,704	4,819,278	0	0	0
Title XIX	0	833,625,102	1,328,022,716	1,416,882,579	1,286,290,909	845,254,972
XIX CHIP Parents	0	0	64,746,447	2,148	0	0
Total	**0**	**3,084,288,459**	**5,335,339,258**	**7,240,697,670**	**7,215,658,858**	**5,242,012,202**

Composite Federal Share Percentages

Waiver Name	01	02	03	04	05	06	07	08	09	10
ABD	50.15%	50.31%	50.25%	50.09%	50.09%	50.09%	50.09%	50.09%	50.09%	50.09%
AWDC	50.83%	51.11%								
Childless Adults	52.85%	51.39%								
DSRIP		50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%
GME State Plan		55.64%	66.80%	*67.00%*	*65.83%*	*64.83%*	*64.50%*	*63.83%*	*63.33%*	*63.33%*
HCBS – 217 Like	50.67%	51.55%	51.35%	50.34%	50.34%	50.00%	50.00%	50.00%	50.00%	50.00%
HCBS – State Plan	50.79%	51.58%	51.36%	50.29%	50.29%	50.00%	50.00%	50.00%	50.00%	50.00%
HRSF & GME	50.00%									
HRSF Transition Payments		50.00%								
IDD/MI – 217 Like			50.51%	50.06%	50.28%	50.28%	50.28%	50.28%	50.28%	50.28%
MATI at Risk	50.50%	52.00%								
New Adult Group	99.98%	100.00%	100.00%	*100.00%*	97.50%	94.50%	93.50%	91.50%	90.00%	90.00%
SED – 217 Like		50.00%	50.09%	50.50%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%
SED at Risk	51.99%	51.83%	51.96%	50.50%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%
Title XIX	50.20%	55.35%	54.86%	*50.20%*	50.20%	50.20%	50.20%	50.20%	50.20%	50.20%
XIX CHIP Parents		51.04%								

CMS 64 - MEDICAID ELIGIBILITY GROUPS AS OF JUNE 2014

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

	DEFINITIONS:	DY1	DY2	DY3	DY4	DY5
1	TITLE XIX	5.773.180	7,850,901	8,699,959	8,893,999	8,785,836
2	ABD (Excluding HCBS and LTC SPC 61)	2.486.117	3,342,730	3,355,975	3,342,883	3,258,769
3	Childless Adults	385.740	225,208	-	-	-
4	Adults W/O Dependent Children	6.057	2,774	3,870,426	4,240,834	4,389,071
5	SED	26.729	43,160	38,453	43,794	46,139
6	HCBS (State Plan)	13.594	18,860	25,656	59,042	98,287
7	HCBS (217 Like)	96.351	127,895	122,272	132,486	146,332
8	LTC					
9	SED (217 Like)	113	145	115	96	1,800
10	IDD/MI (217 Like)	-	-	581	2,974	3,260
11	XIX CHIP Parents *(10/01/2013 - 12/31/2013 Only)*		456,761	-	-	-
12	New Adult Group *(01/01/2014 Onwards)*		1.183.739	2.670.574	2.536.249	2.436.576
	Source = CMS64 MEG report from Dec 2015					

		final dec 13 rpt	final feb 14 rpt	final mar 14 rpt	final apr14 rpt	final may 14 rpt	final jun 14 rpt	final Jul 14 rpt	final aug 14 rpt	final sept14 rpt	final oct 14 rpt	final nov 14 rpt	final dec 14 rpt	final jan 15 rpt	final feb 15 rpt	final mar 15 rpt
	DEFINITIONS:	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13
1	TITLE XIX	643,208	641,115	641,945	643,840	643,718	645,054	645,116	635,183	634,001	633,251	632,536	631,012	628,743	625,874	623,702
2	ABD (Excluding HCBS and LTC SPC 61)	274,854	274,540	274,471	275,897	276,304	276,808	277,259	277,750	278,234	278,390	278,697	279,521	279,906	279,461	278,818
3	Childless Adults	45,455	44,363	43,494	43,024	42,618	42,563	41,976	41,588	40,659	39,738	39,242	38,278	37,737	34,678	35,535
4	Adults W/O Dependent Children	772	750	713	682	670	663	644	610	553	503	491	460	453	442	425
5	SED	2,560	2,618	2,677	2,907	3,029	3,110	3,181	3,313	3,334	3,271	3,291	3,154	3,364	3,566	3,531
6	HCBS (State Plan)	1,518	1,520	1,504	1,467	1,474	1,493	1,511	1,543	1,564	1,553	1,555	1,540	1,567	1,586	1,586
7	HCBS (217 Like)	11,219	11,225	11,221	10,428	10,396	10,420	10,456	10,480	10,506	10,556	10,577	10,645	10,726	10,752	10,751
8	LTC															
9	SED (217 Like)	15	13	14	15	15	10	7	9	15	14	11	15	15	16	13
10	IDD/MI (217 Like)															
11	XIX CHIP Parents *(10/01/2013 - 12/31/2013 Only)*													152,428	152,087	152,246
12	New Adult Group *(01/01/2014 Onwards)*															

		final apr 15 rpt	final may 15 rpt	final jun 15 rpt	final jul 15 rpt	final aug 15 rpt	final sept 15 rpt	final Oct 15 rpt	final Nov 15 rpt	final Dec 15 rpt			
	DEFINITIONS:	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14
1	TITLE XIX	663,241	667,292	678,653	683,673	689,180	693,744	698,873	705,756	712,044	716,443	718,070	721,307
2	ABD (Excluding HCBS and LTC SPC 61)	276,842	277,127	278,134	278,326	278,535	278,973	280,262	280,382	280,535	280,359	280,294	278,829
3	Childless Adults												
4	Adults W/O Dependent Children	145,207	160,725	203,473	221,698	235,947	248,452	261,467	275,824	285,009	293,647	303,733	320,267
5	SED	3,769	3,856	4,162	4,191	3,551	3,454	3,185	3,028	2,810	2,886	2,923	3,039
6	HCBS (State Plan)	1,596	1,583	1,580	1,576	1,573	1,565	1,492	1,546	1,624	1,821	2,011	2,162
7	HCBS (217 Like)	10,758	10,742	10,606	10,604	10,577	10,601	9,863	9,920	9,994	10,300	10,490	10,467
8	LTC	0	0	0	0	0	0	24,537	24,150	23,794	23,313	22,974	22,725
9	SED (217 Like)	9	9	11	15	10	7	14	18	11	6	8	9
10	IDD/MI (217 Like)			0	0	0	0	0	0	0	0	0	0
11	XIX CHIP Parents *(10/01/2013 - 12/31/2013 Only)*												
12	New Adult Group *(01/01/2014 Onwards)*	181.112	186.389	198.362	203.220	205.870	208.786	211.485	214.061	216.647	218.794	220.090	225.796

