Deliverables due during MLTSS 2nd quarter (10/1/2020 – 12/31/2020)

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. This quarterly report reflects the Performance Measures (PMs) that were reported by the Managed Care Organizations (MCOs) and the Division of Aging Services (DoAS) to the Office of MLTSS QM during the seventh year, second quarter (10/1/2020 – 12/31/2020) of the MLTSS program. Depending on the data source for the numerator/denominator, some PMs require longer lag times to allow for collection and analysis of the information. Because of the different lag times, each Performance Measure in this report identifies the measurement period being reported.

The Office of MLTSS QM continues to meet with the Managed Care Organizations (MCOs) at the MLTSS MCO Quality Workgroup on a monthly basis. Due to the COVID-19 State of Emergency Order, this workgroup has been meeting through Zoom. The workgroup provides the opportunity to share information on new or revised reporting requirements and provides a forum for the discussion of issues raised by DMAHS, the Division of Aging Services (DoAS), and the MCOs to facilitate resolution. An ongoing agenda item for the workgroup is the discussion of the MLTSS Performance Measures. The State's External Quality Review Organization (EQRO) continues to work with MLTSS QM and the MCOs to refine and clarify the Performance Measure (PM) specifications and to work with the MCOs to validate their system's source code for each PM and to confirm that the data produced is accurate and captures the information required by the PM specifications. After their source code is approved, the MCOs submit their PM reports to MLTSS QM for review and analysis.

The Division of Aging Services (DoAS) obtains information from their Telesys database, SAMS database, MCO feedback, and the Shared Data Warehouse to compile the data necessary in reporting their PMs to the Office of MLTSS QM.

Unless otherwise noted, Performance Measure (PM) data reports that were due during this reporting period but not included in this document may be a result of source code still in the validation process with the State's EQRO. In some instances, multiple reporting periods may be included in this report due to an MCO's delay in receiving approval for their source code or an MCO's resubmission of a PM. These exceptions will be noted in the narrative for the respective PM in this report.

In March 2020, challenges related to the COVID-19 pandemic mandated changes to the MLTSS program, including the suspension of face-to-face assessments and in-person Care Manager visits. The Office of MLTSS QM anticipates that these changes will be reflected in many of the PMs reported for the measurement periods covering the COVID-19 State of Emergency Order. For those PMs impacted by COVID-19, the data analysis will identify how the data was affected.

Deliverables due during MLTSS 2nd quarter (10/1/2020 – 12/31/2020)

PM # 03	Nursing facility level of care assessments conducted by the MCO determined to be "Not Authorized"
Numerator:	Total number of "Not Authorized" reassessments conducted by OCCO with a determination of "Approved"
Denominator:	Total number of MLTSS level of care assessments that were conducted by MCO with a determination of "Authorized" and "Not Authorized" by OCCO during the measurement period
Data Source:	DoAS
Frequency:	Quarterly

4/1/2020 – 6/30/2020	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**

The MCO Comprehensive Waiver Contract Article 9.2.3 NJ Choice Assessment System Data J. States: *The Contractor shall not exceed a five percent (5%) Not Authorized rate. The Not Authorized rate is defined as the percentage of MCO assessments with a Not Authorized outcome that are subsequently determined as Approved for clinical eligibility following the OCCO reassessment. This rate shall be calculated and maintained by the Division of Aging and reported quarterly to the MCO and MLTSS Quality Monitoring. The Contractor is responsible for conducting further analysis of the report to identify and implement a remediation plan. The remediation plan shall be submitted to DoAS within 30 days of the DoAS report for review, requested revisions, and approval.*

Due to the COVID-19 State of Emergency Order with the subsequent suspension of all face-to-face assessments (initial and annual) effective March 18, 2020, Performance Measure #03 has no data at this time to report on. Once the assessment restrictions are lifted, the State will resume their 100% Audit of all Not Authorized Assessments. Reporting will resume on a quarterly basis.

PM # 04	Timeliness of nursing facility level of care assessment by MCO
Numerator:	Cases in the denominator who received an assessment within 30 days of referral to the MCO or from the date of discharge from rehabilitation.
Denominator:	Unique count of MCO enrolled members with a referral for MLTSS during the measurement period
Data Source:	MCO
Frequency:	Monthly – Due 15th of the 2nd month (lag report) following reporting period

August 2020	A	B	C	D	E	TOTAL
Numerator	0	0	0	0	0	**0**
Denominator	0	48	184	0	151	**383**
%	0	0	0	0	0	**0**

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

Deliverables due during MLTSS 2nd quarter (10/1/2020 – 12/31/2020)

September 2020	A	B	C	D	E	TOTAL
Numerator	0	0	0	0	0	**0**
Denominator	3	85	213	0	265	**566**
%	0	0	0	0	0	**0**

October 2020	A	B	C	D	E	TOTAL
Numerator	0	0	0	0	0	**0**
Denominator	3	82	286	0	364	**735**
%	0	0	0	0	0	**0**

The MCOs are monitoring the timeliness of level of care (LOC) assessments and have identified that there were no assessments completed for referrals received due to COVID-19 NJ State mandate effective March 19, 2020, which states MCOs were to discontinue assessing members face to face for the purposes of MLTSS eligibility. MCO A reported during the September 2020 measurement period that they identified three valid referrals. One was for a 3 years old male child. The second referred member was 18 year old male and the third referral was for an 82 year old female. The assessments could not be completed because assessors were removed out of field due to COVID-19 pandemic and assessment could not be completed telephonically. MCO B reported that during the October 2020 measurement period there were 82 members referred. None of the eighty-two members received a face-to-face visit due to guidance from the State to suspend all face to face interactions with members due to the COVID-19 pandemic. Additionally, MCO B continues to perform telephonic outreaches to members in order to ensure that care management activities continue and members are aware the NJ Choice assessments will take place once the order is lifted. The MCOs will continue to monitor members referred for MLTSS eligibility assessment and will prioritize members upon changes in State guidance regarding field visits. Currently, members' needs are coordinated by care managers assigned as needed.

PM # 04a	Timeliness of nursing facility level of care assessment
Numerator:	The number of assessments in the denominator where the OCCO/ADRC assessment/determination date is less than 30 days from the referral date
Denominator :	Number of new MLTSS enrollees within the reporting month with an assessment completed by OCCO/ADRC
Data Source:	DoAS
Frequency:	Monthly – Due 15th of the 2nd month (lag report) following reporting period

Measurement period	5/2020	6/2020	7/2020
Numerator	N/A	N/A	N/A
Denominator	N/A	N/A	N/A
%	N/A	N/A	N/A

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

Deliverables due during MLTSS 2nd quarter (10/1/2020 – 12/31/2020)

Measurement period	8/2020	9/2020	10/2020
Numerator	N/A	N/A	N/A
Denominator	N/A	N/A	N/A
%	N/A	N/A	N/A

Due to the COVID-19 State of Emergency Order and the subsequent suspension of all face-to-face assessments (initial and annual) effective March 18, 2020, Performance Measure #04a has no data at this time to report. Once the assessment restrictions are lifted, the State will resume monitoring the timeliness of NJ Choice Assessment completion. Reporting will resume on a monthly basis.

PM # 05	Timeliness of nursing facility level of care re-determinations
Numerator:	Total number of MLTSS members in the denominator who are confirmed as appropriate for continued MLTSS enrollment who have not had a level of care assessment by report close out.
Denominator:	Total number of MLTSS members with no level of care assessment conducted in the last 16 months
Data Source:	DoAS
Frequency:	Quarterly – Due 3 months after 13-month report is run

As per the MCO contract 9.6.1 (E) 1. The Contractor shall ensure that all annual clinical eligibility redeterminations are conducted eleven to thirteen months from the last clinical eligibility determination by the Office of Community Choice Options (OCCO). The clinical assessment is known as the NJ Choice Assessment System. MLTSS Performance Measure #05: Timeliness of the Annual Clinical Assessment is monitored by the Division of Aging Services (DoAS) through standardized reports which identify overdue assessments and requires corrective action by the MCO.

Beginning in mid-2015, reports were run to identify MLTSS members with a clinical assessment date older than 13 months. Due to MLTSS implementation challenges, system changes required to prevent involuntary disenrollment, and the high volume of overdue assessments, the clinical assessment report was adjusted to a 16 month report in order to provide some flexibility while the required changes were made.

In January 2020, the DoAS retired the 16 month report and began implementing two reports:

1. Twelve (12) Month Report – identifies MLTSS members due for an annual assessment for whom the prior clinical assessment at least 12 months ago but not more than 13 months. The intent of the 12-month report is to provide an alert that the MLTSS annual reassessment is due with the potential for non-compliance. There is no review by DoAS of the data nor is the MCO required to respond or develop a corrective action plan to the 12-Month Report.
2. Thirteen (13) Month Report - identifies MLTSS members overdue for an annual assessment for whom the prior assessment was more than 13 months ago. The intent of the 13-month report is to notify the MCO that the MLTSS annual reassessment is overdue and non-compliant with contractual requirements. The following actions are required by the MCO for each MLTSS member identified within the report.
    a. Research each member, identify the issue, and identify an action plan for assessment completion, disenrollment, or other closure.

b. The MCO is required to submit a second report within 30 calendar days of initial report receipt providing final outcomes and closing out the report with 100% compliance.
c. Upon receipt of the second report, DoAS will issue a Corrective Action Plan for compliance below 100% of the contractual obligation article 9.6.1 (E) 1.

There are limited instances in which extenuating member circumstances hinder the assessment completion for which an extension of the assessment completion is considered appropriate and the member will not be factored into the compliance rate.

1. The MCO shall document the reason in the spreadsheet for these instances that includes but may not be limited to:
    a. The member was newly enrolled in the MCO during a month in which the 12 or 13-month report was run and they are compliant with enrollment timeframes for new member assessment and plan of care completion
    b. The member has been hospitalized during a month in which the 12 or 13-month report was run and the member is not eligible for MLTSS reassessment while in an acute care setting
    c. Member is Not Authorized and is awaiting the DoAS reassessment
    d. Member is Denied and pending Fair Hearing or Termination
    e. Member is incarcerated
    f. Member is currently placed in a State Psychiatric institution
2. Upon change in circumstance, the MCO is responsible for completing the reassessment.

Due to the COVID-19 State of Emergency Order and the subsequent suspension of all face-to-face assessments (initial and annual) effective March 18, 2020, the 12 and 13 month reports are being sent to the MCOs, however, no action plan is required. Therefore, there is no data to report for the quarterly report due November 2020. Once the assessment restrictions are lifted, the State will issue guidance for the MCOs to initiate clinical assessments.

PM # 07	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
Frequency:	Monthly – Due the 15th of the following month

Measurement Period	09/2020	10/2020	11/2020
Numerator	N/A	N/A	N/A
Denominator	N/A	N/A	N/A
%	N/A	N/A	N/A

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

Deliverables due during MLTSS 2nd quarter (10/1/2020 – 12/31/2020)

Due to the COVID-19 State of Emergency Order and the subsequent suspension of all face-to-face assessments (initial and annual) effective March 18, 2020, Performance Measure #07 was last sent to the MCO's on June 15th. The data in those reports were based on assessments that were completed prior to the Public Health Emergency and shuttled through the system late. There is no data to audit at this time. Once the assessment restrictions are lifted, the State will resume monitoring the documentation of choice between institutional and HCBS settings. Reporting will resume on a monthly basis.

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
Frequency:	Monthly – Due 15th of the following month

Measurement period	9/2020	10/2020	11/2020
Numerator	0	0	0
Denominator	884	944	829
%	N/A	N/A	N/A

As per the COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers, issued by CMS on March 30, 2020 with a retroactive effective date of March 1, 2020, 1135 waivers can be used to implement a range of flexibilities. These flexibilities include, but are not limited to, 1135 waiver reporting and oversight. As such, the one-day and two-day reporting time requirement for critical incident reporting has been waived during the COVID-19 emergency declaration.

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
Frequency:	Monthly – Due 15th of the following month

Measurement period	9/2020	10/2020	11/2020
Numerator	0	0	0
Denominator	28	41	42
%	N/A	N/A	N/A

Deliverables due during MLTSS 2nd quarter (10/1/2020 – 12/31/2020)

As per the COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers, issued by CMS on March 30, 2020 with a retroactive effective date of March 1, 2020, 1135 waivers can be used to implement a range of flexibilities. These flexibilities include, but are not limited to, 1135 waiver reporting and oversight. As such, the one-day and two-day reporting time requirement for critical incident reporting has been waived during the COVID-19 emergency declaration.

PM # 19	Timeliness for investigation of appeals and grievances (complete within 30 days)
Numerator:	# of appeals and grievances investigated within 30 days
Denominator:	Total # of appeals and grievances received for measurement period
Data Source:	MCO Table 3A and 3B Reports
Frequency:	Quarterly - Due 45 days after reporting period.

Table 3A UM Appeals

7/1/2020 – 9/30/2020	A	B	C	D	E	TOTAL
Numerator	7	10	122	40	29	**208**
Denominator	7	11	122	40	29	**209**
%	100	90.9	100	100	100	**99.5**

Table 3B Non-UM Grievances

7/1/2020 - 9/30/2020	A	B	C	D	E	TOTAL
Numerator	21	35	77	18	6	**157**
Denominator	21	35	77	21	6	**160**
%	100	100	100	85.7	100	**98.1**

During the 7/1/2020 – 9/30/2020 measurement period four MCOs reported 100% of cases in Tables 3A were resolved within 30 days. MCO B reported one appeal that took 34 days to resolve due to it being routed to a medical director who was out of the office.

