



***New Jersey Comprehensive Waiver Demonstration  
Section 1115 Annual Report  
Demonstration Year 5: July 1, 2016 – June 30, 2017***

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## I. Introduction

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

This five year demonstration will:

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

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

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

This annual report is submitted in accordance with Special Term and Condition (STC) 102 of the NJCW.

## **II. STC 102(a): Accomplishments, Project Status, Quantitative and Case Study Findings, Interim Evaluation Findings, and Policy and Administrative Difficulties and Solutions in the Operation of the Demonstration.**

During Demonstration Year 5 (DY5), the state continued its progress toward implanting the NJCW. The Managed Long Term Services and Supports (MLTSS) program celebrated its third anniversary on July 1, 2017, the Department of Children and Families (DCF) continued building its Autism Spectrum Disorder (ASD) and Individuals with Intellectual Disabilities with Co-Occurring Mental Illness (ID/DD-MI) pilot programs, and the Supports Program has enrolled 2539 individuals this year.

### *Managed Long Term Services and Supports Program*

The launch of MLTSS was a major shift of how services were delivered to individuals who were in need of long term care. The Managed Care Organizations (MCOs) and the Office on Community Choice Options (OCCO) had to complete and validate over 11,000 NJ Choice assessments affirming that individuals who were transitioned from the four former 1915(c) waivers still met nursing facility level of care.

MLTSS also carves-in the behavioral health benefit into the MCO allowing for greater integration for physical, behavioral and long term care benefits.

Following the transition to MLTSS on July 1, 2014, the state has maintained its efforts to ensure that consumers, stakeholders, MCOs, providers and other community-based organizations have learned and are knowledgeable about the move to managed care. The state has depended on its relationships with stakeholder groups to inform consumers about the implementation of MLTSS. In turn, stakeholders have relayed accurate information to consumers. This strategy has continued in the post-implementation phase.

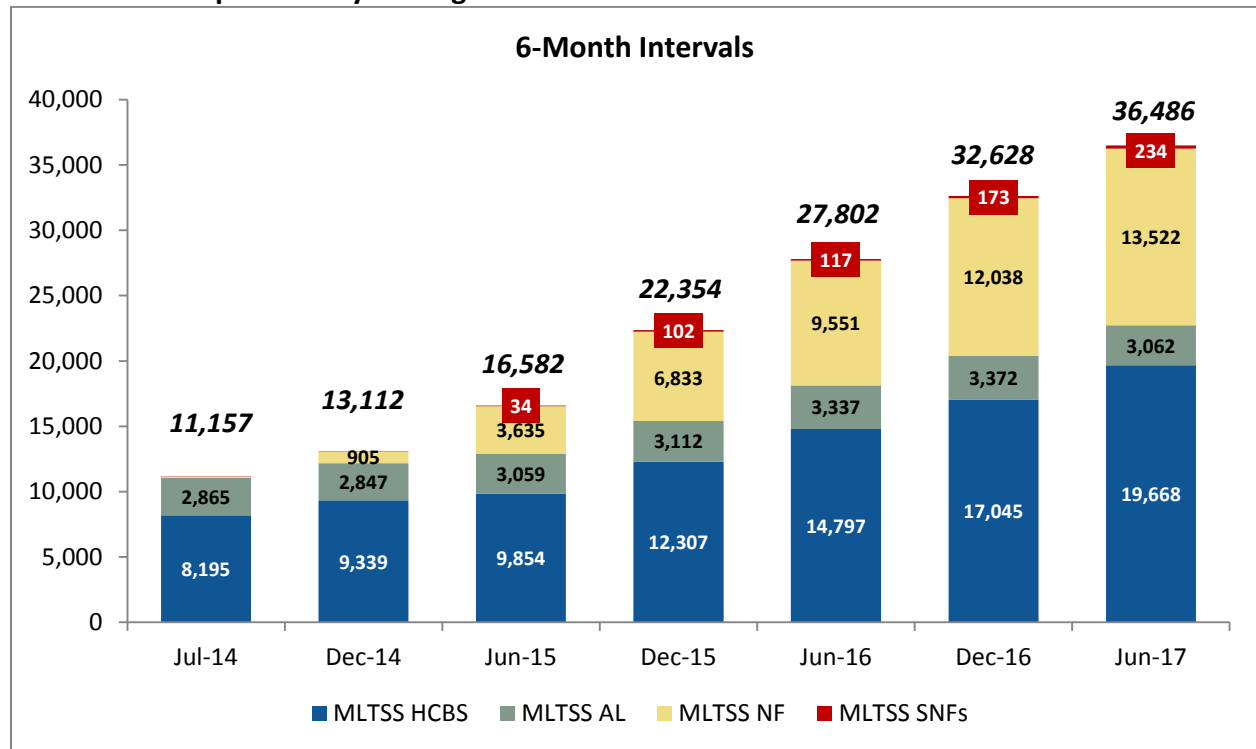
The Division of Aging Services (DoAS) is the primary liaison to the aging and disability networks. The DoAS has oversight of the Aging and Disability Resource Connection (ADRC) partnership as the single entry/no wrong door system for consumers to access MLTSS. The state continues to meet with groups ranging from the Human Services Directors, the 21 Area Agencies on Aging (AAAs), the County Welfare Agencies (CWAs) to the State Health Insurance Assistance Program (SHIP) counselors and Adult Protective Service (APS) providers on a regular basis.

The DMAHS Office of Managed Health Care (OMHC), with its provider relations unit, has been at the forefront in spearheading communications efforts to ensure access through its provider networks in the following categories—HCBS medical; HCBS non-medical; nursing homes; assisted living providers; community residential providers and long-term care pharmacies. As a resource to stakeholders, OMHC addresses provider inquiries on MCO contracting, credentialing, reimbursements, authorizations and appeals. It also handles provider inquiries, complaint resolution and tracking with a dedicated email account for providers to directly contact the Office of Managed Health Care.

The State has had bi-weekly conference calls with the Managed Care Organizations (MCOs) during the demonstration year to review statistics and discuss and create an action plan for any issues that either the State or the MCOs are encountering. Also, state staff from various divisions who are involved in MLTSS meet weekly to discuss any issues to ensure that they are resolved timely and in accordance with the rules and laws that govern the Medicaid program.

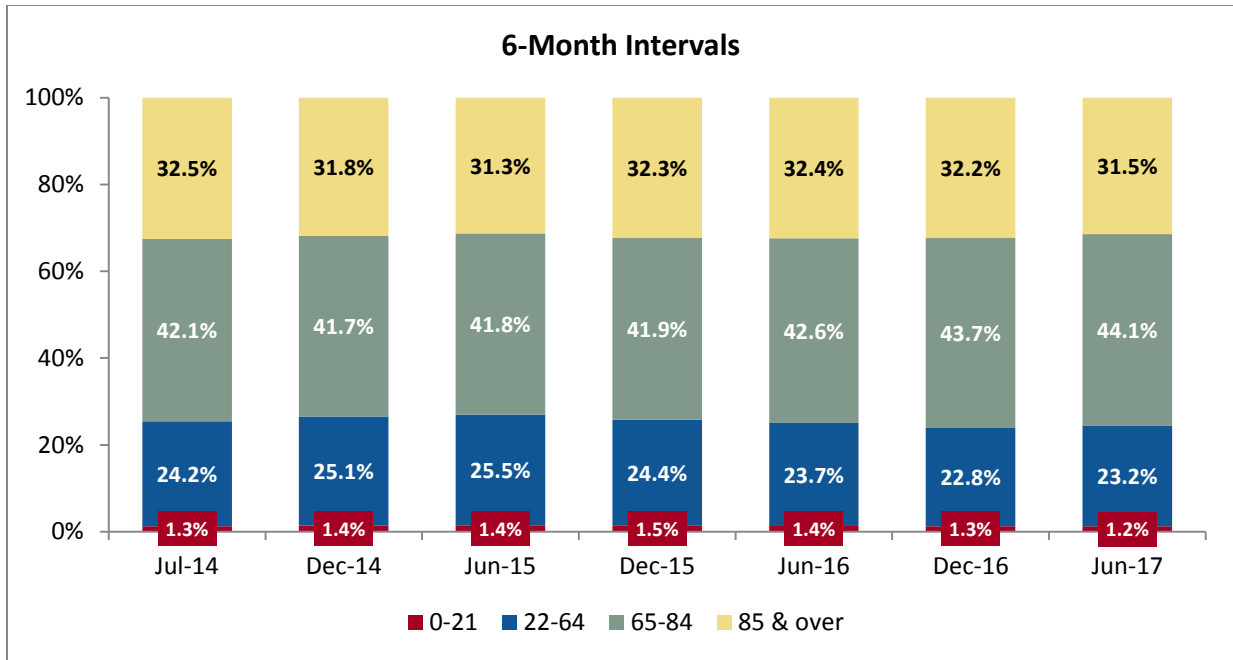
As of June 30, 2017, a total of 36,420 individuals were enrolled in MLTSS. As shown in the chart below, as the program has grown and evolved, more individuals are enrolled in Home and Community-Based (HCBS) settings than Nursing Facilities (NF). Please note that the growth of the NF population since July 1, 2014 is due to new NF enrollees and individuals moving from fee-for-service into MLTSS. The overall NF population has decreased since July 2014 by almost 1,400 people.

### Total MLTSS Population by Setting



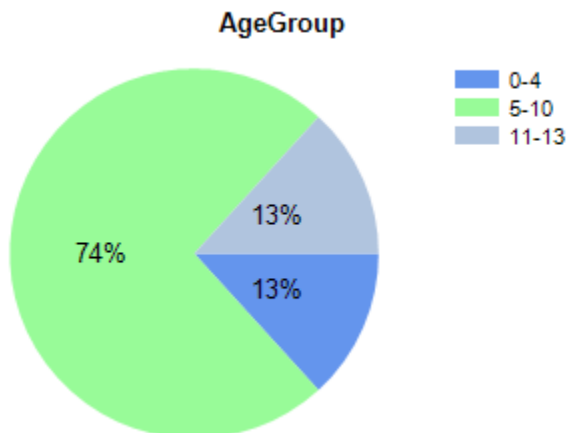
Below is a breakdown of MLTSS participants by age group. The largest segment group of individuals enrolled in MLTSS is between 65 and 84 years of age. Over 75 percent of the MLTSS population is ages 65 and older.

### MLTSS Population by Age Group

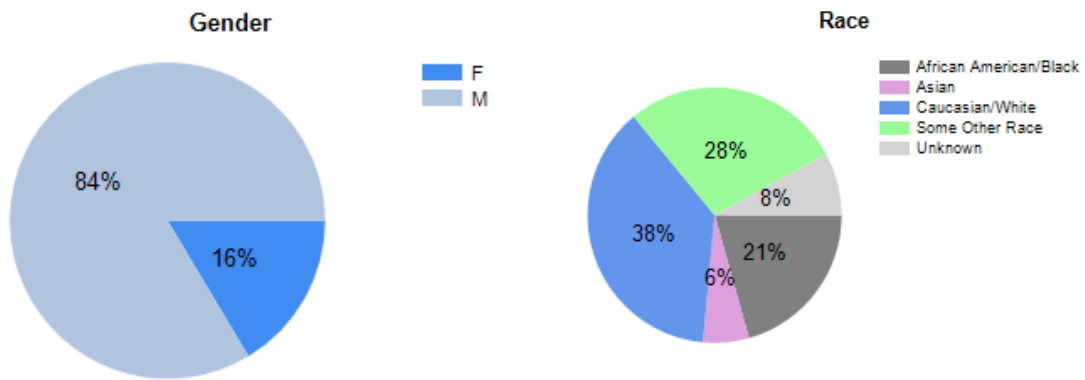


### Autism Spectrum Disorder (ASD) Waiver

As indicated in the chart below the age range of the youth enrolled in the ASD waiver are from 0-13 years old. The largest age group represented is between 5-10 years old which represents 74% of the enrolled youth, a 10% decrease from last year's report. There was a 9% increase in those youth under four years old being added to the waiver representing 13% of the youth versus 4% a year ago. This is consistent with the increase of early intervention strategies and ASD being diagnosed earlier. There was also an increase of 1% in the 11-13 year old group, this 1% shift from the 5-10 year old group is attributed to youth on the waiver aging an additional year and be counted in the last grouping.



The gender distribution of the youth is 84% Male and 16% Female. Additionally, 28% (down from 35% a year ago) youth identified race as 'Some Other Race', 21% as African American and 38% as Caucasian, 6% as Asian and 8% were unknown; 35% of youth identified Hispanic as their ethnicity.

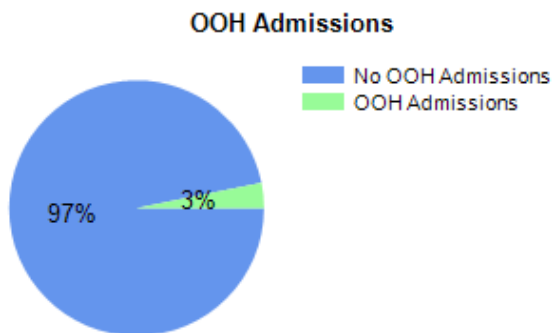


Youth were represented fairly evenly across NJ. The majority of youth (13%) resided in Essex County, followed by Monmouth; with Bergen, Burlington, Camden, and Ocean counties following up with equal percentages.

Parents Home County	Percent
ATLANTIC	11%
BERGEN	6%
BURLINGTON	12%

CAMDEN	10%
CAPE MAY	1%
CUMBERLAND	0%
ESSEX	11%
GLOUCESTER	4%
HUDSON	3%
MERCER	3%
MIDDLESEX	6%
MONMOUTH	13%
MORRIS	3%
OCEAN	12%
PASSAIC	2%
SALEM	1%
SOMERSET	1%
UNION	3%

During this reporting period only 3% of the youth (2% reduction from the year before) entered OOH care during this period. 97% (the majority) of the youth (97%) remained in home/in community with the waiver supports and services. Children’s System of Care (CSOC) is pleased to report that a year later, fewer youth required OOH services.

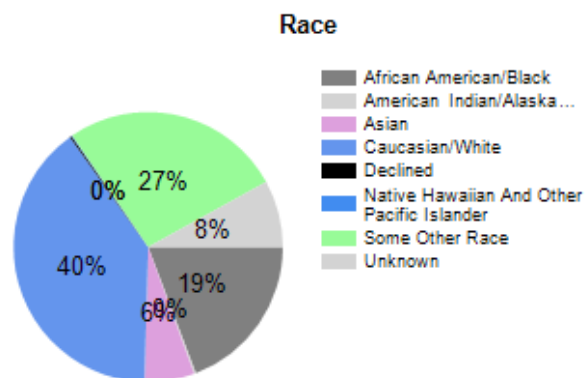


Autism Spectrum Disorder Pilot, Intellectual Disability/Developmental Disability with Co-occurring Mental Illness Pilot, Serious Emotional Disturbance Program

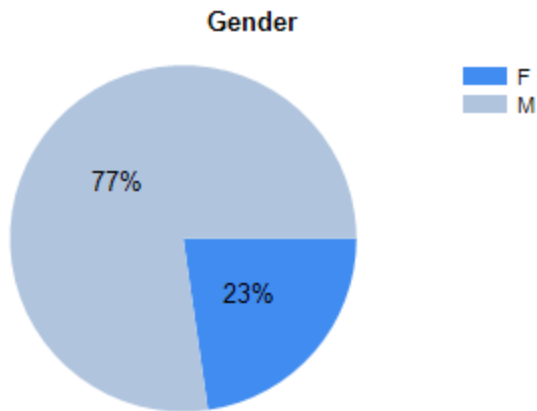
Youth eligible for the ASD and ID/DD-MI pilots began enrolling in March of 2015. The Department of Children and Families (DCF), CSOC has provided and is continuing to provide ongoing support to providers as it relates to procedures and expectations for the programs. CSOC has also work closely with their stakeholders to ensure that the needs of the community are being heard. CSOC reviewed the data for youth enrolled in the programs, during the time period covering July 2016 - June 2017. The goal of this report was to assure that the use of waiver services (therapeutic services and functional supports) that the youth received did indeed have a positive outcome as reflected by the youth remaining in their own home with waiver supports, thereby diverting youth from more costly out of home care.

ID/DD-MI Waiver

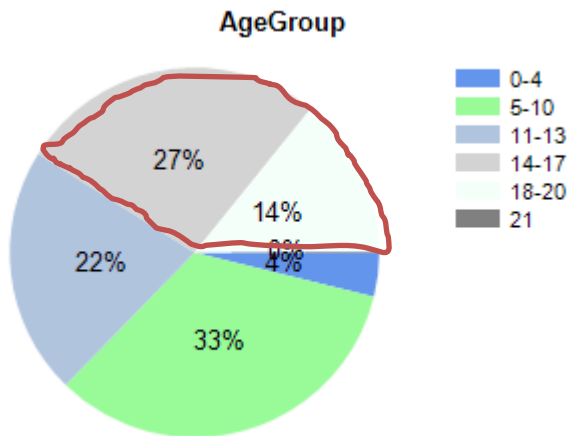
In the ID/DD-MI waiver during the period covering July 1, 2016 - June 30, 2017 there was an identical distribution of males to females. Last year's report included a representation of 23% female and 77% male. The race composition in both this and last year's report was similar for the African American/Black representing 19% vs. 20%.



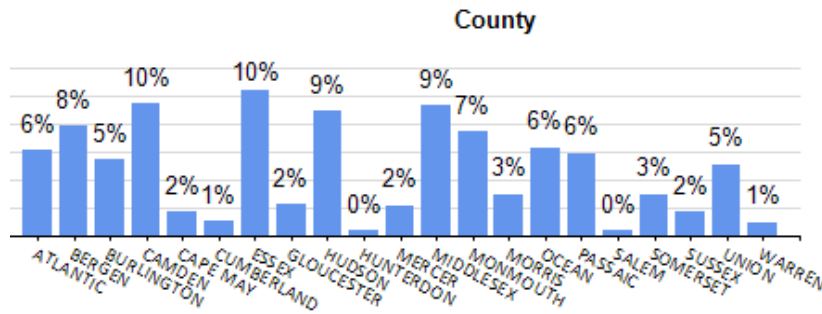




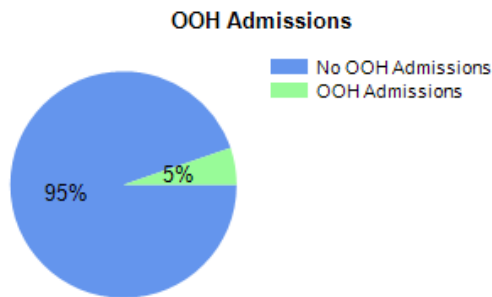
It should be noted that the ID/DD-MI waiver includes youth up to 21 years of age and youth older than 13 represented 41% of the youth served. One youth turned 21 during the waiver period and was dis-enrolled from the waiver when he transitioned into the adult system.



Youth were represented fairly evenly across the region in this review as well. The majority of the population resides in counties typically where major urban cities of NJ are located. Camden, Essex, Hudson, Middlesex, and Monmouth counties had the highest percentage of youth in the waiver.



During this period the results were similar to the ASD waiver, yet there were slightly more youth (5%) that required being admitted into an Out of Home program (OOH).



The data from this report demonstrates that waiver services when implemented in home/in community promote successful outcomes as evident by the number of youth that remained home vs. those that required subsequent out of home care/treatment. While all of the youth identified in this report were CMO involved and at risk of out of home care, at least 95% of the youth remained in home, in HCBS supports and services.

Supports Program

The Supports Program, operated by the Division of Developmental Disabilities (DDD), enrolled 2539 individuals this year. The Department of Human Services (DHS) awarded funding for Fiscal Services Management and all entities involved worked to fully establish Public Partnerships LLC (PPL) as the fiscal intermediary for participant-directed services and supports for individuals served through the Supports Program. The shift to utilizing PPL for all Fiscal Intermediary (FI) services began in July of 2017 and continues presently. DDD continued providing ongoing

opportunities for stakeholders to receive updated information, ask questions, and voice concerns and feedback through quarterly meetings with providers and individuals/families, regularly scheduled webinars, emails, and more specific meetings with individuals/families and providers. The Supports Program participated in the DMAHS Quality Management Unit Comprehensive Audit Review and received the final report indicating that the Supports Program was in compliance with all sub-assurances and a Corrective Action Plan was not required for any sub-assurance based on the results of the audit. A revised Supports Program Policies & Procedures Manual was released based on feedback received from stakeholders, revisions that were made to policies after implementation, and new standards. As services continued to be more widely utilized based on the increased enrollment into the program, issues were identified and addressed. As a result, revisions were made to the various categories available under respite to include camp and further detail overnight respite provided out of the home. In addition, the criteria for classes to be funded through Goods & Services were slightly expanded to ensure individuals had the opportunity to attend these classes provided through generic businesses while ensuring that the class was distinguished from day habilitation.

#### Interim Management Entity:

In January 2015, Governor Chris Christie announced that the Department of Human Services was developing an interim managing entity (IME) for addiction services as the first phase in the overall reform of behavioral health services for adults in NJ. The state identified University Behavioral Health Care (UBHC) within Rutgers University to develop and implement the IME through a Memorandum of Understanding with the Division of Mental Health and Addiction Services. The IME ensures that individuals are receiving the right level of care for the appropriate duration and intensity. This allows the state to manage its resources including Medicaid and other state funds in the continuum of care.

The IME has been designed to provide 24/7 availability for callers; screening for risk and service needs; referral using a bed management system; care coordination to assist individuals to enter care and move through the continuum; utilization management activities which include authorizing and monitoring levels and duration of care; verifying eligibility for Medicaid; and, referral for the Medicaid member to appropriate Medicaid covered service to Medicaid providers.

#### July 1, 2016 to June 30, 2017

Effective July 1, 2016 all Medicaid and State funded Substance Use Disorder (SUD) treatment services required clinical review for appropriate level of care and full utilization management by the IME. To continue to facilitate this change the IME has continued to work with providers using their provider assistance hotline and has hosted additional provider trainings on using ASAM for appropriate level of care determinations and treatment authorizations. The IME and the Department of Human Services have also coordinated Provider webinars and provider assistance calls with FAQ's published on the department website. The IME has participated in

provider targeted assistance for new and/or struggling providers in cooperation with Division of Mental Health and Addiction Services (DMHAS) and Division of Medical Assistance and Health Services (DMAHS).

<b>IME Utilization Management</b>			
D.Y. 5 July 1, 2016 to June 30, 2017	Initial Level of Care reviews/treatment requests	Clinical Care extension requests	Provider Assistance Hotline Calls
	30,675	12,194	11,959

The IME continues to operate the 24 hour addiction services hotline for Medicaid and uninsured individuals or family members who are seeking treatment for Substance Use Disorders. The IME hotline has also met with and coordinated procedures with the NJ Reach hotline that began this year as a single point of entry for anyone seeking SUD treatment, support or information to ensure swift and appropriate referral.

<b>IME Call Center</b>			
D.Y. 5 July 1, 2016 to June 30, 2017	Calls Received	Calls referred to treatment	Calls sent to Care Coordination
	64,148	6,048	4,029

DY5 has been the first complete year for the operation of the IME’s Utilization Management (UM) services for managing Medicaid and state or grant funded services. The IME has begun reporting data they collect regarding level of care treatment requests, payer source usage data, and tracking of wait lists for critical levels of care.

The following graph submitted by the IME shows treatment authorizations issued by payer source from May of 2016 through June 2017. Medicaid recipients account for 81% of the IME authorizations have been provided.

*Evaluation of the Demonstration*

The Rutgers Center for State Health Policy (CSHP) work during this year included the release of the summary of the Draft Final Waiver Evaluation. This report can be found as Attachment A.

### **III. STC 102(d)(i): A Report of Service Use by Program Including Each HCBS Program (encounter data)**

Service Use data for the MLTSS, ASD, ID/DD-MI, SED, and Supports Program is included in Attachment B at the end of this report.

### **IV. STC 102(d)(ii): A Summary of the Use of Self-directed Service Delivery Options in the State**

#### **Overview of Self-Direction**

Self-Direction is a philosophy and an alternative service delivery mechanism for home and community based services whereby informed consumers gauge their own needs, determine how and by whom these needs should be met, and monitor the quality of services received. Consumers have both budget authority and employer authority to make choices that work for them. Budget authority allows consumers to choose how they wish to spend their monthly allowance within program guidelines. Employer authority allows consumers to become common law employers so they can choose who they want to hire to provide direct care.

Self-direction may exist in different degrees and span many types of services, ranging on a continuum from an individual making all decisions to an individual using a representative to manage needed services. Research has found that consumers who participate in self-directed service delivery models report increased satisfaction with their homecare services as well as increased quality of services.

#### **Self-Directed PCA (Personal Preference)**

New Jersey began providing self-directed services as an option to State Plan Medicaid Personal Care Assistance (PCA) Services in 1999 through the Cash and Counseling Demonstration Project, otherwise known as Personal Preference. Personal Preference became a permanent program under a CMS 1915j authority in 2008. As of June 2017, 9,308 consumers were actively participating in Personal Preference. The average monthly budget was \$1,407.77 which equates to approximately 21.67 hours of PCA services per week.

Participants use the majority of their monthly budgets to hire individual workers to provide ADL assistance. Some participants choose to purchase goods and services in lieu of personal care. For example, a consumer may choose to purchase a washer and dryer so he/she can do laundry on their own or so that the worker does not have to spend time out of the home at a Laundromat, allowing the consumer to be independent and not relying on the care provider or freeing the worker up to complete additional care once the laundry can be completed in the home. Participants that purchase goods and services most often purchase small appliances such as microwaves, washer/dryer, toaster ovens, disposable medical supplies including wipes

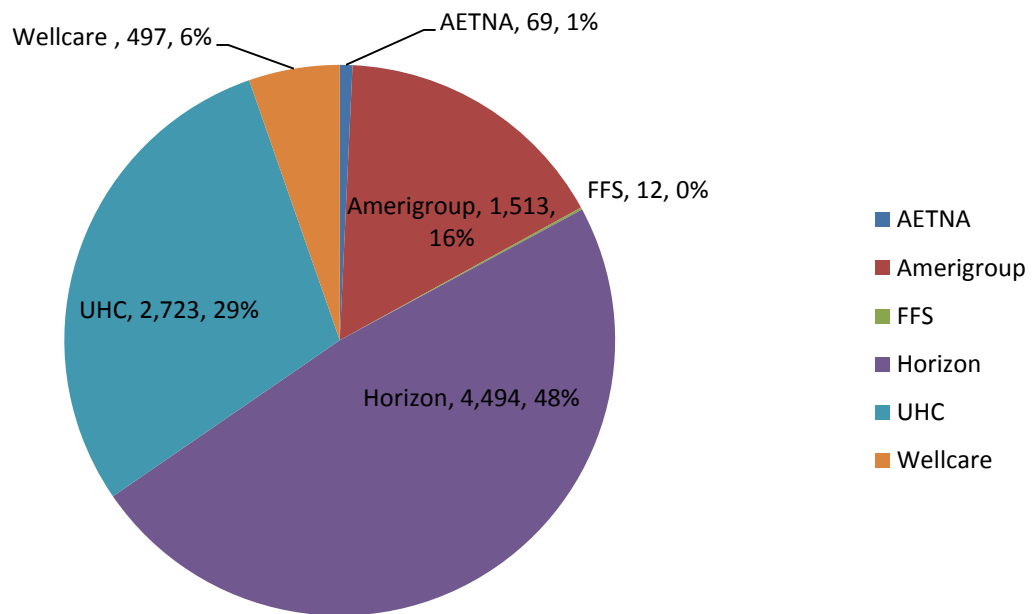
and gloves and other supports such as, transportation and laundry services. Approximately 22% of participants were purchasing these types of goods and services.

From 2008 to July 2011, approximately 30-50 new consumers enrolled each month. During this time, consumers only learned about Personal Preference through word of mouth. There was no formal marketing strategy to enroll consumers. With the inclusion of PCA services, including Personal Preference into Medicaid Managed Care in 2011, enrollment began to increase to about 75-100 new participants each month and has been increasing steadily to date. In the last 12 months, average enrollment has been approximately 257 participants each month. The highest month of enrollment in program history was in December 2016 with a total of 418 new participants. The reason behind increased enrollment continues to be due to the obligation of the Managed Care Organizations to inform their members of the option to self-direct home care services pursuant to CMS regulation. We have also found that some of the MCOs are having difficulty staffing cases through the traditional PCA model.

**•Active Participants by MCO**

As of June 2017, there were 9,308 active consumers enrolled in the Personal Preference Program. The percentage of enrolled consumers by MCOs has increased 14% from 2016.