	DEFINITIONS:	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
1	TITLE XIX	726,830	732,311	736,730	740,261	744,442	746,892	744,994	744,692	744,034	744,176	741,195	739,809
2	ABD (Excluding HCBS and LTC SPC 61)	279,154	279,165	279,205	279,364	279,287	279,139	279,313	279,789	278,996	278,966	278,024	279,820
3	Childless Adults												
4	Adults W/O Dependent Children	332,291	348,973	355,792	362,664	364,468	366,291	362,228	357,424	350,616	345,857	342,309	345,701
5	SED	3,164	3,262	3,413	3,522	3,637	3,584	3,438	3,182	3,107	3,201	3,431	3,581
6	HCBS (State Plan)	2,163	2,265	2,349	2,496	2,703	3,024	3,360	3,715	3,972	4,158	4,528	4,751
7	HCBS (217 Like)	10,246	10,156	10,149	10,181	10,224	10,282	10,517	10,584	10,701	10,734	10,837	11,028
8	LTC												
9	SED (217 Like)	9	5	7	9	11	8	11	8	7	8	9	7
10	IDD/MI (217 Like)	0	0	113	133	145	190	205	220	244	271	275	285
11	XIX CHIP Parents *(10/01/2013 - 12/31/2013 Only)*												
12	New Adult Group *(01/01/2014 Onwards)*	225.810	228.275	228.919	227.858	226.725	226.114	223.139	219.467	215.942	213.041	209.178	207.478

	DEFINITIONS:	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17
1	TITLE XIX	741,320	741,240	740,227	739,262	737,369	735,681	735,154	737,284	738,022	736,405	736,418	736,958	736,533	734,897	733,911	728,898	722,969	708,387
2	ABD (Excluding HCBS and LTC SPC 61)	278,974	278,024	278,259	278,098	277,601	277,019	276,790	276,574	276,205	276,037	274,821	273,472	272,228	270,923	269,376	267,113	264,386	260,844
3	Childless Adults																		
4	Adults W/O Dependent Children	353,211	354,296	355,355	357,219	357,319	359,299	358,462	359,858	357,745	356,276	363,520	369,302	375,277	374,360	374,239	372,399	369,236	358,397
5	SED	3,756	3,875	3,959	4,033	4,148	4,083	3,852	3,604	3,441	3,461	3,592	3,675	3,878	3,963	4,169	4,242	4,315	3,947
6	HCBS (State Plan)	5,067	5,310	5,531	5,797	6,263	6,590	6,848	7,075	7,250	7,433	7,681	8,122	8,318	8,428	8,606	9,080	9,524	9,922
7	HCBS (217 Like)	11,081	11,205	11,255	11,380	11,474	11,690	11,807	11,873	11,909	12,022	12,145	12,276	12,427	12,350	12,359	12,380	12,367	12,417
8	LTC																		
9	SED (217 Like)	9	4	7	12	9	5	1	50	82	117	133	153	178	196	211	222	230	227
10	IDD/MI (217 Like)	262	269	274	230	222	217	199	182	164	145	128	254	361	378	374	371	361	343
11	XIX CHIP Parents *(10/01/2013 - 12/31/2013 Only)*																		
12	New Adult Group *(01/01/2014 Onwards)*	207.706	208.078	208.765	208.497	207.899	207.059	205.634	205.150	203.905	202.968	203.378	204.088	204.677	204.021	203.744	202.298	200.280	196.433

MMX Member Mo	Count(dist) Recip Idn
10/1/2012	29,433.
11/1/2012	29,367.
12/1/2012	29,283.
1/1/2013	29,181.
2/1/2013	28,845.
3/1/2013	28,867.
4/1/2013	28,800.
5/1/2013	28,697.
6/1/2013	28,751.
7/1/2013	28,866.
8/1/2013	29,043.
9/1/2013	29,079.
10/1/2013	29,124.
11/1/2013	29,164.
12/1/2013	29,214.
1/1/2014	29,088.
2/1/2014	28,864.
3/1/2014	28,896.
4/1/2014	28,828.
5/1/2014	28,811.
6/1/2014	28,779.
7/1/2014	29,249.
8/1/2014	29,145.
9/1/2014	29,003.
10/1/2014	28,809.
11/1/2014	28,542.
12/1/2014	28,371.
1/1/2015	28,361.
2/1/2015	28,067.
3/1/2015	27,860.
4/1/2015	27,782.
5/1/2015	27,731.
6/1/2015	27,921.
7/1/2015	27,954.
8/1/2015	28,139.
9/1/2015	28,193.
10/1/2015	28,284.
11/1/2015	28,452.
12/1/2015	28,484.
1/1/2016	28,452.
2/1/2016	28,376.
3/1/2016	28,421.
4/1/2016	28,335.
5/1/2016	28,464.
6/1/2016	28,446.
7/1/2016	28,373.
8/1/2016	28,372.
9/1/2016	28,154.
10/1/2016	28,120.
11/1/2016	27,751.
12/1/2016	27,310.
1/1/2017	26,793.
2/1/2017	24,354.
3/1/2017	23,716.

	MMs
DY1	261,224.
DY2	347,756.
DY3	340,841.
DY4	340,000.
DY5	242,943.

MMX Member Month Date	Count(dist) Recip Idn
10/1/2012	2,376.
11/1/2012	2,353.
12/1/2012	2,332.
1/1/2013	2,322.
2/1/2013	2,302.
3/1/2013	2,291.
4/1/2013	2,270.
5/1/2013	2,242.
6/1/2013	2,220.
7/1/2013	2,195.
8/1/2013	2,177.
9/1/2013	2,157.
10/1/2013	2,130.
11/1/2013	2,109.
12/1/2013	2,076.
1/1/2014	2,047.
2/1/2014	2,032.
3/1/2014	2,017.
4/1/2014	1,970.
5/1/2014	1,930.
6/1/2014	1,876.
7/1/2014	1,845.
8/1/2014	1,823.
9/1/2014	1,811.
10/1/2014	1,791.
11/1/2014	1,769.
12/1/2014	1,744.
1/1/2015	1,724.
2/1/2015	1,712.
3/1/2015	1,695.
4/1/2015	1,678.
5/1/2015	1,665.
6/1/2015	1,650.
7/1/2015	1,638.
8/1/2015	1,631.
9/1/2015	1,611.
10/1/2015	1,584.
11/1/2015	1,586.
12/1/2015	1,577.
1/1/2016	1,570.
2/1/2016	1,557.
3/1/2016	1,548.
4/1/2016	1,541.
5/1/2016	1,524.
6/1/2016	1,514.
7/1/2016	1,500.
8/1/2016	1,503.
9/1/2016	1,497.
10/1/2016	1,493.
11/1/2016	1,480.
12/1/2016	1,477.
1/1/2017	1,463.

	MMs
DY1	20,708.
DY2	24,716.
DY3	20,907.
DY4	18,881.
DY5	10,413.

Deliverables due during MLTSS 4th quarter (4/1/2017 - 6/30/2017)

The Division of Medical Assistance and Health Services' (DMAHS) Office of Managed Long-Term Services and Supports Quality Monitoring (MLTSS/QM) receives and analyzes the Performance Measure (PM) Reports submitted by the respective data source. The MLTSS-MCO Quality Workgroup continues to meet on a monthly basis to discuss any issues raised by the MCOs, review data submitted, and facilitate resolution. To assist in the refining of the existing data submitted in the MLTSS Performance Measure Reports by the Managed Care Organizations, the State's External Quality Review Organization, IPRO, has developed more refined specifications for the current PMs. The development of the refined specifications has been an ongoing agenda item with the IPRO taking the lead on the discussions during the monthly MLTSS MCO Quality Workgroup meetings. IPRO has been working with the MCOs to validate their system's coding for each Performance Measure using the refined specifications. While the MCO coding has been approved, some of the MCOs have reported error data in producing some Performance Measure Reports. They have retracted these report submissions. The instances when this has occurred is noted in the specific Performance Measure section of this report. The refined specifications that pertain to this report are effective with measurement period beginning July 1, 2016. In addition to the PM deliverables, this workgroup discusses other MCO contract required MLTSS reporting deliverables and any other initiative or issues relevant to the MLTSS program. Any areas of concern are discussed at a following meeting along with recommendations and resolution.