During the 7/1/2020 – 9/30/2020 measurement period four MCOs reported 100% of cases in Tables 3B were resolved within 30 days. MCO D had three cases that took from 34-36 days to resolve due to untimely routing of the grievances.

The tables below detail the number and type of MLTSS enrollee appeals (Table 3A) and grievances (Table 3B) filed during the measurement period of 7/1/2020 – 9/30/2020. For this measurement period, the top UM appeal categories for all MCOs combined were Denial of dental services (56/209 = 26.8%); Denial of outpatient medical treatment/diagnostic testing (28/209 = 13.4%); and Denial of inpatient hospital stays (21/209 = 10.0%).

The top three non-UM grievance categories were Reimbursement problems/unpaid claims (21/160 = 13.1%); Dissatisfaction with marketing, member services, member handbook, etc. (16/160 = 10.0%); and Dissatisfaction with provider office administration (16/160 = 10.0%).

Deliverables due during MLTSS 2nd quarter (10/1/2020 – 12/31/2020)

PM 19 - Table 3A Utilization Management (UM) enrollee appeal by Category

PM 19 - Table 3A Utilization Management (UM) enrollee appeal categories	July - September 2020					
	MCO A	MCO B	MCO C	MCO D	MCO E	TOTAL
Denial of acute inpatient rehabilitation services			1		1	2
Denial of assisted living services						
Denial of dental services	**1**		**37**	**12**	**6**	**56**
Denial of hearing aid services						
Denial of home delivered meal services						
Denial of hospice care						
Denial of in-home periodic skilled services (nursing, social services, nutrition, etc.)					2	2
Denial of in-home rehabilitation therapy (PT, OT, speech, etc.)						
Denial of inpatient hospital days	**2**	**2**	**13**	**1**	**3**	**21**
Denial of Medical Day Care (adult & pediatric)						
Denial of medical equipment (DME) and/or supplies		5	6	7		18
Denial of Mental Health services			1			1
Denial of non-medical transportation						
Denial of optical appliances						
Denial of optometric services						
Denial of other TBI services (CRS, Structured Day, Supported Day, etc.)						
Denial of outpatient medical treatment/diagnostic testing			**21**	**3**	**4**	**28**
Denial of outpatient rehabilitation therapy (PT, OT, Cardiac, Speech, Cognitive, etc.)			3	1	1	5
Denial of outpatient TBI habilitation therapy (PT, OT, speech, cognitive etc.)						
Denial of PCA services			12	6		18
Denial of Personal Emergency Response Systems (PERS)						
Denial of Private Duty Nursing			2	1		3
Denial of referral to out-of-network specialist			1			1
Denial of residential modification			1	2		3
Denial of respite services						
Denial of skilled nursing facility (custodial)				4		4
Denial of skilled nursing facility inpatient rehabilitation services			17			17
Denial of Special Care Nursing Facility (custodial) SCNF						
Denial of sub-acute inpatient rehabilitation services		1	1			2
Denial of SUD services			1			1
Denial of surgical procedure		1				1
Denial of vehicle modification						
Other (MLTSS)	3					3
Other (non-MLTSS)					4	4
Pharmacy	1	2	1	3	8	15
Reduction of acuity level (inpatient)			4			4
Service considered cosmetic, not medically necessary						
Service considered experimental/investigational						
Table 3A/UM Appeal TOTALS	**7**	**11**	**122**	**40**	**29**	**209**

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

PM 19 - Table 3B non-utilization management (non-UM) enrollee grievance by Category

PM 19 - Table 3B non-utilization management (non-UM) enrollee grievance categories	July - September 2020					
	MCO A	MCO B	MCO C	MCO D	MCO E	TOTAL
Appointment availability, other type of provider						
Appointment availability, PCP						
Appointment availability, specialist						
Difficulty obtaining access to a healthcare professional after hours (via phone)						
Difficulty obtaining access to DME and/or medical supplies	3		3			6
Difficulty obtaining access to mental health providers						
Difficulty obtaining access to MLTSS providers		1	4			5
Difficulty obtaining access to non-MLTSS providers						
Difficulty obtaining access to other in-home health services (skilled and non-skilled)			4		1	5
Difficulty obtaining access to PCA services						
Difficulty obtaining access to PDN services				1		1
Difficulty obtaining access to self-directed PCA services (PPP)						
Difficulty obtaining access to SUD providers						
Difficulty obtaining access to transportation services					1	1
Difficulty obtaining referral to network specialist of member's choice						
Difficulty obtaining referrals for covered mental health services						
Difficulty obtaining referrals for covered MLTSS services						
Difficulty obtaining referrals for covered services, dental services						
Difficulty obtaining referrals for covered SUD services						
Difficulty related to obtaining emergency services						
Dissatisfaction with dental services			6		1	7
Dissatisfaction with DME and/or medical supplies		2	8		1	11
Dissatisfaction with marketing, member services, member handbook, etc.	**6**	**2**	**6**	**2**		**16**
Dissatisfaction with NJ FamilyCare Benefits						
Dissatisfaction with other in-home health services (skilled and non-skilled)	1	2	1	5		9
Dissatisfaction with PCA services			5			5
Dissatisfaction with PDN services		1				1
Dissatisfaction with policies regarding specialty referrals (i.e. out of network specialist)						
Dissatisfaction with provider network			1	1	1	3
Dissatisfaction with provider office administration		**1**	**15**			**16**
Dissatisfaction with quality of medical care, hospital			4	1		5
Dissatisfaction with quality of medical care, other type of provider	2	5	3	3	1	14
Dissatisfaction with quality of medical care, PCP		1		2		3
Dissatisfaction with quality of medical care, specialist			4			4
Dissatisfaction with transportation services	3	5				8
Dissatisfaction with utilization management appeal process		2				2
Dissatisfaction with vision services				1		1
Enrollment issues			1			1
Laboratory issues			1			1
Pharmacy/formulary issues		1	9	2		12
Reimbursement problems/unpaid claims	**6**	**11**	**1**	**3**		**21**
Waiting time too long at office, PCP						
Waiting time too long at office, specialist		1	1			2
Table 3B/non-UM Grievance TOTALS	**21**	**35**	**77**	**21**	**6**	**160**

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 # 20	MLTSS members receiving MLTSS services
Numerator:	The unique count of members in the denominator with at least one claim for MLTSS services during the measurement period.
Denominator:	The unique count of members enrolled in MLTSS at any time during the measurement period.
Data Source:	MCO
Frequency:	Quarterly/Annually - Lag Report Due: 210 day lag after quarter and year

7/1/2019 - 9/30/2019	A	B	C	D	E	TOTAL
Numerator	3063	6135	16725	7202	6384	**39509**
Denominator	3804	7803	21391	10382	10522	**53902**
%	80.5	78.6	78.2	69.4	60.7	**73.3**

10/1/2019 - 12/31/2019	A	B	C	D	E	TOTAL
Numerator	3318	6535	17208	7176	6701	**40938**
Denominator	4050	8544	21850	10472	11073	**55989**
%	81.9	76.5	78.8	68.5	60.5	**73.1**

1/1/2020 - 3/31/2020	A	B	C	D	E	TOTAL
Numerator	3488	6719	17565	6891	6953	**41616**
Denominator	4276	8788	22235	10184	11330	**56813**
%	81.6	76.5	79.0	67.7	61.4	**73.3**

The MCOs continue to claim under reporting for this measure. MCOs report that there are members receiving services for which the MCO had not yet received a claim as some providers are not submitting claims and/or are delaying the submission of claims for services. MCO A reported the majority of their MLTSS membership resides in NF setting where their needs are met by the facility and the remaining population in the community setting is receiving MLTSS services including PERS, HDM, Private Duty Nursing, respite services, residential modification evaluations, medication dispensing device monitoring, home based supportive care, social adult day care, and chore services. Additionally, MCO A reported that 3488 unique MLTSS members had claims for at least one MLTSS-specific service during the 01/01/2020-03/31/2020 measurement period. This calculates to 81.6% of MLTSS members having claims for MLTSS-specific services during the measurement period. This is a minor decrease from the previous quarter, which showed 81.9%. MCO A reported that CMs continue to offer options counseling to all HCBS members, encouraging them to utilize their MLTSS-specific benefits to meet their needs. The reported rates for MCO D for measurement periods 7/1/2019 - 9/30/2019 and 10/1/2019 – 12/31/2019 are reported within the tables above and are indicated with red font.

Deliverables due during MLTSS 2nd quarter (10/1/2020 – 12/31/2020)

PM # 21	MLTSS members transitioned from NF to Community.
Numerator:	The unique count of members in the denominator who transitioned from NF to HCBS during the measurement period. Members should be counted only once.
Denominator:	The unique count of members meeting eligibility criteria during the measurement period who were enrolled in custodial NF at any point during the measurement period.
Data Source:	MCO
Frequency:	Quarterly/Annually – Due: 30 days after the quarter and year

7/1/2020-9/30/2020	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**

The MCOs are working with the State's EQRO on their coding for this performance measure and have an extension to submit this report next quarter. This data will be included in the next quarterly report.

PM # 23	MLTSS NF to HCBS transitions who returned to NF within 90 days.
Numerator:	The unique count of members in the denominator with a NF living arrangement status within 90 days of initial HCBS transition date.
Denominator:	The unique count of members continuously enrolled with the MCO in MLTSS from the beginning of measurement period or from date of initial enrollment in MLTSS NF, whichever is later, through 90 days after the HCBS transition date.
Data Source:	MCO
Frequency:	Quarterly/Annually – Lag Report Due: 120 days after reporting quarter or year

7/1/2019 - 9/30/2019	A	B	C	D	E	TOTAL
Numerator	0	0	4	0	1	**5**
Denominator	6	0	44	4	11	**65**
%	0	0	9.1	0	9.1	**7.7**

10/1/2019 -12/31/2019	A	B	C	D	E	TOTAL
Numerator	0	0	3	1	0	**4**
Denominator	7	12	53	3	15	**90**
%	0	0	5.7	33.3	0	**4.4**

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

Deliverables due during MLTSS 2nd quarter (10/1/2020 – 12/31/2020)

1/1/2020-3/31/2020	A	B	C	D	E	TOTAL
Numerator	0	0	2	0	1	**3**
Denominator	11	10	42	1	17	**81**
%	0	0	4.8	0	5.9	**3.7**

4/1/2020-6/30/2020	A	B	C	D	E	TOTAL
Numerator	0	0	3	0	8	**11**
Denominator	6	11	49	10	22	**98**
%	0	0	6.1	0	36.4	**11.2**

7/1/2019-6/30/2020	A	B	C	D	E	TOTAL
Numerator	0	3	14	0	9	**26**
Denominator	26	33	238	4	71	**372**
%	0	9.1	5.9	0	12.7	**7.0**

The MCOs are continuing to track and trend members returning to the NF within 90 days. MCO C reported they identified 49 members who transitioned from a NF to HCBS setting. Out of the 49 members who transitioned, three members returned to the NF within 90 days of transition during the measurement period 4/1/2020-6/30/2020. MCO C further discovered that of the three members that returned to the Nursing Facility, two members returned at the member or family member's request and one member returned due to lack of informal supports/needs not met in the community. MCO E reported during the 4/1/2020-6/30/2020 measurement period that there were 22 NF to HCBS transitions, and of those transitions, eight members returned to the NF within 90 days of transition. MCO E reported that during further review of the data they discovered that there was a significant increase in the number of members transitioning from a NF setting into the community as well as readmission within 90 days directly related to the COVID 19 Pandemic. The readmission rate reported during measurement period 1/1/2020-3/31/2020 was 5.9%, increasing to 36.4% during the measurement period 7/1/2019-6/30/2020. The 1/1/2020-3/31/2020 measurement period corresponds to the start of the pandemic. For the measurement period 7/1/2019-6/30/2020, MCO C reported that 238 members transitioned from a Nursing Facility to a Community Setting, and of those who transitioned, 14 returned to the Nursing Facility within 90 days of transition. Furthermore, MCO C discovered that that of the 14 members that returned to the NF, seven members transitioned from NF to private residences with family members, one member lived in community personal care home, three members transitioned from a private residence with non-related family members and 3 members lived alone in a private residence. The average age of these members was 66 years old. The MCOs will continue to monitor and track members that return to the Nursing Facility. The reported rates for MCO D for measurement periods 7/1/2019 - 9/30/2019; 10/1/2019 – 12/31/2019; and 1/1/2020-3/31/2020 are reported within the tables above and are indicated with red font.

