New Jersey Comprehensive Demonstration
Section 1115 Quarterly Report
***Demonstration Year: 10* (7/1/21-6/30/22)**
***State Fiscal Quarter:* Quarter 2 (10/01/21-12/31/21).**

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 October 1, 2017 through June 30, 2022. This five year demonstration will:

- Maintain Medicaid and CHIP State Plan benefits without change;
- Maintain its Managed Long Term Services and Supports (MLTSS) program;
- Increase access to services and supports for individuals with intellectual and developmental disabilities;
- Further streamline NJFC eligibility and enrollment
- Enhance access to critical providers and underserved areas through alternative provider development initiatives.

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

- Maintain its MLTSS program
- Achieve better care coordination for and the promotion of integrated behavioral and physical health to for a more patient centered care experience, and to offer aligned financial incentives and value-based payments;
- Simplify and streamline the administration and oversight of services in order to better
- Monitor the overall health of the Medicaid population; as well as act as the first step to remove silos of care for I/DD youth transitioning from the children's system into the adult system;
- To provide access to services earlier in life in order to avoid unnecessary out-of-home placements, decrease interaction with the juvenile justice system, and see savings in the adult behavioral health and I/DD systems;
- To build on current processes to further streamline eligibility and enrollment for NJFC beneficiaries;
- To reduce hospitalizations and costs associated with disease and injury; and
- Establish an integrated behavioral health delivery system that includes a flexible and comprehensive substance use disorder (SUD) benefit and the state's continuum of care.

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.

On October 28, 2021, CMS approved NJ's amendment request to extend postpartum care from 60 days to 12 months. We are continuing to have ongoing discussions with CMS as we work towards implementation.

III. Enrollment Counts for Quarter

Demonstration Populations by MEG	Total Number of Demonstration participants Quarter Ending 03/21	Total Number of Demonstration participants Quarter Ending 06/21	Total Number of Demonstration participants Quarter Ending 09/21	Total Number of Demonstration participants Quarter Ending 12/21
Title XIX	761,216	777,579	798,891	812,092
ABD	228,780	227,415	226,400	223,837
LTC				
HCBS - State plan	18,160	18,627	18,677	18,625
TBI – SP				
ACCAP – SP				
CRPD – SP				
GO – SP				
HCBS - 217-Like	17,906	18,313	18,636	18,671
TBI – 217-Like				
ACCAP – 217-Like				
CRPD – 217-Like				
GO – 217-Like				
SED - 217 Like	401	419	418	426
IDD/MI – (217 Like)	508	470	397	333
NJ Childless Adults				
Expansion Adults	662,299	681,001	699,996	712,758
SED at Risk	2,749	2,829	2,705	2,523
MATI at Risk				

Title XXI Exp Child	[redacted]
NJFAMCAREWAIV-POP 1	
NJFAMCAREWAIV-POP 2	
XIX CHIP Parents	

IV. Outreach/Innovative Activities to Assure Access

MLTSS
The State has continued to maintain its efforts to ensure that consumers, stakeholders, MCOs, providers and other community-based organizations are knowledgeable about the comprehensive demonstration and informed of changes. The State has depended on its relationships with stakeholder groups to inform consumers. During this quarter, DHS provided updates to the following long-term care industry provider(s): On October 21, 2021 - 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: 1) policy updates on the 1115 Comprehensive Medicaid Demonstration Renewal, American Rescue Plan Enhanced Federal Match for HCBS, and Provider Relief Funds; 2) NJ FamilyCare Updates on Enrollment during the Federal Public Health Emergency and Eligibility Processing; 3) Presentation on the Program of All Inclusive Care for the Elderly (PACE); and 4) Presentation on the federal Lifeline Smartphone and Emergency Broadband Benefits. 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.
I-DD/SED
The Department of Children and Families (DCF), Children System of Care (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 911 questions submitted and answered. Three domains compose approximately 74% of the emails received. These areas are Medicaid troubleshooting (35%), other (14%), and transitioning between demonstration programs (i.e.: From MLTSS to Supports Program + Private Duty Nursing, SP to CCP, CCP to MLTSS, etc.) (25%). Due to a trend of the category "Other" increasing analysis was conducted and the majority of these questions focus on future Medicaid planning, special program code questions (opening and closing), and HMO enrollment questions. Future Medicaid planning is generally around parents retiring. The remainder of the questions focus on citizenship issues, wavier admission questions, emails from the Board of Social Services asking if the individual is affiliated with DDD, follow-up emails that resulted in an immediate resolution, and emails that need to be routed to a different helpdesk or Unit. Included in the 25% above regarding questions about transitioning between programs, the helpdesk is 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 demonstration program to another. Examples include children losing their educational entitlement and needing SP+PDN services, specifically the PDN or individuals wanting to transfer from MLTSS to a DDD program. The helpdesk received 229 questions related to these topics and assisted 20 individuals transition between demonstration programs or enroll onto a program through the age out process this quarter (9 MLTSS to CCP, 1 age out of PDN onto SP+PDN, 8 MLTSS-SP, 2 MLTSS-SP+PDN).

Interim Management Entity (IME)

As part of the NJ FamilyCare Comprehensive Demonstration, the state identified University Behavioral Health Care (UBHC) within Rutgers University to develop and implement a 24-hour call center (ReachNJ) and an Interim Managing Entity (IME) to manage adult Substance Use Disorder (SUD) treatment services while New Jersey moved toward an integrated managed system of care. The IME went live on July 1, 2015 and continues to serve as a point of entry for residents seeking treatment or information about SUD.

The Interim Managing Entity (IME) and ReachNJ received 8,111 calls from individuals seeking information, referral or admission to SUD treatment. ReachNJ made 783 referrals for treatment sent directly to treatment providers. The IME also began tracking referrals for Medication Assisted Treatment (MAT) at Office Based Addictions Treatment (OBAT) providers and during this quarter, 71 referrals were made for MAT services.

The IME responded to 805 requests for Care Coordination services to facilitate treatment admission. CC services are offered to any individual waiting 2 days for admission to treatment.
The IME Utilization Management (UM) staff performed clinical reviews based on ASAM patient placement criteria for admission to the appropriate level of care and completed 7,437 reviews for Medicaid beneficiaries for treatment admission. They also performed 3,333 clinical reviews for Medicaid beneficiaries to extend treatment services based on clinical necessity.

The IME supports providers through education and guidance and responded to 1,455 provider assistance calls that support Medicaid SUD treatment providers.

V. Collection and Verification of Encounter Data and Enrollment Data

Summary of Issues, Activities or Findings

No issues identified.

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 performance metrics and discuss and create an action plan for any issues that either the state or the MCOs are encountering.
I-DD/SED
CSOC continues enrollment in both the Children's Support Services Program Intellectual/Developmental Disabilities (CSSP I/DD) and for Plan A benefits under the Children's Support Services Program Serious Emotional Disturbance (CSSP SED). During this quarter, CSOC enrolled 710 youth in the CSSP I/DD. In addition, there were an additional 454 youth in the CSSP SED that received Plan A benefits that would have not otherwise been eligible for these benefits if not for demonstration participation.
Supports Program and Community Care Program
At the close of this quarter the SP enrollment was approximately 12,300 and the CCP enrollment remains at 12,000. Despite the current flexibilities, DDD continues to work with families to complete timely redeterminations to ensure they do not lose Medicaid at the end of the PHE. Between the 2 programs, approximately 900 redeterminations are completed each quarter. DDD has been working on strategies with both Medicaid and their stakeholders to decrease the number of people who are terminated due to failure to respond to Medicaid notices. Strategies include letters from DDD as well as Medicaid to families and outreach to families by phone when a prospective Medicaid termination date is placed on an 1115 beneficiary. This outreach has continued during the PHE despite the Appendix K and 1135 flexibilities of not losing Medicaid due to non-response. DDD has been successful in maintaining pre-PHE levels of responsiveness to ensuring that Medicaid will remain intact following the end of the PHE and the Appendix K and 1135 flexibilities. Despite meetings remaining remote through platforms such as Zoom, Teams, and Webinars, 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 as well as regularly scheduled meetings with organizations and varied state leaders. 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 continued on NJ's electronic visit verification implementation (EVV) with its state and community partners. This work has been successful and this quarter the EVV Teams began to discuss the new 2023 EVV requirements. Progress has moved swiftly as a result of lessons learned from the first EVV mandate. A DDD specific helpdesk related to

EVV was established January 2020. This past quarter the EVV helpdesk received 2,894 emails this quarter. The majority of the emails were related to billing questions.