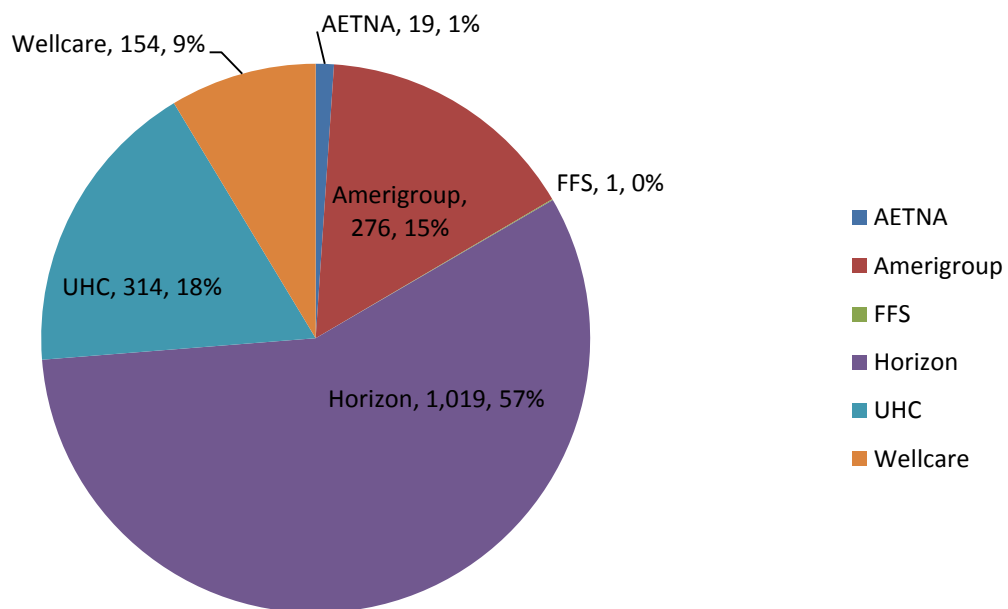
**Personal Preference Program Enrollment June 2017**



**•Active MLTSS Participants by MCO**

Of the total 9,308 active participants, 1,783 were enrolled in Managed Long Term Supports and Services (MLTSS).

**MLTSS Enrollment In Personal Preference June 2017**



Horizon NJ Health has historically maintained the largest enrollment of its members in the Personal Preference Program. While approximately fifty percent of all active participants in Personal Preference are with Horizon NJ Health, 57% of these consumers are enrolled in MLTSS. The percentage remained the same as 2016. WellCare total enrollment of their members in Personal Preference increased by 2% in 2017 but of those members 9% are enrolled in MLTSS as compared to 7% in 2016, demonstrating a slight increase in MLTSS enrollment.

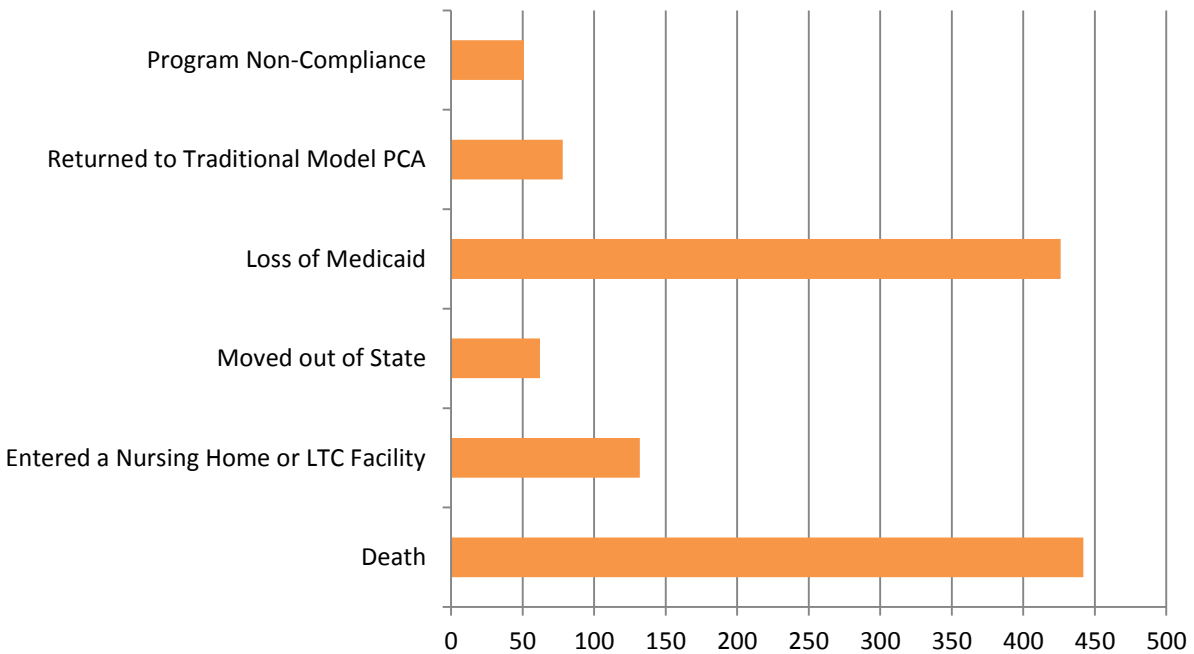
**•Proportion of Active Enrollment and MLTSS Enrollment**

Managed Care Organization	Active Personal Preference Enrollment	Active MLTSS Enrollment
Aetna	1%	1%
Amerigroup	16%	15%
Horizon NJ Health	48%	57%
United Health Care	29%	18%
WellCare	6%	9%

**•Reasons for Disenrollment from PPP**

Consumers disenroll from Personal Preference for a variety of reasons. They are outlined in the chart below.

**Discontinued Participant Details - # of Cases  
July 2016 through June 2017**



In reviewing data, for those consumers who returned to traditional agency model PCA services, the reason continues to most often be due to increased medical need/clinical deterioration and lack of family support to meet the responsibilities of self-direction. Please note that consumers who have disenrolled due to a decline in health or hospitalization, may have subsequently returned to traditional agency model PCA services, entered a LTC facility or may have passed away since their disenrollment from the program. These findings are proportionally similar for



all consumers, whether or not they are enrolled in MLTSS. One difference from the previous year is an increase in the number of consumers who have been terminated due to program non-compliance. This is attributed to growth in enrollment as well as the Divisions efforts to mitigate fraud and abuse.

Other significant information that does not appear on the above chart but deserves to be mentioned relates to consumers who are referred to Personal Preference, but do not complete the enrollment process. Each month there is approximately a half dozen consumers that complete the enrollment process but withdraw prior to their start date, because their worker fell through. About 5 percent of consumers that are referred to Personal Preference do not complete the enrollment process. The most common reasons include, not being able to find a worker, not able to identify a Representative to assist in managing the program, the program is more responsibility than they had realized and the program was not what they thought it would be.

**•Major Disabilities and/or Diagnosis of Self-Directed Participants**

<b>Disabilities and/or Diagnosis of Self-Directed Participants</b>
Alzheimer’s/Dementia
Chronic Obstructive Pulmonary Disease (COPD)
Spinal Cord Injury (SCI)
Intellectual Disability
Autism
Traumatic Brain Injury (TBI)
Cerebral Ventricular Accident (CVA)
Elderly*
Chronic Pain

\*Elderly is a term used to describe the group of multi-system symptoms associated with ageing and the routine deterioration of functional ability.

We speculate that Alzheimer’s/Dementia and Spectrum Disorders are common due to the nature of the disability in that consumers require consistency among caregivers and routine. Self-direction affords a family the ability to self-hire caregivers of their choice with the requisite consistency and flexibility needed to maintain a loved one in decline in the community. These are not always elements that are available from the traditional home care agency.

Many participants experience co-morbid diagnoses which include: hypertension, diabetes, depression and anxiety.

**Self-Direction under MLTSS**

Based on the success of self-directed PCA services, DHS in its creation of MLTSS developed additional self-directed services to meet the various needs of the MLTSS population in an HCBS environment. One of the purposes of offering these self-directed options was to provide a consumer with the mechanism to purchase unique goods & services previously not available under the Medicaid program. For example, one of the MCOs determined that many of its members were having adverse health effects caused by their homes being excessively hot. In an effort to maintain the individual's health and safety while maintaining them in their home in lieu of an institutional setting, the MCO opted to purchase window air conditioners and were only able to do so using the self-directed mechanism which allowed for the purchase of non-routine items.

DDS administers the Self-Directed Service options available to consumers under MLTSS which include:

Chore Services – supports designed to help an individual maintain a clean and safe home environment. Chores covered by this service include: cleaning appliances, cleaning carpets and scrubbing floors, washing walls and windows, cleaning attics and basements to remove fire and health hazards, clearing walkways of ice, snow and leaves, replacing fuses, light bulbs, electric plugs, frayed cords, replacing door locks, window catches, faucet washers, installing safety equipment like smoke detectors, fire extinguishers and grab bars and “Spring Cleaning” and weatherization.

Non-Medical Transportation – is a service which helps individuals to gain access to community services, activities and resources which enhance the individual's life. This service is offered in addition to medical transportation. Transportation covered by this service include: shopping, beauty salon, financial institution and religious services.

Home Based Supportive Care (HBSC) PEP - services are designed to assist MLTSS participants with Instrumental Activities of Daily Living (IADL). IADLs are support services such as, but not limited to: grocery shopping, money management, light housekeeping and laundry.

Since the inception of MLTSS, no requests have been submitted to DDS for the MLTSS self-directed services described above. Care Managers at each of the MCOs continue to report that because PCA services are inclusive of assistance with IADLs, the need for HBSC is being met under PCA. Care Managers have reported some interest for Non-Medical transportation and Chores services by their consumer, but are having barriers related to being unable to find providers.

### **Issues & Trends**

We have been experiencing growing pains since the transition to managed care. Enrollment growth has impacted both DDS and the MCOs. As interest in self-directed services increases it is difficult to meet the demand of enrollment, causing a longer period of time to complete the enrollment process for some consumers. Both DDS and the MCOs are working together to identify priority cases when necessary and to streamline processes and create a more efficient enrollment process for consumers.

Ongoing training to MCO staff is required. Although MCO staff reports having greater knowledge about self-direction since the implementation of MLTSS and further report seeing the benefits it has on their members, the benefits of continued training exists. DDS continues to offer training opportunities to address the noted issues of limited knowledge and MCO staff attrition. Specifically, DDS is planning ancillary training for the use of MLTSS self-directed services, Non-Medical Transportation and Chore Services in hopes that Care Managers will gain a better understanding of the services and consumers will begin to utilize these services.

DDS continues to work with MCO staff to keep communication lines open in order to better serve consumer. Working relationships between DDS and MCOs continue to grow in a positive direction. Consumers who have been enrolled in self-directed services since the transition to managed care are beginning to understand the specific roles and responsibilities of both DDS and the MCO. This is attributed to DDS and the MCOs working together as a team.

#### **V. STC 102(d)(iii): A General Update on the Collection, Analysis and Reporting of Data by the Plans at the Aggregate Level**

The MCOs maintain an automated claim and encounter processing system that supports the requirements of the MCO contract, ensures the accurate and timely processing of claims and encounters and delivers records representing all services provided to covered recipients including those services managed through a subcontracted relationship and the payments to any such subcontractor to the State. Section 3.9 of the managed care contract requires our plans to “collect, process, format, and submit electronic records for all services delivered to an enrollee.” The plans are required to submit encounter records on at least a monthly basis, although there are submissions that generally occur more frequently. DMAHS has a unique set of encounter claim edits to ensure consistency and readability of encounters across the varied MCOs. The State sets category of service utilization benchmarks in certain areas to ensure completeness of the data submitted by the plans and have contractual requirements related to duplicate encounter submissions and encounter MMIS denial rates. Failure to meet these requirements initially results in the withholding of capitation payments to the MCOs until the failure is resolved; if the contracted standards are not met after a specified period of withholding, the withheld amounts are liquidated and not recoverable by the plans.

The Division contracts for the operation of a shared data warehouse that includes nearly all data available from the Medicaid Management Information Systems (MMIS) and some data from external sources (such as NJ Choice MLTSS assessment data and long term care recipient data from the Division of Aging Services, electronic birth certificate information from the Department of Health). Access to this warehouse is available to all Division staff with some exception concerning non-Medicaid individuals’ information and to certain select staff in other state departments/agencies (Department of Treasury – Office of Management and Budget, Office of State Comptroller – Medicaid Fraud Division, Department of Law and Public Safety – Division of Criminal Justice for

example), with data expertise and consulting available through the Division's Office of Business Intelligence and its shared data warehouse contractor. The warehouse allows for ad-hoc and production reporting of various data metrics and is also used as the source of data for various interactive data dashboards maintained by the Office of Business Intelligence. The Research and Performance Evaluation functions within the Office of Business Intelligence are the division's "data experts" and are responsible for defining performance metrics from data available from the shared data warehouse and other sources and presenting this information in audience-specific formats, with products ranging from high level slide presentations to senior level Governor's Office staff to detailed claims-based analysis in support of future policy making and fraud detection.

Data collected from the MCOs is also used to inform Quality Improvement Projects (QIPs), under the Office of Quality Assurance in OMHC.

In December 2013, the MCOs, with the guidance of the External Quality Review Organization (EQRO), initiated a collaborative QIP with a focus on Identification and Management of Obesity in the Adolescent Population. Since inception, the EQRO had held regularly scheduled meetings with the MCOs to ensure a solid and consistent QIP foundation across all MCOs. Starting August 2015, the MCOs met monthly, independent of the EQRO, for continued collaborative activities. The MCOs are expected to show improvement and sustainability of this collaborative QIP. A routine QIP cycle consists of baseline data followed by two remeasurement years and then a sustainability year. Currently, four MCOs are involved in the collaborative QIP. For three of the MCOs, 2013 is their baseline data year for the project; results of calendar year 2014 reflect remeasurement year 1 and results of calendar year 2015 reflect remeasurement year 2. January 2016 started the sustainability year for these MCOs. The fourth MCO entered into the NJ market in December 2013, making their baseline year 2014, with results of calendar year 2015 as their first remeasurement year. January of 2016 was the start of remeasurement year 2 for this MCO. All MCOs submitted a progress report in June 2016 which included remeasurement year 2 data for three MCOs and remeasurement year 1 data for the fourth MCO, and were reviewed by the EQRO. All MCOs submitted a progress report update in September 2016 and were reviewed by the EQRO. January 2017 started the sustainability year for the fourth MCO. In June 2017, three of the MCOs submitted their final report for this QIP as the final sustainability data collection was completed in May 2017, and are currently being reviewed by the EQRO. The fourth MCO submitted a progress report in June 2017 which included the results of the remeasurement year 2 data and is currently being reviewed by the EQRO.

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

Additionally, all MCOs provided individual QIP proposals in September 2015 on Falls Prevention specific to members receiving managed long term support services. The individual proposals were approved and project activities were initiated by the MCOs in early 2016. All MCOs submitted a progress report in June 2016 which included the 2015 baseline data. All MCOs submitted a progress report update in September 2016 and were reviewed by the EQRO. January 2017 was the start of remeasurement year 2 for this QIP. All MCOs submitted a progress report in June 2017 which included the results of the remeasurement year 1 data and are currently being reviewed by the EQRO.

**VI. STC 102(d)(iv): Monitoring of the Quality and Accuracy of Screening and Assessment of Participants who Qualify for HCBS/MLTSS**

The NJ Aging and Disability Resource Connection (NJ ADRC) and the NJ Division of Disability Services (DDS) are the lead agencies responsible for screening non-MCO consumers seeking long term services and support. Through an intake process, consumers who trigger as at-risk for nursing home placement are encouraged to complete the Screen for Community Services (SCS) during the telephone call. The SCS identifies service needs, clinical needs, and potential Medicaid financial eligibility. Individuals who do not score as potentially eligible or without identified needs are provided Options Counseling and Information and Assistance (I&A) on all publicly funded long term services and supports. Individuals who score as potentially eligible are encouraged to accept a referral for a comprehensive assessment and to apply at their local County Welfare Agency for financial screening and application.

During the period of July 1, 2016 through June 30, 2017 the below statistical data identifies the number of SCS that resulted in referrals for comprehensive assessments. 52% of screens that identified at risk individuals were referred for comprehensive assessment based on consumer consent.

SCS - I&A/Options Counseling	4,811
SCS – comprehensive assessment recommended	6,409
SCS referred for comprehensive assessment	<b>3,342</b>
<b>TOTAL</b>	<b>11,220</b>

The NJ Family Care MCO’s are the entities responsible for identifying and screening members who are identified as in need of long term services and supports. Members who screen positively are referred for a comprehensive assessment. The SCS has been shared with the MCOs for their programming and use. It is not a mandatory tool at this time.

The Department of Human Services (DHS) utilizes a standardized comprehensive assessment to determine clinical eligibility for nursing facility level of care which is required for MLTSS eligibility. The standardized assessment is the interRAI Home Care Assessment, Version 9.1 which is referred to as “NJ Choice HC”. The NJ Choice HC is a comprehensive assessment and algorithms which identifies Care Assessment Protocols (CAP) which guide care planning.

There has been a 25% increase in assessment submissions from fiscal year 2016 to fiscal year 2017. During the period of July 1, 2016 through June 30, 2017, 46,004 assessments for MLTSS level of care determination were submitted. 44,184 assessments for MLTSS level of care determination (96.04%) were reviewed and a determination provided for existing MCO members.

The final level of care determination was 39,644 Authorized (89.72%) and 225 Denied (0.51%). 1,295 assessments (2.93%) were not provided a determination through the review process and are labeled as "Not Authorized". OCCO conducts reassessments for these members. This rate continues to drop each year. Fiscal year 2016 averaged 5%; fiscal year 2017 averaged 2.93%. There were 1,820 assessment submissions consisting of duplicate submissions, request that MCO conduct new assessment, outcome pending more information/screening by another entity (i.e. DDD), or other non-determination outcome.

Effective February 1, 2017, the Department changed its internal policy of reviewing 100 percent of the MCO annual reassessments for existing MLTSS members to an "Authorization without Review" and auditing process. This allows the State to enter continued clinical eligibility upon receipt of the assessment without a review of the assessment. The State's role in review and determination has been to ensure that assessment and clinical eligibility determinations are completed accurately and in accordance with policy and regulatory requirements. Through ongoing training and quality assurance oversight, the review and determination process has an overall authorization rate of 96.67% and a less than 1% denial rate. The not authorized outcome percentages dropped significantly in fiscal year 2017 averaging 2.93% of the assessments submitted with determinations, down from 5% of the assessments in fiscal year 2016. This is well within the initial established benchmark which continues to be set at 7%.

Individuals who do not qualify for the Authorization without Review process and require full review and determination by the State are:

1. MLTSS members who no longer appear to meet Nursing Facility Level of Care
2. MLTSS enrolled Youth aged 20 and younger
3. MLTSS members seeking a change in Level of Care Need
4. MLTSS members who require Cost Effectiveness Interdisciplinary Team (IDT)
5. Members seeking MLTSS enrollment including those in nursing facilities or special care nursing facilities
6. Members seeking DDD Waiver enrollment for Supports Plus PDN
7. MLTSS Members previously Not Authorized or Denied by OCCO who now meet NF LOC as a result of a significant change in condition

The MCO is the responsible entity for identifying the criteria and identifying what level of review is required by the State through the assessment submission process. Various quality processes are in place to ensure authorization without review are appropriate including 1) MLTSS enrollment status is validated prior to entering the continued clinical eligibility, 2) evidence of prior clinical eligibility is validated prior to entering the continued clinical eligibility,

3) Monthly auditing of a sample of submitted records. The State may review any assessment submission at its discretion for any reason.

The State has conducted 983 random audits to date on assessments not subject to review between February 1, 2017 through May 31, 2017. Nursing facility level of care was not able to be validated in 21 of those audits. To date, the State has conducted reassessments on 12 of the cases – 11 have been validated as meeting level of care; 1 denial has been issued and resulted in termination from the program. The State will continue to audit monthly and continue technical assistance and training for the MCOs on identified areas of weakness to improve accuracy and quality of the Authorization without Review process.

### NJ Choice HC Annual Recertification

Individuals who conduct assessment utilizing the state's standardized assessment tool were initially required to undergo annual recertification and demonstrate competency. The annual recertification for the MCOs was held in February 2015 for Care Management Supervisors and Master Trainers. The contract has been revised to require full recertification training every three years. The reason for the change is based on the following factors:

1. Significant improvements in assessment quality
2. Intensive annual training is not sustainable
  - a. Staffing levels
  - b. Staffing turnover
  - c. Annual recertification requires a minimum 5 business days

The annual recertification training is scheduled to be completed in February 2018.

### Supports Program

Beginning in November 2014, every individual eligible for DDD services, including individuals who were already in the DDD system, have been assessed using the New Jersey Comprehensive Assessment Tool (NJ CAT). When someone is enrolled in the Supports Program, we ensure that a current NJ CAT has been completed. When developing the Individualized Service Plan (ISP), the assigned Support Coordinator is required to review the NJ CAT to ensure the responses are consistent with their experiences with and observations of the individual as well as any additional information/feedback they have received from the individual and his/her loved ones, guardians, etc. Discrepancies are noted within the electronic health record and shared with DDD personnel. Should the discrepancy indicate the need for a reassessment or a face-to-face evaluation conducted by DDD staff, arrangements are made to conduct these activities and changes to the individuals assigned tier and associated individual budget would be made as applicable. Generally, discrepancies are not significant enough to impact the assigned tier based on new NJ CAT results.

### ASD Pilot, I/DD-MI Pilot Program, Serious Emotional Disturbance Program

DCF/CSOC contracts with a Contracted System Administrator (CSA) to support the delivery of services to youth, coordinated and integrated at the local level that focuses on improved outcomes for youth and their family/caregivers through utilization management, care coordination, quality management, and information management processes.

Through CSOC's CSA, youth/families/caregivers living in New Jersey can access care 24/7 through a single point of entry. The CSA performs a broad range of administrative service functions including, but not limited to, the following:

- A. Providing a Customer Service/ Call Center with 24-hour/ 7-day intake and Customer Service capability;
- B. Providing a web-based application/ interface with the CSA's MIS;
- C. Managing care, which includes utilization management, outlier management, and care coordination;
- D. Coordinating access to services for all youth
- E. Providing Quality and Outcomes Management, and System Measurement that supports CSOC's goal to promote best practices, and providing assistance to the State in assuring compliance with State and federal guidelines;

Additionally, CSOC utilizes an algorithm to enroll youth in the waiver. Youth that meet the waiver criteria, are enrolled into either the ASD pilot or the ID/DD – MI pilot depending on the criteria met. The waiver identification and participation allows CSOC to claim Federal Financial Participation (FFP) on that waiver service where CSOC is unable to claim FFP on that same service delivered to a non-waiver enrolled youth.

All waiver enrolled youth are authorized at minimum to the Care Management Organization (CMO). The CMO are independent, community-based organizations that provide service linkage, advocacy, monitoring, individualized service plan development and assessment. Care management provides accountability to ensure services are accessed, coordinated, and delivered in a strength based, individualized, youth focused, family driven, ethnically, culturally, and linguistically relevant manner. CMOs coordinate Child Family Team (CFT) meetings, and implement Individual Service Plans (ISP) for each youth and his/her family/caregiver. They coordinate the delivery of services and supports needed to maintain stability and progress towards goals for each youth, utilizing a Wraparound approach to planning.

The CFT is an on-going coordinated process that includes participation from the youth, the



youth's family/caregiver, the CMO care manager, and any other individual identified by the youth and family/caregiver to help support the family/caregiver towards sustainable plan of care. The CFT meets, at minimum, every 90 days or as needed. Through the CFT process, strengths and needs are identified, progress and barriers to care, and services to be implemented. Once identified, the request is added to the youth's treatment (care) plan, which is reviewed by CSA's clinical staff. Clinically appropriate services are authorized. If at any time during the CFT process it is determined that the youth no longer requires a service, that service will end.

#### **VII. STC 102(d)(v): GEO Access Reports from Each Participating MCO**

The Geo Access Report Summary is located under Attachment C.

#### **VIII. STC 102(d)(vi): Waiting List(s) Information by Program Including Number of People on the List and the Amount of Time it Takes to Reach the Top of the List Where Applicable**

There are currently no waiting lists being used under the waiver.

#### **IX. STC 102(d)(vii): The Various Service Modalities Employed by the State, Including Updated Service Models, Opportunities for Self-direction in Additional Program, etc.**

Along with streamlining administrative inefficiencies, the Comprehensive Waiver also allowed the State to give different groups of individuals access to more services through MLTSS, and provide more services to children through the ASD, SED, and ID/DD-MI programs. The implementation of the Supports Program in demonstration year 5 is also giving the State the ability to provide home and community based services to developmentally or intellectually disabled individuals who do not meet institutional level of care, however, without these supports would likely deteriorate and would need institutional services.

The services in MLTSS were available prior to implementation; however, these services were only accessible depending on which waiver the individual was in. MLTSS combined four 1915(c) waivers and allowed individuals in those programs access to all available services. For example, private duty nursing services were only accessible in the Global Options (GO) waiver and the Community Resources for Persons with Disabilities (CRPD) waiver prior to implementation of MLTSS. Now individuals who would have been enrolled in the Traumatic Brain Injury (TBI) or AIDS Community Care Alternative Program (ACCAP) waivers can now access private duty nursing services. MLTSS removed the silos of services that were created with the individual 1915(c) waivers.

The ASD, SED, and ID/DD-MI programs are brand new to the State. Previously, children who were in need of intensive behavioral health or specialized services were served at a state only

dollar, which restricted New Jersey's ability to adequately serve the needs of this population. With the waiver programs, the state is working to expand services and serve more children with the services that they need when they need them.

The Supports Program has extended the home and community based services available under the Community Care Waiver to individuals who do not yet meet institutional clinical criteria. It also added new services such as Supported Employment and Support Coordination. The Division of Developmental Disabilities has started to move the services they offer into a Fee-for-Service model beginning with the Supports Program.

#### **X. STC 102(d)(viii): Specific Examples of How HCBS Has Been Used to Assist Participants**

##### *Managed Long-term Services and Supports*

Since the implementation of MLTSS, the state has been holding regular operations meetings with each MCO. The below describes a specific example from each of the five operating MCOs of how HCBS has been used to assist participants with person centered planning.

##### **Aetna:**

A 49 year-old female member transitioned from a rehabilitation center in December of 2015 back to the community to live with her husband and 12 year-old son. When the member transitioned to the community in 2015 her only health conditions were lupus and hypertension; however, while the member was being treated for lupus she had an adverse reaction to Methotrexate, suffering uncontrolled seizures and a stroke, requiring the addition of 14 hours of PDN.

The member's condition began declining in October of 2016 with a decrease in appetite and complaints of mouth pain. Bolus feedings were initiated and quickly changed to continuous tube feedings. The member was seen by a dentist and it was determined that due to an infection all of her remaining teeth had to be removed. An oral surgeon consult was completed; however, the surgeon could not meet the member's needs at that time.

The Aetna team worked diligently with Dentaquest to find an oral surgeon who was able to meet the member's needs due to her level of care. A provider that could provide the needed surgery was contacted and able to meet member's needs, but was an out of network provider. To assure the member's care needs were met Aetna entered into a single case agreement and the surgery was performed on June 29, 2017.

Currently, the member no longer complains about mouth pain and shows no signs of infection. The follow up visit from her primary care provider also went well. The care manager followed up with the member's husband on July 7, 2017 and he verbalized he is happy with the procedure and outcome.

### **Amerigroup:**

Member is a 29 year-old male with an underlying history of cerebral palsy, developmental delays and microcephaly. He is non-verbal, unable to ambulate; wheelchair bound and has a gastrostomy tube for nightly g-tube infusions. He was residing in the community with his mother and sister providing total care needs prior to his mother becoming hospitalized for medical ailments requiring his long-term care admission to a nursing facility on 5/31/16.

The member was enrolled with Amerigroup on 10/1/16 and seen by an assessor shortly after his enrollment to extend his MLTSS services and benefits. Shortly after his enrollment he was then assigned to a care manager to confirm services and gather an understanding of the member and the family's personal needs. After further meeting with the member's mother and sister it was evident that his family wanted nothing else but to have the member return to his home in the community.

After communicating his family's goals to the Amerigroup team, consisting of management, transition coordinators and a community resource specialist, all were eager to assist him in returning home. Amerigroup's communication with the Office of Community Care Options (OCCO) allowed the member to receive a "medically fragile SCNF approval" enabling our team to network with additional providers as well as provide the member with both PCA and licensed nursing care for assistance with his nightly gastrostomy infusions. An interdisciplinary team meeting was scheduled amongst Amerigroup, nursing facility staff (LSW and physical therapist), the state and his family allowing for the continuation of communication regarding the member's care. Assignments were delegated to outreach medical supply companies to order equipment and supplies, and home care agencies were authorized to provide his family assistance with PCA care and daily licensed nursing care. Most importantly a discharge date was established, and the member was able to return to the comfort of his own home.