PM # 26	Acute inpatient utilization by MLTSS HCBS members: HEDIS IPU
Numerator:	Reporting is at the Total level for Total Inpatient. Report rate per 100 in the State template and rate per 1000 in Data Analysis. Report member months, events, and rates per 1000 for the three youngest age groups in Data Analysis.
Denominator:	Follow HEDIS specifications for Inpatient Utilization (IPU) for MLTSS HCBS members. Sum of MLTSS HCBS member months in the measurement period.
Data Source:	MCO
Frequency:	Quarterly/Annually - Lag Report Due: 210 day lag after quarter and year

7/1/2019 - 9/30/2019	A	B	C	D	E	TOTAL
Numerator	154	350	1704	434	458	**3100**
Denominator	3901	12678	37320	16096	23013	**93008**
%	3.9	2.8	4.6	2.7	2.0	**3.3**

10/1/2019 - 12/31/2019	A	B	C	D	E	TOTAL
Numerator	159	403	1789	543	526	**3420**
Denominator	4264	14819	38071	16566	24562	**98282**
%	3.7	2.7	4.7	3.3	2.1	**3.5**

1/1/2020 - 3/31/2020	A	B	C	D	E	TOTAL
Numerator	151	426	1898	502	469	**3446**
Denominator	4258	16023	38378	16391	25351	**100401**
%	3.5	2.7	5.0	3.0	1.9	**3.4**

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. This measure is based on hospital events and not unduplicated members. MCO A reported 151 acute inpatient visits that calculated 3.5% admissions per member months of HCBS members during the 1/1/2020-3/31/2020 measurement period. This rate has slightly decreased from 3.7% for the previous measurement period. Furthermore, MCO A reported the 151 acute inpatient events represents 117 unique members with identified diagnosis of Sepsis Unspecified organism, Hypertensive heart disease with Heart failure, Acute Kidney Failure Unspecified, Chronic Obstructive Pulmonary DZ W/Exacerbation, HTN Heart and CKD W/HF and CKD Stage 1-4 OR UNS CKD, and Urinary Tract Infection Site Not Specified. Additionally, the length of stay for these 151 hospitalizations added up to 840 days, with an average LOS of 5.56 days, mostly occurring in members over the age of 65. For measurement period 1/1/2020-3/31/2020, MCO D reported 502 unique inpatient hospitalizations, a 3.0 % of the total MLTSS HCBS population. This is .27 percentage points less than the 3.27% of inpatient admissions that occurred in the previous measurement period. Furthermore, MCO D reported that the most frequent hospitalization primary diagnoses were Hypertensive Heart Disease, Heart Failure, Atrial Fibrillation, Chronic Obstructive Pulmonary Disease w/Exacerbation, acute respiratory failure, Asthma, ESRD, and Kidney Disease

UTI. In addition, MCO D reported that they discovered 49%, (244/502) of the acute inpatient hospitalization utilizations were DSNP and 70% (352/502) of acute inpatient hospitalizations were 65 years of age or older; of which 55% (193/352) were DSNP. MCO E reported 469 acute inpatient events, corresponding to a 1.85% rate or 18.50 authorizations per thousand for measurement period 1/1/2020-3/31/2020. Further analysis revealed that 403 unique members accounted for the 469 events; 345 of the 403 unique members were age 65 or older (85.61%). In addition, MCO E review of correlating diagnoses showed the majority of multiple admissions were related to chronic conditions such as CHF, and complications including sepsis and pneumonia. The top category of diagnoses during this measurement period for MCO E was circulatory disorders with 125 events, of which 58 (46.40%) events were due to hypertensive heart disease and 14 events (11.20%) were for cerebral infarction. The second highest disease category reported 86 events for diseases of the respiratory system, of which 43 (50.00%) events were due to pneumonia. MCO E continues to closely monitor inpatient admissions using a daily discharge planning report to continue to improve timely outreach and appropriate discharge planning including follow up appointments and medication reconciliation. Also, MCO E continues to monitor COVID-19 related claims to identify risk factors, co-morbidities as well mortality rates among the members in efforts to implement measures that may improve outcomes and decrease mortality for the MLTSS high risk populations. The reported rates for MCO D for measurement periods 7/1/2019 - 9/30/2019 and 10/1/2019 – 12/31/2019 are reported within the tables above and are indicated with red font.

PM # 27	Acute inpatient utilization by MLTSS NF members: HEDIS IPU
Numerator:	Reporting is at the Total level for Total Inpatient. Report rate per 100 in the State template and rate per 1000 in Data Analysis. Report member months, events, and rates per 1000 for the three youngest age groups in Data Analysis.
Denominator:	Follow HEDIS specifications for Inpatient Utilization (IPU) for MLTSS NF members. Sum of MLTSS NF member months in the measurement period.
Data Source:	MCO
Frequency:	Quarterly/Annually - Lag Report Due: 210 day lag after quarter and year

7/1/2019 - 9/30/2019	A	B	C	D	E	TOTAL
Numerator	144	148	754	163	103	**1312**
Denominator	6533	9199	21592	11098	5997	**54419**
%	2.2	1.6	3.5	1.4	1.7	**2.4**

10/1/2019 - 12/31/2019	A	B	C	D	E	TOTAL
Numerator	176	192	759	196	143	**1466**
Denominator	6785	9293	21982	11331	6149	**55540**
%	2.6	2.1	3.5	1.7	2.3	**2.6**

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 2nd quarter (10/1/2020 – 12/31/2020)

1/1/2020 - 3/31/2020	A	B	C	D	E	TOTAL
Numerator	188	161	838	205	156	**1548**
Denominator	7027	9208	22114	11214	6469	**56032**
%	2.7	1.8	3.8	1.8	2.4	**2.8**

Data for this measure is captured on a monthly basis. Quarterly data reflects the number of hospitalizations that occurred per member month. This measure is based on hospital events, not unduplicated members. MCO A reported 188 inpatient visits during the 1/1/2020 – 3/31/2020 measurement period, which calculates to 26.75 Inpatient visits per 1000 member months. These claims for 188 hospital admissions represent 157 unique members. Furthermore, MCO A reported that the most prevalent primary diagnoses for these admissions are Sepsis Unspecified Organism, Sepsis due to Escherichia Coli E.coli, Urinary Tract Infection Site Not Specified, HTN Heart and CKD W/HF and CKD stage 1-4 OR UNS CKD, and Other specified sepsis. For measurement period 1/1/2020 – 3/31/2020, MCO B reported 161 total Inpatient stays, corresponding to 1.8% Inpatient stays, and 17.48 per 1000 Inpatient stays. In addition, MCO B reported that the total average length of stay for this measurement period is 7.52 days, and the longest stay is amongst the 65-74 age group with 11.30 days. MCO D reported 205 unique inpatient hospitalizations during the measurement period 1/1/2020 – 3/31/2020. This is 1.8% of the total MLTSS NF population during the measurement period, which is an increase of .08 percentage points from the previous measurement period of 10/1/2019 – 12/31/2019. Furthermore, MCO D reported that 10% (21/205) of the acute inpatient hospitalization utilizations were DSNP, and 69% (141/205) of acute inpatient hospitalizations were 65 years of age or older; of which 13% (19/141) were DSNP members. Additionally, MCO D reported that the most frequent hospitalization primary diagnoses this measurement period were: Kidney failure, Nephropathy, UTI, and Diabetes-related, Pressure Ulcers, and Metabolic Encephalopathy. The reported rates for MCO D for measurement periods 7/1/2019 - 9/30/2019 and 10/1/2019 – 12/31/2019 are reported within the tables above and are indicated with red font.

PM # 28	All Cause Readmissions of MLTSS HCBS members to hospital within 30 days: HEDIS PCR
Numerator:	Report Observed Readmissions as the numerator and the Observed Readmission rate.
Denominator:	Follow HEDIS specifications for Plan All Cause Readmission (PCR) for the Medicare product for MLTSS HCBS members. Report Observed Discharges as the denominator.
Data Source:	MCO
Frequency:	Quarterly/Annually - Lag Report Due: 240 day lag after quarter and year

7/1/2019 - 9/30/2019	A	B	C	D	E	TOTAL
Numerator	N/A	22	N/A	40	189	**N/A**
Denominator	N/A	145	N/A	349	895	**N/A**
%	N/A	15.2	N/A	11.5	21.1	**N/A**

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

Deliverables due during MLTSS 2nd quarter (10/1/2020 – 12/31/2020)

10/1/2019 - 12/31/2019	A	B	C	D	E	TOTAL
Numerator	N/A	23	N/A	47	173	**N/A**
Denominator	N/A	177	N/A	400	979	**N/A**
%	N/A	13	N/A	11.7	17.7	**N/A**

1/1/2020 - 3/31/2020	A	B	C	D	E	TOTAL
Numerator	N/A	29	N/A	47	150	**N/A**
Denominator	N/A	186	N/A	415	861	**N/A**
%	N/A	15.6	N/A	11.3	17.4	**N/A**

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. This measure is based on hospital events and not unduplicated members. MCO D reported 47 unique re-admissions within 30 day corresponding to 11.3 % for measurement period 1/1/2020 – 3/31/2020; this was a 0.42 percentage point decrease of re-admissions within 30 days from the previous measurement period of 10/01/2019 – 12/31/2019 of 11.7%. Furthermore, MCO D reported that of the 47 readmissions within 30 days in the measurement period, eight members had more than one readmission. In addition, MCO D reported that 39 unique members had at least one readmission. Of these 39 unique members, 46.1% (18/39) identified as female compared to 53.8% (21/39) which identified as male and 61.5% (24/39) were 65 years of age or older, of those 79.17% (19/24) were DSNP members. For measurement period 1/1/2020 – 3/31/2020, MCO E reported 150 unique re-admissions within 30-day corresponding to 17.4%. Furthermore, MCO E reported that the review of the data output file for this measurement period shows slight decrease in the readmission rates in comparison to the previous measurement period, from 17.7% during 10/1/2019 – 12/1/2019 to 17.4% in the 1/1/2020 – 3/31/2020 measurement period. The rates showed an increase in both the inpatient events reported in the denominator as well as the number of readmissions reported in the numerator which can be attributed to the growth in membership seen by MCO E as seen in other utilization measures. In addition, MCO E reported that analysis of trends by disease category showed there were 150 readmission events of which the top three disease categories reported were circulatory system, with hypertension presenting in 17 of 38 events (44.74%); the second category reported with 18 events was diseases of the respiratory system with pneumonia presenting in 5 of the 18 events (27.78%); and the third category reported was for injuries/poisoning due to external causes, with 15 events reported and no significant trends identified. MCO E reported that they continue to monitor daily inpatient census, acute inpatient discharges as well as monthly utilization data to identify members for follow up, trends and utilization patterns. The reported rates for MCO D during the 7/1/2019 - 9/30/2019 and 10/1/2019 – 12/31/2019 measurement periods are reported within the tables above and are indicated with red font. MCOs A and C are working with the State's EQRO on their coding for this performance measure and have an extension to submit this report next quarter. This data along with any reconciled rates will be included in the next quarterly report.

Deliverables due during MLTSS 2nd quarter (10/1/2020 – 12/31/2020)

PM # 29	All Cause Readmissions of MLTSS NF members to hospital within 30 days: HEDIS PCR
Numerator:	Report Observed Readmissions as the numerator and the Observed Readmission rate.
Denominator:	Follow HEDIS specifications for Plan All Cause Readmission (PCR) for the Medicare product for MLTSS NF members. Report Observed Discharges as the denominator.
Data Source:	MCO
Frequency:	Quarterly/Annually - Lag Report Due: 240 day lag after quarter and year

7/1/2019 - 9/30/2019	A	B	C	D	E	TOTAL
Numerator	N/A	8	N/A	9	39	**N/A**
Denominator	N/A	38	N/A	120	226	**N/A**
%	N/A	21.1	N/A	7.5	17.3	**N/A**

10/1/2019 - 12/31/2019	A	B	C	D	E	TOTAL
Numerator	N/A	17	N/A	6	62	**N/A**
Denominator	N/A	53	N/A	151	280	**N/A**
%	N/A	32.1	N/A	4	22.1	**N/A**

1/1/2020 - 3/31/2020	A	B	C	D	E	TOTAL
Numerator	N/A	11	N/A	11	71	**N/A**
Denominator	N/A	58	N/A	160	267	**N/A**
%	N/A	19	N/A	6.9	26.6	**N/A**

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. This measure is based on hospital events and not unduplicated members. MCO B reported 11 readmissions within 30 days of discharge date for measurement period 1/1/2020 – 3/31/2020. Of the 11 readmissions, all are Medicaid. In addition, MCO B reported that the highest readmission rate was amongst the 65+ age band (33.3%), followed by the 18 – 64 age band (23.4%). Furthermore, MCO B reported that Care Managers continue to monitor inpatient census, authorization and claim data to track inpatient admissions and upon planned discharges, Care Managers schedule post-hospitalization visits within 10 days to ensure all services are in place with the home to meet the member's needs in an effort to prevent a readmit. For measurement period 1/1/2020 – 3/31/2020, MCO D reported 11 unique re-admissions within 30 day corresponding to 6.9%. This was a 2.9 percentage point increase of re-admissions within 30 days from the previous measurement period 10/01/2019-12/31/2019 of 3.97%. Additionally, MCO D reported that of the 11 reported readmissions within 30 days in the measurement period, 1 member had more than one readmission and a total of 10 unique members had at least one readmission. Of these 10 unique members, 40.0% (4/10) identified as female compared to 60.0% (6/10) who identified as male and of the 10 unique member re-admissions within 30 days, 60.0% (6/10) was 65 years of age or older. MCO E reported 71 unique re-admissions within 30 day corresponding to 26.6% for measurement period 1/1/2020 – 3/31/2020. As compared to the prior measurement period, the rate for this measure showed a significant increase from 22.1% to 26.6%. In addition, MCO E reported that review

of the data output file showed there were 71 readmissions events reported in the numerator corresponding to 50 unique members; 22 members remain actively enrolled with MCO E, 18 reside in a nursing facility setting and four have transitioned into a community setting. Furthermore, MCO E reported that Sepsis continues to be among the higher trends reported within the readmissions for this population presenting in 20 events of the events (100%) reported under the category of infectious diseases. The second highest category included disorders of the digestive system with 9 events reported, gastritis reported in 2 events (22.22%). The third category reported identified included diseases of the respiratory system with aspiration pneumonia reported in 3 out of the total 9 events (33.33%). Finally, MCO E reported ongoing collaborations with management and staff, including the Quality department for further look at trends by facility for sepsis. In addition, the Population Health Committee meets to analyze trends quarterly, specifically related to utilization of services with diagnosis of sepsis to better understand the root causes in an effort to reduce the occurrence. MCO E reported that they will continue to closely monitor trends by facility to develop initiatives aimed at educational opportunities, especially within chronic degenerative disease processes. The reported rates for MCO D during the 7/1/2019 - 9/30/2019 and 10/1/2019 – 12/31/2019 measurement periods are reported within the tables above and are indicated with red font. MCOs A and C are working with the State's EQRO on their coding for this performance measure and have an extension to submit this report next quarter. This data along with any reconciled rates will be included in the next quarterly report.

