New Jersey Comprehensive Demonstration
Section 1115 Quarterly Report
***Demonstration Year: 9* (7/1/20-6/30/21)**
***State Fiscal Quarter:* Quarter 3 (1/01/21-3/31/21).**

I. Introduction

The New Jersey Comprehensive Demonstration (NJCD) was approved by the Centers for Medicare and Medicaid Services (CMS) on October 2, 2012, and is effective 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 needed services and HCBS supports for an expanded population of individuals with co-occurring developmental/mental health disabilities.
- Encourage structural improvements in the health care delivery system through DSRIP funding.

This quarterly report is submitted pursuant to Special Term and Condition (STC) 71 in the New Jersey Comprehensive Demonstration; and in the format outlined in Attachment A of the STCs.

II. Enrollment and Benefit Information

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

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

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

There are no anticipated changes in populations served or benefits.

III. Enrollment Counts for Quarter

Demonstration Populations by MEG	Total Number of Demonstration participants Quarter Ending 06/20	Total Number of Demonstration participants Quarter Ending 09/20	Total Number of Demonstration participants Quarter Ending 12/20	Total Number of Demonstration participants Quarter Ending 03/21
Title XIX	684,639	717,299	740,728	754,387
ABD	228,012	228,863	225,685	221,869
LTC				
HCBS - State plan	16,613	16,539	17,914	18,129
TBI – SP				
ACCAP – SP				
CRPD – SP				
GO – SP				
HCBS - 217-Like	16,787	17,133	17,789	17,705
TBI – 217-Like				
ACCAP – 217-Like				
CRPD – 217-Like				
GO – 217-Like				
SED - 217 Like	344	343	363	372
IDD/MI – (217 Like)	344	343	363	362
NJ Childless Adults				
AWDC	374,727	399,399	424,783	440,739
New Adult Group	195,100	203,689	211,286	215,883
SED at Risk	2,572	2,583	2,588	2,462
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 and informed of changes. The State has depended on its relationships with stakeholder groups to inform consumers. During this quarter, DHS gave an MLTSS update to the following long-term care industry provider: On January 21, 2021, the New Jersey Medical Assistance Advisory Council, a group comprised of medical care and health services professionals as well as advocacy groups who advise the State's Medicaid Director. The meeting topics included policy updates on Electronic Visit Verification, Managed Care Contract Changes, Autism Steering Committee, Community Doula Services, the State Based Health Insurance Exchange, and the 1115 Demonstration Renewal Listening Sessions. Additionally, an update was provided by the Department on the COVID-19 Vaccination Distribution. During the state of emergency, DHS continues outreach and technical assistance efforts with consumers and stakeholders. DHS has a webpage dedicated to COVID-19 waiver flexibilities and interim processes to communicate to providers and facilitate access to services for consumers. Additionally, DMAHS hosts weekly calls with the five contracted MCOs to provide updates specific to the public health emergency and identify challenges and policy needs. The Office of Managed Health Care (OMHC) has remained committed to its communications efforts to ensure access through its provider networks. Its provider-relations unit has continued to respond to inquiries through its email account on these issues among others: MCO contracting, credentialing, reimbursement, authorizations, appeals and complaint resolution.
ASD/I-DD/SED
CSOC will continue to promote services at community meetings and will review the need to expand the network of providers to assure timely access to services as appropriate.
Supports Program and Community Care Program
Division of Developmental Disabilities (DDD) is responsible for the daily operations of both the Supports Program (SP) and the Community Care Program (CCP). DDD addresses outreach and activities for both their programs concurrently as the same providers and advocacy organizations are affiliated with both programs. Additionally, the majority of the supports and services are identical in both programs. The primary difference between the two programs is the required level of care. Therefore, the below represents outreach and collaboration with our State partners, beneficiaries, families, and the provider and advocacy communities that is representative of both DDD programs. However, data metrics are broken down by program.

The Demonstration Unit established a "DDD Medicaid Eligibility Helpdesk" to assist families, providers, advocates, etc. with questions related to Medicaid and the operations of the SP and CCP as related to Medicaid and billing. During this quarter, there were 1,172 questions submitted and answered. Three domains compose approximately 68% of the emails received. These areas are Medicaid troubleshooting (35%), voucher payments (13%), and transitioning between demonstration programs (i.e.: From MLTSS to Supports Program + Private Duty Nursing, SP to CCP, CCP to MLTSS, etc.) (20%). The remainder of the questions focus on citizenship issues, demonstration admission questions, follow-up emails that resulted in an immediate resolution, and emails that need to be routed to a different helpdesk or Unit. The helpdesk is also involved in assisting DDD eligible children who are losing their EPSDT PDN services on their 21st birthday as well as individuals who want to change from one program to another. Examples include children losing their educational entitlement and needing SP+PDN services, specifically the PDN or individuals wanting to transfer from MLTSS to a DDD program. During this quarter, state staff worked remotely and congregate day facilities were closed for most of the quarter. This quarter represented the fourth decrease in the number of questions submitted to the helpdesk since its inception. Similar to the last quarter, there was a decrease of approximately 200 questions. Anecdotally, the decrease may be due to the approved federal Appendix K flexibilities, the COVID-19 operational guidance page, and the bi-weekly Communication Update webinars conducted by DDD's Assistant Commissioner.

Interim Management Entity (IME)

During this quarter, the Interim Managing Entity (IME) and Reach NJ, received 9,909 calls from individuals seeking information, referral or admission to SUD treatment. There were 1,158 referrals for treatment and beginning March 1, 2021 the IME will be tracking referrals for Medication Assisted Treatment (MAT) at Office Based Addictions Treatment (OBAT) provider offices. In March, the IME referred 14 individuals to OBAT/MAT providers. 927 individuals received Care Coordination (CC) services through the IME to facilitate treatment admission. CC services are offered to any individual waiting 2 days for admission to treatment. In addition, the IME received 1,872 provider assistance calls to support Medicaid SUD treatment providers. The IME Utilization Management (UM) staff perform clinical reviews based on ASAM patient placement criteria for admission to the appropriate level of care. The IME issued 6,451 prior authorizations for Medicaid beneficiaries to enter treatment, and 2,407 clinical reviews for Medicaid beneficiaries to extend treatment based on clinical need.

V. Collection and Verification of Encounter Data and Enrollment Data

Summary of Issues, Activities or Findings

No issues or findings.

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

MLTSS

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

I-DD/SED

There was a total of 806 youth enrolled in the Children's Support Services Program Intellectual/Developmental Disabilities (CSSP I/DD) during this reporting period. There was an additional 396 youth enrolled in the CSSP Serious Emotional Disturbance (SED) that received Plan A Medicaid benefits that would have not otherwise been eligible for these benefits if not for demonstration participation.

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

Supports Program and Community Care Program

At the close of this quarter the SP enrollment was approximately 11,700 and the CCP enrollment was approximately 11,850.

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

Other

Managed Care Contracting:

There are no updates for this quarter.

Self-attestations:

There were a total of 12 self-attestations for the time period of January 1, 2021 to March 31, 2021.

MCO Choice and Auto-assignment:

The number of individuals who changed their MCO after auto-assignment is 1,955.

MLR:

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

Aetna	90.3%	93.5%	
Wellcare	96.8%	95.4%	

VII. Action Plan for Addressing Any Issues Identified

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

VIII. Financial/Budget Neutrality Development/Issues

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

IX. Member Month Reporting

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

A. For Use in Budget Neutrality Calculations

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

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

X. Consumer Issues

Summary of Consumer Issues

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

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
1	Provider search	Service Authorization Status	Benefit and eligibility inquiries	PCP inquiry	Incoming calls from members calling to reach out to their CM/reaching out in regards to questions about authorizations and approvals.
2	Eligibility	Members calling to contact their case manager	Requests to speak with Care Manager	Address Change	Members requesting information on PPP Application status or questions with regards to PPP Process
3	Benefits Information	Members calling with questions regarding the PPP program.	PPP enrollment process	PCP Update/ID Card	Members requesting change of PCP and new ID cards.

4	Need to speak to CM	Benefits questions	PCP Inquiry		Members requesting to speak to their CM.
5	Member looking to enroll in MLTSS				

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

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
1	Authorization Status	Service Authorization Status	Requests to change Primary Care Physician (PCP)	Service Authorizations	Providers calling to obtain updates on their authorization status.
2	Claims Status	Claims denials	Benefit and eligibility inquiries	Claims Status	MDC authorization status.
3	EOB-TPL	Authorization issues other than status (ie Units)	Status of provider in the MCO network	EOB -TPL resolution	new authorization requests
4	Benefit and eligibility information	Benefits questions	Claims status	Member benefit status	
5				Authorization review prior to claims resubmission	

XI. Quality Assurance/Monitoring Activity

MLTSS:

MLTSS Claims Processing Information by MCO

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
# Claims Received	120,086	237,961	835,746	58,027	219,062
# Claims Paid	97,730	219,900	775,584	54,186	189,265
# Claims Denied	18,879	16,494	52,781	3,363	24,542

# Claims Pending	4,369	1,567	7,381	508	5,255

Top Reasons for MLTSS Claims Denial by MCO

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
1	1. M86 - Service denied because payment already made for same/similar procedure within set time frame.	Units exceed UM authorization	This claim is a duplicate of a previously submitted claim	Benefits based on admission date	No Authorization
2	18 - EXACT DUPLICATE CLAIM/SERVICE	Deny preauth not obtained	Resubmit with EOB from Medicare	Secondary medical coverage	No Patient Responsibility
3	29 - THE TIME LIMIT FOR FILING HAS EXPIRED	Procedure non-reimbursable	Provider Not Eligible by Contract for Payment	NPI not billed	Timely Filing
4	96 - NON-COVERED CHARGE(S)		Incomplete/Missing Payer Claim Control Number	Submitted after Provider filing limit	
5				Claim not submitted per EVV guidlines	

I/DD/SED

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

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

Supports and Community Care Program

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

DDD requires reporting on approximately 80 Incident Reporting (IR) codes. The IR codes are the same for both DDD demonstration programs. During this quarter there were 348 incidents reported for 305 individuals on the Supports Program. Approximately 83% of those incidents were coded as a COVID-

19 medical event which represents an increase from the previous quarter. For the CCP, there were 2,438 incidents reported for 1687 individuals this quarter. The COVID-19 related incidents represent the vast majority of incidents (56%). The majority of individuals with incident reports filed in both programs experienced a single incident this quarter. Due to the State of Emergency and anticipated health crisis 2 new Incident Codes were developed for COVID in March 2020. One was for a medically related COVID incident and the other was for an operational breakdown. These codes already existed, but a modifier of COVID was added for trending and tracking. Some IR codes, such as abuse, neglect, or exploitation require an investigation by the Office of Investigations. Less than 1% of the Incident Reports filed required an investigation by the Office of Investigations. If there were minor or no injuries, then the provider agency is responsible to conduct an investigation and submit their findings/action plan for review by the Department of Human Services Critical Incident Management Unit. If there were moderate to major injuries, then the Department of Human Services Special Response Unit will conduct an investigation. The ORM will continues to conduct quarterly analysis around choking and walkaway incidents and provides updates to supporting units (Support Coordination Unit/Provider Performance and Monitoring Unit). The annual Walkaway Report was finalized. A meeting to review the final Walkaway Report, including quality initiatives and remediation actions occurred. The Office of Risk Management is also planning to develop a PowerPoint related to COVID incidents in the next quarter.