### **Horizon:**

Mr. M is a 72 year-old member that worked all of his life in his own business. At the age of 64, he began having memory issues and by the age of 68, he had lost his business due to his inability to work any longer. With the loss of his business, there were significant financial concerns. The member's wife needed to work, but she was unable to leave the member alone because of wandering and his inability to be safe. The member's wife was very overwhelmed and stressed.

The care manager worked with the member's wife identified that Medical Day Care (MDC) would be a benefit to the member and the caregiver, allowing her to work and not worry about the member while she is working and providing a much needed break. The member was authorized for MDC and now attends five days a week, participating in activities, remaining safe and the quality of life has increased for both the member and the caregiver.

### **United HealthCare:**

Mr. M was previously residing in a nursing home for a year and half before enrolling in MLTSS on 9/1/16. Mr. M has transitioned to an apartment with personal care services and a PERS system and eagerly participates with his plan of care. Mr. M is actively engaged in his own health care needs. During the care manager's recent visit Mr. M verbalized over and over again how far he has come since living in a nursing home. As Mr. M stated during the initial visit and subsequent contact, "he is so happy to be home". Mr. M also verbalized that being in bed for a year and half was terrible for his mind.

His care manager has developed a relationship with Mr. M and he is now comfortable with his knowledge and understanding of his MLTSS benefits. The care manager has also assisted him with some financial burdens such as not having enough money to pay for his electric bill. Additionally, his care manager has involved his daughters' assistance to ensure that Mr. M is at his optimal level of functioning.

Mr. M now is socializing with others, family and religious programs. Mr. M has also written a book and has shared some passages from his book with his care manager once again stating he is thankful to be home.

#### **WellCare:**

Ms. R enrolled in the MCO's FIDE SNP on 3/1/17. Between March and May 2017, she had a lengthy hospitalization for cardiac issues followed by rehabilitation. Ms. R was hospitalized again with a diagnosis of non-traumatic intracranial hemorrhage. Following this hospitalization, she again returned to skilled rehabilitation and quickly converted to long term care as her rehabilitation potential was poor and she was not making progress. Ms. R was not eating and became increasingly weak and depressed. There was talk of placing a feeding tube.

Despite the nursing facility's recommendations for custodial care, the member and her family wished for her to return home. Her daughter called the care manager on 5/11/17 in tears stating she was taking the member home the next day, a Friday, with no plan for her discharge in place. The care manager sprang into action and located an agency to staff the member and temporarily authorized PCA for 30 hours per week. The family supplemented the member's care at home with the approved PCA hours.

Recently, when the care manager visited Ms. R and her daughter they were both very appreciative of the efforts made to have services in place so rapidly. The member continues to improve each day now that she is eating home cooked meals from her family and simply back home where she wanted to be. At that time, Ms. R's family was staying with her at her apartment 24 hours a day, continuing to do their part for her success. The care manager increased PCA hours to 42 hours a week, installed a Personal Emergency Response System (PERS) and home delivered meals to begin when the family was ready to move back to their own homes. Now, since returning home, Ms. R has thrived and is doing extremely well. She is now able to live safely at home alone, no longer needing 24 hours of care. The 42 hours of PCA are adequate to meet her needs. She and her family are very happy. She has had no hospitalizations or falls since returning home and recently celebrated her 84th birthday with her extended family.

## Supports Program

At this time there are 4,054 individuals enrolled in the Supports Program with additional participants being enrolled daily. Because this program is provided in a Fee-for-Service system (rather than contract reimbursement), participants have been able to utilize a variety of service providers to access a variety of services instead of being limited to one or two providers and one or two services. As a result, the Supports Program has individuals experiencing all new opportunities such as the following:

A 21 year old, 2017 graduate has begun her adult life filling her days and weeks with activities supported by the following services offered through the Supports Program: Supported Employment – Small Group Employment Supports, Community Based Supports, Day Habilitation, Transportation, and Goods & Services to fund membership at a local community center.

A 36 year old woman who was enrolled in the Supports Program after having only received day habilitation services through one service provider for approximately 14 years, now receives the Behavioral Supports she needs because they are available through the Supports Program, but experiences her community with the addition of Community Based Supports that she receives from two different providers and continues to receive Day Habilitation services. Although, those Day Habilitation hours have decreased now that she has the opportunity for these other experiences.

A 40 year old man who no longer attends a sheltered workshop because after enrolling in the Supports Program he began accessing Career Planning, Prevocational Training, and Day Habilitation services and is job sampling and learning vocational skills that will help him reach his desired outcome of becoming a DJ. This individual has also begun accessing services through multiple providers rather than just the one where he went to the sheltered workshop.

Participants in the Supports Program have also utilized new service options to improve or further their opportunities for full membership in the community. For example, Goods & Services, a service that has only become available through the Supports Program, has provided access to the community through classes within the general public; memberships to community entities; lessons that provide experience and opportunities for growth that leads to further independence; etc. Access to these activities was very limited until the Supports Program became available. Other newly offered services include but are not limited to Career Planning, Community Inclusion Services, Prevocational Training, and Physical, Occupational, and Speech Therapies.

## ASD Pilot, I/DD-MI Pilot Program, SED Program

CSOC is pleased to share three of many success stories received from the CMOs that detail the impact of the waiver services had on the quality of life for the youth and their family/caregiver.

The first example is a youth who had been successful with Intensive in Community-Habilitation (IIH) Behavioral Services. When the CMO first began working with the youth he was showing aggressive behavior including hair pulling, throwing objects and hitting himself or others, and had been without verbal speech, using only gestures. Since working with the program, the youth has increased his vocabulary and learned some coping skills to manage his aggression. He is now able to speak one to two words in English as well as Portuguese.

Currently, IIH-Behavioral support staff is working on expanding his vocabulary and using picture cards/questions to show the youth how to elaborate his words. The youth's incidents of aggression have decreased in frequency, which is attributed to the skill building work imparted by the IIH-Behavioral staff in utilizing relaxation techniques, deep breathing, and reducing noise overstimulation through the use of headphones. The provided has also been working on increasing youth's activities of daily living skills and gaining more independence in the home setting.

The Board Certified Behavioral Analysis (BCBA) had been attending school meetings and collaborating with the school speech therapist to promote consistency across home and schools behavioral plans. The family is pleased with the increase in communication the youth has gained. The collaborative work has been key in promoting the youth's generalization of skills across both home and school environments.

Another CMO began working with a youth and his family in August of 2014. At that time, the youth could be both verbally and physically aggressive towards his family members, especially his mother, who is also diagnosed with an intellectually disability. The youth's grandparents are the primary caregivers for him and expressed concern in 2014 that they would not be able to continue to manage his behaviors as they aged.

The youth had great difficulty following a daily routine. When asked to follow a schedule, he would become agitated and aggressive, engaging in property damage such as throwing things, breaking items, and punching walls. On several occasions the police had to be called to deescalate the situation. The youth needed significant assistance with his activities of daily living including personal hygiene and simple household chores. The youth also had difficulty respecting the personal space of others in the community, especially when it came to members of the opposite sex.

The youth began IIH Behavioral services in October of 2014. The IIH team focused on dealing with his verbal and physical aggression, property damage and routine compliance. They addressed a need for greater independence with activities of daily living and more positive social behaviors in the community. The team worked with the family teaching them how to reinforce behaviors they wanted to increase and reduce the behaviors that they wanted reduced. The family has learned to use positive reinforcement, "planned ignoring" and a token economy to modify behavior.

Since receiving IIH supports the youth's grandmother has reported that her family "*is a better family*". They are more cohesive and communicate better with each other. The family has

learned how to deescalate situations, and the youth is able to follow routines and disruptions in that routine without becoming agitated or aggressive. The youth is more independent with his activities of daily living and has had more positive interactions in the community. The family is able to include him at family functions that they couldn't before. The youth now volunteers at his church and has been baptized. Most recently the youth went on a job interview at the Pretzel Factory.

When the CMO asked the youth's grandmother how she would describe what IHH services have done for their family she said, *"I can't say enough about the services. The youth came into this world a broken child who needed love, understanding and patience. We had that for him, but we didn't have the tools to help him. These services have taught us how to deal with the youth and how to interact with him in a way that encourages his cooperation. The youth will now listen to us because we know how to ask him. The youth is now a compassionate member of our family who is willing to work within our family's structure."* With the support of IHH Services the youth and his family are now able to live their family vision.

The final example is a CMO involved with a high rate of aggressive behaviors at home, at school, and in the community. At school, he has been assigned a 1-1 aide. The school has multiple supports in place to address his behaviors throughout the day. However, these aggressive behaviors have been very concerning for his parents as they try to complete typical daily tasks in the home and in the community.

When the family first became engaged with the CMO, they continuously expressed their desire to have services for this youth in their home. They repeated over and over that they did NOT want this youth to go into any type of out of home care/treatment, which had been recommended to them by various providers and professionals that previously worked with this youth/family. These out of home care/treatment recommendations were based on the high level of safety concerns for the youth and family. For example, this youth would become agitated whenever he heard either of his parents cough, sneeze, or clear their throat. At that point the youth would often bite, scratch or hit his parents. This led to multiple occasions where the parents needing to be seen for medical treatment. As a result, the parents often raced from the room or the house if they need to cough or sneeze to avoid doing this in front of the youth. At other times the youth would exhibit these same aggressive behaviors but the parents were not been able to identify the trigger. The mother was wearing oven mitts around the home in order to cover her arms to protect them from bites and scratches. The parents report they always felt on edge and were fearful of physical aggression.

After a Child Family Team (CFT) meeting, the team decided to implement IHH Behavioral services in the home. These services are in the beginning stages but the parents are already seeing positive outcomes emerge. The youth's mother reports that she does not feel the need to wear the oven mitts to protect her arms when the service provider is working with the youth. The provider has created a plan to put strategies in place to decrease the aggression in the home and in the community. The parents have been given information about ABA and how the process works. The parents have a full understanding that this process takes time and have expressed having a new feeling of hope that their youth's behaviors will improve and they can

continue to keep him safe in his home. The parents feel that these services came at just the right time and when they needed them most.

**XI. STC 102(d)(ix): A description of the intersection between demonstration MLTSS and any other State programs or services aimed at assisting high-needs populations and rebalancing institutional expenditures (e.g. New Jersey's Money Follows the Person demonstration, other Federal grants, optional Medicaid Health Home benefit, behavioral health programs, etc.)**

State programs outside of MLTSS do intersect at times requiring coordination of services. One area where MLTSS intersects with another high need population is with the developmentally disabled individuals who require private duty nursing (PDN). NJ Medicaid allows individuals receiving Division of Developmental Disabilities (DDD) Supports Program services to access PDN if they meet clinical criteria. The Division of Developmental Disabilities provides services to maintain developmentally disabled individuals in the community and PDN is provided through MLTSS. These individuals are now identified in the system so that the capitation payment covers these services, allowing sufficient support to maintain the individual in the community setting while allowing them to receive a service package that is predominately focused on their developmental disability needs.

Individuals enrolled in MLTSS are eligible to receive integrated behavioral and physical health care services through a Behavioral Health Home (BHH) being piloted in five counties in New Jersey. The BHH is responsible to provide care management. This care management works with the managed care plan to get services authorized and coordinated without duplicating MCO case management services. The Behavioral Health Home focuses primarily on the client's behavioral health needs while providing or referring clients for primary physical health care. The MCO case manager is consulted to address service needs outside of the health home environment. Beginning this year, the Department of Corrections has begun referring clients with severe mental illness to the available BHHs to assist with their mental and physical health needs and to ease these clients back into the community. The BHH meets with the clients via phone prior to release to establish a relationship and to explain the services available. They then arrange an intake appointment within 24 hours of release. The BHH is also expected to assist those mentally ill clients with a substance use disorder.

New Jersey was awarded a grant for the addition of Certified Community Behavioral Health Clinics (CCBHCs) to assist individuals with behavioral health needs to obtain integrated care. CCBHC providers are capitated and responsible to provide, or pay for, all required behavioral health services. There are no prior authorization requirements and the CCBHC is responsible for managing all aspects of the care. For those individuals who are enrolled in MLTSS, the programs interact with the MCO care manager to coordinate services outside of the CCBHC including physical health needs for the client.



### Money Follows the Person/Nursing Facility Transitions

New Jersey participates in the federal demonstration project that assists individuals who meet CMS eligibility requirements to transition from institutions to the community in order to improve community based systems of long-term care for low-income seniors and individuals with disabilities. Under MLTSS Nursing Facility Transition refers to the process applicable to all MLTSS Members who are currently residing in a NF/SCNF facility regardless of the length of time the Member has been in the facility. The managed care organizations (MCOs) are responsible for NF/SCNF transition planning and the cost of all assessed transitional service needs. The State is responsible for identifying FFS members and counseling them on enrolling in MLTSS in order to facilitate transition, providing guidance as needed to the MCOs, and tracking and completing Money Follows the Person (MFP) requirements for qualified NF/SCNF residents as identified by the MCO or the State for the MFP demonstration. The Office of Community Choice Options or its designee shall participate in all MFP transitions.

#### First Quarter

<b>MCO</b>	<b># of Transitions</b>
Aetna	5
Amerigroup	17
Horizon	104
United Health Care	24
Wellcare	12
<b>Quarter Total</b>	<b>162</b>

#### Second Quarter

<b>MCO</b>	<b># of Transitions</b>
Aetna	4
Amerigroup	24
Horizon	112
United Health Care	23
Wellcare	10
<b>Quarter Total</b>	<b>173</b>

#### Third Quarter

<b>MCO</b>	<b># of Transitions</b>
Aetna	8
Amerigroup	21
Horizon	98
United Health Care	22

Wellcare	8
<b>Quarter Total</b>	<b>157</b>

#### Fourth Quarter

MCO	# of Transitions
Aetna	4
Amerigroup	24
Horizon	123
United Health Care	27
Wellcare	6
<b>Quarter Total</b>	<b>184</b>

#### Grand Totals for DY5

MCO	# of Transitions
Aetna	21
Amerigroup	86
Horizon	437
United Health Care	96
Wellcare	36
<b>Grand Total</b>	<b>676</b>

#### PACE

Under the Comprehensive Waiver individuals who qualify for MLTSS may select NJ FamilyCare Managed Care Organizations (MCOs) for Managed Long Term Services and Supports (MLTSSO) or the Program of All-Inclusive Care for the Elderly (PACE) program. A PACE organization coordinates and provides all Medicare and NJ FamilyCare services, including nursing facility care and prescription drugs. Many participants are transported to a PACE center to receive services in addition to receiving services in the home as needed. To participate in the PACE program, a person must be 55 years of age or older and able to live safely in the community at the time of enrollment. There are currently five PACE organizations in eight counties, with a sixth program set to open in 2017.

PACE in New Jersey	
NAME	COUNTIES
LIFE at Lourdes -	Most of Camden
Lutheran Senior LIFE -	Parts of Hudson

LIFE St. Francis -	Mercer and parts of northern Burlington
Inspira LIFE -	Parts of Cumberland, parts of Gloucester and parts of Salem
Beacon of LIFE –	Parts of Monmouth County

	BEACON OF LIFE	LOURDES MEDICAL CENTER	LUTHERAN SENIOR LIFE	INSPIRA LIFE	ST. FRANCIS MEDICAL CENTER	Total State Enrollment
Avg. Monthly Enrollment SFY16	23	220	151	193	309	896
Avg. Monthly Enrollment SFY17	56	224	132	229	305	946

*PACE Initiatives during DY5:*

- Five established PACE programs are currently serving approximately 1,000 participants. A sixth PACE program, Atlanticare LIFE Connection, in Atlantic City and serving Atlantic and Cape May Counties, plans to open in fall 2017.
- PACE growth efforts are underway:
  - Zip code expansion for current PACE organizations has occurred during DY5:
    - Beacon of LIFE to serve the remaining zip codes in Monmouth County;
    - Lutheran Social Ministries to developing a program in Union County, and
    - Life at Lourdes to three additional zip codes in southern Burlington County.
  - A “Request for Applications for New PACE Programs,” soliciting Letters of Intent (LOI) for new PACE programs was developed for publication in the September 18, 2017 New Jersey Register.

**XII. STC 102(d)(x): A Summary of the Outcomes of the State’s Quality Strategy for HCBS**

Division of Medical Assistance and Health Services’ Quality Management (QMU) Unit has been assigned to monitor the implementation of the Quality Strategy for targeted HCBS programs to

ensure that the functions related to the operation and performance of the programs are performed according to CMS requirements. QMU has conducted a Comprehensive Audit Review of DDD's Supports Program and CSOC's ASD and ID/DD-MI programs for period January 1, 2015 through December 31, 2016.

The Division of Developmental Disabilities has met all the CMS' Waiver Assurances (Level of Care, Service Plans, Qualified Providers, Health and Safety, and Financial Accountability) as established by the 86% compliance rate threshold. DDD is not required to submit a Corrective Action Plan (CAP) for meeting the compliance rate threshold; however QMU would like DDD to address the findings, specifically in the areas of Service Plan Development and Health and Welfare for quality improvement. Please see below DDD's responses to QMU's recommendations:

### **Level of Care**

1. **QMU**: Recommends that evidence/documentation ensuring that level of care evaluations are conducted at least annually.

**DDD**: A method (most likely check boxes) for indicating that the Support Coordinator has reviewed level of care during the annual service planning process is being developed in iRecord at this time.

### **Service Plan Development:**

1. **QMU**: Recommends that the service delivery documents identified in the Supports Program Policies and Procedure Manual, page 177, Appendix D be uploaded into the iRecord.

**DDD**: The service delivery documents identified in the Supports Program Policies and Procedure Manual, page 177, Appendix D, are forms that are completed by and the property of the Providers rendering services. These documents need to be maintained at the site of service delivery for auditing and monitoring. Additionally, uploading all of these documents would create operational issues with the iRecord (i.e.: storage, speed).

2. **QMU**: Recommends including documentation of the annual review of the PCPT during the completion of the annual ISP.

**DDD**: The iRecord will not allow the Support Coordinator to move forward with the NJISP development until the Support Coordinator indicates that the PCPT has been reviewed and checked. This efficiency was built into the application.

3. **QMU:** Identified 5 findings where the Support Coordinator did not conduct a monthly contact or face to face contact timely.

**DDD:** The Support Program staff will notify the respective Support Coordination agencies of QMU's findings and instruct the agency not to bill for Support Coordination services for the individuals/months identified in the Audit report.

### **Health and Welfare:**

1. **QMU:** Recommends documentation of medical and dental exams in the iRecord to indicate that the participant or his/her family is advised to have exams completed.

**DDD:** Medical and dental exams are not a requirement for individuals enrolled in the Supports Program, but DDD recognizes their importance. Support Coordinator's will be instructed to document discussion of the benefits of medical/dental exams at least annually on the monitoring form or as a case note at the time of the annual Service Plan.

QMU's Comprehensive Audit Review of Children's System of Care's ASD and ID/DD-MI programs requires a CAP in areas of Level of Care, Plan of Care and Health and Safety. CSOC has submitted its CAP based on QMU's recommendations corresponding to specific findings. The audit findings identified on the report are mostly related to comprehensive documentation practice. Please see attached for CSOC's response to the required CAP. The CAP can be found under attachment D

The Children's System of Care also monitors the programs it administers separately of the work performed by the QMU. The results from the performance metrics for the ASD and ID/DD-MI pilots can be found under Attachment D.1.

The MLTSS Quality Monitoring Unit under the DMAHS Office of Managed Health Care is responsible for the quality oversight of the MLTSS program. The outcomes and analysis for the performance measures pertaining to MLTSS can be found under Attachment D.2.

### **XIII. STC 102(d)(xi): Efforts and Outcomes Regarding the Establishment of Cost-effective MLTSS in Community Settings Using Industry Best Practices and Guidelines**

The design incorporated into MLTSS is one where the state requires MCOs to provide service coordination and care management with a holistic perspective. All MLTSS members have an MCO assigned care manager who is responsible to coordinate acute care, long term care (MLTSS) and

behavioral health services to ensure the member is as safe and independent in the community as possible. In addition, the state requires the MCO to ensure linkages to community based services (based on need) that do not necessarily fall into a covered benefit category.

**XIV. STC 102(d)(xii): Policies for Any Waiting Lists Where Applicable**

There are currently no waiting lists in use.

**XV. STC 102(d)(xiii): Other Topics of Mutual Interest Between CMS and the State Related to the HCBS Included in the Demonstration**

*HCBS Settings Requirements*

New Jersey has moved ahead with the development of its Statewide Transition Plan that was originally submitted to CMS in April 2015. After public review and a comment period, an Addendum to the Statewide Transition Plan was submitted to CMS in December 2016. Its purpose was to provide supplemental information and clarifications to the proposed plan. The DHS had received input from affected residents, providers and partner state agencies during the Demonstration Year 5. The DHS has struck a balance of interests among its stakeholders that has resulted in a workable, reasonable blueprint for transition, with policies that comply with the HCBS rules and a level of flexibility and openness to reviewing innovative operations under certain circumstances.

*Rebalancing Long Term Care*

Service utilization of HCBS under MLTSS continues to increase. As of June 2017, over 50,000 individuals were enrolled in Medicaid long term care with approximately 22,000 receiving HCBS under MLTSS and 27,000 residing in nursing facilities. Since MLTSS was launched in July 2014, New Jersey has continued to rebalance Medicaid long-term care with almost 45 percent of individuals receiving HCBS rather than nursing home care. This figure was 28.9 percent when MLTSS began. This is due to several factors including the elimination of waitlists, financial eligibility-related administrative changes like the development of the QIT program, and program expansion.

**XVI. STC 102(d)(xiv): The State may also provide CMS with any other information it believes pertinent to the provision of the HCBS and their inclusion in the demonstration, including innovative practices, certification activity, provider enrollment and transition to managed care special populations, workforce development, access to services, the intersection between the provision of HCBS and Medicaid behavioral health services, rebalancing goals, cost-effectiveness, and short and long-term outcomes.**

### ADRC is No Wrong Door/Single Entry Point

As a provision of New Jersey's 1115 Comprehensive Waiver (Waiver), the Department of Human Services (DHS), Division of Aging Services (DoAS) applied and received approval from to secure Medicaid Federal Financial Participation (FFP) for the Area Agencies on Aging (AAAs). It supports their administrative functions as Aging and Disability Resource Centers (ADRCs) associated with Medicaid eligibility. The ADRC functions are unique to the AAAs and do not duplicate the functions performed by the CWAs.

Federal FFP approval for this initiative was received early in 2017 and will provide a new revenue source for aging services at the county level over the course of this state plan. DoAS prepared and submitted its first FFP claim to DMAHS for submission to CMS in June 2017. This new funding opportunity gives the AAAs added support to address the growing senior population that wants to remain in the *community with supportive services*.

### Any Willing Qualified Provider (AWQP) Initiative

The Department of Human Services (DHS) – the Division of Aging Services (DoAS) and the Division for Medical Assistance and Health Services (DMAHS) – has begun the development of a program aimed at improving the quality of care and outcomes to MLTSS members in NFs. It will require Medicaid certified NFs serving MLTSS participants to meet Quality Performance Standards (QPS) as a means to raise the overall quality of care and provide a basis for future Value Based Purchasing (VBP) of NF services with the goal to reimburse providers based on performance and to encourage consumers to select high value service providers.

Under the program, New Jersey will transition from its current any willing provider (AWP) policy, which requires a MCO to contract with any nursing home who would like a contract and complies with the MCO's provider network participation requirements, to the AWQP program.

The initiative is being developed with the MLTSS Steering Committee's Quality Workgroup which includes representatives from the NFs, MCOs, and other long-term care stakeholders and advocates. The Quality Workgroup has been originally involved with the development of MLTSS and then was reconvened to help drive this initiative, especially the nursing home industry leadership.

### Managed Care and Operational State Relationships

MCOs continue to link with NJ's County Welfare Agencies for the purpose of assisting members with applying for programs such as utility assistance and NJ SNAP. MCOs also continue to connect with county based Aging and Disability Resource Connections (ADRCs) to assist members with linking to community based MLTSS services that are covered by the MCO.

The state continues to work with the MCOs on the nursing facility to community transition process as the Money Follows the Person (MFP) programs sunsets in December of 2018. While the MFP office will be available for technical assistance through 2020 the MCOs are responsible for performing this task. Currently, a member's IDT meets with him/her, the state, his/her MCO care manager and any member identified informal supports to collaborate on a person centered transition plan. The MFP staff offers expertise as the MCOs learn how to effectively utilize available resources and person centered planning to execute sustainable transitions.

#### *Communication Efforts that Ensure Provider Enrollment and Transitions*

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

DHS has continued to work with a quality subgroup of the MLTSS Steering Committee on a NF quality initiative. With consensus from stakeholders, the DHS will use seven performance measures to establish a minimum threshold upon which MCOs will rely in narrowing their networks of NF providers. Those measures address antipsychotic medication, immunizations against influenza, pressure ulcers, physical restraints, falls with major injury, NF resident experience survey and tracking 30-day hospitalizations.

A meeting was on held on February 22, 2017 in which DHS presented to stakeholders on next steps for moving forward, including proposed operational guidelines, policy development, communications and timelines.

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

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

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



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

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

As part of Traumatic Brain Injury (TBI) Workgroup modifications have been made to the descriptions of MLTSS Waiver Services. The Office of Managed Health Care (OMHC), provider relations unit, is working directly with the individual Managed Care Organizations and the TBI Providers to insure that operational and billing issues that may have resulted from initial service definitions are addressed and TBI Providers are reimbursed in a timely manner for services rendered.

On June 1, 2017 the Office of Managed Care Provider Relations staff in conjunction with the Medicaid Fraud Division and the Managed Care Special Investigation's Unit presented to over 300 Adult Day Health Providers and billers. The topics covered in the three hour training were specific to Adult Day Health Services and outlined Medicaid documentation requirements, Third Party Liability, Fraud, Waste and Abuse obligations and criteria for non-compliance. This educational presentation is a cooperative effort of the Managed Care Organizations and Medicaid Fraud as well as the Medicaid Fraud Control Unit which is under the jurisdiction of the New Jersey Department of Law and Public Safety.

On June 15, 2017, the DHS presented to LeadingAge New Jersey to around 50 providers. New Jersey's five MCOs also presented. MLTSS implementation and associated policy initiatives/changes was a major focus.

#### Children System of Care:

##### Provider Enrollment/Access to Services

During this reporting period, CSOC actively recruited additional respite and interpreter service providers.

##### Brief Descriptions of the Waiver Services

Habilitation services are long term supports designed to assist youth diagnosed with Autism or youth that are intellectually/developmentally disabled in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to function successfully in home, at school and in community based settings

#### **I. Intensive in Community – Habilitation (IIH) Behavioral Supports**

Intensive in community – habilitation (IIH) behavioral supports includes a comprehensive integrated program of services to support improved behavioral, social, educational and vocational functioning. In general, this program will provide children, youth, adolescents, or young adults with services such as developing or building on skills that would enhance self-fulfillment, education and potential employability. The youth’s treatment is based on targeted needs as identified in the behavioral support plan.

Behavioral Interventions should include but are not limited to:

Development of an integrated Applied Behavior Analysis (ABA) plan of care, which may include:

- Assessment, including but not limited to:
  1. CARS-2 (Childhood Autism Rating Scale)
  2. GARS-3<sup>rd</sup> Edition (Gilliam Autism Rating Scale)
  3. ADOS-2<sup>nd</sup> Edition (Autism Diagnostic Observation Scale)
  4. ADI-R (Autism Diagnostic Interview-Revised)
- Functional Behavior Assessment (FBA) and related assessments, checklists, or rating scales, including but not limited to:
  1. BASC (Behavior Assessment System for Children, 2<sup>nd</sup> Edition)
  2. FAST (Functional Analysis Screening Tool)
  3. MAS (Motivation Assessment Scale)
  4. QABF (Questionnaire about Behavioral Function)
  5. VB-MAPP (The Verbal Behavior Milestones Assessment and Placement Program)
  6. Vineland II-Adaptive Behavior Scale
  7. ATEC (Autism Treatment Evaluation Checklist)
- Behavior Support Plan (BSP) which may include:
  1. Antecedent Based Interventions
    - Prompting
    - Time Delay
  2. Behavioral Interventions
    - Reinforcement
    - Task Analysis
    - Discrete Trial Training
    - Functional Communication Training
    - Response Interruption/Redirection
    - Differential Reinforcement
  3. Social Narratives- story based intervention
  4. Modeling
  5. Language Training

6. Naturalistic Teaching Strategies
  7. Peer Mediated Intervention
  8. Pivotal Response Training
  9. Schedules
    - visual supports
    - structured work systems
  10. Self-Management
  11. Parent Training
  12. Social Skills Training
  13. Scripting
- Instruction in Basic Activities of Daily Living (BADLs);
  - Instruction in Instrumental Activities of Daily Living (IADLs);
  - Positive Behavioral Supports;
  - Modifying behavior support plans based on frequent, systematic evaluation of direct observational data;
  - Direct observation, training and supervision of support staff providing in home ABA services.