PM # 30	Emergency Department utilization by MLTSS HCBS members: HEDIS AMB
Numerator:	Reporting is at the Total level for ED events. Report rate per 100 in the State template and rate per 1000 in Data Analysis.
Denominator:	Follow HEDIS specifications for Ambulatory Care (AMB) for ED Visits for MLTSS HCBS members. Sum of MLTSS HCBS member months in the measurement period.
Data Source:	MCO
Frequency:	Quarterly/Annually - Lag Report Due: 210 day lag after quarter and year

7/1/2019 - 9/30/2019	A	B	C	D	E	TOTAL
Numerator	408	830	3519	1120	1213	**7090**
Denominator	3901	12678	37316	16096	23177	**93168**
%	10.5	6.5	9.4	7	5.2	**7.6**

10/1/2019 - 12/31/2019	A	B	C	D	E	TOTAL
Numerator	332	935	3323	1033	1104	**6727**
Denominator	4270	14819	38069	16566	24718	**98442**
%	7.8	6.3	8.7	6.2	4.5	**6.8**

1/1/2020 - 3/31/2020	A	B	C	D	E	TOTAL
Numerator	346	961	3392	987	1048	**6734**
Denominator	4535	16023	38401	16391	25453	**100803**
%	7.6	6.0	8.8	6.0	4.1	**6.7**

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

Data for this measure is captured on a monthly basis. Quarterly data reflects the number of ED visits that occurred per member month. This measure is based on ER utilization events and not unduplicated members. MCO B reported 961 emergency room visits during the measurement period 1/1/2020 – 3/31/2020 corresponding to 6% for this population or 60% per 1000, which is slightly lower than last quarter's reported rate for the same population. Additionally, the highest per 1000 rate occurred amongst the 20-44 age band of members in the HCBS population for this measurement period. Furthermore, MCO B reported that they are modifying internal reporting to better monitor ED trends and will utilize the trend data to develop care management interventions in hopes to reduce ED utilization. For the measurement period 1/1/2020 – 3/31/2020, MCO C reported 3,392 ER visits corresponding to 8.8%. Further review of the visits showed that a total of 2,552 (75%) were Medicare Prime, of which 417 (16%) were MLTSS SNP HCBS members. Additionally, MCO C identified the top three diagnoses for ER utilization for MLTSS HCBS members to be 3% had Other Chest Pain, 3% had Chest pain, unspecified and 3% had Urinary Tract Infection, site not specified. MCO C will continue to track and trend the ER Utilization for MLTSS members. MCO E reported 1048 ER events for HCBS membership, corresponding to a 4.1% rate or 41.17 events per thousand during the measurement period 1/1/2020 – 3/31/2020. There were 751 unique members included in the numerator presenting with 1048 ER events; of which 583 members were age 65 and older (77.63%). MCO E saw a decrease in the ER utilization rate for this population for the 3rd consecutive measurement period (from 5.2% during measurement period 7/1/2019 – 9/30/2019 to 4.5% during measurement period 10/1/2019 – 12/31/2019 to 4.2% during measurement period 1/1/2020 – 3/31/2020). Additionally, MCO E reported that of the 751 unique members identified, 627 remain enrolled with them. Review of events reported by member showed 559 members presented with 1 ER event, 179 members presented with 2-3 ER events, 9 members presented with 4-5 ER events, 3 members presented with 7-10 ER events each and 1 member was reported as having 19 ER events during the measurement period. Furthermore, MCO E reported that analyses of the top three frequent diagnoses for events reported showed the highest number reported with General Symptoms and Signs with 214 events, of which, 35 events were for chest pain (16.35%). The second most common disease category reported was for Injuries/Poisoning due to external causes with 111 events, of which injury to head reported with 16 events (14.41%). The third category reported was for Diseases of the respiratory system with 83 events, of which, 19 events were for viral infection due to influenza (22.89%), 15 were for upper respiratory (18.07%) and 12 were for pneumonia (14.45%). MCO E reported detailed reviews will be conducted on all members with multiple ER visits broken down by team and care manager to identify trends further developing their targeted ER utilization reduction plan. The reported rates for MCO's A, C, D, and E during the 7/1/2019 - 9/30/2019 and 10/1/2019 – 12/31/2019 measurement periods are reported within the tables above and are indicated with red font.

Deliverables due during MLTSS 2nd quarter (10/1/2020 – 12/31/2020)

PM # 31	Emergency Department utilization by MLTSS NF members: HEDIS AMB
Numerator:	Reporting is at the Total level for ED events. Report rate per 100 in the State template and rate per 1000 in Data Analysis.
Denominator:	Follow HEDIS specifications for Ambulatory Care (AMB) for ED Visits for MLTSS NF members. Sum of MLTSS NF member months in the measurement period.
Data Source:	MCO
Frequency:	Quarterly/Annually - Lag Report Due: 210 day lag after quarter and year

7/1/2019 - 9/30/2019	A	B	C	D	E	TOTAL
Numerator	269	43	868	208	122	**1510**
Denominator	6556	9199	21633	11098	6403	**54889**
%	4.1	0.5	4.0	1.9	1.9	**2.8**

10/1/2019 - 12/31/2019	A	B	C	D	E	TOTAL
Numerator	240	70	840	215	118	**1483**
Denominator	6812	9293	22009	11331	6576	**56021**
%	3.5	0.8	3.8	1.9	1.8	**2.6**

1/1/2020 - 3/31/2020	A	B	C	D	E	TOTAL
Numerator	234	30	875	197	135	**1471**
Denominator	7054	9208	22132	11214	6782	**56390**
%	3.3	0.3	4.0	1.8	2.0	**2.6**

Data for this measure is captured on a monthly basis. Quarterly data reflects the number of ED visits that occurred per member month. This measure is based on ER utilization events and not unduplicated members. MCO B reported 30 emergency room visits during the measurement period 1/1/2020 – 3/31/2020 corresponding to 0.3% for this population or 3.2% per 1000, which is lower than last measurement period's reported rate for the same population. Additionally, the highest per 1000 rate occurred amongst the 20-44 age band of members in the NF population for this measurement period. Furthermore, MCO B reported that they are modifying internal reporting to better monitor ED trends and will utilize the trend data to develop care management interventions in hopes to reduce ED utilization. For the measurement period 1/1/2020 – 3/31/2020, MCO C reported 875 ER visits corresponding to 4% for this population. Further review of the visits showed that a total of 625 (71%) were Medicare Prime, of which 21 (3%) MLTSS SNP NF members. Additionally, MCO C identified the top three diagnoses for ER utilization for MLTSS NF members to be unspecified injury of head, initial encounter at 6%, Urinary tract infection (UTI) at 4% and other chest pain at 2%. MCO C will continue to track and trend the ER Utilization for MLTSS members. MCO E reported 135 ER events for NF membership, corresponding to a 2% rate or 19.91 events per thousand during the measurement period 1/1/2020 – 3/31/2020. There were 114 unique members included in the numerator presenting with 135 ER events; of which 93 were age 65 and older (81.58%). MCO E saw a slight increase in the rate of ER events reported for NF members with 1.79% or 17.94 events/k reported in the measurement period, 10/1/2019 – 12/31/2019, to the current 2% or 19.91 events/k reported in 1/1/2020 – 3/31/2020 measurement period. Additionally, MCO E

reported that of the 114 unique members identified, 72 remain enrolled with them and 5 transitioned to an HCBS setting. Review of events reported per member showed 96 members presented with 1 ED visit during the measurement period, 15 members reported with 2 events each, and 3 members reported with 3 ER events each. Furthermore, MCO E reported that analyses of the top three frequent diagnoses for events reported were for Injuries and poisoning due to external causes with 39 events, of which, 17 were for head injury including contusion and laceration (43.59%). The second most common diagnoses reporting for this measure were under general symptoms and signs with 28 events, followed by diseases of the respiratory system with 73 events, of which pneumonia was the most common with 9 events. MCO E reported detailed reviews will be conducted on all members with multiple ER visits broken down by team and care manager to identify trends further developing their targeted ER utilization reduction plan. The reported rates for MCO's A, C, D, and E during the 7/1/2019 - 9/30/2019 and 10/1/2019 – 12/31/2019 measurement periods are reported within the tables above and are indicated with red font.

PM # 33	MLTSS services used by MLTSS HCBS members: PCA services only
Numerator:	The unique count of members with at least one claim for PCA services during the measurement period. Exclude members with a claim for any other MLTSS service or for claims for Medical Day services during the measurement period.
Denominator:	Unique count of members enrolled in MLTSS HCBS at any time during the measurement period.
Data Source:	MCO
Frequency:	Quarterly/Annually - Lag Report Due: 210 day lag after quarter and year

1/1/2020 - 3/31/2020	A	B	C	D	E	TOTAL
Numerator	153	992	2603	940	683	**5371**
Denominator	1759	5384	13971	5928	8902	**35944**
%	8.7	18.4	18.6	15.9	7.7	**14.9**

The above data reflects per MCO the unique count of members enrolled in MLTSS HCBS at any time during the measurement period with at least one claim for PCA services and excluding members with a claim for any other MLTSS service or for claims for Medical Day services during the measurement period. The MCOs will continue to monitor for trends.

PM # 34	MLTSS services used by MLTSS HCBS members: Medical Day services only
Numerator:	The unique count of members with at least one claim for Medical Day services during the measurement period. Exclude members with a claim for any other MLTSS service or for PCA services during the measurement period.
Denominator:	The unique count of members enrolled in MLTSS HCBS at any time during the measurement period.
Data Source:	MCO
Frequency:	Quarterly/Annually - Lag Report Due: 210 day lag after quarter and year

1/1/2020 - 3/31/2020	A	B	C	D	E	TOTAL
Numerator	156	229	187	152	1496	**2220**
Denominator	1759	5384	13971	5928	8902	**35944**
%	8.9	4.3	1.3	2.6	16.8	**6.2**

The above data reflects the number of the unique count of MLTSS HCBS members with at least one claim for Medical Day services, excluding members with a claim for any other MLTSS service or PCA services during the measurement period. The MCOs will continue to monitor for trends.

PM # 36	Follow-up after mental health hospitalization for MLTSS HCBS members: HEDIS FUH
Numerator:	Sum of qualifying follow-up visits with a mental health practitioner within 30 days after discharge. Only the 30-day follow-up rate is reported.
Denominator:	Follow HEDIS specifications for Follow-Up after Hospitalization for Mental Illness (FUH) for MLTSS HCBS members. The denominator for this measure is based on discharges, not on members.
Data Source:	MCO
Frequency:	Quarterly/Annually - Lag Report Due: 240 day lag after quarter and year

7/1/2019 - 9/30/2019	A	B	C	D	E	TOTAL
Numerator	N/A	2	4	1	4	**N/A**
Denominator	N/A	8	30	3	14	**N/A**
%	N/A	25	13.3	33.3	28.6	**N/A**

10/1/2019 - 12/31/2019	A	B	C	D	E	TOTAL
Numerator	N/A	4	0	3	1	**N/A**
Denominator	N/A	11	24	7	7	**N/A**
%	N/A	36.4	0	42.9	14.3	**N/A**

1/1/2020 - 3/31/2020	A	B	C	D	E	TOTAL
Numerator	N/A	5	0	4	4	**N/A**
Denominator	N/A	6	17	6	17	**N/A**
%	N/A	83.3	0	66.7	23.5	**N/A**

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

MCOs are reporting challenges in obtaining this data due to dual eligible members and limited access to Medicare claims. MCO C reported during the 1/1/2020 – 3/31/2020 measurement period that 17 MLTSS HCBS acute inpatient mental health discharges. Of the 17 inpatient discharges, there were no follow up visits with a mental health professional within 30 days of discharge. Furthermore, MCO C reported that the top mental health diagnosis for the MLTSS HCBS population was (18%) Schizoaffective disorder, unspecified during the measurement period. Additionally, MCO C reported that out of the 17 MLTSS HCBS inpatient discharges that did not have a follow up visit with a Mental Health practitioner within 30 days of discharge, it was discovered that 2 (12%) members were discharged to another short term general hospital for inpatient care, 2 (12%) members had a Telehealth Visit with a Mental Health Practitioner within the 30 days of discharge, one (6%) member made an appointment but cancelled due to Covid-19, 2 (12%) members had two inpatient discharges within 2 weeks of initial discharge, of which 1 member had a follow up visit scheduled prior to readmission, one (6%) member was discharged to a Nursing Facility for Custodial Care post hospital discharge, one (6%) member had an appointment scheduled but refused to attend, one (6%) member was discharged to a Skilled Nursing Facility post hospital discharge, one (6%) member did have a follow-up visit with a mental health practitioner within 30 days of discharge, however this Provider has yet to submit claims and six (35%) members did not have a scheduled follow up visit within 30 days of discharge. MCO C reported that they have developed a workgroup to strategize and manage Post Facility Follow up visits for Behavioral health admissions. Tracking reports have been created and are being monitored daily with a bi-weekly review to maintain compliance. For the Measurement Period 1/1/2020 – 3/31/2020, MCO D reported that there were 4 claims for a face-to-face follow-up visit for MLTSS HCBS members with a mental health professional within 30 days of members' discharge. Additionally, MCO D reported that in one of the 2 non-compliant cases, a Behavioral Health (BH) Case Manager spoke with the member post discharge. Member stated that she was unable to keep her 7-day mental health appointment because she was out of state due to the death of a relative. In the second case, the member was discharged to a skilled nursing facility. The Behavioral Case Manager spoke to the social worker at the facility who confirmed that the member completed a visit with a psychiatrist. Member declined to speak with the Case Manager. MCO E reported that 4 members (23.5%) received a follow up visit with a mental health provider within 30 days of their post-acute discharge as reported in the numerator for the measurement period 1/1/2020 – 3/31/2020. The 17 events reported were for 16 unique members in the denominator, of which, further analysis of the 16 unique members revealed that 6 of the members were age 65 or older (37.5 %). Furthermore, MCO E reported that results in this measure for this measurement period show an increase from the previous quarter from 14.3% to 23.5%, the number of admissions meeting inclusion criteria in the denominator also increased significantly from 7 to 17. Additionally, MCO E reported that further analysis of diagnosis for the members reported in the numerator (4) showed the following 3 events reported with schizoaffective disorder and 1 event for other schizophrenia. MCO E reported that their administrator will continue to collaborate with the network team to educate providers on the authorization process for MLTSS members so that the plan is aware of the admission in real time to help facilitate timely follow up. The reported rates for MCOs C, D, and E during the 7/1/2019 - 9/30/2019 and 10/1/2019 – 12/31/2019 measurement periods are reported within the tables above and are indicated with red font. MCO A is working with the State's EQRO on their coding for this performance measure and have an extension to submit this report next quarter. This data along with any reconciled rates will be included in the next quarterly report.