This quarterly report reflects the performance measures (PM) data that were reported by the MCOs and the Division of Aging Services (DoAS) to the Office of MLTSS/QM during the fourth quarter of MLTSS (4/1/17 – 6/30/17). Each performance measure identifies its measurement period; however, depending on the source for the numerator/denominator the due date for reporting on a particular measure may have a lag time to allow for collection of the information. Several measures rely on claims data; therefore, a lag of 180 days must be built into the due date to allow for the MCO to receive the claims and process the data. This report reflects the performance measures data the Office of MLTSS/QM should have received during the third year, fourth quarter (4/1/17 – 6/30/17) of MLTSS program.

The data for the PMs that DoAS is responsible for reporting is obtained from their TeleSys database or from the Shared Data Warehouse (PM#2, PM#5). The data for the PMs concerning the timeliness of reporting critical incidents (PM#17, PM#17a) is housed within their SAMS database.–After reviewing the query results from the data source available, the DoAS determined that they were unable to report the numerator/denominator for PM#2 as initially defined. Per the MCO contract, MLTSS services are not provided prior to an individual's enrollment into MLTSS. Therefore, this measure was revised to evaluate the percentage of MLTSS members who have received MLTSS specific services within the first nine months of MLTSS enrollment as evidenced by encounters. The State is eliminating this performance measure effective July 1, 2017. It was also determined that DoAS was unable to track the numerator and denominator as initially defined for PM#5. However, DoAS continues to monitor the timeliness of the MCOs conducting the nursing facility level of care (LOC) re-determinations. A query is run and provided to each MCO every three months identifying the MLTSS members without a LOC re-determination in the past 16-months. The MCOs are then required to submit within a month the status of each member identified on the report. DoAS has been working with MLTSS/QM to develop the means to report the MCO specific data identifying the total number of members for which DoAS does not have data identifying a LOC re-determination within the past 16-months; the number of assessments that were conducted and received by the State since the report was generated; the number of LOC re-determinations the MCO reported were conducted but the State did not receive; the number of members recommended for disenrollment due to inability to contact/voluntary disenrollment; and the number of members who either expired or whose eligibility was termed. The revision of PM #5 is effective 7/1/2017 and will be reported to MLTSS/QM on a quarterly basis.

Unless otherwise noted, Performance Measure(s) data reports that are not included in this document may be a result of measures involved in review from New Jersey's EQRO or lag time allowing for receipt of claims related data.

PM: #2	MLTSS recipients accessing services within 9 months of eligibility date.
Numerator:	Number of members in the denominator that had received MLTSS services within the first 9 months as evidenced by a paid claim.
Denominator:	Members new to MLTSS within the measurement month.
Data Source:	DoAS
Measurement Period:	Monthly with a nine month lag – Due the 15th of the month following the 9 month lag

After reviewing the query results from the data source available, the DoAS determined that they were unable to report the numerator/denominator for PM#2 as initially defined. Per the MCO contract, MLTSS services are not provided prior to an individual's enrollment into MLTSS. Therefore, this measure has been revised, effective July 1, 2016, to evaluate the percentage of MLTSS members newly enrolled during the measurement month who received MLTSS specific services within the first 9 months of enrollment as evidenced by paid claims. There is a significant lag to allow sufficient time to receive the claims and allow for the 9-months. The results for this PM will be reported in the Annual Report to CMS. Note that PM #2 will be deleted beginning measurement period 7/1/17.

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	**3/2017**	**4/2017**	**5/2017**
Numerator	1707	1519	679
Denominator	1730	1550	688
%	99	98.0	98.7

Approval rate is consistently at 98% or above. No action required.

Deliverables due during MLTSS 4th quarter (4/1/2017 - 6/30/2017)

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

February 2017	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	24	254	349	83	56	766
Denominator	31	255	371	97	141	895
%	77.4	99.6	94.0	86.0	39.7	85.6

March 2017	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	42	292	518	70	160	1082
Denominator	48	295	573	78	199	1193
%	87.5	99.0	90.4	89.7	80.4	90.7

April 2017	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	22	247	343	59	185	856
Denominator	24	248	356	66	191	885
%	91.6	99.6	96.4	89.4	96.9	96.7

The MCOs are monitoring the timeliness of level of care (LOC) initial assessments and have identified that some of the delays include: member requested rescheduled assessment, member was assigned to a Care Manager untimely, case reassignment, difficulty contact members due to invalid phone numbers, staff reassignment, and unable to contact until after the 30 day deadline. In one reporting period MCO A reported that they had untimely assessments due to 5 of the 6 assessments completed after the 30 day timeframe. These were located in the same geographical area and were assigned to one Assessor. Additionally MCO A reported that the caseload for that assessor was beginning to grow beyond capacity and the assessor responsible has been counseled and placed on a Performance Improvement Plan. In addition, two additional assessor team staff are being hired for that particular region. MCO D reported that 1 member was on a Medicare Part A stay at the time they received the referral and this caused the assessment to be delayed. MCO E reported for the month of February timeliness declined due to the increase in the number of reassessments required along with a decrease in staffing. Additionally, MCO E reported that their assessment vendor hired 3 new assessors who were trained in March and it has dedicated 3 care management staff to completing assessments only. The addition of these staff has allowed them to increase their completed assessments from 50 to 80 per week. MCO E has increased their compliance rating this reporting quarter to 96.9%.

Deliverables due during MLTSS 4th quarter (4/1/2017 - 6/30/2017)

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

Measurement Period	2/2017	3/2017	4/2017
Numerator	660	810	783
Denominator	1047	1337	1272
%	63.0	60.9	61.6

The average percentage for this reporting period is 61.8%. The criteria are based on the number of level of care assessments conducted by OCCO in the measurement period. OCCO is responsible for conducting assessment for individuals who are newly seeking Medicaid enrollment in order to access long term services and supports in institutional and community settings. These referrals are generated by various provider sources including hospitals, nursing facilities, assisted living, and county offices. OCCO staffing and workload continues to be variable from reporting period to reporting period. The workload includes non-MLTSS individuals and individuals who are not Medicaid eligible. Due to the large population of non-Medicaid eligible individuals OCCO is recommending the measure be taken under advisement for changes and has submitted to a QA workgroup for consideration. Additionally, the DoAS will continue to report the measure while undergoing revision to better report on the MLTSS population.

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

As reported in the third quarter (1/1/17-3/31/17) report, the DoAS has implemented an alternate process to monitor the MCO's completion of MLTSS members' level of care re-determination(s). The DoAS runs a query and generates a report that is submitted to the MCOs on a quarterly basis with the expectation that the MCOs will reconcile this information with their files and take necessary action. A summary of the results and action taken by DoAS for the period of September 2016 through end of July 2017 will be provided in the Annual Report.