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

Demonstration Unit staff and the Provider Performance & Monitoring Unit created monitoring activities and tools. These tools are utilized to monitor Medicaid/DDD approved providers for both DDD programs and provides further guidance technical assistance based on the results/findings. Data is entered into the databases and reports continue to be developed. Databases were/are being built so that data may be analyzed more efficiently and systemic issues can be identified and corrected. However, the Provider Performance and Monitoring Unit has conducted reviews of Day Services and Individual and Community Based Supports and has been providing exit interviews, findings reports, and technical assistance to a variety of providers. Providers are required to submit a plan of correction to PPMU. The PPMU and Demonstration Unit are conducting monthly meetings to ensure demonstration compliance and improvement activities when needed. The PPMU conducted outreach to providers as a result of day facilities closing and to residential providers and families who might be in need of personal protective equipment. A web page dedicated to COVID-19 communications and guidance documents was developed and weekly webinars are conducted for the DDD community to get updates. Congregate day sites remain closed, but work is being conducted related to the safe re-opening.

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

Meetings to address audits for the calendar year 2021 occurred this quarter.

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

Other Quality/Monitoring Issues:

EQR PIP

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

MLTSS PIP Update:

January 2021 was the beginning of the sustainability period for the Gaps in Care PIPs. Recommendations for performance improvement provided to the MCOs regarding this new topic were to target preventative services for MLTSS members and /or to target services related to chronic disease. All 5 MCOs submitted a progress report update in August 2020 on the topic of Decreasing Gaps in Care which included the Project Year 1 update for one MCO and the Project Year 2 update for the remaining 4 MCOs. All PIPs were reviewed by the EQRO in collaboration with DMAHS.

In October 2018, one MCO was required to submit a New Falls PIP proposal as a result of incongruent and inconclusive data observed in the entirety of their initial Falls PIP. This MCO submitted their new Falls PIP proposal in October, 2018. The New Falls PIP Proposal for this MCO was approved and accepted by the State in collaboration with the EQRO. The MCO submitted their New Falls PIP Year 1 Project update in August of 2020. January, 2021 marks the start of the Sustainability Year. The Plan is expected to submit a Project Status Update for Year 2 in April 2021 for this PIP.

Due to the onset of COVID 19 in early 2020, many of the MCOs have identified ongoing challenges with the implementation of planned interventions for their PIPs. In April, 2021 all five MCOs are expected to submit PIP Project updates.

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

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

XII. Demonstration Evaluation

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

A.	***Expanding Medicaid managed care to include long-term care services and supports will result in improved access to care and quality of care and reduced costs, and allow more individuals to live in their communities instead of institutions.***
	This quarter the State's independent evaluator continued claims data preparation and analysis for the interim report due in June 2021. Multi-year analytic datasets of health indicators and quality metrics were built. The independent evaluator completed analysis of data from HEDIS and CAHPS reports as part of monitoring overall quality in managed care during the Demonstration and drafted those portions of the interim report. The State's independent evaluator continued refining the approach for the cost-effectiveness analysis which will address policies relating to this, and several other research questions under the Demonstration. A meeting was held in February 2021 with State subject matter experts (SMEs) involved with MLTSS implementation to develop a feasible strategy for collecting implementation costs and the evaluator began drafting a survey instrument for this purpose. Further meetings were arranged to continue development of the instrument in consultation with the appropriate SMEs. Finally during this quarter, the State's independent evaluator continued to monitor developments related to the Managed Long-term Services and Supports program and Medicaid overall through attendance at the Medical Assistance Advisory Council meeting on January 21, 2021.
B.	***Providing home and community-based services to Medicaid and CHIP beneficiaries and others with serious emotional disturbance, autism spectrum disorder, or intellectual disabilities/developmental disabilities will lead to better care outcomes.***
	The State's independent evaluator met with representatives from Medicaid and the Department of Children and Families (DCF) on January 5th to gather information related to progress on initiatives for populations of children and youth being served under the Demonstration. Information needs for conducting the cost-effectiveness evaluation were also discussed, and a follow-up meeting on February 2nd was held to start exploration of feasible strategies for collecting implementation costs related to demonstration policies under DCF. During this quarter, the State's independent evaluator also continued claims data work in preparation for analyses in the interim report which will address this research question. This included constructing multi-year analytic datasets of outcomes for demonstration participants served by DCF as well as adults served by the Division of Developmental Disabilities through the Supports and Community Care Demonstration programs. They also investigated claims for demonstration services delivered to youth served by DCF to understand any utilization trends relevant for informing the interim report analysis.
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.***
	On January 15th, the State's independent evaluator and an official from the Medicaid Eligibility Unit had a call to discuss requested data related to self-attestations and Qualified Income Trusts (QIT) for the interim evaluation report. Subsequent to this call, a data collection template was

	developed and the State initiated the data pull. The first draft of data related to QITs was shared with the independent evaluator on March 29th.
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.***
	In preparation for the final DSRIP report due in December 2021, the independent evaluator began researching potential comparison states for which to purchase hospital inpatient and emergency department billing data from the Healthcare Cost and Utilization Project.
E.	***Other hypotheses to address new research questions in the Demonstration renewal:*** • ***What is the impact of providing home and community-based services to expanded eligibility groups, who would otherwise have not been eligible for Medicaid or CHIP absent the demonstration?*** • ***What is the impact of mandating individuals who are eligible for NJFC and have access to employee sponsored insurance into the premium assistance program; as conditional of eligibility?*** • ***What is the impact of providing substance use disorder services to Medicaid beneficiaries? Including paying for services rendered in an institution for mental disease (IMD)?***
	With regard to expanded eligibility for home and community-based services, the methodology for identifying in Medicaid claims those individuals eligible for the Supports program due to the income eligibility expansion was validated by a representative from the Division of Developmental Disabilities during this quarter. The Net Savings report for all beneficiaries enrolled in the Premium Support Program (PSP) at any point in the Demonstration period was delivered to the State's independent evaluator in January of this quarter. On January 6th, the independent evaluator participated in a call with representatives from Medicaid and the Office of Managed Health Care, Behavioral Health Unit to discuss progress on initiatives occurring under the 1115 SUD Demonstration such as the status of case management services and incentivizing use of MAT in long-term residential settings. The need for administrative costs associated with implementation of the 1115 SUD Demonstration to incorporate into the CMS-required cost analysis was discussed. On March 15th, the independent evaluator attended the virtual OBAT stakeholder meeting to stay informed on developments around this policy, particularly on the impacts of COVID on treatment for individuals with SUD. During this quarter, the State's independent evaluator also continued claims data preparation to prepare for the interim evaluation of the 1115 SUD Demonstration. This included calculation of IMD and SUD spending, and specification of metrics such as Inpatient and ED visits for SUD and Follow-up after ED visits for Alcohol or Other Drug Treatment. Guidance on approved mappings for Place of Service codes necessary for several quality metrics were provided by DMAHS's Office of Business Intelligence and SUD subject matter experts.

XIII. Enclosures/Attachments

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

XIV. State Contact(s)

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XV. Date Submitted to CMS

July 6, 2021

Deliverables due during MLTSS 3rd quarter (1/1/2021 – 3/31/2021)

The Division of Medical Assistance and Health Services' (DMAHS) Office of Managed Long-Term Services and Supports Quality Monitoring (MLTSS QM) receives and analyzes the Performance Measure (PM) data submitted by the respective data source. This quarterly report reflects the Performance Measures (PMs) that were reported by the Managed Care Organizations (MCOs) and the Division of Aging Services (DoAS) to the Office of MLTSS QM during the seventh year, third quarter (1/1/2021 – 3/31/2021) of the MLTSS program. Depending on the data source for the numerator/denominator, some PMs require longer lag times to allow for collection and analysis of the information. Because of the different lag times, each Performance Measure in this report identifies the measurement period being reported.

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

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

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

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

Deliverables due during MLTSS 3rd quarter (1/1/2021 – 3/31/2021)

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

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

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

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

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

November 2020	A	B	C	D	E	TOTAL
Numerator	0	0	0	0	0	**0**
Denominator	1	52	0	155	141	**349**
%	0	0	0	0	0	**0**

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

Deliverables due during MLTSS 3rd quarter (1/1/2021 – 3/31/2021)

December 2020	A	B	C	D	E	TOTAL
Numerator	0	0	0	0	0	**0**
Denominator	0	63	0	140	160	**363**
%	0	0	0	0	0	**0**

January 2021	A	B	C	D	E	TOTAL
Numerator	0	0	0	N/A	0	**N/A**
Denominator	0	46	156	N/A	220	**N/A**
%	0	0	0	N/A	0	**N/A**

The MCOs are monitoring the timeliness of level of care (LOC) assessments and have identified that there were no assessments completed for referrals received due to COVID-19 NJ State mandate effective March 19, 2020, which states MCOs were to discontinue assessing members face to face for the purposes of MLTSS eligibility. MCO A reported during the November 2020 measurement period that they identified one valid referral. The referral is for a 55 years old male. The assessment could not be completed because assessors were removed out of field due to COVID-19 pandemic and assessment could not be completed telephonically. MCO B reported that during the December 2020 measurement period there were 63 members referred. None of the 63 members received a face-to-face visit due to guidance from the State to suspend all face-to-face interactions with members due to the COVID-19 pandemic. Additionally, MCO B continues to perform telephonic outreaches to members in order to ensure that care management activities continue and members are aware the NJ Choice assessments will take place once the order is lifted. Furthermore, MCO E reported that there were 220 members identified for MLTSS Referral during January 2021 measurement period. Review by referral source showed 20 custodial members and 200 members in an HCBS setting. MCO E reported that no NJHC assessments were completed for the members identified in the denominator due to COVID-19 NJ State mandate. The MCOs will continue to monitor members referred for MLTSS eligibility assessment and will prioritize members upon changes in State guidance regarding field visits. Currently, members' needs are coordinated by care managers assigned as needed.

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

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

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

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

Measurement period	11/2020	12/2020	1/2021
Numerator	N/A	N/A	N/A
Denominator	N/A	N/A	N/A
%	N/A	N/A	N/A

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

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

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

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

Deliverables due during MLTSS 3rd quarter (1/1/2021 – 3/31/2021)

PM # 07	Members offered a choice between institutional and HCBS settings
Numerator:	Number of assessments in the denominator with an indicator showing choice of setting within the IPOC
Denominator:	Number of level of care assessments with a completed Interim Plan of Care (IPOC)
Data Source:	DoAS
Frequency:	Monthly – Due the 15th of the following month

Measurement Period	12/2020	1/2021	2/2021
Numerator	N/A	N/A	N/A
Denominator	N/A	N/A	N/A
%	N/A	N/A	N/A

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

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

Measurement period	12/2020	1/2021	2/2021
Numerator	0	0	0
Denominator	1173	1084	1101
%	N/A	N/A	N/A

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

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

Measurement period	12/2020	1/2020	2/2020
Numerator	0	0	0
Denominator	105	139	60
%	N/A	N/A	N/A

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

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

Table 3A UM Appeals

10/1/2020 – 12/31/2020	A	B	C	D	E	TOTAL
Numerator	8	9	118	42	33	**210**
Denominator	9	9	119	42	33	**212**
%	88.9	100	99.2	100	100	**99.1**

Table 3B Non-UM Grievances

10/1/2020 - 12/31/2020	A	B	C	D	E	TOTAL
Numerator	22	46	66	2	11	**147**
Denominator	23	46	66	2	11	**148**
%	95.7	100	100	100	100	**99.3**

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

Deliverables due during MLTSS 3rd quarter (1/1/2021 – 3/31/2021)

During the 10/1/2020 – 12/31/2020 measurement period three MCOs reported 100% of cases in Tables 3A were resolved within 30 days. MCO C reported one appeal that took 49 days to resolve due to receiving the appeal from vendor after the due date. As a result, the appeal was auto-forwarded to a contractor for review.

