New Jersey Comprehensive Waiver Demonstration
Section 1115 Quarterly Report
***Demonstration Year:* 5 (7/1/16-6/30/17)**
***Federal Fiscal Quarter:* 2 (1/1/17-3/31/17)**

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 (MLTSS);
- 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;
- Provide need services and HCBS supports for an expanded population of individuals with co-occurring developmental/mental health disabilities; and,
- Encourage structural improvements in the health care delivery system through DSRIP funding.

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

II. Enrollment and Benefit Information

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

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

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

There are no anticipated changes in populations served and benefits.

III. Enrollment Counts for Quarter

Demonstration Populations by MEG	Total Number of Demonstration participants Quarter Ending – 09/16	Total Number of Demonstration participants Quarter Ending – 12/16	Total Number of Demonstration participants Quarter Ending – 03/17	Total Number of Demonstration participants Quarter Ending – MM/YY
Title XIX	738,318	736,058	714,909	
ABD	275,434	271,646	263,842	
LTC				
HCBS - State plan	7,247	8,116	8,563	
TBI – SP				
ACCAP – SP				
CRPD – SP				
GO – SP				
HCBS - 217-Like	11,846	12,178	12,220	
TBI – 217-Like				
ACCAP – 217-Like				
CRPD – 217-Like				
GO – 217-Like				
SED - 217 Like	81	150	179	
IDD/MI – (217 Like)	151	234	309	
NJ Childless Adults				
AWDC	357811	368,229	363,683	
New Adult Group	203728	20,3496	198,329	
SED at Risk	3,437	3,640	3,641	
MATI at Risk				
Title XXI Exp Child				
NJFAMCAREWAIV-POP 1				

NJFAMCAREWAIV-POP 2	
XIX CHIP Parents	

IV. Outreach/Innovative Activities to Assure Access

Managed Long Term Services and Supports (MLTSS)

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

DHS has continued to work with a quality subgroup of the MLTSS Steering Committee on a NF quality initiative. With consensus from stakeholders, the DHS will use seven performance measures to establish a minimum threshold upon which MCOs will rely in narrowing their networks of NF providers. Those measures address antipsychotic medication, immunizations against influenza, pressure ulcers, physical restraints, falls with major injury, NF resident experience survey and tracking 30-day hospitalizations.
A meeting was on held on February 22, 2017 in which DHS presented to stakeholders on next steps for moving forward, including proposed operational guidelines, policy development, communications and timelines.

The MLTSS Steering Committee met on February 23, 2017 with its representation from stakeholders, consumers, providers, MCOs and state staff members. The agenda included a report to the Committee, including these topics: SFY18 budget update; 1115 Comprehensive Waiver renewal; overview of the new Task Force on the Abuse of the Elderly and Disabled; the Nursing Home Quality Indicators initiative and the most recent program data, including enrolled members, expenditures and services.

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.

On February 28th and March 1st 2017, the Office of Managed Health Care Provider Relations staff presented to the Partial Care Providers information regarding the essentials of Managed Care contracting and billing. Behavioral Health services are carved into the benefit package for MLTSS members, and as a result there is an increase in Partial Care providers serving managed care members. The majority of New Jersey Medicaid members receive their behavioral health services as a Fee-for-Service (FFS) benefit that is carved out of managed care.

On March 24th and March 31st 2017, the Office of Managed Health Care Provider Relations staff presented to the Brain Alliance Network. Information regarding updated contract guidelines and information regarding the essentials of Managed Care contracting and billing were presented.

As part of the Traumatic Brain Injury (TBI) Workgroup, modifications have been made to the descriptions of MLTSS Waiver Services. The Office of Managed Health Care (OMHC), provider relations unit, is working directly with the individual MCOs and the TBI providers to insure that operational and

billing issues that may have resulted from initial service definitions are addressed and TBI providers are reimbursed in a timely manner for services rendered.

On March 23, 2017, the Department of Human Services (DHS) presented to the NJ Hospital Association and LeadingAge New Jersey at a day-long provider meeting to approximately 150 providers. New Jersey's five MCOs also presented. MLTSS implementation and associated policy initiatives/changes was a major focus.

ASD/ID/DD-MI/SED

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

Supports

During this quarter, the Division of Developmental Disabilities (DDD) 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 initial meeting.

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

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

V. Collection and Verification of Encounter Data and Enrollment Data

Summary of Issues, Activities or Findings

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

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

MLTSS

The Division of Medical Assistance and Health Services (DMAHS) convenes a weekly meeting with state staff from the various Divisions involved in MLTSS to discuss any issues to ensure 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 March 31, 2017, there were 170 youth identified for the ASD pilot and 736 youth identified for the ID/DD-MI pilot.
CSOC continues to enroll youth into the Serious Emotional Disturbance (SED) Plan A coverage through the SED Waiver. CSOC currently has 211 youth enrolled in the SED Plan A coverage.

CSOC operationalized interpreter services this quarter under ID/DD-MI waiver authority.

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

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

Supports Program

During this quarter, the Division of Developmental Disabilities (DDD) reached 1,500 individuals enrolled 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). It is anticipated that they will begin providing FI services for individuals enrolled in the Supports Program in June 2017. 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.

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

DDD continues enrollment of individuals into Supports Program + Private Duty Nursing (PDN) and provided 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 meeting with the trade organizations and individual providers to assist in preparation for the Medicaid-based, Fee-for-Service system. In addition, DDD reached out to Medicaid/DDD approved providers to identify which providers are stating that they are not ready to provide services in the Medicaid based, Fee-for-Service model so we can identify providers in need of technical assistance. In addition, DDD continued to hold regular calls with providers and individuals/families regarding the system reform (including the Supports Program). These calls provide the opportunity for stakeholders to

share issues/concerns as they come up, receive updates, and suggest ideas/feedback. Any additional assistance to individuals with Medicaid eligibility is supplied. DDD continues to provide ongoing support and guidance on the application process for provider enrollment.

DDD continues the identification of quality measures for the DDD system, providers, individuals, and services. In addition, DDD received a draft report from Medicaid's Quality Management Unit titled, *A Comprehensive Audit Review of the Supports Program*, and developed responses as needed. The draft report indicated that a Corrective Action Plan was not required for any sub-assurance based on the results of the audit.

DDD revised options under Respite in order to better meet the needs of individuals and service providers. These changes were vetted with stakeholders and were included in the revised Supports Program Policies & Procedures Manual released in April. In addition, DDD revised criteria for classes funded through Goods & Services in order to ensure that individuals would be able to access them more readily while maintaining a clear distinction between these classes offered by business entities and Day Habilitation services. The new criterion was vetted with stakeholders and is included in the revised Supports Program Policies & Procedures Manual released in April.

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

Interim Management Entity (IME)

During Federal Fiscal Quarter 2, January 1, 2017 through March 31, 2017, the IME partnered with the Department of Mental Health and Addiction Services (DMHAS) to facilitate two provider trainings on Clinical Assessment and two provider trainings on submitting clinical materials in New Jersey Substance Abuse Monitoring System (NJSAMS) for Clinical Authorization as a response to provider need. The IME Call Center received and responded to 18,074 calls from individuals and/or family members of individuals in need of services or information. 1,110 of those calls were referred and accepted into treatment and 1,048 were screened and placed in care coordination services to maintain contact and facilitate admission to treatment. The IME Utilization Management (UM) department processed 2,833 calls on their provider assistance call line. The IME issued 6,233 prior authorizations for treatment to Medicaid beneficiaries and 4,733 clinical care authorizations for extended treatment of Medicaid beneficiaries.

Delivery System Reform Incentive Payment (DSRIP)

Quarterly Payment Reports – On January 10, 2017, CMS approved $3,809,552.56 for federal drawdown by New Jersey for Quarter 2, Demonstration Year 5 (DY5) for payments earned under Stage 1 and Stage 2 measures. This drawdown represents federal share only.

Progress in meeting DSRIP goals – For DY5 Q3, all progress reports were submitted to CMS for review.

Performance – DY4 results: hospitals have begun submitting formal Requests for Information (RFIs) in order to verify MMIS data. All RFIs have been received. 25 hospitals submitted appeals. CMS is currently reviewing 4 chart/EHR appeals.