Deliverables due during MLTSS 4th quarter (4/1/2017 - 6/30/2017)

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	3/2017	4/2017	5/2017
Numerator	1730	1563	700
Denominator	1730	1563	700
%	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. This measure will be deleted beginning measurement period 7/1/17.

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	3/2017	4/2017	5/2017
Numerator	1153	1079	518
Denominator	1754	1563	700
%	66.0	69.0	74.0

In March, the range of compliance for the MCOs was 19% - 92% with an overall compliance rate of 66%. DoAS reported that this was a 5 percentage point increase from the previous month. DoAS reported a 3 percentage point increase in April, with an overall compliance rate of 69%. The range for the MCOs was 45.18% - 86.24%. Continued improvement was noted in May with another 5 point overall increase in the MCO compliance rate. The range of compliance was 52.28% - 95.04% with an overall rate of 74%. DoAS reports each MCO's compliance to the respective MCO to ensure assessor staff are continually updated on the coding requirements and to ensure choice of settings is documented on the IPOC as a result of the Options Counseling session. DoAS reports that they expect to see increased compliance rates within the next three months.

Deliverables due during MLTSS 4th quarter (4/1/2017 - 6/30/2017)

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	3/2017	4/2017	5/2017
Numerator	359	293	283
Denominator	361	294	287
%	99.4	99.6	98.6

DoAS reports that the reporting from the MCOs is uniform for this measure. Established monitoring of the timeliness of CI reporting has revealed that current analysis doesn't support any significant impact in reporting based on plan enrollment. DoAS has established the minimum percentage accepted is 100% and requires the MCOs provide a corrective action plan to improve timeliness. Three MCOs fell below 100% during this reporting period and have provided DoAS with acceptable corrective action plans. The action plans for all three MCOs included re-educating the CM regarding the contractual timeframes for reporting. One MCO reported reviewing their reporting procedures and created a new procedure delineating the order in which CI reporting is to occur: 1. State database; 2. Plan's (internal) database; 3. Check off list, which includes confirming reporting to the State.

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	3/2017	4/2017	5/2017
Numerator	3	8	2
Denominator	3	8	2
%	100	100	100

DoAS reported that the established procedures for timely reporting seem to be sufficient. DoAS continues to analyze data to determine trends in CI reporting and identify strategies to improve the timeliness by the MCOs. No actions taken for this month.

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

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

Appeals and Grievances (Table 3A)

1/1/2017 3/31/2017	A	B	C	D	E	TOTAL
Numerator	0	19	52	32	14	117
Denominator	0	19	52	32	14	117
%	0	100	100	100	100	100

Complaints (Table 3B)

1/1/2017 3/31/2017	A	B	C	D	E	TOTAL
Numerator	10	35	110	2	3	160
Denominator	11	35	110	2	3	161
%	90.9	100	100	100	100	99.4

For Table 3B, one MCO reported a resolution that took more than 30 days. The member complained about the care at a NF/Rehab center. The case was referred to his CM team and resolved in 41 days. The MCO reported that this was a data entry error (resulting in exceeding the 30-days) and that they have since instituted a corrective action plan to address such issues. The MCO does not expect them to occur in the future.

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

Deliverables due during MLTSS 4th quarter (4/1/2017 - 6/30/2017)

7/1/2016 – 9/30/2016	A	B	C	D	E	TOTAL
Numerator	716	3300	11256	5148	2475	22895
Denominator	980	3931	14734	6457	4280	30382
%	73.1	83.9	76.4	79.7	57.8	75.4

In analyzing their data, MCOs discovered that there were members with authorizations for MLTSS services but no claims to determine if needed services are being provided. There were also individuals who had lost eligibility with the MCO, MLTSS or had refused program and submitted for disenrollment. MCO A reports they will identify members who do not receive MLTSS specific services and will determine ongoing MLTSS eligibility. Members who meet NF Level of Care will receive options counseling that encourages MLTSS specific services. MCO B reports as an intervention related to their Quality Improvement Program, they are completing falls screening for members in residential settings. The tool identifies the member's current services and whether or not the member utilizes PERS services. A list of members without PERS is identified for care manager follow up. MCO E reports the percentage of members receiving MLTSS specific services decreased significantly from the prior submission due to claims denial or for services with codes that did not match the new specifications. Additionally, MCO E reports there were 301 members without any services. Of those 301 members, 173 members that are currently enrolled of which 120 members now have MLTSS specific services in place. MCOs report that they will continue to provide a member-centric focus during options counseling and will continue to encourage the use of MLTSS services as part of the care planning process.

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

Due to the EQRO validation process there was refinement to the PM specification, and as a result the MCOs had to revise the coding. Although there was an extension granted for reporting, there appeared to be some discrepancies in the submitted reports. As a result they were returned to the respective MCOs and the EQRO was notified of the need to revisit the MCOs system code for producing the report as well as sample reports. It is anticipated that this will be completed and submitted in the Annual Report.

Deliverables due during MLTSS 4th quarter (4/1/2017 - 6/30/2017)

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

10/1/16-12/31/16	A	B	C	D	E	TOTAL
Numerator	0	0	8	1	0	9
Denominator	3	22	129	52	0	206
%	0	0	6.2	1.9	0	4.4

MCOs are monitoring the reasons for MLTSS members' readmission to the NF. MCO C identified members returning to the Nursing Facility related to functional decline, safety concerns, member or family request, lack of informal supports, and needs not being met in the community. MCO D had identified 1 member who returned to the facility because of insufficient supports within the community due to geographical location. MCO D additionally reported that the member successfully returned to the community with the addition of informal supports in place. MCO A reported that members who transitioned home were provided services including PCA, PERS, DME, and HDM. MCO A added that their NF Transition team provides support to members who have transitioned to the community setting, ensuring members have the resources needed to successfully maintain in the community. The MCOs continue to track and trend elements that are successful to transition such as care manager accessibility, transportation and proximity of community services.

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

7/1/16 – 9/30/16	A	B	C	D	E	TOTAL
Numerator	4	37	157	75	8	281
Denominator	5	39	173	82	10	309
%	80	94.9	90.8	91.5	80	90.9

The MCOs are monitoring the success of transitions to determine results. MCO B reports continued interventions such as an additional PERS provider that offers sophisticated technology that measures their members activity, sleep patterns, and wear time to keep members independent and safe in the community as long as possible. Additionally, MCO B reports they are introducing a NF Transition Screening Tool that MLTSS care managers would be expected to complete for all NF members. The tool is used to identify members that are interested in and would qualify for a safe transition to a community setting. Another MCO reports that all transitioned members were over 65 years old, and 50% of those members were age 90 or greater. All MCOs report they are reviewing transitions from HCBS to NF to identify trends. MCO C reports that of the 157 members that remained in the NF after 180 days, the top referral source for the NF admit was family members and the second highest was facility referrals.

