New Jersey Comprehensive Waiver Demonstration
Section 1115 Quarterly Report
***Demonstration Year:* 6 (7/1/17-6/30/18)**
***Federal Fiscal Quarter:* 1 (10/1/17-12/31/17)**

I. Introduction

The New Jersey Comprehensive Waiver Demonstration (NJCW) was approved by the Centers for Medicare and Medicaid Services (CMS) on July 27, 2017, and is effective August 1, 2017 through June 30, 2022.

This five year demonstration will:

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

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

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

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

II. Enrollment and Benefit Information

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

There have been no 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.

During this quarter, the remaining 1915(c) waiver, the Community Care Waiver (CCW) transitioned under the 1115(a) authority and was renamed the Community Care Program (CCP).

III. Enrollment Counts for Quarter

Demonstration Populations by MEG	Total Number of Demonstration participants Quarter Ending – 09/17	Total Number of Demonstration participants Quarter Ending – 12/17	Total Number of Demonstration participants Quarter Ending – MM/YY	Total Number of Demonstration participants Quarter Ending – MM/YY
Title XIX	721,949	697,453		
ABD	265,203	257,440		
LTC				
HCBS - State plan	10,678	11,228		
TBI – SP				
ACCAP – SP				
CRPD – SP				
GO – SP				
HCBS - 217-Like	12,845	12,850		
TBI – 217-Like				
ACCAP – 217-Like				
CRPD – 217-Like				
GO – 217-Like				
SED - 217 Like	281	249		
IDD/MI – (217 Like)	460	411		
NJ Childless Adults				
AWDC	358,214	350,685		
New Adult Group	199,136	192,834		
SED at Risk	3,424	3,356		
MATI at Risk				

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

IV. Outreach/Innovative Activities to Assure Access

MLTSS

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

The MLTSS Steering Committee met on December 7, 2017 with its representation from stakeholders, consumers, providers, MCOs and state staff members. The December meeting focused Medicaid's Aged, Blind and Disabled (ABD) application going online. In addition, the State presented highlights of the Comprehensive Waiver renewal approval and gave an update on the Any Willing Qualified Provider (AWQP) program aimed at improving the quality of care and outcome to MLTSS members living in nursing facilities (NFs). This program is a foundational step in the State's evolving value based purchasing (VBP) strategy.

The AWQP initiative will softly launch in February 2018 when the second release of Minimum Data Set (MDS) quality performance data is sent to the NFs. The multi-year rollout of AWQP is under the purview of DHS in collaboration with a NF Quality Workgroup, which is comprised of long term care industry and consumer stakeholders. DHS is also preparing a comprehensive webinar on the initiative on 1/23, 2/1 and 2/7 hosted by the NJ Hospital Association and extended to all NFs, all nursing facilities are invited to participate

The Quality Workgroup was originally involved with the development of MLTSS and then was reconvened to help drive this initiative, especially the nursing home industry leadership.

DHS held a meeting with the MCOs on October 31, 2017 to continue the discussion of their role in AWQP, which will include the provision of training, education, and technical assistance to the NF providers and counseling to affected residents and/or their family. It was agreed that a State/MCO committee should be created with bi-annual meetings. Membership makeup, structure and coordination will need to be decided.

During this quarter, The Department of Human Services (DHS) gave MLTSS updates to the long term care industry providers on October 19, 2017 at the New Jersey Medical Assistance Advisory Council, a group comprised of medical care and health services professionals who advise the State's Medicaid Director. In cooperation with the Behavioral Health Services Unit, the Provider Relations Unit presented at the New Jersey ATOD meeting on November 9, 2017. In cooperation with the Medicaid Fraud Unit and the State Investigation Units at the MCOs, the Provider Relations Unit participated in Provider Training for Behavioral Health providers on December 6, 2017.

In preparation for the implementation of the 21st Century Cures Act (42 U.S.C.1396u-2(d)) and requirement MCO Network provider enroll with the State Medicaid Program or risk being removed from a MCO provider network the Provider Relations Unit in conjunction with the State Monitoring Unit and Network and Credentialing Unit conducted conference calls to disseminate enrollment information and address question for the individual MCOs in December 2017. Provider Relations will continue to provide conference calls and updates to the MCOS for the enrollment of managed care providers especially non-traditional MLTSS providers in the state Medicaid program.

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

SED/I-DD/ASD:

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

Supports

The 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 to address access to both their programs concurrently as both programs have very similar providers, advocacy organizations, and supports and services. The primary difference between the two programs is the required level of care. It is intentional that information about both programs is shared at the same time and to the same audiences. This enables clear and consistent communication to individuals, families, providers, advocacy organizations and State staff.

During this quarter, the Division of Developmental Disabilities (DDD) continues enrollment of individuals into the Supports Program. As of the end of the reporting quarter, DDD enrolled 1,000 individuals in the Supports Program.

DDD began reviewing results of National Core Indicators family surveys in order to begin identifying areas in need of improvement and developing plans to address these areas. DDD is awaiting results from the individual surveys before initiating stakeholder involvement in this process. DDD also began revisions to the Supports Program Policies & Procedures Manual based on input from stakeholders, changes made to improve services, etc.

DDD is continuing enrollment of individuals into Supports Program + Private Duty Nursing (PDN) and provides options counseling to individuals identified as needing PDN.

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

NJ CAT assessments, supplemental assessments, reassessments as needed and DDD continues to work through the process for Day Habilitation.

CCP

The Division of Developmental Disabilities (DDD) is responsible for the daily operations of both the SP and the CCP. DDD addresses outreach and activities to address access to both their programs concurrently as both programs have very similar providers, advocacy organizations, and supports and services. The primary difference between the two programs is the required level of care. It is intentional that information about both programs is shared at the same time and to the same audiences. This enables clear and consistent communication to individuals, families, providers, advocacy organizations and State staff.

On October 31, 2017, DDD submitted a Transition Plan and other required documents satisfying Standard Terms & Conditions (STC) 37A(b) to transition the Community Care Program (CCP) to the 1115(a) demonstration from the 1915(c) Waiver to CMS. The transition of the CCP to the 1115(a) was also shared at the October 19, 2017 Medical Advisory Committee meeting . On November 1, 2017, the 1915(c) HCBS Community Care Waiver (CCW) was terminated. As of December 31, 2017, 11,052 individuals were enrolled in the CCP Program. During this quarter, 286 Individuals were determined both clinically and Medicaid eligible and enrolled on the CCP, at the end of the quarter there were an additional 34 CCP clinical determinations completed with Medicaid applications pending, 203 individuals were terminated from the CCP, and 6 individuals were determined ineligible for the CCP due to excess resources or refusal to sign the Medicaid application. Most common reasons for CCP termination include death and failure to complete a Medicaid redetermination. In addition, 1,680 individuals in the CCP were transitioned into FFS/Rate Structure model from the existing cost-reimbursement model; have approved service plans.

After the transition from CCW to CCP, revisions began to the Community Care Program Policies & Procedures Manual based on input from stakeholders, changes made to provide additional language to ensure policies and procedures are clear.

Routine meetings with providers and individuals/families regarding the system reform (including both the Supports and CCP Programs). These calls provide the opportunity for stakeholders to share issues/concerns as they come up, receive updates, and suggest ideas/feedback.

DDD provided ongoing guidance to providers on the application process for provider enrollment. In addition, DDD provided guidance to providers and families regarding obtaining and maintaining Medicaid and to providers regarding claiming questions.

DDD continues to meet with the trade organizations and individual providers to assist in preparation for the Medicaid-based, Fee-for-Service system.

NJ CAT assessments, supplemental assessments, reassessments as needed and DDD continues to work through the process for Day Habilitation.

V. Collection and Verification of Encounter Data and Enrollment Data

Summary of Issues, Activities or Findings

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

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

MLTSS

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

SED/I-DD/ASD:

DCF, CSOC continues ongoing enrollment of youth in the Children's Support Service Program (CSSP) Intellectual/ Development Disabilities (CSSP I/DD) and the Autism Spectrum Disorder (ASD) Pilot.
As of December 31, 2017, there were 146 youth identified for the ASD Pilot program and 966 youth identified for the CSSP I/DD Program. As of December 31, 2017, 273 CSSP SED Plan A youth have been enrolled through the Children's Support Services Serious Emotional Disturbance program.

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

CSOC continues to build ASD, I/DD-MI and SED provider networks. A request for Intensive in-Home providers was posted this quarter.

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

Non-medical transportation was operationalized this quarter under CSSP I/DD and SED waiver authority and seven new service providers added under the CSSP I/DD and ASD Pilot.

Supports

As previously indicated most operational, policy, systems and fiscal developments/issues for both the SP and CCP are concurrently shared/discussed at meetings and through communications.

During this quarter, the Division of Developmental Disabilities (DDD) held three quarterly meetings In December; the support coordination supervisors meeting, the provider update meeting, and the family update meeting. In addition to the quarterly meetings, DDD held the family Advisory Council meeting and Provider Leadership meeting.

DDD conducted site visits, meetings, and phone calls with providers in need of technical assistance as they shift to Fee-For-Service (FFS) and begin to serve individuals enrolled in the Supports Program.

DDD provided Question & Answer webinars on the Supports Program and FFS. These webinars, usually attended by 250-300 people, provide individuals, families, providers, and support coordinators a regular opportunity to ask questions, provide feedback, and voice concerns. In addition, DDD provided an update on the Supports Program and employment for the NJ APSE (Association of People Supporting EmploymentFirst) leadership link.

DDD provided a presentation on Support Coordination at The Arc/Morris annual meeting and also provided presentations at the Regional Family Support Councils throughout the state.

DDD met with CEArc (group of local Arc Executive Directors) to provide information regarding the shift to FFS and answered questions. DDD also met with postsecondary programs to provide guidance on how they can continue to provide services and receive funding through the Supports Program and met with representatives from the trade organizations.

CCP

As previously indicated most operational, policy, systems and fiscal developments/issues for both the SP and CCP are concurrently shared/discussed at meetings and through communications.

During this quarter, the Division of Developmental Disabilities (DDD) held three quarterly meetings In December; the Support Coordination Supervisors meeting, the provider update meeting, and the family update meeting. In addition to the quarterly meetings, DDD held the family Advisory Council meetings and Provider Leadership meetings.

DDD Conducted site visits, meetings, and phone calls with providers in need of technical assistance as they shift to FFS and begin to serve individuals enrolled in the Supports Program.

DDD provided Question & Answer webinars on the Supports Program and Fee-for-Service. These webinars, usually attended by 250-300 people provide individuals, families, providers, and support coordinators a regular opportunity to ask questions, provide feedback, and voice concerns. In addition, provided presentations at the Regional Family Support Councils throughout the state.

DDD met with CEArc (group of local Arc Executive Directors) to provide information regarding the shift to FFS and answered questions.

IME

During this quarter the IME Access Call Center received and responded to 13,205 calls from consumers and/or family members inquiring about substance use disorder treatment. 2,496 calls resulted in direct referral to a provider and 1,451 calls were sent to IME Care Coordination to facilitate admission to treatment. The IME also provides utilization management and has provided 5,766 Clinical reviews of LOCi-3 assessments to authorize treatment at the appropriate level of care for Medicaid recipients. In addition to the initial authorizations the IME clinically reviewed 3,246 provider requests to extend

treatment for Medicaid recipients. The IME continues to work with DMHAS and DMAHS to support providers with targeted assistance calls and/or training requests. Both Divisions continue to operate a provider assistance call line where they have received and responded to 3,110 calls.

DSRIP

Quarterly Payment Reports – The Centers for Medicare and Medicaid (CMS) approved the Final DY5 SFY 2017 DSRIP payments (which included DY4 appeal adjustments) and were sent to hospitals on October 27, 2017. No payments have been made yet to hospitals for DY6. Payments are being considered for March or April.

Progress in meeting DSRIP goals – DY4 Appeals were approved by CMS. DY4 and DY5 appeal and payment documents were posted to hospital SFTP folders on October 27, 2017. Measure acknowledgement was sent to hospitals on October 31, 2017. CMS approved releasing DY6 Reapplications and Semi-Annual 1 Progress Reports.

Performance – Three hospitals (Hackensack/Mountainside, Cape Regional, and St Luke's Hospital) have informed the New Jersey Department of Health (NJDOH) they intend to withdraw from the DSRIP program, effective with DY6. NJDOH is requesting formal letters of withdrawal from these hospitals.

Challenges – CMS and NJDOH continue discussions on the design of DY7 and DY8. CMS and New Jersey (NJ) agreed that, for DY6 and forward, the state will utilize the national benchmark when possible, followed by the NJ statewide benchmark. The CarePoint duplicate funding issue has been resolved, and CMS stated that no duplication of funds has occurred.

Mid-course corrections – CMS, New Jersey Department of Human Services (NJDHS) and NJDOH are holding weekly calls to discuss the 1115 Waiver renewal, including extending NJ DSRIP under the 1115 Waiver Renewal. CMS and NJDOH are working together on a final version of the FMP for DY6, DY7 and DY8.

Successes and evaluation – CMS issued and approved the Funding and Mechanics Protocol applicable to DY5 and was posted on the NJ DSRIP website. This protocol included the UPP Redesign and a calculation of DY4 payments based on adjudicated appeals with appeal adjustments made as part of DY5 payments. The September quarterly Learning Collaborative and QMC meetings were rescheduled for October 26, 2017. The Learning Collaborative included DSRIP updates (including the DY5 Appeal Process), DY6 Next Steps, and a panel discussion of Chart Measurement Validation (representatives from Trinitas RMC, RWJUH, and Monmouth MC were on the panel). The meeting was well attended.

Other

Managed Care Contracting:

There are no updates for this quarter.

Self-attestations:

There were a total of 147 self-attestations for the time period from October 1, 2017 to December 31, 2017. There was a significant decrease in self-attestation forms received this quarter due to education around the process to the plans on an individual basis.

MCO Choice and Auto-assignment:

The number of individuals who changed their MCO after auto-assignment is 5,288.

MLR:
MCO Medical Loss Ratios for the 12 month Period July 1, 2015 to June 30, 2016: Horizon NJ Health: 91.8% UnitedHealthcare: 87.8% Amerigroup: 83.5% WellCare: 89.4% Aetna: 97.5% *Note:* The MCO Medical Loss Ratios are updated once a year and will be reported in Demonstration Year 6: Federal Fiscal Quarter 2 report.

VII. Action Plan for Addressing Any Issues Identified

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

VIII. Financial/Budget Neutrality Development/Issues

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

IX. Member Month Reporting

A. For Use in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Title XIX				
ABD				
LTC (following transition to				

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

X. Consumer Issues

Summary of Consumer Issues

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

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
1	Eligibility	Authorization Status - Inquiries regarding request receipt/nurse assignment/authorization completion	Requests to speak with Care Manager	Medical Benefits	Benefits questions
2	Benefits Questions	Authorization Correction or Duplicate Copy	Authorization Inquiries	PCP Update	Requests for new/additional services
3	Providers Information	Authorization completed but missing authorization confirmation/request to resend	Requests to change PCP	ID Card	Request for PPP information and check on status of PPP application
4	PCP Change	Care Manager Inquiry- verbal request to speak with MLTSS care		Eligibility Inquiry	Auth Status

		manage			
5		Questions regarding MLTSS benefits			Requests for changes in PCP

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

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
1	Eligibility	Authorizations	Claims resolution	Auths	Claims
2	Benefit related questions	Claims processing	Single Case Agreements	Claims	Auths
3	Auth status	TBI claims issues	Credentialing Status	Provider billing incorrectly inquiries	Credentialing/Recredentialing inquiries
4	Claims denials		Training for new providers		
5					

XI. Quality Assurance/Monitoring Activity

MLTSS:

MLTSS Claims Processing Information by MCO

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
# Claims Received	50,501	81,322	444,556	52,571	195,076
# Claims Paid	36,181	76,524	407,585	45,824	151,358
# Claims Denied	9,684	4,531	31,637	3,841	45,103
# Claims Pending	4,636	267	5,334	2,906	5,161
Average # days for adjudication	15	15	15	15	15

Top 5 Reasons for MLTSS Claims Denial by MCO

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
1	Service denied because payment already made for	NetworX Std Fee Sched	Duplicate	No Authorization on file	No Authorization

	same/similar procedure within set time frame.				
2	Exact duplicate claim/service.	Disallow-not allowed under contract	Provider not contracted	Benefits Based on Admission Date	No Patient Responsibility
3	Non-covered charge(s).	Procedure non-reimbursable	Timely Filing	Medicaid 2ndary Carrier	Timely Filing
4		Units exceed UM Authorization	Member not eligible	The proc code inconsistent w/pos	
5		Paid at contracted rate			

SED/I-DD/ASD:

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

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

Supports:

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.

The Department of Human Services Quality Management Unit (QMU) conducts an annual audit of the Supports Program. The unit completed their annual audit in December and will provide a report with their findings in the upcoming months.

The Provider Performance & Monitoring Unit is in the process of revising monitoring tools and gathering stakeholder input. These tools will be utilized to monitor Medicaid/DDD approved providers and provide further guidance and technical assistance based on the results/findings.

DDD requires reporting on 86 distinct Unusual Incident Codes. At the end of this quarter there were 5,400 individuals on the Supports Program. From this group, there were 196 unusual incidents reported for 179 individuals (some individuals had more than 1 unusual incident report). Therefore, approximately 97% of individuals on the Supports Program during this quarter did not require an UIR. Some UIR codes, such as abuse, neglect, or exploitation require an investigation. 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.

Support Coordination Agencies expressed some concern that their staff needs additional training in order to understand "how to be a Support Coordinator." Initial meetings have been held with

representatives from the Support Coordination Agencies, the Boggs Center on Developmental Disabilities, and internal staff to discuss the best way to ensure that Support Coordinators receive all the training needed to successfully perform their duties. Discussions regarding the development of this training and entity providing this training will continue with the expectation that this concern will be addressed soon.

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.

The Department of Human Services Quality Management Unit (QMU) conducts an annual audit of the CCP. Audit findings and corrective actions will be reported in the next quarterly update.

The Provider Performance & Monitoring Unit is in the process of revising monitoring tools and gathering stakeholder input. These tools will be utilized to monitor Medicaid/DDD approved providers and provide further guidance and technical assistance based on the results/findings.