During the 10/1/2020 – 12/31/2020 measurement period four MCOs reported 100% of cases in Tables 3B were resolved within 30 days. MCO D had three cases that took from 34-36 days to resolve due to untimely routing of the grievances.

The tables below detail the number and type of MLTSS enrollee appeals (Table 3A) and grievances (Table 3B) filed during the measurement period of 10/1/2020 – 12/31/2020.

For this measurement period, the top UM appeal categories for all MCOs combined were Denial of dental services (64/212 = 30.2%); Denial of outpatient medical treatment/diagnostic testing (27/212= 12.7%); and Denial of inpatient hospital stays (24/212 = 11.3%).

The top three non-UM grievance categories were Dissatisfaction with provider office administration (31/148 = 20.9%); Reimbursement problems/unpaid claims. (21/148 = 14.2%); and Dissatisfaction with quality of medical care, other type of provider (17/148 = 11.5%).

Deliverables due during MLTSS 3rd quarter (1/1/2021 – 3/31/2021)

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

PM 19 - Table 3A Utilization Management (UM) enrollee appeal categories	October - December 2020					
	MCO A	MCO B	MCO C	MCO D	MCO E	TOTAL
Denial of acute inpatient rehabilitation services			3	1		4
Denial of assisted living services						
Denial of dental services	**3**	**6**	**37**	**8**	**10**	**64**
Denial of hearing aid services						
Denial of home delivered meal services						
Denial of hospice care						
Denial of in-home periodic skilled services (nursing, social services, nutrition, etc.)				1		1
Denial of in-home rehabilitation therapy (PT, OT, speech, etc.)						
Denial of inpatient hospital days	**2**		**17**		**5**	**24**
Denial of Medical Day Care (adult & pediatric)						
Denial of medical equipment (DME) and/or supplies		1	2	6		9
Denial of Mental Health services			1			1
Denial of non-medical transportation						
Denial of optical appliances						
Denial of optometric services						
Denial of other TBI services (CRS, Structured Day, Supported Day, etc.)						
Denial of outpatient medical treatment/diagnostic testing	**1**		**23**		**3**	**27**
Denial of outpatient rehabilitation therapy (PT, OT, Cardiac, Speech, Cognitive, etc.)		1				1
Denial of outpatient TBI habilitation therapy (PT, OT, speech, cognitive etc.)						
Denial of PCA services	1		9	3		13
Denial of Personal Emergency Response Systems (PERS)						
Denial of Private Duty Nursing				18		18
Denial of referral to out-of-network specialist						
Denial of residential modification			2	1		3
Denial of respite services						
Denial of skilled nursing facility (custodial)						
Denial of skilled nursing facility inpatient rehabilitation services			8		3	11
Denial of Special Care Nursing Facility (custodial) SCNF						
Denial of sub-acute inpatient rehabilitation services	1		7			8
Denial of SUD services			1			1
Denial of surgical procedure				1		1
Denial of vehicle modification						
Other (MLTSS)						
Other (non-MLTSS)						
Pharmacy	1	1		3	12	17
Reduction of acuity level (inpatient)			9			9
Service considered cosmetic, not medically necessary						
Service considered experimental/investigational						
Table 3A/UM Appeal TOTALS	**9**	**9**	**119**	**42**	**33**	**212**

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

Deliverables due during MLTSS 3rd quarter (1/1/2021 – 3/31/2021)

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

PM 19 - Table 3B non-utilization management (non-UM) enrollee grievance categories	October - December 2020					
	MCO A	MCO B	MCO C	MCO D	MCO E	TOTAL
Appointment availability, other type of provider		1	1		1	3
Appointment availability, PCP				1		1
Appointment availability, specialist		1				1
Difficulty obtaining access to a healthcare professional after hours (via phone)						
Difficulty obtaining access to DME and/or medical supplies		1	1			2
Difficulty obtaining access to mental health providers						
Difficulty obtaining access to MLTSS providers		1				1
Difficulty obtaining access to non-MLTSS providers						
Difficulty obtaining access to other in-home health services (skilled and non-skilled)					2	2
Difficulty obtaining access to PCA services		2				2
Difficulty obtaining access to PDN services						
Difficulty obtaining access to self-directed PCA services (PPP)						
Difficulty obtaining access to SUD providers						
Difficulty obtaining access to transportation services						
Difficulty obtaining referral to network specialist of member's choice						
Difficulty obtaining referrals for covered mental health services						
Difficulty obtaining referrals for covered MLTSS services						
Difficulty obtaining referrals for covered services, dental services						
Difficulty obtaining referrals for covered SUD services						
Difficulty related to obtaining emergency services				1	1	2
Dissatisfaction with dental services		1	4			5
Dissatisfaction with DME and/or medical supplies		1	2		1	4
Dissatisfaction with marketing, member services, member handbook, etc.	5	7	3			15
Dissatisfaction with NJ FamilyCare Benefits	1				2	3
Dissatisfaction with other in-home health services (skilled and non-skilled)		2	3			5
Dissatisfaction with PCA services		1	3			4
Dissatisfaction with PDN services		2				2
Dissatisfaction with policies regarding specialty referrals (i.e. out of network specialist)						
Dissatisfaction with provider network			2			2
Dissatisfaction with provider office administration	**1**	**4**	**26**			**31**
Dissatisfaction with quality of medical care, hospital			2			2
Dissatisfaction with quality of medical care, other type of provider	**3**	**7**	**7**			**17**
Dissatisfaction with quality of medical care, PCP		2	2		2	6
Dissatisfaction with quality of medical care, specialist	1	1	2		1	5
Dissatisfaction with transportation services	1	2			1	4
Dissatisfaction with utilization management appeal process			1			1
Dissatisfaction with vision services			1			1
Enrollment issues						
Laboratory issues			1			1
Pharmacy/formulary issues		2	3			5
Reimbursement problems/unpaid claims	**11**	**8**	**2**			**21**
Waiting time too long at office, PCP						
Waiting time too long at office, specialist						
Table 3B/non-UM Grievance TOTALS	**23**	**46**	**66**	**2**	**11**	**148**

Deliverables due during MLTSS 3rd quarter (1/1/2021 – 3/31/2021)

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

4/1/2020 - 6/30/2020	A	B	C	D	E	TOTAL
Numerator	3537	6590	17403	6308	6688	**40526**
Denominator	4579	8671	22036	9590	11368	**56244**
%	77.2	76	78.9	65.8	58.8	**72.1**

7/1/2019 - 6/30/2020	A	B	C	D	E	TOTAL
Numerator	4614	8560	21709	9036	9131	**53050**
Denominator	5674	10717	26321	12222	13305	**68239**
%	81.3	79.9	82.5	74	68.6	**77.7**

The MCOs continue to claim under reporting for this measure. MCOs report that there are members receiving services for which the MCO had not yet received a claim as some providers are not submitting claims and/or are delaying the submission of claims for services. MCO A reported the majority of their MLTSS membership resides in NF setting where their needs are met by the facility and the remaining population in the community setting is receiving MLTSS services including PERS, HDM, Private Duty Nursing, respite services, residential modification evaluations, medication dispensing device monitoring, home based supportive care, social adult day care, and chore services. Additionally, MCO B reported 76% of unique members during the measurement period 4/1/2020-6/30/2020 received an MLTSS service (excluding PCA, Medical Day, BH and care management services). Of the 2081 members not receiving an MLTSS service, 492 termed MLTSS within the quarter and an additional 25 termed within 60 days of close of the quarter. MCO B further reported that the 4/12020-6/30/2020 measurement period follows the peak of the COVID-19 pandemic during which time members worked with Care Managers to adjust services based on their informal supports and other identified needs. While some members increased LTSS services, some requested services be paused due to fear of exposure. MCO B has also observed an increased denominator during the public health emergency, as members unable to be contacted do not follow the standard disenrollment process. In addition, MCO E reported that there were 13305 members identified for inclusion in the denominator during the measurement period 07/1/2019- 06/30/2020, of which 9131 members met inclusion criteria for the numerator, corresponding to a 68.63% rate of members with MLTSS services. MCO E reported that there was a slight increase in the number of members receiving MLTSS services as reported for this measure from measurement period 07/1/2018-6/30/2019, reported at 68.30% with 7,756 members to 9,131 members with services during 07/1/2019- 6/30/2020 or 68.63%. MCO E further reported that a review of output file showed that of the 13,305 members identified in the denominator, 9,648 remain actively enrolled in the plan, 1,736 now reside in a NF setting while 7,912 members remain in an HCBS setting. MCO E reported that they will continue to emphasize establishing services upon a member's new enrollment into the

plan and managers will review members without services in the monthly 1:1 review as well as in monthly case rounds.

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

7/1/2019 -6/30/2020	A	B	C	D	E	TOTAL
Numerator	0	3	14	0	39	**56**
Denominator	26	33	238	4	1276	**1577**
%	0	9.1	5.9	0	3.1	**3.5**

7/1/2020-9/30/2020	A	B	C	D	E	TOTAL
Numerator	10	N/A	109	40	10	**N/A**
Denominator	1866	N/A	6687	4001	1942	**N/A**
%	0.5	N/A	1.6	1	0.5	**N/A**

10/1/2020-12/31/2020	A	B	C	D	E	TOTAL
Numerator	10	N/A	89	34	8	**N/A**
Denominator	2003	N/A	6998	3886	2045	**N/A**
%	0.5	N/A	1.3	0.9	0.4	**N/A**

The MCOs report that they continue to work with approved programs such as Money Follows the Person to identify members who are appropriate for NF to HCBS transitions. For the 10/1/2020 - 12/31/2020 measurement period, MCO A reported 2003 unique members who met the eligibility requirements in the denominator. Out of the reported 2003 unique members, 10 members transitioned out of the NF setting during the measurement period, which calculates to 0.50%. MCO A further reported that there were 8 women and 2 men who made the transition this measurement period; the oldest was 90 years old and youngest was 21 years old. MCO A reported that all of the NF transition activities were completed telephonically during the pandemic. This includes transition IDT, care plan development, the procurement of transition supplies and services. Once the member transitions to the community, case managers follow the HCBS workflows and visit the member telephonically on a quarterly basis and make monthly calls. MCO A reported that members transition to HCBS receive intensive case management during the first year of the transition. In addition, MCO D reported 3886 continuously enrolled MLTSS members during the measurement period 10/1/2020 – 12/31/2020 and of those members; 34 transitioned out of the NF setting during the measurement period. MCO D further reported that they 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 will continue to follow these approved programs and plans to identify and assess members for community transitions and will continue to collaborate with their providers to identify members who may be able to move to a less restrictive living arrangement. MCO E reported that with further review, necessary changes were made to PM#21 for measurement period 7/1/2019 – 6/30/2020 and have resubmitted their data. The updated rates for MCO E with totals are reported within the Measurement Period tables above and are indicated with red font. Following the completion of the validation process, rates for MCO A and D for measurement period 7/1/2020 - 9/30/2020 are reported within the tables above and are indicated with red font. MCO B is working with the State's EQRO on their coding for this performance measure and have an extension to submit this report next quarter. This data will be included in the next quarterly report.