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

7/1/16 - 9/30/16	A	B	C	D	E	TOTAL
Numerator	1	2	16	7	2	28
Denominator	5	39	173	82	10	309
%	20	5.1	9.2	8.5	20	9.1

MCOs report they are continuing to track and trend transitions into the NF to confirm that appropriate community to NF transitions are occurring. MCO D reports that they noticed that some of the placements were of a very short duration. They reported continuing efforts to rapidly assess new members in nursing facilities as they are identified and that the expedited NF designation on the data exchange has sped up proper plan code assignments. MCO E reported a total of 10 HCBS members who transitioned to a NF setting. However, 80% of the members stayed in the NF past 181 days, and only 2 members transitioned back to HCBS setting. Additionally, MCO E reports that 5 out of 10 or 50% were over age 85 which can be a contributing factor to the length of stay. MCO C reports that the top referral source for the return to the community was family members with 61% (11 referrals) and the second highest were the member self-referral 28% (5 referrals). MCO C continues to track and trend transitions into the NF to confirm that appropriate community to NF transitions are occurring. In addition, for tracking and reporting purposes, their staff was educated on adding into the system the reasons the member transitioned back to the community.

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

7/1/16 – 9/30/16	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	61	485	1309	204	475	2534
Denominator	1076	8565	27790	10591	9069	57091
%	5.7	5.7	4.89	1.9	5.2	4.4

Data for this measure is captured on a monthly basis and the numerators are added together and the denominators are added together to report quarterly data reflecting the number of hospitalizations that occurred per member month. It is based on hospital events and not unduplicated members. The top diagnosis for hospital admission include: COPD, UTI, cellulitis, fractures, osteomyelitis, sepsis, acute kidney failure, muscle weakness, other malaise, CHF, sepsis, septicemia, GI bleeding, gastritis, GI ulcers, enterocolitis, CVA, pneumonia, renal failure, diabetes and neoplasms. MCO E reports that their highest incidence reported was enterocolitis due to Clostridium difficile. Additionally, MCO E has been tracking and trending hospitalizations by facility and plans to examine trends and develop strategies to decrease utilization, especially in members with chronic conditions. MCO B reports that they are planning to complete claim data analysis on the MLTSS dual, non-dual, and FIDE-SNP population because they do not have complete claims transparency. They hope to provide clarification around what types of claims they are receiving for the dual population (hospital utilization, physician/specialist visit, etc.). MCO D reports there were 8 members with more than 2 admissions during the quarter. Additionally, it was reported that 1 of the 8 members was admitted 9 times for complications from ESRD. MCO E reports 85 members had more than one admission during the measurement period and 78% of them were age 65 and older.

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

Deliverables due during MLTSS 4th quarter (4/1/2017 - 6/30/2017)

7/1/16 – 9/30/16	A	B	C	D	E	TOTAL
Numerator	68	326	543	85	151	1173
Denominator	1553	6109	13849	7365	2740	31616
%	4.4	5.3	3.92	1.2	5.5	3.7

Data for this measure is captured on a monthly basis and the numerators are added together and the denominators are added together to report quarterly data reflecting the number of hospitalizations that occurred per member month. It is based on hospital events and not unduplicated members. Some of the reported diagnoses were related to sepsis, schizoaffective disorder, osteoarthritis, cellulitis, essential hypertension, alcohol induced acute pancreatitis, gastro-esophageal reflux disease without esophagitis, CHF, myocardial infarction, GI bleed, diverticulosis, UTI, and COPD. MCO D reports that one member was admitted four times for alcohol induced acute pancreatitis.

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

7/1/16 – 9/30/16	A	B	C	D	E	TOTAL
Numerator	11	75	171	21	76	354
Denominator	54	434	1252	204	396	2340
%	20.4	17.3	13.66	10.3	19.2	15.1

Data for this measure is captured on a monthly basis and the numerators are added together and the denominators are added together to report quarterly data reflecting the number of hospitalizations that occurred per member month. It is based on hospital events and not unduplicated members. Some of the reported diagnoses include fever, diabetes, schizophrenia, opioid usage, thrombocytopenia, respiratory failure with ventilator, pneumonia, gastro esophageal reflux, alcohol induced pancreatitis, sepsis, diverticulosis, hematemesis, post procedural intestinal obstruction, bacteremia, bradycardia, neoplasms, CHF, and COPD. MCO E reported that review of facilities did not demonstrate any significant trends. Additionally, MCO E reports that only 1 member had multiple readmissions during the measurement period for sepsis. MCO B reports that all readmissions captured in the numerator consisted of unique members – 54 MLTSS Medicaid and 21 MLTSS FIDE-SNP.

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

7/1/16 – 9/30/16	A	B	C	D	E	TOTAL
Numerator	14	0	61	6	15	96
Denominator	58	274	515	82	92	1021
%	24.1	0	11.84	7.3	16.3	9.4

Data for this measure is captured on a monthly basis and the numerators are added together and the denominators are added together to report quarterly data reflecting the number of hospitalizations that occurred per member month. It is based on hospital events and not unduplicated members. MCO A reports that there were 14 readmissions for 12 unique members within 30 days. Additionally, MCO A reports that two members were readmitted twice within 30 days of discharge. The first member with 2 readmissions had a discharge diagnosis of cellulitis and the subsequent re-admissions were for CVA and then complications of gastrostomy. The second member with 2 readmissions had a discharge diagnosis of complications of graft, followed by readmissions for UTI, and then sepsis. MCO D reports that they identified 1 member with 3 admissions with diagnosis of alcohol induced pancreatitis, alcohol dependence, and depression. MCO E reports that there were a total of 14 unique members, of which 79% were over 65 years of age.

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

7/1/16 – 9/30/16	A	B	C	D	E	TOTAL
Numerator	106	176	2951	543	756	4532
Denominator	1074	8565	27212	10588	8947	56386
%	9.9	2.1	10.8	5.1	8.4	8.0

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

Data for this measure is captured on a monthly basis and the numerators are added together and the denominators are added together to report quarterly data reflecting the number of ER utilizations that occurred per member month. It is based on ER utilization events and not unduplicated members. The diagnoses across all MCOs include: UTI, chest Pain, abnormal clinical findings, syncope and collapse, dizziness and giddiness, abdominal pain, headache, abrasions, lacerations, heart failure, essential hypertension, and back pain. MCO A reported that there was not specific diagnosis trends identified during this measurement period although the most frequent diagnoses were UTI and chest pain. MCO B reported that 1 member with 12 ER utilizations had various primary diagnosis codes. MCO D reported that they had 1 member with 10 ER utilizations related to alcohol and contusions. Additionally, MCO D reported that members with more than 5 visits were given to the Care Managers for follow-up and it will be determined if these members are receiving additional care management and are enrolled in any additional programs. The MCOs will continue to monitor this data for trends.

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

7/1/16 – 9/30/16	A	B	C	D	E	TOTAL
Numerator	81	86	748	199	133	1247
Denominator	1551	6113	14172	7365	2745	31946
%	5.2	1.4	5.3	2.7	4.8	3.9

MCOs are monitoring their respective data to determine trends by facility and develop ongoing prevention strategies especially those with multiple ER visits. MCO B reports that the 86 instances of ER utilization consist of 43 members and 26 of the 43 members experienced 2 or more ER admissions in the measurement period. MCO D reported that the top 5 diagnoses were psychiatric related disorders, injury of head, lacerations, attention to ostomy openings, and UTI. MCO D also reported there were multiple visits for the same member including one member that had 6 visits related to alcohol abuse, convulsions and contusions. Additionally, MCO D reported that 80% of the members that utilized the Emergency Room were over the age of 65. MCO C reports that they will continue to track and trend ER Utilization by Nursing Facility to identify overutilization. The MCOs will continue to monitor this data for trends.