Challenges – CMS approved the Stage 3 substitution measures and remaining Improvement Target Goals (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. Mid-course corrections – CMS, NJDHS and NJDOH are holding weekly calls to discuss the 1115 Waiver renewal, including extending NJDSRIP under the 1115 Waiver Renewal. Successes and evaluation – The Learning Collaborative was held on March 9, 2017. The agenda included: DSRIP Community-based Reporting Partner Experience, with Hackensack University Medical Center and Jersey City Medical Center discussing their experiences. It was well attended.
Other
Managed Care Contracting:
There are no updates for this Quarter.
Self-attestations:
There were a total of 239 self-attestations for the time period from January 1, 2017 to March 31, 2017.
MCO Choice and Auto-assignment:
The number of individuals who changed their MCO after auto-assignment is 7,403.
Medical Loss Ratio (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 issue identified.	Development: Implementation: Administration:

VIII. Financial/Budget Neutrality Development/Issues

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

IX. Member Month Reporting

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

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	Care Manager inquiries	Care Manager inquiries	PCP Update	PCP Update
2	Benefits	Authorization follow up	Request for MTLSS Assessment	Eligibility questions	Care Manager inquiries
3	PCP Change	Benefits	Care Plan inquiries	ID Card	Benefit inquiries
4	Provider Search	Nurse Assignment	Benefits	Benefit inquiries	
5			Eligibility		

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

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
1	Member Eligibility	Authorization status	Eligibility inquiries	Authorization status	Eligibility inquiries
2	Claims Inquiries	Authorization correction	Authorization requests	Eligibility inquiries	Authorization requests
3	Provider participation	Contracting updates	CM follow up calls	Billing questions	Pharmacy inquiries
4	Training inquiries	Claims resolution	Enrollment requests	Claims inquiries	Claims inquiries
5	Claims inquiries				

XI. Quality Assurance/Monitoring Activity

MLTSS:

MLTSS Claims Processing Information by MCO

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
# Claims Received	26,820	71,828	306,863	53,158	166,492
# Claims Paid	19,356	64,275	266,295	44,538	123,379
# Claims Denied	6,434	6,745	35,040	5,718	41,741
# Claims Pending	1,030	808	5,528	2,902	1,372
Average # days for adjudication	15	15	15	15	15

Top 5 Reasons for MLTSS Claims Denial by MCO

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
1	Service denied because payment already made for same/similar	Units exceed UM Authorization	Duplicate	Benefits Based on Admission Date	No Authorization

	procedure within set time frame				
2	Non-covered charge(s)	State responsibility	No authorization	No authorization on file	No Patient Responsibility
3	Procedure code incidental to primary procedure	Paid at contracted rate	Timely Filing	Claim is a duplicate	Timely Filing
4		Disallow-not allowed under contract	Provider not eligible for service	Resubmit to Secondary Carrier	
5		NetworX Std Fee Sched		Send Primary Carrier EOB	

SED/IDD/ASD:

The Department of Children and Families (DCF), Children's System of Care (CSOC) has continued to collaborate with the DMAHS Quality Monitoring team that is providing oversight on quality assurance. Please find the attached performance measures for the IDD-MI and ASD pilot programs that include the outcomes of the States Quality Strategy for HCBS.

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

Supports Program:

The Division of Developmental Disabilities (DDD) continues to hold quarterly update meetings for families and providers.

Families currently self-directing their services and using Self-Directed Employees (frequently referred to as "self-hires") expressed concerns over the upcoming change in model from the current Agency with Choice model (in which the FI is the employer of record) to a Fiscal/Employer Agent model (in which the individual or representative is the employer of record). DDD assured families that the changes in their procedures will be minimal and released a FAQ on the subject to assist in making clarification for families. In addition, PPL (the new FI) will be providing training to individuals, families, providers, and Support Coordinators to assist them in understanding the transition to a new FI and any changes that may occur.

Other Quality/Monitoring Issues:

External Quality Review Performance Improvement Project(EQR PIP)

In December 2013, the MCOs, with the guidance of the External Quality Review Organization (EQRO), initiated a collaborative Quality Improvement Projects (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 re-measurement 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 re-measurement year 1 and results of calendar year 2015 reflect re-measurement year 2. January 2016 started the sustainability year for these plans. The fourth MCO entered into the NJ market in December 2013, making their baseline year 2014, with results of calendar year 2015 as their first re-measurement year. January 2016 was the start of re-measurement year 2 for this plan. The MCOs submitted a progress report in September 2016 which was reviewed by the EQRO. In June 2017, three of the MCOs will be submitting their final report for this QIP as the final sustainability data collection should be completed by May 2017. The fourth MCO will be in their sustainability year and will be submitting a progress report in June 2017.

The MCOs are also involved in a non-collaborative Prenatal QIP with the focus on Reduction of Preterm Births. The initial proposals were submitted by the MCOs in October 2014 for review by the EQRO. The individual proposals were approved and project activities were initiated by the plans in early 2015. The June interim reports included the 2014 baseline data. The September 2015 reports included an analysis of plan specific activities and any revisions for the upcoming year. Results of calendar year 2015 measures represented re-measurement year 1. January 2016 was the start of re-measurement year 2 for this QIP. The MCO's submitted a progress report in September 2016 which was reviewed by the EQRO. In June 2017, the plans will submit a progress report which will include results of the re-measurement year 2 data.

Additionally, all MCOs submitted individual QIP proposals in September 2015 on Falls Prevention specific to members receiving MLTSS. 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 MCOs submitted a progress report in September 2016, which was reviewed by the EQRO. The plans will submit a progress report in June 2017 which will include the re-measurement year 1 data.

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.***
	During this quarter, the Rutgers Center for State Health Policy (CSHP) completed preparation of nearly all evaluation metrics and population characteristics using 2015 Medicaid fee-for-service claims and managed care encounter data. CSHP identified beneficiaries with behavioral health conditions using the AHRQ Clinical Classification software. Rates of avoidable inpatient hospitalizations and emergency department visits, follow-up after hospitalization for mental illness, ambulatory visit 14 days after discharge, and all of the 30-day readmission metrics were calculated accommodating, to the extent necessary and feasible, changes in metric specifications by the measure steward and the changeover to ICD-10 coding. Analytic datasets were prepared for regression analyses, and we began developing final model specifications. During this quarter, CSHP also began preparing tables using data from the 2016 HEDIS report and 2015 Adult, Child, and

	MLTSS CAHPS reports provided to us by the State. CSHP continued to attend public and stakeholder meetings on MLTSS implementation and related developments in NJ Medicaid. In January, CSHP attended the Medical Assistance Advisory Council (MAAC) meeting where the waiver renewal application was discussed. In February, CSHP attended the MLTSS Steering Committee meeting, and CSHP had the regular quarterly meeting with DHS staff in March of this quarter. CSHP completed the final qualitative interviews for MLTSS this quarter.
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 preparation of nearly all metrics related to the evaluation of this hypothesis using 2015 Medicaid claims data was completed during this quarter. This included calculating various measures of hospital use for mental health conditions for the cohorts of children targeted for home and community-based waiver services. In March, CSHP held the quarterly meeting with a representative from the Department of Children and Families for updates on Waiver program implementation. CSHP was able to confirm the timeline of service implementation for each of the Waiver pilots and discuss the claim patterns CSHP was seeing for use of residential treatment facilities and out-of-home treatment. In February and March, CSHP completed our stakeholder qualitative interviews regarding the Supports Program (7 interviews with 16 participants).
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.***
	CSHP reviewed the State's quarterly reports to monitor the volume of self-attestations received and requested and received updates from DMAHS on the audits of self-attestations being conducted by the State's Bureau of Quality Control (BQC). The State communicated the challenges of accurately measuring the impact of self-attestations on the timing from application to approval. Also during this quarter, CSHP reviewed DHSs reports to the Office of Legislative Services which summarized use of Qualified Income Trusts (QITs) and asked for clarification on the numbers reported.
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.***
	The ongoing monitoring of developments in the DSRIP program continued this quarter. CSHP reviewed all new materials posted to the DSRIP website, including the February 2017 update of the Databook, the presentation of CMS's vision for next generation DSRIP, and slides from the March Learning Collaborative meeting. The preparation of the 2015 Medicaid claims metrics and datasets, as mentioned in Part A above, will also be used in the final evaluation of DSRIP and therefore, are activities which relate to this hypothesis as well.

XIII. Enclosures/Attachments

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

XIV. State Contact(s)

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XV. Date Submitted to CMS

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Budget Neutrality Monitoring Spreadsheet

Supplemental Test #1

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

TOTAL COMPUTABLE

	DY1	DY2	DY3	DY4	DY5	5-Yr Demo Total
NO WAIVER						
HCBS 217-like	217,434,338	299,298,600	296,727,244	333,171,219	351,840,087	1,498,471,488
Adults w/o Depend. Children	1,677,789	798,912	-	-	-	2,476,701
SED 217-like	253,840	345,267	290,262	256,844	277,253	1,423,466
Former XIX Chip Parents	-	140,335,250	-	-	-	140,335,250
IDD/MI	-	-	6,423,263	34,008,161	36,710,351	77,141,774
	$ 219,365,967	$ 440,778,028	$ 303,440,769	$ 367,436,224	$ 388,827,690	$ 1,719,848,679

	DY1	DY2	DY3	DY4	DY5	5-Yr Demo Total
WITH WAIVER						
HCBS 217-like	207,462,499	278,158,918	331,075,359	375,247,258	390,454,546	1,582,398,580
Adults w/o Depend. Children-AWDC	1,529,772	674,018	-	-	-	2,203,790
SED 217-like	83	58,922	27,837	96,680	104,362	287,884
Former XIX Chip Parents	-	126,863,607	-	-	-	126,863,607
IDD/MI	-	-	1,186,792	7,785,548	8,404,167	17,376,507
	$ 208,992,354	$ 405,755,465	$ 332,289,988	$ 383,129,486	$ 398,963,074	$ 1,729,130,367
Difference	**10,373,613**	**35,022,563**	**(28,849,219)**	**(15,693,262)**	**(10,135,384)**	**(9,281,688)**

Notes:

1. Federal share is calculated using Composite Federal Share Ratios (source data is CMS 64 Schedule C as reported in QE Dec 2016 with a run date of Feb 27, 2017).
2. "With Waiver" expenditures from CMS 64 Schedule C as reported in QE Sept 2016 with a run date of Dec 5, 2016
3. Member-months are reported from MMIS with last actual reported as of Dec 2016.
4. "With Waiver" pmpm's calculated using Sch C expenditures and MMIS eligibility actual member-months reported through Jun 2016 as reported in Sept 2016.