Other

Managed Care Contracting:

There are no updates for this quarter.

Self-attestations:

There were a total of 17 self-attestations for the time period of October 1, 2021 to December 31, 2021.

MCO Choice and Auto-assignment:

The number of individuals who changed their MCO after auto-assignment is 1754.

MLR:

	SFY20 MLR Summary	
	Acute	**MLTSS**
Horizon	91.9%	95.9%
UHC	93.3%	96.1%
Amerigroup	93.5%	94.5%
Aetna	92.3%	96.0%
Wellcare	92.9%	95.9%

VII. Action Plan for Addressing Any Issues Identified

No Issues Identified.

VIII. Financial/Budget Neutrality Development/Issues

New Jersey has been in discussions with CMS related to budget neutrality issues and continues to have ongoing conversations to address them.

IX. Member Month Reporting

Please refer to the budget neutrality spreadsheet for Member Month Reporting.

X. Consumer Issues

Summary of Consumer Issues

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

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
1	Speak to CM	Members/Providers calling for authorization status.	Benefits Inquiry	Medical Benefits-Inquiry regarding member benefits	Provider requesting Authorization updates, specifically related to EVV/HHAeXchange
2	Benefits	Members calling to contact their Care Manager.	Requests to speak with CM or CCC	PCP Update/ ID Card- PCP inquiry	Member or provider calling to request increase of hours for MDC and/or PCA
3	PCP information and education	Members calling with questions regarding the PPP program.	PCP information and education	Misdirected Call Received-General inquiry	Member requesting to speak to their assigned Care Manager
4	Eligibility	Members calling in reference to public health emergency protocols - AMDC	Provider Request	Change Address /phone #-Address update	Member requesting PPP status or more information on PPP increase.
5	Network Info	Members calling in reference to scheduled visits.	DME related Inquiry	Claim Status-Claims inquiry	Member requesting PPP status or more information on PPP increase.

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

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
1	Status - Providers calling our Customer Service Unit to request status of claims	Not being reimbursed correct rate when the State issues guidance on rate enhancements	Claim Status	Claims Payment Discrepancies	AMDC provider calls requesting remote services provision as a result of closure due to COVID.
2	Payment/Denial Issues - Claims requiring reprocessing	Claim denials for lack of units in authorization	Authorization Inquiry	Denied Claims	Provider calls, specifically MDC, requesting

	due to PPL updates				initial services or checking on status of authorization request as they reopen to F2F services
3	Appeals - Providers calls requesting status of appeal submission. Our Customer service unit as well as Network relations Consultant will collaborate with our G&A team to address these requests.	Claims not appropriately applying member liability	Authorization Request	HHA Billing	Providers calling for request of authorizations and status
4	Resubmissions - Corrected claims	Turnaround time for authorization incongruences	Verification of Benefits	Authorization Issue	Authorization status
5	Authorizations - Provider calls requesting status of authorizations. Our Customer service unit as well as Network relations Consultant will collaborate with our UM team to address these requests.	Providers calling in reference to public health emergency protocols.	General Inquiry	Rejected Claims	Claims processing

XI. Quality Assurance/Monitoring Activity

MLTSS:

MLTSS Claims Processing Information by MCO

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
# Claims Received	167,175	412,591	902,973	120,409	322,183
# Claims Paid	134,979	370,061	837,340	108,902	262,415
# Claims Denied	26,008	41,556	60,578	9,644	50,545
# Claims Pending	6,188	974	5,055	1,863	9,223

Top Reasons for MLTSS Claims Denial by MCO

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
1	M86 - Service denied because payment already made for same/similar procedure within set time frame.	Duplicate claim/service	This claim is a duplicate of a previously submitted claim	Benefits Based on Admission Date	Service was not billed through Electronic Visit Verification
2	18 – Exact duplicate claim/service	Units exceed UM authorization	Received after timely filing limit	No authorization on file	Denied: Prior Authorization required but not obtained
3	29 – The time limit for filing has expired	EVV submission error	Provider not eligible by contract for payment	Medi Medi 2ndary Carrier - Medi Medi 2ndary Carrier refers to a member that is dual Medicaid and Medicare. To process those claims the health plan coordinate benefits.	Denied: The time limit for filing this claim has expired

4	96 – Non-covered charge(s)	Deny pre-authorization not obtained	Resubmit with EOB from primary carrier	PCA Pend Override	Denied: Exact duplicate of another claim or service
5	N519 – Invalid combination of HCPS modifiers	Submitted after timely filing	Incomplete missing payer claim control number	Claim is a duplicate	Denied: Must submit an EOB from Medicare

SED/IDD/ASD:

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

Supports and CCP:

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 440 incidents reported for 398 individuals on the Supports Program. For the CCP, there were 2,847 incidents reported for 1,804 individuals this 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. This quarter started in the same way as the last quarter, with a decrease in positive COVID incidents. However, the number of COVID incidents began to increase in September. Despite the increase in September the number of service recipients with a positive COVID outcome this quarter was approximately 960. This is a significant increase since last quarter's positive COVID outcome number of 110, however is in alignment with the COVID outcomes of 2020 Oct-Dec increase. DDD also collects positive COVID data for staff as well and the same trend was identified. Although there was a large number of individuals testing positive for COVID, most individuals are vaccinated and have their booster shot. Deaths with a diagnosis related to COVID were significantly lower this year compared to last year. 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 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 finalized. The Office of Risk Management also developed a PowerPoint related to COVID incidents and trending.

A Risk Council meets to look at IR from a system perspective. This committee meets quarterly and develops action items based on the data. This meeting took place this quarter and was held remotely. The Risk Management Unit also conducts systemic and individual remediation activities because of IR analysis which has continued during the remote work.

Demonstration 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. 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. Congregate day settings re-opened.

DDD participates in the National Core Indicators. DDD will be participating again this year and is including the COVID-19 questions developed by HSRS. 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 and agencies have expressed staffing infrastructure concerns as a result of the PHE. The draft results were received this quarter to the 2020 staff stability survey.

The New Jersey Comprehensive Assessment Tool (NJ CAT), continues to be conducted using secure video conferencing or by telephone. In addition to the clinical assessment a check is completed by State staff to ensure that all Demonstration Program criteria are met for eligibility. This includes items like: age, Medicaid eligibility, living arrangement, if they are on another demonstration program, etc. In addition to verifying the accuracy of screening and assessment of participants at the time of enrollment DDD conducts monthly audits to check the ongoing eligibility criteria. In addition, to DDD's internal monitoring, Medicaid conducts an annual audit as well as the external auditors.

Other Quality/Monitoring Issues:

EQR PIP

Currently, the Division of Medical Assistance and Health Services (DMAHS) is 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. A final project status report was submitted and reviewed by the EQRO in August 2021.

In January 2019, ABHNJ, AGNJ, HNJH, UHC and WCHP initiated a collaborative clinical PIP with a focus on Risk Behaviors and Depression in the Adolescent Population. The sustainability year concluded on December 31, 2021 for all five MCOs. A final project status report will be submitted in August 2022.

In September 2020, the MCOs submitted individual non-clinical PIP proposals with a focus on Access to and Availability of Provider Services tied to claims. Four MCOs submitted a PIP progress report in August 2021 which included results of the 2019 baseline data (due to PHE), analysis of MCO specific activities, any revisions for the upcoming year, and were reviewed by the EQRO. One MCO revised their aim statement and performance indicators, resulting in a new PIP cycle. This MCO resubmitted their PIP proposal in August 2021. It was reviewed and approved by the EQRO, and project activities will be initiated in early 2022.