Deliverables due during MLTSS 4th quarter (4/1/2017 - 6/30/2017)

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

7/1/16 – 9/30/16	A	B	C	D	E	TOTAL
Numerator	87	225	1777	380	527	2996
Denominator	474	2217	14734	4261	3258	24944
%	18.4	10.1	12.1	8.9	16.2	12.0

MCO A reported their data analysis showed that although 6 of the members who were only receiving PCA services, those 6 members began PERS and/or HDM soon after this measurement period. One member had home modifications completed but the claim was paid in October. Additionally, MCO A reports that many members were provided with support under other State Plan services. MCO D reported that there were 8,808 PCA claims for the 380 members counted in the numerator. Additionally, MCO D reports the percentage of members with PCA only has been slightly decreasing over the past 3 measurement periods, and is a result of the inclusion and growth of self-directed PCA services as well as the correct coding of the home-based supportive care benefit. MCO C reports that of the 1,777 members that had PCA services only, there were 1,358 members receiving PCA services from a provider and 419 members were receiving PCA services through the self-directed program. The MCOs will continue to monitor this data for trends.

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

7/1/16 – 9/30/16	A	B	C	D	E	TOTAL
Numerator	18	89	168	42	371	688
Denominator	474	2217	14734	4261	3258	24944
%	3.8	4.0	1.1	1.0	11.4	2.8

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

MCO E reports that the percentage of members receiving Medical Day services only declined slightly as well as the overall count of unique members. They report that the decrease may be partially attributed to measures put in place at the time of care plan review to offer MLTSS specific services and the change in the timeframe of the measurement period could have possibility contributed as well. MCO C reports that of the members that had only Medical Day services, there were 165 adults and 3 pediatric members and the member's age ranged from 95 to 2 years old. MCO E reports that 12 of the 371 members identified in the numerator were MLTSS-FIDE-SNP and 333 of these members remain enrolled with the MCO including the 12 MLTSS-FIDE-SNP members. Additionally, MCO E reports that of the members who are on longer enrolled with them, 14 transferred to another MCO, 19 lost eligibility, and 5 have expired. The MCOs will continue to monitor this data for trends.

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

7/1/16 – 9/30/16	A	B	C	D	E	TOTAL
Numerator	111	1075	1464	536	668	3854
Denominator	406	3125	9437	3653	3232	19853
%	27.3	34.4	15.5	14.7	20.7	19.4

MCOs report they used claims payment systems based on the claims submitted/received by the MCO. Also, MLTSS members may transition between HCBS and NF during the year and as a result may appear in both PM's data. MCO A reports that the most frequently occurring diagnosis was major depression. MCO C reports that of the 1464 members with a behavioral health diagnosis 151 had a substance abuse diagnosis, 1,210 had a mental illness diagnosis, and 103 had both mental illness and substance abuse diagnoses. MCO D reports the leading 3 disorders during the measurement period were major depressive disorder, single episode, unspecified; bipolar disorder, unspecified; and other depressive disorders. MCO E reports that a review of all diagnoses received without a unique member count of all claims was completed to identify trends within the population. The most frequent diagnoses identified for AOD Dependence were: alcohol abuse/dependence, opioid dependence, cocaine dependence/abuse, other psychoactive substance dependence not specified, cannabis dependence, and inhalant abuse. Additionally, MCO E reported mental illness claims for non-unique members were much greater. The most frequent diagnosis were depression, schizophrenia / schizoaffective disorders, bipolar disorder, mood/affective disorder, post-traumatic stress disorder, autism/retts syndrome, personality disorder, psychosis, psychotic episode and attention-deficit hyperactive disorders. The MCOs will continue to monitor the data for trends.

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

7/1/16 – 9/30/16	A	B	C	D	E	TOTAL
Numerator	6	62	151	32	38	289
Denominator	406	3125	9437	3653	3232	19853
%	1.5	2.0	1.6	0.9	1.2	1.5

This is a new stratification of the PM. The MCOs will continue to monitor this data for trends.

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

7/1/16 – 9/30/16	A	B	C	D	E	TOTAL
Numerator	100	899	1219	476	613	3307
Denominator	406	3125	9437	3653	3232	19853
%	24.6	28.8	12.9	13.0	19.0	16.7

This is a new stratification of this PM. The MCOs will continue to monitor this data for trends.

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

7/1/16 – 9/30/16	A	B	C	D	E	TOTAL
Numerator	5	114	103	28	17	267
Denominator	406	3125	9437	3653	3232	19853
%	1.2	3.6	1.1	0.8	0.5	1.3

This is a new stratification of this PM. The MCOs will continue to monitor this data for trends.

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

7/1/16 – 9/30/16	A	B	C	D	E	TOTAL
Numerator	312	1100	1679	990	437	4518
Denominator	574	2309	5297	2727	994	11901
%	54.4	47.6	31.7	36.3	44.0	38.0

MCOs report they used claims payment system based on the claims submitted/received by the MCO. Also, MLTSS members may transition between HCBS and NF during the year and as a result may appear in both PM's data. MCO A reports that 169 of the 312 members (54%) had a diagnosis of major depression and the remainder substance abuse diagnoses were for alcohol abuse and opioid abuse. MCO B reports that the nursing facility population has reported a higher percentage of members with a selective behavioral health diagnosis compared to their HCBS population. Additionally, MCO B reports the percentage of NF members with a mental illness is significantly higher than those reported with a diagnosis of substance abuse and believes the use of substance abuse specific diagnosis codes is relatively low amongst primary care

physicians. MCO E reported that most common diagnoses identified within this population were depressive disorder, post-traumatic stress, adjustment disorders, schizophrenia, and schizoaffective disorder. MCO E also reports other diagnoses identified with this group were bipolar disorder, psychosis not due to substance abuse, OCD, delirium, mood disorders, and psychotic disorders. Among this group of members with substance abuse, the most frequently reported was alcohol abuse followed by psychoactive substance dependence. Additionally, MCO E reports they have 332 members of this population still enrolled and 74 are assigned to a behavioral health care manager. MCO D reports they utilize a behavioral health administrator who works collaboratively with an interdisciplinary team to ensure that MLTSS NF members diagnosed with a mental illness or a substance abuse disorder are connected to appropriate behavioral health services. MCOs will continue to monitor.

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

7/1/16 – 9/30/16	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	10	15	63	37	12	137
Denominator	574	2309	5297	2727	994	11901
%	1.7	0.6	1.2	1.4	1.2	1.2

This is a new stratification of this PM. The MCOs will continue to monitor this data for trends.

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

7/1/16 – 9/30/16	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	294	1026	1537	924	418	4199
Denominator	574	2309	5297	2727	994	11901
%	51.2	44.4	29	33.9	42.1	35.3

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

This is a new stratification of this PM. The MCOs will continue to monitor this data for trends.

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

7/1/16 – 9/30/16	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	8	59	85	29	7	188
Denominator	574	2309	5297	2727	994	11901
%	1.4	2.6	1.6	1.1	0.7	1.6

This is a new stratification of this PM. The MCOs will continue to monitor this data for trends.