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

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

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

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

4/1/2020 - 6/30/2020	A	B	C	D	E	TOTAL
Numerator	103	378	1723	392	344	**2940**
Denominator	5430	15757	38109	15331	25758	**100385**
%	1.9	2.4	4.5	2.5	1.3	**2.9**

7/1/2019 - 6/30/2020	A	B	C	D	E	TOTAL
Numerator	606	1576	6826	1654	1810	**12472**
Denominator	18150	60019	147758	60906	98267	**385100**
%	3.3	2.6	4.6	2.7	1.8	**3.2**

Data for this measure is captured on a monthly basis and the numerators are added together and the denominators are added together to report quarterly data reflecting the number of hospitalizations that occurred per member month. This measure is based on hospital events and not unduplicated members. MCO A reported 103 acute inpatient visit which calculates to 1.9% admissions per member month of HCBS members during the measurement period 4/1/2020 – 6/30/2020. This rate has significantly decreased from 3.3% for the previous measurement period. Furthermore, MCO A reported 103 acute inpatient visits among 85 unique members. Repeat visits in the measurement period ranged from 2 to 3 visits with identified diagnosis of COVID-19 (14), Acute Kidney Failure Unspecified (4), Gastrointestinal hemorrhage unspecified (3), HTN heart & CKD W/HF and CKD stage 1-4 or UNS CKD (3), Parkinson's disease (3), Pneumonia unspecified organism (3), Sepsis unspecified organism (3), Type 1 diabetes mellitus w/ketoacidosis w/o coma (3), and Urinary tract infection site not specified (3). For the measurement period 4/1/2020 – 6/30/2020, MCO C reported 1723 acute inpatient visit, of which 1,414 (82%) were Dual Medicaid/Medicare and 209 (15%) were enrolled in our MLTSS SNP plan. MCO C discovered the top three diagnoses for Acute inpatient utilization for MLTSS HCBS members to be COVID-19 at 7% (126), Sepsis, unspecified organism at 7% (112) and Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease at 3% (48). MCO C reported that their clinical team will continue to review admissions daily, contact facilities and review discharge planning. MCO E reported 1810 acute inpatient events, corresponding to a 1.84% rate or 18.42 events per thousand for measurement period 7/1/2019 – 6/30/2020. Further analysis revealed that 1293 unique members accounted for the 1810 events in the numerator; 1105 of the 1293 unique members were age 65 or older (85.46%). In addition, MCO E review of correlating diagnoses showed the most frequent disease category reported was circulatory disorders with 450 events of which hypertensive heart disease was reported in 179 cases (39.78%). The second disease category reported 246 events for Infectious and Parasitic Diseases, of which 230 or (93.50%) events were due to sepsis. The third category reported was 210 events for Diseases of the Respiratory system of which 93 or (44.29%) events were due to Pneumonia. Due to the COVID-19 pandemic, further review of member utilization showed that of the 1293 unique members in the numerator, 312 members were reported as COVID-19 positive with 85 deaths reported within the measurement period. MCO E continues to closely monitor inpatient admissions using a daily discharge planning report to continue to improve timely outreach and appropriate discharge planning including follow up appointments and medication

reconciliation. Also, MCO E continues to monitor COVID-19 related claims to identify risk factors, co-morbidities as well mortality rates among the members in efforts to implement measures that may improve outcomes and decrease mortality for the MLTSS high risk populations.

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

4/1/2020 - 6/30/2020	A	B	C	D	E	TOTAL
Numerator	183	242	1119	224	129	**1897**
Denominator	6105	8314	20279	9475	6295	**50468**
%	3	2.9	5.5	2.4	2.1	**3.8**

7/1/2019 - 6/30/2020	A	B	C	D	E	TOTAL
Numerator	766	741	3273	619	502	**5901**
Denominator	26635	34074	80256	34687	24169	**199821**
%	3	2.2	4.1	1.8	2.1	**2.9**

Data for this measure is captured on a monthly basis. Quarterly data reflects the number of hospitalizations that occurred per member month. This measure is based on hospital events, not unduplicated members. MCO A reported 183 inpatient visits during the 4/1/2020 -6/30/2020 measurement period, which calculates to 29.98 Inpatient visits per 1000 member months. The percentage of inpatient visits per member months calculates to 3.0%. Furthermore, MCO A reported that the most prevalent primary diagnoses for these admissions were COVID-19 (58), other specified sepsis (18), Sepsis Unspecified Organism (17), Pneumonia unspecified organism (6), Acute kidney failure unspecified (4), INF&INFLM REAC INDWLL URETH CTH INT (4), and Pneumonitis due to inhalation of food and vomit (3). For measurement period 4/1/2020 – 6/30/2020, MCO C reported 1119 acute inpatient utilization. Upon data analysis, MCO C discovered the top three diagnoses for acute inpatient utilization for MLTSS NF members to be COVID-19 at 22% (245), other specified sepsis at 10% (115) and 10% (111) Sepsis, unspecified organism. MCO C's clinical team continues to review admissions daily, contact facilities and review discharge planning. MCO E reported 502 acute inpatient events, corresponding to a 2.08% rate or 20.77 authorizations per thousand for measurement period 7/1/2019 - 6/30/2020. Further analysis revealed that 349 unique members accounted for the 502 events in the numerator; 267 of the 349 unique members were age 65 or older (76.50%). In addition, MCO E review of correlating diagnosis showed the most frequent disease category reported was infectious and parasitic diseases with 162 events, sepsis was reported in 160 of these events or 98.77%. The second disease category reported 53 events for Diseases of the respiratory system, of which 30 or 56.60% events were due to pneumonia. The third category

reported was 50 events for Injury, poisoning due to external cause of which 25 or 50% events were due to infection and inflammation. Due to the COVID-19 pandemic, further review of members reported in the measurement period showed 202 members were reported as COVID-19 positive with 56 deaths reported in the measurement period related to COVID-19. MCO E reported that they will continue to closely monitor inpatient admissions in real time using the newly developed discharge planning report to help improve timely outreach and appropriate discharge planning including follow up appointments and medication reconciliation. Furthermore, Additional analysis is being conducted by the MCO E to identify trends for members reported as being COVID positive as well as mortality rates by nursing facility to be able to identify best practices as well as identification of quality of care issues impacting membership.

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

7/1/2019 - 9/30/2019	A	B	C	D	E	TOTAL
Numerator	40	22	364	40	189	**655**
Denominator	184	145	2219	349	895	**3792**
%	21.7	15.2	16.4	11.5	21.1	**17.3**

10/1/2019 - 12/31/2019	A	B	C	D	E	TOTAL
Numerator	42	23	364	47	173	**649**
Denominator	187	177	2260	400	979	**4003**
%	22.5	13	16.1	11.7	17.7	**16.2**

1/1/2020 - 3/31/2020	A	B	C	D	E	TOTAL
Numerator	33	29	444	47	150	**703**
Denominator	192	186	2304	415	861	**3958**
%	17.9	15.6	19.3	11.3	17.4	**17.8**

4/1/2020 - 6/30/2020	A	B	C	D	E	TOTAL
Numerator	30	39	482	50	51	**652**
Denominator	126	152	1872	334	446	**2930**
%	23.8	25.7	25.8	15	11.4	**22.2**

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 3rd quarter (1/1/2021 – 3/31/2021)

7/1/2019 - 6/30/2020	A	B	C	D	E	TOTAL
Numerator	135	76	1657	101	579	**2548**
Denominator	644	803	8370	1137	3147	**14101**
%	20.9	9.5	19.8	8.9	18.4	**18.1**

Data for this measure is captured on a monthly basis and the numerators are added together and the denominators are added together to report quarterly data reflecting the number of hospitalizations that occurred per member month. MCO C reported 482 unique re-admissions within 30 day corresponding to 25.8% for measurement period 4/1/2020 – 6/30/2020. Furthermore, MCO C identified the top three diagnoses for Acute inpatient utilization for MLTSS HCBS members to be 2019-nCoV Acute Respiratory Disease at 7%, Sepsis, unspecified organism at 5.13% and Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease at 2.62%. Further review showed that the highest age range for acute inpatient utilization for MLTSS HCBS members for MCO C ranged from 22 years old to 109 years old, with the average age being 69 years old. MCO D reported 50 unique re-admissions within 30 day corresponding to 15% for measurement period 04/01/2020-06/30/2020; this was a 3.64 percentage point increase of re-admissions within 30 days from the previous reporting period (1/1/2020 - 3/31/2020) of 11.33%. Furthermore, MCO D reported that of the 50 readmissions within 30 days in the measurement period, 12 members had more than one readmission. There were a total of 38 unique members who had at least one readmission in the measurement period. Of these 38 unique members, 60.53% (23/38) identified as female compared to 39.47% (15/38) which identified as male and of the 38 unique member re-admissions within 30 days, 57.89% (22/38) were 65 years of age or older. For measurement period 7/1/2019 – 6/30/2020, MCO E reported that there were 579, 30-day readmission events identified for 384 unique members meeting inclusion criteria for the numerator, corresponding to an 18.40% readmission rate. Of the 384 unique members, 311 were age 65 or older (80.99%). MCO E reported that review of the data output file for the current measurement period 7/1/2019 - 6/30/2020 shows a decrease in the readmission rates in comparison to the prior measurement period 7/1/2018 - 6/30/2019 from 21.33% to 18.40%. MCO E reported that the decrease in rate can be mainly attributed to on-going monitoring and care management coordination including interventions conducted through the MCO's High Utilizer Task Force. Additionally, the MCO E reported a decrease in utilization of acute care services especially during the fourth quarter of the measurement period 7/1/2019 to 6/30/2020 mainly due to the public health emergency of the COVID-19 pandemic. Furthermore, MCO E analysis of trends by disease category showed there were 115 readmission events, for diseases of circulatory system, with hypertension presenting in 51 of reported events (44.35%). The second category reported 69 events for infectious disease, of which 58 events were due to sepsis (84.06%). The third category reported 63 events for general signs and symptoms, with chest pain accounting for 23 out of the 63 events (36.51%). The fourth category reported 62 events for disease of the respiratory system, with pneumonia presenting in 16 out of the 62 events (25.81%), with no other trends identified. The fifth category reported 58 events for injuries/poisoning due to external causes, with infection and inflammation accounting for 17 out of the 58 events (29.31%), no significant trends were identified. MCO E reported that they continue to monitor daily inpatient

census, acute inpatient discharges as well as monthly utilization data to identify members for follow up, trends and utilization patterns. Following the completion of the validation process, rates for MCO A and C during the 7/1/2019 - 9/30/2019; 10/1/2019 – 12/31/2019; and 1/1/2020 - 3/31/2020 measurement periods are reported within the tables above and are indicated with red font.