DDD requires reporting on 86 distinct Unusual Incident Codes. At the end of this quarter, there were 11,052 individuals on the Community Care Program. From this group, there were 2,708 unusual incidents reported for 1,850 individuals (some individuals had more than 1 unusual incident report). Therefore, approximately 84% of individuals on the CCP during this quarter did not require an UIR. Some UIR codes, such as abuse, neglect, or exploitation require an investigation by the Office of Investigations. Less than 1% of the Unusual 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. Danielle's Law is practiced in NJ. This law requires that 911 be called in a potential life-threatening emergency (e.g.: seizures, pain breathing). Over 33% of the reported UIRs had a single code of Danielle's Law. Often Danielle's Law incidents are determined to not be life-threatening; Direct Support Professionals are held to the prudent person standard and failure to report a perceived emergency may result in a $5,000 fine. DDD's Risk Management Unit conducts analysis if someone has more than 2 incidents in a single month summaries are created and sent to Support Coordination/Case Management staff as well as DDD's Provider Performance Monitoring Unit.

DDD engaged in a new quality initiative with the Council on Quality and Leadership (CQL). DDD is conducting an Interviewer Training Project for key staff. This project will help staff learn the principles and methods of interviewing individuals receiving services using CQL Personal Outcome Measures. CQL is training staff how to use the Personal Outcome Measures as a means of improving quality of services to individuals. These staff will learn to conduct interviews to help identify what is most important to each individual and how to incorporate it into service plans. Workshops were held during October 2017 which consisted of classroom and filed based activities. Twelve interviewer candidates participated, four of whom were identified to become trainer candidates and pursue trainer certification at a later date. CQL interviews were conducted with individuals on the CCP, but will be implemented in both the SP and the CCP.

DDD also participates in the National Core Indicators (NCI). Adult Family Surveys and Family Guardian Surveys were mailed out for individuals on both the SP and CCP. Between the 2 types of Surveys a total

of 16,370 surveys were mailed and 1,282 completed surveys were returned. Additionally, the Adult Consumer Survey was conducted via face to face interviews with recipients of both the SP and the CCP. A total of 400 interviews were conducted (CCP=284, SP=116)

Support Coordination Agencies expressed some concern that their staff needs additional training in order to understand "how to be a Support Coordinator." Initial meetings have been held with representatives from the Support Coordination Agencies, the Boggs Center on Developmental Disabilities, and internal staff to discuss the best way to ensure that Support Coordinators receive all the training needed to successfully perform their duties. Discussions regarding the development of this training and entity providing this training will continue with the expectation that this concern will be addressed soon.

Other Quality/Monitoring Issues:

EQR PIP

In December 2013, the MCOs, with the guidance of the EQRO, initiated a collaborative QIP with a focus on Identification and Management of Obesity in the Adolescent Population. Since inception, the EQRO had held regularly scheduled meetings with the MCOs to ensure a solid and consistent QIP foundation across all MCOs. Starting August 2015, the MCOs met monthly, independent of the EQRO, for continued collaborative activities. The MCOs are expected to show improvement and sustainability of this collaborative QIP. A routine QIP cycle consists of baseline data followed by two remeasurement years and then a sustainability year. Four MCOs were involved in the collaborative. For three of the MCOs, 2013 was their baseline data year for the project; results of calendar year 2014 reflect remeasurement year 1 and results of calendar year 2015 reflect remeasurement year 2. January 2016 started the sustainability year for these MCOs. The fourth MCO entered into the NJ market in December 2013, making their baseline year 2014, with results of calendar year 2015 as their first remeasurement year. January 2016 was the start of remeasurement year 2 for this MCO. All MCOs submitted a progress report in June 2016 which included remeasurement year 2 data for three MCOs and remeasurement year 1 data for the fourth MCO and were reviewed by the EQRO. All MCOs submitted a progress report update in September 2016 and were reviewed by the EQRO. January 2017 started the sustainability year for the fourth MCO. In June 2017, three of the MCOs submitted their final report for this QIP as the final sustainability data collection was completed in May 2017, and were reviewed by the EQRO. Three MCOs have now completed their collaborative QIP cycle with a focus on Identification and Management of Obesity in the Adolescent Population. Two of the MCOs showed improvement in their baseline rates to the sustainability rates on the three sub-metrics; BMI percentile, BMI risk categorization, and evaluation of family history. One of the MCOs showed improvement in their baseline rate to the sustainability rate on the sub-metric, BMI risk categorization. The fourth MCO is currently in their sustainability year and submitted a progress report in June 2017 which included the results of remeasurement year 2 data and were reviewed by the EQRO. The fourth MCO submitted a progress report update in September 2017 and was reviewed by the EQRO.

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

data and were reviewed by the EQRO. In the June 2017 report, one of the MCOs revised their Prenatal QIP aim statement and performance indicators, resulting in a new QIP cycle. For this MCO, 2016 is now the baseline data year for the project; results of calendar year 2017 will reflect remeasurement year 1 and results of calendar year 2018 will reflect remeasurement year 2. January 2019 will be the start of the sustainability year for this MCO. All MCOs submitted a progress report update in September 2017 and were reviewed by the EQRO. Additionally, the MCOs submitted individual QIP proposals with the focus on Developmental Screening and Early Intervention. The initial proposals were submitted by the MCOs in September 2017 for review by the EQRO. Upon approval, the MCOs will begin their project activities in early 2018. Lastly, all MCOs submitted individual QIP proposals in September 2015 on Falls Prevention specific to members receiving managed long term services and supports. The individual proposals were approved and project activities were initiated by the MCOs in early 2016. The MCOs submitted a progress report in June 2016 which included the 2015 baseline data. The MCOs submitted a progress report update in September 2016 and was reviewed by the EQRO. January 2017 was the start of remeasurement year 2 for this QIP. The MCOs submitted a progress report in June 2017 which included the results of the remeasurement year 1 data and were reviewed by the EQRO. The MCOs submitted a progress report update in September 2017 and were reviewed by the EQRO.
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.***
	The Center for State Health Policy (CSHP) draft final evaluation report covering all findings related to this hypothesis was submitted to the State in June 2017. CSHP activities during the quarter starting October 1, 2017 included general monitoring of ongoing activities related to MLTSS. CSHP attended the MAAC Meeting on October 19, 2017 and the MLTSS Steering Committee Meeting on December 7, 2017.
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.***
	Since the draft final evaluation report covering all findings related to this hypothesis was submitted to the State in June 2017, no further activities related to this hypothesis were undertaken this quarter.
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.***

	Since the draft final evaluation report covering all findings related to this hypothesis was submitted to the State in June 2017, no further activities related to this hypothesis were undertaken this quarter.
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 CSHP continued activities related to both the quantitative and qualitative components of our DSRIP summative evaluation. The Medicaid claims data for the first two quarters of 2017 were processed and prepared with a claim runout through October 2017. CSHP began preparing the four condition-specific, 30-day readmissions metrics for 2016 and the first two quarters of 2017 using the 2017 ICD-10 compliant SAS Packs developed by the Yale Center for Outcomes Research. CSHP made necessary adjustments to the preparation of the heart failure readmissions metric due to changes in the cohort specification. CSHP calculated avoidable inpatient admissions and avoidable ED visits for the first half of 2017 and pulled data from CMS cost reports for 2014-2016 to calculate hospital's total and operating margins. CSHP also started updating the hospital-level information on DSRIP participation over 2014 to June 2017 to track hospitals which left or joined the program during these years, as well as updating our reconciliation of hospitals' Medicaid provider IDs so all hospitals can be tracked in the claims data over the entire evaluation period. Additionally during this quarter, the State responded to our request for hospitals' DY4 and DY5 performance results on selected Stage 4 quality metrics. CSHP finalized the analysis plan for these secondary data and began the analysis. On the qualitative side, CSHP conducted the second round of key informant interviews this quarter (10 interviews with 29 informants, including participating hospitals, associations, outpatient partners, and state staff). Preliminary findings from these interviews informed some revisions and additions to the web survey instrument so it would capture hospitals' experiences during demonstration years 4 and 5, as well as their overall perceptions of the DSRIP program. The survey instrument was finalized during this quarter, along with the text of the advance email and email invite with consent script and link to the survey. A request for an endorsement letter was submitted to DOH. Finally, CSHP attended the DSRIP Learning Collaborative meeting on October 28, 2017 to stay abreast of developments in the program, and continued to monitor any announcements or training materials posted to the NJ DSRIP website.

XIII. Enclosures/Attachments

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

XIV. State Contact(s)

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XV. Date Submitted to CMS

Febraury 28, 2018

Federal Budget Neutrality Summary

SUBJECT TO PUBLIC COMMENT PROCESS

Room Under the Budget Neutrality Cap	**$ 31,585,462,768**

	Total				
State Fiscal Year	Date of Service Budget Neutrality Ceiling*	CMS 64 Waiver Date of Service Expenditures	BN Savings Phase-Down	DSRIP Expenditures	Variance
Initial Waiver Period					
SFY13 Actual	$ 6,647,835,190	$ 5,891,234,624			$ 756,600,566
SFY14 Actual	$ 9,550,939,510	$ 8,176,873,789			$ 1,374,065,721
SFY15 Actual	$ 10,094,035,306	$ 8,107,194,433			$ 1,986,840,873
SFY16 Actual	$ 10,698,461,481	$ 8,160,946,809			$ 2,537,514,672
SFY17 Actual	$ 11,152,667,461	$ 8,292,013,152			$ 2,860,654,309
SFY13-17	$ 48,143,938,948	$ 38,628,262,807	$ -	$ -	$ 9,515,676,141
First Waiver Extension Period					
SFY18 Projected	$ 11,890,120,244	$ 8,314,484,440			$ 3,575,635,804
SFY19 Projected	$ 12,678,499,229	$ 8,851,042,070			$ 3,827,457,159
SFY20 Projected	$ 13,521,479,765	$ 9,240,362,954			$ 4,281,116,812
SFY21 Projected	$ 14,423,013,593	$ 9,490,177,583			$ 4,932,836,010
SFY22 Projected	$ 15,387,350,378	$ 9,934,609,536			$ 5,452,740,842
SFY18-22	$ 67,900,463,210	$ 45,830,676,583			$ 22,069,786,627
Second Waiver Extension Period					
Total					**$ 31,585,462,768**

Budget Neutrality Monitoring Spreadsheet

Main Budget Neutrality Test

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

TOTAL COMPUTABLE

Waiver Year	1	2	3	4	5	***Demo***	6	7	8	9	10	***Renewal***
State Fiscal Year	2013	2014	2015	2016	2017	***Period 1***	2018	2019	2020	2021	2022	***Period 1***
NO WAIVER												
Title XIX	$ 1,888,003,055	$ 2,721,828,868	$ 3,190,622,964	$ 3,450,278,327	$ 3,617,934,962	**$ 14,868,668,176**	$ 3,929,594,634	$ 4,268,101,597	$ 4,635,768,555	$ 5,035,107,438	$ 5,468,846,559	$ 23,337,418,783
***ABD/LTC/HCBS State Plan**	$ 4,759,832,135	$ 6,829,110,642	$ 6,903,412,342	$ 7,248,183,154	$ 7,534,732,499	**$ 33,275,270,771**	$ 7,960,525,610	$ 8,410,397,632	$ 8,885,711,210	$ 9,387,906,155	$ 9,918,503,819	$ 44,563,044,427
	$ -	$ -	$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	$ -	$ -	$ -
NO WAIVER -TOTAL COMPUTABLE	**$ 6,647,835,190**	**$ 9,550,939,510**	**$ 10,094,035,306**	**$ 10,698,461,481**	**$ 11,152,667,461**	**$ 48,143,938,948**	**$ 11,890,120,244**	**$ 12,678,499,229**	**$ 13,521,479,765**	**$ 14,423,013,593**	**$ 15,387,350,378**	**$ 67,900,463,210**
WITH WAIVER												
Title XIX	$ 1,660,533,500	$ 2,401,466,400	$ 2,585,213,176	$ 2,542,983,914	$ 2,574,294,783	**$ 11,764,491,773**	$ 2,896,618,544	$ 3,146,141,876	$ 3,417,159,889	$ 3,711,524,199	$ 4,031,245,926	$ 17,202,690,434
****ABD/LTC/HCBS State Plan**	$ 4,009,676,348	$ 5,468,130,944	$ 5,219,407,337	$ 5,283,892,825	$ 5,508,360,696	**$ 25,489,468,150**	$ 5,209,108,223	$ 5,496,142,521	$ 5,614,445,392	$ 5,735,895,711	$ 5,860,605,937	$ 27,916,197,784
HCBS state plan	$ -	$ -	$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	$ -	$ -	$ -
DDD Supports-PDN	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	$ -
DSRIP	$ 192,443,637	$ 266,607,552	$ 266,600,001	$ 293,872,727	$ 166,600,000	**$ 1,374,123,917**	$ 166,000,000	$ 166,000,000	$ 166,000,000			$ 498,000,000
CNOMS	$ 28,581,139	$ 40,668,893	$ 35,973,919	$ 40,197,343	$ 42,757,673	**$ 188,178,967**	$ 42,757,673	$ 42,757,673	$ 42,757,673	$ 42,757,673	$ 42,757,673	$ 213,788,365
WITH WAIVER - TOTAL COMPUTABLE	**$ 5,891,234,624**	**$ 8,176,873,789**	**$ 8,107,194,433**	**$ 8,160,946,809**	**$ 8,292,013,152**	**$ 38,816,262,807**	**$ 8,314,484,440**	**$ 8,851,042,070**	**$ 9,240,362,954**	**$ 9,490,177,583**	**$ 9,934,609,536**	**$ 45,830,676,583**
Difference	**$ 756,600,566**	**$ 1,374,065,721**	**$ 1,986,840,873**	**$ 2,537,514,672**	**$ 2,860,654,309**	**$ 9,327,676,141**	**$ 3,575,635,804**	**$ 3,827,457,159**	**$ 4,281,116,812**	**$ 4,932,836,010**	**$ 5,452,740,842**	***$ 22,069,786,627***

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

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

FEDERAL SHARE

Waiver Year	1	2	3	4	5	***Demo***	6	7	8	9	10	***Renewal***
State Fiscal Year	2013	2014	2015	2016	2017	***Period 1***	2018	2019	2020	2021	2022	***Period 1***
NO WAIVER												
Title XIX	$ 947,820,711	$ 1,506,480,875	$ 1,750,301,926	$ 1,750,849,768	$ 1,817,659,517	**$ 7,773,112,796**	$ 1,968,451,578	$ 2,138,019,848	$ 2,322,195,233	$ 2,522,236,033	$ 2,739,508,942	**$ 11,690,411,635**
***ABD/LTC/HCBS State Plan**	$ 2,387,158,543	$ 3,436,382,656	$ 3,469,876,490	$ 3,630,976,127	$ 3,770,293,097	**$ 16,694,686,913**	$ 3,983,800,093	$ 4,208,936,056	$ 4,446,804,108	$ 4,698,124,794	$ 4,963,659,467	**$ 22,301,324,519**
	$ -	$ -	$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	$ -	$ -	**$ -**
	$ -	$ -	$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	$ -	$ -	**$ -**
NO WAIVER - FEDERAL SHARE	**$ 3,334,979,254**	**$ 4,942,863,530**	**$ 5,220,178,416**	**$ 5,381,825,895**	**$ 5,587,952,614**	**$ 24,467,799,710**	**$ 5,952,251,672**	**$ 6,346,955,905**	**$ 6,768,999,341**	**$ 7,220,360,827**	**$ 7,703,168,410**	**$ 33,991,736,154**
WITH WAIVER												
Title XIX	$ 833,625,792	$ 1,329,166,299	$ 1,418,188,126	$ 1,290,441,632	$ 1,293,332,097	**$ 6,164,753,946**	$ 1,451,002,934	$ 1,575,996,640	$ 1,711,757,675	$ 1,859,213,570	$ 2,019,371,753	**$ 8,617,342,572**
****ABD/LTC/HCBS State Plan**	$ 2,011,078,783	$ 2,751,925,405	$ 2,624,021,751	$ 2,647,176,890	$ 2,756,303,271	**$ 12,790,506,100**	$ 2,606,769,888	$ 2,750,408,977	$ 2,809,604,662	$ 2,870,374,958	$ 2,932,776,115	**$ 13,969,934,599**
HCBS state plan	$ -	$ -	$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	$ -	$ -	**$ -**
HOLD DDD Supports-PDN	$ -	$ -	$ -	$ -	$ -	**$ -**	$ -	$ -	$ -	$ -	$ -	**$ -**
DSRIP	$ 96,221,820	$ 138,946,279	$ 150,097,502	$ 167,888,474	$ 83,300,002	**$ 636,454,077**	$ 83,000,002	$ 83,000,002	$ 83,000,002			**$ 249,000,006**
CNOMS	$ 14,798,341	$ 21,084,004	$ 18,690,296	$ 20,590,547	$ 21,873,649	**$ 97,036,837**	$ 21,873,649	$ 21,873,649	$ 21,873,649	$ 21,873,649	$ 21,873,649	**$ 109,368,245**
WITH WAIVER - FEDERAL SHARE	**$ 2,955,724,736**	**$ 4,241,121,987**	**$ 4,210,997,674**	**$ 4,126,097,543**	**$ 4,154,809,019**	**$ 19,688,750,959**	**$ 4,162,646,474**	**$ 4,431,279,268**	**$ 4,626,235,988**	**$ 4,751,462,176**	**$ 4,974,021,517**	**$ 22,945,645,422**
	$ 2,011,069,653											
Difference	**$ 379,254,518**	**$ 701,741,543**	**$ 1,009,180,742**	**$ 1,255,728,352**	**$ 1,433,143,595**	**$ 4,779,048,751**	**1,789,605,198**	**1,915,676,637**	**2,142,763,353**	**2,468,898,651**	**2,729,146,893**	**11,046,090,732**

Notes:

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

Budget Neutrality Monitoring Spreadsheet

Supplemental Test #1

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

TOTAL COMPUTABLE

Waiver Year	1	2	3	4	5	*Demo*		6	7	8	9	10	*Renewal*
State Fiscal Year	2013	2014	2015	2016	2017	*Period 1*		2018	2019	2020	2021	2022	*Period 1*
NO WAIVER													
HCBS 217-like	$ 217,434,338	$ 299,298,600	$ 296,727,244	$ 333,440,492	$ 384,364,109	**$ 1,531,264,783**		$ 405,901,993	$ 428,646,755	$ 452,666,022	$ 478,031,211	$ 504,817,741	**$ 2,270,063,721**
Adults w/o Depend. Children	$ 1,677,789	$ 798,912	$ -	$ -	$ -	**$ 2,476,701**		$ -	$ -	$ -	$ -	$ -	**$ -**
SED 217-like	$ 253,840	$ 345,267	$ 290,262	$ 256,844	$ 5,238,074	**$ 6,384,287**		$ 5,654,277	$ 6,103,550	$ 6,588,522	$ 7,112,028	$ 7,677,130	**$ 33,135,507**
Former XIX Chip Parents	$ -	$ 140,335,250	$ -	$ -	$ -	**$ 140,335,250**		$ -	$ -	$ -	$ -	$ -	**$ -**
IDD/MI	$ -	$ -	$ 6,423,263	$ 34,933,951	$ 47,116,646	**$ 88,473,860**		$ 50,860,407	$ 54,901,637	$ 59,263,973	$ 63,972,928	$ 69,056,044	**$ 298,054,989**
NO WAIVER -TOTAL COMPUTABLE	**$ 219,365,967**	**$ 440,778,028**	**$ 303,440,769**	**$ 368,631,287**	**$ 436,718,829**	**$ 1,768,934,881**		**$ 462,416,677**	**$ 489,651,943**	**$ 518,518,516**	**$ 549,116,167**	**$ 581,550,915**	**$ 2,601,254,217**
WITH WAIVER													
HCBS 217-like	$ 207,465,132	$ 278,302,398	$ 331,241,469	$ 375,764,811	$ 403,186,286	**$ 1,595,960,096**		$ 457,424,548	$ 483,056,382	$ 510,124,498	$ 538,709,379	$ 568,896,017	**$ 2,558,210,823**
Adults w/o Depend. Children	$ 1,529,772	$ 674,018	$ -	$ -	$ -	**$ 2,203,790**		$ -	$ -	$ -	$ -	$ -	**$ -**
SED 217-like	$ 83	$ 58,922	$ 27,837	$ 96,680	$ 12,178,590	**$ 12,362,112**		$ 13,146,268	$ 14,190,835	$ 15,318,400	$ 16,535,559	$ 17,849,429	**$ 77,040,490**
Former XIX Chip Parents	$ -	$ 126,863,607	$ -	$ -	$ -	**$ 126,863,607**		$ -	$ -	$ -	$ -	$ -	**$ -**
IDD/MI	$ -	$ -	$ 1,186,792	$ 7,798,525	$ 10,933,029	**$ 19,918,346**		$ 11,353,890	$ 12,256,039	$ 13,229,871	$ 14,281,080	$ 15,415,816	**$ 66,536,696**
WITH WAIVER - TOTAL COMPUTABLE	**$ 208,994,987**	**$ 405,898,945**	**$ 332,456,098**	**$ 383,660,016**	**$ 426,297,905**	**$ 1,757,307,951**		**$ 481,924,706**	**$ 509,503,255**	**$ 538,672,768**	**$ 569,526,018**	**$ 602,161,262**	**$ 2,701,788,009**
Difference	**$ 10,370,980**	**$ 34,879,083**	**$ (29,015,329)**	**$ (15,028,729)**	**$ 10,420,924**	**$ 11,626,930**		**$ (19,508,029)**	**$ (19,851,313)**	**$ (20,154,252)**	**$ (20,409,851)**	**$ (20,610,347)**	**$ (100,533,792)**

FEDERAL SHARE

Waiver Year	1	2	3	4	5	*Demo*		6	7	8	9	10	*Renewal*
State Fiscal Year	2013	2014	2015	2016	2017	*Period 1*		2018	2019	2020	2021	2022	*Period 1*
NO WAIVER													
HCBS 217-like	$ 110,183,049	$ 154,284,438	$ 152,379,463	$ 167,842,464	$ 192,204,169	**$ 776,893,582**		$ 202,958,742	$ 214,331,557	$ 226,341,649	$ 239,024,727	$ 252,418,503	**$ 1,135,075,178**
Adults w/o Depend. Children	$ 852,857	$ 408,324	$ -	$ -	$ -	**$ 1,261,182**		$ -	$ -	$ -	$ -	$ -	**$ -**
SED 217-like	$ -	$ 172,639	$ 145,397	$ 129,706	$ 2,619,037	**$ 3,066,779**		$ 2,827,138	$ 3,051,775	$ 3,294,261	$ 3,556,014	$ 3,838,565	**$ 16,567,753**
Former XIX Chip Parents	$ -	$ 71,621,870	$ -	$ -	$ -	**$ 71,621,870**		$ -	$ -	$ -	$ -	$ -	**$ -**
IDD/MI	$ -	$ -	$ 3,244,338	$ 17,467,002	$ 23,678,297	**$ 44,389,637**		$ 25,559,711	$ 27,590,616	$ 29,782,892	$ 32,149,360	$ 34,703,861	**$ 149,786,438**
NO WAIVER -TOTAL COMPUTABLE	**$ 111,035,906**	**$ 226,487,272**	**$ 155,769,198**	**$ 185,439,173**	**$ 218,501,503**	**$ 897,233,051**		**$ 231,345,591**	**$ 244,973,948**	**$ 259,418,801**	**$ 274,730,101**	**$ 290,960,929**	**$ 1,301,429,369**
WITH WAIVER													
HCBS 217-like	$ 105,131,236	$ 143,461,176	$ 170,103,683	$ 189,147,069	$ 201,616,340	**$ 809,459,504**		$ 228,721,003	$ 241,537,408	$ 255,071,983	$ 269,364,969	$ 284,458,864	**$ 1,279,154,227**
Adults w/o Depend. Children	$ 777,617	$ 344,491	$ -	$ -	$ -	**$ 1,122,108**		$ -	$ -	$ -	$ -	$ -	**$ -**
SED 217-like	$ -	$ 29,462	$ 13,944	$ 48,823	$ 6,089,295	**$ 6,181,524**		$ 6,573,134	$ 7,095,417	$ 7,659,200	$ 8,267,779	$ 8,924,715	**$ 38,520,245**
Former XIX Chip Parents	$ -	$ 64,746,447	$ -	$ -	$ -	**$ 64,746,447**		$ -	$ -	$ -	$ -	$ -	**$ -**
IDD/MI	$ -	$ -	$ 599,439	$ 3,899,268	$ 5,494,354	**$ 9,993,061**		$ 5,705,855	$ 6,159,227	$ 6,648,623	$ 7,176,904	$ 7,747,162	**$ 33,437,772**
WITH WAIVER - TOTAL COMPUTABLE	**$ 105,908,853**	**$ 208,581,576**	**$ 170,717,066**	**$ 193,095,161**	**$ 213,199,989**	**$ 891,502,644**		**$ 240,999,992**	**$ 254,792,053**	**$ 269,379,806**	**$ 284,809,653**	**$ 301,130,740**	**$ 1,351,112,244**
Difference	**$ 5,127,053**	**$ 17,905,696**	**$ (14,947,868)**	**$ (7,655,988)**	**$ 5,301,514**	**$ 5,730,407**		**$ (9,654,401)**	**$ (9,818,105)**	**$ (9,961,005)**	**$ (10,079,552)**	**$ (10,169,811)**	**$ (49,682,874)**

Supplemental Test #2

Budget Neutrality Monitoring Spreadsheet

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

TOTAL COMPUTABLE

Waiver Year	1	2	3	4	5	*Demo*		6	7	8	9	10	*Renewal*
State Fiscal Year	2013	2014	2015	2016	2017	*Period 1*		2018	2019	2020	2021	2022	*Period 1*
NO WAIVER													
New Adult Group	$ -	$ 655,329,429	$ 3,208,229,680	$ 3,490,111,740	$ 3,707,738,354	**$ 11,061,409,203**		$ 3,964,587,236	$ 4,239,228,999	$ 4,532,896,222	$ 4,846,906,871	$ 5,182,670,210	**$ 22,766,289,538**
NO WAIVER -TOTAL COMPUTABLE	**$ -**	**$ 655,329,429**	**$ 3,208,229,680**	**$ 3,490,111,740**	**$ 3,707,738,354**	**$ 11,061,409,203**		**$ 3,964,587,236**	**$ 4,239,228,999**	**$ 4,532,896,222**	**$ 4,846,906,871**	**$ 5,182,670,210**	**$ 22,766,289,538**
WITH WAIVER													
New Adult Group	$ -	$ 849,333,950	$ 2,859,197,403	$ 2,912,681,554	$ 3,122,924,982	**$ 9,744,137,889**		$ 3,308,656,276	$ 3,537,859,252	$ 3,782,939,973	$ 4,044,998,352	$ 4,325,210,493	**$ 18,999,664,346**
WITH WAIVER - TOTAL COMPUTABLE	**$ -**	**$ 849,333,950**	**$ 2,859,197,403**	**$ 2,912,681,554**	**$ 3,122,924,982**	**$ 9,744,137,889**		**$ 3,308,656,276**	**$ 3,537,859,252**	**$ 3,782,939,973**	**$ 4,044,998,352**	**$ 4,325,210,493**	**$ 18,999,664,346**
Difference	**$ -**	**$ (194,004,521)**	**$ 349,032,277**	**$ 577,430,186**	**$ 584,813,372**	**$ 1,317,271,314**		**$ 655,930,960**	**$ 701,369,747**	**$ 749,956,249**	**$ 801,908,519**	**$ 857,459,717**	**$ 3,766,625,192**

FEDERAL SHARE

Waiver Year	1	2	3	4	5	*Demo*		6	7	8	9	10	*Renewal*
State Fiscal Year	2013	2014	2015	2016	2017	*Period 1*		2018	2019	2020	2021	2022	*Period 1*
NO WAIVER													
New Adult Group	$ -	$ 655,310,813	$ 3,208,083,440	$ 3,488,533,220	$ 3,615,044,895	**$ 10,966,972,368**		$ 3,746,534,938	$ 3,963,679,114	$ 4,147,600,043	$ 4,362,216,184	$ 4,664,403,189	**$ 20,884,433,468**
NO WAIVER -TOTAL COMPUTABLE	**$ -**	**$ 655,310,813**	**$ 3,208,083,440**	**$ 3,488,533,220**	**$ 3,615,044,895**	**$ 10,966,972,368**		**$ 3,746,534,938**	**$ 3,963,679,114**	**$ 4,147,600,043**	**$ 4,362,216,184**	**$ 4,664,403,189**	**$ 20,884,433,468**
WITH WAIVER													
New Adult Group	$ -	$ 849,309,823	$ 2,859,067,073	$ 2,911,364,196	$ 3,044,851,857	**$ 9,664,592,949**		$ 3,126,680,181	$ 3,307,898,400	$ 3,461,390,076	$ 3,640,498,517	$ 3,892,689,444	$ 17,429,156,618
WITH WAIVER - TOTAL COMPUTABLE	**$ -**	**$ 849,309,823**	**$ 2,859,067,073**	**$ 2,911,364,196**	**$ 3,044,851,857**	**$ 9,664,592,949**		**$ 3,126,680,181**	**$ 3,307,898,400**	**$ 3,461,390,076**	**$ 3,640,498,517**	**$ 3,892,689,444**	**$ 17,429,156,618**
Difference	**$ -**	**$ (193,999,010)**	**$ 349,016,367**	**$ 577,169,024**	**$ 570,193,038**	**$ 1,302,379,419**		**$ 619,854,757**	**$ 655,780,714**	**$ 686,209,968**	**$ 721,717,667**	**$ 771,713,745**	**$ 3,455,276,851**

Notes:

1. Federal share is calculated using Composite Federal Share Ratios (source data is CMS 64 Schedule C as reported in QE Dec 2017 with a run date of Jan 30, 2018).
2. Member-months based on MMIS report with last actual reported as of Dec 2017.
3. "With Waiver" pmpm's based on calculations using Sch C expenditures and MMIS eligibility actual member-months reported through Sept 2015

Federal Budget Neutrality - Cap														
TOTAL EXPENDITURES IN WAIVER	**$6,867,201,157**	**$10,647,046,967**	**$13,605,705,755**	**$14,557,204,508**	**$15,297,124,644**	**$60,974,283,032**		**$16,317,124,157**	**$17,407,380,170**	**$18,572,894,504**	**$19,819,036,631**	**$21,151,571,503**	**$93,268,006,966**	
														Original STC
Waiver Year	1	2	3	4	5	***Demo***		6	7	8	9	10	***Renewal***	Growth %'s
State Fiscal Year	2013	2014	2015	2016	2017	***Period 1***		2018	2019	2020	2021	2022	***Period 1***	used for
Member Months	*actual*	*actual*	*actual*	*actual*	*actual*			*projected*	*projected*	*projected*	*projected*	*projected*		BN
Title XIX	5,773,180	7,850,901	8,699,959	8,893,616	8,815,631			9,050,128	9,290,863	9,538,002	9,791,714	10,052,175		2.7%
***ABD/LTC/HCBS State Plan**	2,499,711	3,453,171	3,381,631	3,402,743	3,398,321			3,460,700	3,524,225	3,588,915	3,654,793	3,721,880		1.8%
														1.8%
														1.8%
Total Waiver Member Months	**8,272,891**	**11,304,072**	**12,081,590**	**12,296,359**	**12,213,952**			**12,510,829**	**12,815,088**	**13,126,917**	**13,446,507**	**13,774,055**		
Per Member Per Month														
Title XIX	$327.03	$346.69	$366.74	$387.95	$410.40			$434.20	$459.39	$486.03	$514.22	$544.05		5.8%
***ABD/LTC/HCBS State Plan**	$1,904.15	$1,977.63	$2,041.44	$2,130.10	$2,217.19			$2,300.26	$2,386.45	$2,475.88	$2,568.66	$2,664.92		3.75%
Total Expenditures (Member Months x PMPM)														
Title XIX	$1,888,003,055	$2,721,828,868	$3,190,622,964	$3,450,278,327	$3,617,934,962	**$14,868,668,176**		**$3,929,594,634**	**$4,268,101,597**	**$4,635,768,555**	**$5,035,107,438**	**$5,468,846,559**	**$23,337,418,783**	
***ABD/LTC/HCBS State Plan**	$4,759,832,135	$6,829,110,642	$6,903,412,342	$7,248,183,154	$7,534,732,499	**$33,275,270,771**		**$7,960,525,610**	**$8,410,397,632**	**$8,885,711,210**	**$9,387,906,155**	**$9,918,503,819**	**$44,563,044,427**	
Total Base Expenditures	**$6,647,835,190**	**$9,550,939,510**	**$10,094,035,306**	**$10,698,461,481**	**$11,152,667,461**	**$48,143,938,948**		**$11,890,120,244**	**$12,678,499,229**	**$13,521,479,765**	**$14,423,013,593**	**$15,387,350,378**	**$67,900,463,210**	
** ABD, LTC, and HCBS State Plan Member Months, PMPM, and Total Expenditures are combined in the WOW Cap Consolidated Calculation*														
Hypothetical Population Expenditures														
HCBS 217-Like	$217,434,338	$299,298,600	$296,727,244	$333,440,492	$384,364,109	**$1,531,264,783**		**$405,901,993**	**$428,646,755**	**$452,666,022**	**$478,031,211**	**$504,817,741**	**$2,270,063,721**	
***Adults w/o Dependent Children**	$1,677,789	$798,912	$0	$0	$0	**$2,476,701**		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	
SED 217-Like	$253,840	$345,267	$290,262	$256,844	$5,238,074	**$6,384,287**		**$5,654,277**	**$6,103,550**	**$6,588,522**	**$7,112,028**	**$7,677,130**	**$33,135,507**	
***XIX CHIP Parents**	$0	$140,335,250	$0	$0	$0	**$140,335,250**		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	
IDD/MI	$0	$0	$6,423,263	$34,933,951	$47,116,646	**$88,473,860**		**$50,860,407**	**$54,901,637**	**$59,263,973**	**$63,972,928**	**$69,056,044**	**$298,054,989**	
New Adult Group	$0	$655,329,429	$3,208,229,680	$3,490,111,740	$3,707,738,354	**$11,061,409,203**		**$3,964,587,236**	**$4,239,228,999**	**$4,532,896,222**	**$4,846,906,871**	**$5,182,670,210**	**$22,766,289,538**	
Total Hypothetical Expenditures	**$219,365,967**	**$1,096,107,457**	**$3,511,670,449**	**$3,858,743,027**	**$4,144,457,183**	**$12,830,344,084**		**$4,427,003,913**	**$4,728,880,941**	**$5,051,414,739**	**$5,396,023,038**	**$5,764,221,125**	**$25,367,543,756**	
** Adults w/o Dependent Chidren and Title XIX CHIP Parents are now in New Adult Group as of 1/1/14.*														