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

7/1/16 – 9/30/16	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	14	70	391	508	511	1494
Denominator	474	2217	14734	4261	3258	24944
%	3	3.2	2.7	11.9	15.7	6.0

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

Deliverables due during MLTSS 4th quarter (4/1/2017 - 6/30/2017)

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

	MCO	A			B			C			D			E			Quarter - TOTAL		
	Participant Safeguards:	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
18	Critical Incident (CI) reporting Types:																		
a	Unexpected death of a member	0	7	**0**	0	109	**0**	1	686	**0.1**	4	114	**3.5**	0	34	**0**	5	950	**0.5**
b	Media involvement or the potential for media involvement	0	7	**0**	2	109	**1.8**	3	686	**0.4**	3	114	**2.6**	0	34	**0**	8	950	**0.8**
c	Physical abuse (including seclusion and restraints both physical and chemical)	0	7	**0**	2	109	**1.8**	5	686	**0.7**	1	114	**0.8**	0	34	**0**	8	950	**0.8**
d	Psychological / Verbal abuse	0	7	**0**	0	109	**0**	2	686	**0.3**	0	114	**0**	1	34	**2.9**	3	950	0.3
e	Sexual abuse and/or suspected sexual abuse	0	7	**0**	0	109	**0**	2	686	**0.3**	0	114	**0**	0	34	**0**	2	950	**0.2**
f	Fall resulting in the need for medical treatment	4	7	**57.1**	63	109	**57.8**	205	686	**29.9**	43	114	**37.7**	22	34	**64.7**	337	950	**35.5**
g	Medical emergency resulting in need for medical treatment	1	7	**14.3**	0	109	**0**	324	686	**47.2**	12	114	**10.5**	9	34	**26.5**	346	950	**36.4**
h	Medication error resulting in serious consequences	0	7	**0**	5	109	**4.6**	2	686	**0.3**	0	114	**0**	0	34	**0**	7	950	**0.7**
i	Psychiatric emergency resulting in need for medical treatment	0	7	**0**	2	109	**1.8**	22	686	**3.2**	2	114	**1.8**	0	34	**0**	26	950	**2.7**

Deliverables due during MLTSS 4th quarter (4/1/2017 - 6/30/2017)

j	Severe injury resulting in the need for medical treatment	0	7	**0**	7	109	**6.4**	15	686	**2.2**	4	114	**3.5**	0	34	**0**	26	950	**2.7**
k	Suicide attempt resulting in the need for medical attention	0	7	**0**	3	109	**2.8**	2	686	**0.3**	0	114	**0**	0	34	**0**	5	950	**0.5**
l	Neglect/Mistreatment, caregiver (paid or unpaid)	0	7	**0**	5	109	**4.6**	7	686	**1.0**	4	114	**3.5**	0	34	**0**	16	950	**1.7**
m	Neglect/Mistreatment, self	0	7	**0**	0	109	**0**	3	686	**0.4**	1	114	**0.9**	0	34	**0**	4	950	**0.4**
n	Neglect/Mistreatment, other	0	7	**0**	0	109	**0**	2	686	**0.3**	1	114	**0.9**	0	34	**0**	3	950	**0.3**
o	Exploitation, financial	1	7	**14.3**	3	109	**2.8**	4	686	**0.6**	0	114	**0**	0	34	**0**	7	950	**0.8**
p	Exploitation, theft	0	7	**0**	0	109	**0**	2	686	**0.3**	0	114	**0**	0	34	**0**	2	950	**0.2**
q	Exploitation, destruction of property	0	7	**0**	0	109	**0**	0	686	**0**	0	114	**0**	0	34	**0**	0	950	0
r	Exploitation, other	0	7	**0**	0	109	**0**	2	686	**0.3**	0	114	**0**	0	34	**0**	2	950	**0.2**
s	Theft with law enforcement involvement	0	7	**0**	1	109	**0.9**	3	686	**0.4**	2	114	**1.8**	0	34	**0**	6	950	**0.6**
t	Failure of member's Back-up Plan	0	7	**0**	0	109	**0**	0	686	**0**	0	114	**0**	0	34	**0**	0	950	**0**
u	Elopement/Wandering from home or facility	0	7	**0**	1	109	**0.9**	4	686	**0.6**	0	114	**0**	1	34	**2.9**	6	950	**0.6**
v	Inaccessible for initial/on-site meeting	0	7	**0**	4	109	**3.7**	3	686	**0.4**	17	114	**14.9**	0	34	**0**	24	950	**2.5**
w	Unable to Contact	0	7	**0**	2	109	**1.8**	25	686	**3.6**	7	114	**6.1**	0	34	**0**	34	950	**3.6**
x	Inappropriate or unprofessional conduct by a provider involving member	0	7	**0**	1	109	**0.9**	30	686	**4.4**	0	114	**0**	0	34	**0**	31	950	**3.3**
y	Cancellation of utilities	0	7	**0**	0	109	**0**	0	686	**0**	0	114	**0**	0	34	**0**	0	950	0
z	Eviction/loss of home	1	7	**14.3**	0	109	**0**	13	686	**1.9**	3	114	**2.6**	0	34	**0**	17	950	**1.8**
aa	Facility closure, with direct impact to member's health and welfare	0	7	**0**	0	109	**0**	0	686	**0**	0	114	**0**	0	34	**0**	0	950	**0**

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

Deliverables due during MLTSS 4th quarter (4/1/2017 - 6/30/2017)

ab	Natural disaster, with direct impact to member's health and welfare	0	7	**0**	0	109	**0**	0	686	**0**	0	114	**0**	0	34	**0**	0	950	**0**
ac	Operational Breakdown	0	7	**0**	0	109	**0**	0	686	**0**	0	114	**0**	0	34	**0**	0	950	**0**
ad	Other	0	7	**0**	8	109	**7.3**	5	686	**0.7**	10	114	**8.8**	1	34	**2.9**	24	950	**2.5**

There were a total of 950 Critical Incidents reported by the five MCOs during the January - March 2017 measurement period. These are reported events not unduplicated members. Overall the three most common incidents were: Medical Emergency resulting in the need for medical treatment (36.4%); Fall resulting in the need for medical treatment (35.5%); and Unable to Contact (3.6%). Four of the five MCOs reported that falls accounted for the highest percentage of reported CIs during this quarter. One MCO reported that 63 of their 109 CIs for this measurement period were for falls. This MCO partnered with CareFamily, an independent organization, to complete fall surveys amongst their top PCA providers. Data from these surveys has been received and is being reviewed internally. They are also recommending the authorization of QMedic, a sophisticated PERS technology that measures member sleep patterns and daytime activity. QMedic is able to provide the MCO with member-level reports. Another MCO, which reported that 20 of their 22 CIs were for falls, detailed a fall prevention program scheduled to begin before the end of SFY 2017. Their program will focus on The Otago program, PCA provider education, and member education in an effort to reduce the risk of falls for their members. The MCO whose top category was medical emergencies, focused on more frequent outreach by their CMs as well as evaluating whether a change in the member's POC is indicated.