Deliverables due during MLTSS 2nd quarter (10/1/2020 – 12/31/2020)

PM # 38	Follow-up after mental health hospitalization for MLTSS NF members: HEDIS FUH
Numerator:	Sum of qualifying follow-up visits with a mental health practitioner within 30 days after discharge. Only the 30-day follow-up rate is reported.
Denominator:	Follow HEDIS specifications for Follow-Up after Hospitalization for Mental Illness (FUH) for MLTSS NF members. The denominator for this measure is based on discharges, not on members.
Data Source:	MCO
Frequency:	Quarterly/Annually - Lag Report Due: 240 day lag after quarter and year

7/1/2019 - 9/30/2019	A	B	C	D	E	TOTAL
Numerator	N/A	0	1	1	0	**N/A**
Denominator	N/A	0	15	2	1	**N/A**
%	N/A	0	6.7	50	0	**N/A**

10/1/2019 - 12/31/2019	A	B	C	D	E	TOTAL
Numerator	N/A	0	0	0	0	**N/A**
Denominator	N/A	0	12	1	0	**N/A**
%	N/A	0	0	0	0	**N/A**

1/1/2020 - 3/31/2020	A	B	C	D	E	TOTAL
Numerator	N/A	0	0	0	0	**N/A**
Denominator	N/A	1	3	0	0	**N/A**
%	N/A	0	0	0	0	**N/A**

MCOs are reporting some challenges in obtaining this data due to dual eligible members and limited access to Medicare claims. MCO C reported during the 1/1/2020 – 3/31/2020 measurement period that there were 3 MLTSS NF acute inpatient mental health discharges and of the 3 inpatient discharges, there were no follow up visits with a mental health professional within 30 days of discharge. Additionally, MCO C reported that the diagnoses for the 3 MLTSS NF mental health discharges were 1 (33.33%) Schizophrenia, unspecified, 1 (33.33%) Schizoaffective disorder, unspecified and 1 (33.33%) Unspecified dementia with behavioral disturbance type during the measurement period. Furthermore, MCO C reported that out of the 3 MLTSS NF Mental Health discharges that did not have a follow up visit with a mental health practitioner within 30 days of discharge, it was discovered that 3 (100%) members were discharged to a Skilled Nursing Facility post hospital discharge. MCO C reported that they have developed a workgroup to strategize and manage Post Facility Follow up visits for Behavioral health admissions. Tracking reports have been created and are being monitored daily with a bi-weekly review to maintain compliance. MCOs D and E reported that there were no claims for inpatient admissions events for NF population with a principal diagnosis of mental illness during the measurement period for inclusion for the measurement period 1/1/2020 – 3/31/2020. The MCOs reported that Behavioral health admissions and tracking reports are being monitored frequently to maintain compliance. The reported rates for MCOs C, D, and E during the 7/1/2019 - 9/30/2019 and 10/1/2019 – 12/31/2019 measurement periods are reported within the tables above and are indicated with red font. MCO A is working with the State's EQRO on their coding for this performance measure and have an extension to submit this

report next quarter. This data along with any reconciled rates will be included in the next quarterly report

PM # 41	MLTSS services used by MLTSS HCBS members: PCA services and Medical Day services only.
Numerator:	The unique count of members with at least one claim for Medical Day services AND at least one claim for PCA services during the measurement period. Exclude members with a claim for any other MLTSS service during the measurement period.
Denominator:	The unique count of members enrolled in MLTSS HCBS at any time during the measurement period.
Data Source:	MCO
Frequency:	Quarterly/Annually - Lag Report Due: 210 day lag after quarter and year

1/1/2020 - 3/31/2020	A	B	C	D	E	TOTAL
Numerator	136	348	615	146	1374	**2619**
Denominator	1759	5384	13971	5928	8902	**35944**
%	7.7	6.5	4.4	2.5	15.4	**7.3**

The above data reflects per MCO the unique count of members enrolled in MLTSS HCBS at any time during the measurement period with at least one claim for Medical Day services AND at least one claim for PCA services, excluding members with a claim for any other MLTSS service during the measurement period. MCO A reported 136 out of 1759 members had claims submitted for MDC and PCA services provided during the 1/1/2020 – 3/31/2020 measurement period. These 136 members did not have MLTSS-specific services during this period, according to paid claims. This result calculates to 7.7% of HCBS members received MDC and PCA and not any MLTSS-specific services. This result is increase from the previous measurement period where the percentage was 6.1%. Additionally, MCO A reported that all 136 of the MDC recipients were receiving Adult Day services; none received Pediatric Day services. Furthermore, MCO A reported that data for this measure is shared with MLTSS Care Managers, so that members can be targeted for options counseling to add MLTSS-specific services. If data review indicates authorizations for MLTSS services but no claims for that period, the Provider Relations liaison will be notified to follow up with providers. For Measurement Period 1/1/2020 – 3/31/2020, MCO C reported that 4% (615) members out of 13,971 had at least one claim for PCA and MDC services and did not have any other MLTSS service claims during the 1/1/2020 3/31/2020 measurement period. Additionally, MCO C reported that the average amount of PCA services authorized was 22 hours per week and the average amount of MDC services authorized was 5 days per week. Furthermore, MCO C reported that the member's age ranged from 33 years old to 105 years old, with the average age being 78 years old. There were no pediatric members receiving both MDC and PCA only. MCO C reported they will continue to monitor these members to verify their needs are being met, continue to be appropriate for the MLTSS Program and will also determine if the member can benefit from additional services. MCO E reported that there were 1374 members identified as having PCA and Medical Day Care Services only or 15.43% during the measurement period 1/1/2020 – 3/31/2020. Of the 1374 members reported in the numerator, 1305 (94.98%) were age 65 or older; 189 of 1374 were enrolled in FIDE-SNP (13.76%). Additionally, MCO E reported that 1298 of the 1374 members identified in the numerator are still actively enrolled in the plan and 17 members have since transitioned to a NF setting.

Furthermore, MCO E reported reveals a large representation of members of Asian or Indian ethnicity. Care managers continue to offer the full complement of MLTSS services to all members but have found cultural values can affect the services members are comfortable accepting and may be a factor for this measure. MCO E reported that they will continue to re-educate staff regarding MLTSS services and continue routine review of services offered by care managers to monitor for trends and to ensure that the full complement of MLTSS services is made available to all members.

PM # 42	Follow-up after Emergency Department visit for Alcohol or Other Drug Dependence (AOD) for MLTSS HCBS members: HEDIS FUA
Numerator:	Sum of qualifying follow-up visits with any practitioner, with a principle diagnosis of AOD within 30 days after the ED visit (31 total days). Only the 30 day follow-up rate is reported.
Denominator:	Follow HEDIS specifications for Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) for MLTSS HCBS members. The denominator for this measure is based on ED visits, not on members.
Data Source:	MCO
Frequency:	Quarterly/Annually - Lag Report Due: 240 day lag after quarter and year

7/1/2019 - 9/30/2019	A	B	C	D	E	TOTAL
Numerator	0	1	4	1	0	**6**
Denominator	6	10	33	9	15	**73**
%	0	10	12.1	11.1	0	**8.2**

10/1/2019 - 12/31/2019	A	B	C	D	E	TOTAL
Numerator	0	0	9	0	1	**10**
Denominator	7	4	31	6	10	**58**
%	0	0	29	0	10	**17.2**

1/1/2020 - 3/31/2020	A	B	C	D	E	TOTAL
Numerator	2	1	5	1	0	**9**
Denominator	7	6	32	6	10	**61**
%	28.6	16.7	15.6	16.7	0	**14.7**

The MCOs are reporting some challenges in obtaining this data due to limited access to Medicare claims for dual eligible members. MCO A reported that they received ED claims for 7 HCBS members with a principal diagnosis of Alcohol or other Drug Dependence (AOD) during the 1/1/2020 – 3/31/2020 measurement period. Of these 7 members, two members had claims for a qualifying follow-up visit within 30 days of the ED visit which calculates to 28.6 % of having timely follow-up. Additionally, MCO A reported that all of the ED visit members were men. The diagnosis were Alcohol abuse uncomplicated (1), Alcohol abuse with intoxication unspecified (2), Sedative HYP/Anxiolytic depend W/Withdrawal UNS (1), Opioid dependence uncomplicated (1), Alcohol dependence

uncomplicated (1), and Opioid abuse uncomplicated/ other psychoactive substance abuse uncomplicated (1). Furthermore, MCO A reported that MLTSS care manager will continue to outreach to the Behavioral Health team for guidance and resources, in order to coordinate care between Substance Abuse and physical health needs. For the measurement period, 1/1/2020 -3/31/2020 measurement period, MCO C reported 32 MLTSS HCBS ED visits with a principal diagnosis of Alcohol or Other Drug Dependence; of which 5 (16%) had a follow-up visits that occurred within 30 days following the ED visit. Additionally, MCO C reported that out of the 27 MLTSS HCBS ED visits that did not have a follow-up visit within 30 days, 23 (85%) claims were received within the 30 day window timeframe however there was no follow-up visit. Furthermore, MCO C identified the top three diagnoses of Alcohol or Other Drug Dependence during the measurement period to be (34%) Alcohol abuse with intoxication, unspecified, (9%) Alcohol abuse, uncomplicated and (9%) Alcohol abuse with intoxication, uncomplicated. MCO C reported that they will continue to track the number of follow up visits within 30 days of the ED visits for the MLTSS HCBS members with a principle diagnosis of Alcohol or Other Drug Dependence. MCO E reported 10 Emergency Department events for 9 unique HCBS members with a principal diagnosis of Alcohol or other Drug Dependence (AOD), of which none received a follow up visit after the ED event (0.00%). MCO E reported that there was a decrease in the percentage of members reported for this measure from 10% in the measurement period 10/1/2019 – 12/1/2019 to the current 0.0% rate for this measurement period. Additionally, MCO E reported that timely outreach for coordination of follow up appointments for this population is a challenge as most of the ER visits are not reported timely to the plan. Most of the findings are claims based as authorization for ED treatment is not required. Furthermore, MCO E reported that they will continue to have care management staff reinforce the need for notification for all ED visits to ensure ongoing appropriate follow up and care. The reported rates for MCOs A and D during the 7/1/2019 - 9/30/2019 and 10/1/2019 – 12/31/2019 measurement periods are reported within the tables above and are indicated with red font.

PM # 43	Follow-up after Emergency Department visit for Alcohol or Other Drug Dependence (AOD) for MLTSS NF members: HEDIS FUA
Numerator:	Sum of qualifying follow-up visits with any practitioner, with a principle diagnosis of AOD within 30 days after the ED visit (31 total days). Only the 30 day follow-up rate is reported.
Denominator:	Follow HEDIS specifications for Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) for MLTSS NF members. The denominator for this measure is based on ED visits, not on members.
Data Source:	MCO
Frequency:	Quarterly/Annually - Lag Report Due: 240 day lag after quarter and year

7/1/2019 - 9/30/2019	A	B	C	D	E	TOTAL
Numerator	0	0	3	0	0	**3**
Denominator	0	0	8	0	0	**8**
%	0	0	37.5	0	0	**37.5**

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

Deliverables due during MLTSS 2nd quarter (10/1/2020 – 12/31/2020)

10/1/2019 - 12/31/2019	A	B	C	D	E	TOTAL
Numerator	0	0	0	0	0	**0**
Denominator	0	0	3	0	0	**3**
%	0	0	0	0	0	**0**

1/1/2020 - 3/31/2020	A	B	C	D	E	TOTAL
Numerator	0	0	0	0	0	**0**
Denominator	1	0	5	0	0	**6**
%	0	0	0	0	0	**0**

The MCOs are reporting some challenges in obtaining this data due to limited access to Medicare claims for dual eligible members. MCO C reported that there were 5 MLTSS NF ED visits with a principal diagnosis of Alcohol or Other Drug Dependence during the measurement period, of which 0 (0%) had follow-up visits that occurred within 30 days after the ED visit during the 1/1/2020 – 3/31/2020 measurement period. Additionally, MCO C reported there was 1 (20%) MLTSS NF member that had 3 ED visits within the measurement period, of which 0 (0%) were found to have follow up visit that occurred within 30 days after the ED visit. MCO C discovered that out of the 5 MLTSS NF ED visits that did not have a follow-up visit within 30 days, 4 (80%) claims were received within the 30 day window timeframe however there was no follow-up visit. Furthermore, MCO C identified the diagnoses of Alcohol or Other Drug Dependence during the measurement period to be (40%) Alcohol abuse with intoxication, unspecified, (40%) Alcohol abuse, uncomplicated and (20%) Other psychoactive substance abuse, uncomplicated. MCO C reported they will continue to track the number of follow up visits within 30 days of the ED visits for the MLTSS NF members with a principle diagnosis of Alcohol or Other Drug Dependence and are in the process of developing more frequent claims reports to identify members that have been treated in an ED for AOD dependence. MCOs B, D, and E reported 0 ED visits that require follow-up with a practitioner for a principle AOD diagnosis. The MCOs reported that they will continue to monitor these members to verify that their needs are being met and continue to monitor this data for trends. The reported rates for MCOs A and D during the 7/1/2019 - 9/30/2019 and 10/1/2019 – 12/31/2019 measurement periods are reported within the tables above and are indicated with red font.