With Waiver - Expenditures

TOTAL EXPENDITURES IN WAIVER	**$6,100,229,611**	**$9,432,106,684**	**$11,298,847,934**	**$11,457,288,379**	**$12,029,236,039**	**$50,317,708,647**		**$12,105,065,421**	**$12,898,404,577**	**$13,561,975,696**	**$14,104,701,953**	**$14,861,981,292**	**$67,532,128,938**	
														Original STC
Waiver Year	1	2	3	4	5	***Demo***		6	7	8	9	10	***Renewal***	Growth %'s
State Fiscal Year	2013	2014	2015	2016	2017	***Period 1***		2018	2019	2020	2021	2022	***Period 1***	used for
Member Months	*actual*	*actual*	*actual*	*actual*	*estimated*			*projected*	*projected*	*projected*	*projected*	*projected*		BN
Title XIX	5,773,180	7,850,901	8,699,959	8,893,616	8,815,631			9,050,128	9,290,863	9,538,002	9,791,714	10,052,175		2.7%
***ABD/LTC/HCBS State Plan**	2,499,711	3,361,590	3,381,631	3,401,925	3,357,056			3,046,489	3,102,410	3,159,358	3,217,351	3,276,409		1.8%
														1.8%
														1.8%
Total Waiver Member Months	**8,272,891**	**11,212,491**	**12,081,590**	**12,295,541**	**12,172,687**			**12,096,617**	**12,393,273**	**12,697,360**	**13,009,065**	**13,328,584**		
Per Member Per Month														
Title XIX	$287.63	$305.88	$297.15	$285.93	$302.52			$320.06	$338.63	$358.27	$379.05	$401.03		5.8%
***ABD/LTC/HCBS State Plan**	$1,604.06	$1,626.65	$1,543.46	$1,553.21	$1,609.12			$1,667.05	$1,727.06	$1,727.06	$1,727.06	$1,727.06		3.6%
														3.9%
														3.7%
Total Expenditures (Member Months x PMPM)														
Title XIX	$1,660,533,500	$2,401,466,400	$2,585,213,176	$2,542,983,914	$2,574,294,783	**$11,764,491,773**		$2,896,618,544	$3,146,141,876	$3,417,159,889	$3,711,524,199	$4,031,245,926	**$17,202,690,434**	
***ABD/LTC/HCBS State Plan**	$4,009,676,348	$5,468,130,944	$5,219,407,337	$5,283,892,825	$5,508,360,696	**$25,489,468,150**		$5,209,108,223	$5,496,142,521	$5,614,445,392	$5,735,895,711	$5,860,605,937	**$27,916,197,784**	
Total Base Actual Expenditures	**$5,670,209,848**	**$7,869,597,344**	**$7,804,620,513**	**$7,826,876,739**	**$8,082,655,479**	**$37,253,959,923**		**$8,105,726,767**	**$8,642,284,397**	**$9,031,605,281**	**$9,447,419,910**	**$9,891,851,863**	**$45,118,888,218**	
** ABD, LTC, and HCBS State Plan Member Months, PMPM, and Total Expenditures are combined in the Actuals Consolidated Calculation*														
Hypothetical Population Expenditures														
HCBS 217-Like	$207,465,132	$278,302,398	$331,241,469	$375,764,811	$403,186,286	**$1,595,960,096**		$457,424,548	$483,056,382	$510,124,498	$538,709,379	$568,896,017	**$2,558,210,823**	
****Adults w/o Dependent Children**	$1,529,772	$674,018	$0	$0	$0	**$2,203,790**		$0	$0	$0	$0	$0	**$0**	
SED 217-Like	$83	$58,922	$27,837	$96,680	$12,178,590	**$12,362,112**		$13,146,268	$14,190,835	$15,318,400	$16,535,559	$17,849,429	**$77,040,490**	
****XIX CHIP Parents**	$0	$126,863,607	$0	$0	$0	**$126,863,607**		$0	$0	$0	$0	$0	**$0**	
IDD/MI - 217-Like	$0	$0	$1,186,792	$7,798,525	$10,933,029	**$19,918,346**		$11,353,890	$12,256,039	$13,229,871	$14,281,080	$15,415,816	**$66,536,696**	
New Adult Group	$0	$849,333,950	$2,859,197,403	$2,912,681,554	$3,122,924,982	**$9,744,137,889**		$3,308,656,276	$3,537,859,252	$3,782,939,973	$4,044,998,352	$4,325,210,493	**$18,999,664,346**	
Total Hypothetical Expenditures	**$208,994,987**	**$1,255,232,895**	**$3,191,653,501**	**$3,296,341,570**	**$3,549,222,887**	**$11,501,445,840**		**$3,790,580,981**	**$4,047,362,507**	**$4,321,612,742**	**$4,614,524,370**	**$4,927,371,756**	**$21,701,452,356**	
*** Adults w/o Dependent Chidren and Title XIX CHIP Parents are now in New Adult Group as of 1/1/14.*														
Supports Program	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	
Hospital Subsidies														
HRSF & GME	$ 192,443,637	$ -	$ -	$ -	$ -	**$192,443,637**		$ -	$ -	$ -	$ -	$ -	**$0**	
HRSF Transition Payments	$ -	$ 83,302,681	$ -	$ -	$ -	**$83,302,681**							**$0**	
GME State Plan	-	100,000,001	100,000,000	127,272,727	188,000,000	**$515,272,728**							**$0**	
DSRIP	-	83,304,870	166,600,001	166,600,000	166,600,000	**$583,104,871**		166,000,000	166,000,000	166,000,000	-	-	**$498,000,000**	
Hospital Subsidies Expenditures	**$ 192,443,637**	**$ 266,607,552**	**$ 266,600,001**	**$ 293,872,727**	**$ 354,600,000**	**$1,374,123,917**		**$ 166,000,000**	**$ 166,000,000**	**$ 166,000,000**	**$ -**	**$ -**	**$498,000,000**	
Costs Otherwise Not Matchable (CNOMs)														
SED at Risk	$ 24,511,364	$ 37,239,735	$ 35,973,919	$ 40,197,343	$ 42,757,673	**$180,680,034**		$ 42,757,673	$ 42,757,673	$ 42,757,673	$ 42,757,673	$ 42,757,673	**$213,788,365**	
MATI at Risk	4,069,775	3,429,158	-	-	-	**$7,498,933**		-					**$0**	
DDD non-Disabled Adult Children	-	-	-											
DDD Community / Supports Equalization	-	-	-											
CNOM Expenditures	***$ 28,581,139***	***$ 40,668,893***	***$ 35,973,919***	***$ 40,197,343***	***$ 42,757,673***	**$188,178,967**		***$ 42,757,673***	***$ 42,757,673***	***$ 42,757,673***	***$ 42,757,673***	***$ 42,757,673***	**$213,788,365**	

Federal Budget Neutrality - Cap

TOTAL EXPENDITURES IN WAIVER	**$6,867,201,157**	**$10,647,046,967**	**$13,605,705,755**	**$14,557,204,508**	**$15,297,124,644**	**$60,974,283,032**		**$16,317,124,157**	**$17,407,380,170**	**$18,572,894,504**	**$19,819,036,631**	**$21,151,571,503**	**$93,268,006,966**	
														Original STC
Waiver Year	1	2	3	4	5	***Demo***		6	7	8	9	10	***Renewal***	Growth %'s
State Fiscal Year	2013	2014	2015	2016	2017	***Period 1***		2018	2019	2020	2021	2022	***Period 1***	used for
Member Months	*actual*	*actual*	*actual*	*actual*	*actual*			*projected*	*projected*	*projected*	*projected*	*projected*		BN
Title XIX	5,773,180	7,850,901	8,699,959	8,893,616	8,815,631			9,050,128	9,290,863	9,538,002	9,791,714	10,052,175		2.7%
ABD	2,205,410	3,062,023	2,996,757	2,982,486	2,942,552			2,996,565	3,051,570	3,107,584	3,164,627	3,222,717		1.8%
LTC	280,707	372,288	359,218	361,215	357,482			364,044	370,726	377,531	384,461	391,518		1.8%
HCBS State Plan	13,594	18,860	25,656	59,042	98,287			100,091	101,928	103,799	105,705	107,645		1.8%
Total Waiver Member Months	**8,272,891**	**11,304,072**	**12,081,590**	**12,296,359**	**12,213,952**			**12,510,829**	**12,815,088**	**13,126,917**	**13,446,507**	**13,774,055**		
Per Member Per Month														
Title XIX	$327.03	$346.69	$366.74	$387.95	$410.40			$434.20	$459.39	$486.03	$514.22	$544.05		5.8%
ABD	$1,045.04	$1,124.49	$1,164.91	$1,206.78	$1,250.17			$1,295.18	$1,341.80	$1,390.11	$1,440.15	$1,492.00		3.6%
LTC	$8,636.81	$8,975.89	$9,325.83	$9,689.41	$10,067.17			$10,459.79	$10,867.72	$11,291.56	$11,731.93	$12,189.48		3.9%
HCBS State Plan	$2,256.69	$2,347.84	$2,434.29	$2,523.94	$2,616.93			$2,713.76	$2,814.17	$2,918.29	$3,026.27	$3,138.24		3.7%
Total Expenditures (Member Months x PMPM)														
Title XIX	$1,888,003,055	$2,721,828,868	$3,190,622,964	$3,450,278,327	$3,617,934,962	**$14,868,668,176**		**$3,929,594,634**	**$4,268,101,597**	**$4,635,768,555**	**$5,035,107,438**	**$5,468,846,559**	**$23,337,418,783**	
ABD	$2,304,741,666	$3,443,214,243	$3,490,952,197	$3,599,204,455	$3,678,690,234	**$16,516,802,795**		**$3,881,079,819**	**$4,094,604,222**	**$4,319,876,044**	**$4,557,541,589**	**$4,808,282,721**	**$21,661,384,396**	
LTC	$2,424,413,025	$3,341,616,136	$3,350,006,001	$3,499,960,233	$3,598,832,066	**$16,214,827,461**		**$3,807,822,790**	**$4,028,949,986**	**$4,262,918,441**	**$4,510,473,869**	**$4,772,405,291**	**$21,382,570,378**	
HCBS State Plan	$30,677,444	$44,280,262	$62,454,144	$149,018,465	$257,210,199	**$543,640,515**		**$271,623,000**	**$286,843,424**	**$302,916,726**	**$319,890,697**	**$337,815,807**	**$1,519,089,653**	
Total Base Expenditures	**$6,647,835,190**	**$9,550,939,510**	**$10,094,035,306**	**$10,698,461,481**	**$11,152,667,461**	**$48,143,938,948**		**$11,890,120,244**	**$12,678,499,229**	**$13,521,479,765**	**$14,423,013,593**	**$15,387,350,378**	**$67,900,463,210**	
Hypothetical Population Expenditures														
HCBS 217-Like	$217,434,338	$299,298,600	$296,727,244	$333,440,492	$384,364,109	**$1,531,264,783**		**$405,901,993**	**$428,646,755**	**$452,666,022**	**$478,031,211**	**$504,817,741**	**$2,270,063,721**	
***Adults w/o Dependent Children**	$1,677,789	$798,912	$0	$0	$0	**$2,476,701**		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	
SED 217-Like	$253,840	$345,267	$290,262	$256,844	$5,238,074	**$6,384,287**		**$5,654,277**	**$6,103,550**	**$6,588,522**	**$7,112,028**	**$7,677,130**	**$33,135,507**	
***XIX CHIP Parents**	$0	$140,335,250	$0	$0	$0	**$140,335,250**		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	
IDD/MI	$0	$0	$6,423,263	$34,933,951	$47,116,646	**$88,473,860**		**$50,860,407**	**$54,901,637**	**$59,263,973**	**$63,972,928**	**$69,056,044**	**$298,054,989**	
New Adult Group	$0	$655,329,429	$3,208,229,680	$3,490,111,740	$3,707,738,354	**$11,061,409,203**		**$3,964,587,236**	**$4,239,228,999**	**$4,532,896,222**	**$4,846,906,871**	**$5,182,670,210**	**$22,766,289,538**	
Total Hypothetical Expenditures	**$219,365,967**	**$1,096,107,457**	**$3,511,670,449**	**$3,858,743,027**	**$4,144,457,183**	**$12,830,344,084**		**$4,427,003,913**	**$4,728,880,941**	**$5,051,414,739**	**$5,396,023,038**	**$5,764,221,125**	**$25,367,543,756**	
** Adults w/o Dependent Chidren and Title XIX CHIP Parents are now in New Adult Group as of 1/1/14.*														

With Waiver - Expenditures

TOTAL EXPENDITURES IN WAIVER	**$6,100,227,468**	**$9,442,488,618**	**$11,297,320,773**	**$11,437,497,403**	**$12,005,158,050**	**$50,282,692,312**		**$12,044,101,459**	**$12,833,033,560**	**$13,491,860,168**	**$14,029,478,279**	**$14,781,257,604**	**$67,179,731,070**	
														Original STC
Waiver Year	1	2	3	4	5	***Demo***		6	7	8	9	10	***Renewal***	Growth %'s
State Fiscal Year	2013	2014	2015	2016	2017	***Period 1***		2018	2019	2020	2021	2022	***Period 1***	used for
Member Months	*actual*	*actual*	*actual*	*actual*	*estimated*			*projected*	*projected*	*projected*	*projected*	*projected*		BN
Title XIX	5,773,180	7,850,901	8,699,959	8,893,999	8,785,836			9,019,541	9,259,462	9,505,765	9,758,620	10,018,201		2.7%
***ABD**	2,486,117	3,342,730	3,355,975	3,342,883	3,258,769			2,946,398	3,000,482	3,055,559	3,111,646	3,168,764		1.8%
***LTC**														1.8%
HCBS State Plan	13,594	18,860	25,656	59,042	98,287			100,091	101,928	103,799	105,705	107,645		1.8%
Total Waiver Member Months	**8,272,891**	**11,212,491**	**12,081,590**	**12,295,924**	**12,142,892**			**12,066,029**	**12,361,872**	**12,665,123**	**12,975,971**	**13,294,610**		
Per Member Per Month														
Title XIX	$287.63	$305.59	$296.85	$284.99	$301.52			$319.01	$337.51	$357.09	$377.80	$399.71		5.8%
***ABD**	$1,595.54	$1,616.41	$1,525.65	$1,508.82	$1,563.14			$1,619.41	$1,677.71	$1,677.71	$1,677.71	$1,677.71		3.6%
***LTC**														3.9%
HCBS State Plan	$3,162.12	$3,441.37	$3,872.47	$4,066.37	$4,216.83			$4,372.85	$4,534.64	$4,702.43	$4,876.42	$5,056.84		3.7%
Total Expenditures (Member Months x PMPM)														
Title XIX	$1,660,532,120	$2,399,180,142	$2,582,613,493	$2,534,724,200	$2,649,124,657	**$11,826,174,612**		$2,877,328,130	$3,125,189,727	$3,394,402,860	$3,686,806,812	$4,004,399,310	**$17,088,126,839**	
***ABD**	$3,966,690,442	$5,403,226,627	$5,120,055,291	$5,043,806,205	$5,093,901,545	**$24,627,680,110**		$4,771,424,809	$5,033,933,470	$5,126,336,408	$5,220,435,488	$5,316,261,845	**$25,468,392,019**	
***LTC**	$0	$0	$0	$0	$0	**$0**		$0	$0	$0	$0	$0	**$0**	
HCBS State Plan	$42,985,906	$64,904,317	$99,352,046	$240,086,620	$414,459,151	**$861,788,040**		$437,683,414	$462,209,051	$488,108,984	$515,460,224	$544,344,093	**$2,447,805,765**	
Total Base Actual Expenditures	**$5,670,208,468**	**$7,867,311,086**	**$7,802,020,830**	**$7,818,617,025**	**$8,157,485,353**	**$37,315,642,762**		**$8,086,436,352**	**$8,621,332,248**	**$9,008,848,252**	**$9,422,702,523**	**$9,865,005,247**	**$45,004,324,623**	
** ABD and LTC Member Months, PMPM, and Total Expenditures are combined in the Actual Detail Calculation*														
Hypothetical Population Expenditures														
HCBS 217-Like	$207,464,369	$278,302,398	$331,117,748	$375,476,571	$430,061,851	**$1,622,422,937**		$454,160,413	$479,609,340	$506,484,301	$534,865,203	$564,836,432	**$2,539,955,689**	
****Adults w/o Dependent Children**	$1,529,772	$674,018	$0	$0	$0	**$2,203,790**		$0	$0	$0	$0	$0	**$0**	
SED 217-Like	$83	$58,922	$27,837	$96,680	$6,135,308	**$6,318,830**		$6,622,803	$7,149,033	$7,717,076	$8,330,254	$8,992,153	**$38,811,319**	
****XIX CHIP Parents**	$0	$126,863,607	$0	$0	$0	**$126,863,607**		$0	$0	$0	$0	$0	**$0**	
IDD/MI - 217-Like	$0	$0	$1,186,792	$7,795,679	$9,058,086	**$18,040,557**		$9,777,817	$10,554,736	$11,393,387	$12,298,675	$13,275,894	**$57,300,509**	
New Adult Group	$0	$862,002,142	$2,860,394,406	$2,901,491,432	$3,068,397,436	**$9,692,285,416**		$3,280,956,785	$3,508,240,914	$3,751,269,863	$4,011,134,335	$4,289,000,589	**$18,840,602,486**	
Total Hypothetical Expenditures	**$208,994,224**	**$1,267,901,087**	**$3,192,726,783**	**$3,284,860,362**	**$3,513,652,681**	**$11,468,135,137**		**$3,751,517,818**	**$4,005,554,023**	**$4,276,864,626**	**$4,566,628,466**	**$4,876,105,068**	**$21,476,670,002**	
*** Adults w/o Dependent Chidren and Title XIX CHIP Parents are now in New Adult Group as of 1/1/14.*														
Supports Program	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	
Hospital Subsidies														
HRSF & GME	$ 192,443,637	$ -	$ -	$ -	$ -	**$192,443,637**		$ -	$ -	$ -	$ -	$ -	**$0**	
HRSF Transition Payments	-	83,302,681	-	-	-	**$83,302,681**							**$0**	
GME State Plan	-	100,000,001	100,000,000	127,272,727	188,000,000	**$515,272,728**							**$0**	
DSRIP	-	83,304,870	166,600,001	166,600,000	166,600,000	**$583,104,871**		166,000,000	166,000,000	166,000,000	-	-	**$498,000,000**	
Hospital Subsidies Expenditures	**$ 192,443,637**	**$ 266,607,552**	**$ 266,600,001**	**$ 293,872,727**	**$ 354,600,000**	**$1,374,123,917**		**$ 166,000,000**	**$ 166,000,000**	**$ 166,000,000**	**$ -**	**$ -**	**$498,000,000**	
Costs Otherwise Not Matchable (CNOMs)														
SED at Risk	$ 24,511,364	$ 37,239,735	$ 35,973,159	$ 40,147,289	$ 40,147,289	**$178,018,836**		$ 40,147,289	$ 40,147,289	$ 40,147,289	$ 40,147,289	$ 40,147,289	**$200,736,445**	
MATI at Risk	4,069,775	3,429,158	-	-	-	**$7,498,933**		-					**$0**	
DDD non-Disabled Adult Children	-	-	-											
DDD Community / Supports Equalization	-	-	-											
CNOM Expenditures	***$ 28,581,139***	***$ 40,668,893***	***$ 35,973,159***	***$ 40,147,289***	***$ 40,147,289***	**$185,517,769**		***$ 40,147,289***	***$ 40,147,289***	***$ 40,147,289***	***$ 40,147,289***	***$ 40,147,289***	**$200,736,445**	