In September 2021, the MCOs submitted individual clinical PIP proposals with a focus on Preventative Care in the first 30 months of life. The individual proposals were reviewed and approved by the EQRO, and project activities will be initiated by the MCOs in early 2022.

MLTSS PIP Update:

All 5 MCOs submitted a Sustainability progress report update in August 2021 on the topic of Decreasing Gaps in Care which included the 2018 baseline data, all of which were reviewed and accepted by the EQRO and the State in November 2021. Recommendations for performance improvement provided to the MCOs regarding this topic were to target preventative services for MLTSS members and/or target services related to chronic disease.

In October 2018, one MCO was required to submit a New Falls PIP proposal as a result of incongruent and inconclusive data observed in the entirety of their initial Falls PIP. This MCO submitted their New Falls PIP proposal in October 2018. The New Falls PIP Proposal for this MCO was approved and accepted by the State in collaboration with the EQRO. The MCO submitted their Falls PIP Topic Sustainability update in August of 2021.

A new PIP Topic was introduced to the Plans in June of 2021. All 5 MCOs have submitted New PIP Proposals on the topic of “Improving Coordination of Care and Ambulatory Follow-up after Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations" in September 2021. The PIP proposals were reviewed by the EQRO and accepted by the State in the Fall of 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.***

	This quarter, the state's independent evaluator finalized the interim report chapters on HEDIS/CAHPS metrics and the Premium Support Program, met with state subject matter experts regarding the interim evaluation report chapter on MLTSS secondary measures, and submitted clarifying revisions (i.e., not new analyses but some clarifying explanations for the analyses conducted) to that chapter. The evaluator submitted the interim cost effectiveness evaluation for MLTSS and met with state subject matter experts and then submitted clarifying revisions to the chapter. Also 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, 2021.
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.***
	This quarter the state's independent evaluator finalized the interim report chapter relating to children served by the Department of Children and Families (SED, ASD and IDD) with some clarifying revisions after state subject matter expert feedback. The evaluator also responded to questions from state officials on the chapter on adults with IDD submitted last quarter. The evaluator had a meeting with DCF officials and discussed the feasibility of a cost-effectiveness evaluation for the final report.
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.***
	This quarter the state's independent evaluator met with state subject matter experts to discuss the interim report chapter on QIT and self-attestation and submitted clarifying revisions to the chapter.
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.***
	This quarter the state's independent evaluator worked extensively on the final DSRIP report Activities this quarter included: • Continued Medicaid claims data preparation and statistical analysis of outcome metrics and beneficiary characteristics through 2020; • Received, prepared and analyzed inpatient and emergency department databases for New Jersey data from the AHRQ Healthcare Cost and Utilization Project and population denominators from the American Community Survey to examine DSRIP's impact on the uninsured population. • Communicated with subject matter experts at the NJ Department of Health to verify labor cost estimates received last quarter, regarding the cost-effectiveness component of the evaluation.
E.	***Other hypotheses to address new research questions in the Waiver 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 providing substance use disorder services to Medicaid***

	beneficiaries? Including paying for services rendered in an institution for mental disease (IMD)?
	Expanded eligibility: This quarter, the state's independent evaluator finalized (with minor clarifying revisions) the interim report chapter on claims and secondary measures for children served by the Department of Children and Families (SED, ASD and IDD). The evaluator answered state subject matter expert questions regarding the draft interim report chapter on adults served by the Division of Developmental Disabilities that was submitted last quarter. OUD/SUD: The independent evaluator met with state subject matter experts on OUD/SUD to discuss their questions and feedback regarding the draft interim evaluation report on the OUD/SUD Demonstration submitted last quarter. After receiving further written feedback on that chapter, the evaluator submitted clarifying revisions. OUD/SUD Midpoint Assessment: Interviews were completed in September 2021. The evaluator met with state subject matter experts to discuss the structure of the report underway and data to come for the final report. The draft report was reviewed by a subject matter expert in SUD/OUD policy who is unaffiliated with the State of New Jersey and the Center for State Health Policy. The final report was sent to the State.

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

March 30, 2022

Deliverables due during MLTSS 2nd quarter (10/1/2021 – 12/31/2021)

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 eighth year, second quarter (10/1/2021 – 12/31/2021) 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 regular 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 MCOs 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 (CM) visits. Policy guidance was issued to the MCOs in August 2021 regarding the phase in of the resumption of face-to-face CM visits. High-risk MLTSS members were prioritized for visits from 8/15/2021 to 11/15/2021 for wellness checks and Plan of Care (POC) reviews.

Beginning 11/16/2021, the face-to-face visits were expanded to all MLTSS members and MCO CMs resumed conduction the NJ Choice level of care assessment. The changes that took place during this reporting period may affect some of the PMs in this report and subsequent reports. The impact will be noted in the narrative for the respective PM in this and subsequent reports.

Deliverables due during MLTSS 2nd quarter (10/1/2021 – 12/31/2021)

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

4/1/2021 – 6/30/2021	A	B	C	D	E	TOTAL
Numerator	N/A	N/A	N/A	N/A	N/A	**N/A**
Denominator	N/A	N/A	N/A	N/A	N/A	**N/A**
%	N/A	N/A	N/A	N/A	N/A	**N/A**

Due to the COVID-19 State of Emergency Order with the subsequent suspension of all face-to-face assessments (initial and annual), effective March 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 2021	A	B	C	D	E	TOTAL
Numerator	0	0	0	0	0	**0**
Denominator	0	49	182	181	93	**505**
%	0	0	0	0	0	**0**

September 2021	A	B	C	D	E	TOTAL
Numerator	0	0	0	0	0	**0**
Denominator	0	33	172	154	85	**444**
%	0	0	0	0	0	**0**

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

Deliverables due during MLTSS 2nd quarter (10/1/2021 – 12/31/2021)

October 2021	A	B	C	D	E	TOTAL
Numerator	0	0	13	0	0	**13**
Denominator	0	33	150	141	102	**426**
%	0	0	8.7	0	0	**0**

The MCOs are monitoring referrals for level of care (LOC) assessments for MLTSS, but no assessments were completed during this quarter due to the COVID-19 NJ State mandate effective March 2020, which states MCOs were to discontinue assessing members face to face for the purposes of MLTSS eligibility. Level of care assessments using the NJ Choice assessment resumed on 11/16/2021, so the State anticipates there will be data reported in the next quarterly report.

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	8/2021	9/2021	10/2021
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. Level of care assessments using the NJ Choice assessment resumed on 11/16/2021, so the State anticipates there will be data reported in the next quarterly report.

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

Due to the COVID-19 State of Emergency Order and the subsequent suspension of all face-to-face assessments, initial and annual, effective March 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 December 2021. Level of care assessments and re-assessments using the NJ Choice assessment resumed on 11/16/2021, so the State anticipates there will be data reported in the next quarterly report.

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	9/2021	10/2021	11/2021
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 2020. Therefore, there is no data to audit at this time. Level of care assessments using the NJ Choice assessment resumed on 11/16/2021, so the State anticipates there will be data reported in the next quarterly report.

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

Measurement period	9/2021	10/2021	11/2021
Numerator	1136	1034	855
Denominator	1188	10730	896
%	95.6	96.4	95.4

The COVID-19 Emergency Declaration Blanket Waivers issued by CMS on March 30, 2020 were lifted as of September 1, 2021. As such, MCOs are required to comply with the one-day and two-day reporting time requirement as outlined in the contract. DoAS reports that all five MCOs were required to submit Corrective Action Plans (CAPs) due to a delay in CI reporting.

Deliverables due during MLTSS 2nd quarter (10/1/2021 – 12/31/2021)

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	9/2021	10/2021	11/2021
Numerator	16	13	11
Denominator	16	13	11
%	100	100	100

The COVID-19 Emergency Declaration Blanket Waivers issued by CMS on March 30, 2020 were lifted as of September 1, 2021. As such, MCOs are required to comply with the one-day and two-day reporting time requirement as outlined in the contract. DoAS reports all five MCOs reported critical incidents for unexpected death and potential for media involvement within the contractual timeframe during this measurement period.