PM # 44	Follow-up after Emergency Department visit for Mental Illness for MLTSS HCBS members: HEDIS FUM
Numerator:	Sum of qualifying follow-up visits with any practitioner, with a principle diagnosis of a mental health disorder or with a principle diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 30 days after the ED visit (31 total days). Only the 30 day follow-up rate is reported.
Denominator:	Follow HEDIS specifications for Follow-Up after Emergency Department Visit for Mental Illness (FUM) for MLTSS HCBS members. The denominator for this measure is based on ED visits, not on members.
Data Source:	MCO
Frequency:	Quarterly/Annually - Lag Report Due: 240 day lag after quarter and year

Deliverables due during MLTSS 2nd quarter (10/1/2020 – 12/31/2020)

7/1/2019 – 9/30/2019	A	B	C	D	E	TOTAL
Numerator	0	5	15	9	6	35
Denominator	1	10	35	12	8	66
%	0	50	42.9	75	75	53

10/1/2019 – 12/31/2019	A	B	C	D	E	TOTAL
Numerator	0	2	22	9	2	35
Denominator	2	6	41	13	3	65
%	0	33.3	53.7	69.2	66.7	53.8

1/1/2020 - 3/31/2020	A	B	C	D	E	TOTAL
Numerator	0	5	19	9	3	36
Denominator	2	5	42	15	9	73
%	0	100	45.2	60	33.3	49.3

The MCOs are reporting some challenges in obtaining this data due to limited access to Medicare claims for dual eligible members. MCO B reported 5 ED visits for mental illness that required a follow-up visit with a healthcare professional; of those 5, all successfully resulted in a visit within 30 days of discharge during the measurement period 1/1/2020 – 3/31/2020. Additionally, MCO B reported this denominator consisted of 5 unique members, 4 of the members were in the 65+ age bracket while 1 was in the 18-64 age bracket. Furthermore, MCO B reported that they will continue the interdisciplinary efforts between MLTSS care management and BH care management to ensure appropriate follow-up visits are completed timely. For Measurement Period 1/1/2020 – 3/31/2020, MCO D reported that there were 15 ED visits for eligible MLTSS HCBS members with a principle diagnosis of Mental Illness or Intentional Self-Harm; of which 9 had a follow-up visits that occurred within thirty days after an ED visit for MLTSS HCBS members with a principal diagnosis of Mental Illness or Intentional Self-Harm. MCO D reported that 6 discharges had no claims received for a qualifying follow up visit.

Additionally, MCO D reported that they will continue to monitor emergency room discharges for MLTSS HCBS members with a diagnosis of Mental Illness or Intentional Self-Harm. MCO E reported that they identified 9 qualifying events for follow up after ED visit for Mental illness for HCBS members, and of the members identified in the denominator, 3 met the criteria for inclusion in the numerator as having had a follow up visit with a provider within 30 days after an ED visit, for a 33.33% compliance rate for the measurement period 1/1/2020 – 3/31/2020. This is a decrease from the previous measurement period from 66.67% to 33.33%. Additionally, MCO E reported that of the 9 members identified in the denominator, 5 members were over the age 65 (55.6%) and there were 4 members enrolled in FIDE- SNP (44.4%). Furthermore, MCO E reported the diagnoses for treatment include: 5 events for major depressive disorder single episode unspecified, 2 events for schizoaffective disorder unspecified, 1 event for adjustment disorder and 1 event for bipolar disorder unspecified. MCO E reported that they will continue to monitor claims-based reporting on a regular basis as well as continue to discuss high ED utilizers within the plan's High Utilizer Task Force. The purpose of this group is to develop inter-departmental interventions to decrease ED utilization. The

reported rates for MCOs A and D during the 7/1/2019 - 9/30/2019 and 10/1/2019 – 12/31/2019 measurement periods are reported within the tables above and are indicated with red font.

PM # 45	Follow-up after Emergency Department visit for Mental Illness for MLTSS NF members: HEDIS FUM
Numerator:	Sum of qualifying follow-up visits with any practitioner, with a principle diagnosis of a mental health disorder or with a principle diagnosis of intentional self-harm and any diagnosis of a mental health disorder within 30 days after the ED visit (31 total days). Only the 30 day follow-up rate is reported.
Denominator:	Follow HEDIS specifications for Follow-Up after Emergency Department Visit for Mental Illness (FUM) for MLTSS NF members. The denominator for this measure is based on ED visits, not on members.
Data Source:	MCO
Frequency:	Quarterly/Annually - Lag Report Due: 240 day lag after quarter and year

7/1/2019 - 9/30/2019	A	B	C	D	E	TOTAL
Numerator	0	0	7	1	0	**8**
Denominator	0	0	19	2	0	**21**
%	0	0	36.8	50	0	**38.1**

10/1/2019 - 12/31/2019	A	B	C	D	E	TOTAL
Numerator	0	0	5	3	0	**8**
Denominator	0	0	17	4	0	**21**
%	0	0	29.4	75	0	**38.1**

1/1/2020 - 3/31/2020	A	B	C	D	E	TOTAL
Numerator	0	0	6	0	0	**6**
Denominator	0	0	16	3	0	**19**
%	0	0	37.5	0	0	**31.6**

MCOs are reporting some challenges in obtaining this data due to dual eligible members and limited access to Medicare claims. MCO C reported there were 16 MLTSS NF ED visits with a principal diagnosis of Mental Illness during the measurement period, of which none were MLTSS SNP NF, and of the 16 ED visits, there were 6 (38%) follow-up visits that occurred within 30 days following the ED visit during the measurement period 1/1/2020 – 3/31/2020. Additionally, MCO C identified the top three diagnoses for Mental Illness during the measurement period to be (25%) Major depressive disorder, single episode, unspecified, (19%) Conduct disorder, unspecified and (13%) Bipolar disorder, Unspecified. Furthermore, MCO C reported that of the 16 MLTSS NF ED visits, there were 12 (75%) Dual Medicaid/Medicare of which none were enrolled in our MLTSS SNP plan. MCO C reported that 7 (44%) of the members were 65 years old or older and 9 (56%) were between the ages of 18-64 years old. MCO C reported that they will continue to track the number of follow up visits within 30 days of the ED visits for the MLTSS NF members with a principle diagnosis of Mental Illness.

For the measurement period, 1/1/2020 – 3/31/2020, MCO D reported 3 ED visits for eligible MLTSS NF members with a principle diagnosis of Mental Illness or Intentional Self-Harm during the measurement period; of which none had a claim for a qualifying follow-up visit that occurred within thirty days after an ED visit for MLTSS NF members with a principal diagnosis of Mental Illness or Intentional Self-Harm. MCO D reported that they will continue to monitor emergency room discharges for MLTSS NF members with a diagnosis of Mental Illness or Intentional Self-Harm.
The reported rates for MCOs A and D during the 7/1/2019 - 9/30/2019 and 10/1/2019 – 12/31/2019 measurement periods are reported within the tables above and are indicated with red font.

PM # 46	MLTSS HCBS members not receiving MLTSS HCBS, PCA or Medical Day Services
Numerator:	The unique count of members with no PCA, Medical Day or MLTSS HCBS services while enrolled in MLTSS HCBS during the measurement period.
Denominator:	The unique count of members enrolled in MLTSS HCBS at any time during the reporting period.
Data Source:	MCO
Frequency:	Quarterly/Annually - Lag Report Due: 180 day lag after quarter and year

7/1/2019 - 9/30/2019	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**

10/1/2019 - 12/31/2019	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**

1/1/2020 - 3/31/2020	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**

The MCOs are working with the State's EQRO on their coding for this performance measure and have an extension to submit this report next quarter. This data will be included in the next quarterly report.

Deliverables due during MLTSS 2nd quarter (10/1/2020 – 12/31/2020)

PM # 46a	MLTSS HCBS members not receiving MLTSS HCBS, PCA or Medical Day Services: Members with 60 days continuous enrollment in MLTSS HCBS
Numerator:	The unique count of members with no PCA, Medical Day or MLTSS HCBS services while enrolled in MLTSS HCBS during the measurement period.
Denominator:	The unique count of members enrolled in MLTSS HCBS during the reporting period who met continuous enrollment criteria.
Data Source:	MCO
Frequency:	Quarterly/Annually - Lag Report Due: 180 day lag after quarter and year

7/1/2019 - 9/30/2019	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**

10/1/2019 - 12/31/2019	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**

1/1/2020 - 3/31/2020	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**

The MCOs are working with the State's EQRO on their coding for this performance measure and have an extension to submit this report next quarter. This data along with any reconciled rates will be included in the next quarterly report.

Deliverables due during MLTSS 2nd quarter (10/1/2020 – 12/31/2020)

PM # 18A	% of CIs the MCO became aware of during the measurement period that were reported to the State
Numerator:	# of CIs in the denominator reported to the State as of the 7th day of the month following the end of the measurement period
Denominator:	# of CIs the MCO became aware of during the measurement period
Data source:	MCO
Measurement period:	7/1/2020 – 9/30/2020

PM # 18B	% of CIs in the denominator the MCO reported to the State within 2 business days
Numerator:	# of CIs in the denominator that were reported to the State within two business days
Denominator:	# of CIs the MCO became aware of during the measurement period
Data source:	MCO
Measurement period:	7/1/2020 – 9/30/2020

PM # 18C	% of CIs that the MCO became aware of during the measurement period for which a date of occurrence was available
Numerator:	# of CIs in the denominator for which a date of occurrence is known
Denominator:	# of CIs the MCO became aware of during the measurement period
Data source:	MCO
Measurement period:	7/1/2020 – 9/30/2020

PM # 18D	Of those CIs with a known date of occurrence, average # of days from date of occurrence to date MCO became aware
Numerator:	Sum of days from date of occurrence to date MCO became aware of the CI
Denominator:	# of CIs the MCO became aware of during the measurement period for which a date of occurrence is known
Data source:	MCO
Measurement period:	7/1/2020 – 9/30/2020

The MCOs are working with the State's EQRO on their coding for PM #18 and have an extension to submit this report next quarter. This data will be included in the second quarter report.

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

New Jersey Comprehensive Demonstration
Section 1115 Quarterly Report
***Demonstration Year: 9* (7/1/19-6/30/20)**
***State Fiscal Quarter:* Quarter 2 (10/01/20-12/31/20).**

I. Introduction

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

This five year demonstration will:

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

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

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

This quarterly report is submitted pursuant to Special Term and Condition (STC) 71 in the New Jersey Comprehensive Demonstration; 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.

Excepting certain temporary changes due to the COVID-19 emergency, there have been no anticipated changes in trends or issues related to eligibility, enrollment, disenrollment, access, and delivery networks in the current quarter.

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

There are no anticipated changes in populations served or benefits.