Hypotheticals: Enrollment and PMPM's															
Waiver Year		1	2	3	4	5	***Demo***		6	7	8	9	10	***Renewal***	Growth %'s
State Fiscal Year		2013	2014	2015	2016	2017	***Period 1***		2018	2019	2020	2021	2022	***Period 1***	
WOW-CAP															
HCBS 217-Like	Enrollment	96,351	127,895	122,272	132,498	147,284			149,988	152,741	155,544	158,400	161,307		1.8%
	PMPM	$2,256.69	$2,340.19	$2,426.78	$2,516.57	$2,609.68			$2,706.24	$2,806.37	$2,910.20	$3,017.88	$3,129.54		3.7%
Adults w/o DC	Enrollment	6,057	2,774	3,870,426	4,240,639	4,406,447			4,406,447	4,406,447	4,406,447	4,406,447	4,406,447		
	PMPM	$277.00	$288.00						$0.00	$0.00	$0.00	$0.00	$0.00		
SED 217-Like	Enrollment	113	145	115	96	1,847			1,881	1,915	1,951	1,986	2,023		1.8%
	PMPM	$2,246.37	$2,381.15	$2,524.02	$2,675.46	$2,835.99			$3,006.15	$3,186.52	$3,377.71	$3,580.37	$3,795.19		6.0%
XIX Chip Parents	Enrollment	0	456,761	0	0	0			0	0	0	0	0		
	PMPM		$307.24						$0.00	$0.00	$0.00	$0.00	$0.00		
IDD/MI	Enrollment	0	0	581	2,981	3,793			3,863	3,934	4,006	4,079	4,154		1.8%
	PMPM	$9,839.39	$10,429.75	$11,055.53	$11,718.87	$12,422.00			$13,167.32	$13,957.36	$14,794.80	$15,682.49	$16,623.44		6.0%
New Adult Group	Enrollment	0	1,408,947	6,541,000	6,776,916	6,856,659			6,982,519	7,110,690	7,241,213	7,374,133	7,509,492		1.8%
	PMPM		$465.12	$490.48	$515.00	$540.75			$567.79	$596.18	$625.99	$657.29	$690.15		5.0%
ACTUALS															
HCBS 217-Like	Enrollment	96,351	127,895	122,272	132,498	147,284			149,988	152,741	155,544	158,400	161,307		1.8%
	PMPM	$2,153.22	$2,176.02	$2,709.05	$2,836.00	$2,940.94			$3,049.75	$3,162.59	$3,279.61	$3,400.95	$3,526.79		3.7%
Adults w/o DC	Enrollment	6,057	2,774	3,870,426	4,240,639	4,406,447			4,406,447	4,406,447	4,406,447	4,406,447	4,406,447		
	PMPM	$252.56	$242.98						$0.00	$0.00	$0.00	$0.00	$0.00		
SED 217-Like	Enrollment	113	145	115	96	1,847			1,881	1,915	1,951	1,986	2,023		1.8%
	PMPM	$0.73	$406.36	$242.06	$1,007.08	$6,593.71			$6,989.34	$7,408.70	$7,853.22	$8,324.41	$8,823.88		6.0%
***XIX CHIP Parents**	Enrollment	0	456,761	0	0	0									
	PMPM		$277.75												
IDD/MI - 217-Like	Enrollment	0	0	581	2,981	3,793			3,863	3,934	4,006	4,079	4,154		1.8%
	PMPM	$0.00	$0.00	$2,042.67	$2,616.08	$2,773.04			$2,939.42	$3,115.79	$3,302.74	$3,500.90	$3,710.95		6.0%
New Adult Group	Enrollment	0	1,186,513	6,541,000	6,776,916	6,856,659			6,982,519	7,110,690	7,241,213	7,374,133	7,509,492		1.8%
	PMPM		$715.82	$437.12	$429.79	$451.28			$473.85	$497.54	$522.42	$548.54	$575.97		5.0%

Hospital Subsidy Summary

Waiver Year	1	2	3	4	5	*Demo*		6	7	8	9	10	*Renewal*
State Fiscal Year	2013	2014	2015	2016	2017	*Period 1*		2018	2019	2020	2021	2022	*Period 1*
TOTAL COMPUTABLE													
HRSF & GME	$ 192,443,637	$ -	$ -	$ -	$ -	**$ 192,443,637**		$ -	$ -	$ -	$ -	$ -	**$ -**
HRSF Transition Payments	-	83,302,681	-	-	-	**$ 83,302,681**							**$ -**
GME State Plan	-	100,000,001	100,000,000	127,291,443	188,000,000	**$ 515,291,444**		218,000,000	218,000,000	218,000,000	218,000,000	218,000,000	**$ 1,090,000,000**
DSRIP	-	83,304,870	166,600,001	166,600,000	166,600,000	**$ 583,104,871**		166,000,000	166,000,000	166,000,000	-	-	**$ 498,000,000**
TOTAL COMPUTABLE	**$ 192,443,637**	**$ 266,607,552**	**$ 266,600,001**	**$ 293,891,443**	**$ 354,600,000**	**$ 1,374,142,633**		**$ 384,000,000**	**$ 384,000,000**	**$ 384,000,000**	**$ 218,000,000**	**$ 218,000,000**	**$ 1,588,000,000**
Composite Federal Share Percentage													
HRSF & GME	50.00%	0.00%	0.00%	0.00%	0.00%								
HRSF Transition Payments	0.00%	50.00%	0.00%	0.00%	0.00%			0.00%	0.00%	0.00%	0.00%	0.00%	
GME State Plan	0.00%	55.64%	66.80%	66.45%	65.08%			65.08%	65.08%	65.08%	65.08%	65.08%	
DSRIP	0.00%	50.00%	50.00%	50.00%	50.00%			50.00%	50.00%	50.00%	50.00%	50.00%	
FEDERAL SHARE													
HRSF & GME	$ 96,221,820	$ -	$ -	$ -	$ -	**$ 96,221,820**		$ -	$ -	$ -	$ -	$ -	**$ -**
HRSF Transition Payments	$ -	$ 41,651,341	$ -	$ -	$ -	**$ 41,651,341**		-	-	-	-	-	**$ -**
GME State Plan	$ -	$ 55,642,502	$ 66,797,499	$ 84,588,472	$ 122,350,400	**$ 329,378,873**		141,874,400	141,874,400	141,874,400	141,874,400	141,874,400	**$ 709,372,000**
DSRIP	$ -	$ 41,652,436	$ 83,300,003	$ 83,300,002	$ 83,300,002	**$ 291,552,443**		83,000,002	83,000,002	83,000,002	-	-	**$ 249,000,006**
FEDERAL SHARE	**$ 96,221,820**	**$ 138,946,279**	**$ 150,097,502**	**$ 167,888,474**	**$ 205,650,402**	**$ 758,804,477**		**$ 224,874,402**	**$ 224,874,402**	**$ 224,874,402**	**$ 141,874,400**	**$ 141,874,400**	**$ 958,372,006**

DY6-10: Total Computable amounts tie to the amounts budgeted in SFY2016.

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

Costs Otherwise Not Matchable (CNOM) Summary

Waiver Year	1	2	3	4	5	***Demo***		6	7	8	9	10	***Renewal***	Growth %
State Fiscal Year	2013	2014	2015	2016	2017	***Period 1***		2018	2019	2020	2021	2022	***Period 1***	
TOTAL COMPUTABLE														
SED at Risk	$ 24,511,364	$ 37,239,735	$ 35,973,919	$ 40,197,343	$ 42,757,673	$ 180,680,034		$ 42,757,673	$ 42,757,673	$ 42,757,673	$ 42,757,673	$ 42,757,673	$ 213,788,365	
MATI at Risk	$ 4,069,775	$ 3,429,158	$ -	$ -	$ -	$ 7,498,933		$ -	$ -	$ -	$ -	$ -	$ -	
DDD non-Disabled Adult Children	$ -	$ -	$ -			$ -		$ -	$ -	$ -	$ -	$ -	$ -	3.00%
DDD Community / Supports Equalization	$ -	$ -	$ -			$ -								3.00%
TOTAL COMPUTABLE	**$ 28,581,139.00**	**$ 40,668,893.00**	**$ 35,973,919.00**	**$ 40,197,343.00**	**$ 42,757,673.00**	**$ 188,178,967**		**$ 42,757,673**	**$ 42,757,673**	**$ 42,757,673**	**$ 42,757,673**	**$ 42,757,673**	**$ 213,788,365**	
Composite Federal Share Percentage														
SED at Risk	51.99%	51.83%	51.96%	51.22%	51.16%			51.16%	51.16%	51.16%	51.16%	51.16%		
MATI at Risk	50.50%	52.00%	0.00%	0.00%	0.00%			0.00%	0.00%	0.00%	0.00%	0.00%		
DDD non-Disabled Adult Children				50.00%	50.00%			50.00%	50.00%	50.00%	50.00%	50.00%		
DDD Community / Supports Equalization				50.00%	50.00%			50.00%	50.00%	50.00%	50.00%	50.00%		
FEDERAL SHARE														
SED at Risk	$ 12,743,019	$ 19,300,842	$ 18,690,296	$ 20,590,547	$ 21,873,649	$ 93,198,353		$ 21,873,649	$ 21,873,649	$ 21,873,649	$ 21,873,649	$ 21,873,649	$ 109,368,245	
MATI at Risk	$ 2,055,322	$ 1,783,162	$ -	$ -	$ -	$ 3,838,484		$ -	$ -	$ -	$ -	$ -	$ -	
DDD non-Disabled Adult Children	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	$ -	
DDD Community / Supports Equalization	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	$ -	
FEDERAL SHARE	**$ 14,798,341**	**$ 21,084,004**	**$ 18,690,296**	**$ 20,590,547**	**$ 21,873,649**	**$ 97,036,837**		*$ 21,873,649*	*$ 21,873,649*	*$ 21,873,649*	*$ 21,873,649*	*$ 21,873,649*	**$ 109,368,245**	

Notes: SED at Risk and MATI at Risk

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

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

Notes: DDD programs

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

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

Budgent Neutrality Monitoring Sheet Notes

Enrollment Trends

No Waiver Spending

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

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

With Waiver Spending

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

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

BN caps should be as of 3-27-14

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

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

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

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

Schedule C

CMS 64 Waiver Expenditure Report

Cumulative Data Ending Quarter/Year : 4/2017

State: New Jersey

Summary of Expenditures by Waiver Year

Waiver: 11W00279

MAP Waivers

Total Computable

Waiver Name	A	01	02	03	04	05	06
ABD	0	3,968,073,211	5,408,229,628	5,120,958,562	5,070,404,308	5,180,893,704	2,237,363,552
ACCAP – 217 Like	0	630,539	880,454	0	0	0	0
ACCAP – SP	0	900,000	966,297	0	0	0	0
AWDC	0	1,529,772	674,018	0	0	0	0
Childless Adults	0	27,844,394	48,216,389	0	0	0	0
CRPD – 217 Like	0	11,803,536	16,894,842	0	0	0	0
CRPD –SP	0	10,672,842	15,247,535	0	0	0	0
DSRIP	0	0	83,304,870	166,600,001	166,600,000	166,600,000	0
GME State Plan	0	0	100,000,001	100,000,000	127,291,443	188,000,000	108,999,984
GO – 217 Like	0	181,068,236	221,682,839	0	0	0	0
GO – SP	0	23,869,092	33,606,671	0	0	0	0
HCBS – 217 Like	0	288,889	21,406,012	331,241,469	375,764,811	403,186,286	320,278,141
HCBS – State Plan	0	86,858	5,718,886	99,376,696	240,137,067	365,054,865	311,561,548
HRSF & GME	0	192,443,637	0	0	0	0	0
HRSF Transition Payments	0	0	83,302,681	0	0	0	0
IDD/MI – 217 Like	0	0	0	1,186,792	7,798,525	10,933,029	7,848,030
MATI at Risk	0	4,069,775	3,429,158	0	0	0	0
New Adult Group	0	7,940,104	849,333,950	2,859,197,403	2,912,681,554	3,122,924,982	1,547,213,664
SED – 217 Like	0	83	58,922	27,837	96,680	12,178,590	9,400,323
SED at Risk	0	24,511,364	37,239,735	35,973,919	40,197,343	42,757,673	17,357,365
TBI – 217 Like	0	13,673,932	17,438,251	0	0	0	0
TBI – SP	0	7,457,114	9,364,928	0	0	0	0
Title XIX	0	1,660,533,500	2,401,466,400	2,585,213,176	2,542,983,914	2,574,294,783	1,162,559,141
XIX CHIP Parents	0	0	126,863,607	0	0	0	0
Total	**0**	**6,137,396,878**	**9,485,326,074**	**11,299,775,855**	**11,483,955,645**	**12,066,823,912**	**5,722,581,748**

Federal Share

Waiver Name	A	01	02	03	04	05	06
ABD	0	1,989,939,987	2,720,966,897	2,573,448,372	2,539,761,068	2,592,519,950	1,119,705,005
ACCAP – 217 Like	0	319,151	446,869	0	0	0	0

Composite Federal Share Percentages

Waiver Name	01	02	03	04	05	06	07	08	09	10
ABD	50.15%	50.31%	50.25%	50.09%	50.04%	50.05%	50.05%	50.05%	50.05%	50.05%

ACCAP – SP	0	454,312	489,362	0	0	0	0													
AWDC	0	777,617	344,491	0	0	0	0		AWDC	50.83%	51.11%									
Childless Adults	0	14,715,147	24,778,164	0	0	0	0		Childless Adult	52.85%	51.39%									
CRPD – 217 Like	0	6,026,151	8,740,654	0	0	0	0													
CRPD –SP	0	5,447,877	7,899,121	0	0	0	0													
DSRIP	0	0	41,652,435	83,300,003	83,300,002	83,300,002	0		DSRIP		50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%
GME State Plan	0	0	55,642,502	66,797,499	84,588,472	122,350,400	69,792,690		GME State Pla		55.64%	66.80%	66.45%	65.08%	*65.08%*	*65.08%*	*65.08%*	*65.08%*	*65.08%*
GO – 217 Like	0	91,709,982	114,209,771	0	0	0	0													
GO – SP	0	12,108,906	17,304,835	0	0	0	0													
HCBS – 217 Like	0	147,458	11,076,822	170,103,683	189,147,069	201,616,340	160,145,182		HCBS – 217 Lik	50.67%	51.55%	51.35%	50.34%	50.01%	50.00%	50.00%	50.00%	50.00%	50.00%
HCBS – State Plan	0	44,439	2,963,002	51,039,962	120,764,158	182,601,978	155,804,712		HCBS – State P	50.79%	51.58%	51.36%	50.29%	50.02%	50.01%	50.01%	50.01%	50.01%	50.01%
HRSF & GME	0	96,221,820	0	0	0	0	0		HRSF & GME	50.00%									
HRSF Transition Payments	0	0	41,651,341	0	0	0	0		HRSF Transitio		50.00%								
IDD/MI – 217 Like	0	0	0	599,439	3,903,695	5,466,597	3,924,021		IDD/MI – 217			50.51%	50.00%	50.25%	50.25%	50.25%	50.25%	50.25%	50.25%
MATI at Risk	0	2,055,322	1,783,162	0	0	0	0		MATI at Risk	50.50%	52.00%								
New Adult Group	0	7,938,698	849,309,823	2,859,067,073	2,911,364,196	3,039,184,051	1,469,852,982		New Adult Gro	99.98%	100.00%	100.00%	99.95%	97.50%	94.50%	93.50%	91.50%	90.00%	90.00%
SED – 217 Like	0	42	29,462	13,944	48,354	6,090,280	4,700,889		SED – 217 Like		50.00%	50.09%	50.50%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%
SED at Risk	0	12,743,019	19,300,842	18,690,296	20,590,547	21,873,649	8,678,683		SED at Risk	51.99%	51.83%	51.96%	51.22%	51.16%	51.16%	51.16%	51.16%	51.16%	51.16%
TBI – 217 Like	0	6,928,494	8,987,060	0	0	0	0													
TBI – SP	0	3,776,704	4,819,278	0	0	0	0													
Title XIX	0	833,625,792	1,329,166,299	1,418,188,126	1,290,441,632	1,293,332,097	582,360,673		Title XIX	50.20%	55.35%	54.86%	50.75%	50.24%	50.09%	50.09%	50.09%	50.09%	50.09%
XIX CHIP Parents	0	0	64,746,447	2,148	0	0	0		XIX CHIP Parer		51.04%								
Total	**0**	**3,084,980,918**	**5,326,308,639**	**7,241,250,545**	**7,243,909,193**	**7,548,335,344**	**3,574,964,837**												
Created On: Tuesday, January 30, 2018 2:53 PM																			
DY1 & DY2 HCBS expenditures		DY1	DY2																
		total computable																	
HCBS – 217 Like		207,465,132	278,302,398																
HCBS – State Plan		42,985,906	64,904,317																
		Federal share																	
HCBS – 217 Like		105,131,236	143,461,176																
HCBS – State Plan		21,832,238	33,475,598																

CMS 64 - MEDICAID ELIGIBILITY GROUPS AS OF JUNE 2014

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

	DEFINITIONS:	DY1	DY2	DY3	DY4	DY5	DY6
1	TITLE XIX	5,773,180	7,850,901	8,699,959	8,893,616	8,815,631	5,036,309
2	ABD (Excluding HCBS and LTC SPC 61)	2,486,117	3,342,730	3,355,975	3,343,701	3,300,034	1,851,813
3	Childless Adults	385,740	225,208	-	-	-	-
4	Adults W/O Dependent Children	6,057	2,774	3,870,426	4,240,639	4,406,447	2,520,396
5	SED	26,729	43,160	38,453	43,795	47,049	25,672
6	HCBS (State Plan)	13,594	18,860	25,656	59,042	98,287	74,747
7	HCBS (217 Like)	96,351	127,895	122,272	132,498	147,284	89,574
8	LTC						
9	SED (217 Like)	113	145	115	96	1,847	1,871
10	IDD/MI (217 Like)	-	-	581	2,981	3,793	3,164
11	XIX CHIP Parents *(10/01/2013 - 12/31/2013 Only)*		456,761	-	-	-	
12	New Adult Group *(01/01/2014 Onwards)*		1,183,739	2,670,574	2,536,277	2,450,212	1,391,441
	Source = CMS64 MEG report from Dec 2015						

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

	DEFINITIONS:	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14
		final jan 15 rpt	final feb 15 rpt	final mar 15 rpt	final apr 15 rpt	final may 15 rpt	final jun 15 rpt	final jul 15 rpt	final aug 15 rpt	final sept 15 rpt	final Oct 15 rpt	final Nov 15 rpt	final Dec 15 rpt
1	TITLE XIX	628,743	625,874	623,702	663,241	667,292	678,653	683,673	689,180	693,744	698,873	705,756	712,044
2	ABD (Excluding HCBS and LTC SPC 61)	279,906	279,461	278,818	276,842	277,127	278,134	278,326	278,535	278,973	280,262	280,382	280,535
3	Childless Adults	37,737	34,678	35,535									
4	Adults W/O Dependent Children	453	442	425	145,207	160,725	203,473	221,698	235,947	248,452	261,467	275,824	285,009
5	SED	3,364	3,566	3,531	3,769	3,856	4,162	4,191	3,551	3,454	3,185	3,028	2,810
6	HCBS (State Plan)	1,567	1,586	1,586	1,596	1,583	1,580	1,576	1,573	1,565	1,492	1,546	1,624
7	HCBS (217 Like)	10,726	10,752	10,751	10,758	10,742	10,606	10,604	10,577	10,601	9,863	9,920	9,994
8	LTC				0	0	0	0	0	0	24,537	24,150	23,794
9	SED (217 Like)	15	16	13	9	9	11	15	10	7	14	18	11
10	IDD/MI (217 Like)						0	0	0	0	0	0	0
11	XIX CHIP Parents *(10/01/2013 - 12/31/2013 Only)*	152,428	152,087	152,246									
12	New Adult Group *(01/01/2014 Onwards)*				181,112	186,389	198,362	203,220	205,870	208,786	211,485	214,061	216,647