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

7/1/2019 - 9/30/2019	A	B	C	D	E	TOTAL
Numerator	36	8	115	9	39	**207**
Denominator	182	38	814	120	226	**1380**
%	19.8	21.1	14.1	7.5	17.3	**15**

10/1/2019 - 12/31/2019	A	B	C	D	E	TOTAL
Numerator	49	17	127	6	62	**261**
Denominator	201	53	848	151	280	**1533**
%	24.4	32.1	15	4	22.1	**17**

1/1/2020 - 3/31/2020	A	B	C	D	E	TOTAL
Numerator	28	11	161	11	71	**282**
Denominator	184	58	894	160	267	**1563**
%	15.2	19	18	6.9	26.6	**18**

4/1/2020 - 6/30/2020	A	B	C	D	E	TOTAL
Numerator	34	12	212	10	14	**282**
Denominator	169	70	1075	192	195	**1701**
%	20.1	17.1	19.7	5.2	7.2	**16.6**

7/1/2019 - 6/30/2020	A	B	C	D	E	TOTAL
Numerator	135	29	614	26	194	**998**
Denominator	686	203	3428	494	935	**5746**
%	19.7	14.3	17.9	5.3	20.8	**17.4**

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

Data for this measure is captured on a monthly basis and the numerators are added together and the denominators are added together to report quarterly data reflecting the number of hospitalizations that occurred per member month. This measure is based on hospital events and not unduplicated members. MCO C reported 212 unique re-admissions within 30 day corresponding to 19.7% for measurement period 4/1/2020 – 6/30/2020. Furthermore, MCO C identified the top three diagnoses for Acute inpatient utilization for MLTSS NF members to be 2019-nCoV Acute Respiratory Disease at 21.30%, Other specified sepsis at 9.30% and Sepsis, unspecified organism at 8.37%. Further review showed the highest age range for acute inpatient utilization for MLTSS NF members ranged from 22 years old to 103 years old, with the average age being 71 years old. MCO D reported 10 unique re-admissions within 30 day (5.21%) for measurement period 04/01/2020-06/30/2020; this was a 1.67 percentage point decrease of re-admissions within 30 days from the previous reporting period (01/01/2020 – 03/31/2020) of 6.88%. Furthermore, MCO D reported that of the 10 readmissions within 30 days in the measurement period, two individual members had more than one readmission. There was a total of 8 unique members who had at least one readmission in the measurement period. Of these 8 unique members, 62.50% (5 / 8) identified as female compared to 37.5 % (3 / 8) which identified as male. Of the 8 unique member re-admissions within 30 days, 37.5 % (3/ 8) were 65 years of age or older. For measurement period 7/1/2019 – 6/30/2020, MCO E reported that there were 194 events reported in the numerator, as 30-day readmissions for 123 unique members corresponding to 20.75%. 86 members were age 65 or older (69.92%). Furthermore, MCO E reported that this measure showed a decrease from 23.48% from measurement period 7/1/2018 – 6/30/2019 to the current measurement period of 7/1/2019 -6/30/2020 (20.75%). MCO E reported that a larger decrease in overall utilization seen within the fourth quarter of the measurement year (April-June 2020) was directly related to the COVID-19 pandemic. MCO E saw an overall decrease in acute inpatient admissions as well as ED visits during this measurement period. Furthermore, MCO E analysis of trends by disease category showed Sepsis diagnosis was the primary diagnosis on 51 of the 54 total events (94.44%) reported under the category of infectious diseases. The second category included diseases of the digestive system with 21 events, no trends identified. The third category reported disease of the respiratory system with 8 of the total 18 events related as pneumonia (44.44%). The fourth category was under injury/poisoning due to external causes with 17 events, 10 of them related to general infection and inflammation (58.82%). The fifth category included endocrine, nutritional and metabolic diseases, with 6 of the 16 events related to diabetes (37.50%). MCO E reported that they will continue to monitor inpatient census, conduct outreach, and educate the NF staff to focus and effectively assist the coordinate of services for members post discharge. Following the completion of the validation process, rates for MCO A and C during the 7/1/2019 - 9/30/2019; 10/1/2019 – 12/31/2019; and 1/1/2020 - 3/31/2020 measurement periods are reported within the tables above and are indicated with red font.

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

4/1/2020 - 6/30/2020	A	B	C	D	E	TOTAL
Numerator	231	437	1991	518	530	**3707**
Denominator	5458	15757	38139	15331	25765	**100450**
%	4.2	2.8	5.2	3.4	2.1	**3.7**

7/1/2019 - 6/30/2020	A	B	C	D	E	TOTAL
Numerator	1260	3154	11845	3401	3826	**23486**
Denominator	18156	60019	147797	60906	99072	**385950**
%	6.9	5.3	8	5.6	3.9	**6.1**

Data for this measure is captured on a monthly basis. Quarterly data reflects the number of ED visits that occurred per member month. This measure is based on ER utilization events and not unduplicated members. MCO A reported 231 ED visits, calculating the utilization rate for ED visits per 1000 member months to 42.32 for the measurement period 4/1/2020 – 6/30/2020. MCO A reported that the utilization rate for ED visits per 1000 member months significantly decreased from the previous measurement period rate of 76.30. Furthermore, MCO A reported that most prevalent ED diagnosis was Other Chest Pain, Urinary Tract Infection, COVID-19, Low back pain, Pneumonia unspecified organism, Shortness of breath, Unspecified Injury of Head Initial Encounter. The 231 ED visits occurred among 161 unique members. Members with multiple visits ranged from 2 to 6 visits in the measurement period. COVID-19 pandemic affected results this measurement period. MCO A reported that they will continue to track and trend the ER Utilization for MLTSS members. For measurement period, 4/1/2020 -6/30/2020, MCO C reported 1991 ER visits corresponding to 5.2% for the measurement period. Further review of the visits showed that a total of 1,449 (73%) were Medicare Prime, of which 228 (16%) were MLTSS SNP HCBS. Additionally, MCO C identified the top three diagnoses for ER utilization for MLTSS HCBS members to be 3% had Chest pain, unspecified, 3% had Other Chest Pain and 3% had Urinary Tract Infection, site not specified. MCO C will continue to track and trend the ER Utilization for MLTSS members. MCO D reported a total of 3401 unique ER visits (not unique members) corresponding to 5.6% for the measurement period of 7/1/2019 – 6/30/2020. Additionally, MCO D reported that ER visits did decrease by 299 visits (from 3700 in measurement period 7/1/2018 – 6/30/2019) and the overall percentage decreased by 0.71%. Out of the 3401 unique ER visits, 393 (11.56%) visits were from DSNP members. Furthermore, MCO D reported that the most common admitting diagnoses for the measurement period were UTI, Chest pain, unspecified; other chest pain; Syncope and collapse and SOB. MCO D reported that care managers will continue to follow-up and monitor members with 5 or more ED visits.

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

4/1/2020 - 6/30/2020	A	B	C	D	E	TOTAL
Numerator	214	66	659	137	121	**1197**
Denominator	6261	8314	20348	9475	6311	**50709**
%	3.4	0.8	3.2	1.5	1.9	**2.4**

7/1/2019 - 6/30/2020	A	B	C	D	E	TOTAL
Numerator	896	206	2943	636	473	**5154**
Denominator	26662	34074	80318	34687	26090	**201831**
%	3.4	0.6	3.7	1.9	1.8	**2.5**

Data for this measure is captured on a monthly basis. Quarterly data reflects the number of ED visits that occurred per member month. This measure is based on ER utilization events and not unduplicated members. MCO A reported 214 ED visits for NF members, which calculates to 3.4% and a rate 34.18 ED visits per 1000 member months for the measurement period of 4/1/2020 - 6/30/2020. This is a slight increase from the previous measurement period at 33.17. Furthermore, MCO A reported that the most prevalent diagnoses for these ED visits included COVID-19, Unspecified Injury of Head Initial Encounter, Anemia unspecified, Chest pain unspecified, Gastrostomy malfunction, Laceration W/O FB other part head initial ENC, Laceration W/O foreign body scalp initial ENC. The 214 claims occurred among 172 unique members living in the NF setting. Members with multiple visits ranged from 2 to 4 visits in the quarter. MCO A reported that they will continue to track and trend the ER Utilization for MLTSS NF members. For measurement period, 4/1/2020 - 6/30/2020, MCO C reported 659 ER visits corresponding to 5.2% for the measurement period. Further review of the visits showed that a total of 480 (73%) were Medicare Prime, of which 14 (3%) were MLTSS SNP NF members. Additionally, MCO C identified the top three diagnoses for ER utilization for MLTSS NF members to be COVID-19 at 10%, unspecified injury of head, initial encounter at 4% and Urinary tract infection, site not specified at 3%. MCO C will continue to track and trend the ER Utilization for MLTSS NF members. MCO D reported a total of 636 unique ER visits (not unique members) corresponding to 1.9% for the measurement period of 7/1/2019 – 6/30/2020. Additionally, MCO D reported that this is a decrease of 55 visits when compared to the prior measurement period (691 ED visits 7/1/2018 – 6/30/2019). MCO D reported that of the 636 Emergency Department visits, 299 (or 47.01%) were for members age 65 and over at the time of the visit. The number of Emergency Department visits for members under the age of 18 at the time of the ED visit was 11 (1.73%). Furthermore, MCO D reported that the most common admitting diagnoses for the measurement period were unspecified injury of head, Gastrostomy malfunction; Urinary tract infection; Chest pain, unspecified; and Altered mental status. MCO D reported that care managers will continue to follow-up and monitor members with 10 or more ED visits and will discuss Emergency visits as part of their face to face visits.

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

4/1/2020 - 6/30/2020	A	B	C	D	E	TOTAL
Numerator	163	831	2446	758	622	**4820**
Denominator	2092	5370	13823	5473	8790	**35548**
%	7.8	15.5	17.7	13.9	7.0	**13.6**

7/1/2019 - 6/30/2020	A	B	C	D	E	TOTAL
Numerator	188	970	2841	978	632	**5609**
Denominator	2739	6726	17016	7373	10339	**44193**
%	6.9	14.4	16.7	13.3	6.1	**12.7**

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

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

4/1/2020 - 6/30/2020	A	B	C	D	E	TOTAL
Numerator	256	245	173	136	1491	**2301**
Denominator	2092	5370	13823	5473	8790	**35548**
%	12.2	4.6	1.3	2.5	17.0	**6.5**
7/1/2019 - 6/30/2020	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	265	251	195	170	1400	**2281**

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

Denominator	2739	6726	17016	7373	10339	**44193**
%	9.7	3.7	1.2	2.3	13.5	**5.2**

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

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

7/1/2018 - 9/30/2018	A	B	C	D	E	TOTAL
Numerator	3	2	4	2	6	**17**
Denominator	15	7	22	5	12	**61**
%	20	28.6	18.2	40.0	50.0	**27.9**

10/1/2018 - 12/31/2018	A	B	C	D	E	TOTAL
Numerator	1	3	2	1	3	**10**
Denominator	12	10	43	3	5	**73**
%	8.3	30	4.6	33.3	60.0	**13.7**

1/1/2019 - 3/31/2019	A	B	C	D	E	TOTAL
Numerator	0	4	6	2	4	**16**
Denominator	5	10	19	6	10	**50**
%	0	40	31.6	33.3	40.0	**32**

4/1/2019 - 6/30/2019	A	B	C	D	E	TOTAL
Numerator	1	4	5	1	4	**15**
Denominator	10	10	31	3	8	**62**
%	10.0	40	16.1	33.3	50.0	**24.2**

7/1/2019 - 9/30/2019	A	B	C	D	E	TOTAL
Numerator	0	3	4	1	4	**12**

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

Deliverables due during MLTSS 3rd quarter (1/1/2021 – 3/31/2021)

Denominator	4	7	30	3	14	**54**
%	0	42.9	13.3	33.3	28.6	**22.2**

10/1/2019 - 12/31/2019	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	0	8	0	3	1	**12**
Denominator	6	18	24	7	7	**62**
%	0	44.4	0	42.9	14.3	**19.3**

1/1/2020 - 3/31/2020	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	0	4	0	4	4	**12**
Denominator	4	8	17	6	17	**52**
%	0	50	0	66.7	23.5	**23.1**

4/1/2020 - 6/30/2020	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	0	3	4	3	5	**15**
Denominator	4	10	17	8	6	**45**
%	0	30	23.5	37.5	83.3	**33.3**

7/1/2019 - 6/30/2020	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	0	16	11	7	11	**45**
Denominator	16	38	86	18	33	**191**
%	0	42.1	12.8	38.9	33.3	**23.6**

MCOs are reporting challenges in obtaining this data due to dual eligible members and limited access to Medicare claims. MCO A reported during the 4/1/2020 – 6/30/2020 measurement period 4 acute inpatient discharges of HCBS members with principal diagnoses of Mental Illness or Intentional self-Harm. None of these 4 discharges had claims submitted for appropriate BH follow-up within 30 days of the discharge, which calculates to 0% timely follow-up. MCO A reported that all four are unique members with single inpatient event discharges with principal diagnoses that ranged from Schizophrenia Unspecified, Schizoaffective Disorder Bipolar type, Adjustment Disorder with depressed mood, and Bipolar D/O CURR MIXED SEVERE W/PSYCH FEATURES. In addition, MCO A reported that behavioral health case managers are working with the MLTSS case managers and UM team to identify members in need. When appropriate and feasible, face to face visits are conducted with members with high ED and inpatient usage to engage the member and build relationships. The team assists with securing appointments and providing resources for the members. The multidisciplinary approach provides the member with supports for optimal functioning and outcomes. For the measurement period 4/1/2020 – 6/30/2020, MCO B reported that 2 members had a successful visit within 30 days out of 5 members that required a follow-up within 30 days of discharge. MCO B reported that 1 of the 2 completed the visit within 7 days and 3 of which are in the 18-64 age group and 2 in the 65+ age group. Furthermore, MCO B reported that all 5 cases were open to BH care management. MCO B expected to not see full compliance, especially during this period.