FEDERAL SHARE

	DY1	DY2	DY3	DY4	DY5	5-Yr Demo Total
NO WAIVER						
HCBS 217-like	110,183,067	154,286,829	152,383,180	167,709,842	177,107,271	761,670,188
Adults w/o Depend. Children - AWDC	852,857	408,324	-	-	-	1,261,182
SED 217-like	128,449	172,639	145,397	129,706	138,626	714,818
Former XIX Chip Parents	-	71,621,870	-	-	-	71,621,870
IDD/MI	-	-	3,244,338	17,023,531	18,459,135	38,727,004
	$ 111,164,373	$ 226,489,663	$ 155,772,915	$ 184,863,078	$ 195,705,033	$ 873,995,062

	DY1	DY2	DY3	DY4	DY5	5-Yr Demo Total
WITH WAIVER						
HCBS 217-like	105,129,919	143,389,436	170,020,627	188,889,840	196,544,798	803,974,620
Adults w/o Depend. Children	777,617	344,491	-	-	-	1,122,108
SED 217-like	42	29,462	13,944	48,823	52,181	144,452
Former XIX Chip Parents	-	64,746,447		-	-	64,746,447
IDD/MI	-	-	599,439	3,897,227	4,225,883	8,722,549
	$ 105,907,578	$ 208,509,836	$ 170,634,010	$ 192,835,890	$ 200,822,862	$ 878,710,176
Difference	**5,256,795**	**17,979,827**	**(14,861,095)**	**(7,972,812)**	**(5,117,830)**	**(4,715,114)**

Deliverables due during MLTSS 3rd quarter (1/1/2017 - 3/31/2017)

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) data submitted by the respective data source. The MLTSS-MCO Quality Workgroup continues to meet on a monthly basis to discuss any issues raised by the MCOs, review data submitted, and facilitate resolution. To assist in the refining of the existing MLTSS Performance Measure data reported by the Managed Care Organizations, the State's External Quality Review Organization, IPRO, has developed more refined specifications for the current PMs. The development of the refined specifications has been an ongoing agenda item with the IPRO taking the lead on the discussions during the monthly meetings. IPRO has encouraged the MCOs to begin revising their system coding for the measures and make available for IPRO review during the development phase so that 'technical assistance' may be provided. The refined specifications are effective with measurement period beginning July 1, 2016; however, due to the lag time in reporting the majority of the refined measures will not be submitted until April 2017. In addition to the PM deliverables, this workgroup discusses other MCO contract required MLTSS reporting deliverables. Any areas of concern are discussed at a following meeting along with recommendations and resolution.

This quarterly report reflects the performance measures that were reported by the MCOs, the Division of Aging Services (DoAS), and IPRO to the Office of MLTSS/QM during the third quarter of MLTSS (1/1/17 – 3/31/17). 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 with a reporting period for the third year, third quarter (1/1/17 – 3/31/17) of MLTSS and the annual measures calculated by IPRO using data from the annual Home and Community Based Services MLTSS Care Management Audit. The report covered the period of 7/1/15 - 6/30/16.

The data for the PMs that DoAS is responsible for reporting is obtained from within their TeleSys database, or the intent is to extract from the Shared Data Warehouse (PM#2, PM#5), and the measures concerning the timeliness of critical incidents (PM#17, PM#17a) are housed within their SAMS database. After reviewing the query results and data source available, the DoAS has discovered that they are unable to report the numerator/denominator for PM#2 as initially defined. Per the MCO contract, MLTSS services are not provided prior to an individual's enrollment into MLTSS. DoAS is currently reviewing the results of queries that examine the number of members newly enrolled in MLTSS during the reporting period and then examining the number of members in the denominator that received MLTSS services as identified through encounters within the first nine months after enrollment. This review has a nine month lag in reporting to allow for encounter submission. It was also discovered that DoAS is unable to track the numerator and denominator as initially defined for PM#5. However, DoAS is monitoring the timeliness of the MCOs conducting the nursing facility level of care re-determinations. A query is run and provided to each MCO every two months identifying the MLTSS members that have not had a level of care (LOC) re-determination within the past 16-months. The MCOs are required to submit within a month the status of each member. Moving forward the DoAS is proposing to provide the MCO specific data identifying the total number of members for which DoAS does not have data identifying a LOC re-determination within the past 16-months; the number of assessments that were conducted and received by the State since report was developed; number of determinations that MCO reported were conducted but State did not received the date; number of members recommended for disenrollment due to inability to contact/voluntary disenrollment; and members who either expired or eligibility was termed.

Measures that are not included in this report may be a result of measures involved in review from New Jersey's EQRO or lag time allowing for receipt of claims related data.

Deliverables due during MLTSS 3rd quarter (1/1/2017 - 3/31/2017)

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

As per the Contract, MLTSS specific HCBS services are not provided prior to enrollment into MLTSS. Therefore, this measure has been revised to evaluate the percentage of enrollees who have received MLTSS specific HCBS services within the first nine months of enrollment. Individuals enrolled in a MCO without MLTSS enrollment are receiving state plan services through the continuity of care requirement. Services determined medically necessary are provided regardless of MLTSS enrollment. CM is received by all MLTSS enrollees; however, is not captured as a billable and reportable service via encounters. DoAS reported that for the period of 7/1/15 through 7/1/16 the percentage of MLTSS enrollees receiving MLTSS specific services (excluding the state plan services - PCA and MDC, and MLTSS CM) within nine months of enrollment was consistently in the range of 70 – 75% and the percentages for MLTSS services regardless of timeframes was in the range of 75-83%. For the period of 2/1/16 through 7/1/16, DoAS reported that the differential between the two timeframes decreased and was consistently with a 1 to 5 percent range of difference. Reportedly, there was a minimal increase in service utilization when the 9 month claim restriction was removed from the query. It was noted that an average of 73% of MLTSS enrollees are receiving the MLTSS specific services with the exclusions noted previously. This is a gross utilization measure and does not measure program effectiveness. This measure is being eliminated beginning July 1, 2017.

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	12/2016	1/2017	2/2017
Numerator	1022	964	1458
Denominator	1038	981	1469
%	98.0	98.0	99.0

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

Deliverables due during MLTSS 3rd quarter (1/1/2017 - 3/31/2017)

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

November 2016	A	B	C	D	E	TOTAL
Numerator	12	125	167	62	151	517
Denominator	13	128	168	68	172	549
%	92.0	97.7	99.0	91.2	87.8	94.2

December 2016	A	B	C	D	E	TOTAL
Numerator	17	100	149	45	157	468
Denominator	19	109	150	49	185	512
%	89.0	91.7	99.0	92.0	84.9	91.4

January 2017	A	B	C	D	E	TOTAL
Numerator	13	190	384	53	105	745
Denominator	14	192	410	67	193	876
%	93.0	99.0	94.0	79.0	54.4	85.0

The MCOs are monitoring the timeliness of level of care (LOC) assessments and have identified that some of the delays include: member requested rescheduled assessment, internal case reassignment, difficulty contacting member, member receiving rehabilitation in a skilled nursing facility with no definite discharge plan, staff reassignment, and unable to contact until after the 30 day deadline. In one reporting period a MCO reported that they had an untimely assessment due to the member transferring into rehab and the assessment being rescheduled when discharged from the rehab facility. Another MCO reported that members incurred delays with scheduling appointments due to unable to reach the member or personal representative. Another MCO reported that one member was hospitalized after the referral was received. MCO A reports they have made revisions to the referral process in order to reduce duplication and other errors of referral by revising the Interdepartmental Referral Workflow.

Deliverables due during MLTSS 3rd quarter (1/1/2017 - 3/31/2017)

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	11/2016	12/2016	1/2017
Numerator	603	684	619
Denominator	1065	1130	1127
%	57.0	61.0	55.0

The average percentage for this reporting period is 57.6%. 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)

DoAS has reported that they are unable to track the data as specified in the above measure. Therefore, they've implemented an alternate process to monitor the MCO's completion of MLTSS members' level of care re-determination. As described in the narrative at the beginning of this report, DoAS runs a query and generates a report that is submitted to the MCOs on a quarterly basis; frequency changed from every 2 months to allow sufficient time for the MCOs and DoAS to reconcile files. The below chart reflects the results of the most recent 16-month report.