	DEFINITIONS:	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
1	TITLE XIX	716,443	718,070	721,307	726,830	732,311	736,730	740,261	744,442	746,892	744,994	744,692	744,034
2	ABD (Excluding HCBS and LTC SPC 61)	280,359	280,294	278,829	279,154	279,165	279,205	279,364	279,287	279,139	279,313	279,789	278,996
3	Childless Adults												
4	Adults W/O Dependent Children	293,647	303,733	320,267	332,291	348,973	355,792	362,664	364,468	366,291	362,228	357,424	350,616
5	SED	2,886	2,923	3,039	3,164	3,262	3,413	3,522	3,637	3,584	3,438	3,182	3,107
6	HCBS (State Plan)	1,821	2,011	2,162	2,163	2,265	2,349	2,496	2,703	3,024	3,360	3,715	3,972
7	HCBS (217 Like)	10,300	10,490	10,467	10,246	10,156	10,149	10,181	10,224	10,282	10,517	10,584	10,701
8	LTC	23,313	22,974	22,725									
9	SED (217 Like)	6	8	9	9	5	7	9	11	8	11	8	7
10	IDD/MI (217 Like)	0	0	0	0	0	113	133	145	190	205	220	244
11	XIX CHIP Parents *(10/01/2013 - 12/31/2013 Only)*												
12	New Adult Group *(01/01/2014 Onwards)*	218,794	220,090	225,796	225,810	228,275	228,919	227,858	226,725	226,114	223,139	219,467	215,942

	DEFINITIONS:	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16
1	TITLE XIX	744,176	741,195	739,809	741,320	741,240	740,227	739,262	737,369	735,298	734,757	736,857	737,189
2	ABD (Excluding HCBS and LTC SPC 61)	278,966	278,024	279,820	278,974	278,024	278,259	278,098	277,601	277,837	277,679	277,578	277,969
3	Childless Adults												
4	Adults W/O Dependent Children	345,857	342,309	345,701	353,211	354,296	355,355	357,219	357,319	359,104	358,260	359,657	357,358
5	SED	3,201	3,431	3,581	3,756	3,875	3,959	4,033	4,148	4,084	3,854	3,608	3,449
6	HCBS (State Plan)	4,158	4,528	4,751	5,067	5,310	5,531	5,797	6,263	6,590	6,848	7,074	7,242
7	HCBS (217 Like)	10,734	10,837	11,028	11,081	11,205	11,255	11,380	11,474	11,702	11,818	11,872	11,923
8	LTC												
9	SED (217 Like)	8	9	7	9	4	7	12	9	5	1	50	82
10	IDD/MI (217 Like)	271	275	285	262	269	274	230	222	224	207	194	177
11	XIX CHIP Parents *(10/01/2013 - 12/31/2013 Only)*												
12	New Adult Group *(01/01/2014 Onwards)*	213,041	209,178	207,478	207,706	208,078	208,765	208,497	207,899	207,087	205,668	205,206	203,996

	DEFINITIONS:	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
1	TITLE XIX	735,578	735,602	736,218	736,000	734,762	734,668	731,784	731,730	730,486	727,701	726,588	721,949	719,681	712,451	697,453
2	ABD (Excluding HCBS and LTC SPC 61)	277,957	276,991	275,863	274,978	274,182	273,432	272,260	271,247	269,898	268,498	267,176	265,203	263,092	260,506	257,440
3	Childless Adults															
4	Adults W/O Dependent Children	355,904	363,152	368,942	375,050	374,396	374,932	374,324	374,020	370,452	364,270	361,215	358,214	355,912	359,648	350,685
5	SED	3,469	3,609	3,694	3,905	4,001	4,238	4,357	4,497	4,368	3,993	3,620	3,424	3,423	3,488	3,356
6	HCBS (State Plan)	7,426	7,673	8,114	8,310	8,417	8,600	9,082	9,536	9,965	10,322	10,494	10,678	10,958	11,102	11,228
7	HCBS (217 Like)	12,054	12,190	12,322	12,477	12,418	12,463	12,537	12,577	12,633	12,774	12,774	12,845	12,840	12,858	12,850
8	LTC															
9	SED (217 Like)	116	132	153	178	196	211	225	245	258	270	278	281	277	258	249
10	IDD/MI (217 Like)	157	137	290	416	435	431	445	451	453	453	459	460	484	444	411
11	XIX CHIP Parents *(10/01/2013 - 12/31/2013 Only)*															
12	New Adult Group *(01/01/2014 Onwards)*	203,087	203,539	204,304	204,972	204,460	204,550	203,949	203,582	202,899	201,743	200,428	199,136	197,878	196,523	192,834

RUN DATE: 1/23/18

MMX Member Mo	Count(dist) Recip Idn
12/1/2012	29,284.
1/1/2013	29,181.
2/1/2013	28,846.
3/1/2013	28,870.
4/1/2013	28,803.
5/1/2013	28,701.
6/1/2013	28,754.
7/1/2013	28,869.
8/1/2013	29,047.
9/1/2013	29,081.
10/1/2013	29,126.
11/1/2013	29,167.
12/1/2013	29,217.
1/1/2014	29,089.
2/1/2014	28,868.
3/1/2014	28,900.
4/1/2014	28,830.
5/1/2014	28,813.
6/1/2014	28,782.
7/1/2014	29,252.
8/1/2014	29,150.
9/1/2014	29,007.
10/1/2014	28,814.
11/1/2014	28,549.
12/1/2014	28,376.
1/1/2015	28,366.
2/1/2015	28,077.
3/1/2015	27,873.
4/1/2015	27,801.
5/1/2015	27,749.
6/1/2015	27,942.
7/1/2015	27,984.
8/1/2015	28,167.
9/1/2015	28,227.
10/1/2015	28,334.
11/1/2015	28,514.
12/1/2015	28,550.
1/1/2016	28,525.
2/1/2016	28,456.
3/1/2016	28,532.
4/1/2016	28,479.
5/1/2016	28,651.
6/1/2016	28,701.
7/1/2016	28,738.
8/1/2016	28,877.
9/1/2016	28,824.
10/1/2016	28,966.
11/1/2016	28,797.
12/1/2016	28,666.
1/1/2017	28,568.
2/1/2017	28,314.
3/1/2017	28,163.
4/1/2017	28,147.
5/1/2017	28,061.
6/1/2017	28,011.
7/1/2017	27,834.
8/1/2017	27,572.
9/1/2017	27,220.
10/1/2017	27,075.
11/1/2017	26,812.
12/1/2017	24,808.
1/1/2018	24,745.

	MMs
DY1	260,355.
DY2	348,275.
DY3	338,705.
DY4	342,584.
DY5	339,923.
DY6	130,660.

MMX Member Month Date	Count(dist) Recip Idn
12/1/2012	2,332.
1/1/2013	2,323.
2/1/2013	2,302.
3/1/2013	2,291.
4/1/2013	2,270.
5/1/2013	2,242.
6/1/2013	2,220.
7/1/2013	2,195.
8/1/2013	2,177.
9/1/2013	2,157.
10/1/2013	2,130.
11/1/2013	2,109.
12/1/2013	2,076.
1/1/2014	2,048.
2/1/2014	2,032.
3/1/2014	2,017.
4/1/2014	1,970.
5/1/2014	1,930.
6/1/2014	1,876.
7/1/2014	1,845.
8/1/2014	1,823.
9/1/2014	1,811.
10/1/2014	1,791.
11/1/2014	1,769.
12/1/2014	1,744.
1/1/2015	1,724.
2/1/2015	1,712.
3/1/2015	1,695.
4/1/2015	1,679.
5/1/2015	1,666.
6/1/2015	1,651.
7/1/2015	1,639.
8/1/2015	1,632.
9/1/2015	1,612.
10/1/2015	1,585.
11/1/2015	1,587.
12/1/2015	1,578.
1/1/2016	1,571.
2/1/2016	1,557.
3/1/2016	1,548.
4/1/2016	1,541.
5/1/2016	1,525.
6/1/2016	1,515.
7/1/2016	1,507.
8/1/2016	1,505.
9/1/2016	1,501.
10/1/2016	1,495.
11/1/2016	1,485.
12/1/2016	1,482.
1/1/2017	1,469.
2/1/2017	1,465.
3/1/2017	1,460.
4/1/2017	1,456.
5/1/2017	1,446.
6/1/2017	1,438.
7/1/2017	1,435.
8/1/2017	1,427.
9/1/2017	1,424.
10/1/2017	1,419.
11/1/2017	1,405.

	MMs
DY1	20,352.
DY2	24,013.
DY3	20,513.
DY4	18,631.
DY5	17,559.

Deliverables due during MLTSS 1st quarter (10/1/2017 - 12/31/2017)

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

This quarterly report reflects the performance measures (PM) that were reported by the MCOs and the Division of Aging Services (DoAS) to the Office of MLTSS/QM during the first quarter of MLTSS (10/1/17 – 12/31/17). Each performance measure identifies its measurement period; however, depending on the source for the numerator/denominator the due date for reporting on a particular measure may have a lag time to allow for collection of the information. Several measures rely on claims data; therefore, a lag of 180 days must be built into the due date to allow for the MCO to receive the claims and process the data. This report reflects the performance measures data the Office of MLTSS/QM should have received during the fourth year, first quarter (10/1/17 – 12/31/17) of MLTSS program.

The data for the PMs that DoAS is responsible for reporting is obtained from within their TeleSys database, SAMS database, and/or the Shared Data Warehouse. The PM # 02 was eliminated effective with the July 2017 contract. It was a gross utilization measure and did not measure program effectiveness. As previously reported, the State discontinued reporting on PM #02 and PM #06 beginning July 1, 2017. The reporting period for PM #03 and PM #05 have been revised effective 7/1/17. A lag time of three months was added to PM #03 and PM #05's frequency was changed to quarterly. Lastly, some revisions were made to how the denominator for PM #04a is defined. The OCCO is responsible for conducting the nursing facility level of care determinations for individuals seeking admission to nursing facilities regardless of funding source. The change to the denominator will assist in better focusing the data on the MLTSS population.

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

Deliverables due during MLTSS 1st quarter (10/1/2017 - 12/31/2017)

PM # 03	Nursing Facility level of care authorized by Office of Community Choice Options (OCCO) for MCO referred members
Numerator:	# of MLTSS level of care assessment outcomes in the denominator that were "authorized" or "approved" by OCCO
Denominator:	Total number of MLTSS level of care assessments that were "authorized", "approved" or "denied" by OCCO during the measurement month
Data Source:	DoAS
Measurement Period:	Monthly – Due the 15th of the following month

Measurement period	07/2017	08/2017
Numerator	1145	1160
Denominator	1164	1195
%	98.4	97.1

Beginning 7/1/2017, PM #03 was revised and a lag time of three months added to allow for reassessment by OCCO. DoAS reported that rates were as expected.

PM # 04	Timeliness of nursing facility level of care assessment by MCO
Numerator:	The number of assessments in the denominator where the MCO assessment/ determination date is less than 30 days from the referral date to MLTSS
Denominator:	Number of level of care assessments conducted by MCO in the measurement month
Data Source:	MCO
Measurement Period:	Monthly – Due 15th of the 2nd month (lag report) following reporting period

August 2017	A	B	C	D	E	TOTAL
Numerator	21	115	442	61	135	774
Denominator	29	123	475	67	139	833
%	72.4	93.5	93.1	91.0	97.1	92.9

September 2017	A	B	C	D	E	TOTAL
Numerator	18	69	445	89	141	762
Denominator	29	76	453	91	143	792
%	62.0	90.7	98.2	97.8	98.6	96.2

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 1st quarter (10/1/2017 - 12/31/2017)

October 2017	A	B	C	D	E	TOTAL
Numerator	28	58	401	91	160	738
Denominator	43	64	429	100	160	796
%	65.1	90.6	93.4	91.0	100	92.7

The MCOs are monitoring the timeliness of level of care (LOC) assessments and have identified that some of the delays include: staffing issues among the Assessor team, members that were hospitalized soon after the referral, RN assessor staffing re-alignment due to new assessors in training, difficulty contacting the member, no documented date of internal referral in internal tracking database, Care Manager not scheduling the appointment within 30 days, unable to contact for initial appointment, member requested a later appointment or rescheduled the original appointment, not assigned to a Care Manager in timely manner, member rescheduled original appointment beyond the 30 day limit, delay with the initial outreach, member hospitalization, and members dis-enrolled. MCO B reports efforts to improve data entry as a vital component including, enrollment data and NJ Choice assessment data reviewed weekly, addition of data integrity flags intended to trigger immediate RN follow-up and assessor staffing improvements to turnaround times by providing necessary support with MLTSS enrollment, referrals and assessments. MCO E reports implementing a Risk of Institutionalization screening tool in an attempt to further identify members for referral to the MLTSS program. Additionally, MCO E reports adherence and completion of the tool is monitored to assess the impact on the referral process for members and they will continue to monitor vendor and internal assessor assignments to maintain compliance of 30 day completion. MCO A reported plans for ICM care managers to receive NJ Choice training and certification in efforts to assist in timely completion of these referrals. Additionally, MCO A reported they re-educated the entire team regarding the prioritization of NJ Choice referrals and supervisors are closely monitoring each assessor's task list for timely completion. The MCOs continue improvement procedures such as monitoring the referral and submission process for all completed assessments, ensuring NF residents have custodial authorizations in place, evaluating the performance of the Rapid Assessment model and ongoing monitoring of the plan's referral queues with increased oversight of the referral and assessment process.

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
Measurement Period:	Monthly – Due 15th of the 2nd month (lag report) following reporting period

Measurement Period	08/2017	09/2017	10/2017
Numerator	903	823	800
Denominator	1419	1214	1234
%	63.6	67.8	64.8

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

DoAS noted a 4% increase in August and September 2017, but continue to report challenges. Though the denominator for this measure was revised beginning 7/1/2017 to include only new MLTSS enrollees, OCCO staff continues to assess members referred to them, including those whose outcome is not MLTSS enrollment.

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 within the last 13 months
Denominator:	Total number of MLTSS members with no level of care assessment conducted in the last 16 months
Data Source:	DoAS
Measurement Period:	Beginning 7/1/2017, this is a quarterly report – due 3 months after the 16-month report is run

August 2017	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	0	2	3	6	8	19
Denominator	32	76	120	117	65	410
%	0	2.6	2.5	5.1	12.3	4.6

In March 2017, DoAS finalized a quarterly schedule for the 16 month report, requiring close out by the MCOs within 8 weeks. The processes for Voluntary Disenrollment and Involuntary Disenrollment were also finalized. DoAS provided training for the MCOs regarding streamlined assessment review; disenrollment; 16 month report process and timelines; and requirement for a Corrective Action Plan if all cases are not closed out or an extension requested within 30 days of receipt of report. As of 7/1/2017, the revised definition for PM #05 is: Timeliness of nursing facility level of care re-determinations. This is the first report using the new guidelines.
Analysis: The resolution for cases reported include-

	A	**B**	**C**	**D**	**E**	**TOTAL**
Clinical Assessments Completed	22	55	98	79	43	**297**
Terminations Completed	9	15	17	25	13	**79**
Terminations pending denial/fair hearings	1	4	2	7	1	**15**

The trend continues to be a decrease in the number of outstanding overdue assessments. The number of individuals without a level of care reassessment since MLTSS started on July 1, 2014 has been reduced from 2.5% to 0%. Overall final compliance rate for this reporting month is at 95.4% for follow up on outstanding assessments.

Action Steps: DoAS continues to educate MCO's on a bi-monthly basis through MCO Care Manager Meetings in regard to the contractual agreement of annual assessments. MCO compliance continues to improve. DoAS will continue to work with the MCO's to ensure a 100% compliance rate for the completion of outstanding clinical assessments.

Deliverables due during MLTSS 1st quarter (10/1/2017 - 12/31/2017)

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
Measurement Period:	Monthly – Due the 15th of the following month

Measurement Period	09/2017	10/2017	11/2017
Numerator	882	775	714
Denominator	1111	1023	929
%	79.4	75.8	76.9

DoAS reported a decrease in compliance overall during this reporting period. MCOs are sent individual compliance reports each month and are reminded to continually update assessors on coding requirements as they relate to choice of settings. DoAS reported that they noted a decrease in compliance of 1.6 points in September; a 3.6 point decrease in October; and a 1.1 point increase in November.

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

Measurement Period	09/2017	10/2017	11/2017
Numerator	285.0	342	333
Denominator	287.0	347	334
%	99.3	98.6	99.7

DoAS reports that a high percentage of Critical Incident reports were filed on a timely basis during this reporting period. Three MCOs fell below the 100% threshold during this reporting period. All three MCOs provided Corrective Action Plans to DoAS to address their delays.

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

Measurement Period	09/2017	10/2017	11/2017
Numerator	6.0	7.0	5.0
Denominator	6.0	7.0	5.0
%	100.0	100.0	100.0

DoAS reported that all Critical Incidents for Media Involvement and Unexpected Death were reported on time for this reporting period.

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

Table 3A Appeals and Grievances

7/1/17-9/30/17	A	B	C	D	E	TOTAL
Numerator	2	11	85	44	18	160
Denominator	2	11	87	44	18	162
%	100	100	97.7	100	100	98.8

Table 3B Complaints

7/1/17-9/30/17	A	B	C	D	E	TOTAL
Numerator	25	94	90	5	5	219
Denominator	27	94	91	5	5	222
%	92.6	100	98.9	100	100	98.6

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

MCO A had two cases in Table 3B that took more than 30 days to resolve. As per the MCO, one of the delays was due to user error and the other was decided in 45 days by policy. MCO C had two cases in Table 3A that took 31 days to resolve and one case in Table 3B that took 32 days to resolve. These delays were reported by the MCO to be the result of analyst oversight, for which education was provided.