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

7/1/2021 – 9/30/2021	A	B	C	D	E	TOTAL
Numerator	18	8	113	47	33	**219**
Denominator	18	8	113	47	32	**219**
%	100	100	100	100	100	**100**

Table 3B Non-UM Grievances

7/1/2021 – 9/30/2021	A	B	C	D	E	TOTAL
Numerator	32	42	79	18	14	**185**
Denominator	32	42	80	18	14	**186**
%	100	100	98.8	100	100	**99.5**

During the 7/1/2021 – 9/30/2021 measurement period all MCOs reported that 100% of UM Appeals in Table 3A were resolved within 30 days. For this measurement period, the top five UM appeal categories for all MCOs combined were Denial of dental services (72/219 = 32.9%); Denial of skilled

nursing facility inpatient rehabilitation services (28/219 = 12.8%); Denial of inpatient hospital stays (25/219 = 11.4%); Pharmacy (21/219 = 9.6%); and Denial of PCA services (20/219 = 9.1%). All 28 appeals for denial of skilled nursing facility inpatient rehabilitation services came from MCO C, accounting for 28 of their 113 (24.8%) UM Appeals.

During the 7/1/2021 – 9/30/2021 measurement period, four MCOs reported 99.5% of non-UM Grievances were resolved within 30 days. MCO C reported that a single grievance took more than 30 days to resolve (42 days). Thirty-eight grievances that were received at the end of the quarter were unable to obtain feedback, and sixteen grievances were pending resolution. The overall member satisfaction rate was 60.8% (113/186). MCO C had the highest percentage of satisfactory resolutions (63/113 = 55.8%).

The top three non-UM grievance categories were Reimbursement problems/unpaid claims (43/186 = 23.1%); Dissatisfaction with marketing, member services, member handbook, etc. (18/186 = 9.7%); Dissatisfaction with PCA services (15/186 = 8.1%).

The tables below detail the number and type of MLTSS enrollee appeals (Table 3A) and grievances (Table 3B) filed during the measurement period of 7/1/2021 – 9/30/2021.

Deliverables due during MLTSS 2nd quarter (10/1/2021 – 12/31/2021)

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

PM 19 - Table 3A Utilization Management (UM) enrollee appeal categories	July - September 2021					
	MCO A	MCO B	MCO C	MCO D	MCO E	TOTAL
Denial of acute inpatient rehabilitation services			2			**2**
Denial of assisted living services						
Denial of dental services	6	4	35	17	10	**72**
Denial of hearing aid services						
Denial of home delivered meal services						
Denial of hospice care	1					**1**
Denial of in-home periodic skilled services (nursing, social services, nutrition, etc.)						
Denial of in-home rehabilitation therapy (PT, OT, speech, etc.)						
Denial of inpatient hospital days	7	1	14		3	**25**
Denial of Medical Day Care (adult & pediatric)					1	**1**
Denial of medical equipment (DME) and/or supplies	2	2	3	5		**12**
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			7	2	4	**13**
Denial of outpatient rehabilitation therapy (PT, OT, Cardiac, Speech, Cognitive, etc.)			2		1	**3**
Denial of outpatient TBI habilitation therapy (PT, OT, speech, cognitive etc.)						
Denial of PCA services			7	13		**20**
Denial of Personal Emergency Response Systems (PERS)						
Denial of Private Duty Nursing	1		4	3		**8**
Denial of referral to out-of-network specialist			1			**1**
Denial of residential modification			2			**2**
Denial of respite services						
Denial of skilled nursing facility (custodial)	1			1		**2**
Denial of skilled nursing facility inpatient rehabilitation services			28			**28**
Denial of Special Care Nursing Facility (custodial) SCNF						
Denial of sub-acute inpatient rehabilitation services			1			**1**
Denial of SUD services						
Denial of surgical procedure				1		**1**
Denial of vehicle modification						
Other (MLTSS)					1	**1**
Other (non-MLTSS)					1	**1**
Pharmacy		1	4	5	11	**21**
Reduction of acuity level (inpatient)			3			**3**
Service considered cosmetic, not medically necessary						
Service considered experimental/investigational						
Table 3A/UM Appeal TOTALS	**18**	**8**	**113**	**47**	**33**	**219**

Deliverables due during MLTSS 2nd quarter (10/1/2021 – 12/31/2021)

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 2021					
	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		2		**5**
Difficulty obtaining access to mental health providers						
Difficulty obtaining access to MLTSS providers	1			3		**4**
Difficulty obtaining access to non-MLTSS providers						
Difficulty obtaining access to other in-home health services (skilled and non-skilled)		7		1		**8**
Difficulty obtaining access to PCA services				2		**2**
Difficulty obtaining access to PDN services						
Difficulty obtaining access to self-directed PCA services (PPP)	1	1				**2**
Difficulty obtaining access to SUD providers						
Difficulty obtaining access to transportation services						
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		2				**2**
Difficulty obtaining referrals for covered services, dental services	1		1			**2**
Difficulty obtaining referrals for covered SUD services						
Difficulty related to obtaining emergency services						
Dissatisfaction with dental services			7	1	2	**10**
Dissatisfaction with DME and/or medical supplies			2	1		**3**
Dissatisfaction with marketing, member handbook, etc.	6	1	10	1		**18**
Dissatisfaction with Member Services		3		3		**6**
Dissatisfaction with NJ FamilyCare Benefits		1				**1**
Dissatisfaction with other in-home health services (skilled and non-skilled)	7	2	1			**10**
Dissatisfaction with PCA services		1	14			**15**
Dissatisfaction with PDN services			2			**2**
Dissatisfaction with policies regarding specialty referrals (i.e. out of network specialist)						
Dissatisfaction with provider network						
Dissatisfaction with provider office administration		2	4			**6**
Dissatisfaction with quality of medical care, hospital	1		2			**3**
Dissatisfaction with quality of medical care, other type of provider	2	2	6	1	3	**14**
Dissatisfaction with quality of medical care, PCP			1			**1**
Dissatisfaction with quality of medical care, specialist			4			**4**
Dissatisfaction with transportation services	1	5			3	**9**
Dissatisfaction with utilization management appeal process			1		1	**2**
Dissatisfaction with vision services		1	3			**4**
Enrollment issues				1		**1**
Laboratory issues						
Pharmacy/formulary issues	1	3	3	2		**9**
Reimbursement problems/unpaid claims	11	8	19		5	**43**
Waiting time too long at office, PCP						
Waiting time too long at office, specialist						
Table 3B/non-UM Grievance TOTALS	**32**	**42**	**80**	**18**	**14**	**186**

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 (10/1/2021 – 12/31/2021)

PM # 20	MLTSS members receiving MLTSS-specific 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

1/1/2021 – 3/31/2021	A	B	C	D	E	TOTAL
Numerator	3745	7478	17130	5626	7328	**41307**
Denominator	5083	9584	21846	9005	12094	**57612**
%	73.7	78.0	78.4	62.5	60.6	**71.7**

The MCOs reported that the COVID-19 pandemic affected MLTSS services during this measurement period. Due to COVID-19, members moved out of nursing facilities to home. Some members were not comfortable with outside personnel visiting their home and refused services. Members worked with Care Managers to adjust services based on their informal supports and other identified needs. MCO A reported that a majority of their MLTSS members with claims for MLTSS-specific services during this quarter are for NF and Assisted Living (3047/3745 = 81.4%).

PM # 20a	New MLTSS members with MLTSS-specific services within 120 days of enrollment
Numerator:	The unique count of members in the denominator with at least one claim for MLTSS services within 120 days of enrollment into MLTSS. Services for CM, PCA, Medical Day and Behavioral Health Services are not counted.
Denominator:	The unique count of members enrolled in MLTSS at any time during the measurement period who were newly enrolled in MLTSS during the measurement period. New to MLTSS is defined as no MLTSS enrollment with the MCO in the preceding 6 months.
Data Source:	MCO
Frequency:	Annually - Lag Report Due: 210 day lag after year

7/1/2019 - 6/30/2020	A	B	C	D	E	TOTAL
Numerator	1647	2303	4799	1780	2205	**12734**
Denominator	2371	3609	6559	2859	4028	**19426**
%	69.5	63.8	73.2	62.3	54.7	**65.6**

MCO C reported that of the 1,760 members without paid MLTSS-specific service claims, they found that 45.2% (796) had paid PCA/MDC claims; 3.5% (61) received hospice services; 2.2% (39) had an inpatient claim; and 6.0% (105) had denied MLTSS Service claims. Their Care Managers will continue to monitor these members to verify that they continue to be appropriate for the MLTSS program and will also determine if the member would benefit from additional services.