Deliverables due during MLTSS 3rd quarter (1/1/2017 - 3/31/2017)

MCO	Total w/o reassessment within 16-mos	Conducted & rec'd by State since date of report	Conducted per MCO but not rec'd in State's clinical sys.	Reassessment not conducted	Member requires disenrollment from MLTSS	Member expired or Medicaid elig. termed
A	104	0	52	48	1	3
B	93	31	27	13	11	11
C	105	17	43	32	5	8
D	180	25	104	18	21	12
E	144	3	15	116	4	6
TOTAL	**627**	**76**	**241**	**227**	**42**	**40**

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	12/2016	1/2017	2/2017
Numerator	1040	981	1469
Denominator	1040	981	1469
%	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

Deliverables due during MLTSS 3rd quarter (1/1/2017 - 3/31/2017)

Measurement Period	12/2016	1/2017	2/2017
Numerator	613	566	927
Denominator	975	943	1524
%	63.0	60.0	61.0

The range of compliance was from 19% to 97% during this quarter. DoAS reports compliance percentage to each individual MCO. MCO are expected to ensure assessor staff are continually updated on the coding requirements to ensure choice of settings is documented on the IPOC as a result of the Options Counseling session.

PM # 8	Plans of Care (POC) established within 30-days of enrollment into MLTSS/HCBS
Numerator:	Number of records in the denominator that have a plan of care developed 30-days or less from MLTSS/HCBS enrollment date
Denominator:	HCBS records reviewed for members enrolled in MLTSS in the measurement year.
Data Source:	IPRO
Measurement Period:	Annual

7/1/15-6/30/16	A	B	C	D	E	Weighted Average
Numerator	32	72	84	75	39	**302**
Denominator	79	102	98	91	99	**469**
%	40.5	70.6	85.7	82.4	39.4	**64.4**

IPRO reported the overall rate (weighted average) for Groups C and D combined increased from 51.7% in the prior review period to 64.4% in the current review period. Four MCOs demonstrated an increase in this measure from the prior review period. MCO A does not have prior data for comparison. Individual MCO level results are as follows: MCO B's performance significantly increased from 55.0% to 70.6%, MCO C's performance significantly increased from 55.0% to 85.7%, MCO D's performance increased from 72.3% to 82.4%, MCO E's performance increased from 24.8% to 39.4%. The MCOs were required to submit a work plan to address rates less than 85%.

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

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 3rd quarter (1/1/2017 - 3/31/2017)

7/1/15-6/30/16	A	B	C	D	E	Weighted Average
Numerator	1	5	7	15	4	**32**
Denominator	2	5	8	16	4	**35**
%	50.0	100	87.5	93.8	100	**91.4**

The MCOs were required to submit a work plan to address rates less than 85%.

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

7/1/15-6/30/16	A	B	C	D	E	Weighted Average
Numerator	0	10	11	6	4	**31**
Denominator	7	11	16	10	10	**54**
%	0.0	90.9	68.8	60.0	40.0	**57.4**

The MCOs were required to submit a work plan to address rates less than 85%.

PM #10	POC are aligned with member's needs based on the results of the NJ Choice Assessment
Numerator:	Number of records in the denominator where the POC aligned with member's needs based on NJ Choice results, including type, scope, amount, frequency, and duration.
Denominator:	Total number of MLTSS records selected for review during measurement year.
Data Source:	IPRO
Measurement Period:	Annual

7/1/15-6/30/16	A	B	C	D	E	Weighted Average
Numerator	43	97	92	80	88	**400**
Denominator	46	98	96	81	89	**410**
%	93.5	99.0	95.8	98.8	98.9	**97.6**

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

IPRO reported that the overall rate for groups C and D combined increased from 92.5% in the prior review period to 97.6% in the current review period. Four MCOs demonstrated an increase in this measure from the prior review period. MCO A does not have prior data for comparison. Individual MCO level results are as follows: MCO B's performance increased from 96.0% to 99.0%, MCO C's performance increased from 86.6% to 95.8%, MCO D's performance increased from 90.6% to 98.8%, MCO E's performance increased from 96.8% to 98.9%. The MCOs were required to submit a work plan to address rates less than 85%.

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

7/1/15-6/30/16	A	B	C	D	E	Weighted Average
Numerator	4	53	72	48	32	**209**
Denominator	79	102	98	91	99	**469**
%	5.1	52.0	73.5	52.7	32.3	**44.6**

IPRO reported that the overall rate for groups C and D combined decreased from 61.3% in the prior review period to 44.6% in the current review period. In order to be compliant with Performance Measure #11 in the current review period, the MCO needed to show evidence that the Plan of Care (POC) was completed, signed and given to the member and/or authorized representative. Documentation should have also demonstrated that the member was present at the time of POC development, that the member and/or authorized representative were involved in the goal setting, and in agreement with established goals. Two MCOs demonstrated an increase while two MCOs showed a decrease in the measure from the prior review period.
Individual MCO level results are as follows: MCO A does not have prior data for comparison. MCO B's performance significantly decreased from 97.0% to 52.0%, MCO C's performance increased from 71.4% to 73.5%, MCO D's performance decreased from 65.7% to 52.7%, MCO E's performance significantly increased from 10.3% to 32.3%. The MCOs were required to submit a work plan to address rates less than 85%.

PM #12	MLTSS/HCBS POC that contain a back-up plan.
Numerator:	Number of records in the denominator in which the POC contained a back-up plan.
Denominator:	Total number of MLTSS records selected for review during measurement year.
Data Source:	IPRO
Measurement Period:	Annual

Deliverables due during MLTSS 3rd quarter (1/1/2017 - 3/31/2017)

7/1/15-6/30/16	A	B	C	D	E	Weighted Average
Numerator	18	57	63	46	72	**256**
Denominator	56	68	69	51	85	**329**
%	32.1	83.8	91.3	90.2	84.7	**77.8**

IPRO reported that the overall rate for groups C and D combined decreased from 83.0% in the prior review period to 77.8% in the current review period. The denominator for this measure excluded cases where no Back-up Plan was provided and documentation was submitted showing that the member was residing in a Nursing Facility or Community Alternative Residential Setting (CARS). In addition, members were excluded if they were not receiving any of the following HCBS services: Home Base Supportive Care, including participant directive services; In-home respite, Skilled Nursing; and/or Private Duty Nursing. Three of the four MCOs demonstrated an increase in this measure from the prior review period. Individual MCO level results are as follows: MCO A does not have prior data for comparison; MCO B's performance decreased from 94.9% to 83.8%; MCO C's performance increased from 75.9% to 91.3%; MCO D's performance increased from 83.1% to 90.2%; and MCO E's performance increased from 78.7% to 84.7%. The MCOs were required to submit a work plan to address rates less than 85%.

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

7/1/15-6/30/16	A	B	C	D	E	Weighted Average
Numerator	7	101	90	81	1	**280**
Denominator	79	102	98	91	99	**469**
%	8.9	99.0	91.8	89.0	1.0	**59.7**

This was the first year that that EQRO captured this data; therefore no comparison to year one of MLTSS. The MCOs were required to submit a work plan to address rates less than 85%.

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

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

Deliverables due during MLTSS 3rd quarter (1/1/2017 - 3/31/2017)

Measurement Period	12/2016	1/2017	2/2017
Numerator	251	308	294
Denominator	252	309	295
%	99.6	99.7	99.6

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. Two MCOs fell below this threshold during this reporting period and have provided DoAS with acceptable action plans.

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

Measurement Period	12/2016	1/2017	2/2017
Numerator	7	6	7
Denominator	7	6	7
%	100	100	100

DoAS reported that they will analyze data to determine trends in CI reporting and identify strategies to improve the timeliness by the MCOs. They will take into account variations between MCO enrollment, i.e. number of reports per 1,000, and other factors to ensure comparisons are fair and equitable. DoAS has determined that established procedures for reporting seem to be sufficient.

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

Deliverables due during MLTSS 3rd quarter (1/1/2017 - 3/31/2017)

Appeals and Grievances (Table 3A)

10/1/2016 12/31/2016	A	B	C	D	E	TOTAL
Numerator	3	14	51	32	14	114
Denominator	3	14	51	32	14	114
%	100	100	100	100	100	**100**

Complaints (Table 3B)

10/1/2016 12/31/2016	A	B	C	D	E	TOTAL
Numerator	4	29	84	9	2	128
Denominator	5	29	84	9	2	129
%	80	100	100	100	100	**99.2**

MCO A reported that one complaint took 31 days to resolve, one day longer than required.

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

4/1/16-6/30/16	A	B	C	D	E	TOTAL
Numerator	594	3874	9384	5533	3580	22965
Denominator	771	4978	14034	6022	3669	29474
%	77.0	77.8	67.0	92.0	97.6	77.9

7/1/15 – 6/30/16	A	B	C	D	E	TOTAL
Numerator	713	4792	14792	6597	3950	30844
Denominator	890	6053	16227	7177	4057	34404
%	80.1	79.2	91.0	92.0	97.4	89.7

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 initiated a delay in the initial face to face visit, potentially delaying services. Members refusing services and members choosing care management still appeared in the denominator but would not be captured within the numerator. Also, the MCOs will be taking a closer look at members that may have dis-enrolled a short time after enrollment. The members identified as enrolled, eligible and not receiving services will be targeted for care management contact and recurrent options counseling, in order to increase the percentage in this measure. One MCO reported that members who decline services remain the top reason for members presenting without services. Additionally, 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:	# of MLTSS NF (SPC 61, 63, 64) members identified in the denominator who transitioned from a NF to the community (SPC 60, 62) at any time during the measurement period
Denominator:	# of MLTSS members with the living arrangement of NF (SPC 61, 63, 64) at any time during the measurement period (quarter or annual) and continuously enrolled in MCO.
Data Source:	MCO – living arrangement file and client tracking system
Measurement Period:	Quarterly/Annually – Due: 30 days after the quarter and year

10/1/2016-12/31/2016	A	B	C	D	E	TOTAL
Numerator	N/A	N/A	N/A	N/A	N/A	N/A
Denominator	N/A	N/A	N/A	N/A	N/A	N/A
%	N/A	N/A	N/A	N/A	N/A	N/A

Due to the EQRO validation process there was refinement to the PM specification, and as a result the MCOs had to revise the coding. Therefore, an extension was granted for this measurement period and will be included in the next quarterly report.