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

1/1/17 – 3/31/17	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	N/A	4073	12457	5749	3209	
Denominator	N/A	4933	16326	7169	5198	
%	N/A	82.6	76.3	80.2	61.7	

The MCOs continue to claim under reporting for this measure. MCOs report that there are members receiving services but the MCO had not yet received a claim as some providers are not submitting, and or delaying the submission of claims for services. MCO B reported that because the denominator captures members eligible at any time during the measurement period, members in this population may be new to MLTSS and still in the plan of care development phase. Also, members have the opportunity to request a later home visit or may be difficult to contact, delaying their authorizations. Additionally, MCO B reports that they continue to monitor authorized services for the MLTSS population monthly and members without open authorizations are reviewed against the most current plan of care data. MCO C reported that 76% of MLTSS membership is receiving at least one MLTSS service, which is consistent with the previous quarters. Of the 3,869 members that did not have MLTSS claims, 1,775 had paid PCA/MDC claims and 175 were receiving Hospice services. In addition, of the 24% not receiving MLTSS services 2% were MLTSS SNP members. Additionally, MCO C reported that of the members with denied claims, the top denial reasons are: members not eligible for the benefit, lack of authorization, and the billed charges exceed the allowable, untimely submission of claim, and provider not contracted for service. MCO E reported that there were 61.74% of MLTSS members with at least one MLTSS service during the measurement period. Further review showed that 81.9% were age 65 or older, 221 were identified as FIDE-SNP MLTSS members but only 104 had at least one MLTSS service. Furthermore, there were 262 members without claims for any service during the measurement period. With 145 members still enrolled in the plan, 101 remain in an HCBS setting, and 44 are in a NF setting. Additionally, MCO E reported that members without services were identified as members awaiting their PPP application process/approval and have declined other services, members that have PDN services only and declined other services, unable to contact, moving out of service area, refusal of

services, and members receiving hospice services. MCOs report they continue to provide a member-centric focus during options counseling and continue to encourage the use of MLTSS services as part of the care planning process. MCO A reported that they discovered an issue with two new providers of PERS services. There was an issue with their claims submission resulting in a significant under reporting of MLTSS members receiving MLTSS services. As a result, MCO A requested and was granted an extension to submit this PM Report next quarter. This data will be included in next quarter's report.

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

7/1/17-9/30/17	A	B	C	D	E	TOTAL
Numerator	N/A	21	119	42	4	
Denominator	N/A	2477	5460	6956	1197	
%	N/A	0.9	2.2	0.6	0.3	

The MCOs continue to report that as they continue to work with approved programs such as Money Follows the Person to identify appropriate NF transitions to the community, there have been increases in the number of MLTSS members transitioning from the NF to the community. MCO C reported of the 119 members transitioned none were MLTSS FIDE/SNP members. Additionally, MCO C reported that 90 transitioned to a private residence, 23 transitioned into an ALR/ALP/CPCH, 5 members transitioned to a TBI Community Residential Setting, and 1 transitioned to an Adult Family Care. The age range of the members that transitioned ranged from 1 to 96; the average age was 61. The highest age range was 50-59 at 40 members. MCO D reported they will continue to evaluate members for possible NF to community transition as per the State approved MLTSS Care Management Program Description as well as the Nursing Transition Diversion Process and Nursing Facility Transition to Community Plan. MCO D reported they follow these approved programs and plans to identify members for transitioning and follow the MFP program. MCO E identified 4 members who transitioned from a NF setting: 3 of the members were referred to the NF transition team by OCCO and the other member had been in a NF following a hospital and subacute rehabilitation stay. Additionally, MCO E reported they had 10 additional transitions facilitated by the NF transition team; however, they did not meet the eligibility criteria due to lack of continuous enrollment. The MCOs continue to track and trend NF to community transitions and assist with identifying members that may be candidates for transition. MCO A is still working with the State's EQRO on their coding for this performance measure and has an extension to submit this report next quarter. This data will be included in the third quarter report.

Deliverables due during MLTSS 1st quarter (10/1/2017 - 12/31/2017)

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

4/1/17-6/30/17	A	B	C	D	E	TOTAL
Numerator	0	0	5	1	0	6
Denominator	3	17	74	34	5	133
%	0	0	6.8	2.9	0	4.5

7/1/16-6/30/17	A	B	C	D	E	TOTAL
Numerator	3	0	37	2	0	42
Denominator	13	54	381	50	26	524
%	23.0	0	9.7	4	0	8.0

The MCO's are continuing to track and trend members returning to the NF within 90 days. During the quarter MCO C reported 4 of the members returned due to a functional decline, and 1 returned due to lack of informal supports/needs not met in the community. There were no MLTSS SNP members that returned to the NF. Additionally, MCO C reported they will continue to monitor and track members that return to the Nursing Facility. During the quarter, MCO E reported that 1 of the 5 members identified in the denominator transferred from a NF to an ALF; all other members transitioned to a home or apartment setting. 4 out of the 5 members were age 65 or older. 2 of the 5 members identified in the denominator were referred through the MFP program. Within the annual measurement period MCO D reported continuing efforts to evaluate members for possible NF to community transition as per the State approved MLTSS Care Management Program Description as well as the Nursing Transition Diversion Process and Nursing Facility Transition to Community Plan. Additionally, MCO D reports they will continue to follow approved programs and plans to identify members for transitioning, work with the State MFP program to transition FFS members who are not yet part of managed care, and continue to work with providers identifying members for a possible less restrictive living arrangement.

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

1/1/17 – 3/31/17	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	6	17	139	49	13	224
Denominator	6	17	160	57	13	253
%	100	100	86.9	86.0	100	88.5

The MCO's are continuing to track and trend members returning to the NF for greater than 180 days. MCO A reports from the home setting 4 women and 2 men were placed into custodial care and prior to this placement the members had maximized their services in the home. They report that care managers receive refresher education on options counseling at MLTSS staff meetings, including the options for institutional versus HCBS setting placement. Furthermore, MCO A reported that care managers are required to document options counseling in the IPOC, and to indicate which option the member chooses. Additionally, MCO A reported their goal is to maintain members in the home setting for as long as possible, and then to assist them in transitioning to an institutional setting if that is their ultimate decision. MCO B reported the average length of time in the community setting amongst the 17 members is 265 days with a range from 215 to 302. Additionally, MCO B is completing detailed monthly review on members that transition from HCBS to NF to understand root cause and identify processes to prevent institutionalization, if possible. MCO C reported 139 members remaining in the NF after 180 day post transition. MCO C reported the top referral source for the NF admit was the family members and the second highest was the Facility referrals. Additionally, MCO C reports they review transitions from HCBS to NF identifying possible interventions to return members to the community. MCO E reported of their 13 transitions, 11 of the 13 members were age 65 or older and 5 of the 11 members were 90 years of age or greater. Additionally, MCO E reported there were no DSNP MLTSS members identified. MCOs will continue to monitor.

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

1/1/17 – 3/31/17	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	0	0	21	8	0	29
Denominator	6	17	161	57	13	254
%	0	0	13.0	14.0	0	11.4

MCOs report they are continuing to monitor and work with community and family supports to prevent hospitalizations and institutionalization. MCO E reported there were 13 HCBS members who transitioned to a nursing facility setting with no members who remained in the setting for less than 180 days. MCO E also reported 11 of the 13 members were 65 years of age or older and 5 of those members were age 90 or greater. Additionally, MCO E reported that they did not identify any FIDE/SNP members and 9 members remain active with the plan and continue to live in a NF setting. MCO C transitioned 161 members from the community to the NF where 3 were MLTSS FIDE/SNP members and of those that returned to the community they identified that the top initial referral source for the transition was member's family member or representative. MCO A reported 6 members entered the custodial setting and none remained in the NF for less than 180 days. Additionally, MCO A reported all 6 members came from a home setting with maximized services, but in order to achieve member safety and satisfaction, the members needed long term institutionalization. Furthermore, MCO A reports they perform options counseling with every visit and custodial setting members are counseled on the options to return to the HCBS setting.

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

Deliverables due during MLTSS 1st quarter (10/1/2017 - 12/31/2017)

1/1/17 – 3/31/17	A	B	C	D	E	TOTAL
Numerator	75	540	1480	352	572	3019
Denominator	1426	9701	28666	11197	11376	62366
%	5.3	5.6	5.2	3.1	5.0	4.8

Data for this measure is captured on a monthly basis and the numerators are added together and the denominators are added together to report quarterly data reflecting the number of hospitalizations that occurred per member month. It is based on hospital events and not unduplicated members. The top diagnosis for hospital admission include: cardiovascular disease, CHF, CVA, arrhythmias, COPD, pneumonia, sepsis, acute kidney failure, non-ST elevation myocardial infarction, acute and chronic respiratory failure with hypoxia, acute respiratory failure unspecified with hypoxia or hypercapnia, urinary tract infection, hypertensive heart with heart failure, stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease, and cellulitis. MCO D reports there were 3 members with greater than 2 admissions during the quarter. Additionally, 1 of the 3 members was admitted 3 times during the quarter for renal disease diagnoses and the other 2 were admitted 3 times for heart disease diagnoses. MCO E reported that admission rate for this quarter is slightly higher than the previous reporting period and there were 86 members who had more than 1 inpatient event. Additionally, MCO E is tracking and trending the number of events per facility and reports St Joseph's Regional Medical Center at the highest admission rate, followed by Englewood Hospital. Furthermore, MCO E reported their top inpatient admissions are for cardiovascular disease with CHF being the most commonly reported diagnosis.

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

1/1/17 – 3/31/17	A	B	C	D	E	TOTAL
Numerator	86	423	667	79	194	1449
Denominator	2031	7309	15907	8717	3371	37335
%	4.2	5.8	4.2	0.9	5.8	3.8

Data for this measure is captured on a monthly basis and the numerators are added together and the denominators are added together to report quarterly data reflecting the number of hospitalizations that occurred per member month. It is based on hospital events and not unduplicated members. MCO A reported they had 74 unique members where 11 of them had more than 1 inpatient hospitalization and the top admitting diagnosis for the 86 admissions was sepsis. Additionally, MCO A reported that they continue to track and trend for any potential patterns of

acute care utilization for members and/or facility. MCO B reports their top diagnoses include essential hypertension, sepsis and muscle weakness. They report reviewing top diagnosis codes to review implementation of new processes to prevent hospitalization. Additionally, MCO B has developed an MLTSS CI3 report to categorize members by disease cohorts for increase follow-up to avoid hospitalization and/or re-hospitalization. MCO C discovered their top three diagnoses are sepsis, urinary tract infection and acute kidney failure. Additionally, MCO C reports conducting weekly inpatient conference calls to review readmission reasons; actions that can be taken to prevent readmission are also discussed. MCO E reported conducting in depth review of member records with multiple admissions to help identify interventions that will prevent future recurrence and is forming an inpatient and emergency department utilization taskforce to meet monthly aimed at preventing avoidable inpatient admissions, readmissions, and ED use.

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

1/1/17 – 3/31/17	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	15	65	140	14	90	324
Denominator	63	475	1370	355	480	2743
%	23.8	13.7	10.0	4.0	18.8	11.8

Data for this measure is captured on a monthly basis and the numerators are added together and the denominators are added together to report quarterly data reflecting the number of hospitalizations that occurred per member month. It is based on hospital events and not unduplicated members. Some of the reported diagnoses include: COPD, sepsis, chemotherapy, urinary tract infection, acute respiratory failure, chronic respiratory failure, hypoxia, anemia, hyperlipidemia, hypertensive emergency, hypertensive chronic kidney disease, non-ST elevation myocardial infarct, chronic degenerative conditions, pneumonia, diabetes, congestive heart failure, pulmonary embolism, asthma, pleural effusion, renal failure, and blood disorders. MCO C reports acute inpatient admissions are tracked and monitored with weekly inpatient conference calls conducted by a team comprised of readmission nurses, medical director, supervisors, and MLTSS Care managers. MCO E reports identified members with multiple readmissions are being closely monitored to ensure best practices are being followed. Additionally, MCO E reported that closer monitoring of medication reconciliation, 7 day follow up appointment with PCP, and CM face to face visit within 48 hours of transition home, are approaches toward reducing the overall readmission rate.

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

1/1/17 – 3/31/17	A	B	C	D	E	TOTAL
Numerator	11	48	68	3	33	163
Denominator	66	349	606	82	115	1218
%	16.6	13.7	11.0	4.0	28.7	13.3

Data for this measure is captured on a monthly basis and the numerators are added together and the denominators are added together to report quarterly data reflecting the number of hospitalizations that occurred per member month. It is based on hospital events and not unduplicated members. MCO A reported that there were 10 members that accounted for the 11 readmissions and 1 of the members had 2 readmissions with the diagnosis of acute respiratory failure. MCO C reported that they discovered the top 3 diagnoses for acute inpatient utilization for MLTSS NF members to be sepsis-unspecified organism, urinary tract infection, and acute kidney failure. MCO E reports there were 93 unique members that accounted for the 115 acute inpatient events and 26 unique members were identified as having an acute readmission for any diagnosis within 30 days of an index discharge date. Of the 26 unique members identified, 19 were aged 65 or older and there were 6 unique members identified with more than 1 event during the quarter, 1 member with 3 events and 5 members with 2 reported readmissions. MCO E further reviewed and identified the diagnoses including sepsis, reported in 15 events, complications with catheters in 4 events, pneumonia reported in 3 events, and 2 events each for cardiovascular disease, UTI, seizures/epilepsy, COPD, and gastrointestinal disorders. Additionally, MCO E also reviewed for trends by admitting facility and reported there were 2 facilities identified as requiring further analysis. One facility was identified with readmissions for 5 unique members, of which 3 had more than 1 event reported and all 3 members were admitted with a sepsis diagnosis. The other 2 members identified as residing in this facility were readmitted with diagnoses of UTI and sepsis. The second facility was identified with 4 unique members; 1 member reported as having more than 1 event during the quarter also reported with a diagnosis of sepsis; the other 3 members were admitted with diagnoses of GI hemorrhage, epilepsy and gastrostomy infection.

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

1/1/17 – 3/31/17	A	B	C	D	E	TOTAL
Numerator	144	110	2556	539	940	4289
Denominator	1423	9701	28666	11197	11376	62363
%	10.1	1.1	8.9	4.8	8.3	6.8

Data for this measure is captured on a monthly basis and the numerators are added together and the denominators are added together to report quarterly data reflecting the number of ER utilizations that occurred per member month. It is based on ER utilization events and not unduplicated members. MCO A reported reasons for visits to the ED were for urinary tract infection, acute kidney failure, altered mental status, dehydration, sepsis and injury of the head. MCO A reports that 25 unique members had 2 or more ED visits and there was 1 member that had 6 ED visits and that 3 of those visits were for abdominal pain. Additionally, MCO A reported the quality management staff shared outcome reports to facilitate and identify any member specific needs or obstacles to care. MCO E reported that 562 unique members were identified for the 940 events and of the 11376 member months, 575 were FIDE-SNP members. MCO E reported there was 1 member with 36 events due to alcohol dependency and plans to conduct a follow up IDT. Additionally, MCO E reported that the member with 36 ED visits is currently being seen by a BH care manager with a substance abuse background.

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

Deliverables due during MLTSS 1st quarter (10/1/2017 - 12/31/2017)

1/1/17 – 3/31/17	A	B	C	D	E	TOTAL
Numerator	97	88	578	206	145	1114
Denominator	2015	7309	15907	8717	3371	37319
%	4.8	1.2	3.6	2.4	4.3	2.9

MCOs are monitoring their respective data to identify patterns, trends, and frequency. MCO A reports here were no specific diagnosis trends identified and the 3 most frequent ED visit reasons were for gastrostomy malfunction, sepsis and injury of head. Additionally, MCO A reported 72 unique members accounted for the 97 ED visits during this reporting period and 19 of the members had 2 or more ED visits during this time frame. They continue to track ED utilization and use it as a source of data mining.

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

1/1/17 – 3/31/17	A	B	C	D	E	TOTAL
Numerator	93	298	1884	463	502	3240
Denominator	623	2676	16008	4030	3945	27282
%	14.9	11.1	11.8	11.5	12.7	11.8

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

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

1/1/17 – 3/31/17	A	B	C	D	E	TOTAL
Numerator	18	104	166	41	519	848
Denominator	623	2676	16008	4030	3945	27282
%	2.9	3.9	1.0	1.0	13.2	3.1

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

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

1/1/17 – 3/31/17	A	B	C	D	E	TOTAL
Numerator	125	1253	1671	665	511	4225
Denominator	509	3590	10140	3875	3992	22106
%	24.6	34.9	16.5	17.2	12.8	19.1

MCOs report they used claims payment systems based on the claims submitted/received by the MCO. MCO C reported they identified that of the 1,671 MLTSS HCBS members with a behavioral health diagnosis, 143 had a substance abuse only diagnosis, 1399 had a mental illness only diagnosis and 129 had both mental illness and substance abuse diagnoses. Additionally, MCO C reported there were 37 MLTSS FIDE/SNP members with either a primary or secondary diagnosis of mental illness, substance abuse or both. MCO E reported they identified that of the 511 MLTSS HCBS members with a behavioral health diagnosis 23 had a substance abuse only diagnosis, 456 had a mental illness only diagnosis and 32 had both mental illness and substance abuse diagnoses. MCO E reported there were 312 members that were 65 years of age or older and 45 MLTSS FIDE/SNP members with either a primary or secondary diagnosis of mental illness, substance abuse or both. Additionally, MCO E reported the top 5 mental illness diagnoses identified were depression/depressive disorder, schizophrenia, bipolar disorders, adjustment disorders, and dysthymic disorder. The MCOs will continue to monitor the data for trends.

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

1/1/17 – 3/31/17	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	3	71	143	48	23	427
Denominator	509	3590	10140	3875	3992	22106
%	0.6	2.0	1.4	1.2	0.6	1.9

The MCOs will continue to monitor this data stratification for trends.

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

1/1/17 – 3/31/17	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	111	1049	1399	583	456	3598
Denominator	509	3590	10140	3875	3992	22106
%	21.8	29.2	13.8	15.1	11.4	16.2

The MCOs will continue to monitor this data stratification for trends.

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

1/1/17 – 3/31/17	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	11	133	129	34	32	339
Denominator	509	3590	10140	3875	3992	22106
%	2.2	3.7	1.3	0.9	0.8	1.5

The MCOs will continue to monitor this data stratification for trends.