III. Enrollment Counts for Quarter

Demonstration Populations by MEG	Total Number of Demonstration participants Quarter Ending 03/20	Total Number of Demonstration participants Quarter Ending 06/20	Total Number of Demonstration participants Quarter Ending 09/20	Total Number of Demonstration participants Quarter Ending 12/20
Title XIX	652,618	684,639	717,299	740,728
ABD	230,478	228,012	228,863	225,685
LTC				
HCBS - State plan	16,831	16,613	16,539	17,914
TBI – SP				
ACCAP – SP				
CRPD – SP				
GO – SP				
HCBS - 217-Like	16,847	16,787	17,133	17,789
TBI – 217-Like				
ACCAP – 217-Like				
CRPD – 217-Like				
GO – 217-Like				
SED - 217 Like	334	344	343	363
IDD/MI – (217 Like)	733	595	486	432
NJ Childless Adults				
AWDC	344,613	374,427	399,322	424,783
New Adult Group	176,072	195,100	203,689	211,286
SED at Risk	2,931	2,752	2,583	2,588
MATI at Risk				
Title XXI Exp Child				

NJFAMCAREWAIV-POP 1	[redacted]
NJFAMCAREWAIV-POP 2	
XIX CHIP Parents	

IV. Outreach/Innovative Activities to Assure Access

MLTSS
The State has continued to maintain its efforts to ensure that consumers, stakeholders, MCOs, providers and other community-based organizations are knowledgeable about MLTSS and informed of changes. The State has depended on its relationships with stakeholder groups to inform consumers. During this quarter, DHS gave an MLTSS update to the following long-term care industry providers: October 21, 2020- the New Jersey Medical Assistance Advisory Council, a group comprised of medical care and health services professionals as well as advocacy groups who advise the State's Medicaid Director. The meeting topics included Behavioral Health, Nursing Facility Legislation, COVID-19 Program Impact including federal flexibilities and NJ FamilyCare enrollment trends, Autism Services, and Department Initiatives including 1115 Renewal, Doula Benefits, and Electronic Visit Verification. During the state of emergency, DHS continues outreach and technical assistance efforts with consumers and stakeholders. DHS has a webpage dedicated to COVID-19 waiver flexibilities and interim processes to communicate to providers and facilitate access to services for consumers. Additionally, DMAHS hosts weekly calls with the five contracted MCOs to provide updates specific to the public health emergency and identify challenges and policy needs. The Office of Managed Health Care (OMHC) has remained committed to its communications efforts to ensure access through its provider networks. Its provider-relations unit has continued to respond to inquiries through its email account on these issues among others: MCO contracting, credentialing, reimbursement, authorizations, appeals and complaint resolution.
ASD/I-DD/SED
CSOC will continue to promote services at community meetings and will review the need to expand the network of providers to assure timely access to services as appropriate.
Supports Program and Community Care Program
Division of Developmental Disabilities (DDD) is responsible for the daily operations of both the Supports Program (SP) and the Community Care Program (CCP). DDD addresses outreach and activities for both their programs concurrently as the same providers and advocacy organizations are affiliated with both programs. Additionally, the majority of the supports and services are identical in both programs. The primary difference between the two programs is the required level of care. Therefore, the below represents outreach and collaboration with our State partners, beneficiaries, families, and the provider and advocacy communities that is representative of both DDD programs. However, data metrics are broken down by program. The Demonstration Unit established a "DDD Medicaid Eligibility Helpdesk" to assist families, providers, advocates, etc. with questions related to Medicaid and the operations of the SP and CCP as related to

Medicaid and billing. During this quarter, there were 1404 questions submitted and answered. Three domains compose approximately 74% of the emails received. These areas are Medicaid troubleshooting (36%), voucher payments (18%), and transitioning between demonstration programs (i.e.: From MLTSS to Supports Program + Private Duty Nursing, SP to CCP, CCP to MLTSS, etc.) (20%). The remainder of the questions focus on citizenship issues, wavier admission questions, follow-up emails that resulted in an immediate resolution, emails that need to be routed to a different helpdesk or Unit, and Boards of Social Services verifying that certain applicants were DDD eligible. The Boards of Social Services reaching out to the helpdesk remains a very low number, but this marks the second quarter of this outreach between social service agencies and demonstrates the success of the DDD and Medicaid teams working together and meeting routinely to discuss systems intersection. This outreach helps ensure that all available Medicaid eligibility categories are looked into before a determination is made. Families have reported their appreciation for these efforts of inter-agency collaboration. The helpdesk is also involved in assisting DDD eligible children who are losing their EPSDT PDN services on their 21st birthday as well as individuals who want to change from one program to another. Examples include children losing their nursing benefit on their 21st birthday and needing the SP+PDN to cover the nursing benefit until graduation from high school, individuals wanting to transfer from MLTSS to a DDD program, or movement from the SP to the CCP. During this quarter, state staff worked remotely and congregate day facilities were closed for most of the quarter. This quarter represented the third decrease in the number of questions submitted to the helpdesk since its inception. Similar to the last quarter, there was a decrease of approximately 200 questions. Anecdotally, the decrease may be due to the approved federal Appendix K flexibilities, the COVID-19 operational guidance page, and the bi-weekly Communication Update webinars conducted by DDD's Assistant Commissioner.

Interim Management Entity (IME)

During this quarter, the Interim Managing Entity (IME) received 9,005 calls from individuals seeking information, referral or admission to SUD treatment. There were 1,084 referrals for treatment and 982 individuals who received Care Coordination (CC) services through the IME to facilitate treatment admission. CC services are offered to any individual waiting 2 days for admission to treatment. In addition, the IME received 1,976 provider assistance calls to support Medicaid SUD treatment providers. The IME Utilization Management (UM) staff perform clinical reviews based on ASAM criteria for treatment admission to appropriate levels of care. The IME issued 6,040 prior authorizations for Medicaid beneficiaries to enter treatment, and 2,189 clinical reviews for Medicaid beneficiaries to extend treatment based on clinical need.

V. Collection and Verification of Encounter Data and Enrollment Data

Summary of Issues, Activities or Findings

No issues or findings.

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

MLTSS

DMAHS convenes a bi-weekly meeting with state staff from the various Divisions involved in MLTSS to discuss any issues to ensure that they are resolved timely and in accordance with the rules and regulations that govern the Medicaid program. The state also continues to have monthly 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/I-DD/SED

There were a total of 815 youth enrolled in the Children's Support Services Program Intellectual/Developmental Disabilities (CSSP I/DD) during this reporting period. There were an additional 376 youth enrolled in the CSSP Serious Emotional Disturbance (SED) that received Plan A Medicaid benefits that would have not otherwise been eligible for these benefits if not for demonstration participation.

As needed, implementation meetings were held with the Division of Medical Assistance and Health Services (DMAHS), Gainwell Technologies (Medicaid's fiscal agent), Children's System of Care (CSOC) and CSOC's Contracted Systems Administrator (CSA). CSOC will continue to assist and provide technical assistance to providers as it relates to procedures. CSOC will continue to promote services at community meetings and will review the need to expand the network of providers to assure timely access to services as appropriate.

Supports Program and Community Care Program

At the close of this quarter the SP enrollment was approximately 11,400 and the CCP enrollment was approximately 11,775.

Despite working remotely this quarter, DDD administration continued to participate in or facilitate meetings with the provider community, families, advocacy organizations, councils, and disability rights leaders through bi-weekly webinars which provided operational updates and guidance. In addition to the bi-weekly webinars, the Department of Human Services created a COVID-19 webpage that provides ongoing guidance in addition to a dashboard related to DDD operations and individuals served. Work also continued on NJ's electronic visit verification implementation with its state and community partners.

Other

Managed Care Contracting:

There are no updates for this quarter.

Self-attestations:

There were a total of 10 self-attestations for this quarter. The total number of self-attestations as of December 31, 2020 is 1109.

MCO Choice and Auto-assignment:

The number of individuals who changed their MCO after auto-assignment is 3,246.

MLR:

	SFY19 MLR Summary	
	Acute	**MLTSS**
Horizon	91.1%	91.9%
UHC	96.0%	94.3%
Amerigroup	92.4%	98.7%

Aetna	90.3%	93.5%
Wellcare	96.8%	95.4%

VII. Action Plan for Addressing Any Issues Identified

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

VIII. Financial/Budget Neutrality Development/Issues

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

IX. Member Month Reporting

Please refer to the Budget Neutrality workbook for Member Month Reporting.

A. For Use in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Title XIX				
ABD				
LTC (following transition to MLTSS)				
HCBS -State Plan				
TBI – SP				
ACCAP – SP				

CRPD – SP				
GO – SP				
HCBS -217 Like				
TBI – 217-Like				
ACCAP – 217-Like				
CRPD – 217-Like				
GO – 217-Like				
SED -217 Like				
IDD/MI -(217 Like)				
NJ Childless Adults				
New Adult Group				
Title XXI Exp Child				
XIX CHIP Parents				

X. Consumer Issues

Summary of Consumer Issues

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

	Aetna	Amerigroup	Horizon NJ Health	United Healthcare	WellCare
1	PCP Changes	Members/Providers calling for authorization status.	Medical emergency resulting in need for Medical treatment	Membership Record- eligibility inquiry	Member inquired regarding PPP, new application or update of status.
2	Eligibility	Members calling to contact their Care Manager.	Inappropriate Provider Conduct	Benefits	Members calling to speak to Care Managers or inquiring about additional OTC benefits.
3	Provider Search	Member calling with questions regarding the PPP program.	Fall resulting in in the need for medical treatment	PCP Inquiry	MLTSS members calling to speak to their assigned CM.
4			PCA Provider issues		Authorization status updates and new requests.

5			Claims questions		

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

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
1	Prior Auth Status	Service coding	PPP questions	Service coordination	Provider calls requesting status updates or new authorization requests for services
2	Claims status	PPP questions	Claims status	Member eligibility status	Authorization status updates and new requests.
3	Service coding	Eligibility verification	Prior Authorization	Claims status	Provider network status
4		Claims status	Claims payment issue	Prior authorization status	Member eligibility verification
5		Service coding	Member eligibility status	PPP question	Claims status

XI. Quality Assurance/Monitoring Activity

MLTSS:

MLTSS Claims Processing Information by MCO

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
# Claims Received	123,855	149,647	808,404	62,382	217,040
# Claims Paid	97,729	140,270	734,443	59,625	191,065
# Claims Denied	19,597	9,149	44,588	2,306	19,232
# Claims Pending	6,529	228	29,283	424	6,743

Top Reasons for MLTSS Claims Denial by MCO

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
1	M86 - Service denied because payment already made	Paid at contracted rate	The claim is a duplicate of a previously submitted claim	benefits based on admission date	No Authorization

	for same/similar procedure within set time frame.				
2	18 - EXACT DUPLICATE CLAIM/SERVICE	Paid per established rates	Provider not eligible by contract for payment	Secondary medical coverage	No Patient Responsibility
3	96 - NON-COVERED CHARGE(S)	Procedure non-reimbursable	Resubmit with EOB from Medicare	no authorization on file	Timely Filing
4		Units exceed UM authorization	Incomplete/Missing Payer Claim Control Number		Members requesting change of PCP and new ID cards as needed.
5		Deny preauth not obtained	Provider not eligible by contract for payment		

ASD/I-DD/SED

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

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

CSOC continues ongoing collaboration with the DMAHS Quality Monitoring team that is providing oversight on quality assurance. Please see Attachment B.

Supports and Community Care Program:

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

DDD requires reporting on approximately 80 Incident Reporting (IR) codes. The IR codes are the same for both DDD demonstration programs. During this quarter there were 396 incidents reported for 375 individuals on the Supports Program. Approximately 77% of those incidents were coded as a COVID-19 medical event which represents a significant decrease from the previous quarter which was 92% of incidents were coded as COVID-19. The event ranges from possible exposure to COVID-19, a negative or positive COVID-19 test result, or death from COVID-19.. For the CCP, there were 2,758 incidents reported for 2,499 individuals this quarter. The COVID-19 related incidents represent the majority of

incidents (55%), however this is a 9% decrease in CCP COVID incidents since last quarter. The majority of individuals with incident reports filed in both programs experienced a single incident this quarter. Due to the State of Emergency and anticipated health crisis 2 new Incident Codes were developed for COVID in March 2020. One was for a medically-related COVID incident and the other was for an operational breakdown such as insufficient staffing. These codes already existed, but a modifier of COVID was added for trending and tracking. Some IR codes, such as abuse, neglect, or exploitation require an investigation by the Office of Investigations. Less than 1% of the Incident Reports filed required an investigation by the Office of Investigations. If there were minor or no injuries, then the provider agency is responsible to conduct an investigation and submit their findings/action plan for review by the Department of Human Services Critical Incident Management Unit. If there were moderate to major injuries, then the Department of Human Services Special Response Unit will conduct an investigation. The ORM will continues to conduct quarterly analysis around choking and walkaway incidents and provides updates to supporting units (Support Coordination Unit/Provider Performance and Monitoring Unit). The annual Walkaway Report was worked on this quarter and is expected to be finalized and shared next quarter. A meeting to review the final Walkaway Report, including quality initiatives and remediation actions, is scheduled for next quarter.

A Risk Council meets to look at IR from a system perspective. This committee meets quarterly and develops action items based on the data, however this has been put on hold since moving to remote work and new COVID-19 initiatives and policies needed to be developed and implemented by this team. A Risk Council meeting is scheduled for the next quarter and will be held remotely via Teams. The Risk Management Unit also conducts systemic and individual remediation activities because of IR analysis which has continued during the remote work.

Quality Unit staff and the Provider Performance & Monitoring Unit created monitoring activities and tools. These tools are utilized to monitor Medicaid/DDD approved providers for both DDD programs and provides further guidance technical assistance based on the results/findings. Data is entered into the databases and reports continue to be developed. Databases were/are being built so that data may be analyzed more efficiently and systemic issues can be identified and corrected. However, the Provider Performance and Monitoring Unit has conducted reviews of Day Services and Individual and Community Based Supports and has been providing exit interviews, findings reports, and technical assistance to a variety of providers. Providers are required to submit a plan of correction to PPMU. The PPMU and Demonstration Unit are conducting monthly meetings to ensure demonstration compliance and improvement activities when needed. The PPMU conducted outreach to providers as a result of day facilities closing and to residential providers and families who might be in need of personal protective equipment. A web page dedicated to COVID-19 communications and guidance documents was developed and bi-weekly webinars are conducted for the DDD community to get updates. Since the day facilities were closed due to COVID-19, the Provider Performance and Monitoring Unit, together with the Provider community developed requirements and protocols to be put into place when in order to reopen. Congregate day facilities were allowed to reopen to 25% capacity as long as safety protocols were in place during this quarter, but were closed again around the holidays in order to prevent a possible surge from anticipated holiday gatherings.