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

Deliverables due during MLTSS 3rd quarter (1/1/2017 - 3/31/2017)

7/1/16-9/30/16	A	B	C	D	E	TOTAL
Numerator	0	0	10	1	0	11
Denominator	3	8	110	49	2	172
%	0.0	0.0	10.0	2.0	0.0	6.4

MCOs are monitoring the reasons for MLTSS members' readmission to the NF. MCO C identified members returning to the Nursing Facility at the member's request, family's request, or because member's needs were not able to be met in the community due to lack of informal supports or the need for increased therapeutics for members that had a functional decline. Additionally, MCO C had identified one member with a pattern of transitioning back to the Nursing Facility after the respite benefit was exhausted and as a result, the Care Manager and Family member were educated by the MLTSS Supervisor. MCO E had identified members who returned to the facility who may not have had the proper family/other support in place and has implemented processes that include those individuals in all IDTs. MCO A added a member advocate role into the NF transition care team. This position provides support to members who have transitioned to the home setting, to make sure they have the resources they need to stay in the community home setting. Additionally, 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	# of MLTSS HCBS members transitioned from the community to NF for greater than 180 days
Numerator:	# of unique MLTSS HCBS members in the denominator who were still in the NF greater than 180 days during the measurement period
Denominator:	Quarterly: # of unique MLTSS HCBS members that transitioned from the community to NF during the measurement quarter Annually: Total # of unique MLTSS HCBS members that transitioned from the community to NF during the state fiscal year 7/1-6/30
Data Source:	MCO -Living arrangement file, CM tracking and prior auth system (r/o respite/rehab). MCO to identify how the dates were calculated
Measurement Period:	Quarterly/Annually Lag Report Due: 210 day lag after quarter and year

4/1/2016 – 6/30/2016	A	B	C	D	E	TOTAL
Numerator	27	40	148	90	36	341
Denominator	30	41	184	105	57	417
%	90.0	97.6	80.0	85.7	63.2	81.8

7/1/15 – 6/30/16	A	B	C	D	E	TOTAL
Numerator	4	152	258	277	85	776
Denominator	14	163	318	321	146	962
%	29.0	93.3	81.0	86.0	58.2	80.7

The MCOs are monitoring the success of transitions to determine results. MCO E reports they use findings to assist in developing a strategic plan aimed at increasing NF transitions and preventing long term institutionalization. The MLTSS custodial census will continue to be monitored for length of stay to review the clinical status of members during timeframes of short stay to facilitate timely transition whenever possible. Another MCO reports that in reviewing the

data, the top referral source for the NF admit were family members and the second highest were Facility referrals. MCOs are reviewing transitions from HCBS to NF to identify reasons for members that returned to the nursing facility.

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

4/1/16 – 6/30/16	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	3	1	36	15	21	76
Denominator	30	41	184	105	57	417
%	10.0	2.4	20.0	14.3	36.8	18.2

7/1/15 - 6/30/16	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	10	11	60	44	61	186
Denominator	14	163	318	321	146	962
%	71.0	6.8	19.0	14.0	41.8	19.3

MCOs report they are continuing to track and trend transitions into the NF to confirm that appropriate community to NF transitions are occurring. MCO A reported they work closely with providers, members, and families during these transitions into the Nursing Facility. The MLTSS Case Manager continues to visit and places a NF Contact Information Sheet on each chart. This form provides direct numbers for care manager and MLTSS support personnel. The form requests a call for any hospitalization, change in status, Critical Incident, or planned case conference. MCO B reports that the average stay in the NF amongst the population in this performance measure is 82 days. MCO D reports that they noticed that some of the placements were of a very short duration. MCO E reports the percentage was significantly less than the prior period, from 58.33% to 36.84%. Additionally, for the nursing facilities identified, there were no trends and none of them had more than 1 member during the measurement period.

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

4/1/16 – 6/30/16	A	B	C	D	E	TOTAL
Numerator	17	361	735	220	473	1806
Denominator	696	8021	25911	10279	7786	52693
%	2.4	4.5	2.8	2.1	6.1	3.4

7/1/15 – 6/30/16	A	B	C	D	E	TOTAL
Numerator	42	1206	2700	744	1383	6075
Denominator	1760	28811	95551	38976	23083	188181
%	2.4	4.2	2.8	1.9	6.0	3.2

Data for this measure is captured on a monthly basis and the numerators are added together and the denominators are added together to report quarterly data reflecting the number of hospitalizations that occurred per member month. It is based on hospital events and not unduplicated members. The top diagnosis for hospital admission include: heart failure, sepsis/septicemia, end stage renal disease, pneumonia, acute kidney failure, UTI, COPD, essential hypertension, hypo-osmolality, hyponatremia and, encephalopathy. MCO D reported they have been tracking and trending hospitalizations for this population, including members over 65 years of age, and hospitalizations of members with multiple admissions. Additionally, MCO D reported that one member was admitted five times during the quarter for complications from Diabetes Type 2. The MCOs report their member level detail will be reviewed to provide greater specificity and to examine trends to evaluate the effectiveness of their work process and where to institute improvements. MCO D reports the MLTSS Case Management department supports continuity of care by following up with members post discharge to ensure that the member and care providers understand the discharge plan and follow up appointments are scheduled. MCO D also reports that they confirm that necessary MLTSS services are in place and make changes to the care plan if a change in condition is observed.

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

Deliverables due during MLTSS 3rd quarter (1/1/2017 - 3/31/2017)

4/1/16 – 6/30/16	A	B	C	D	E	TOTAL
Numerator	53	174	318	161	123	829
Denominator	1305	5322	12464	6255	2368	27714
%	4.1	3.3	2.6	2.6	5.2	3.0

7/1/15 – 6/30/16	A	B	C	D	E	TOTAL
Numerator	123	548	1097	503	343	2614
Denominator	3391	15472	39265	19446	6540	84114
%	3.6	3.5	2.8	2.6	5.2	3.1

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 were related to sepsis, acute kidney failure, pneumonia, renal failure, pulmonary disease, infections, GI disorders, encephalopathy, pressure ulcers, urinary tract infections and metabolic disorders. MCO E reports that they have been tracking and trending hospitalizations by location and plan to use findings to develop strategic initiatives to facilitate continued reduction in preventable hospitalizations.

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

4/1/16 – 6/30/16	A	B	C	D	E	TOTAL
Numerator	0	48	91	116	86	341
Denominator	17	361	761	220	473	1832
%	0	13.3	12.0	52.7	18.2	18.6

7/1/15 – 6/30/16	A	B	C	D	E	TOTAL
Numerator	1	107	320	371	263	1062
Denominator	39	1206	2725	729	1383	6082
%	2.6	8.9	12.0	50.9	19.0	17.5

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 end stage renal disease, acute kidney failure, sepsis, urinary tract infection, and acute congestive heart failure. MCO E reported that the readmission rate increased by 23.58% over the prior reporting period (18.18% as compared to 14.07% or 48/341). The increase is partially attributable to multiple readmissions for the same member. Ten members had 2 readmissions; five members with 3 readmissions; one member experienced 5 readmissions and one member experienced 9 readmissions. The member with 9 readmissions was hospitalized for complications of end-stage renal failure. MCO D reports overall, 13.8% (16/116) of re-admissions were made up of members that were readmitted greater than one time. Of the 116 re-admissions, there were 84 unique members, of which 19% (16/84) had greater than 1 admission. Additionally MCO D reports of the 84 unique members that were readmitted, 79.9% (67/84) were identified as dual eligible and 17.8% (15/84) were identified Medicaid only. Of the 16 unique members with greater than one re-admission, 68.7% (11/16) were identified as dual eligible and 31.2% (5/16) were identified as Medicaid only.

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

4/1/16 – 6/30/16	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	4	12	41	54	13	124
Denominator	26	174	325	161	123	809
%	15.4	6.9	13.0	33.5	10.6	15.3

7/1/15 – 6/30/16	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	4	41	130	143	49	367
Denominator	55	548	1105	494	343	2545
%	7.3	7.5	12.0	28.9	14.3	14.4

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 the leading diagnoses for readmissions in this measure are gastrointestinal issues (gastritis and constipation), cerebral infarct, and end stage renal disease. MCO A also reports they will continue to monitor admissions and readmissions based on claims data. Additionally, Care Managers have a NF Contact Sheet that is placed on the custodial members' charts, requesting the NF to notify the CM directly with any admission, critical incident, or change in condition. MCO C reports that the top diagnoses for MLTSS NF members being readmitted are unspecified sepsis and chronic obstructive pulmonary disease. MCO D reported that the MLTSS Case Management department supports continuity of care by following up with members post discharge to ensure that the member and care providers understand the discharge plan and follow up appointments are scheduled. Additionally, they report the confirmation of necessary MLTSS services are in place and make changes to the care plan if a change in condition to the member is observed.