**Qualifications:** Applied Behavior Analysis- Functional Behavior Assessment, development of a Behavior Support Plan and supervision of Behavior Technicians: Bachelor's degree in psychology, special education, guidance and counseling, social work or a related field and at least one year of supervised experience in developing and implementing behavior support plans for individuals who have intellectual/developmental disabilities.

Behavioral Technician (BT) Qualification: Registered Behavior Technician (RBT) by the Behavior Analyst Certification Board (BACB) and at least one year of supervised experience in implementing behavior support plans for individuals who have intellectual/developmental disabilities.

## **II. Intensive in Community – Habilitation (IIH) Clinical/Therapeutic Supports**

Intensive in community – Habilitation (IIH) Clinical/Therapeutic supports are intensive community-based, family-centered services delivered face-to-face as a defined set of interventions by a clinically licensed practitioner. The purpose of IIH services is to improve or stabilize the youth's level of functioning within the home and community in order to prevent, decrease or eliminate behaviors or conditions that may lead to or that may place the youth at increased clinical risk, or that may impact on the ability of the youth to function in their home, school or community.

The clinical and therapeutic services to be delivered are those necessary to improve the individual's independence and inclusion in their community. These services are flexible, multi-purpose, in-home/community, clinical supports for youth and their parents/caregivers/guardians. These services are flexible both as to where and when they are provided based on the family's needs.

Development of an integrated plan of care, which may include:

- Other assessment tools as indicated; clinicians must be familiar with the array of considerations that would indicate preferred assessment methods;
- Cognitive Behavioral Intervention -Individual, family and group counseling;
- Trauma informed counseling;
- Positive Behavioral Supports;
- Psycho-educational services to improve decision making skills to manage behavior and reduce risk behaviors;
  1. Instruction in learning adaptive frustration tolerance and expression, which may include anger management;
  2. Instruction in stress reduction techniques;
  3. Problem solving skill development;
  4. Social skills development

**Qualifications:** Master's degree in psychology, special education, guidance and counseling, social work or a related field with at least one year of experience in providing clinical services for individuals who have intellectual/developmental disabilities and clinically licensed to independently practice in NJ or a master's level licensed practitioner (e.g. LSW under a LCSW or LAC under a LPC) practicing under the supervision of a clinician who is clinically licensed to independently practice in NJ.

**III. Individual Supports**

Individual Support Services assist the youth with acquiring, retaining, improving and generalizing the behavioral, self-help socialization and adaptive skills necessary to function successfully in the home and community. Tasks are performed and/or supervised face-to-face by a service provider in the individuals' family home, the home of a relative or in the community.

Individual Support Services are family centered and intended to develop a safe structured home environment while increasing the ability of the family/caregiver to provide the youth with needed support to remain home with their natural supports. Services are not office-based, and work to improve the youth's functioning in his/her natural environment.

Individual Support Services include:

Providers are required to assist youth who exhibit behavior challenges when performing Activities of Daily Living (ADLs), some of which are described below. ADLs are defined as needed skills related to daily self-care activities within an individual's place of residence, in outdoor environments, or both.

- Basic ADLs (BADLs) skill building: BADLs consist of self-care tasks, including but not limited to:
  - Bathing and showering
  - Dressing

- Eating
- Personal hygiene and grooming (including washing hair and brushing teeth)
- Toilet hygiene
- Instrumental ADLs skill building: Instrumental activities of daily living (IADLs) are not necessary for fundamental functioning, but they enable an individual to live independently in a community and include but are not limited to:
  - Housework
  - Taking medications as prescribed
  - Managing money
  - Shopping for groceries or clothing
  - Use of telephone or other form of communication
  - Using technology (as applicable)
  - Transportation within the community

#### Individual Support Plan:

The Individual Support Plan is a requested component of the youth's approved Individualized Service Plan (ISP). Individual Support Services as described in the Individual Support Plan must be directly related to the goals and objectives established in the youth's ISP.

The Individual Support Plan assists the youth with acquiring, retaining, improving and generalizing the behavioral, self-help, socialization and adaptive skills necessary to function successfully in the home and community. Family/caregiver involvement is extremely important and, unless contraindicated, should occur from the beginning of treatment and continue throughout the service delivery.

The Individual Support Plan as a component of the ISP includes multicomponent intervention(s) based on the principles of Positive Behavior Support with target dates for accomplishment of goals that focus on changing the many facets of an youth's living context that are problematic and interfere with a youth acquiring, retaining, improving and generalizing skills needed to remain in the home and participate in the community. It combines assessment and strategies of Positive Behavior Supports with the principle and ideal of normalization/inclusion and person-centered values.

Specifically, the Individual Support Plan will be driven by the Children's Adaptive Behavior Summary (CABS). The CABS is intended to gather information about the typical functioning within the last 6 months and reflect, to the extent possible, how the youth acts and reacts in common daily routines at home, in school, and in the community. Other critical information necessary in the development of the Individual Support Plan may also include collateral information and other assessments such as the: Vineland, Occupational, Physical, or Speech assessments if available.

#### IV. Respite Services

Respite service provides care and supervision to youth with intellectual/developmental disabilities, either in their family home or in a community setting, to temporarily relieve the family from the demands of caring for them. The care is intended to be provided during the times when the family normally would be available to provide care. Respite also provides a positive experience for the youth receiving care.

Respite services will also allow caregivers to improve the nature of their caregiving activities through attendance at trainings and educational programs that will increase their ability to become experts on handling the challenges facing their families. Full-time caregivers of youth with special needs have to develop expertise in areas such as nursing and physiotherapy and need time to learn these skills.

Respite services as part of a service plan can achieve several goals:

1. avoid “burnout”
2. reduce stress
3. prevent family disruption
4. enhance relationships

The qualified provider, in consultation with the families, clearly states reasons and goals for the type of respite provided in a respite service plan that is to be reviewed quarterly, at a minimum, to ensure achievement of goals and track progress. The type of respite that is right for the family will depend on what is available in the community as well as the family’s unique needs and preferences. Identifying the specific reason that the family needs respite may help clarify the type of respite that will work best and help plan how to use the respite time effectively. Respite is not a substitute for childcare, school, or participation in other age appropriate activities. Respite is also not a substitute for services provided by a home health aide for self-care needs (bathing, dressing, feeding and toileting).

V. Interpreter Services

Interpreter Services are delivered face-to-face to youth to support them in carrying out the treatment/plan of care. Interpreter services are provided in the youth’s home and/or in community-based settings, and not in provider offices or office settings. This service may be used only when Language Line interpretation is not available, feasible or when natural interpretive supports, i.e. an adult family member, neighbor, friend, etc. who can provide the interpretation, are not available.

For language interpretation, the interpreter service must be delivered by an individual proficient in reading and speaking in the language that the youth and family speak.

Qualified interpreter means an interpreter who, via an on-site appearance, is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary

specialized vocabulary. Qualified interpreters include but not limited to sign language interpreters, oral translators, and cued-language translators.

**Total Number of Agencies Qualified by the CSOC to Deliver Waiver Services**

Pilot Waiver	Waiver Service	Number of Qualified Agencies
ID/DD-MI ASD	Individual Supports	42
ID/DD-MI ASD	Intensive In- Community Services – Habilitation (IHH) (Clinical/ Therapeutic)	47
ID/DD-MI ASD	Intensive In- Community Services – Habilitation (IHH) (Behavioral)	46
ID/DD-MI	Respite	87
ID/DD-MI	Interpreter Services	3

**Agencies Qualified by the CSOC to Deliver Waiver Services During 7/1/2016 – 6/30/2017 Reporting Period**

Pilot Waiver	Waiver Service	Number of Qualified Agencies
ID/DD-MI	Respite	7
ID/DD-MI	Interpreter Services	3

**XVII. STC 102(d)(xv): A Report of the Results of the State’s Monitoring Activities of Critical Incident Reports**

The results of the State’s monitoring activities of critical incidents can be found in Attachment D.2

**XVIII. STC 102(d)(xvi): An updated budget neutrality analysis, incorporating the most recent actual data on expenditures and member months, with updated projections of expenditures and member months through the end of the demonstration, and proposals for corrective action should the projections show that the demonstration will not be budget neutral on its scheduled end date.**

The updated Budget Neutrality analysis is enclosed at the end of this report.

**XIX. Enclosures**

- A) Waiver Evaluation Summary
- B) 1115 Waiver Service Units and Claims
- C) Geo Access Report by MCO
- D CSOC Corrective Action Plan (CAP)
  - D.1) ASD and ID/DD-MI Performance Measurement Report
  - D.2) MLTSS Performance Measurement Report
- E) Budget Neutrality Analysis

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# Center for State Health Policy

*A Unit of the Institute for Health, Health Care Policy and Aging Research*

## Examining the Effect of the NJ Comprehensive Waiver on Access to Care, Quality, and Cost of Care: Draft Final Evaluation Report

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# **Examining the Effect of the NJ Comprehensive Waiver on Access to Care, Quality, and Cost of Care: Draft Final Evaluation Report**

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## **Executive Summary**

The New Jersey Medicaid Comprehensive Waiver Demonstration was approved for the period October 1, 2012 through June 30, 2017. This §1115 waiver not only consolidated authority for several existing Medicaid waivers, but initiated a variety of health reforms in New Jersey's Medicaid program. The key changes authorized by the Waiver are an expansion in managed care to Long-term Services and Supports (LTSS) and behavioral health (BH) services, targeted home and community-based services (HCBS) for populations of children and in-home community supports for individuals with intellectual and developmental disabilities, administrative simplifications in the Medicaid eligibility process for low-income applicants seeking LTSS, and the establishment of a hospital-based Delivery System Reform Incentive Payment (DSRIP) Program.

The Rutgers Center for State Health Policy (CSHP) was engaged to evaluate New Jersey's Medicaid Comprehensive Waiver Demonstration. In this draft final evaluation report, we examine the expansions in managed care and targeted home and community-based services occurring under the Waiver as well as the impact of the changes in administrative processes surrounding financial eligibility determination for LTSS applicants.<sup>1</sup> These policy changes were associated with the first three of the four evaluation hypotheses and their supporting research questions as outlined in the waiver Special Terms and Conditions document (CMS 2014) and enumerated below.

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<sup>1</sup> The Supports program, which is part of the targeted home and community-based services expansion for individuals with intellectual and developmental disabilities has been evaluated qualitatively in a separate report (Farnham, et al., forthcoming). The DSRIP program is evaluated as a separate component and the midpoint evaluation was submitted to the New Jersey Division of Medical Assistance and Health Services (DMAHS) on September 2015 with the final evaluation due in March 2018.

**Hypothesis 1: "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."**

**Research Question 1a: "What is the impact of the managed care expansion on access to care, the quality, efficiency, and coordination of care, and the cost of care for adults and children?"**

**Research Question 1b: "What is the impact of including long-term care services in the capitated managed care benefit on access to care, quality of care, and mix of care settings employed?"**

**Hypothesis 2: "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."**

**Research Question 2a: "What is the impact of providing additional home and community-based services to Medicaid and CHIP beneficiaries with serious emotional disturbance, autism spectrum disorder, or intellectual disabilities/developmental disabilities?"**

**Research Question 2b: "What is the impact of the program to provide a safe, stable, and therapeutically supportive environment for children from age 5 up to age 21 with serious emotional disturbance who have, or who otherwise would be at risk for, institutionalization?"**

**Hypothesis 3: "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."<sup>2</sup>**

**Research Question 3a: "What is the impact of the projected spend-down provision on the Medicaid eligibility and enrollment process? What economies or efficiencies were achieved, and if so, what were they? Was there a change in the number of individuals or on the mix of individuals qualifying for Medicaid due to this provision?"**

**Research Question 3b: "What is the impact of eliminating the transfer of assets look-back period for long term care and home and community based services for individuals who are at or below 100% of the FPL? Was there a change in the number of individuals or on the mix of individuals qualifying for Medicaid due to this provision?"**

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<sup>2</sup> Hypothesis 3 and the associated research questions enumerated here reflect the wording used in the waiver Special Terms and Conditions document as approved by CMS (CMS 2014). The projected spend-down provision originally proposed in the Waiver was not implemented since the State chose to adopt Qualified Income Trusts (QITs), and we assess the impact of the QIT implementation.



Hypothesis 4: **“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 costs through improvement.”**

This report is comprised of five distinct chapters each covering one analytic component of our evaluation. Organized by chapter, the following table presents a brief description of the contents of this report, the data sources used and time periods covered, the focus of the analyses (i.e. populations and/or plans), and the corresponding hypothesis(es) and research question(s) addressed to the extent possible given the available data and timing of policy implementation.

<b>Data Sources</b>	<b>Focus of Analysis</b>	<b>Hyp.</b>	<b>RQ</b>
<b>Chapter 1</b>			
HEDIS® and CAHPS®, 2011-2015	All managed care beneficiaries and MCOs	1	1a
<b>Chapter 2</b>			
Reports from MCOs, EQROs, and State Government, 2014-2017	Medicaid beneficiaries in MLTSS and their MCOs	1	1b
<b>Chapter 3</b>			
Medicaid claims and encounter data, 2011-2015	Medicaid beneficiaries and managed care beneficiaries, overall and by eligibility group, and those in long-term care (facility and community-based)	1	1a, 1b
<b>Chapter 4</b>			
Medicaid claims and encounter data, 2011-2015	Individuals with ASD, ID-DD/MI, and SED eligible for home and community-based waiver services, and all Medicaid youth	2	2a, 2b
<b>Chapter 5</b>			
State-provided statistics and public reports, 2012-2017; Medicaid claims and encounter data, 2011-2015	Individuals seeking entrance into MLTSS using self-attestations and Qualified Income Trusts	3	3a, 3b

Hyp.=Hypothesis; RQ=Research Question; MCO=Managed Care Organization; EQRO=External Quality Review Organization; ASD=Autism Spectrum Disorder; ID-DD/MI=Co-occurring intellectual/developmental disability and mental illness; SED=Serious Emotional Disturbance.

**Chapter 1: HEDIS® and CAHPS® Quality Indicators: Preventive Care, Behavioral Health Care, Treatment of Chronic Conditions, and Consumer Satisfaction**

This section examines the performance of NJ Medicaid managed care organizations (MCOs) comparing changes between the baseline period of the waiver evaluation (2011-2012) and the three post-implementation years (2013-2015). Examining potential changes across all managed care beneficiaries monitors Medicaid managed care organizations’ (MCOs’) overall adherence to the State’s managed care Quality Strategy when preparing for and implementing specific waiver policies. It provides evidence needed to assess the impact of the managed care expansion on access to care, and the quality, efficiency, and coordination of care for all adults and children, an

evaluation Research Question enumerated in the waiver Special Terms and Conditions document (CMS 2014).

The measures in the tables are related to preventive care, behavioral health care, treatment of chronic conditions, and consumer satisfaction with care. These measures are based on the Healthcare Effectiveness Data and Information Set (HEDIS®), a system of standardized performance measures developed by the National Committee for Quality Assurance (NCQA); and the CAHPS® (Consumer Assessment of Healthcare Providers and Systems), an annual independent survey of members' perceptions of the quality of care and services they receive in their Medicaid health plan. For the HEDIS® metrics, in addition to select measures which are publicly reported, we also used data from the annual Performance Measure Validation reports created by the State's EQRO and provided to us by DMAHS.

*Preventive Care Quality Measures:* These HEDIS® measures are related to immunizations, screenings, and visits to primary care practitioners.

- The rates for childhood vaccine combinations 2 (DTaP, IPV, MMR, HiB, HepB, and VZV) and 3 (DTaP, IPV, MMR, HiB, HepB, VZV, and PCV) declined significantly from the baseline (2011-2012) to the waiver (2013-2015) period (-1.0 percentage points (pp) and -1.7 pp, respectively). The rates for adolescent meningococcal vaccination and Tdap or Td improved (1.0 pp and 2.9 pp, respectively).
- Rates significantly improved for wellness visits for both young children (1.3 pp in first 15 months of life and 0.3 pp in ages 3-6), and adolescents (2.1 pp). However, rates for frequency of ongoing prenatal care declined (-1.0 pp), as did timeliness of prenatal (-1.9 pp) and postpartum care (-2.4 pp).
- Rates improved for all the access to primary care measures for children of all ages except for those between 12-24 months (1.7 pp for 25 months-6 years, 1.4 pp for 7-11 years, and 0.7 pp for 12-19 years).
- BMI assessment rates for both younger children (8.5 pp) and adolescents (9.1 pp) improved. For adults, the BMI assessment rate also improved (8.6 pp), as did the breast cancer screening rate (1.6 pp). However, cervical cancer screening rate declined (-4.0 pp).
- For the CAHPS® measure for dental care utilization, the pattern of rates suggests a general improvement in dental care utilization among adults and children overall in Medicaid managed care from 2011 to 2015, although rates still do not exceed 50%.

*Behavioral Health Care Services Quality Measures:* These HEDIS® measures are related to follow-up care for individuals with certain behavioral health diagnoses (DDD population only for 2011-2014; DDD and MLTSS populations for 2015).

- There was no change in follow-up care for children prescribed ADHD medication from 2011-2012 to 2013-2015.
- There was an improvement from 2011-2012 to 2013-2015 in the rate for 7-day follow-up for DDD beneficiaries ages 6 and older who were hospitalized for treatment of certain mental illness conditions (4.0 pp), but there was no change in the rate for 30-day follow-up for this population (although there was an upward trend over the 3-year waiver period).

*Treatment of Chronic Conditions Quality Measures:* These HEDIS® measures are related to high prevalence chronic conditions like diabetes and asthma.

- Rates were unchanged for the measures for monitoring of patients on persistent medications.
- Rates were unchanged for the diabetes care measures.
- The rates for blood pressure control were unchanged.
- The rates for the percentage of patients who had persistent asthma and were appropriately prescribed medication were also unchanged.

*Measures of Consumer Satisfaction:* These CAHPS® measures relate to perceptions of quality of care among adults and children in Medicaid managed care.

- The results were mixed across the different plans for children, but the overall trends for both adults and children showed improvements in all or most of the measures, as did the individual plan rates for adults.

With a few exceptions, the findings presented in this chapter support the conclusion that overall quality of care for Medicaid managed care beneficiaries was at the least maintained, and in several cases improved, during the first three years of the demonstration period.

## **Chapter 2: An Examination of MLTSS-related Measures Reported by Managed Care Organizations, External Quality Review, and State Government**

This chapter discusses data and performance measures relevant to managed long-term services and supports (MLTSS) that have been collected and reported by MCOs, external quality review organizations and state government relating to a post-implementation period spanning 2014 through early 2017.

Measures related to MLTSS are collected/reported in a number of ways, as listed below. We have drawn upon these sources for the analysis in this chapter.

- MCOs are required to report regularly on a number of measures, and to report all claims and encounter data to the state.
- The Division of Aging Services collects and reports a number of metrics to CMS.

- The Division of Banking and Insurance reports on its Independent Health Care Appeals Program.
- The Division of Medical Assistance and Health Services (DMAHS) and the Office of Administrative Law (OAL) report on fair hearing requests and decisions.
- An external quality review organization (EQRO) does annual audits of MCOs, including care management provided to MLTSS enrollees.
- New Jersey MCOs participate in the CAHPS® (Consumer Assessment of Healthcare Providers and Systems) survey that, on an annual basis, assesses members' perceptions of the quality of care and services they receive in their Medicaid health plan. These measure sets apply to all MCO enrollees, not just those receiving MLTSS services.
- New Jersey participates in the National Core Indicators – Aging and Disabilities (NCI-AD)™ Survey, which involves face-to-face surveys of long-term care consumers.

Some of the measures we discuss are part of the MLTSS Quality Strategy, a group of about 40 measures that was created prior to the inception of MLTSS. We have also considered stakeholder input as discussed in separate reports (Farnham et al., forthcoming; Farnham et al. 2015) to review and discuss additional metrics.

The following are the measures that are discussed in more detail in the chapter:

#### **Share of Population by Setting; Distribution of Age Groups in MLTSS**

- The share of the population receiving long-term care services in home and community-based settings has increased, while the share of the population in nursing facilities has decreased, indicating that the state is moving toward providing more services in home and community settings (Figure 1). Among the HCBS population, about 15% are in assisted living facilities and the remaining 85% are in other types of community settings.
- The share of people enrolled in the former §1915(c) waiver programs who have moved to nursing facilities remains small, indicating that people who begin receiving services in community settings are largely able to remain there (Table 2).
- The distribution of MLTSS enrollees across age groups has remained steady since MLTSS implementation (Figure 2).

#### **Assessment Timeliness and Care Management Audits**

- The timeliness of nursing home level of care assessments by both the state Office of Community Choice Options and MCOs has improved from the time of MLTSS implementation, but has also been quite variable (Figures 3 and 4). The impact of timeliness on consumers is not completely clear, as some consumers receive services while awaiting assessments.

- All MCOs showed gains from Year 1 to Year 2 of MLTSS in the extent to which their nursing home level of care assessments were authorized by OCCO (Table 3). This means that consumers are less likely to have to undergo an additional assessment by OCCO to verify their clinical eligibility.
- For care management audits, the external quality review organization (EQRO) looks at new MLTSS enrollees who are new to Medicaid managed care as well as those previously enrolled in Medicaid managed care. During the audits in Year 1, after initial implementation, they also looked at those who had transitioned from fee-for-service HCBS (Table 4). To be included in the audit, individuals must have been continuously enrolled in Medicaid and in the same MCO for at least 6 months. The audits involve file review only, with no discussions with members. Four plans were audited in both Years 1 and 2. One plan began operations in 2015 and was only included in the Year 2 audit. If fewer than 85% of audited files meet required standards, MCOs must form a corrective action plan.
  - From Year 1 to Year 2, four MCOs increased the extent to which care plans were completed within 30 days (from 52%-64%) and were aligned with the member’s needs (from 93% to 98%). Two plans increased the extent to which their care plans were person-centered, while two plans decreased—across all plans, compliance on this measure decreased (from 61% to 45%). Three plans increased the extent to which their care plans included back-up plans for members in case of service failure but the overall compliance rate decreased from 83% to 78%. See Figure 6 and Table 5.
  - There is not a straightforward relationship between care plan completion within 30 days and establishment of services within 30 days. While 64% of audited care plans were completed within 30 days, 79% of audited files had services in place within 30 days. Three MCOs were more likely to show services established within 30 days than to complete care plans within 30 days, and the two MCOs exhibiting higher compliance with care plan completion were less likely than two of the less compliant plans to show services established within 30 days (Figure 7). Some enrollees may be getting their services through a different program prior to MLTSS enrollment, making it easier to establish services.
  - Alignment of needs with the care plan can only be calculated for those files in which both are present. There was some difference in this across MCOs (Figure 8).
  - Care plan alignment with the PCA (personal care assistance) assessment was examined by the MCO where applicable, and alignment values were similar to the care plan and NJ Choice assessment.
  - Reassessments appear to generally happen in a timely fashion.
  - Evidence for required critical incident training for consumers and caregivers in Year 2 was mixed, with three MCOs at 89% or higher and two below 10% (Figure 10).

### **Critical Incidents, Appeals/Grievances/Complaints, Fair Hearings**

- Critical incidents are generally reported in a timely fashion. The number of incidents varies a bit from month to month, but remains small when compared with total MLTSS enrollment (Figure 11). The most common incidents are injuries or falls and medical or psychiatric emergencies (including harms from medication errors). Together, these account for more than half of incidents in Year 1 and more than three quarters in Year 2 (Table 6).
- Appeals, grievances and complaints have declined from about 1.2% of MCO MLTSS members in early 2015 to a number corresponding to about 0.6% of members in mid-2016 (Figure 12). These are rough estimates, as members can have multiple issues and reporting does not remove duplicates (in other words, the true percentage of members with appeals, grievances or complaints may be lower).
  - MCOs generally respond in a timely way to appeals, grievances and complaints, but overwhelmingly uphold their original decisions (more than 90%).
- Limited information on service reductions reported by MCOs in one quarter in 2015 indicates that they were not numerous and that most were not appealed.
- Fair hearing data are not segregated by Medicaid program, so MLTSS cannot be viewed separately. A minority of fair hearing filings result in a decision. The share of filings by MCO appears similar to the share of decisions in 2016 (i.e., there do not appear to be differences in the rate of withdrawals). The number of filings and decisions appears small in relation to the number of Medicaid enrollees (Table 7).
- Data from the Division of Banking and Insurance supports advocate perceptions that appeals of private duty nursing denials increased in 2015. In 2016, cases seem to be decreasing (Figure 13).

### **Transitions between Nursing Home and Community Settings**

- MCOs report 227 transitions from nursing facilities to community settings in the first year of MLTSS and 371 in the second year. Fewer than 20 members who had been transitioned each year returned to a nursing facility for more than 90 days.
- MCOs report that 1,199 consumers moved from community settings to a nursing home in the first year of MLTSS and 962 consumers had a similar move in the second year. In both cases, a majority of consumers who moved stayed for 180 days or longer.

### **Acute Care Utilization**

- MCOs report that hospital and ED use increased for the HCBS population from Year 1 to Year 2, while decreasing for the nursing facility population (Figure 14). Some members make multiple visits. Without risk adjustment information it is not possible to know whether such an increase is due to increasing frailty of the HCBS population, as opposed to other factors.

### **Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey Results**

- CAHPS® survey results (mail or phone) comparing the MLTSS population with the D-SNP (dual eligible, special needs plan) and general adult Medicaid population found that MLTSS beneficiaries surveyed tended to be older, were more likely to identify their race as white, and rated their health as poorer than the other groups.
- Individuals in MLTSS are on par with non-MLTSS beneficiaries in overall satisfaction with their health care providers and access to care. When examining satisfaction with the administrative responsiveness of their plan, MLTSS beneficiaries are slightly less satisfied.
- More than 40% of MLTSS respondents to the survey reported difficulty with their health plan with respect to obtaining, replacing, or repairing mobility equipment. Estimates were not available for the other groups because they had less need for such equipment. State officials told us that frequently there is confusion about whether Medicare or Medicaid is the payer for such equipment. In the NCI-AD™ survey (discussed next), New Jersey's MLTSS members were generally less likely to report needs for equipment than MLTSS recipients in four other states. So, while there is clearly room for improvement here, it does not appear that New Jersey is an outlier.

### **NCI-AD (National Core Indicators, Aging and Disabilities™) Survey**

- The NCI-AD™ is a face-to-face survey with questions developed by experts in long-term care. In its 2015 survey, New Jersey included about 100 surveys for each of the following (Table 10): each MCO enrolling MLTSS consumers, fee-for-service nursing home residents, Program of All-inclusive Care for the Elderly (PACE) participants, and those receiving Older Americans Act HCBS services (at least one service--including adult day, chore, homemaker, personal care and/or home delivered meals--three or more times per week).
- Comparing responses from MLTSS enrollees in New Jersey with those in Delaware, Minnesota, Tennessee and Texas showed that New Jersey's MLTSS members:
  - were older and seemed to have more family support;
  - felt more comfortable going home after a hospital or rehab discharge;
  - were less likely than members in 3 other states to be able to do things outside their home, primarily due to transportation;
  - frequently reported better access to primary care services, equipment and modifications (Table 8);
  - were equally likely to report that services met needs and goals and to participate in self-direction of services (Table 9);
  - were more likely to have a case manager discuss unmet needs (Table 9);
  - were more likely to say that their paid support staff changed too often (Table 9);
  - were less likely than enrollees in 3 other states to talk to someone about job options if they wanted a job (Table 9);

- were less likely to report a mental health diagnosis or to discuss loneliness/sadness or depression with anyone.
- Comparing responses from long-term care programs across New Jersey (MLTSS, fee-for-service nursing home, PACE and Older Americans Act services) showed that:
  - MLTSS members reported needing more assistance with self-care and were more likely to report that a family member was the person who helped them most (Figure 19);
  - MLTSS and nursing homes were more likely to be serving consumers with physical disabilities (Figure 20);
  - MLTSS members were more likely to report being able to get a primary care appointment but less likely than respondents in nursing homes or PACE to report a routine dental visit in the past year (Figure 22);
  - MLTSS members were more likely than respondents in nursing homes or Older Americans Act recipients to say that their services met all their needs and goals, and more likely than all others to say that they could choose or change their services or who provides them. They were a bit less likely to know who to call with a complaint about their services than nursing home or PACE respondents, but as likely as all except PACE respondents to know who to call if their needs changed (Figure 24);
  - MLTSS members were the most likely of all program respondents to think their direct support staff changed too often. Otherwise, they generally compared favorably to nursing home respondents and somewhat worse than PACE or Older American’s Act recipients in their experience with direct support staff (Figure 24).
- Comparing responses across MLTSS members in four different MCOs showed differences by MCO with respect to the following:
  - member diagnosis and self-rated health by MCO (Figure 25);
  - member mobility and need for self-care assistance (Figure 26);
  - member fall history, concerns, ED visits, and counseling or help regarding falls (Figure 27);
  - member social context (language, residence setting, who members lived with, ability to get to safety in an emergency, social support network)
  - access to/knowledge of care management (Figure 28);
  - follow-up or help based on member-specific needs (Figure 29);
  - adequacy of help received (Figure 30);
  - experience with paid support staff (Figure 31).
- Because enrollees self-select into MCOs and programs, and there are other differences across MCOs and other programs in terms of geographic availability, provider networks, and so on, it is not possible to use these data as a rigorous performance review of MLTSS or individual



MCOs, but the data may contain useful information regarding how to improve services for members.