Three surveys were developed around the demonstration service: support coordination. Specifically, the surveys were: 1) Providers to complete on various questions related to their overall experiences with support coordination agencies, 2) Support Coordinators are to complete various questions related to their caseload size, salary, overall experiences with provider agencies, 3) Support Coordination Supervisors to complete various questions related to their role and tasks. Because of feedback from

the advocacy community, a fourth survey was created for families to complete including a Spanish version. All surveys were released and closed the end of July, but were re-opened for an additional few weeks to allow for additional respondents. The survey results have been placed into 3 different Power Point presentations and was shared with Division Leadership. The data was scheduled to be shared at the March 2020 quarterly Provider and Family meetings, however due to the State of Emergency and work from home order this did not occur. The quarterly meetings did occur, but they were focused on the new work climate and COVID. The intent remains to share the results of the survey, receive feedback from the provider and family community, and implement quality improvement initiatives, however this has not yet occurred. A meeting is scheduled for next quarter to discuss how this information should be shared now that working remotely has occurred for an extended period of time.

A committee was developed to create a guidebook for Support Coordinators related to the Person Centered Planning Tool that is used to develop Outcomes in the service plan. The guidebook was developed as a quality improvement activity to increase the person-centered philosophy when completing the PCPT and NJ ISP (DDD's service plan). A review sheet is being finalized determine if the guidebook is having an influence of the service plan development.

Meetings to address audits for the calendar year 2021 were scheduled for next quarter.

DDD participates in the National Core Indicators. DDD will be participating again this year and is including the COVID-19 questions developed by HSR will be included. DDD will also participate in the Staff Stability survey again this year. HSRS recognized DDD's participation rate by providers during our first year (2019) as high and just informed NJ DDD of the 2020 response rate that far exceeded the previous year's rate. DDD is appreciative of the providers participating as it is expected to yield interesting and informative data since it was during the public health emergency.

Other Quality/Monitoring Issues:

EQR PIP

Currently, the Division of Medical Assistance and Health Services (DMAHS) is actively engaged in three performance improvement projects (PIPs) in both clinical and non-clinical areas. In January 2018, Aetna (ABHNJ), Amerigroup (AGNJ), Horizon (HNJH), United (UHC), and WellCare (WCHP) initiated a PIP with the focus on Developmental Screening and Early Intervention. The sustainability period concluded for all five MCOs on December 31, 2020 and a final project status report will be submitted in August 2021. In January 2019, the MCOs initiated a collaborative PIP with a focus on Risk Behaviors and Depression in the Adolescent Population. The year 2 measurement period concluded on December 31, 2020 for all five MCOs. In September 2020, the MCOs submitted individual Non-Clinical PIP proposals with a focus on Access to and Availability of PCP Services tied to claims. The individual proposals were reviewed and approved by the EQRO, and project activities will be initiated by the MCOs in early 2021.

State Sanctions against MCO, ASO, SNP or PACE Organization:

There were no State Sanctions taken against an MCO, ASO, SNP, or Pace Organization this quarter.

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.***
	Claims data preparation and analysis for the interim report due in June 2021 continued during this quarter. This included identification of populations and calculation of quality metrics and health indicators through calendar year 2019. The State's independent evaluator also received requested HEDIS and CAHPS reports from the State that will be used for monitoring overall quality in managed care during the Demonstration and began the analysis of these data. The State's independent evaluator continued work related to the cost-effectiveness analysis which will address policies relating to this, and several other research questions under the Demonstration. The State's independent evaluator also began discussions with the State around measurement of implementation costs and investigated the feasibility of calculating relevant effectiveness measures in the claims. Finally during this quarter, the State's independent evaluator continued to monitor developments related to the Managed Long-term Services and Supports program and Medicaid overall through attendance at the Medical Assistance Advisory Council meeting on October 21, 2020. Important information on changes due to COVID were shared during these meetings that inform the evaluation. Additionally, the State's independent evaluator also attended two DMAHS listening sessions for the 1115 Demonstration renewal.
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 State's independent evaluator met with representatives from Medicaid and the Department of Children and Families (DCF) on October 8th to gather information related to progress on initiatives for populations of children and youth being served under the Demonstration. The State's independent evaluator also discussed considerations for a comparison group of youth for evaluation of these initiatives and the availability of data under the Department's Quality Strategy for the Comprehensive Demonstration. During this quarter, claims data work continued in preparation for analyses in the interim report which will address this research question. This included identification of populations and calculation of quality metrics and health indicators for demonstration participants served by DCF as well as adults served by the Division of Developmental Disabilities through the Supports program. Finally, the State's independent evaluator continued discussions with the co-investigator and her team leading the cost-effectiveness analysis related to this research question around potential effectiveness measures for youth that could be calculated in the Medicaid claims.
C.	***Utilizing a projected spend-down provision and eliminating the look back period at time of application for transfer of assets for applicants or beneficiaries seeking long term services and supports whose income is at or below 100% of the FPL will simplify Medicaid eligibility and enrollment processes without compromising program integrity.***
	During this quarter, the State's independent evaluator reached out to the State to request data related to self-attestations and Qualified Income Trusts (QIT) for the interim evaluation report. The State's independent evaluator included contextual questions for understanding

	implementation of these policies during the Demonstration renewal period and proposed a meeting to discuss the requested data and relevant context. Claims data work, mentioned in Part A above, which identifies Medicaid long-term care populations and their living arrangements, was also an activity relevant to this demonstration hypothesis.
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 State's independent evaluator researched methods, models and sensitivity analysis that will be potentially relevant in the final DSRIP report.
E.	***Other hypotheses to address new research questions in the Demonstration renewal:*** • ***What is the impact of providing home and community-based services to expanded eligibility groups, who would otherwise have not been eligible for Medicaid or CHIP absent the demonstration?*** • ***What is the impact of mandating individuals who are eligible for NJFC and have access to employee sponsored insurance into the premium assistance program; as conditional of eligibility?*** ***What is the impact of providing substance use disorder services to Medicaid beneficiaries? Including paying for services rendered in an institution for mental disease (IMD)?***
	With regard to expanded eligibility for home and community-based services, the State's independent evaluator identified individuals eligible for the Supports program due to the income eligibility expansion in the Medicaid claims dataset over 2016-2019. The State's independent evaluator will validate these numbers with a representative from the Division of Developmental Disabilities. The State's independent evaluator also began activities related to evaluation of the premium support program (PSP) during this quarter. A request was sent to the State for the Net Savings report for all beneficiaries enrolled in PSP at any point in the Demonstration period. During this quarter, the State's independent evaluator also worked extensively on activities for the interim evaluation of the 1115 SUD Demonstration. The State's independent evaluator completed a literature review on relevant outcomes for measuring policy impacts on SUD treatment and selected the final measure set for the interim report. The State's independent evaluator continued claims data preparation, consulting with DMAHS's Office of Business Intelligence and SUD subject matter experts on billing codes for identifying Medication Assisted Treatment as well as receiving provider numbers for identification of Institutions for Mental Disease. On October 21st, The State's independent evaluator had a call with representatives from Medicaid and the Office of Managed Health Care, Behavioral Health Unit to discuss progress on initiatives occurring under the 1115 SUD Demonstration such as data on overdose deaths from the State Medical Examiner's office and information on peer recovery support services and associated billing. The State also shared version 1.1 and 3.0 specifications with the State's independent evaluator for the monitoring metrics, and began calculating categories of spending needed for the cost analysis which will be part of the interim evaluation. On December 14th, the State's independent evaluator attended the virtual OBAT stakeholder meeting to stay informed on developments around this policy, particularly on the impacts of COVID on treatment for individuals with SUD.

XIII. Enclosures/Attachments

A. MLTSS Quality Measures
B.ASD/ ID/DD-MI Performance Measures

XIV. State Contact(s)

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XV. Date Submitted to CMS

July 6, 2021

1115 Comprehensive Waiver Quarterly Report
Demonstration Year 9
Federal Fiscal Quarter: 2 (10/01/20-12/31/20)
Department of Children and Families
Division of Children's System of Care

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

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

#2 Quality of Life Sub Assurance	All youth that meet the clinical criteria for services through the Department of Children and Families (DCF), Division of Children' s System of Care (CSOC) will be assessed utilizing the comprehensive Child and Adolescent Needs and Strengths (CANS) assessment tool
Data Source	Review of Child and Adolescent Needs and Strengths scores Contracted System Administrator (CSA) Data Data report: CSA NJ1225 Strengths & Needs Assessment – Post SPC Start
Sampling Methodology	100% New youth enrolled in the waiver
Waiver	**I/DD**
Numerator: Number of youth receiving Child and Adolescent Needs	111

and Strengths (CANS) assessment	
Denominator: Total number of new enrollees	112
Percentage	99%

One youth was enrolled in the CSSP I/DD waiver during this quarter that did not have a Child and Adolescent Needs and Strength (CANS) prior to enrollment. This is due to the youth receiving the service before meeting waiver qualification and enrollment. The youth had a biopsychosocial assessment prior to enrollment which was followed up with a CANS that was reported early in the next quarter.

#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	**I/DD**
Numerator: Number of youth who improved within one year of admission	709
Denominator: Number of youth with Child and Adolescent Needs and Strengths assessments conducted 1 year from admission or last CANS conducted	776
Percentage	91%

#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 report: CSA 136 New Enrollees, Quarterly Count and IOS Completed
Sampling Methodology	100% new youth enrolled in the waiver
Waiver	**I/DD**
Numerator: Number of youth receiving initial level	112

of care determination prior to enrollment	
Denominator: Number of new enrollees	112
Percentage	100%

#5 Plan of Care Sub Assurance	The Plan of Care (aka Individual Service Plan (ISP)) is developed based on the needs identified in the Child and Adolescent Needs and Strengths assessment tool and according to CSOC policies
Data Source	CSA Data on Plans of Care completions, Record Review Data report: CSA NJ1219 Follow – Up Treatment Plan and Associated SNA
Sampling Methodology	100% of youth enrolled during the measurement period
Waiver	**I/DD**
Numerator: Number of Plans of Care that address youth's assessed needs	111
Denominator: Number of Plans of Care reviewed	112
Percentage	99%

One youth was enrolled in the CSSP I/DD waiver during this quarter that did not have a Child and Adolescent Needs and Strength (CANS) prior to enrollment. This is due to the youth receiving the service before meeting waiver qualification and enrollment. The youth had a Biopsychosocial assessment prior to enrollment which was followed up with a CANS that was reported early in the next quarter.

#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	**I/DD**

Numerator: Number of current Plans of Care updated at least annually	214
Denominator: Number of Plans of Care reviewed	214
Percentage	100%

#7 Plan of Care Sub Assurance	Services are authorized in accordance with the approved plan of care 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	**I/DD**
Numerator: Number of Plans of Care that had services authorized based on the Plan of Care	111
Denominator: Number of Plans of Care reviewed	112
Percentage	99%

One youth was added in error and was promptly removed. This measure should be 100%.

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

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

#9 Plan of Care Sub Assurance	Youth/families are provided a choice of providers, based on the available qualified provider network
Data Source	Record review Statewide CSA Data Report: NJ1384 Provider List - CSA Data Report
Sampling Methodology	Random sample representing a 95% confidence level
Waiver	I/DD
Numerator: Number of youth/families given a choice of providers as indicated in progress notes	466
Denominator: Number of records reviewed	665
Percentage	70%

A review for all the youth during the reporting period served under the I/DD waiver was conducted. Families are provided a choice during the Child Family Team Meeting and the care managers are required to upload the sign off form into the youth's record. The form is not always uploaded timely and counted towards the data in the reporting quarter. This was addressed with the appropriate agencies to ensure that the form is being uploaded according to the established protocol. CSOC will continue to monitor this indicator.

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

No new waiver providers were enrolled during this reporting period.

# 11 Qualified Providers Sub Assurance	Children's System of Care verifies that providers of waiver services continually meet required qualified status, including any applicable licensure and/or certification standards
Data Source	Provider Certification
Sampling Methodology	100% Agency
Waiver	**I/DD**
Numerator: Number of providers that meet the qualifying standards applicable-licensures/certification	60
Denominator: **Total** number of providers that initially met the qualified status	60
Percentage	100%

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

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

# 13 Health and Welfare Sub Assurance	The State demonstrates on an on-going basis, that it identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation
Data Source	Review of UIRMS database and Administrative policies & procedures
Sampling Methodology	100% of youth enrolled for the reporting period
Waiver	**I/DD**
Numerator: Total number of UIRs submitted timely according to State policies	25
Denominator: Number of UIRs submitted involving enrolled youth	26
Percentage	96%

The report was submitted four days after the incident occurred. This is outside the submission timeframe. DCF is working with CSOC to overhaul the existing UIR process to eliminate these gaps.

# 14 Health and Welfare Sub Assurance	The State incorporates an unusual incident management reporting system (UIRMS), as articulated in Administrative Order 2:05, which reviews incidents and develops polices to prevent further similar incidents (i.e., abuse, neglect and runaways)
Data Source	Review of UIRMS database and Administrative policies & procedures
Sampling Methodology	100% of youth enrolled for the reporting period
Waiver	**I/DD**
Numerator: The number of incidents that were reported through UIRMS and had required follow up	26
Denominator: Total number of incidents reported that required follow up	26
Percentage	100%

# 15 Health and Welfare Sub Assurance	The State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed
Data Source	Review of UIRMS
Sampling Methodology	100% of all allegations of restrictive interventions reported
Waiver	**I/DD**
Numerator: Number of unusual incidents reported involving restrictive interventions that were remediated in accordance to policies and procedures	0
Denominator: Total number of unusual incidents reported involving restrictive interventions	0
Percentage	N/A

No incidents of restraints were documented this quarter.

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

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

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