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

4/1/16 – 6/30/16	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	55	709	1424	433	554	1875
Denominator	696	8021	25911	10279	7786	52693
%	7.9	8.8	5.5	4.1	7.1	3.6

7/1/15 – 6/30/16	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	131	2330	5025	1695	1660	10841
Denominator	1760	28811	95551	38976	23083	188181
%	7.4	8.1	5.3	4.3	7.2	5.8

Data for this measure is captured on a monthly basis and the numerators are added together and the denominators are added together to report quarterly data reflecting the number of ER utilizations that occurred per member month. It is based on ER utilization events and not unduplicated members. The diagnoses across all MCOs include: urinary tract infection, head injury, abdominal pain, low back pain, headache, epistasis, retention of urine, essential hypertension, chest pain, diabetes, and syncope and collapse. MCO C reports that there was a slight increase in the percentage of MLTSS HCBS members being seen in the Emergency Room; however, the overall diagnoses remain consistent. MCO E reports that one member made 29 trips to the emergency department, 13 of which were for alcohol related intoxication with injury. MCO E has identified their top multiple ED utilizations by location and reports that information regarding members with multiple ED visits was shared individually with managers for immediate follow up and is in development of a plan to prevent recurrence. Additionally, one site Care Manager will be placed on location to specifically address frequent ED utilization and hospital recidivism. Findings will be shared with managers and staff to develop a strategic ED use reduction plan.

Deliverables due during MLTSS 3rd quarter (1/1/2017 - 3/31/2017)

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

4/1/16 – 6/30/16	A	B	C	D	E	TOTAL
Numerator	51	196	292	171	76	786
Denominator	1305	5322	12464	6255	2368	27714
%	3.9	3.7	2.3	2.7	3.2	2.8

7/1/15 – 6/30/16	A	B	C	D	E	TOTAL
Numerator	155	653	988	509	237	2042
Denominator	3391	15472	39265	19446	6540	84114
%	4.5	4.2	2.5	2.6	3.6	2.4

MCOs are monitoring their respective data to determine trends by facility and develop ongoing prevention strategies especially those with multiple ER visits. MCO E reports that in the 4th quarter of those 76 occurrences, 54 were for members 65 years of age or older and 9 members had two ED visits each. Additionally, during the 4th quarter MCO E reports that ED utilization for nursing facility members decreased slightly again this measurement from 3.77% in the prior quarter to 3.20 % and this downward trend has been sustained over 3 prior quarters. MCO A reports the most frequent diagnosis was gastrostomy related issues and was noted in 4 of the 51 cases of ER utilization during the 4th quarter period. The other two most frequent reasons for ER visits were identified as: syncope/collapse and unspecified injury of head. Additionally, MCO A views the ED claims during member file review, and monitors ER reports allowing decreased response times for addressing ED visits that indicate a possible fall or other critical incident.

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

Deliverables due during MLTSS 3rd quarter (1/1/2017 - 3/31/2017)

1/1/16 – 6/30/16	A	B	C	D	E	TOTAL
Numerator	61	666	33	378	948	2086
Denominator	282	3400	13559	4033	3043	24317
%	21.6	19.6	0.2	9.4	31.2	8.6

The MCOs will continue to monitor this data for trends. MCO C reports that in reviewing the data, of the members that only had PCA services, there were 29 (88%) that were receiving their PCA services through the self-directed program and 4 (22%) that were receiving their services from a PCA provider. The amount of PCA services authorized ranged from 12 hours/week to 40 hours/week, with the average hours being 25. MCO E reports that the percentage of members receiving only PCA services had a significant increase from the previous measurement period where the reported percentage was 22.00%. Additionally, they report there has been a significant increase in program membership which can be seen in the increase in the number of members reported in the denominator in this semi-annual submission, where there were 3043 members identified, in comparison to 1977 in the last review of the measure. There has also been an increase in the total number of members requesting PCA only. MCO C reports that they are going to start reviewing this report monthly to identify if members need to be reassessed for MLTSS appropriateness, and if additional services are required. MCO E reports that they continue with on-going monitoring of the services on a case by case basis during managers one-to-one reviews to assess appropriateness of additional services that may be beneficial in helping maintain members safely at home.

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

1/1/16 – 6/30/16	A	B	C	D	E	TOTAL
Numerator	9	246	37	46	397	735
Denominator	282	3400	13559	4033	3043	24317
%	3.2	7.2	0.3	1.1	13.0	3.0

The MCOs will continue to monitor this data for trends. MCO E reports that the percentage of members receiving only MDC services has increased significantly from the previous submission (4.40% to 13.04%) in this review period. While the increase in percentage may be related to the continuous growth of the membership, there were a much larger number of members that only had MDC services based on member preference. MCO D reports that there were 971 medical day care visits for those 46 members and the results are very similar compared to the prior submissions. Additionally, MCO D reports they provide care managers with list of MLTSS members whose only claimed service is medical day care to ensure the care plan and level of care are accurate. MCO D reported 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 # 35	MLTSS HCBS members who received face-to-face follow-up with a MH professional within 7-days of hospitalization for mental illness (for selected DSM V Diagnoses: 295,296,297,298,299,300,301,302,307,308,309,311,312,313,314 and all sub-codes)
Numerator:	# of unique hospitalizations defined as unique combination of provider/HCBS patient/service date during measurement year with one of the mental illness diagnoses listed above and followed by a f2f visit with a MH professional within 7-days of discharge date.
Denominator:	# of unique hospitalizations defined as unique combination of provider/HCBS patient/service date during measurement period with one of the above mental illness diagnoses.
Data Source:	MCO claims data
Measurement Period:	Annually Due:240 day Lag Report after end of reporting period

7/1/15 – 6/30/16	A	B	C	D	E	TOTAL
Numerator	1	4	8	0	9	22
Denominator	1	7	9	0	10	27
%	100	57.1	89.0	0	90.0	81.5

MCOs are reporting some challenges in obtaining this data due to dual eligible members and limited access to Medicare claims. MCO C reports that of the 9 members that had an acute inpatient hospitalization with mental illness, 8 (89%) had a face to face follow up with a mental health professional within 7 days. Additionally, 1 member left the hospital against medical advice and refused outpatient follow up. MCO E reported that of the 10 reported admissions during the measurement period, there were 8 unique HCBS members identified, 3 of which were age 65 or older at the time of admission. Review of the individual member status showed there are 7, out of the 8 unique members reported, currently still active in the plan. There was 1 member identified to have presented with 3 admissions for mental health illness who is also still enrolled in the plan. There was 1 member who did not have a follow up with a mental health provider per review of claims, notes and authorizations. While CM attempted to contact the member on numerous occasions for routine care management, there was no notification to the plan of the member's IP status, and member was unable to be contact during the time.

The diagnoses reported were: schizophrenia (unspecified and chronic paranoid type, paranoid) (4), bipolar disorder (1), bipolar 1 disorder/depressed with psychotic behavior (1), schizoaffective disorder (unspecified and chronic) (2), depressive disorder (1), major depressive disorder (1). The overall rate in compliance of 7 day follow up post a mental health admission has improved in comparison to the previous year, where the rate was reported at 50% with 3 out of 6 admissions meeting the criteria for inclusion in the measure for SFY2015. While the membership has doubled in size, the continuous monitoring of the mental health admissions by the behavioral health team has been instrumental in identifying members and assisting with the discharge planning as well as the post discharge follow up with their mental health provider. MCOs report they are continuing to monitor.