Deliverables due during MLTSS 2nd quarter (10/1/2021 – 12/31/2021)

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

7/1/2021 - 9/30/2021	A	B	C	D	E	TOTAL
Numerator	4	N/A	53	N/A	10	**N/A**
Denominator	2250	N/A	7710	N/A	2351	**N/A**
%	0.2	N/A	0.7	N/A	0.4	**N/A**

MCO A reported transitioning four members for the measurement period 7/1/2021-9/30/2021. The oldest was 66 years old and youngest was 43 years old. At the time of the report submission, MCO A stated that three of the four members transitioned are still enrolled with them and receiving MLTSS services. One member expired. It was discovered during this period that some members transitioned without notifying MCO A. CMs contacted facilities to obtain details but because the data entry in their system occurred transition after the actual transition dates, data was not captured in the report.

MCO C reported that 53 members transitioned during the 7/1/2021-9/30/2021 measurement period. Of the 53 members who moved from NF to HCBS, 38% (20) transitioned to a private residence; 9.5% (5) transitioned to an Assisted Living Residence (ALR); 9.5% (5) transitioned to a Community Personal Care Home (CPCH); 30% (16) transitioned to a Private Residence to live alone; 11% (6) transitioned to a Private Residence with Non-Related Family members; and 2% (1) moved to a CRS. The age range of the members that transitioned ranged from 8 to 92 years old. The average age was 62. The highest age range was 51-70 with 45% (24) members.

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

4/1/2021 - 6/30/2021	A	B	C	D	E	TOTAL
Numerator	3	1	5	2	0	**11**
Denominator	15	12	103	43	11	**184**
%	20.0	8.3	4.9	4.7	0.0	**6.0**

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

Deliverables due during MLTSS 2nd quarter (10/1/2021 – 12/31/2021)

7/1/2020 - 6/30/2021	A	B	C	D	E	TOTAL
Numerator	4	2	18	11	3	**38**
Denominator	41	43	235	156	54	**529**
%	9.8	4.7	7.7	7.1	5.6	**7.2**

For the 4/1/2021-6/30/2021 measurement period, MCO C found that of the five members who returned to the NF, three (60%) returned at the member or family member's request; one (20%) member returned due to a functional decline; and one (20%) member returned due to lack of informal supports/needs not met in the community.

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

7/1/2020 - 9/30/2020	A	B	C	D	E	TOTAL
Numerator	187	340	N/A	429	N/A	**N/A**
Denominator	5812	14892	N/A	14246	N/A	**N/A**
%	3.2	2.3	N/A	3.0	N/A	**N/A**

10/1/2020 – 12/31/2020	A	B	C	D	E	TOTAL
Numerator	230	422	N/A	450	N/A	**N/A**
Denominator	6951	17436	N/A	14383	N/A	**N/A**
%	3.3	2.4	N/A	3.1	N/A	**N/A**

1/1/2021 – 3/31/2021	A	B	C	D	E	TOTAL
Numerator	183	497	N/A	561	N/A	**N/A**
Denominator	6748	17805	N/A	15583	N/A	**N/A**
%	2.7	2.8	N/A	3.6	N/A	**N/A**

After completing the validation process, MCO B reported rates for the first three quarters of the 2020-2021 waiver year, shown in red font in the tables above for the first two quarters. MCO B reports that their MLTSS CMs monitor inpatient census, authorization and claim data to track inpatient admissions. Upon planned discharges, CMs 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 readmission (currently telephonic due to the public health emergency). For the 1/1/2021-3/31/2021 measurement period, MCO D reported that of the 561 unique inpatient hospitalizations,

the most common hospitalization primary diagnoses were Sepsis, Unspecified Organism - 7.7% (43/561); Acute Respiratory Failure - 5.7% (32/561); and Other Specified Sepsis 4.1% - (23/561). MCOs C and E 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 # 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

7/1/2020 - 9/30/2020	A	B	C	D	E	TOTAL
Numerator	191	154	N/A	182	N/A	**N/A**
Denominator	5929	8164	N/A	8724	N/A	**N/A**
%	3.2	1.9	N/A	2.1	N/A	**N/A**

10/1/2020 – 12/31/2020	A	B	C	D	E	TOTAL
Numerator	188	141	N/A	159	N/A	**N/A**
Denominator	6394	8772	N/A	8249	N/A	**N/A**
%	2.9	1.6	N/A	1.9	N/A	**N/A**

1/1/2021 – 3/31/2021	A	B	C	D	E	TOTAL
Numerator	179	160	N/A	155	N/A	**N/A**
Denominator	6383	8690	N/A	8272	N/A	**N/A**
%	2.8	1.8	N/A	1.9	N/A	**N/A**

After completing the validation process, MCO B reported rates for the first three quarters of the 2020-2021 waiver year, shown in red font in the tables above for the first two quarters. MCO B reports that they continue to remain closely connected to nursing facilities during the public health emergency, conducting and documenting monthly outreaches in an effort to ensure no new issues arise. For the 7/1/2020 - 9/30/2020 measurement period, MCO D reported that of the 182 unique inpatient hospitalizations, the most common hospitalization primary diagnoses were Sepsis, Unspecified Organism – 17.03% (31/182); Acute Kidney failure – 5.49% (10/182); and Infection and inflammatory reaction – 4.40% (8/182). MCOs C and E 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 (10/1/2021 – 12/31/2021)

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

7/1/2020 - 9/30/2020	A	B	C	D	E	TOTAL
Numerator	9	50	N/A	55	N/A	**N/A**
Denominator	25	254	N/A	280	N/A	**N/A**
%	36.0	19.7	N/A	19.6	N/A	**N/A**

10/1/2020 – 12/31/2020	A	B	C	D	E	TOTAL
Numerator	3	47	N/A	34	N/A	**N/A**
Denominator	10	288	N/A	233	N/A	**N/A**
%	30.0	16.3	N/A	14.6	N/A	**N/A**

1/1/2021 – 3/31/2021	A	B	C	D	E	TOTAL
Numerator	4	63	N/A	74	N/A	**N/A**
Denominator	14	335	N/A	332	N/A	**N/A**
%	28.6	18.8	N/A	22.3	N/A	**N/A**

After completing the validation process, MCO B reported rates for the first three quarters of the 2020-2021 waiver year, shown in red font in the tables above for the first two quarters. For the first three quarters, MCO B reported rates for hospital readmission of the MLTSS HCBS population of 16.3% to 19.7%. They state they are working with clinical teams to improve readmission rates amongst the MLTSS population. Ongoing interventions include increased medical management education by CMs with members; bi-weekly MLTSS rounds with clinical staff, medical directors and BH; and process improvements to increase oversight and improve discharge planning. For the 1/1/2021 – 3/31/2021 measurement period, MCO D reported that of the 74 readmissions within 30 days in the measurement period, 37.8% (28/74) were from 13 individual members who had greater than one readmission within the reporting period. MCO D's CMs use this report to identify members with two or more re-admissions within 30 days and follow-up with the members and their PCPs. MCOs C and E 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 (10/1/2021 – 12/31/2021)

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

7/1/2020 - 9/30/2020	A	B	C	D	E	TOTAL
Numerator	2	15	N/A	8	N/A	**N/A**
Denominator	12	57	N/A	64	N/A	**N/A**
%	16.7	26.3	N/A	12.5	N/A	**N/A**

10/1/2020 – 12/31/2020	A	B	C	D	E	TOTAL
Numerator	1	10	N/A	13	N/A	**N/A**
Denominator	14	75	N/A	65	N/A	**N/A**
%	7.1	13.3	N/A	20.0	N/A	**N/A**