### **Chapter 3: Analysis of Medicaid Claims Data to Examine Access to Care, Quality, and Cost of Care: Assessing Avoidable Hospital Use, Readmissions, Behavioral Health Care, and Ambulatory Visits in Managed Care and MLTSS**

This chapter assesses the impact of the expansion of managed care to Long Term Services and Supports (LTSS) and behavioral health (for selected LTSS-eligible populations) by examining measures related to access to care, quality of care, and health care spending for NJ Medicaid beneficiaries calculated from Medicaid fee-for-service (FFS) claims and managed care encounter data over 2011-2015. These measures include rates of avoidable inpatient hospitalizations and ED visits that arise due to inadequate ambulatory or primary care in the community; hospital readmission rates overall, and for specific diseases that reflect potentially inadequate inpatient care and lack of care coordination; follow-up rate after mental illness hospitalization that examines similar issues specifically for individuals with behavioral health conditions; ambulatory visit rates that reflect the quality of care transitions; and spending-related measures to examine potential changes in distribution of spending over time and across places-of-care. We also compare trends in selected metrics between Medicaid and NJ overall (based on all-payer data) to put Medicaid findings in the context of broader health system patterns in the state.

We present tables with annual estimates of such metrics for Medicaid overall and specific subpopulations based on Medicaid eligibility and the focus of the managed care expansion. This is followed with results of multivariate regression analyses that use statistical techniques such as segmented regression analysis and difference-in-differences modeling to account for individual, geographic and provider characteristics while identifying the impacts of the managed care expansion under the Waiver. Through these models we examine changes over time of specific metrics across all managed care beneficiaries to monitor overall adherence to the Quality Strategy by Medicaid managed care organizations (MCOs) undertaking the MLTSS reforms and provide evidence for answering Research Question 1a. These findings supplement those presented in Chapter 1. We also examine selected metrics for specific groups of Medicaid beneficiaries that come under the managed care expansion immediately on July 1, 2014. This is primarily the long-term care (LTC) beneficiaries group meeting an institutional level of care and residing in their homes and communities under the former 1915(c) waiver programs or, after July 1, 2014, under MLTSS. In separate models, we examine outcomes for the subset of nursing facility (NF) residents who transitioned into MLTSS any time during the first 18 months of the program. These regression analyses supplement the findings presented in Chapter 2 and provide the evidence needed for answering Research Question 1b.

**Annual Descriptive Estimates:** Our focus is on changes in these estimates during 2015, the full year subsequent to the implementation of MLTSS. While these trends may broadly indicate effects of the Waiver on the overall managed care population or the HCBS population, it is important to remember that descriptive estimates are not adjusted for changing beneficiary characteristics (subsequent to the Medicaid expansion) or underlying trends in outcomes unrelated to the policy. Our regression-based analysis adjusts for these effects.

Below we highlight the key findings related to the expansion of managed care and also those that highlight the differences across groups of Medicaid beneficiaries. For comprehensive findings, Chapter 3 should be reviewed.

*Avoidable and Overall Inpatient and Emergency Department Use and Spending:*

- Avoidable hospitalization rates are generally lower by 2015 than they were in the baseline period for the managed care population overall. However, for the General Assistance (GA) category overall, which experienced major changes in size and managed care composition due to the Medicaid expansion in 2014, the rate of avoidable hospitalizations increased in 2015.
- In 2015, avoidable inpatient hospitalization rates were the highest among those receiving HCBS (780 per 10,000 beneficiaries), and even higher among HCBS beneficiaries with a BH condition (1,142 per 10,000 beneficiaries). This rate had decreased from 2013 to 2014, but by 2015 was back at the level of the pre-waiver baseline years (2011-2012). In contrast, the rate of avoidable hospitalizations for the nursing facility population, overall and among those with a behavioral health (BH) condition, has been steadily declining since 2011.
- Despite declines in avoidable ED visit rates between 2012 and 2014 for the HCBS population, rates climbed to their highest by 2015 (2,373 per 10,000 population). The same trend is seen for the HCBS population in overall ED utilization. Rates for the managed care population overall and the NF population do not show this pattern.
- The ABD eligibility group enrolled in managed care has the highest per-person avoidable spending (\$221) and also overall hospital spending (\$1350) in 2015 compared to other eligibility groups, but the avoidable spending for this population was even higher prior to waiver implementation (\$273 and \$1605, respectively in 2011).
- Total spending per Medicaid beneficiary decreased from \$5,744 in 2013 to \$5,069 in 2015, but this is largely due to drops in non-hospital spending. Hospital-based spending per beneficiary actually ended up at a higher level in 2015 than in the baseline years primarily attributable to growth in ED spending.
- Around three quarters of total avoidable spending among the LTC population was incurred by NF residents in 2011-2014, but the growth in avoidable spending among the HCBS

population and decrease among the NF population after 2014 shifts this to a nearly even split between these two LTC populations by 2015.

#### *Hospital Readmissions:*

- In every category of readmission, and every year, beneficiaries with a BH condition had a higher readmission rate compared to those who were LTC-eligible and also Medicaid beneficiaries overall.
- For the overall managed care population, we find an improvement in quality reflected through AMI readmission rates, but a worsening for heart failure (HF) readmission rates.
- Among the HCBS population, all readmission rates exhibited a worsening except for AMI which had no clear trend.
- Readmission rates for the NF population indicate improvements in care except for HF readmission which increased between 2014 and 2015, consistent with the trends seen for the entire managed care and HCBS populations.

#### *Follow-up after Hospitalization for Mental Illness and Ambulatory Visit after Hospital Discharge:*

- For Medicaid beneficiaries overall and in managed care, rates of follow-up seven days and thirty days after discharge from a mental illness hospitalization do not change very much over 2011-2015, but there is an indication of a slightly increasing trend starting in 2014 after slight declines from 2011-2013.
- Rates of an ambulatory visit 14 days after discharge home have declined since 2011 for managed care overall and for the ABD and NJ FamilyCare populations. They have also declined for the HCBS population through 2014, but then increase by 7.5 percentage points from 2014 to 2015.

#### *LTSS, Non-LTSS, and Total Costs:*

- Total spending is higher for the NF population compared to the HCBS population and this is largely driven by their high LTSS spending, although that spending is at its lowest by 2015.
- Spending related to avoidable hospitalizations for the HCBS and NF populations accounted for less than 1% of overall spending for these two populations combined.

#### *Rebalancing*

- The share of LTSS spending has shifted slightly more towards the HCBS population over 2011-2015. The greatest increases in the proportion of spending for the HCBS population occurred after implementation of MLTSS in July 2014.
- Overall annual spending for the HCBS and NF populations has declined by about \$300 million over 2011-2015, mostly as a result of declines in the magnitude of spending for the NF population.

### *Quality Metrics for the Medicaid Population with a Behavioral Health Condition*

- During the first two quarters when the IME was operational, avoidable hospitalizations in the Medicaid population with a behavioral health condition are lower than in prior years, but the declines were underway in 2013.
- Thirty-day readmission and mental health follow-up visits are not markedly different in the last two quarters of 2015 compared to the period prior to IME operation.

**MLTSS Impact on the Overall Medicaid Managed Care Population:** Using segmented regression analysis, we examine changes in outcomes for the entire managed care population immediately after implementation of MLTSS and identify the impact of the policy on these outcomes during the first 18 months of the program. We assess immediate changes (changes in the level) as well as changes in time trend. We calculate the estimated change at the end of the study period among the MLTSS population compared to the scenario without MLTSS. These models adjust for individual and provider characteristics, geography/residence, and time trends unrelated to MLTSS.

### *Avoidable Inpatient and Emergency Department Use:*

- There is no significant impact of MLTSS on avoidable inpatient utilization for the overall managed care population, but we observe significant effects on avoidable ED utilization. By the end of 2015 that amounts to 11 fewer avoidable ED visits per 1,000 beneficiaries than there would have been without MLTSS.

### *Hospital Readmissions:*

- We find a statistically significant effect only for hospital wide readmissions. There was a decrease in the likelihood of readmission by 4.6 percentage points (pp) by the last month of 2015 in the overall managed care population. While there were decreases for heart failure, AMI, and pneumonia readmissions, none of these were statistically significant.
- Among Medicaid managed care beneficiaries with a BH condition, there was also a statistically significant decline in the probability of hospital-wide readmission. By December 2015, hospital-wide readmissions were 5.2 pp lower for the managed care population with a BH condition than they would have been without MLTSS.

### *Follow-up after Hospitalization for Mental Illness and Ambulatory Visit 14 Days after Discharge Home:*

- There are decreases in follow-up rates within 7 and 30 days of hospitalization, but these decreases are not statistically significant.
- We estimate a 1.6 pp increase in the probability of an ambulatory visit in December 2015 compared to the scenario without MLTSS but this is only marginally significant ( $p < 0.1$ ).

**MLTSS Impact on the HCBS and NF Populations:** Using a difference-in-differences estimation strategy, we are able to examine average changes in outcomes, separately for HCBS and NF beneficiaries, whose long-term services and supports were integrated with their physical and behavioral health care after implementation of MLTSS. These models use the non-LTC ABD population as a comparison group to account for outcome trends unrelated to the MLTSS policy and further adjust for individual and provider characteristics and geography/residence to isolate the impact of MLTSS on these outcomes.

*Avoidable Inpatient and Emergency Department Use and Associated Costs:*

- There was no statistically significant impact of MLTSS on avoidable inpatient utilization by the HCBS or NF population.
- MLTSS implementation increased the rate of avoidable ED visits over a quarter by 13 per 1,000 HCBS beneficiaries, and this change was statistically significant. The effect for the nursing facility population over a quarter was a decline of 5 visits per 1,000 beneficiaries and this effect was only marginally significant ( $p < 0.1$ ). There was also a significant decrease in avoidable ED visit-related spending in the NF population under MLTSS.
- We find that the MLTSS policy significantly increased avoidable IP costs for the HCBS population, but not the NF population. It also significantly decreased avoidable ED costs in the NF population, but does not have a significant impact on avoidable ED costs for the HCBS population.

*Hospital Readmissions:*

- Across all readmission metrics, estimated effects are positive in magnitude indicating increases in the probability of hospital readmission for the HCBS and NF populations in MLTSS, but these increases are not all statistically significant.
- There was a statistically significant 6.1 pp increase in pneumonia readmission rates among the HCBS population due to the MLTSS implementation.
- There was an 8.7 pp increase in hospital-wide 30-day readmissions due to MLTSS implementation for the NF population. We observe a 1.2 pp increase for the HCBS population, but this was only marginally significant ( $p < 0.1$ ).
- MLTSS implementation increased the probability of a readmission for the HCBS population with a BH condition 1.5 pp. This finding is only marginally significant. In contrast, MLTSS implementation is associated with a 9 pp increase in the hospital-wide readmission rate among the NF population with a BH condition. The effect is statistically significant.

*Follow-up after Hospitalization for Mental Illness and Ambulatory Visit 14 Days after Discharge Home:*

- MLTSS implementation increased the follow up rate within 7 days of a mental illness hospitalization by 6.7 pp, but decreased the follow-up within 30 days by 3.1 pp. Neither effect is statistically significant, and, due to small numbers of HCBS beneficiaries with a qualifying mental illness index hospitalization in the post-MLTSS period, there are statistical issues with the reliability of these results.
- MLTSS implementation increased the probability of an ambulatory visit 14 days following discharge from a medical hospitalization by 0.6 pp for the HCBS population. This effect is not statistically significant.

**All-Payer Comparisons:** Using statewide data on hospital utilization from the New Jersey State Health Assessment Data system, we explored trends in metrics between Medicaid and NJ overall to put Medicaid findings in the context of broader health system patterns in the state. We compared the slope of linear trend lines for rates of avoidable hospitalizations and overall emergency department visits between Medicaid and NJ overall. Noted comparisons have not been tested for statistical significance, and not adjusted for patient, provider and geographic characteristics.

- During the waiver demonstration period, avoidable hospitalizations for both acute and chronic conditions appear to be decreasing across the board in New Jersey, with the exception of some diabetes-related admissions. This declining trend has been at least mirrored in the Medicaid population and often, Medicaid declines have been steeper over this time period.
- Despite the overall positive trend in preventable hospitalizations, it is worth noting that for some acute conditions, the decline in Medicaid has been leveling off, or, in the case of conditions related to chronic diseases like uncontrolled diabetes and heart failure, reversing from 2014 to 2015.
- Emergency department visits appear to be on the rise in New Jersey overall and increasing in Medicaid as well.

**Conclusions:**

Overall, there were no negative effects on the quality, efficiency, and coordination of care for the managed care population as a whole during the first 18 months of MLTSS implementation. However, we find increased avoidable ED visits and hospital readmissions, indicating a worsening in outcomes related to access to care and quality of care for the HCBS population during the first year and a half of MLTSS implementation. There are some findings suggestive of small improvements in post-hospitalization follow-up visits for the HCBS population post-MLTSS, but

they do not meet the threshold of statistical reliability. It may be that more time is needed both in terms of available data and program evolution before improvements become detectable. We also do not observe any improvements in behavioral health care under MLTSS so far. These findings are largely consistent between our descriptive results and our adjusted regression results. There are statistically significant increases in readmission rates among NF residents, but there was also a slight decrease in avoidable ED visits and avoidable ED visit related costs for the NF population. Because of the phased in transition of the NF population, the post MLTSS period for assessing changes in NF residents is much shorter. NF findings are subject to this limitation. Racial ethnic disparities, except for hospital wide readmission rates among HCBS black beneficiaries, did not appear to have increased due to MLTSS. Spending trends indicate MLTSS has helped accelerate the rebalancing of spending away from facility care to supporting individuals in their homes and communities.

#### **Chapter 4: Examining Care Outcomes for Populations of Children and Youth Targeted for Home and Community-Based Services**

This chapter presents Medicaid claims-based metrics related to selected types of hospital utilization for several populations of children targeted for additional home and community-based services (HCBS) under the Waiver. Specifically, the Waiver authorized the NJ Department of Children and Families' Division of Children's System of Care (DCF's CSOC) to coordinate new supportive services for children with Autism Spectrum Disorder (ASD), co-occurring intellectual/developmental disabilities and mental illness (ID-DD/MI), and Serious Emotional Disturbance (SED). The Waiver also expanded Medicaid eligibility for children with SED.

All of the services authorized under the Waiver for the DCF populations started being offered during calendar year 2014 or later, limiting the data on the post-implementation period available for this final report. Because of this, and due to small sample sizes in the ASD cohort, we present descriptive results with no adjustment for patient or provider characteristics. We conducted statistical testing on unadjusted utilization rates, comparing estimates for 2015 to the year prior to waiver service initiation. Still, estimates based on small samples should be interpreted with the caveat that observed variation for the metrics between years might be the result of outliers in the data or random events unrelated to the policy change.

##### *Avoidable Hospital Utilization, Overall Hospital Utilization, and Per Capita Hospital Spending*

- Rates of avoidable hospital use were very low in the baseline and early demonstration period. Compared to 0.2 or fewer avoidable hospitalizations per 100 Medicaid youth in each year of the study period, the rate was higher in the ID-DD/MI cohort, reaching 1.8 per 100 ID-DD/MI youth in 2013, but dropping down to zero in 2015.

- We observe a slight downward trend in inpatient utilization for Medicaid youth overall over 2011-2015 which is mirrored in the ID-DD/MI and ASD cohorts, but the declines are not statistically significant.
- The emergency department visit rate for the ASD and ID-DD/MI cohorts showed a statistically significant increase from the year preceding waiver service initiation, to 2015, following a steady or declining trend in the preceding year(s). An increase was also observed for Medicaid youth overall.
- Per-capita spending for the ASD and the ID-DD/MI cohorts were statistically significantly lower in 2015 versus the comparison year (\$644 vs. \$954 and \$856 vs. \$2,847, respectively).

#### *Inpatient Hospital Use for Mental Health Conditions*

- Although rates were steady for Medicaid youth overall, rates of mental illness hospitalizations for the ID-DD/MI cohort dropped to their lowest level of 2.8 per 100 youth in 2015, although this decline was not statistically significant.
- Admissions to either long-term or short-term psychiatric hospitals for children in the ID-DD/MI cohort reached their highest in 2015 at 4.1 per 100 youth, but this was not a statistically significant increase. The different trends between inpatient facility types (general acute care vs. psychiatric) is relevant to consider given the goal of expanded home and community-based services in reducing institutionalization.
- Hospitalizations for severe mental illness were infrequent in general, with rates of 1 or less per 100 for all cohorts in all years.

#### *Admission to Residential Treatment Facilities*

- There was a statistically significant decline between 2014 and 2015 in the incidence of residential treatment facility admissions for children with SED. In 2014, 1 in every 100 children with SED had at least one admission to a residential treatment facility. The corresponding rate in 2015 was 0.4 per 100 children.

#### *Post-acute Care Following Hospitalization*

- We could not reach the minimum sample size for assessing utilization (hospital readmission or ED visits) subsequent to mental or severe mental illness hospitalizations in the ASD or ID-DD/MI cohorts.
- For all-cause hospitalizations, we found that the combined populations of youth eligible for the HCBS waiver programs started in 2012 with lower rates of readmissions and ED visits within 30 days of discharge than Medicaid youth overall, but by 2015, ED visits following hospitalization was higher.



There is no net positive or negative impact on acute care utilization outcomes that we can attribute to the additional waiver services for children in the ASD or ID-DD/MI pilot programs. Data from DMAHS's annual waiver reports extending further out than our claims analysis are suggestive that the pilots are being implemented successfully, with very low rates of out-of-home placements for children in the ASD and ID-DD/MI cohorts and high achievement on the process metrics monitored as part of CSOC's Quality Strategy. The statistically significant decline in the number of children with SED ever being admitted to a residential treatment facility in 2015 is a positive finding, but there would be, at most, three months of exposure to the new waiver services for this cohort of children in 2015. So while the declining trend is promising, it is not conclusive regarding the impact of these new services on reducing the need for out-of-home placement in a residential treatment facility for children with SED.

### **Chapter 5: Impact of Administrative Simplifications to Streamline Medicaid Eligibility Processes**

In this chapter we assess administrative changes under the Waiver intended to streamline Medicaid eligibility for long term services and supports. These include a spend down provision through a qualified income trust (QIT) for individuals in need of long term care whose income is above the threshold eligibility level and the elimination of the transfer of assets look-back period for individuals who are at or below 100% of the FPL. To evaluate these reforms we draw on statistics from administrative records provided to us by State officials or available in public reports and presentations. We also rely on audit data collected by the State's Bureau of Quality Control (BQC) and contextual information on the audit process and findings from direct communications with State officials. We also use Medicaid fee-for-service (FFS) claims and managed care encounter data for January 1, 2011 through December 31, 2015 to examine the share of long-term care recipients in home and community-based setting in the pre- and post-waiver period.

Many individuals utilized the self-attestation option. Before MLTSS, 1,670 self-attestation forms were collected and another 2,017 were collected between July 2014 and March 2017. Eight randomly sampled applications for each quarter between October 2015 and December 2016 underwent a detailed audit process by BQC staff to determine the accuracy of the self-attestation. They reviewed financial documents to determine whether any assets were transferred for less than fair market value during the five years prior to application. There was a zero error rate on these samples.

During fiscal year 2015, 544 QIT applications were approved out of the 1,800 received (30%). Projections made by the State for fiscal years 2016 and 2017 show similar rates of approval (36% and 33%, respectively).

During the period December 2014 to March 1, 2016, out of 1,054 QIT users, 72% were in nursing facilities, 21% were in Assisted Living (considered a community setting) and 7% were living at home. This reflected 291 people who were able to enroll in MLTSS and stay in the community who would not have been able to without the QIT mechanism. We further estimated that 225 individuals were able to receive LTSS services due to the availability of QITs over July 2016-June 2017.

Using Medicaid claims data we calculated any change in the share of LTC designated recipients receiving services in the community. We found that the percentage of beneficiaries in the community receiving HCBS services increased from the pre-waiver baseline period (2011-2012) to the waiver period under analysis (2013-2015). This share increased from 25.9% in 2011 to 32.5% in 2015.

The full potential of these administrative simplifications to reduce barriers to MLTSS enrollment relies on their uniform and equitable application. While the representativeness of counties in the early self-attestation audit samples raised the question of whether all counties were using the self-attestation form, the BQC has seen more diversity in recent samples and has not expressed concern that there is any systematic differences in the use of the form across County Welfare Agencies (CWAs). With regard to QITs, stakeholders have expressed concerns about access to legal assistance for consumers with limited financial or social resources, who may be at a disadvantage for drawing up the trust documents and designating a representative to administer the trust over time. The State has informed the CWAs to reach out if they encounter these situations, but as of April 2017, only one or two such cases have been brought to the State's attention and they have been resolved.

The data and information we have reviewed indicates that the elimination of the transfer of assets look-back period for low-income LTSS applicants and the establishment of QITs have been successfully implemented. It is reasonable to conclude that the expanded eligibility for HCBS made possible by the QIT and the streamlined pathway into Medicaid long-term care service made possible by the self-attestation process contributed to the growth in the HCBS population during the waiver demonstration period.

# Examining the Effect of the NJ Comprehensive Waiver on Access to Care, Quality, and Cost of Care: Draft Final Evaluation Report

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## Introduction

The New Jersey Medicaid Comprehensive Waiver Demonstration was approved for the period October 1, 2012 through June 30, 2017. This §1115 waiver not only consolidated authority for several existing Medicaid waivers, but initiated a variety of health reforms in New Jersey's Medicaid program. The key changes authorized by the Waiver are an expansion in managed care to Long-term Services and Supports (LTSS) and behavioral health (BH) services, targeted home and community-based services (HCBS) for populations of children and in-home community supports for individuals with intellectual and developmental disabilities, administrative simplifications in the Medicaid eligibility process for low-income applicants seeking LTSS, and the establishment of a hospital-based Delivery System Reform Incentive Payment (DSRIP) Program.

The Rutgers Center for State Health Policy (CSHP) was engaged to evaluate New Jersey's Medicaid Comprehensive Waiver Demonstration. In this draft final evaluation report, we examine the expansions in managed care and targeted home and community-based services occurring under the Waiver as well as the impact of the changes in administrative processes related to financial eligibility determination for LTSS applicants.<sup>3</sup> In brief, the Waiver authorized shifting the delivery of LTSS and behavioral health (BH) services for certain aged or physically disabled beneficiaries to managed care reimbursement system (referred to as MLTSS – Managed Long-term Services and Supports), establishment of an Administrative Services Organization (ASO) that will manage behavioral health services,<sup>4</sup> and the provision of new supportive services for children and youth with Autism Spectrum Disorder (ASD), co-occurring

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<sup>3</sup> The Supports program, which is part of the targeted home and community-based services expansion for individuals with intellectual and developmental disabilities has been evaluated qualitatively in a separate report (Farnham, et al., forthcoming). The DSRIP program is evaluated as a separate component and the midpoint evaluation was submitted to the New Jersey Division of Medical Assistance and Health Services (DMAHS) on September 2015 with the final evaluation due in March 2018.

<sup>4</sup> This reform was only partially implemented during the study period covered in this interim evaluation. As of July 2015, Rutgers University Behavioral Health Care became the Interim Managing Entity for addiction services.

intellectual/developmental disabilities and mental illness (ID-DD/MI), and Serious Emotional Disturbance (SED). The Waiver also expanded Medicaid eligibility for children with SED and made possible administrative simplifications which streamline the Medicaid eligibility processes for lower-income individuals seeking LTSS. These abovementioned policy changes are addressed by the first three of the four evaluation hypotheses and their supporting research questions as outlined in the waiver Special Terms and Conditions document (CMS 2014) and enumerated below.

**Hypothesis 1: "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."**

**Research Question 1a: "What is the impact of the managed care expansion on access to care, the quality, efficiency, and coordination of care, and the cost of care for adults and children?"**

**Research Question 1b: "What is the impact of including long-term care services in the capitated managed care benefit on access to care, quality of care, and mix of care settings employed?"**

**Hypothesis 2: "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."**

**Research Question 2a: "What is the impact of providing additional home and community-based services to Medicaid and CHIP beneficiaries with serious emotional disturbance, autism spectrum disorder, or intellectual disabilities/developmental disabilities?"**

**Research Question 2b: "What is the impact of the program to provide a safe, stable, and therapeutically supportive environment for children from age 5 up to age 21 with serious emotional disturbance who have, or who otherwise would be at risk for, institutionalization?"**

**Hypothesis 3: "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."<sup>5</sup>**

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<sup>5</sup> Hypothesis 3 and the associated research questions enumerated here reflect the wording used in the waiver Special Terms and Conditions document as approved by CMS (CMS 2014). The projected spend-down provision originally proposed in the Waiver was not implemented since the State chose to adopt Qualified Income Trusts (QITs), and we assess the impact of QIT the implementation.

Research Question 3a: **“What is the impact of the projected spend-down provision on the Medicaid eligibility and enrollment process? What economies or efficiencies were achieved, and if so, what were they? Was there a change in the number of individuals or on the mix of individuals qualifying for Medicaid due to this provision?”**

Research Question 3b: **“What is the impact of eliminating the transfer of assets look-back period for long term care and home and community based services for individuals who are at or below 100% of the FPL? Was there a change in the number of individuals or on the mix of individuals qualifying for Medicaid due to this provision?”**

Hypothesis 4: **“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 costs through improvement.”**

These hypotheses were tested utilizing a mix of quantitative and qualitative methods. Hypothesis 4 relating to the DSRIP program is covered in a separate set of reports. This report is comprised of five distinct chapters each covering one analytic component of our evaluation and supplements two standalone reports with qualitative findings from key informant interviews of stakeholders and state officials on implementation of MLTSS<sup>6</sup> and the Supports program.<sup>7</sup>

Organized by chapter, the following table presents a brief description of the contents of this report, the data sources used and time periods covered, the focus of the analyses (i.e. populations and/or plans), and the corresponding hypothesis(es) and research question(s) addressed to the extent possible given the available data and timing of policy implementation.

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<sup>6</sup> Farnham J, S Chakravarty, and K Lloyd. 2017. *Stakeholder Feedback on Implementation of the Managed Care Expansion in Long-Term Services and Supports (Second Round)*. New Brunswick, NJ: Rutgers Center for State Health Policy.

<sup>7</sup> Farnham J, S Chakravarty, and K Lloyd. 2017. *Stakeholder Feedback on Implementation of the Supports Program for Individuals with Developmental Disabilities*. New Brunswick, NJ: Rutgers Center for State Health Policy

Data Sources	Focus of Analysis	Hyp.	RQ
<b>Chapter 1</b>			
HEDIS® and CAHPS®, 2011-2015	All managed care beneficiaries and MCOs	1	1a
<b>Chapter 2</b>			
Reports from MCOs, EQROs, and State Government, 2014-2017	Medicaid beneficiaries in MLTSS and their MCOs	1	1b
<b>Chapter 3</b>			
Medicaid claims and encounter data, 2011-2015	Medicaid beneficiaries and managed care beneficiaries, overall and by eligibility group, and those in long-term care (facility and community-based)	1	1a, 1b
<b>Chapter 4</b>			
Medicaid claims and encounter data, 2011-2015	Individuals with ASD, ID-DD/MI, and SED eligible for home and community-based waiver services, and all Medicaid youth	2	2a, 2b
<b>Chapter 5</b>			
State-provided statistics and public reports, 2012-2017; Medicaid claims and encounter data, 2011-2015	Individuals seeking entrance into MLTSS using self-attestations and Qualified Income Trusts	3	3a, 3b

Hyp.=Hypothesis; RQ=Research Question; MCO=Managed Care Organization; EQRO=External Quality Review Organization; ASD=Autism Spectrum Disorder; ID-DD/MI=Co-occurring intellectual/developmental disability and mental illness; SED=Serious Emotional Disturbance.