1115 Comprehensive Waiver Quarterly Report
Demonstration Year 5
Federal Fiscal Quarter: 3/2017 (4/1/17 -6/30/17)
Department of Children and Families/Division of Children's System of Care (DCF/CSCO)

Quality Assurance Activities:

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

- **IDD –MI and ASD Pilots**

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

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

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

- **IDD –MI and ASD Pilots**
- **Measurement period 04/01/2017 - 06/30/2017**

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

Data Source	Review of Child and Adolescent Needs and Strengths scores Contracted System Administrator (CSA) Data. Data report: CSA NJ1225 Strengths & Needs Assessment – Post SPC Start	
Sampling Methodology	100% New youth enrolled in the waiver	
Waiver	**ID/DD –MI**	**ASD**
Numerator: Number of youth receiving Child and Adolescent Needs and Strengths (CANS) assessment	150	11
Denominator : Total number of new enrollees	150	11
Percentage	100%	100%

CSOC conducted a review of the data for all the youth enrolled during the reporting period under the ID/DD – MI and ASD waivers. For all the youth added during the waiver period the record contained strength and needs assessment. CSOC will continue to conduct ongoing monitoring for this sub assurance.

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

- **IDD –MI and ASD Pilots**
- **Measurement period 04/01/2017 - 06/30/2017**

#3 Quality of Life Sub Assurance	80% of youth should show improvement in Child and Adolescent Needs and Strengths composite rating within a year	
Data Source	CSA Data on CANS Initial and Subsequent Assessments. Data report: CSA NJ2021CANS Waiver Outcome	
Sampling Methodology	Number of youth enrolled in the waiver for at least 1 year.	
Waiver	**ID/DD –MI**	**ASD**
Numerator: Number of youth who improved within one year of admission	718	179
Denominator: Number of youth with Child and	770	185

Adolescent Needs and Strengths assessments conducted 1 year from admission or last CANS conducted		
Percentage	93%	97%

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

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

- **IDD –MI and ASD Pilots**
- **Measurement period 04/01/2017 - 06/30/2017**

#4 Level of Care Sub Assurance	CSOC's Contracted System's Administrator (CSA), conducts an initial Level of Care assessments (aka Intensity of Services (IOS) prior to enrollment for all youth.	
Data Source	CSA Data. Data report: CSA NJ1218 New Enrollees, Quarterly Count and IOS Completed	
Sampling Methodology	100% new youth enrolled in the waiver	
Waiver	**ID/DD –MI**	**ASD**
Numerator: Number of youth receiving initial level of care determination prior to enrollment	150	11
Denominator: Number of new enrollees	150	11
Percentage	100%	100%

CSOC reviewed all new enrollees for the ID/DD – MI and ASD waivers. During the reporting period all the youth met the sub assurance.

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

- **IDD –MI and ASD Pilots**
- **Measurement period 04/01/2017 - 06/30/2017**

#5 Plan of Care Sub Assurance	The Plan of Care (aka Individual Service Plan (ISP)) is developed based on the needs identified in the Child and Adolescent Needs and Strengths assessment tool and according to CSOC policies	
Data Source	CSA Data on Plans of Care completions, Record Review. Data report: CSA NJ1219 Follow – Up Treatment Plan and Associated SNA	
Sampling Methodology	100% of youth enrolled during the measurement period.	
Waiver	**ID/DD –MI**	**ASD**
Numerator: Number of Plans of Care that address youth's assessed needs	150	11
Denominator: Number of Plans of Care reviewed	150	11
Percentage	100%	100%

CSOC reviewed all new enrollees for the ID/DD – MI and ASD waivers. During the reporting period all those youth records met the sub assurance.

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

- **IDD –MI and ASD Pilots**
- **Measurement period 04/01/2017 - 06/30/2017**

#6 Plan of Care Sub Assurance	Plan of Care (ISP) is updated at least annually or as the needs of the youth changes

Data Source	CSA Data Report : CSA NJ1289 Waiver ISP Aggregate Report All Youth	
Sampling Methodology	100% of youth enrolled during the measurement period.	
Waiver	**ID/DD –MI**	**ASD**
Numerator: Number of current Plans of Care updated at least annually	56	1
Denominator: Number of Plans of Care reviewed	56	1
Percentage	100%	100%

CSOC conducted a review of the data for all youth during the reporting period served under the ID/DD – MI and ASD waivers that have been in the waiver for at least a year. During the reporting all youth on the waiver had at least an annual ISP update. CSOC will continue to monitor this indicator to make sure that ISPs are updated at least annually.

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

- **IDD –MI and ASD Pilots**
- **Measurement period 04/01/2017 - 06/30/2017**

#7 Plan of Care Sub Assurance	Services are authorized in accordance with the approved plan of care (ISP). Data Report: CSA NJ1220 Waiver Services Provided	
Data Source	CSA Data Report of Authorizations Record Review	
Sampling Methodology	100% of youth enrolled during the measurement period.	
Waiver	**ID/DD –MI**	**ASD**
Numerator: Number of plans of care that had	150	11

services authorized based on the plan of care		
Denominator: Number of plans of care reviewed	150	11
Percentage	100%	100%

CSOC conducted a review of the data for the youth enrolled during the reporting period under the ID/DD – MI and ASD waivers. All the youth who were enrolled in the waiver during this period had an authorization for provided services.

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

- **IDD –MI and ASD Pilots**
- **Measurement period 04/01/2017 - 06/30/2017**

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

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

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

- **IDD –MI and ASD Pilots**
- **Measurement period 04/01/2017 - 06/30/2017**

#9 Plan of Care Sub Assurance	Youth/Families are provided a choice of providers, based on the available qualified provider network.	
Data Source	Record review Statewide Provider List -CSA Data Report	
Sampling Methodology	Random sample representing a 95% confidence level	
Waiver	**ID/DD –MI**	**ASD**
Numerator: Number of youth/families given a choice of providers as indicated in progress notes	N/A*	N/A*
Denominator: Number of records reviewed	N/A*	N/A*
Percentage	N/A*	N/A*

*CSOC does not have data available for this reporting range; we plan to report on this sub assurance next quarter.

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

- **IDD –MI and ASD Pilots**
- **Measurement period 04/01/2017 - 06/30/2017**

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

services		
Denominator: Total number of new providers	N/A*	N/A*
Percentage	N/A*	N/A*

*CSOC does not have data available for this reporting range; we plan to report on this sub assurance next quarter.

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

- **IDD –MI and ASD Pilots**
- **Measurement period 04/01/2017 - 06/30/2017**

# 11 Qualified Providers Sub Assurance	Children's System of Care verifies that providers of waiver services continually meet required qualified status, including any applicable licensure and/or certification standards.	
Data Source	Provider HR Record Review	
Sampling Methodology	100% Agency	
Waiver	**ID/DD –MI**	**ASD**
Numerator: Number of providers that meet the qualifying standards –applicable Licensures/certification	In Development	In Development
Denominator: Total number of providers that initially met the qualified status	In Development	In Development
Percentage	In Development	In Development

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

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

- **IDD –MI and ASD Pilots**

- **Measurement period 04/01/2017 - 06/30/2017**

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

*CSOC does not have data available for this reporting range; we plan to report on this sub assurance next quarter.

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

Percentage	In Development	In Development

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

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

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

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

accordance to policies and procedures		
Denominator: Total number of unusual incidents reported involving restrictive interventions	In Development	In Development
Percentage	In Development	In Development

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

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

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

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

within youth's centered plan authorization		
Denominator: Total number of claims submitted	In Development	In Development
Percentage	In Development	In Development

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