1/1/2021 – 3/31/2021	A	B	C	D	E	TOTAL
Numerator	6	18	N/A	13	N/A	**N/A**
Denominator	16	68	N/A	76	N/A	**N/A**
%	37.5	26.5	N/A	17.1	N/A	**N/A**

After completing the validation process, MCO B reported rates for the first three quarters of the 2020-2021 waiver year, shown in red font in the tables above for the first two quarters. For the first three quarters, MCO B reported rates for hospital readmission of the MLTSS NF population of 13.3% to 26.5%. They state they work closely with clinical teams to improve readmission rates amongst the MLTSS population. Ongoing interventions include increased medical management education by CMs for members and NF facilities; bi-weekly MLTSS rounds with clinical staff, medical directors and BH; process improvements to increase oversight and improve discharge planning. For the 1/1/2021 – 3/31/2021 measurement period, MCO A states their goal is intensive care management for members with readmissions in order to ensure adequate services and supplies are in place. They found that many NF residents with frequent hospitalizations are experiencing end of life situations. In some cases, the CM may initiate discussions about palliative care options. MCOs C and E 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 (10/1/2021 – 12/31/2021)

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

7/1/2020 - 9/30/2020	A	B	C	D	E	TOTAL
Numerator	256	655	N/A	752	N/A	**N/A**
Denominator	5812	14892	N/A	14246	N/A	**N/A**
%	4.4	4.4	N/A	5.3	N/A	**N/A**

10/1/2020 – 12/31/2020	A	B	C	D	E	TOTAL
Numerator	235	733	N/A	758	N/A	**N/A**
Denominator	6951	17436	N/A	14,383	N/A	**N/A**
%	3.4	4.2	N/A	5.3	N/A	**N/A**

1/1/2021 – 3/31/2021	A	B	C	D	E	TOTAL
Numerator	236	783	N/A	842	N/A	**N/A**
Denominator	6748	17805	N/A	15583	N/A	**N/A**
%	3.5	4.4	N/A	5.4	N/A	**N/A**

After completing the validation process, MCO B reported rates for the first three quarters of the 2020-2021 waiver year, shown in red font in the tables above for the first two quarters. For the first three quarters, MCO B reported rates for ED utilization for the MLTSS HCBS population were stable, ranging from 4.2% to 4.4%. They state that they support members through care planning and care management practices to avoid gaps in MLTSS services and minimizing emergency room visits. For the 1/1/2021 – 3/31/2021 measurement period, MCO D reported that of the 842 ED visits, 397 (47.2%) were from 142 individual members who had multiple admissions within the reporting period. MCO D's MLTSS department will utilize this report and the detailed member data for members with five or more ED visits and follow-up with the members and their PCPs. MCOs C and E 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 (10/1/2021 – 12/31/2021)

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

7/1/2020 - 9/30/2020	A	B	C	D	E	TOTAL
Numerator	13	48	N/A	44	N/A	**N/A**
Denominator	5929	8164	N/A	8724	N/A	**N/A**
%	0.2	0.6	N/A	0.5	N/A	**N/A**

10/1/2020 – 12/31/2020	A	B	C	D	E	TOTAL
Numerator	21	36	N/A	68	N/A	**N/A**
Denominator	6394	8772	N/A	8249	N/A	**N/A**
%	0.3	0.4	N/A	0.8	N/A	**N/A**

1/1/2021 – 3/31/2021	A	B	C	D	E	TOTAL
Numerator	18	51	N/A	54	N/A	**N/A**
Denominator	6383	8690	N/A	8272	N/A	**N/A**
%	0.3	0.6	N/A	0.7	N/A	**N/A**

After completing the validation process, MCO B reported rates for the first three quarters of the 2020-2021 waiver year, shown in red font in the tables above for the first two quarters. For the first three quarters, MCO B reported rates for ED utilization for the MLTSS NF population were stable, ranging from 0.4% to 0.6%. The age group 20-44 years old had the highest rates, 9/198 (44.5 per 1000) for the 7/1/2020-9/30/2020 measurement period and 2/207 (9.66 per 1000) for the 10/1/2020-12/31/2020 measurement period. For the 1/1/2021 – 3/31/2021 measurement period, MCO B reported that the age group with the highest rates was 65-74 years old at 25/2052 (12.18 per 1000). MCOs C and E 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 # 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

1/1/2021 – 3/31/2021	A	B	C	D	E	TOTAL
Numerator	193	1118	2472	868	617	**5268**
Denominator	2666	6441	14226	5865	9651	**38849**
%	7.2	17.4	17.4	14.8	6.4	**13.6**

For the 1/1/2021-3/31/2021 measurement period, MCO E reported that of the 617 members receiving only PCA services, 525 (85.1%) remain enrolled in the plan, and 11 members (2.1%) have transitioned to a nursing facility setting. A review by services rendered per week revealed that 51/525 (9.7%) members received over 40 hours per week of PCA services as of the report run date. Additionally, 155/525 (29.5%) members have since been authorized for additional MLTSS service including home delivered meals; emergency response systems; home modifications; physical/speech, occupational therapy; or respite services.

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

1/1/2021 – 3/31/2021	A	B	C	D	E	TOTAL
Numerator	426	165	145	162	1795	**2693**
Denominator	2664	6441	14226	5865	9651	**38847**
%	16.0	2.6	1.0	2.8	18.6	**6.9**

Due to State DMAHS guidance related to COVID-19, medical day providers were able to continue to operate under 'alternate services' guidance. For the 1/1/2021-3/31/2021 measurement period, MCO B saw an increase in utilization of medical day care. Members historically authorized five days may previously have used less based on informal supports, personal schedules, etc. Given the ability to operate to support members during COVID, these members now utilize a full five days of services. MCO E reported a slight increase in the rate of members identified, from 18.2% to 18.6%. Review of

members' status revealed that 1632/1795 (90.9%) members identified in the numerator remain actively enrolled in the plan as of report run date. Additionally, 6/1795 (0.3%) have since transitioned into a NF setting.

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

7/1/2020 - 9/30/2020	A	B	C	D	E	TOTAL
Numerator	2	6	9	1	N/A	**N/A**
Denominator	4	13	14	3	N/A	**N/A**
%	50	46.2	64.3	33.3	N/A	**N/A**

10/1/2020 – 12/31/2020	A	B	C	D	E	TOTAL
Numerator	2	3	5	3	N/A	**N/A**
Denominator	4	14	13	7	N/A	**N/A**
%	50.0	21.4	38.5	42.9	N/A	**N/A**

1/1/2021 – 3/31/2021	A	B	C	D	E	TOTAL
Numerator	2	4	N/A	2	N/A	**N/A**
Denominator	4	7	N/A	3	N/A	**N/A**
%	50.0	57.1	N/A	66.7	N/A	**N/A**

After completing the validation process, MCO B reported rates for the first three quarters of the 2020-2021 waiver year, shown in red font in the tables above for the first two quarters. For the 1/1/2021-3/31/2021 measurement period, MCO A reported four acute inpatient discharges of HCBS members with principal diagnoses of Mental Illness or Intentional Self-Harm. Two of the four discharges (50%) had claims submitted for appropriate BH follow-up within 30 days of the discharge. They expected low compliance with follow-up visits due to residual impacts of COVID-19 that have contributed to member hesitancy in visiting with PCPs/specialists. MCO A continues to encourage providers to engage in telehealth visits to avoid any gaps in member care or access to services. MCO C is working with the State's EQRO and the MCO's HEDIS vendor on a potential issue with the inclusion criteria for the MLTSS population for this measure. MCO E is still working with the State's EQRO on their coding for this performance measure and has extensions to submit this report next quarter. The data for MCOs C and E along with any reconciled rates will be included in the next quarterly report.