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

1/1/17 – 3/31/17	A	B	C	D	E	TOTAL
Numerator	417	1346	1846	1230	409	5248
Denominator	792	2719	5868	3201	1206	13786
%	52.7	49.5	31.5	38.4	33.9	38.0

MCOs report they used claims payment system based on the claims submitted/received by the MCO. MCO A reported they identified that of the 417 MLTSS Nursing Facility members with a behavioral health diagnosis 7 had a substance abuse only diagnosis, 398 had a mental illness only diagnosis and 12 had both mental illness and substance abuse diagnoses. Additionally, MCO A reported of the 417 members with a behavioral health diagnosis, 232 members had a top diagnosis of major depression and 52 members had a diagnosis of adjustment disorder as the second most frequent diagnosis identified. MCO D reported they identified that of the 1230 MLTSS Nursing Facility members with a behavioral health diagnosis 33 had a substance abuse only diagnosis, 1160 had a mental illness only diagnosis and 37 had both mental illness and substance abuse diagnoses. Additionally, MCO D reported of the 1230 MLTSS Nursing Facility members with a behavioral health diagnosis, the top 3 diagnosis identified were major depressive disorder, single episode, unspecified; major depressive disorder, recurrent, unspecified; unspecified psychosis not due to a substance or known physiological condition. MCOs will continue to monitor.

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

1/1/17 – 3/31/17	A	B	C	D	E	TOTAL
Numerator	7	26	61	33	5	132
Denominator	792	2719	5868	3201	1206	13786
%	0.9	1.0	1.0	1.0	0.4	0.9

The MCOs will continue to monitor this data stratification for trends.

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

1/1/17 – 3/31/17	A	B	C	D	E	TOTAL
Numerator	398	1249	1682	1160	388	4877
Denominator	792	2719	5868	3201	1206	13786
%	50.3	45.9	28.7	36.2	32.2	35.3

The MCOs will continue to monitor this data stratification for trends.

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

1/1/17 – 3/31/17	A	B	C	D	E	TOTAL
Numerator	12	71	103	37	16	239
Denominator	792	2719	5868	3201	1206	13786
%	1.5	2.6	1.8	1.2	1.3	1.7

The MCOs will continue to monitor this data stratification for trends.

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

1/1/17 – 3/31/17	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	20	149	445	583	566	1763
Denominator	623	2676	16008	4030	3945	27282
%	3.2	5.6	2.8	14.5	14.4	6.4

MCO C identified that the amount of PCA services claimed ranged from 3 hours/week to 28 hours/week and the members' ages ranged from 26 years old to 103 years old. Additionally, MCO C reported review processes in place that verify discrepancies between claimed amounts of services and authorized amounts, identifying members that require 2 or more services to remain in a home based setting. All MCOs report they will continue to monitor these members to verify that their needs are being met and continue to monitor this data for trends, etc.

Deliverables due during MLTSS 2nd quarter (10/1/2017 - 12/31/2017)

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

MCO		MCO A		MCO B		MCO C		MCO D		MCO E		TOTAL	
18	**Critical Incident (CI) reporting types:**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
a	Unexpected death of a member	1	5.6	1	0.9	2	0.3	0	0	2	4.1	**6**	**0.7**
b	Media involvement or the potential for media involvement	0	0	1	0.9	6	1	1	1.5	0	0	**8**	**0.9**
c	Physical abuse (incl. seclusion and restraints both physical and chemical)	1	5.6	1	0.9	5	0.8	1	1.5	2	4.1	**10**	**1.2**
d	Psychological / Verbal abuse	0	0	1	0.9	0	0	0	0	0	0	**1**	**0.1**
e	Sexual abuse and/or suspected sexual abuse	0	0	4	3.6	3	0.5	0	0	0	0	**7**	**0.8**
f	Fall resulting in the need for medical treatment	8	44.4	45	40.2	183	29.4	28	41.8	22	44.9	**286**	**32.9**
g	Medical emergency resulting in need for medical treatment	1	5.6	6	5.4	308	49.4	3	4.5	5	10.2	**323**	**37.2**
h	Medication error resulting in serious consequences	0	0	1	0.9	0	0	0	0	0	0	**1**	**0.1**
i	Psychiatric emergency resulting in need for medical treatment	1	5.6	9	8	26	4.2	0	0	1	2	**37**	**4.3**
j	Severe injury resulting in the need for medical treatment	0	0	3	2.7	14	2.2	2	3	2	4.1	**21**	**2.4**
k	Suicide attempt resulting in the need for medical attention	0	0	1	0.9	3	0.5	0	0	0	0	**4**	**0.5**
l	Neglect/Mistreatment, caregiver (paid or unpaid)	0	0	2	1.8	4	0.6	3	4.5	1	2	**10**	**1.2**
m	Neglect/Mistreatment, self	0	0	0	0	4	0.6	0	0	0	0	**4**	**0.5**
n	Neglect/Mistreatment, other	0	0	2	1.8	1	0.2	0	0	0	0	**3**	**0.3**
o	Exploitation, financial	0	0	0	0	4	0.6	1	1.5	0	0	**5**	**0.6**
p	Exploitation, theft	0	0	0	0	0	0	1	1.5	0	0	**1**	**0.1**
q	Exploitation, destruction of property	0	0	0	0	0	0	0	0	0	0	**0**	**0**
r	Exploitation, other	0	0	0	0	0	0	0	0	0	0	**0**	**0**
s	Theft with law enforcement involvement	2	11.1	1	0.9	0	0	0	0	1	2	**4**	**0.5**
t	Failure of member's Back-up Plan	2	11.1	2	1.8	1	0.2	0	0	0	0	**5**	**0.6**
u	Elopement/Wandering from home or facility	0	0	0	0	3	0.5	1	1.5	0	0	**4**	**0.5**
v	Inaccessible for initial/on-site meeting	0	0	10	8.9	3	0.5	13	19.4	7	14.3	**33**	**3.8**

N = Numerator D = Denominator % = Percentage

Deliverables due during MLTSS 2nd quarter (10/1/2017 - 12/31/2017)

MCO		MCO A		MCO B		MCO C		MCO D		MCO E		TOTAL	
18	**Critical Incident (CI) reporting types:**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
w	Unable to Contact	0	0	8	7.1	21	3.4	4	6	3	6.1	**36**	**4.1**
x	Inappropriate or unprofessional conduct by a provider involving member	0	0	0	0	20	3.2	2	3	0	0	**22**	**2.5**
y	Cancellation of utilities	0	0	2	1.8	1	0.2	0	0	0	0	**3**	**0.3**
z	Eviction/loss of home	2	11.1	3	2.7	4	0.6	0	0	0	0	**9**	**1**
aa	Facility closure, with direct impact to member's health and welfare	0	0	0	0	0	0	0	0	0	0	**0**	**0**
ab	Natural disaster, with direct impact to member's health and welfare	0	0	0	0	0	0	0	0	0	0	**0**	**0**
ac	Operational Breakdown	0	0	0	0	3	0.5	0	0	0	0	**3**	**0.3**
ad	Other	0	0	9	8	4	0.6	7	10.4	3	6.1	**23**	**2.6**
TOTAL # OF CRITICAL INCIDENTS REPORTED FOR 7/1/2017 - 9/30/2017		18	**A**	112	**B**	623	**C**	67	**D**	49	**E**	**869**	**TOTAL**

There were a total of 869 Critical Incidents reported by the five MCOs during the July 1, 2017 to September 30, 2017 measurement period. These are reported events not unduplicated members. The top two categories account for 70% of the overall CIs. The five most common CIs were:

1. Medical emergency resulting in the need for medical treatment (323 reported CIs - 37.2% overall)
2. Fall resulting in the need for medical treatment at (286 reported CIs - 32.9% overall)
3. Psychiatric emergency resulting in need for medical treatment (37 reported CIs – 4.3% overall)
4. Unable to Contact (36 reported CIs – 4.1% overall)
5. Inaccessible for initial/on-site meeting (33 reported CIs - 3.8% overall)

One MCO detailed the steps they initiated to improve the timeliness of their CI reporting, including quarterly refresher training for their MLTSS staff as well as training network providers regarding CI reporting requirements. This MCO also reported that they started distributing refrigerator magnets to their members in October 2017. The magnets provide the CM's direct phone number and remind members to call their CM in the case of a fall or hospital visit.

Another MCO, after studying the trends over time, determined that the majority of falls resulting in the need for medical treatment for their members are members 65 and over who fall in their own home. Of the 183 reported CIs for the falls category, this MCO reported that 115

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

were in a private home; 13 in the community; and 55 in a facility. By age group, 44 of the 183 CIs were for members 64 and under and 139 for members 65 and older.

A third MCO had two CIs for one member. The first was for a member who reported that her son hit her and that a neighbor called the police. The CM contacted Adult Protective Services (APS) to complete an intake referral. Less than two months later, the member reported that her son emptied her bank account, but she refused to press charges. The MCO reported that the CM again contacted APS and that the member was offered options, such as Assisted Living, when the CM was reviewing the risk agreement.

In cooperation with the EQRO and the MCOs, the Office of MLTSS Quality Monitoring and DoAS have revised PM #18. Effective 1/1/2018, the MCOs will be reporting not only the number of CIs per category, but how many CIs have a known date of occurrence, and the average time it takes for the MCO to be notified of a CI. The MCOs have been given a 30-day extension for the revised PM #18, measurement period 1/1/18 – 3/31/18, to allow the EQRO time to review and validate the data from the MCOs. The first revised report is due to DMAHS on 5/30/18.

1115 Comprehensive Waiver Quarterly Report
Demonstration Year: 6
Federal Fiscal Quarter: 1 (10/1/17-12/31/17)
Department of Children and Families (DCF), Children's System of Care (CSOC)

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

- **Children's Support Services Program Intellectual/Developmental Disabilities (CSSP I/DD) and Autism Spectrum Disorder (ASD) Pilot**

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

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

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

- **I/DD and ASD**
- **Measurement period 10/1/2017 - 12/31/2017**

#2 Quality of Life Sub Assurance	All youth that meet the clinical criteria for services through the Department of Children and Families (DCF), Division of Children' s System of Care (CSOC) will be assessed utilizing the comprehensive Child and Adolescent Needs and Strengths (CANS) assessment tool.	
Data Source	Review of Child and Adolescent Needs and Strengths scores Contracted System Administrator (CSA) Data. Data report: CSA NJ1225 Strengths & Needs Assessment – Post SPC Start	
Sampling Methodology	100% New youth enrolled in the waiver	
Waiver	**I/DD**	**ASD**
Numerator: Number of youth receiving Child and Adolescent Needs and	172	12

Strengths (CANS) assessment		
Denominator : Total number of new enrollees	172	12
Percentage	100%	100%

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

- **I/DD and ASD**
- **Measurement period 10/1/2017 - 12/31/2017**

#3 Quality of Life Sub Assurance	80% of youth should show improvement in Child and Adolescent Needs and Strengths composite rating within a year	
Data Source	CSA Data on CANS Initial and Subsequent Assessments. Data report: CSA NJ2021CANS Waiver Outcome	
Sampling Methodology	Number of youth enrolled in the waiver for at least 1 year.	
Waiver	**I/DD**	**ASD**
Numerator: Number of youth who improved within one year of admission	853	182
Denominator: Number of youth with Child and Adolescent Needs and Strengths assessments conducted 1 year from admission or last CANS conducted	936	191
Percentage	91%	95%

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

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

- **I/DD and ASD**
- **Measurement period 10/1/2017 - 12/31/2017**

#4 Level of Care Sub Assurance	CSOC's Contracted System's Administrator (CSA), conducts an initial Level of Care assessments (aka Intensity of Services (IOS) prior to enrollment for all youth.
Data Source	CSA Data. Data report: CSA NJ1218 New Enrollees, Quarterly Count and IOS Completed
Sampling Methodology	100% new youth enrolled in the waiver

Waiver	I/DD	ASD
Numerator: Number of youth receiving initial level of care determination prior to enrollment	172	12
Denominator: Number of new enrollees	172	12
Percentage	100%	100%

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

- **I/DD and ASD**
- **Measurement period 10/1/2017 - 12/31/2017**

#5 Plan of Care Sub Assurance	The Plan of Care (aka Individual Service Plan (ISP)) is developed based on the needs identified in the Child and Adolescent Needs and Strengths assessment tool and according to CSOC policies	
Data Source	CSA Data on Plans of Care completions, Record Review. Data report: CSA NJ1219 Follow – Up Treatment Plan and Associated SNA	
Sampling Methodology	100% of youth enrolled during the measurement period.	
Waiver	**I/DD**	**ASD**
Numerator: Number of Plans of Care that address youth's assessed needs	171	12
Denominator: Number of Plans of Care reviewed	172	12
Percentage	99%	100%

This youth should have had a plan of care (ISP) since they were participating with the CMO. CSOC will continue to monitor this item.

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

- **I/DD and ASD**
- **Measurement period 10/1/2017 - 12/31/2017**

#6 Plan of Care Sub Assurance	Plan of Care (ISP) is updated at least annually or as the needs of the youth changes	
Data Source	CSA Data Report : CSA NJ1289 Waiver ISP Aggregate Report All Youth	
Sampling Methodology	100% of youth enrolled during the measurement period.	
Waiver	**I/DD**	**ASD**
Numerator: Number of current Plans of Care updated at least annually	316	59
Denominator: Number of Plans of Care reviewed	316	59
Percentage	100%	100%

All youth enrolled during the reporting period had a documented annual review.

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

- **I/DD and ASD**
- **Measurement period 10/1/2017 - 12/31/2017**

#7 Plan of Care Sub Assurance	Services are authorized in accordance with the approved plan of care (ISP). Data Report: CSA NJ1220 Waiver Services Provided	
Data Source	CSA Data Report of Authorizations Record Review	
Sampling Methodology	100% of youth enrolled during the measurement period.	
Waiver	**I/DD**	**ASD**
Numerator: Number of plans of care that had services authorized based on the plan of care	171	12
Denominator: Number of plans of care reviewed	172	12
Percentage	99%	100%

The majority of the youth had evidence of an ISP and services within the plan. There was one youth participating with the CMO who was missing a plan of care (ISP). CSOC will continue to monitor this item.

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

- **I/DD and ASD**
- **Measurement period 10/1/2017 - 12/31/2017**

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

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

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

- **I/DD and ASD**
- **Measurement period 10/1/2017 - 12/31/2017**

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

choice of providers as indicated in progress notes		
Denominator: Number of records reviewed	N/A*	N/A*
Percentage	N/A*	N/A*

*CSOC does not have data available for this, our Electronic Health Record recently incorporated a way to document family choice and CSOC is working on a method on how to report this data.

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

- **I/DD and ASD**
- **Measurement period 10/1/2017 - 12/31/2017**

#10 Qualified Providers Sub Assurance	Children's System of Care verifies that providers of waiver services initially meet required qualified status, including any applicable licensure and/or certification standards prior to their furnishing waiver services.	
Data Source	Record review.	
Sampling Methodology	100% Agency	
Waiver	**I/DD**	**ASD**
Numerator: Number of new providers that met the qualifying standards prior to furnishing waiver services	0	7
Denominator: Total number of new providers	0	7
Percentage	NA	100%

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

- **I/DD and ASD**
- **Measurement period 10/1/2017 - 12/31/2017**

# 11 Qualified Providers Sub Assurance	Children's System of Care verifies that providers of waiver services continually meet required qualified status, including any applicable licensure and/or certification standards.	
Data Source	Provider HR Record Review	
Sampling Methodology	100% Agency	
Waiver	**I/DD**	**ASD**

Numerator: Number of providers that meet the qualifying standards – applicable Licensures/certification	In Development	In Development
Denominator: Total number of providers that initially met the qualified status	In Development	In Development
Percentage	In Development	In Development

All providers are qualified at the Request for Qualifications or Providers (RFP/Q) stage so any certifications/qualifications of providers added during the reporting period were confirmed. The reporting of this for established providers is in development.

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

- **I/DD and ASD**
- **Measurement period 10/1/2017 - 12/31/2017**

# 12 Qualified Providers Sub Assurance	CSOC implements its policies and procedures for verifying that applicable certifications/checklists and training are provided in accordance with qualification requirements as listed in the waiver.	
Data Source	Record Review	
Sampling Methodology	100% Community Provider Agencies	
Waiver	**I/DD**	**ASD**
Numerator: Number of providers that have been trained and are qualified to provide waiver services	0	7
Denominator: Total number of providers that provide waiver services	0	7
Percentage	NA	100%

All providers are qualified at the RFQ/P stage so any certifications and trainings of providers added during the reporting period were verified.

# 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**	**ASD**
Numerator: Total number of UIRs submitted timely according to State policies	2	0
Denominator: Number of UIRs submitted involving enrolled youth	3	0
Percentage	67%	NA

There was an incident not completed timely, the UIR was documented but not within the timeframe established by State policy. The provider will be reminded of the timeframes policy for reporting of unusual incidents.

# 14 Health and Welfare Sub Assurance	The State incorporates an unusual incident management reporting system (UIRMS), as articulated in administrative order 205, which reviews incidents and develops policies to prevent further similar incidents (i.e., abuse, neglect and runaways).	
Data Source	Review of UIRMS database and Administrative policies & procedures	
Sampling Methodology	100% of youth enrolled for the reporting period	
Waiver	**I/DD**	**ASD**
Numerator: The number of incidents that were reported through UIRMS and had required follow up	0	0
Denominator: Total number of incidents reported that required follow up	2	0
Percentage	0%	NA

There were two incidents that required a follow-up and one was not completed. CSOC will work with the providers documenting the UIR and reinforce with them State policy about the follow-up procedures.

# 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**	**ASD**
Numerator: Number of unusual incidents reported involving restrictive interventions that were remediated in accordance to policies and procedures	In Development	In Development
Denominator: Total number of unusual incidents reported involving restrictive interventions	In Development	In Development
Percentage	In Development	In Development

The reporting of this quality strategy is in development and CSOC plans to be able to address this with a future update in the Electronic Health Record.

# 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**	**ASD**
Numerator: Number of youth enrolled that received a well visit	In Development	In Development
Denominator: Total number of youth enrolled	In Development	In Development
Percentage	In Development	In Development

The reporting of this quality strategy is in development and will be addressed with a future update in the Electronic Health Record.

# 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**	**ASD**
Numerator: The number of claims there were paid according to code within youth's centered plan authorization	In Development	In Development
Denominator: Total number of claims submitted	In Development	In Development
Percentage	In Development	In Development

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