## References

CMS (Centers for Medicare & Medicaid Services). 2014. *Technical Corrections to the New Jersey Comprehensive Waiver Section 1115 of the Social Security Act (the Act) Demonstration (Project No. 11-W-00279/2)*. Baltimore: CMS. <https://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nj/nj-1115-request-ca.pdf>.

# Chapter 1: HEDIS® and CAHPS® Quality Indicators: Preventive Care, Behavioral Health Care, Treatment of Chronic Conditions, and Consumer Satisfaction

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## Introduction

This section compares the performance of NJ Medicaid<sup>8</sup> managed care organizations (MCOs) during calendar years 2011-2012, the baseline period of the waiver evaluation, and calendar years 2013-2015, the three years of the waiver implementation period. It presents quality and utilization-based metrics from two sources: first, the Healthcare Effectiveness Data and Information Set (HEDIS®), a system of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) in conjunction with a variety of public and private partners; second, the CAHPS® (Consumer Assessment of Healthcare Providers and Systems) survey that, on an annual basis, assesses members' perceptions of the quality of care and services they receive in their Medicaid health plan. Examining potential changes across all managed care beneficiaries (not just restricted to those directly affected by the waiver policy) provides evidence needed to answer Research Question 1a under Hypothesis 1 of the waiver evaluation, as enumerated in the waiver Special Terms and Conditions document (CMS 2014).

Hypothesis 1: **"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."**;

Research Question 1a: **"What is the impact of the managed care expansion on access to care, the quality, efficiency, and coordination of care, and the cost of care for adults and children?"**

Monitoring Medicaid managed care organizations' (MCOs') adherence to the goals of the Quality Strategy governing the State's improvement efforts for all Medicaid managed care services (DMAHS 2014) is intended to ensure that preparation for and full implementation of the Managed Long-term Services and Supports (MLTSS) expansion did not negatively affect quality of care for members served by MCOs including those not directly impacted by the waiver policy.

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<sup>8</sup> The term Medicaid will be used in this report to refer to NJ FamilyCare beneficiaries who are insured under the State's Medicaid or CHIP programs, including those covered by MCOs.

The measures in the tables are related to preventive care, behavioral health care, treatment of chronic conditions, and consumer satisfaction.

## Methods

### Data Sources

The health plans covering Medicaid enrollees in New Jersey regularly collect and report quality indicators assessing care and service delivered to members that are consistent with the DMAHS Quality Strategy. These measures are based on the Healthcare Effectiveness Data and Information Set (HEDIS®), a system of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) in conjunction with a variety of public and private partners. These measures have specific definitions governing data preparation and reporting to accurately measure members' care and service across several health domains. NJ Medicaid plans also have their HEDIS® results validated by an external quality review organization (EQRO).

On an annual basis, an independent survey organization also assesses members' perceptions of the quality of care and services they receive in their Medicaid health plan. The CAHPS® (Consumer Assessment of Healthcare Providers and Systems) survey, a part of the HEDIS® measurement set developed by the NCQA, is the instrument used for this survey. A sample of health plan members, sometimes stratified by eligibility categories of interest, is interviewed using child and adult versions of the CAHPS® instrument.

Both types of quality measures, those from plan records (referred to in this report as HEDIS® measures) and those from member surveys (referred to in this report as CAHPS® measures) are presented in this report for the years 2011, 2012, 2013, 2014, and 2015<sup>9</sup>. For the HEDIS® metrics, in addition to select measures which are publicly reported, we also used data from the annual Performance Measure Validation reports created by the State's EQRO and provided to us by DMAHS. The 2011 and 2012 CAHPS® Health Plan Survey 4.0 reports prepared by ACS Government Healthcare Solutions, the 2013 and 2014 CAHPS® Health Plan Survey 5.0 reports prepared by Xerox State Healthcare LLC, and the 2015 CAHPS® Health Plan Survey 5.0H reports prepared by DataStat, Inc., and also provided to us by DMAHS, were the source of the CAHPS® metrics reported for the years 2011-2015.<sup>10</sup>

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<sup>9</sup> Further information about HEDIS® and CAHPS® measures, such as measure development processes and details on measure specifications, can be found at [www.ncqa.org](http://www.ncqa.org). Additionally, information on methods specific to collection of these measures for NJ Medicaid MCOs can be found in the DMAHS's Annual Reports at <http://www.state.nj.us/humanservices/dmahs/news/>.

<sup>10</sup> The baseline period for the evaluation of the Medicaid Comprehensive Waiver (exclusive of the DSRIP) is 1/1/2011-9/30/2012. HEDIS® and CAHPS® measures are collected annually using a calendar year performance period that,



## **Statistical Testing**

In this section we present methods to examine whether there were any differences in quality between the two baseline years and the first three implementation years of the evaluation period.

*Comparison of HEDIS® Measures:* For HEDIS® measures, a weighted average of individual plan results based on the entire Medicaid managed care population is available for each year. To compare estimates between the baseline (2011-2012) and waiver periods (2013-2015), 95% confidence intervals (CI) of the difference between the 2011-2012 and 2013-2015 pooled estimates were calculated using the following formula:

$$(\text{plan rate}_{2013-2015} - \text{plan rate}_{2011-2012}) \pm 1.96 \times SEDiff$$

The formula for the standard error of the difference (*SEDiff*) is as follows:

$$SEDiff = \sqrt{\frac{p_1 q_1}{n_1} + \frac{p_2 q_2}{n_2}}$$

where

$n_1$  is the population denominator for years 2011+2012

$n_2$  is the population denominator for years 2013+2014+2015

$p_1$  is the weighted pooled rate for years 2011-2012

$p_2$  is the weighted pooled rate for years 2013-2014-2015

$q_1$  is  $(1-p_1)$

$q_2$  is  $(1-p_2)$

If the 95% CI was a range of only negative numbers, then the 2013-2015 pooled rate was considered below the 2011-2012 pooled rate indicating that performance based on that HEDIS® measure declined for the Medicaid managed care population. If the CI contained zero, the performance between the two periods was not considered to be statistically different, and if the CI was a range of only positive numbers then performance based on that HEDIS® metric improved from 2011-2012 to 2013-2015. Due to very large sample sizes, small changes in rates may be significant.

Certain HEDIS® measures were not required to be reported by plans in 2011. For these, estimates are available for year 2012 only, and this single year served as the baseline.

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while not exactly matching our proposed baseline, tracks with and is representative of care and services delivered during that period.

*Comparison of CAHPS® Measures:* CAHPS® data-based metrics are available from samples that are representative of individual plans.<sup>11</sup> However, for the baseline years, only the reported overall average across plans was available in the provided reports, and this average does not reflect the differences in enrollment across plans. Also, whether or not estimates were case-mix adjusted was not consistent across years. Because of this, we could not conduct statistical tests of differences across the years for the entire managed care population. Accordingly, we adopted a descriptive approach where we examined estimates separately for each plan and also the overall average across plans, examining changes from 2011-2012 to 2013-2015.<sup>12</sup> Differences of 1% or less were ignored since these could be due to rounding off. Changes were color-coded to indicate whether the point estimates improved, stayed the same/showed a mixed trend, or declined. For 2015, we calculated and reported an overall plan average which is a simple mean of the individual plan estimates.

## Results

Results are organized by the following domains – preventive health, behavioral health services, treatment of chronic conditions, and consumer satisfaction. Below, a brief discussion of findings is presented.

*Preventive Care Quality Measures:* Tables 1.1 and 1.2 show quality measures related to preventive care for adults and children in Medicaid managed care during the baseline and waiver periods spanning years 2011-2015 (data shown for 2011-2012 is pooled). The HEDIS® measures in Table 1.1 are predominantly National Quality Forum (NQF) endorsed measures related to immunizations, screenings, and visits to primary care practitioners. For 2011-2012, 82.23% of adolescents in managed care received both their meningococcal vaccination and their Tdap or Td (tetanus, diphtheria toxoids and acellular pertussis vaccine or tetanus, diphtheria toxoids) vaccine by their 13th birthday. For 2013-2015, the pooled rate was 84.45% and this represented a statistically significant improvement in the vaccination rate for this population. The rates for vaccine combinations 2 and 3 declined. Rates significantly improved from 2011-2012 to 2013-2015 for wellness visits for both young children and adolescents, but the rate for frequency of ongoing prenatal care declined. Rates also declined for the prenatal and postpartum care metric which assesses visit timeliness surrounding delivery. Rates improved for all the access to primary

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<sup>11</sup> Effective July 1, 2014, Healthfirst's Medicaid beneficiaries were migrated to WellCare. The field period for the 2014 CAHPS began in April 2014 and respondents were required to have been enrolled with their health plan for at least the prior 6 months to be eligible for the survey. Therefore, the 2014 estimates relate to beneficiaries enrolled in Healthfirst, and are thus comparable to previous years. The 2015 estimates are just WellCare, and thus not comparable to the Healthfirst estimates for previous years.

<sup>12</sup> Other limitations relating to CAHPS® survey include low response rates making sample sizes small for some questions for some plans. Differential non-response, particularly in small samples, can create unquantifiable bias in estimates.

care measures for children of all ages except for those ages 12-24 months. BMI assessment rates for both younger children and adolescents improved. For adults, the BMI assessment rate also improved, as did the breast cancer screening rate, but the cervical cancer screening rate declined.

Table 1.2 shows the CAHPS® measure for dental care utilization. In each plan and separately for adults and children, the percentage of respondents who self-report that they have received care from a dental office or clinic in the past six months is shown for 2011, 2012, 2013, 2014, and 2015. The pattern of rates suggests a general improvement in dental care utilization among both adults and children in Medicaid managed care, both overall and among the different plans, but rates are still quite low. For example, the overall rates for adults who received care from a dental office or clinic in the past six months were 28% and 31% for 2011 and 2012, respectively, while the rates were 32%, 43%, and 41% for 2013, 2014 and 2015, respectively.

*Behavioral Health Care Services Quality Measures:* Table 1.3 shows quality measures related to behavioral health care services for adults in Medicaid managed care. The HEDIS® measures in Table 1.3 are also National Quality Forum (NQF) endorsed measures related to follow-up care for individuals with certain behavioral health diagnoses. The rates shown for *Initiation Phase* under *Follow-up Care for Children Prescribed ADHD Medication* refer to the percentage of 6-12 year old children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least one face-to-face follow-up care visit within 30 days of when ADHD medication was first dispensed. In 2011-2012, the pooled rate was 31.81% among the eligible population. In 2013-2015, the pooled rate was 32.19%. There was no statistically significant difference in rates between these two periods, nor was there a difference in rates for the *Continuation and Maintenance Phase*. The measure, *Follow-Up After Hospitalization for Mental Illness*, applies only to the DDD Medicaid managed care beneficiaries ages 6 and older who were hospitalized for treatment of certain mental illness diagnoses in years 2011-2014, but also includes the MLTSS population in 2015. In 2011-2012, 19.42% of this population had a qualifying follow-up visit within 7 days after discharge. In 2013-2015, the rate was 23.42%, representing a significant improvement in this quality measure. There was no change in the 30-day follow-up rates between the two periods.

*Treatment of Chronic Conditions Quality Measures:* Table 1.4 shows quality measures related to treatment of chronic conditions for adults and children in Medicaid managed care. These HEDIS® measures are all National Quality Forum (NQF) endorsed measures related to high prevalence chronic conditions like diabetes and asthma. Rates were unchanged for the measures under *Annual Monitoring for Patients on Persistent Medications* and for measures under *Comprehensive Diabetes Care*. The rates for blood pressure control were also unchanged, as were the rates for all age groups for *Use of Appropriate Medications for People with Asthma*.

*Measures of Consumer Satisfaction:* Tables 1.5 and 1.6 show a variety of CAHPS® measures related to perceptions of care quality among adults and children in Medicaid managed care. The first three measures in the tables are composite measures which group together questions on similar topics to simplify interpretation of the data and to enhance the reliability of results (ACS Government Healthcare Solutions 2011). For example, the *Getting Needed Care* composite is a combination of beneficiaries' responses to questions on the ease of getting appointments and the ease of getting the care, tests, and treatment needed under their health plan. For 2015, composite measures were only presented graphically in the CAHPS report and complete response scale break-downs for these composite measures were not reported (i.e., a combined bar for "usually" or "always" was shown), so the results shown here are for the first item in the composite measure. In Table 1.5 for adults, all measures showed improved rates from 2011-2012 to 2013-2015 both overall and for all Medicaid managed care plans. This includes these measures: *Getting Needed Care* composite, *Getting Care Quickly* composite, *How Well Doctors Communicate* composite, *Overall Rating of Personal Doctor*, *Ease of Getting Appointments with Specialists*, and *Personal Doctor Informed about Other Providers*. For children in Medicaid managed care plans in Table 1.6, the rates improved overall from 2011-2012 to 2013-2014 for four of the five measures with data for all four years (*Getting Needed Care* composite, *Getting Care Quickly* composite, *Overall Rating of Personal Doctor*, and *Ease of Getting Appointments with Specialists*). There was no change in the *How Well Doctors Communicate* composite. Three of the four individual plans showed improvement in at least four of the measures.

**Table 1.1: HEDIS® measures of preventive care quality, 2011–2015**

New Jersey Medicaid Managed Care Population

	2011-2012	2013		2014		2015		2013-2015	2013/2015-	SE	95% Confidence Interval		Performance 2013/2015- 2011/2012
	Pooled Rate	Population	Rate	Population	Rate	Population	Rate	Pooled Rate	2011/2012 Difference		LCI	UCI	
Childhood Immunization Status													
Vaccine Combination 2 <sup>a</sup>	70.55%	29,515	69.86%	28,725	70.94%	29,994	67.85%	69.53%	-0.01020	0.00241	-0.01492	-0.00548	Declined
Vaccine Combination 3 <sup>b</sup>	65.36%	29,515	64.63%	28,725	65.16%	29,994	61.42%	63.71%	-0.01653	0.00251	-0.02145	-0.01160	Declined
Immunizations for Adolescents													
Meningococcal	84.61%	28,328	86.36%	27,900	86.28%	28,868	84.22%	85.61%	0.00999	0.00201	0.00605	0.01392	Improved
Tdap/Td	89.22%	27,328	90.72%	27,900	93.79%	28,868	91.85%	92.12%	0.02901	0.00166	0.02574	0.03227	Improved
Vaccine Combination 1 <sup>c</sup>	82.23%	27,328	84.92%	27,900	85.68%	28,868	82.81%	84.45%	0.02217	0.00211	0.01803	0.02631	Improved
Well-Child Visits in First 15 Months of Life	66.78%	20,798	68.71%	19,654	69.98%	19,743	65.66%	68.13%	0.01342	0.00298	0.00757	0.01927	Improved
Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	78.72%	133,964	81.36%	137,429	78.10%	136,209	77.72%	79.04%	0.00323	0.00100	0.00127	0.00520	Improved
Adolescent Well-Care Visits	60.14%	190,350	64.00%	205,676	63.72%	219,914	59.38%	62.26%	0.02120	0.00101	0.01922	0.02318	Improved
Frequency of Ongoing Prenatal Care <sup>d</sup>	59.26%	21,979	59.14%	21,945	61.18%	22,702	54.49%	58.23%	-0.01029	0.00321	-0.01659	-0.00399	Declined
Prenatal and Postpartum Care													
Timeliness of Prenatal Care	83.71%	21,975	79.42%	21,945	85.42%	22,702	80.72%	81.84%	-0.01864	0.00234	-0.02323	-0.01406	Declined
Postpartum Care	59.70%	21,975	57.86%	21,945	57.61%	22,702	56.55%	57.33%	-0.02372	0.00306	-0.02972	-0.01771	Declined
Children and Adolescents' Access to Primary Care Practitioners <sup>e</sup>													
12-24 months	97.42%	30,468	97.73%	28,222	96.57%	30,528	97.31%	97.22%	-0.00207	0.00105	-0.00413	-0.00001	Declined
25 months - 6 years	91.20%	162,659	92.95%	167,569	92.61%	167,607	93.20%	92.92%	0.01719	0.00077	0.01567	0.01870	Improved
7-11 years	93.24%	124,466	93.68%	130,909	94.60%	132,136	95.51%	94.61%	0.01371	0.00080	0.01215	0.01527	Improved
12-19 years	91.55%	147,962	91.59%	154,598	92.15%	159,391	93.08%	92.29%	0.00747	0.00083	0.00584	0.00909	Improved
BMI Assessment for Children/Adolescents <sup>d</sup>													
3 - 11 years	51.37%	250,689	49.01%	262,524	59.84%	267,908	70.08%	59.88%	0.08506	0.00092	0.08326	0.08685	Improved
12 - 17 years	50.35%	122,091	53.22%	130,029	58.36%	136,669	65.95%	59.41%	0.09065	0.00132	0.08806	0.09325	Improved
Total	51.07%	372,780	50.43%	392,533	59.18%	404,577	68.62%	59.66%	0.08586	0.00075	0.08438	0.08734	Improved
Adult BMI Assessment <sup>e</sup>	65.41%	149,284	74.73%	148,786	76.58%	170,099	85.74%	79.32%	0.13910	0.00138	0.13639	0.14181	Improved
Breast Cancer Screening	52.76%	17,811	53.58%	16,237	54.67%	17,258	54.98%	54.40%	0.01636	0.00284	0.01080	0.02192	Improved
Cervical Cancer Screening	64.52%	136,535	67.12%	163,017	62.16%	224,602	55.37%	60.54%	-0.03980	0.00112	-0.04200	-0.03760	Declined

Notes: Data shown indicate performance during year indicated; SE=standard error; LCI=lower bound of 95% confidence interval; UCI=upper bound of 95% confidence interval

<sup>a</sup>Combination 2 includes DTaP, IPV, MMR, HiB, HepB, and VZV vaccinations

<sup>b</sup>Combination 3 includes DTaP, IPV, MMR, HiB, HepB, VZV, and PCV vaccinations

<sup>c</sup>Combination 1 indicates receipt of both component vaccinations (Meningococcal and Tdap/Td)

<sup>d</sup>Excludes members in one health plan due to differing methodology in the calculation of this measure

<sup>e</sup>This metric was not reported in 2011.

Difference is weighted, pooled 2013-2015 estimate minus weighted, pooled 2011-2012 estimate

**Table 1.2: CAHPS® measures of preventive care quality, 2011–2015**

New Jersey Medicaid Managed Care Population

		Amerigroup					Healthfirst				WellCare	Horizon					United Healthcare					Overall Plan Average				
		2011	2012	2013	2014	2015	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015
Received Care from Dental	Adults	n=684	n=474	n=528	n=277	n=124	n=543	n=238	n=464	n=286	n=97	n=723	n=580	n=572	n=486	n=199	n=766	n=556	n=560	n=369	n=195	n=2716	n=1848	n=2124	n=1418	n=615
		26%	33%	30%	42%	37%	28%	24%	32%	37%	33%	30%	33%	36%	45%	48%	28%	32%	29%	48%	47%	28%	31%	32%	43%	41%
Office or Clinic in Past 6 Months	Children	n=733	n=558	n=499	n=516	n=274	n=750	n=290	n=474	n=587	n=284	n=810	n=676	n=613	n=505	n=336	n=834	n=701	n=610	n=428	n=339	n=3127	n=2225	n=2196	n=2036	n=1233
		60%	68%	69%	69%	65%	60%	63%	56%	56%	68%	59%	67%	64%	64%	69%	58%	63%	65%	65%	70%	59%	65%	64%	64%	68%

Note: Shading scheme does not indicate statistically significant differences, only the direction of change (>1%) in point estimates from 2011-2012 to 2013-2015 as follows:

Improved
No Change or Mixed Trend
Declined

**Table 1.3: HEDIS® measures of behavioral health care services quality, 2011–2015**

New Jersey Medicaid Managed Care Population

	2011-2012	2013		2014		2015		2013-2015	2013/2015-	SE	95% Confidence Interval		Performance 2013/2015- 2011/2012
	Pooled Rate	Population	Rate	Population	Rate	Population	Rate	Pooled Rate	2011/2012 Difference		LCI	UCI	
Follow-up Care for Children Prescribed ADHD Medication													
Initiation Phase	31.81%	5,755	32.49%	5,638	32.51%	5,994	31.61%	32.19%	0.00385	0.00574	-0.00741	0.01511	Same
Continuation and Maintenance Phase <sup>a</sup>	34.61%	1,147	35.92%	1,088	37.32%	1,226	35.32%	36.15%	0.01541	0.01525	-0.01448	0.04530	Same
Follow-Up After Hospitalization for Mental Illness <sup>b</sup>													
7 Day Follow-up	19.42%	453	14.35%	262	28.25%	327	32.11%	23.42%	0.04000	0.01973	0.00134	0.07867	Improved
30 Day Follow-up	38.28%	453	28.70%	262	40.08%	327	46.79%	37.24%	-0.01044	0.02349	-0.05649	0.03561	Same

Notes: Data shown indicate performance during year indicated; SE=standard error; LCI=lower bound of 95% confidence interval; UCI=upper bound of 95% confidence interval

<sup>a</sup>This metric was not reported in 2011.

<sup>b</sup>DDD only 2011-2014; DDD and MLTSS 2015

**Table 1.4: HEDIS® measures of chronic condition treatment quality, 2011–2015**

New Jersey Medicaid Managed Care Population

	2011-2012	2013		2014		2015		2013-2015	2013/2015-	SE	95% Confidence Interval		Performance 2013/2015- 2011/2012
	Pooled Rate	Population	Rate	Population	Rate	Population	Rate	Pooled Rate	2011/2012 Difference		LCI	UCI	
Annual Monitoring for Patients on Persistent Medications													
ACE Inhibitors or ARBs <sup>a</sup>	86.03%	25,518	86.52%	28,275	85.78%	46,896	88.02%	87.01%	0.00984	0.45218	-0.87642	0.89610	Same
Digoxin <sup>a</sup>	90.13%	532	91.92%	392	46.42%	518	50.19%	64.56%	-0.25567	0.62129	-1.47340	0.96206	Same
Diuretics <sup>a</sup>	85.72%	17,326	86.18%	19,416	84.91%	30,568	87.11%	86.24%	0.00518	0.46248	-0.90129	0.91165	Same
Anti-convulsants <sup>a</sup>	63.41%	4,683	62.55%	-- <sup>b</sup>	-- <sup>b</sup>	-- <sup>c</sup>	-- <sup>c</sup>		-0.63405	0.60783	-1.82541	0.55730	Same
Total <sup>a</sup>	83.68%	48,059	84.12%	48,083	85.11%	77,982	87.41%	85.87%	0.02189	0.47672	-0.91249	0.95626	Same
Comprehensive Diabetes Care													
HbA1c Testing	78.70%	27,582	80.68%	28,699	82.95%	46,682	82.74%	82.25%	0.03545	0.42849	-0.80440	0.87529	Same
HbA1c Poor Control (>9.0%)	45.48%	27,582	45.40%	28,699	39.40%	46,682	42.81%	42.55%	-0.02930	0.74616	-1.49177	1.43317	Same
Eye Exam	54.24%	27,582	56.97%	28,699	59.21%	46,682	52.87%	55.73%	0.01494	0.66085	-1.28032	1.31020	Same
Controlling High Blood pressure <sup>a</sup>	51.70%	42,231	50.53%	45,525	58.25%	75,793	54.32%	54.44%	0.02732	0.84115	-1.62134	1.67597	Same
Use of Appropriate Medications for People with Asthma													
5-11 Years	85.28%	4,658	85.34%	4,515	85.03%	-- <sup>c</sup>	-- <sup>c</sup>	85.18%	-0.00091	0.38452	-0.75456	0.75274	Same
12-18 Years	80.28%	3,675	82.15%	3,690	81.65%	-- <sup>c</sup>	-- <sup>c</sup>	81.90%	0.01622	0.42721	-0.82111	0.85356	Same
19-50 Years	74.89%	3,627	74.86%	3,654	75.67%	-- <sup>c</sup>	-- <sup>c</sup>	75.26%	0.00377	0.49790	-0.97211	0.97965	Same
51-64 Years	78.10%	1,266	75.75%	1,279	75.21%	-- <sup>c</sup>	-- <sup>c</sup>	75.48%	-0.02616	0.49081	-0.98814	0.93582	Same
Total	81.21%	13,226	80.66%	13,109	80.53%	-- <sup>c</sup>	-- <sup>c</sup>	80.60%	-0.00610	0.43941	-0.86735	0.85514	Same

Notes: Data shown indicate performance during year indicated; SE=standard error; LCI=lower bound of 95% confidence interval; UCI=upper bound of 95% confidence interval

<sup>a</sup>This metric was not reported in 2011.

<sup>b</sup>This metric was not reported in 2014.

<sup>c</sup>This metric was not reported in 2015.