PM # 36	MLTSS HCBS members who received face-to-face follow-up with a MH professional within 30-days of hospitalization for mental illness (for selected DSM V Diagnoses: 295,296,297,298,299,300,301,302,307,308,309,311,312,313,314 and all sub-codes)
Numerator:	# of unique hospitalizations defined as unique combination of provider/HCBS patient/service date during measurement year with one of the mental illness diagnoses listed above and followed by a f2f visit with a MH professional within 7-days of discharge date.
Denominator:	# of unique hospitalizations defined as unique combination of provider/HCBS patient/service date during measurement period with one of the above mental illness diagnoses.
Data Source:	MCO claims data
Measurement Period:	Annually Due:240 day Lag Report after end of reporting period

Deliverables due during MLTSS 3rd quarter (1/1/2017 - 3/31/2017)

7/1/15 – 6/30/16	A	B	C	D	E	TOTAL
Numerator	1	7	8	0	9	26
Denominator	1	7	9	0	10	27
%	100	100	88.8	0	90.0	96.3

MCOs are reporting some challenges in obtaining this data due to dual eligible members and limited access to Medicare claims. MCO E reported that out of the 10 reported admissions during the measurement period, there were 8 unique HCBS members identified, 3 of which were age 65 or older at the time of admission. Review of the individual member status showed there are 7, out of the 8 unique members reported, currently still active in the plan. There was 1 member identified to have presented with 3 admissions for mental health illness who is also still enrolled in the plan. There was 1 member who did not have a follow up with a mental health provider per review of claims, notes and authorizations. While CM attempted to contact member on numerous occasions for routine care management, there was no notification to the plan of the member's IP status, and member was unable to be contacted. The diagnoses reported were: schizophrenia (unspecified and chronic paranoid type, paranoid) (4), bipolar disorder (1), bipolar 1 disorder/depressed with psychotic behavior (1), schizoaffective disorder (unspecified and chronic) (2), depressive disorder (1), major depressive disorder (1). Additionally MCO E reported that the Behavioral Health team will continue to monitor and review the Inpatient BH admission queue for notification and member follow up. MCO A reported that 1 member was hospitalized with an admitted diagnosis of major depressive disorder. Additionally, care managers will be reminded on a regular basis that any inpatient psychiatric care must be followed up within timeframe for outpatient visits to a Behavioral Health provider. MCO A also reports that they will work with Network Management to educate providers to submit claims for BH services for MLTSS members, even if the plan is the payer of last resort. MCOs report they are continuing to monitor and some are working with their behavior health administrator and staff to track hospital admissions and to ensure follow-up care.

PM # 37	MLTSS NF members who received face-to-face follow-up with a MH professional within 7-days of hospitalization for mental illness (for selected DSM V Diagnoses: 295,296,297,298,299,300,301,302,307,308,309,311,312,313,314 and all sub-codes)
Numerator:	# of unique hospitalizations defined as unique combination of provider/NF patient/service date during measurement year with one of the mental illness diagnoses listed above and followed by a f2f visit with a MH professional within 7-days of discharge date.
Denominator:	# of unique hospitalizations defined as unique combination of provider/NF patient/service date during measurement period with one of the above mental illness diagnoses.
Data Source:	MCO claims data
Measurement Period:	Annually Due:240 day Lag Report after end of reporting period

7/1/15 – 6/30/16	A	B	C	D	E	TOTAL
Numerator	0	5	5	0	4	14
Denominator	2	12	9	0	4	27
%	0.0	41.7	56.0	0.0	100.0	51.9

MCOs are reporting some challenges in obtaining this data are due to dual eligible members and limited access to Medicare claims. MCO C reported that of the 9 members that had an acute inpatient hospitalization for mental illness, 5 (56%) had a follow up in the Nursing Facility within 7 days of discharge by a mental health provider. Out of the 4 members, 1 (25%) refused follow up. Three members (75%) were discharged to a nursing facility with no evidence of follow up and no documented reason for the lack of follow up by a mental health care provider. Additionally, MCO C reported that BH Utilization Management and Care Management staff were re-educated on the requirements of follow up visits post discharge and that moving forward new guidelines for performance measures

will be instituted. MCO E reported that during the measurement period there were 4 mental health inpatient admissions reported for nursing facility members. All members included in the review, four have evidence of a follow up with a mental health professional within 7 days of discharge. There were 4 unique members identified, 1 member was 59 yrs. old while the other 3 were 65 and older at the time of admission. MCOs report they are continuing to monitor and some are working with their behavioral health administrator and staff to track hospital admissions and to ensure follow-up care.

PM # 38	MLTSS NF members who received face-to-face follow-up with a MH professional within 30-days of hospitalization for mental illness (for selected DSM V Diagnoses: 295,296,297,298,299,300,301,302,307,308,309,311,312,313,314 and all sub-codes)
Numerator:	# of unique hospitalizations defined as unique combination of provider/NF patient/service date during measurement year with one of the mental illness diagnoses listed above and followed by a f2f visit with a MH professional within 7-days of discharge date.
Denominator:	# of unique hospitalizations defined as unique combination of provider/NF patient/service date during measurement period with one of the above mental illness diagnoses.
Data Source:	MCO claims data
Measurement Period:	Annually Due:240 day Lag Report after end of reporting period

7/1/15 – 6/30/16	A	B	C	D	E	TOTAL
Numerator	0	6	7	0	4	17
Denominator	2	12	9	0	4	27
%	0.0	50.0	78.0	0.0	100.0	63.0

MCOs are reporting some challenges in obtaining this data due to dual eligible members and limited access to Medicare claims. MCO C reported after review of individual files for the 4 NF members the admitting diagnosis as: factitious disorder, schizophrenia (unspecified), suicide attempt, and episodic mood disorder. All 4 members are currently actively enrolled in the plan and continue to reside in a NF setting. Additionally, all members included in the review (4) have evidence of a follow up with a mental health professional within 30 days of discharge. The admissions were reported for the months of August 2015, February, April and June of 2016, with 1 admission for each month. There were 4 unique members identified, 1 member was 59 years old while the other 3 were 65 and older at the time of admission. MCO D reported that there were 11 NF members who were hospitalized during the measurement year with a mental health diagnosis, and met all of the criteria as detailed in the measure; however, these 11 members were readmitted in to a non-acute facility within thirty days of their discharge. MCOs report they are continuing to monitor and some are working with their behavioral health administrator and staff to track hospital admissions and to ensure follow-up care.

PM # 39	MLTSS HCBS members with a selective behavioral health diagnoses (DSM V Diagnoses: 292,295,296,297,298,299,300,301,302,303,304,305,307,308,309,311,312,313,314 and all sub-codes)
Numerator:	# of MLTSS unique HCBS members with selective behavioral health diagnoses during the measurement year
Denominator:	# of unique MLTSS HCBS members eligible anytime during the measurement year (HCBS living arrangement on date of service)
Data Source:	MCO claims data
Measurement Period:	Annually Due:210 day Lag Report after end of reporting period

Deliverables due during MLTSS 3rd quarter (1/1/2017 - 3/31/2017)

7/1/15 – 6/30/16	A	B	C	D	E	TOTAL
Numerator	52	1759	508	2334	515	5168
Denominator	319	4315	11689	4592	3301	24216
%	16.0	40.8	4.3	50.8	15.6	21.3

MCOs report they used claims payment system to identify which is limited 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 C reported that the percentage of HCBS members with a mental health diagnosis is significantly higher than the percentage of members with a substance abuse diagnosis. Overall, the percentage of NF members with a BH diagnosis is higher than the percentage for community based members. MCO E reported that the top 5 diagnosis identified were: major depressive disorder with a single episode (96 members), major depressive disorder with recurrent episode (65 members), anxiety disorder (65 members), bipolar disorder/major depressive affective disorder (63 members), adjustment disorder with anxiety (51 members), and unclassified depressive disorder (49 members). The data reported in this measurement period has nearly doubled in the denominator which correlates with the increase membership growth that the plan has seen over the past year which went from 1613 to 3301. However, the numerator has increased only slightly from the previous submission of 472 members to the current 515. Therefore, there has been overall decrease in the rate of members presenting with a BH diagnosis in an HCBS setting from 29.26% to 15.60%. The MCOs will continue to monitor.

PM # 40	MLTSS NF members with a selective behavioral health diagnoses (DSM V Diagnoses: 292,295,296,297,298,299,300,301,302,303,304,305,307,308,309,311,312,313,314 and all sub-codes)
Numerator:	# of MLTSS unique NF members with selective behavioral health diagnoses during the measurement year
Denominator:	# of unique MLTSS NF members eligible anytime during the measurement year (HCBS living arrangement on date of service)
Data Source:	MCO claims data
Measurement Period:	Annually Due:210 day Lag Report after end of reporting period

7/1/15 – 6/30/16	A	B	C	D	E	TOTAL
Numerator	220	1387	593	2218	367	4785
Denominator	574	2658	6402	2993	1059	13686
%	38.3	52.2	9.3	74.1	34.7	35.0

MCOs report they used claims payment system to identify which is limited 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 38.3 percent of the NF residents in MLTSS had evidence of the applicable mental health diagnosis codes. The most predominant diagnosis of depressive disorder accounted for 48% of all behavioral health diagnoses reported (110 of 220). Additionally MCO A reports that they review these specific reports with the Behavioral Health Administrator in order to ensure that member BH needs are monitored and appropriate assessments and interventions are in place. They will also continue to monitor NF residents for PASRR I and II, as appropriate, and ensure that care managers and Nursing Facilities are aware of the S-COPE resource available for MH issues in the institutionalized elderly. Also, the BH administrator and the member's individual case manager will work closely with the facility and other participants of the member's care to ensure there is continuity and coordination with the member's behavioral health and physical health needs. Difficult or high intensity cases will be discussed utilizing a multidisciplinary team approach to discuss and determine appropriate services. MCOs will continue to monitor.