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

Many members, especially in the MLTSS population feared exposure to the COVID-19 virus. MCO B reported that they encouraged providers to engage in telehealth visits to avoid any gaps in member care. Regardless of the increase in telehealth utilization, MCO B saw a drop in visit completion due to this reason. MCO B behavioral health care managers worked in tandem with MLTSS care managers to improve member compliance with follow-up visits post hospital stay. MCO C reported 86 MLTSS HCBS acute inpatient mental health discharges during the measurement period 7/1/2019 to 6/30/2020. Of the 86 inpatient discharges, there were 11 follow up visits with a mental health professional within 30 days of discharge, corresponding to 12.8% for the measurement period. Further review of the data by MCO C showed that the top age group was 18-64 years old with 59 (69%) of which 9 (15%) had a follow-up visit and the top mental health diagnosis for the HCBS population was (10.47%) Bipolar disorder, unspecified during the measurement period. Furthermore, MCO C reported that out of the 75 MLTSS HCBS inpatient discharges that did not have a follow up visit with a Mental Health practitioner within 30 days of discharge, 6 (8%) members were discharged to another short term general hospital for inpatient care, 3 (4%) members had a Telehealth Visit with a Mental Health Practitioner within the 30 days of discharge, 8 (10.67%) members had an appointment scheduled but refused to attend, 4 (5.33%) members had two inpatient discharges within 2 weeks of initial discharge, of which 2 members had a follow up visit scheduled prior to readmission, 6 (8%) member was discharged to a Nursing Facility for Custodial Care post hospital discharge, 9 (12%) members were discharged to a Skilled Nursing Facility post hospital discharge, 1 (1.33%) member was discharged to a long term care hospital, 2 (2.67%) members made an appointment but cancelled due to Covid-19, 11 (14.67%) members did have a follow-up visit with a mental health practitioner within 30 days of discharge, however this provider has yet to submit claims and 25 (33.33%) members did not have a scheduled follow up visit within 30 days of discharge. MCO C reported that they developed a workgroup to strategize and manage Post Facility Follow up visits for Behavioral health admissions and will continue to track and monitor behavioral health reports daily with a bi-weekly review to maintain compliance. Following the completion of the validation process, rates for MCO A during the 7/1/2019 - 9/30/2019; 10/1/2019 – 12/31/2019; and 1/1/2020 – 3/31/2020 measurement periods are reported within the tables above and are indicated with red font. MCO B reported that with further review, necessary changes were made to PM#36 for measurement periods 7/1/2018 - 9/30/2018, 10/1/2018 – 12/31/2018, 1/1/2019 – 3/31/2019, 4/1/2019 – 6/30/2019, 7/1/2019 – 9/30/2019, 10/1/2019 – 12/31/2019, and 1/1/2020 – 3/31/2020 and have resubmitted their data. The updated rates for MCO B with totals are reported within the Measurement Period tables above and are indicated with red font.

PM # 38	Follow-up after mental health hospitalization for MLTSS NF members: HEDIS FUH
Numerator:	Sum of qualifying follow-up visits with a mental health practitioner within 30 days after discharge. Only the 30-day follow-up rate is reported.

Deliverables due during MLTSS 3rd quarter (1/1/2021 – 3/31/2021)

Denominator:	Follow HEDIS specifications for Follow-Up after Hospitalization for Mental Illness (FUH) for MLTSS NF members. The denominator for this measure is based on discharges, not on members.
Data Source:	MCO
Frequency:	Quarterly/Annually - Lag Report Due: 240 day lag after quarter and year

4/1/2019 - 6/30/2019	A	B	C	D	E	TOTAL
Numerator	1	0	1	0	0	**2**
Denominator	5	2	13	1	0	**21**
%	20.0	0	7.7	0	0	**9.5**

7/1/2019 - 9/30/2019	A	B	C	D	E	TOTAL
Numerator	0	0	1	1	0	**2**
Denominator	0	1	15	2	1	**19**
%	0	0	6.7	50	0	**10.5**

10/1/2019 - 12/31/2019	A	B	C	D	E	TOTAL
Numerator	0	1	0	0	0	**1**
Denominator	0	1	12	1	0	**14**
%	0	100	0	0	0	**7.1**

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

4/1/2020 - 6/30/2020	A	B	C	D	E	TOTAL
Numerator	0	0	0	0	0	**0**
Denominator	0	0	6	2	0	**8**
%	0	0	0	0	0	**0**

7/1/2019 - 6/30/2020	A	B	C	D	E	TOTAL
Numerator	0	0	2	1	0	**3**
Denominator	0	2	41	3	0	**46**
%	0	0	4.9	33.3	0	**6.5**

MCOs are reporting some challenges in obtaining this data due to dual eligible members and limited access to Medicare claims. MCOs A, B, and E had reported zero discharges from inpatient setting with a principal diagnosis of Mental Illness or Intentional Self-Harm during the measurement period 4/1/2020 – 6/30/2020. Since no discharges were reported during measurement period, therefore there were no qualifying follow-up visit with a mental health professional within 30 days of the

discharge date. MCO C reported 41 MLTSS NF acute inpatient mental health discharges during the measurement period 7/1/2019 – 6/30/2020. Of the 41 inpatient discharges, there were 2 (5%) follow up visits with a mental health professional within 30 days of discharge. Additionally, MCO C reported that the top mental health diagnosis for the 41 NF mental health discharges was (21.95%) Schizoaffective disorder, bipolar type during the measurement period. Furthermore, MCO C reported that out of the 39 MLTSS NF Mental Health discharges that did not have a follow up visit with a Mental Health practitioner within 30 days of discharge, 14 (35.90%) members were discharged to a Skilled Nursing Facility post hospital discharge, 21 (53.85%) members were discharged to a Nursing Facility for Custodial Care post hospital discharge, 1 (2.56%) member had a Telehealth Visit with a Mental Health Practitioner within the 30 days of discharge, 1 (2.56%) member had an appointment scheduled but refused to attend, 1 (2.56%) member was readmitted to the hospital within 2 weeks of initial discharge, and 1 (2.56%) was discharged to another short term general hospital for inpatient care. MCO C reported that they developed a workgroup to strategize and manage Post Facility Follow up visits for Behavioral health admissions and will continue to track and monitor behavioral health reports daily with a bi-weekly review to maintain compliance. Following the completion of the validation process, rates for MCO A during the 7/1/2019 - 9/30/2019; 10/1/2019 – 12/31/2019; and 1/1/2020 – 3/31/2020 measurement periods are reported within the tables above and are indicated with red font. MCO B reported that with further review, necessary changes were made to PM#38 for measurement periods 4/1/2019 – 6/30/2019, 7/1/2019 – 9/30/2019, and 10/1/2019 – 12/31/2019, and have resubmitted their data. The updated rates for MCO B with totals are reported within the Measurement Period tables above and are indicated with red font.

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

4/1/2020 - 6/30/2020	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	169	308	502	115	1195	**2289**
Denominator	2092	5370	13823	5473	8790	**35548**
%	8.1	5.7	3.6	2.1	13.6	**6.4**

7/1/2019 - 6/30/2020	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	196	383	672	177	1289	**2717**
Denominator	2739	6726	17016	7373	10339	**44193**

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

%	7.2	5.7	4	2.4	12.5	**6.1**

The above data reflects per MCO the unique count of members enrolled in MLTSS HCBS at any time during the measurement period with at least one claim for Medical Day services AND at least one claim for PCA services, excluding members with a claim for any other MLTSS service during the measurement period. MCO A reported 169 claims submitted for MDC and PCA during the measurement period 4/1/2020 – 6/30/2020, which calculates to 8.1% of HCBS members. This shows increase from the previous measurement period where the percentage was 7.7%. MCO A reported that 169 of the MDC recipients received Adult Day services while none received Pediatric Day services. Furthermore, MCO A reported that COVID-19 pandemic affected services this measurement period. Members were not comfortable with outside personal visiting homes and refused PCA services. Members preferred Medical Day services. Medical Day centers supported members with routine checks, doctor's visits, grocery and meal delivered. MCO A reported that data for this measure is shared with MLTSS Care Managers, so that members can be targeted for options counseling to add MLTSS-specific services. If data review indicates authorizations for MLTSS services but no claims for that period, the Provider Relations liaison will be notified to follow up with providers. For Measurement Period 4/1/2020 – 6/30/2020, MCO B reported that 308 members received both medical day and PCA services of all available MLTSS services, corresponding to 5.7%. This percentage is slightly lower than the previous measurement period. MCO B reported that COVID impact on personal care and medical day services was most during the early months of the pandemic (March/April). During this time, MCO B experienced members putting services on hold while they limited exposure and navigated the unprecedented time with their families. As the State allowed for medical day cares to resume operations with alternate services in place, MCO B saw an increase in utilization for medical day. Additionally, as PCA agencies secured PPE and began regular testing, members became more comfortable allowing them back in the homes with the necessary precautions. For this reason, MCO B did not see a large utilization shift downwards for these services. MCO B continues to monitor MLTSS members closely to ensure services are met, this includes COVID wellness calls, increasing services and extending existing services that require face-to-face visits. Additionally, MCO B is also working closely with members to anticipate any food insecurities, gaps in medication and/or DME. MCO B will continue to make an effort to avoid gaps and ensure services go uninterrupted. MCO C reported that 4% (672) members out of 17,016 had at least one claim for PCA and MDC services and did not have any other MLTSS service claims during the measurement period 7/1/2019 – 6/30/2020. Furthermore, MCO C reported that the average amount of PCA services authorized was 19 hours per week and the average amount of MDC services authorized was 5 days per week. The member's age ranged from 33 years old to 105 years old, with the average age being 79 years old. Additionally, there were no pediatric members receiving both MDC and PCA only. MCO C reported that they wll continue to monitor these members to verify that their needs are being met by the MLTSS program and will also determine if the member can benefit from additional services.