**Table 1.5: CAHPS® measures of consumer satisfaction with adult health care services, 2011–2015**

New Jersey Medicaid Managed Care Population

Adult Survey	Amerigroup					Healthfirst				WellCare	Horizon					United Healthcare					Overall Plan Average				
	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015
Getting Needed Care composite <sup>a</sup>	n=355	n=255	n=436	n=436	n=236	n=306	n=109	n=472	n=472	n=218	n=406	n=330	n=493	n=493	n=332	n=430	n=335	n=492	n=492	n=311	n=1497	n=1029	n=1893	n=1893	n=1097
Always	40%	42%	57%	53%	49%	46%	46%	50%	56%	55%	41%	47%	52%	56%	53%	45%	43%	51%	53%	48%	43%	45%	53%	54%	51%
Usually	32%	32%	27%	28%	32%	27%	23%	28%	29%	25%	34%	29%	32%	28%	32%	32%	30%	29%	29%	34%	31%	28%	29%	28%	31%
Never/Sometimes	27%	26%	16%	19%	19%	27%	31%	21%	15%	20%	25%	24%	16%	16%	15%	22%	27%	20%	19%	18%	25%	27%	18%	17%	18%
Getting Care Quickly composite <sup>a</sup>	n=513	n=363	n=435	n=230	n=105	n=433	n=178	n=386	n=259	n=97	n=583	n=474	n=491	n=393	n=162	n=607	n=453	n=476	n=290	n=152	n=2136	n=1468	n=1788	n=1172	n=516
Always	50%	52%	60%	58%	53%	50%	47%	55%	60%	63%	55%	57%	60%	62%	64%	54%	56%	60%	61%	60%	52%	53%	59%	60%	60%
Usually	28%	26%	22%	25%	26%	23%	28%	22%	24%	14%	26%	23%	24%	22%	20%	25%	25%	24%	25%	28%	26%	26%	23%	24%	22%
Never/Sometimes	22%	21%	18%	17%	21%	27%	24%	22%	16%	23%	19%	20%	16%	16%	16%	22%	19%	17%	14%	12%	22%	21%	18%	16%	18%
How Well Doctors Communicate composite <sup>a</sup>	n=476	n=344	n=416	n=225	n=176	n=407	n=185	n=366	n=252	n=194	n=531	n=442	n=470	n=386	n=303	n=574	n=432	n=466	n=285	n=271	n=1988	n=1402	n=1718	n=1148	n=944
Always	68%	64%	75%	74%	71%	68%	70%	73%	73%	71%	65%	68%	71%	77%	70%	67%	65%	72%	75%	66%	67%	67%	73%	75%	70%
Usually	22%	25%	18%	17%	22%	21%	22%	19%	21%	21%	21%	21%	20%	18%	22%	22%	25%	19%	19%	26%	21%	23%	19%	19%	23%
Never/Sometimes	10%	10%	7%	9%	7%	12%	8%	8%	6%	8%	14%	12%	9%	5%	8%	11%	10%	8%	6%	8%	11%	10%	8%	6%	8%
Overall Rating of Personal Doctor	n=576	n=412	n=485	n=241	n=236	n=460	n=209	n=411	n=266	n=225	n=622	n=494	n=547	n=441	n=347	n=653	n=494	n=525	n=329	n=331	n=2311	n=1609	n=1968	n=1148	n=1139
Best Doctor (9-10 Rating)	56%	53%	68%	71%	62%	63%	61%	69%	73%	61%	54%	59%	66%	73%	63%	61%	55%	67%	73%	62%	58%	57%	67%	72%	62%
7-8 Rating	25%	29%	23%	16%	27%	23%	27%	22%	20%	29%	29%	22%	21%	22%	28%	24%	31%	22%	18%	25%	25%	27%	22%	19%	27%
Worst Doctor (0-6 Rating)	19%	18%	9%	13%	11%	14%	12%	9%	7%	10%	17%	19%	13%	6%	9%	15%	15%	12%	9%	13%	16%	16%	11%	9%	11%
Ease of Getting Appointments with Specialists	n=258	n=204	n=238	n=137	n=129	n=238	n=86	n=230	n=165	n=114	n=328	n=262	n=309	n=231	n=207	n=331	n=235	n=286	n=174	n=188	n=1155	n=787	n=1063	n=707	n=638
Always	41%	42%	56%	50%	45%	42%	47%	45%	50%	39%	39%	45%	51%	55%	43%	44%	40%	47%	51%	51%	42%	43%	50%	52%	45%
Usually	32%	30%	26%	26%	33%	26%	23%	29%	32%	26%	34%	29%	29%	25%	35%	31%	29%	28%	28%	25%	31%	28%	28%	28%	30%
Never/Sometimes	27%	28%	18%	23%	22%	32%	30%	26%	18%	35%	27%	27%	20%	20%	22%	24%	31%	24%	21%	24%	28%	29%	22%	21%	26%
Personal Doctor Informed about Other Providers	n=210	n=163	n/a	n/a	n=105	n=184	n=77	n/a	n/a	n=103	n=285	n=242	n/a	n/a	n=184	n=293	n=209	n/a	n/a	n=145	n=972	n=691	n/a	n/a	n=537
Always	48%	44%			54%	48%	52%			52%	50%	47%			51%	49%	46%			49%	49%	47%			52%
Usually	30%	29%			32%	27%	26%			29%	24%	27%			31%	29%	31%			29%	27%	28%			30%
Never/Sometimes	23%	26%			14%	24%	22%			19%	26%	26%			18%	22%	23%			22%	24%	24%			18%

Note: Shading scheme does not indicate statistically significant differences, only the direction of change (>1%) in point estimates from 2011-2012 to 2013-2015 as follows:

Improved
No Change or Mixed Trend
Declined

<sup>a</sup>Full composite scale break-downs not available for 2015; 1st item in composite reported

**Table 1.6: CAHPS® measures of consumer satisfaction with child health care services, 2011–2015**

New Jersey Medicaid Managed Care Population

Child Survey	Amerigroup					Healthfirst				WellCare	Horizon					United Healthcare					Overall Plan Average				
	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015
Getting Needed Care composite <sup>a</sup>	n=242	n=195	n=195	n=429	n=318	n=248	n=101	n=101	n=474	n=303	n=276	n=288	n=288	n=417	n=383	n=298	n=242	n=242	n=348	n=382	n=1064	n=826	n=826	n=1668	n=1386
Always	51%	50%	55%	59%	60%	44%	55%	48%	54%	56%	48%	49%	55%	59%	60%	49%	50%	59%	56%	57%	48%	51%	54%	57%	58%
Usually	25%	32%	27%	23%	23%	29%	25%	25%	21%	27%	31%	31%	30%	21%	24%	29%	24%	26%	25%	29%	28%	28%	27%	22%	26%
Never/Sometimes	24%	18%	19%	18%	17%	26%	20%	27%	25%	17%	22%	21%	15%	20%	16%	22%	25%	15%	20%	14%	24%	21%	19%	21%	16%
Getting Care Quickly composite <sup>a</sup>	n=765	n=603	n=546	n=423	n=517	n=771	n=317	n=562	n=473	n=98	n=874	n=751	n=742	n=402	n=151	n=884	n=773	n=711	n=342	n=140	n=3294	n=2244	n=2561	n=1640	n=906
Always	67%	62%	67%	65%	72%	57%	57%	54%	60%	66%	66%	64%	65%	70%	70%	65%	62%	68%	65%	76%	64%	61%	63%	65%	71%
Usually	16%	16%	17%	16%	14%	17%	19%	23%	18%	16%	15%	15%	18%	14%	13%	19%	17%	18%	13%	14%	17%	17%	19%	15%	14%
Never/Sometimes	17%	22%	16%	19%	14%	27%	25%	23%	22%	18%	19%	21%	17%	17%	17%	16%	21%	15%	23%	10%	20%	22%	18%	20%	15%
How Well Doctors Communicate composite <sup>a</sup>	n=573	n=450	n=450	n=423	n=303	n=591	n=232	n=232	n=475	n=333	n=641	n=542	n=542	n=421	n=380	n=655	n=557	n=557	n=348	n=357	n=2640	n=1781	n=1781	n=1667	n=1373
Always	74%	74%	75%	80%	78%	76%	79%	74%	76%	70%	73%	72%	73%	75%	73%	74%	78%	75%	76%	79%	74%	76%	74%	77%	75%
Usually	18%	20%	20%	17%	13%	18%	16%	20%	20%	19%	20%	21%	20%	19%	17%	19%	16%	19%	16%	13%	19%	18%	20%	18%	16%
Never/Sometimes	8%	5%	5%	4%	9%	6%	5%	6%	5%	11%	8%	7%	7%	6%	10%	7%	6%	6%	8%	8%	7%	6%	6%	6%	10%
Overall Rating of Personal Doctor composite <sup>a</sup>	n=663	n=494	n=476	n=461	n=359	n=654	n=257	n=437	n=532	n=383	n=718	n=608	n=570	n=466	n=438	n=737	n=637	n=581	n=387	n=424	n=2772	n=1996	n=2064	n=2064	n=1604
Best Doctor (9-10 Rating)	70%	70%	73%	82%	74%	74%	74%	70%	74%	74%	67%	69%	72%	74%	76%	70%	73%	75%	73%	78%	70%	72%	72%	76%	76%
7-8 Rating	21%	22%	21%	14%	18%	21%	23%	22%	21%	20%	22%	22%	22%	18%	17%	21%	20%	19%	20%	20%	21%	22%	21%	18%	19%
Worst Doctor (0-6 Rating)	8%	8%	7%	4%	8%	5%	3%	8%	5%	6%	11%	9%	6%	7%	7%	9%	6%	6%	7%	2%	8%	6%	7%	6%	6%
Ease of Getting Appointments with Specialists composite <sup>a</sup>	n=199	n=185	n=153	n=153	n=113	n=175	n=82	n=121	n=121	n=97	n=227	n=250	n=193	n=193	n=135	n=288	n=237	n=241	n=241	n=136	n=889	n=754	n=708	n=708	n=481
Always	46%	44%	45%	45%	53%	38%	44%	38%	38%	45%	44%	47%	51%	51%	50%	49%	47%	56%	56%	43%	44%	45%	48%	48%	48%
Usually	27%	36%	27%	27%	20%	29%	30%	23%	23%	23%	30%	30%	30%	30%	24%	26%	26%	23%	23%	28%	28%	31%	26%	26%	24%
Never/Sometimes	28%	20%	28%	28%	27%	34%	26%	39%	39%	32%	25%	23%	19%	19%	26%	25%	27%	20%	20%	29%	28%	24%	26%	26%	29%
Personal Doctor Informed about Other Providers composite <sup>a</sup>	n=218	n=190	n/a	n/a	n=99	n=196	n=83	n/a	n/a	n=95	n=235	n=236	n/a	n/a	n=133	n=267	n=207	n/a	n/a	n=130	n=916	n=716	n/a	n/a	n=457
Always	57%	52%			52%	47%	47%			48%	51%	47%			53%	52%	49%			51%	52%	49%			51%
Usually	25%	33%			29%	29%	37%			32%	29%	34%			27%	26%	29%			29%	27%	34%			29%
Never/Sometimes	18%	15%			19%	24%	16%			20%	20%	18%			20%	21%	21%			20%	21%	18%			20%

Note: Shading scheme does not indicate statistically significant differences, only the direction of change (>1%) in point estimates from 2011-2012 to 2013-2015 as follows:

Improved
No Change or Mixed Trend
Declined

<sup>a</sup>Full composite scale break-downs not available for 2015; 1st item in composite reported

## Discussion

In this chapter, we presented HEDIS<sup>®</sup> and CAHPS<sup>®</sup> managed care performance data for the baseline (2011-2012) and first three implementation years (2013-2015) of the Comprehensive Medicaid Waiver Demonstration. We assessed differences between these two time periods to evaluate the broad impact of the managed care expansion in long-term services and supports on access to care, and the quality, efficiency, and coordination of care for Medicaid managed care beneficiaries overall.<sup>13</sup> With a few exceptions, the findings presented in this chapter support the conclusion that overall quality of care for Medicaid managed care beneficiaries was at the least maintained, and in several cases improved, during the first three years of the demonstration period.

Measures related to chronic condition treatment showed no significant changes between the pre and post-waiver periods. In the preventive care quality domain, most metrics demonstrate improvement and the few declines are, on average, of a smaller magnitude than the improvements. Assessing BMI for children and adolescents increased by almost nine percentage points, and the largest decline in this domain was a four percentage point drop in cervical cancer screening. In terms of behavioral health care quality, no deterioration of quality is observed. It is important to note that the availability of data pertaining to behavioral health care was limited to only two HEDIS<sup>®</sup> metrics calculated for individuals with developmental disabilities, MLTSS beneficiaries (in 2015 only), and children prescribed ADHD medication. Some CAHPS<sup>®</sup> metrics in this domain which we proposed examining in our evaluation plan were from a standalone survey module which was not administered in 2013, 2014, or 2015 and, consequently, not reported here.<sup>14</sup> Metrics pertaining to behavioral health care quality were conceived in our evaluation plan to capture the impact of the behavioral health-related policy changes, namely the establishment of an ASO/MBHO, as part of the waiver demonstration. However, this change was not fully implemented during the study period presented in this report. Claims-based analyses presented in Chapter 3 will include additional findings in the behavioral health domain for Medicaid overall, as a way to gauge overall adherence to quality standards during the waiver demonstration period, and for recipients of MLTSS whose behavioral health was integrated under their MCOs.

Consumer satisfaction with care showed improvement across health plans during the first three years of waiver implementation (compared to the baseline period) and this was consistent across all measures for adults. Among children, improvements in satisfaction are also evident, most

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<sup>13</sup> Evaluation of the impact of the managed care expansion on cost of care, which is part of Research Question 1a, will be assessed in Chapter 3 using claims-based analyses. HEDIS<sup>®</sup> and CAHPS<sup>®</sup> metrics do not address this domain.

<sup>14</sup> Please see our baseline report for the 2011-2012 estimates.

consistently among the health plans covering the largest number of lives. The one plan with declines on multiple measures exited the Medicaid managed care market in 2014.

While examining the findings presented in this chapter it is important to remember that they are descriptive and do not adjust for beneficiary characteristics. The change in Medicaid coverage from fee-for-service to managed care during 2011-2012 for certain eligibility groups and the statewide Medicaid expansion in 2014 brought individuals with different demographic and health profiles into managed care. CAHPS® metrics are not reported for the population of Medicaid managed care beneficiaries as a whole and the statistical significance of changes in the overall plan average or within plans could not be assessed. Nevertheless, examining unadjusted trends in the metrics presented in this chapter is an essential part of monitoring progress toward the goals of the Division of Medical Assistance and Health Services (DMAHS) Quality Strategy (DMAHS 2014) during the waiver demonstration period. The evidence from the metrics we examined in this chapter suggests that quality of care has not been compromised for most managed care beneficiaries during the demonstration period and overall consumer satisfaction in Medicaid has improved.

## References

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# Chapter 2: An Examination of MLTSS-related Measures Reported by Managed Care Organizations, External Quality Review, and State Government

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## Introduction and Background

To prepare for the transition in July 2014, when New Jersey brought four §1915(c) home and community based services (HCBS) waivers into managed care with its comprehensive §1115 waiver,<sup>15</sup> the state updated its Quality Strategy<sup>16</sup> to include 40 measures addressing several aspects of managed long-term services and supports (MLTSS). This chapter will discuss some of these measures, in addition to other relevant data that has been presented in a variety of reports and settings. Two additional reports we authored (Farnham et al. 2015 & forthcoming) provide more details about MLTSS implementation in New Jersey—in them we discuss stakeholder feedback from providers, consumer advocates, managed care organizations (MCOs) and state officials on MLTSS implementation. We have considered suggestions from stakeholders with respect to the data we draw upon in our evaluation. This chapter focuses on describing data and performance measures collected and reported by MCOs, external quality review organizations and state government relating to a post-implementation period spanning 2014 through early 2017.

### **Description of MLTSS Quality Oversight and Member Appeal Mechanisms**

MCOs are required to report regularly on a number of measures, and to report all claims and encounter data to the state. There are monthly meetings of an MLTSS—MCO Quality Workgroup with membership from each MCO as well as the Division of Medical Assistance and Health Services (DMAHS), the Division of Aging Services (DoAS), and an external quality review organization to discuss details around reporting and ensure comparability. In addition to these measurement-focused meetings, MCOs and state divisions have more frequent standing meetings to discuss general operational issues. DMAHS and DoAS maintain hotlines for consumers and providers to report quality issues. An external quality review organization (EQRO)

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<sup>15</sup> See NJ Department of Human Services, Division of Medical Assistance and Health Services, “Comprehensive Medicaid Waiver” web page with links to descriptive documents at <http://www.nj.gov/humanservices/dmahs/home/waiver.html>.

<sup>16</sup> See a copy of the Quality Strategy as updated June 12, 2014 at [http://www.nj.gov/humanservices/dmahs/home/MLTSS\\_Quality\\_Strategy-CMS.pdf](http://www.nj.gov/humanservices/dmahs/home/MLTSS_Quality_Strategy-CMS.pdf).

does annual audits of MCO case files. New Jersey participates in the National Core Indicators – Aging and Disabilities (NCI-AD)<sup>TM</sup> Survey, which involves face-to-face surveys of long-term care consumers.<sup>17</sup> On a quarterly basis, the state reports quality measure data to CMS.<sup>18</sup> It also reports regularly to the MLTSS Steering Committee and the Medical Assistance Advisory Committee.<sup>19</sup> Finally, as discussed in Chapter 1 of this report, New Jersey MCOs participate in the Healthcare Effectiveness Data and Information Set (HEDIS<sup>®</sup>), a system of standardized performance measures developed by the National Committee for Quality Assurance (NCQA) in conjunction with a variety of public and private partners and the CAHPS<sup>®</sup> (Consumer Assessment of Healthcare Providers and Systems) survey that, on an annual basis, assesses members' perceptions of the quality of care and services they receive in their Medicaid health plan. These measure sets apply to all MCO enrollees, not just those receiving MLTSS services.

MLTSS members looking to appeal an MCO decision may appeal directly to the MCO, call the state quality hotlines, request an independent review in some cases through New Jersey's Division of Banking and Insurance,<sup>20</sup> or file a Medicaid fair hearing request.<sup>21</sup>

### **MLTSS Measure Domains**

The measures in the state's Quality Strategy span six areas of focus: *participant access* (timeliness of assessments and evidence of options counseling), *participant-centered service planning and delivery* (examination of care plans along several dimensions), *provider capacity* (network adequacy and credentialing timeliness), *participant safeguards* (critical incident reporting), *participant rights and responsibilities* (complaints, grievances and appeals), and *effectiveness of MLTSS activities* (hospital use, transitions between facilities and community settings, and followup after hospitalization for mental illness).

### **MLTSS Measure Frequency**

The frequency of measure calculation and reporting varies from monthly to annually. There is also variation in the lag time needed to calculate measures due to claim filing windows that apply to some measures.

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<sup>17</sup> See <http://nci-ad.org/>; data were collected through the summer and fall of 2015.

<sup>18</sup> Most of these reports are posted here: [https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers\\_faceted.html?filterBy=New%20Jersey](https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers_faceted.html?filterBy=New%20Jersey).

<sup>19</sup> Agendas, Presentations and Meeting Minutes are posted here: <http://www.state.nj.us/humanservices/dmahs/boards/maac/>.

<sup>20</sup> See [http://www.state.nj.us/dobi/division\\_insurance/managedcare/i incap.htm](http://www.state.nj.us/dobi/division_insurance/managedcare/i incap.htm).

<sup>21</sup> See <http://www.state.nj.us/humanservices/dmahs/info/fads.html>.

## **MLTSS Measure Sources**

Data to calculate the measures in the Quality Strategy comes from three sources: Managed Care Organization (MCO) reports to the state, External Quality Review Organization (EQRO) review of MCO files, and state government departments, based on the data that they collect.

In addition to measures included in the Quality Strategy, the state has calculated a variety of other measures to describe LTSS-related programs and populations and included them in presentations to the MLTSS Steering Committee<sup>22</sup> or the Medical Assistance Advisory Council (MAAC).<sup>23</sup> These additional measures were calculated in response to stakeholder inquiries or as part of state efforts to describe the program and affected populations.

Finally, other relevant data are included in the CAHPS<sup>®</sup> (Consumer Assessment of Healthcare Providers and Systems) and National Core Indicators – Aging and Disabilities (NCI-AD)<sup>™</sup> surveys.

## **Analytic Objective**

This chapter will examine selected measures reported in the state's reports to CMS, the MLTSS Steering Committee, or the Medical Assistance Advisory Council (MAAC), and draw implications where possible on what they reflect regarding the MLTSS implementation process. Based on a review of all available data, we have selected those that seem to have the most bearing on our evaluation hypotheses and research questions, listed below.

**Hypothesis 1: "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."**

**Research Question 1a: "What is the impact of the managed care expansion on access to care, the quality, efficiency, and coordination of care, and the cost of care for adults and children?"**

**Research Question 1b: "What is the impact of including long-term care services in the capitated managed care benefit on access to care, quality of care, and mix of care settings employed?"**

Table 1 describes the measures we examine and their sources.

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<sup>22</sup> See [http://www.nj.gov/humanservices/dmahs/home/mltss\\_committee.html](http://www.nj.gov/humanservices/dmahs/home/mltss_committee.html) for more information about the MLTSS Steering Committee, including a description of members and recommendations made prior to MLTSS implementation.

<sup>23</sup> See <http://www.state.nj.us/humanservices/dmahs/boards/maac/> for more information about the MAAC, including agendas, minutes, and presentations.

**Table 1: Secondary metric list**

	<b>Metric</b>	<b>Metric Source</b>	<b>CSHP's Source</b>	<b>Description</b>
1	Long-term care population by setting	NJ DMAHS	MAAC Presentation	Based on the available numbers of HCBS, PACE, and Nursing Facility Residents, we have calculated the percent of the LTC population every 6 months from August 2014 to March 2017 in each setting.
2	Setting, former waiver enrollees	NJ DMAHS	MAAC/MLTSS Steering Committee Presentations	Tracks the current status of waiver enrollees who transitioned in July 2014 as of November 2015, March 2016, and April 2017
3	Age of MLTSS Enrollees	NJ DMAHS	DMAHS 1115 Waiver Annual Report	Shows the ages of participants in MLTSS as of July 2014, 2015 and 2016
4	Assessment Timeliness	NJ OCCO, <sup>24</sup> MCOs	DMAHS reports to CMS	<ul style="list-style-type: none"> <li>• Number and timeliness of level of care assessments (required to receive MLTSS services), monthly from July 2014 to January 2017</li> <li>• Number of assessments by MCO in the period July 2014 to January 2017 and % authorized by OCCO (OCCO must approve)</li> </ul>
6	External audit information	EQRO	DMAHS reports to CMS, EQRO reports, OCCO (for reassessment information)	<ul style="list-style-type: none"> <li>• Number of files selected for review among various categories in Years 1 and 2 (Former fee-for-service, new to managed care, existing managed care)</li> <li>• For Years 1 and 2, the extent to which care plans were completed within 30 days of enrollment, were aligned with member needs as per assessment data, were developed using person-centered care principles, and had a back-up plan to ensure safety</li> <li>• Care plan completion and establishment of services within 30 days, Year 2</li> <li>• Files with both assessment and plan of care information, Years 1 and 2</li> <li>• Files with a documented face-to-face initial visit, Year 2</li> </ul>

<sup>24</sup> Division of Aging Services, Office of Community Choice Options.



	<b>Metric</b>	<b>Metric Source</b>	<b>CSHP's Source</b>	<b>Description</b>
				<ul style="list-style-type: none"> <li>• Reassessment information (includes OCCO tabulations)</li> <li>• Critical incident training, Year 2</li> </ul>
6	Critical incidents	DoAS	DMAHS reports to CMS	Number, timeliness (monthly July 2014 to February 2017) and categories of reporting (Year 1 and Year 2) of incidents that had or could have adverse effects on members
7	Appeals, Grievances Complaints and Service Reductions	MCOs, DMAHS, DOBI	DMAHS reports to CMS, MLTSS Steering Committee presentations, DMAHS MAAC presentations, DMAHS final agency decisions, DOBI IHCAP reports	<ul style="list-style-type: none"> <li>• MCO appeals, grievances and complaints in 2015 and 2016, including outcomes of home health and private duty nursing appeals.</li> <li>• MCO service reduction reports in Q3, 2015</li> <li>• Fair hearing dispositions for January-July 2016 and August-December 2016</li> <li>• Fair hearing outcomes 2014, 2015, 2016, and Q1 of 2017, based on all Medicaid enrollees, by plan</li> <li>• NJ DOBI, Independent Health Care Appeals Program (IHCAP), Jan 2014 to Jan 2017 (semiannual)</li> </ul>
8	Transitions between nursing facility and community	MCOs	DMAHS reports to CMS	<ul style="list-style-type: none"> <li>• Transitions from NF to community and back to NF within 90 days</li> <li>• Transitions from community to NF, short-term and long-term</li> </ul> Years 1 and 2, continuously enrolled members
9	Hospital and ED Use	MCOs	DMAHS reports to CMS	Any hospitalization or ED visit by continuously enrolled MLTSS members: Years 1 and 2, HCBS and NF
10	Quality of health care and health plan services	CAHPS®	CAHPS®	Comparison of enrollees in MLTSS, D-SNP and NJ FamilyCare
12	Quality of life and care	NCI-AD™	NCI-AD™	<ul style="list-style-type: none"> <li>• Comparison of NJ MLTSS with MLTSS in 4 other states</li> <li>• Comparison of NJ MLTSS with other NJ long-term care programs (fee-for-service nursing home, Program of All-</li> </ul>

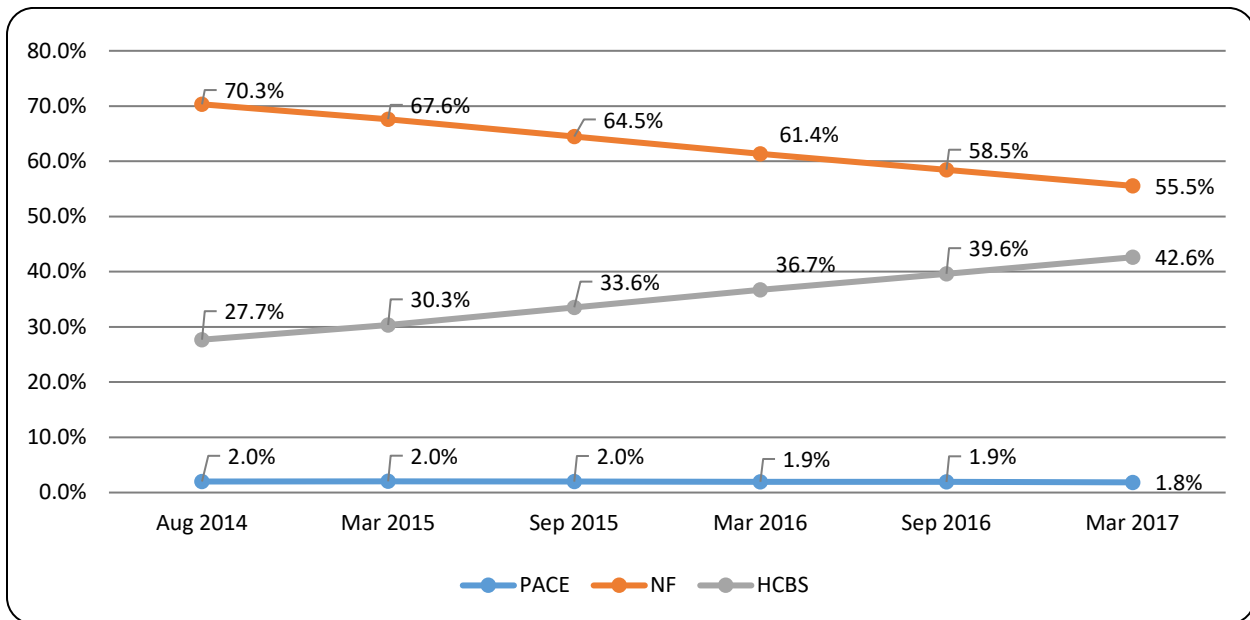
	Metric	Metric Source	CSHP's Source	Description
				inclusive Care for the Elderly (PACE), Older Americans Act HCBS services) <ul style="list-style-type: none"> <li>• Comparison of NJ MLTSS member profiles and experiences by MCO</li> </ul>

## Results

### Setting, All LTC Enrollees

As shown in Figure 1, the share of the population receiving long-term care services in home and community-based settings (not including PACE) increased from 28% in August 2014 to 43% in March 2017. The share of the same population in nursing facilities has dropped from 70% in August 2014 to 56% in March 2017. This appears to indicate that the state is moving toward providing more services in home and community settings. PACE has remained steady at about 2% of the long-term care population.<sup>25</sup> Among the HCBS population, about 15% are in assisted living facilities and the remaining 85% are in other types of community settings.<sup>26</sup>

**Figure 1: NJ Medicaid LTC population by setting, August 2014–March 2017**



Source: Calculated from MAAC Slides - April 2017 (slide 35), which is based on “Monthly Eligibility Universe (MMX) in Shared Data Warehouse (SDW), accessed on 4/4/2017.”

<sup>25</sup> The Program of All-inclusive Care for the Elderly (PACE) enrolls people initially in community settings, but will provide nursing facility care if it becomes necessary. For more information, see <http://www.state.nj.us/humanservices/doas/services/pace/>.

<sup>26</sup> Calculated from data in MAAC Presentation 4/13/17 (slide 33), which is based on “DMAHS Shared Data Warehouse Monthly Eligibility Universe, accessed 4/4/17.”

### **Setting, Former Waiver Enrollees**

Among the group of people enrolled in the former §1915(c) waiver programs who transitioned to managed care in July 2014, 52% were still receiving HCBS services through MLTSS as of April 2017. About 8.5% are now in nursing facilities, and the remaining 36% are no longer enrolled in MLTSS or no longer enrolled in Medicaid. Many of the latter category have likely passed away. This appears to indicate that people who begin receiving services in community settings are largely able to remain there. Table 2 shows the change from November 2015 to April 2017 in the status of former waiver enrollees (on June 30, 2014 all of these enrollees were receiving HCBS waiver services).

**Table 2: Current status of former waiver enrollees**

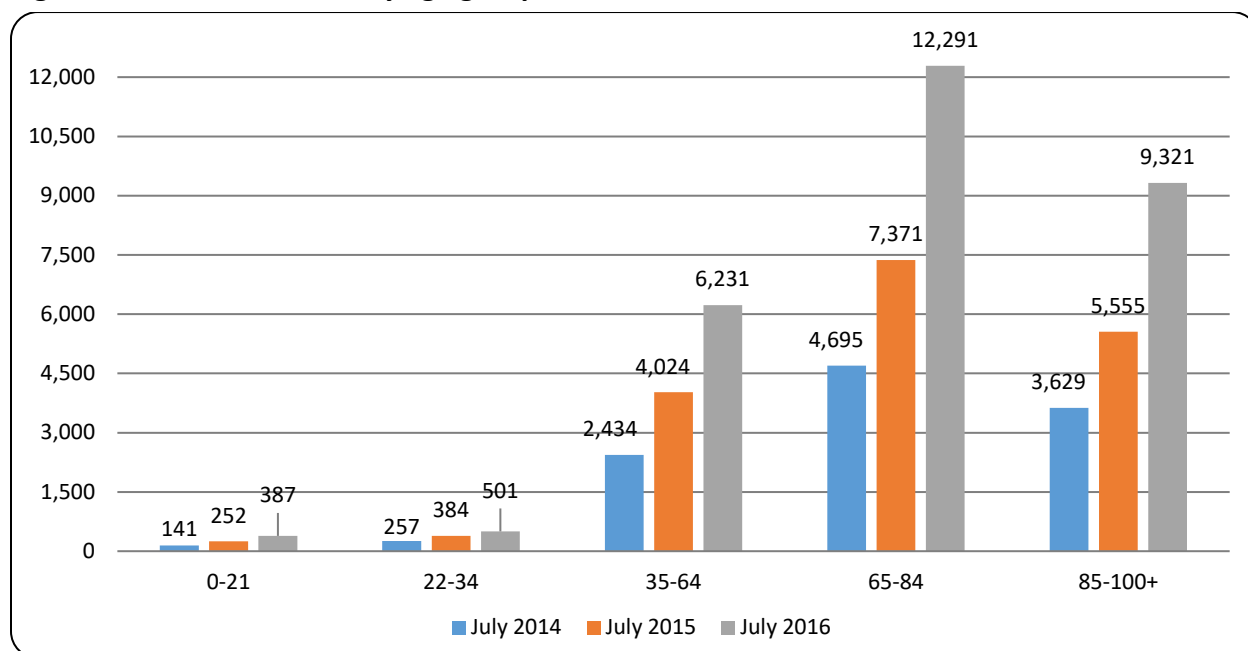
<b>Current Service Status</b>	<b>Percent, July 2014</b>	<b>Percent, November 2015</b>	<b>Percent, March 2016</b>	<b>Percent, April 2017</b>
MLTSS HCBS	100%	69%	65%	52%
MLTSS Nursing Facility	n/a	7%	8%	8.5%
No Longer Enrolled	n/a	20%	25%	36%
Other (Non MLTSS Medicaid)	n/a	4%	3%	3%

Sources: MAAC Meeting Presentation 4/13/17 (slide 37), based on “DMAHS Shared Data Warehouse Monthly Eligibility Universe, accessed 4/7/17”; MAAC Meeting Presentation 4/20/16, based on “DMAHS Shared Data Warehouse Monthly Eligibility Universe, accessed 3/11/16.”; MLTSS Presentation for Steering Committee December 2015 (slide 12), based on “DMAHS Shared Data Warehouse Monthly Eligibility Universe, accessed 11/16/15.”