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

1/1/16 – 6/30/16	A	B	C	D	E	TOTAL
Numerator	8	162	4	485	560	1219
Denominator	282	3400	13559	4033	3043	24317
%	2.8	4.8	0.0	12.0	18.4	5.0

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

Deliverables due during MLTSS 3rd quarter (1/1/2017 - 3/31/2017)

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:	October-December 2016

	MCO	A			B			C			D			E			Quarter - TOTAL		
	Participant Safeguards:	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
18	Critical Incident (CI) reporting Types:																		
a	Unexpected death of a member	0	7	0	1	90	**1.1**	4	456	**0.8**	4	106	**3.8**	2	33	**6.1**	11	692	**1.6**
b	Media involvement or the potential for media involvement	1	7	**14.3**	4	90	**4.4**	0	456	0	2	106	**1.9**	1	33	**3.0**	8	692	**1.2**
c	Physical abuse (including seclusion and restraints both physical and chemical)	0	7	0	2	90	**2.2**	7	456	**1.5**	3	106	**2.8**	0	33	0	12	692	**1.7**
d	Psychological / Verbal abuse	0	7	0	0	90	0	0	456	0	0	106	0	0	33	0	0	692	0
e	Sexual abuse and/or suspected sexual abuse	0	7	0	0	90	0	0	456	0	1	106	**0.9**	0	33	0	1	692	**0.1**
f	Fall resulting in the need for medical treatment	5	7	**71.4**	30	90	**33.3**	132	456	**28.9**	32	106	**30.2**	18	33	**54.5**	217	692	**31.4**
g	Medical emergency resulting in need for medical treatment	0	7	0	1	90	**1.1**	211	456	**46.3**	13	106	**12.3**	11	33	**33.3**	236	692	**34.1**
h	Medication error resulting in serious consequences	0	7	0	0	90	0	1	456	**0.2**	2	106	**1.9**	0	33	0	3	692	**0.4**
i	Psychiatric emergency resulting in need for medical treatment	0	7	0	1	90	**1.1**	10	456	**2.2**	0	106	0	0	33	0	11	692	**1.6**

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

Deliverables due during MLTSS 3rd quarter (1/1/2017 - 3/31/2017)

j	Severe injury resulting in the need for medical treatment	0	7	0	3	90	**3.3**	8	456	**1.8**	7	106	**6.6**	0	33	0	18	692	**2.6**
k	Suicide attempt resulting in the need for medical attention	0	7	0	0	90	0	3	456	**0.7**	1	106	**0.9**	0	33	0	4	692	**0.6**
l	Neglect/Mistreatment, caregiver (paid or unpaid)	0	7	0	4	90	**4.4**	4	456	**0.8**	4	106	**3.8**	0	33	0	12	692	**1.7**
m	Neglect/Mistreatment, self	0	7	0	0	90	0	6	456	**1.3**	0	106	0	0	33	0	6	692	**0.9**
n	Neglect/Mistreatment, other	0	7	0	0	90	0	2	456	**0.4**	0	106	0	0	33	0	2	692	**0.3**
o	Exploitation, financial	0	7	0	0	90	0	1	456	**0.2**	0	106	0	0	33	0	1	692	**0.1**
p	Exploitation, theft	0	7	0	2	90	**2.2**	4	456	**0.8**	0	106	0	0	33	0	6	692	**0.9**
q	Exploitation, destruction of property	0	7	0	0	90	0	0	456	0	0	106	0	0	33	0	0	692	0
r	Exploitation, other	0	7	0	0	90	0	1	456	**0.2**	0	106	0	0	33	0	1	692	**0.1**
s	Theft with law enforcement involvement	0	7	0	1	90	**1.1**	2	456	**0.4**	0	106	0	0	33	0	3	692	**0.4**
t	Failure of member's Back-up Plan	1	7	**14.3**	0	90	0	3	456	**0.7**	0	106	0	0	33	0	4	692	**0.6**
u	Elopement/Wandering from home or facility	0	7	0	4	90	**4.4**	6	456	**1.3**	2	106	**1.9**	0	33	0	12	692	**1.7**
v	Inaccessible for initial/on-site meeting	0	7	0	12	90	**13.3**	0	456	0	21	106	**20.0**	0	33	0	33	692	**4.8**
w	Unable to Contact	0	7	0	9	90	**10.0**	17	456	**3.7**	6	106	**5.7**	0	33	0	32	692	**4.6**
x	Inappropriate or unprofessional conduct by a provider involving member	0	7	0	1	90	**1.1**	26	456	**5.7**	0	106	0	1	33	0	28	692	**4.0**
y	Cancellation of utilities	0	7	0	0	90	0	0	456	0	0	106	0	0	33	0	0	692	0
z	Eviction/loss of home	0	7	0	2	90	**2.2**	6	456	**1.3**	0	106	0	0	33	0	8	692	**1.2**
aa	Facility closure, with direct impact to member's health and welfare	0	7	0	2	90	**2.2**	0	456	0	0	106	0	0	33	0	2	692	**0.3**

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

Deliverables due during MLTSS 3rd quarter (1/1/2017 - 3/31/2017)

ab	Natural disaster, with direct impact to member's health and welfare	0	7	**0**	0	90	**0**	0	456	0	1	106	**0.9**	0	33	0	1	692	**0.1**
ac	Operational Breakdown	0	7	**0**	0	90	**0**	1	456	**0.2**	2	106	**1.9**	0	33	0	3	692	**0.4**
ad	Other	0	7	**0**	11	90	**12.2**	1	456	**0.2**	5	106	**4.7**	0	33	0	17	692	**2.5**

There were a total of 692 Critical Incidents reported by the five MCOs during the October - December 2016 measurement period. These are reported events not unduplicated members. Overall the three most common incidents were: Medical Emergency resulting in the need for medical treatment (34.1%); Fall resulting in the need for medical treatment (31.4%); and Inaccessible for initial/on-site meeting (4.8%). Four of the five MCOs reported that falls accounted for the highest percentage of reported CIs during this quarter. Three MCOs detailed new approaches to reducing the number of falls. One MCO stated that 4 of the 5 falls reported by them occurred in a previous quarter and were identified upon claims review, so they reinforced with staff the importance of reviewing claims with every file review and prior to calling or meeting with members. Another MCO implemented the completion of a falls screening tool with every visit as well as partnering with a consultant to survey their PCA providers regarding falls prevention training for their aides. The MCO who reported that 55% of their CIs this quarter were for falls, reported that they are starting a new falls prevention program in FY 2017 that includes: The Otago Program, an individualized exercise program designed to reduce falls in older adults; provider education for PCA agencies; and member education. The MCO whose top category was medical emergencies, focused on increased outreach by their Care Managers and reviewed the location and age groups identified for each CI. Where indicated, they initiated a Quality of Care referral when there was a concern of care being provided.

Q4 2016

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 10/1/2016 - 12/31/2016**

#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	272	51
Denominator : Total number of new enrollees	272	51
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 10/1/2016 - 12/31/2016**

#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	466	162
Denominator: Number of youth with Child and Adolescent Needs and Strengths assessments conducted 1 year from admission or last CANS conducted	489	168
Percentage	95%	96%

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

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

- **IDD –MI and ASD Pilots**
- **Measurement period 10/1/2016 - 12/31/2016**

#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	272	51
Denominator: Number of new enrollees	272	51
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 10/1/2016 - 12/31/2016**

#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	272	51
Denominator: Number of Plans of Care reviewed	272	51
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 10/1/2016 - 12/31/2016**

#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	22	16
Denominator: Number of Plans of Care reviewed	22	16
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 10/1/2016 - 12/31/2016**

#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	272	51

plans of care that had services authorized based on the plan of care		
Denominator: Number of plans of care reviewed	272	51
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 10/1/2016 - 12/31/2016**

#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 10/1/2016 - 12/31/2016**

#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 10/1/2016 - 12/31/2016**

#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 services	N/A*	N/A*
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 10/1/2016 - 12/31/2016**

# 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 10/1/2016 - 12/31/2016**

# 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	In Development	In Development

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

The reporting of this quality strategy is in development and 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 within youth's centered plan authorization	In Development	In Development
Denominator: Total number of claims submitted	In Development	In Development
Percentage	In Development	In Development

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

Q1 2017

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 1/1/2017 - 3/31/2017**

#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	305	19
Denominator : Total number of new enrollees	305	19
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 1/1/2017 - 3/31/2017**

#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	686	178
Denominator: Number of youth with Child and Adolescent Needs and Strengths assessments conducted 1 year from admission or last CANS conducted	735	184
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 1/1/2017 - 3/31/2017**

#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	305	19
Denominator: Number of new enrollees	305	19
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 1/1/2017 - 3/31/2017**

#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	305	19
Denominator: Number of Plans of Care reviewed	305	19
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 1/1/2017 - 3/31/2017**

#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	102	1
Denominator: Number of Plans of Care reviewed	102	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 1/1/2017 - 3/31/2017**

#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 services authorized based on the plan of care	305	19
Denominator: Number of plans of care reviewed	305	19
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 1/1/2017 - 3/31/2017**

#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 1/1/2017 - 3/31/2017**

#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 1/1/2017 - 3/31/2017**

#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 services	N/A*	N/A*
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 1/1/2017 - 3/31/2017**

# 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 1/1/2017 - 3/31/2017**

# 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	N/A*	N/A*

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

The reporting of this quality strategy is in development and 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 within youth's centered plan authorization	In Development	In Development
Denominator: Total number of claims submitted	In Development	In Development
Percentage	In Development	In Development

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