PM # 42	Follow-up after Emergency Department visit for Alcohol or Other Drug Dependence (AOD) for MLTSS HCBS members: HEDIS FUA

Deliverables due during MLTSS 3rd quarter (1/1/2021 – 3/31/2021)

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

7/1/2018 - 9/30/2018	A	B	C	D	E	TOTAL
Numerator	1	1	3	0	0	**5**
Denominator	4	10	30	0	8	**52**
%	25.0	10	10.0	0	0	**9.7**

10/1/2018 - 12/31/2018	A	B	C	D	E	TOTAL
Numerator	0	0	5	0	1	**6**
Denominator	0	8	34	7	5	**54**
%	0	0	14.7	0	20.0	**11.1**

1/1/2019 - 3/31/2019	A	B	C	D	E	TOTAL
Numerator	1	0	2	1	0	**4**
Denominator	7	10	27	5	9	**58**
%	14.3	0	7.4	20.0	0	**6.9**

4/1/2019 - 6/30/2019	A	B	C	D	E	TOTAL
Numerator	1	0	5	1	0	**7**
Denominator	7	10	37	9	11	**74**
%	14.3	0	13.5	11.1	0	**9.4**

7/1/2019 - 9/30/2019	A	B	C	D	E	TOTAL
Numerator	0	1	4	1	0	**6**
Denominator	6	13	33	9	15	**76**
%	0	7.7	12.1	11.1	0	**7.9**

10/1/2019 - 12/31/2019	A	B	C	D	E	TOTAL
Numerator	0	0	9	0	1	**10**
Denominator	7	6	31	6	10	**60**
%	0	0	29	0	10	**16.7**

1/1/2020 - 3/31/2020	A	B	C	D	E	TOTAL

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

Deliverables due during MLTSS 3rd quarter (1/1/2021 – 3/31/2021)

Numerator	2	1	5	1	0	**9**
Denominator	7	8	32	6	10	**63**
%	28.6	12.5	15.6	16.7	0	**14.3**

4/1/2020 - 6/30/2020	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	3	1	3	0	1	**8**
Denominator	7	4	30	7	12	**60**
%	42.9	25	10	0	8.3	**13.3**

7/1/2019 - 6/30/2020	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	4	2	19	1	3	**29**
Denominator	25	29	123	24	48	**249**
%	16	6.9	15.5	4.2	6.3	**11.6**

The MCOs are reporting some challenges in obtaining this data due to limited access to Medicare claims for dual eligible members. MCO C reported 30 MLTSS HCBS ED visits with a principal diagnosis of Alcohol or Other Drug Dependence during the measurement period 4/1/2020 – 6/30/2020, of which 3 (10%) had a follow-up visits that occurred within 30 days following the ED visit. Additionally, MCO C identified the top diagnoses of Alcohol or Other Drug Dependence during the measurement period to be Alcohol abuse with intoxication, unspecified at 40%. Furthermore, MCO C reported that of the 30 MLTSS HCBS ED visits, 13 (43%) were Dual Medicaid/Medicare of which 2 (15%) were enrolled in MCO C MLTSS SNP plan. MCO C reported that they will continue to track the number of follow up visits within 30 days of the ED visits for the MLTSS HCBS members with a principle diagnosis of Alcohol or Other Drug Dependence. For measurement period 7/1/2019 – 6/30/2020, MCO E reported 3 follow-up visits within 30 days of ER event identified for 2 unique members, corresponding to a 6.25% follow up rate. There were 32 unique members identified in the denominator accounting for the 48 events. Fifteen of the 32 unique members were 65 years of age or older (46.88%). There were 5 members enrolled as FIDE-SNP during the measurement period in the denominator and 1 in the numerator. Additionally, MCO E reported the diagnoses included 39 events for Alcohol Abuse related and 9 for Substance Abuse related. Furthermore, MCO E reported that timely outreach for coordination of follow up appointments for this population is a challenge, as ER visits do not require an authorization and providers have several months to submit claims. MCO E reported that they will continue to monitor claims based reporting to identify members with high utilization. These members are then discussed within the MCO E High Utilizer Task Force. The purpose of this group is to develop inter-departmental interventions to decrease ED utilization. MCO E will continue to have care management staff reinforce with members the need for notification for all ED visits to ensure ongoing appropriate follow up and care. MCO B reported that with further review, necessary changes were made to PM#42 for measurement periods 7/1/2018 -9/30/2018, 10/1/2018 – 12/31/2018, 1/1/2019 – 3/31/2019, 4/1/2019 – 6/30/2019, 1/1/2019 – 3/31/2019, 4/1/2019 – 6/30/2019, 7/1/2019 – 9/30/2019, 10/1/2019 – 12/31/2019, and 1/1/2020 –

3/31/2020 and have resubmitted their data. The updated rates for MCO B with totals are reported within the Measurement Period tables above and are indicated with red font.

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

1/1/2019 - 3/31/2019	A	B	C	D	E	TOTAL
Numerator	0	0	3	0	0	**3**
Denominator	2	0	9	3	1	**15**
%	0	0	33.3	0	0	**0.2**

4/1/2020 - 6/30/2020	A	B	C	D	E	TOTAL
Numerator	0	0	3	0	0	**3**
Denominator	0	0	9	1	0	**10**
%	0	0	33.3	0	0	**30**

7/1/2019 - 6/30/2020	A	B	C	D	E	TOTAL
Numerator	0	0	6	0	2	**8**
Denominator	1	0	20	1	3	**25**
%	0	0	30	0	66.7	**32**

The MCOs are reporting some challenges in obtaining this data due to limited access to Medicare claims for dual eligible members. MCO C reported that there were 9 MLTSS NF ED visits with a principal diagnosis of Alcohol or Other Drug Dependence during the measurement period 4/1/2020 – 6/30/2020, of which 3 (33%) had follow-up visits that occurred within 30 days after the ED visit. Additionally, MCO C identified the diagnoses of Alcohol or Other Drug Dependence during the measurement period to be (40%) Alcohol abuse with intoxication, unspecified at 33.33%. Furthermore, MCO C discovered that out of the 6 MLTSS NF ED visits that did not have a follow-up visit within 30 days, 5 (83.33%) claims were received within the 30 day window timeframe however there was no follow-up visit. MCO C reported that they are in the process of developing more frequent claims reports to identify members that have been treated in an ED for AOD dependence and will continue to track the number of follow up visits within 30 days of the ED visits for the MLTSS NF members with a principle diagnosis of Alcohol or Other Drug Dependence. For measurement period

7/1/2019 – 6/30/2020, MCO E reported that there were 2 follow up 30-days visits post-ED events identified for 1 unique member, corresponding to a 66.67% rate. The member identified in the denominator was over age 65. Additionally, results increased over the last measurement period (7/1/2018 – 6/30/2019) reported 0% in this measure to 66.67% for the current reporting measurement period. MCO E reported that the diagnoses reported were all related to alcohol abuse and timely outreach for coordination of follow up appointments for this population is a challenge for the plan, as ER visits do not require an authorization and providers have several months to submit a claims. MCO E therefore, is not aware of the visit until several months after it occurred. MCO E reported that they will continue to monitor claims based reporting to identify members with high utilization. These members are then discussed within the MCO E High Utilizer Task Force. The purpose of this group is to develop inter-departmental interventions to decrease ED utilization. MCO E will continue to have care management staff reinforce with members the need for notification for all ED visits to ensure ongoing appropriate follow up and care. MCO B reported that with further review, necessary changes were made to PM#43 for measurement periods 1/1/2019 – 3/31/2019, and have resubmitted their data. The updated rates for MCO B with totals are reported within the Measurement Period tables above and are indicated with red font.

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

7/1/2018 - 9/30/2018	A	B	C	D	E	TOTAL
Numerator	2	5	15	3	3	**28**
Denominator	8	10	46	8	5	**77**
%	25.0	50	32.6	37.5	60.0	**36.4**

10/1/2018 - 12/31/2018	A	B	C	D	E	TOTAL
Numerator	0	4	18	3	2	**27**
Denominator	2	7	44	7	12	**72**
%	0	57.1	40.9	42.9	16.7	**37.5**

1/1/2019 - 3/31/2019	A	B	C	D	E	TOTAL

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

Deliverables due during MLTSS 3rd quarter (1/1/2021 – 3/31/2021)

Numerator	1	8	16	3	0	**28**
Denominator	4	8	50	4	4	**70**
%	25.0	100	32.0	75.0	0	**40**

4/1/2019 - 6/30/2019	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	2	1	19	5	5	**32**
Denominator	5	4	41	12	8	**70**
%	40.0	25	46.3	41.7	62.5	**45.7**

7/1/2019 – 9/30/2019	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	0	11	15	9	6	**41**
Denominator	1	17	35	12	8	**73**
%	0	64.7	42.9	75	75	**56.2**

10/1/2019 – 12/31/2019	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	0	6	22	9	2	**39**
Denominator	2	12	41	13	3	**71**
%	0	50	53.7	69.2	66.7	**54.9**

1/1/2020 - 3/31/2020	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	0	10	19	9	3	**41**
Denominator	2	10	42	15	9	**78**
%	0	100	45.2	60	33.3	**52.6**

4/1/2020 - 6/30/2020	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	0	4	16	6	4	**30**
Denominator	1	4	26	6	8	**45**
%	0	100	61.5	100	50	**66.7**

7/1/2019 - 6/30/2020	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	0	28	70	28	8	**134**
Denominator	6	41	142	39	25	**253**
%	0	68.3	49.3	71.8	32	**53**

The MCOs are reporting some challenges in obtaining this data due to limited access to Medicare claims for dual eligible members. MCO C reported 26 MLTSS HCBS ED visits with a principal diagnosis of Mental Illness, and of the 26 ED visits, there were 16 (62%) follow-up visits that occurred within 30 days following the ED visit for the measurement period 4/1/2020 – 6/30/2020. Additionally, MCO C discovered that there was 1 MLTSS HCBS member that had 3 (12%) ED visits within the measurement period, of which 100% were found to have follow up visit that occurred within 30 days

after the ED visit. Furthermore, MCO C identified the top 3 diagnoses for Mental Illness during the measurement period to be Major depressive disorder, single episode, unspecified at 23.08%, Delusional disorders at 11.54% and Adjustment disorder, unspecified at 7.69%. MCO C reported that they are in the process of developing more frequent claims reports to identify members that have been treated in an ED for AOD dependence and they will continue to track the number of follow up visits within 30 days of the ED visits for the MLTSS HCBS members with a principle diagnosis of Mental Illness. For the measurement period 7/1/2019 – 6/30/2020, MCO E identified 25 qualifying events for this measure, and of the 25 qualifying events, there were 8 (32%) follow-up visits that occurred within 30 days. Additionally, MCO E reported that of the 23 unique members identified in the denominator accounting for 25 ED events, 11 members were over the age 65 (50.00%) and there were 10 FIDE- SNP members in the denominator (45.45%), of which 4 presented in the numerator. MCO E reported that breakdown of the 25 events in the denominator revealed the following: 7 events were for major depressive disorder single episode unspecified, 4 events were for schizoaffective disorder unspecified, 3 events were for bipolar disorder unspecified, 3 events were for schizophrenia unspecified, 2 events were for paranoid schizophrenia, 1 event was for adjustment disorder unspecified, 1 event was for adjustment disorder mixed anxiety depressed mood, 1 event was for delusional disorders, 1 event was for schizotypal disorder, 1 was for major depressive disorder recurrent moderate and 1 was for major depressive disorder single episode mild. MCO E reported that they will continue to monitor claims-based reporting on a regular basis as well as continue to discuss high ED utilizers within the plan's High Utilizer Task Force which focuses on interdepartmental discussion and care management interventions to decrease utilization. MCO B reported that with further review, necessary changes were made to PM#44 for measurement periods 7/1/2018 -9/30/2018, 10/1/2018 – 12/31/2018, 1/1/2019 – 3/31/2019, 4/1/2019 – 6/30/2019, 7/1/2018 – 9/30/2018, 1/1/2019 – 3/31/2019, 7/1/2019 – 9/30/2019, 10/1/2019 – 12/31/2019, and 1/1/2020 – 3/31/2020 and have resubmitted their data. The updated rates for MCO B with totals are reported within the Measurement Period tables above and are indicated with red font.