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

7/1/2020 - 9/30/2020	A	B	C	D	E	TOTAL
Numerator	0	0	0	0	N/A	**N/A**
Denominator	2	1	0	2	N/A	**N/A**
%	0	0	0	0	N/A	**N/A**

10/1/2020 – 12/31/2020	A	B	C	D	E	TOTAL
Numerator	0	0	0	0	N/A	**N/A**
Denominator	2	1	1	0	N/A	**N/A**
%	0	0	0	0	N/A	**N/A**

1/1/2021 – 3/31/2021	A	B	C	D	E	TOTAL
Numerator	0	0	N/A	0	N/A	**N/A**
Denominator	0	0	N/A	0	N/A	**N/A**
%	0	0	N/A	0	N/A	**N/A**

After completing the validation process, MCO B reported rates for the first three quarters of the 2020-2021 waiver year, shown in red font in the tables above for the first two quarters. For the 1/1/2021-3/31/2021 measurement period, MCO A, MCO B, and MCO D had no discharges meeting the criteria for this measure. MCO C is working with the State's EQRO and the MCO's HEDIS vendor on a potential issue with the inclusion criteria for the MLTSS population for this measure. MCO E is still working with the State's EQRO on their coding for this performance measure and has extensions to submit this report next quarter. The data for MCOs C and E 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

1/1/2021 – 3/31/2021	A	B	C	D	E	TOTAL
Numerator	245	304	496	143	1337	**2525**
Denominator	2664	6441	14226	5865	9651	**38847**
%	9.2	4.7	3.5	2.4	13.9	**6.5**

For the 1/1/2021-3/31/2021 measurement period, MCO C reported 496 MLTSS members receiving only PCA and MDC services. The average amount of PCA services authorized was 23 hours per week. The average amount of MDC services authorized was 5 days per week. The members' age ranged from 34 years old to 106 years old, with the average age being 78 years old. There were no pediatric members receiving both MDC and PCA only. MCO E saw a continued decrease in the rate reported from the prior quarter for the measure, from 14.5% to 13.9%. The number of members reported in the numerator receiving both MDC and PCA services remained consistent through the public health emergency, however there was a slight decrease in the HCBS eligible membership reported for the measure. Review of member's current status revealed that 1215/1337 (90.9%) members identified in the numerator are still active with the plan and 11 members (0.9%) have since transitioned into a NF setting. As of October 2021, 173 of the 1215 (14.2%) members who remain active in the plan are now authorized for additional MLTSS services, such as home delivered meals, emergency response systems, and respite.

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

7/1/2020 - 9/30/2020	A	B	C	D	E	TOTAL
Numerator	0	2	5	2	N/A	**N/A**
Denominator	4	9	21	12	N/A	**N/A**
%	0	22.2	23.8	16.7	N/A	**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

10/1/2020 – 12/31/2020	A	B	C	D	E	TOTAL
Numerator	1	1	5	0	N/A	N/A
Denominator	5	13	27	5	N/A	N/A
%	20.0	7.7	18.5	0	N/A	N/A

1/1/2021 – 3/31/2021	A	B	C	D	E	TOTAL
Numerator	0	3	N/A	2	N/A	N/A
Denominator	3	8	N/A	10	N/A	N/A
%	0	37.5	N/A	20.0	N/A	N/A

After completing the validation process, MCO B reported rates for the first three quarters of the 2020-2021 waiver year, shown in red font in the tables above for the first two quarters. For the first three quarters 2020-2021 waiver year, MCO B anticipated low compliance with follow-up visits due to residual impacts of COVID-19 that have contributed to member hesitancy in visiting with PCPs/specialists. MCO B continues to encourage providers to engage in telehealth visits to avoid any gaps in member care or access to services. For the 7/1/2020 - 9/30/2020measurement period, MCO A reported that four MLTSS HCBS members identified with ED visits for alcohol and other drug dependence. None of the ED visits had qualifying follow up visits with any practitioner. Three of the four members had Medicare as primary insurance at time of ED visit, so claims data was not available to the plan to enable timely follow up. For one member with MCO A as primary, the CM was unable to reach the member for two months following the ED visit, despite multiple attempts by CM. MCO C is working with the State's EQRO and the MCO's HEDIS vendor on a potential issue with the inclusion criteria for the MLTSS population for this measure. MCO E is still working with the State's EQRO on their coding for this performance measure and has extensions to submit this report next quarter. The data for MCOs C and E along with any reconciled rates will be included in the next quarterly report.

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

7/1/2020 - 9/30/2020	A	B	C	D	E	TOTAL
Numerator	0	0	0	0	N/A	N/A
Denominator	0	1	4	0	N/A	N/A
%	0	0	0	0	N/A	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

10/1/2020 – 12/31/2020	A	B	C	D	E	TOTAL
Numerator	0	0	1	0	N/A	N/A
Denominator	2	0	3	0	N/A	N/A
%	0	0	33.3	0	N/A	N/A

1/1/2021 – 3/31/2021	A	B	C	D	E	TOTAL
Numerator	0	0	N/A	0	N/A	N/A
Denominator	0	0	N/A	0	N/A	N/A
%	0	0	N/A	0	N/A	N/A

After completing the validation process, MCO B reported rates for the first three quarters of the 2020-2021 waiver year, shown in red font in the tables above for the first two quarters. MCO B had one ED visit for Alcohol and Other Drug Abuse or Dependence (FUA) for MLTSS NF members. That visit had no qualifying follow-up visit with any practitioner, with a principle diagnosis of AOD within 30 days. For the 1/1/2021-3/31/2021 measurement period, MCO A, MCO B, and MCO D had no discharges meeting the criteria for this measure. MCO C is working with the State's EQRO and the MCO's HEDIS vendor on a potential issue with the inclusion criteria for the MLTSS population for this measure. MCO E is still working with the State's EQRO on their coding for this performance measure and has extensions to submit this report next quarter. The data for MCOs C and E along with any reconciled rates will be included in the next quarterly report.

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

7/1/2020 - 9/30/2020	A	B	C	D	E	TOTAL
Numerator	2	7	10	5	N/A	N/A
Denominator	2	9	18	6	N/A	N/A
%	100	77.8	55.6	83.3	N/A	N/A

Deliverables due during MLTSS 2nd quarter (10/1/2021 – 12/31/2021)

10/1/2020 – 12/31/2020	A	B	C	D	E	TOTAL
Numerator	0	3	9	3	N/A	**N/A**
Denominator	1	3	13	5	N/A	**N/A**
%	0	100	69.2	60.0	N/A	**N/A**

1/1/2021 – 3/31/2021	A	B	C	D	E	TOTAL
Numerator	2	8	N/A	4	N/A	**N/A**
Denominator	3	15	N/A	12	N/A	**N/A**
%	66.7	53.3	N/A	33.3	N/A	**N/A**

After completing the validation process, MCO B reported rates for the first three quarters of the 2020-2021 waiver year, shown in red font in the tables above for the first two quarters. For the 7/1/2020-9/30/2020 measurement period, MCO B reported that 6/9 (77.8%) ED visits had a follow-up visit within seven days of ED visit, while one additional follow-up visit was completed within 30 days.

MCO C is working with the State's EQRO and the MCO's HEDIS vendor on a potential issue with the inclusion criteria for the MLTSS population for this measure. MCO E is still working with the State's EQRO on their coding for this performance measure and has extensions to submit this report next quarter. The data for MCOs C and E along with any reconciled rates will be included in the next quarterly report.