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

7/1/2018 - 9/30/2018	A	B	C	D	E	TOTAL

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

Deliverables due during MLTSS 3rd quarter (1/1/2021 – 3/31/2021)

Numerator	3	2	8	0	0	**13**
Denominator	5	3	33	1	0	**42**
%	60.0	66.7	24.2	0	0	**30.9**

10/1/2018 - 12/31/2018	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	3	1	5	2	0	**11**
Denominator	4	1	26	5	0	**36**
%	75.0	100	19.2	40.0	0	**30.5**

1/1/2019 - 3/31/2019	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	8	0	5	3	0	**16**
Denominator	13	0	24	3	0	**40**
%	61.5	0	20.8	100	0	**40**

4/1/2020 - 6/30/2020	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	0	0	5	0	0	**5**
Denominator	0	1	13	0	0	**14**
%	0	0	38.5	0	0	**35.7**

7/1/2019 - 6/30/2020	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	0	0	25	4	0	**29**
Denominator	0	1	60	7	0	**68**
%	0	0	41.7	57.1	0	**42.6**

MCOs are reporting some challenges in obtaining this data due to dual eligible members and limited access to Medicare claims. MCO C reported there were 13 MLTSS NF ED visits with a principal diagnosis of Mental Illness, and of the 13 ED visits, there were 5 (38%) follow-up visits that occurred within 30 days following the ED visit for the measurement period 4/1/2020 – 6/30/2020. Additionally, MCO C discovered that there was 1 MLTSS NF member that had 2 (15%) ED visits within the measurement period, of which 100% were found to have follow up visit that occurred within 30 days after the ED visit. MCO C also identified the top diagnosis for Mental Illness during the measurement period to be schizoaffective disorder, unspecified at 23.08%. Furthermore, MCO C reported that of the 13 MLTSS NF ED visits, there were 9 (69%) Dual Medicaid/Medicare. MCOC reported that they are in the process of developing more frequent claims reports to identify members that have been treated in an ED for AOD dependence and will continue to track the number of follow up visits within 30 days of the ED visits for the MLTSS NF members with a principle diagnosis of Mental Illness. For measurement period 7/1/2019 – 6/30/2020, MCO D reported that there were 7 ED visits for eligible MLTSS NF members with a principle diagnosis of Mental Illness and of the 7 ED visits, there was a record of 4 claims for a qualifying follow-up visit that occurred within thirty days after an ED visit for MLTSS NF members with a principal diagnosis of Mental Illness. MCO E reported that no patterns were identified in discovery due to the small sample size. MCO E will continue to monitor emergency room discharges for MLTSS NF members with a diagnosis of Mental Illness. MCO B reported that with further review, necessary changes were made to PM#45 for measurement

periods 7/1/2018 – 9/30/2018, 10/1/2018 – 12/31/2018, and 1/1/2019 – 3/31/2019 and have resubmitted their data. The updated rates for MCO B with totals are reported within the Measurement Period tables above and are indicated with red font.

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

7/1/2019 - 9/30/2019	A	B	C	D	E	TOTAL
Numerator	N/A	N/A	N/A	N/A	N/A	**N/A**
Denominator	N/A	N/A	N/A	N/A	N/A	**N/A**
%	N/A	N/A	N/A	N/A	N/A	**N/A**

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

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

4/1/2020 - 6/30/2020	A	B	C	D	E	TOTAL
Numerator	N/A	N/A	N/A	N/A	N/A	**N/A**
Denominator	N/A	N/A	N/A	N/A	N/A	**N/A**
%	N/A	N/A	N/A	N/A	N/A	**N/A**

7/1/2019 - 6/30/2020	A	B	C	D	E	TOTAL
Numerator	N/A	N/A	N/A	N/A	N/A	**N/A**
Denominator	N/A	N/A	N/A	N/A	N/A	**N/A**
%	N/A	N/A	N/A	N/A	N/A	**N/A**

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

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

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

7/1/2019 - 9/30/2019	A	B	C	D	E	TOTAL
Numerator	N/A	N/A	N/A	N/A	N/A	**N/A**
Denominator	N/A	N/A	N/A	N/A	N/A	**N/A**
%	N/A	N/A	N/A	N/A	N/A	**N/A**

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

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

4/1/2020 - 6/30/2020	A	B	C	D	E	TOTAL
Numerator	N/A	N/A	N/A	N/A	N/A	**N/A**
Denominator	N/A	N/A	N/A	N/A	N/A	**N/A**
%	N/A	N/A	N/A	N/A	N/A	**N/A**

7/1/2019 - 6/30/2020	A	B	C	D	E	TOTAL
Numerator	N/A	N/A	N/A	N/A	N/A	**N/A**
Denominator	N/A	N/A	N/A	N/A	N/A	**N/A**
%	N/A	N/A	N/A	N/A	N/A	**N/A**

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

Deliverables due during MLTSS 3rd quarter (1/1/2021 – 3/31/2021)

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

PM # 18A	% of CIs the MCO became aware of during the measurement period that were reported to the State
Numerator:	# of CIs in the denominator reported to the State as of the 7th day of the month following the end of the measurement period
Denominator:	# of CIs the MCO became aware of during the measurement period
Data source:	MCO
Measurement period:	10/1/2020 – 12/31/2020

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

PM # 18B	% of CIs in the denominator the MCO reported to the State within 2 business days
Numerator:	# of CIs in the denominator that were reported to the State within two business days
Denominator:	# of CIs the MCO became aware of during the measurement period
Data source:	MCO
Measurement period:	10/1/2020 – 12/31/2020

Deliverables due during MLTSS 1st quarter (7/1/2020 – 9/30/2020)

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

PM # 18C	% of CIs that the MCO became aware of during the measurement period for which a date of occurrence was available
Numerator:	# of CIs in the denominator for which a date of occurrence is known
Denominator:	# of CIs the MCO became aware of during the measurement period
Data source:	MCO
Measurement period:	10/1/2020 – 12/31/2020

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

PM # 18D	Of those CIs with a known date of occurrence, average # of days from date of occurrence to date MCO became aware
Numerator:	Sum of days from date of occurrence to date MCO became aware of the CI
Denominator:	# of CIs the MCO became aware of during the measurement period for which a date of occurrence is known
Data source:	MCO
Measurement period:	10/1/2020 – 12/31/2020

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

1115 Comprehensive Waiver Quarterly Report
Demonstration Year 9
Federal Fiscal Quarter: 3 (1/01/21-3/31/21)
Department of Children and Families
Division of Children's System of Care

STC 73(n) A summary of the outcomes of the State's Quality Strategy for HCBS as outlined above - CSSP I/DD Waiver

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

#2 Quality of Life Sub Assurance	All youth that meet the clinical criteria for services through the Department of Children and Families (DCF), Division of Children' s System of Care (CSOC) will be assessed utilizing the comprehensive Child and Adolescent Needs and Strengths (CANS) assessment tool
Data Source	Review of Child and Adolescent Needs and Strengths scores Contracted System Administrator (CSA) Data Data report: CSA NJ1225 Strengths & Needs Assessment – Post SPC Start
Sampling Methodology	100% New youth enrolled in the waiver
Waiver	**I/DD**
Numerator: Number of youth receiving Child and Adolescent Needs	131

and Strengths (CANS) assessment	
Denominator: Total number of new enrollees	132
Percentage	99%

One youth was eligible from 3/1/2021 – 3/30/2021 and was enrolled in the CMO on 3/25/2021. This youth was enrolled near the end of the report period and did have the required Strength and Needs Assessment (SNA) The SNA occurred on 4/14/2021, which was after this report reporting quarter.

#3 Quality of Life Sub Assurance	80% of youth should show improvement in Child and Adolescent Needs and Strengths composite rating within a year
Data Source	CSA Data on CANS Initial and Subsequent Assessments Data report: CSA NJ2021CANS Waiver Outcome
Sampling Methodology	Number of youth enrolled in the waiver for at least 1 year
Waiver	**I/DD**
Numerator: Number of youth who improved within one year of admission	699
Denominator: Number of youth with Child and Adolescent Needs and Strengths assessments conducted 1 year from admission or last CANS conducted	769
Percentage	91%

#4 Level of Care Sub Assurance	CSOC's Contracted System's Administrator (CSA), conducts an initial Level of Care assessments (aka Intensity of Services (IOS) prior to enrollment for all youth
Data Source	CSA Data report: CSA NJ1218 New Enrollees, Quarterly Count and IOS Completed
Sampling Methodology	100% new youth enrolled in the waiver
Waiver	**I/DD**
Numerator: Number of youth receiving initial level	137

of care determination prior to enrollment	
Denominator: Number of new enrollees	138
Percentage	99%

One youth had an incorrect transition date for CMO in their CYBER record as 2019 instead of 2021. This measure should be 100%.

#5 Plan of Care Sub Assurance	The Plan of Care (aka Individual Service Plan (ISP)) is developed based on the needs identified in the Child and Adolescent Needs and Strengths assessment tool and according to CSOC policies
Data Source	CSA Data on Plans of Care completions, Record Review Data report: CSA NJ1219 Follow – Up Treatment Plan and Associated SNA
Sampling Methodology	100% of youth enrolled during the measurement period
Waiver	**I/DD**
Numerator: Number of Plans of Care that address youth's assessed needs	130
Denominator: Number of Plans of Care reviewed	132
Percentage	98%

One youth was eligible from 3/1/2021 – 3/30/2021 and was enrolled in the CMO on 3/25/2021. This youth was enrolled near the end of the report period and did have a Treatment Plan on 4/14/2021, but that was after this reporting period. Another youth was identified as not having an appropriate treatment plan during the reporting period. An inquiry into this youth's situation was escalated as this was outside the typical treatment plan schedule.

#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	100% of youth enrolled during the measurement period

Methodology	
Waiver	**I/DD**
Numerator: Number of current Plans of Care updated at least annually	233
Denominator: Number of Plans of Care reviewed	233
Percentage	100%

#7 Plan of Care Sub Assurance	Services are authorized in accordance with the approved plan of care Data Report: CSA NJ1220 Waiver Services Provided
Data Source	CSA Data Report of Authorizations Record Review
Sampling Methodology	100% of youth enrolled during the measurement period
Waiver	**I/DD**
Numerator: Number of Plans of Care that had services authorized based on the Plan of Care	131
Denominator: Number of Plans of Care reviewed	132
Percentage	99%

One youth became eligible for CSSP I/DD near the end of their involvement with CMO and was transitioned on 4/5/2021. Eligible services for this youth were discontinued on 1/25/2021. This may be an IT issue and it has been reported.

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

Number of services that were authorized	
Percentage	In Development

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

#9 Plan of Care Sub Assurance	Youth/families are provided a choice of providers, based on the available qualified provider network
Data Source	Record review Statewide CSA Data Report: NJ1384 Provider List - CSA Data Report
Sampling Methodology	Random sample representing a 95% confidence level
Waiver	I/DD
Numerator: Number of youth/families given a choice of providers as indicated in progress notes	496
Denominator: Number of records reviewed	661
Percentage	75%

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

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

prior to furnishing waiver services	
Denominator: Total number of new providers	0
Percentage	N/A

No new waiver providers were enrolled during this reporting period.

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

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

Total number of providers that provide waiver services	
Percentage	In Development

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

# 13 Health and Welfare Sub Assurance	The State demonstrates on an on-going basis, that it identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation
Data Source	Review of UIRMS database and Administrative policies & procedures
Sampling Methodology	100% of youth enrolled for the reporting period
Waiver	**I/DD**
Numerator: Total number of UIRs submitted timely according to State policies	14
Denominator: Number of UIRs submitted involving enrolled youth	14
Percentage	100%

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

Percentage	100%

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

No incidents of restraints were documented this quarter.

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

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

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