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

7/1/2020 - 9/30/2020	A	B	C	D	E	TOTAL
Numerator	0	0	0	0	N/A	**N/A**
Denominator	0	2	0	0	N/A	**N/A**
%	0	0	0	0	N/A	**N/A**

Deliverables due during MLTSS 2nd quarter (10/1/2021 – 12/31/2021)

10/1/2020 – 12/31/2020	A	B	C	D	E	TOTAL
Numerator	1	1	0	0	N/A	**N/A**
Denominator	1	1	1	0	N/A	**N/A**
%	100	100	0	0	N/A	**N/A**

1/1/2021 – 3/31/2021	A	B	C	D	E	TOTAL
Numerator	0	0	N/A	0	N/A	**N/A**
Denominator	0	1	N/A	1	N/A	**N/A**
%	0	0	N/A	0	N/A	**N/A**

After completing the validation process, MCO B reported rates for the first three quarters of the 2020-2021 waiver year, shown in red font in the tables above for the first two quarters. MCO D reported that, due to the small sample size for the 1/1/2021-3/31/2021 measurement period, no trends were identified. They continue to monitor emergency room discharges for MLTSS NF members with a diagnosis of Mental Illness. Typically, the health plan becomes aware of ED visits when a member or their family/guardian contacts the health plan. MCO C is working with the State's EQRO and the MCO's HEDIS vendor on a potential issue with the inclusion criteria for the MLTSS population for this measure. MCO E is still working with the State's EQRO on their coding for this performance measure and has extensions to submit this report next quarter. The data for MCOs C and E along with any reconciled rates will be included in the next quarterly report

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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

1/1/2021 – 3/31/2021	A	B	C	D	E	TOTAL
Numerator	236	339	1266	548	596	**2985**
Denominator	2256	4226	10506	5798	7762	**30548**
%	10.5	8.0	12.1	9.5	7.7	**9.8**

For the 1/1/2021-3/31/2021 measurement period, MCO A reported that of the 236 HCBS members without the PCA, MDC or MLTSS HCBS services, 42 (17.8%) members were enrolled in March 2021, and therefore may have service claims in the following month. Random review of members identified in the numerator show multiple members who were in NF setting since their enrollment. Data is pulled based on CAP code during the measurement period, and many of the reviewed NF members had HCBS CAP codes assigned upon Aetna enrollment. File review indicates that these inaccurate CAP codes were corrected during or soon after the measurement period. MCO C found that, of the 1266

members in the numerator, 417 (33%) Refused Services; 354 (28%) had Other Insurance; 117 (9%) Members expired; 92 (7%) Unable to contact; 63 (5%) had an Inpatient Stay; 47 (4%) Transitioned to/from Nursing Facility; 42 (3%) Moved out of state; 30 (2%) Informal Supports; 27 (2%) Disenrolled, 22 (2%) Rehab; 17 (1%) Member is receiving BH Services; 16 (1%) Pediatric PDN; 6 (0%) Family paid out of pocket; 6 (0%) New Member; 2 (0%) Hospice; 2 (0%) Member Incarcerated; 2 (0%) Enrollment Issue; 1 (0%) Skilled Nursing visits; 1 (0%) Receiving PT Services; 1 (0%) transitioned to PACE and 1 (0%) Member had an authorization issue. .

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

1/1/2021 – 3/31/2021	A	B	C	D	E	TOTAL
Numerator	92	166	787	310	370	**1725**
Denominator	1757	3447	8280	4887	6956	**25327**
%	5.2	4.8	9.5	6.3	5.3	**6.8**

For the 1/1/2021-3/31/2021 measurement period, MCO E reported that 301/370 (81.4%) members remain enrolled in the plan as of report run date. Comparison to the previous quarter reported showed an increase in the percentage of members identified without services and continuously enrolled in HCBS, 5% to 5.4% due to both an increase in enrollment but also due to an increase in members refusing services or UTC. Analysis of those members enrolled in the plan show seven transitioned to an NF setting; three had respite services; 99 were UTC; 101 refused services; 24 members were out of the service area; and five members are deceased. The remaining members were in an acute/subacute inpatient setting or had a delay in services due to member choice. The continued PHE and postponement of member disenrollment from the program by the state have been the main cause of members refusing services while they remain actively enrolled in the plan.

Deliverables due during MLTSS 2nd quarter (10/1/2021 – 12/31/2021)

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:	7/1/2021 – 9/30/2021

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:	7/1/2021 – 9/30/2021

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:	7/1/2021 – 9/30/2021

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:	7/1/2021 – 9/30/2021

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.

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

1115 Comprehensive Waiver Quarterly Report
Demonstration Year 10
Federal Fiscal Quarter: 2 (10/01/21 – 12/31/21)
Department of Children and Families
Division of Children's System of Care

A summary of the outcomes of the State's Quality Strategy for Home and Community Based Services (HCBS) - I/DD program

#1 Administrative Authority Sub Assurance	The New Jersey State Medicaid Agency (DMAHS) retains the ultimate administrative authority and responsibility for the operation of the waiver program by exercising oversight of the performance of the waiver functions by other state and contracted agencies
Data Source	Record Review and or CSA data
Sampling Methodology	Random sample of case files representing a 95% confidence level
Numerator: Number of sub assurances that are substantially compliant (86 % or greater)	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 and Strengths (CANS) assessment	87

Denominator: Total number of new enrollees	87
Percentage	100%

#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	609
Denominator: Number of youth with Child and Adolescent Needs and Strengths Assessments conducted 1 year from admission or last CANS conducted	674
Percentage	90%

#4 Level of Care Sub Assurance	CSOC's Contracted System's Administrator (CSA), conducts an initial Level of Care assessments (aka Intensity of Services (IOS) prior to enrollment for all youth
Data Source	CSA Data. Data report: CSA NJ1218 New Enrollees, Quarterly Count and IOS Completed
Sampling Methodology	100% new youth enrolled in the waiver
Waiver	**I/DD**
Numerator: Number of youth receiving initial level of care determination prior to enrollment	87
Denominator: Number of new enrollees	87
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	85
Denominator: Number of Plans of Care reviewed	87
Percentage	98%

CSOC conducted a review of the data for all the youth enrolled during the reporting period under the CSSP I/DD waiver. One youth was transitioned to a different Care Management Entity and their care plan was not completed in a timely manner. Another youth was between out-of-home treatment services and was added to the waiver in error.

#6 Plan of Care Sub Assurance	Plan of Care 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	225
Denominator: Number of Plans of Care reviewed	225
Percentage	100%

#7 Plan of Care Sub Assurance	Services are authorized in accordance with the approved plan of care (treatment plan) 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	87
Denominator: Number of plans of care reviewed	87
Percentage	100%

#8 Plan of Care Sub Assurance	Services are delivered in accordance with the approved plan of care (ISP).
Data Source	CSA Data Report of Authorizations Claims paid on authorized services through MMIS Record Review
Sampling Methodology	Random sample representing a 95% confidence level
Waiver	**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	392
Denominator: Number of records reviewed	559
Percentage	70.1%

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

CSOC did not enroll any new waiver providers 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 HR Record Review
Sampling Methodology	100% agency
Waiver	**ID/D**
Numerator: Number of providers that meet the qualifying standards/applicable licensures/certification	177
Denominator: Total number of providers that initially met the qualified status	177
Percentage	100%

CSOC monitors certifications/qualifications of contracted providers as part of the contract renewal process. Monitoring and reporting on this measure is based on the provider population that was required to verify licensure and certification standards during this quarter.

# 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	177
Denominator: Total number of providers that provide waiver services	177
Percentage	100%

CSOC monitors certifications/qualifications of contracted providers as part of the contract renewal process. Monitoring and reporting on this measure is based on the provider population that was required to verify licensure and certification standards during this quarter.

# 13 Health and Welfare Sub Assurance	The State demonstrates on an on-going basis, that it identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation.
Data Source	Review of UIRMS database and Administrative policies & procedures
Sampling Methodology	100% of youth enrolled for the reporting period
Waiver	**I/DD**
Numerator: Total number of UIRs submitted timely according to State policies	0
Denominator: Number of UIRs submitted involving enrolled youth	0
Percentage	N/A

There were no incidents of abuse, neglect or exploitation reported during this quarter.

# 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 policies to prevent further similar incidents (i.e., abuse, neglect and runaways)
Data Source	Review of UIRMS database and Administrative policies & procedures
Sampling Methodology	100% of youth enrolled for the reporting period
Waiver	**I/DD**
Numerator: The number of incidents that were reported through UIRMS and had required follow up	0
Denominator: Total number of incidents reported that required follow up	0
Percentage	N/A

There were no unusual incidents reported during this quarter.

# 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

There were no incidents that documented the use of a restraint.

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

# 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 authorization	DMAHS measure
Denominator: Total number of claims submitted	DMAHS measure
Percentage	DMAHS measure