### **Age of MLTSS Enrollees**

Figure 2 shows the distribution across age groups for individuals enrolled in MLTSS in July of 2014, 2015 and 2016. Most MLTSS enrollees are ages 65 and older. The share of enrollment by age group has remained similar over time, with all age groups experiencing enrollment growth.

**Figure 2: MLTSS enrollees, by age group**



Source: DMAHS, New Jersey Comprehensive Waiver Demonstration Section 1115 Annual Report: Demonstration Year 4: July 1, 2015 –June 30, 2016.

### **Assessment Timeliness**

Two of the Quality Strategy measures examine the timeliness of the assessment to determine whether or not the consumer meets a nursing facility level of care. In order to enroll into MLTSS, consumers must meet this level of care. This assessment is done by the Department of Human Services, Division of Aging Services, Office of Community Choice Options (OCCO) for consumers who are not already both on Medicaid and enrolled in managed care and by MCOs for consumers who are enrolled with them through Medicaid. The consumers for whom MCOs conduct the assessment will generally be enrolling in MLTSS. This is less true for OCCO, which receives thousands of referrals each month because assessments must be conducted for anyone going into a nursing home, whether or not they are eligible for Medicaid. There is discussion in the quality workgroup regarding how to revise the OCCO-related measure to be more specific to MLTSS.

The metric measures whether or not the assessment is completed within 30 days of the referral date (there is no measure of duration to assess the magnitude of delay beyond 30 days). Figure 3 shows the results for OCCO, the MCO average, and the individual MCO results (dashed lines). The MCOs with the most variability also have the lowest enrollment. OCCO began reporting this metric upon implementation in July 2014; MCOs began reporting this data in January 2015 due to the need for system development.<sup>27</sup>

<sup>27</sup> DMAHS, MLTSS Performance Measure Report, 1/1/2015 – 3/31/2015, p. 1.

The OCCO average climbed from 49% in July 2014 to a high of 76% in October 2015, after which it decreased. The average during 2016 was 57%. There is some regional variability in this, though specific numbers are not available. It has been historically more difficult to recruit and retain staff in Northern New Jersey because of more alternative employment opportunities and a higher cost of living. Working conditions for staff making numerous home visits are frequently more onerous in the North because of greater difficulty with transportation and parking. Where possible, OCCO has shifted work to the Southern office (e.g., electronic approvals). OCCO staffing resources were strained during the initial implementation of MLTSS because they had to conduct re-assessments for after MCO assessment submissions could not be authorized (discussed in more detail in Table 4 and surrounding text).<sup>28</sup> OCCO has hired new staff and conducted training for MCO assessors to address the issue.<sup>29</sup>

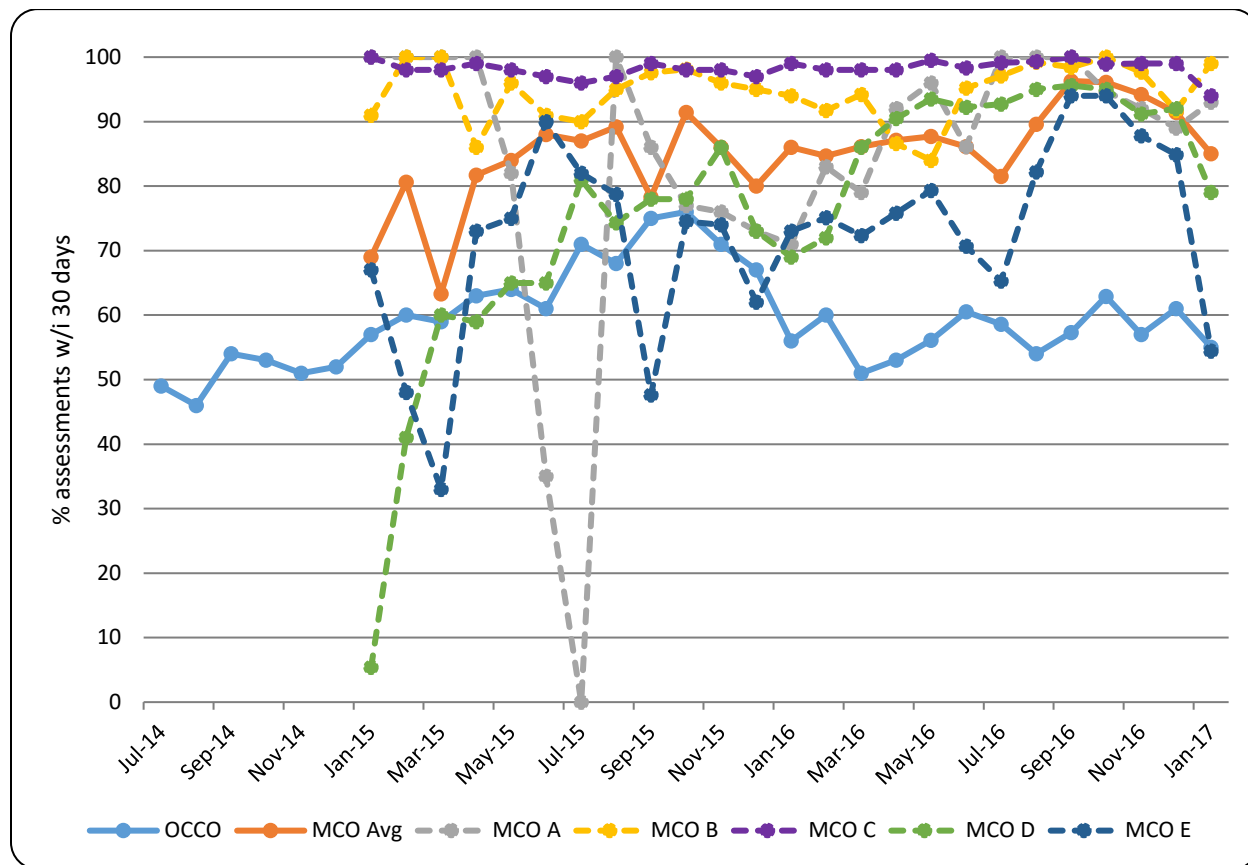
The MCO overall monthly average for this metric increased from 69% in January 2015 to a high of 96% in fall 2016 and decreasing somewhat thereafter. Individual averages showed considerable range. For the period January 2015 to January 2017, individual MCO averages ranged from 73% to 98% per month, with an 85% average for all MCOs together. During the same period, OCCO's monthly average was 59%.

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<sup>28</sup> OCCO is responsible for authorizing all MCO level of care assessments. If it looks from the MCO-submitted documents as if the client does not qualify, OCCO does its own face-to-face assessment of the client before ruling them ineligible.

<sup>29</sup> DMAHS, MLTSS Performance Measure Report, 7/1/14-6/30/15, p. 4.

**Figure 3: Timeliness of nursing facility level of care assessment, by month (July 2014–January 2017)**

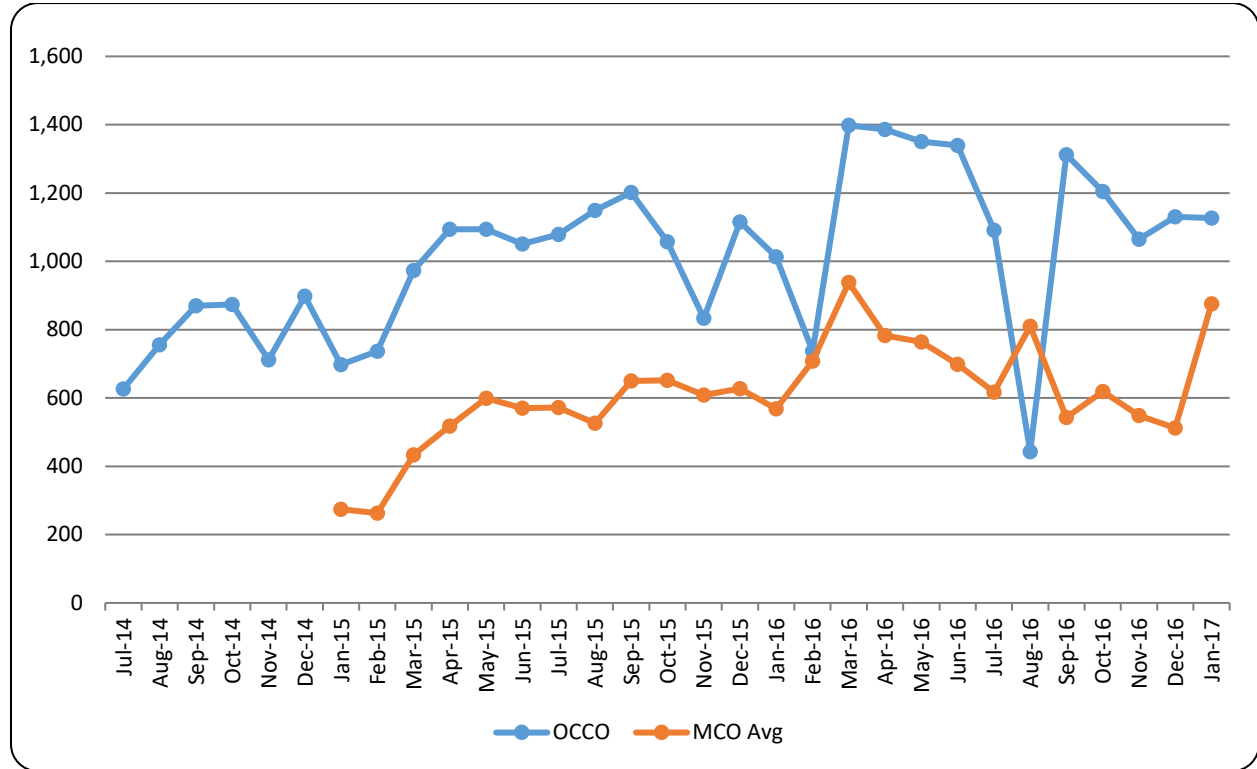


Source: DMAHS, MLTSS Performance Measure Reports.

OCCO conducts a larger volume of assessments compared with all MCOs combined, as shown in Figure 4. For the period of January 2015 to January 2017, OCCO conducted an average of 1,067 assessments per month, as compared with an average of 611 per month for all MCOs combined. OCCO staff report that referrals have increased since the implementation of MLTSS. OCCO receives referrals for anyone applying for long-term care services through Medicaid as well as anyone entering a nursing home for any reason (including rehab) who may become eligible for Medicaid within 180 days. As of April 2016, OCCO was receiving an average of 5,800 referrals a month—many of these referrals do not result in an assessment because the consumer is discharged quickly or passes away before an assessment can be done.<sup>30</sup> This means that OCCO is able to triage referrals when they are aware of people who need to be assessed quickly.

<sup>30</sup> This information as well as some other facts in this section were gathered by a telephone conversation with staff from the Division of Aging Services in April of 2016.

**Figure 4: Number of level of care assessments conducted, by month (July 2014–January 2017)**

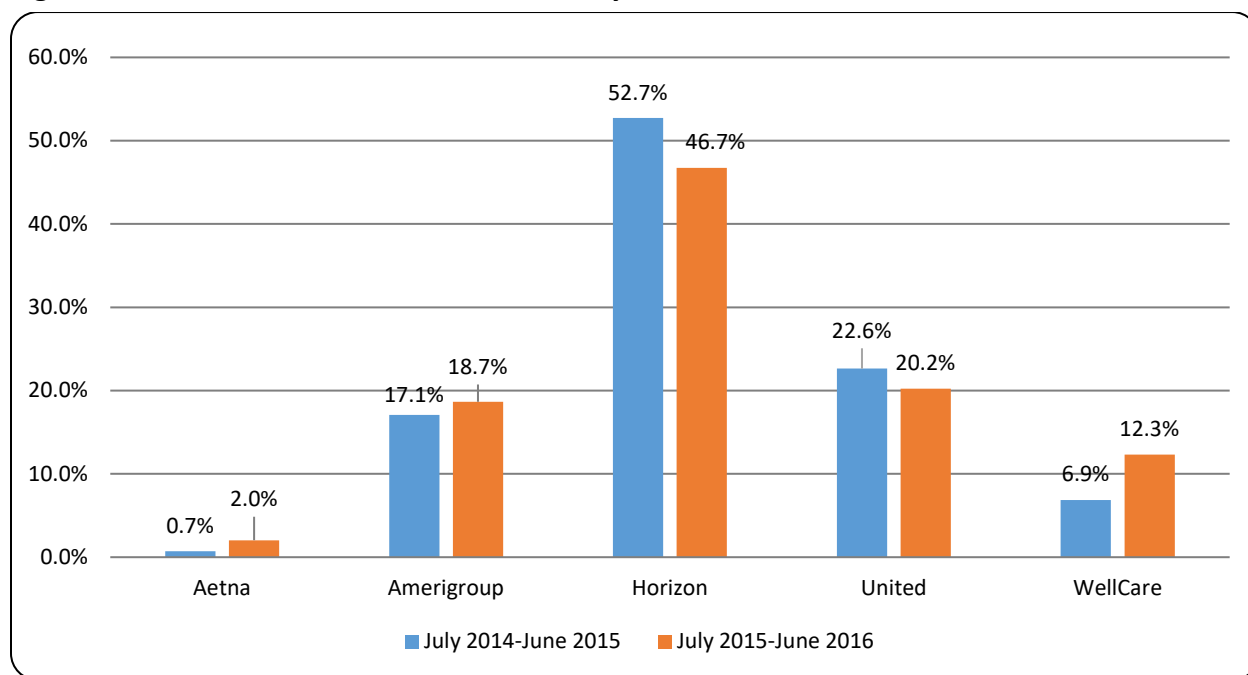


Source: DMAHS, MLTSS Performance Measure Reports.

**MLTSS Level of Care Assessments by Plan**

Figure 5 shows the percentage of level of care assessments done by each plan in state fiscal years 2015 and 2016. About half of the assessments were done by Horizon, meaning that their results are very influential in the overall MCO average. Between state fiscal years 2015 and 2016, Horizon and United showed small decreases in their share of assessments while the other three plans showed increases.

**Figure 5: Share of level of care assessments by MCO**



Source: New Jersey Comprehensive Waiver Demonstration Section 1115 Annual Report, Demonstration Year 3: July 1, 2014–June 30, 2015, Attachment C.2.; New Jersey Comprehensive Waiver Demonstration Section 1115 Annual Report, Demonstration Year 4: July 1, 2016–June 30, 2016, Attachment C.

Table 3 shows the number of assessments, the percentage of each plan’s assessments that were authorized by OCCO (this means that OCCO was able to certify that the client met nursing facility level of care requirements based on the information provided by the MCO) and the percentage of not authorized assessments that were ultimately approved for each plan. Most clients (95% in SFY 2015 and 80% in SFY 2016) are ultimately approved. Across all plans, 5% of the not authorized assessments were ultimately denied in SFY 2015 and 20% in SFY 2016<sup>31</sup> (this represented 209 individuals in SFY 2015 and 273 in SFY 2016). All plans showed gains from SFY 2015 to SFY 2016 in the extent to which their assessments were authorized. There was some variation by plan in the extent to which assessments were authorized and less so in the extent to which assessments were ultimately approved, as shown in Table 3.<sup>32</sup> The extent to which assessments are not authorized by OCCO depends upon the completeness of the assessment information provided by the MCO as well as the acuity level or extent of care needs of the client being assessed. OCCO has provided and continues to provide training to MCOs to ensure that assessors provide all necessary information. When plans submit assessments to OCCO that cannot be authorized, this means that OCCO has to do its own face-to-face assessment, which is required before any denial of eligibility. Higher than expected rates of not authorized submissions early in MLTSS implementation resulted in an unexpected level of workload for OCCO, straining staff resources.

<sup>31</sup> Shown in Table 4 as 95% ultimately approved.

<sup>32</sup> Aetna began operations in January 2015 and had a small number of assessments.



**Table 3: MLTSS level of care assessments and assessment outcomes for state fiscal years 2015 and 2016 (July 2014–June 2015 and July 2015–June 2016), by plan**

MCO	Number of Assessments		% of Assessments Authorized by OCCO		% of Not Authorized Assessments Ultimately Approved	
	SFY 2015	SFY 2016	SFY 2015	SFY 2016	SFY 2015	SFY 2016
Aetna	187	721	40.0%	58.8%	88.9%	81.4%
Amerigroup	4,542	6,593	70.0%	75.6%	97.6%	83.9%
Horizon	14,012	16,513	70.0%	87.0%	93.8%	77.3%
United	6,016	7,151	65.0%	76.0%	93.9%	79.3%
WellCare	1,824	4,358	73.0%	81.4%	96.4%	79.8%
<i>Total</i>	<i>26,581</i>	<i>35,335</i>	<i>68.4%</i>	<i>81.5%</i>	<i>94.5%</i>	<i>80.0%</i>

Source: New Jersey Comprehensive Waiver Demonstration Section 1115 Annual Report, Demonstration Year 4: July 1, 2015–June 30, 2016, Attachment C (contains SFY 2015 also).

### **External Quality Review Information**

**Overview.** An external quality review organization (EQRO) audits MCO records (based on a random sample of about 100 from each of the participating MCOs), reports contract-related data and calculates metrics based on several aspects of consumers’ care plans. Audits were done twice during the first year of MLTSS (with results combined to get an annual average), and will happen annually thereafter. Audits are completed over a one-week period with a standardized audit tool and ongoing communication and coordination among the review team to ensure interrater reliability. Audits involve MCO records only, with no interaction with members or caregivers.

The 2014 and 2015 samples included people who transitioned from fee-for-service LTSS, MLTSS members new to managed care and those who were previous Medicaid managed care members (but had not enrolled in MLTSS). The 2016 sample included MLTSS members new to Medicaid managed care and those who were previous Medicaid managed care (but not in MLTSS) who had enrolled in MLTSS between July 1, 2015 and January 1, 2016 and been in MLTSS HCBS for the entire period of enrollment with the same MCO. There were similar continuity requirements for inclusion in the earlier audits. Thus, members who switch MCOs or have a gap in enrollment (for instance, if they were already in Medicaid but let their financial eligibility lapse) will not be included among the audited files. In addition, nursing home residents are not included in these focused audits, though they are included among the population reviewed for the EQRO’s annual assessment of the plans.

Table 4 shows the number of files of each type for each MCO. There are some deviations from 100 because the EQRO oversamples files in case some must be excluded. MCO A did not begin enrolling MLTSS participants until January 2015. There are some differences in the compositions

of samples among MCOS with respect to new versus existing managed care enrollees. We are not sure if that is due to the audit selection process or something to do with how MCOs enroll new MLTSS members.

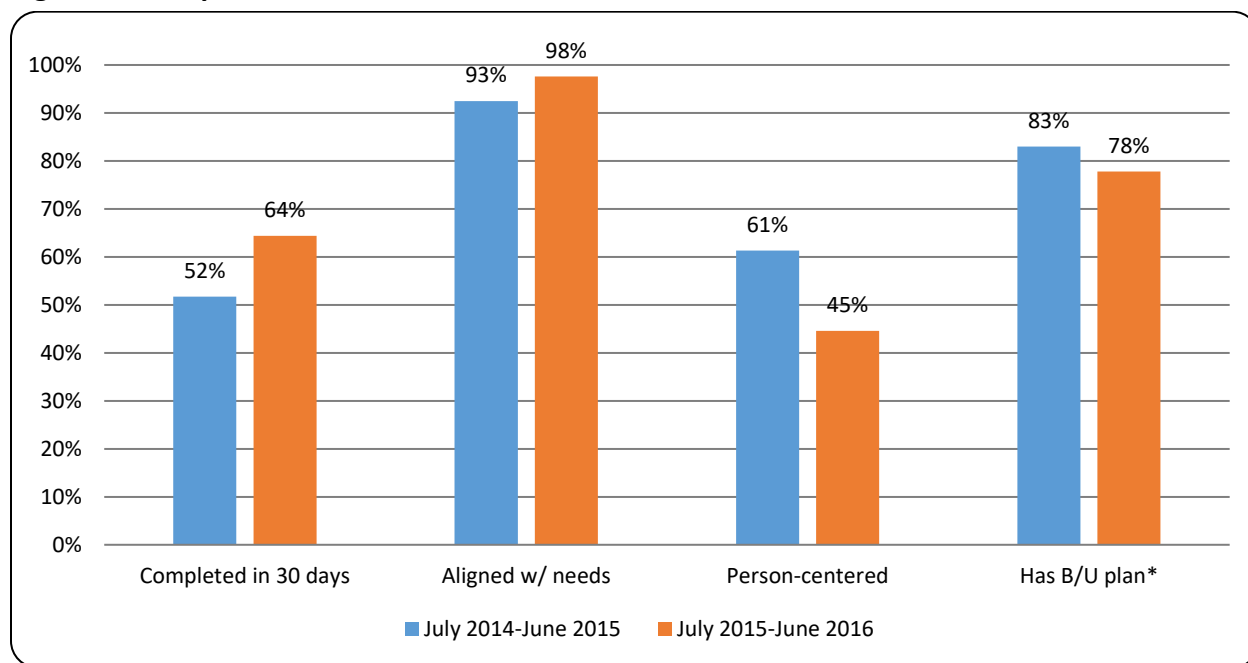
**Table 4: Number of files selected for audit, by year and MCO**

MCO	Year 1 (July 1, 2014–June 30, 2015)				Year 2 (July 1, 2015–June 30, 2016)		
	Former FFS	New to managed care	Existing managed care	Total	New to managed care	Existing managed care	Total
MCO A					68	11	79
MCO B	20	34	46	100	57	45	102
MCO C	34	22	44	100	46	52	98
MCO D	37	46	18	101	76	45	121
MCO E	25	28	48	101	13	86	99
All MCOs	116	130	156	402	260	239	499

Sources: IPRO, MCO MLTSS Focused Care Management Audit, 2015 and MCO MLTSS Care Management Audit, 2016.

Care Plan-Related Metrics. Our interim evaluation report (Chakravarty et al. 2016) presented four care-plan related metrics. Figure 6 shows these metrics have changed in the latest audit, and Table 5 shows results from both audits for comparison. Because the reported metrics are seen as important to ensure quality, MCOs are required to submit a work plan to improve rates less than 85%.

**Figure 6: Care plan-related metrics in EQRO audits, Years 1 and 2**



Source: DMAHS, MLTSS Performance Measure Reports (Oct-Dec 2015 and Jan-Mar 2017).

**Table 5: Results of EQRO care plan audits in Year 1 (July 2014–June 2015) and Year 2 (July 2015–June 2016)**

MCO	Completed in 30 days		Aligned with needs		Person-centered		Has B/U plan*	
	Year 1	Year 2	Year 1	Year 2	Year 1	Year 2	Year 1	Year 2
MCO A		40.5%		93.5%		5.1%		32.1%
MCO B	55.0%	<b>70.6%</b>	96.0%	<b>99.0%</b>	97.0%	52.0%	94.9%	83.8%
MCO C	55.0%	<b>85.7%</b>	86.6%	<b>95.8%</b>	71.4%	<b>73.5%</b>	75.9%	<b>91.3%</b>
MCO D	72.3%	<b>82.4%</b>	90.6%	<b>98.8%</b>	65.7%	52.7%	83.1%	<b>90.2%</b>
MCO E	24.8%	<b>39.4%</b>	96.8%	<b>98.9%</b>	10.3%	<b>32.3%</b>	78.7%	<b>84.7%</b>
All MCOs	51.7%	<b>64.4%</b>	92.5%	<b>97.6%</b>	61.3%	44.6%	83.0%	77.8%

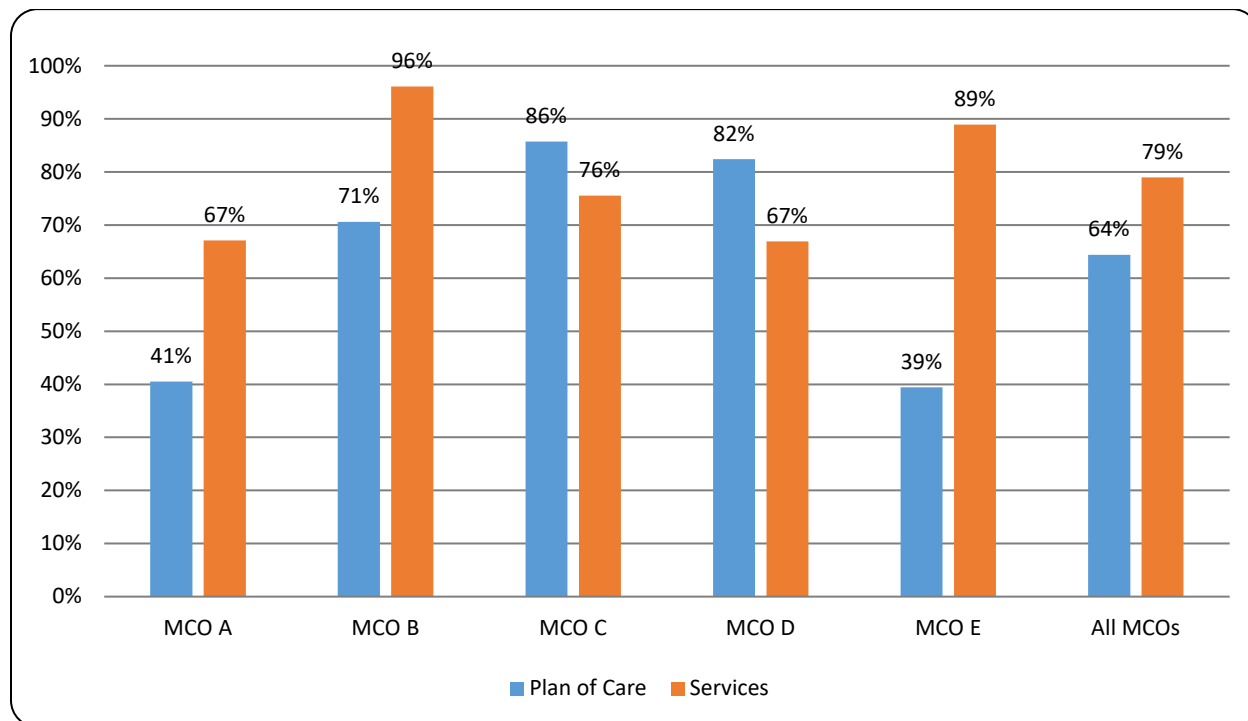
Increases from Year 1 to Year 2 are indicated with boldface type.

\*There were some disagreements by the MCOs about the files selected for backup plan review in the Year 1 audits.

Source: DMAHS, MLTSS Performance Measure Reports (Oct-Dec 2015 and Jan-Mar 2017).

*Timeliness.* Care plans completed within 30 days of enrollment into MLTSS/HCBS are considered timely. Examining the percent of care plans that were timely (out of all care plans audited) reveals that the average for all MCOs increased for all plans in Year 2, though only one met the 85% threshold. As Figure 7 shows, there is not a straightforward relationship between care plan completion within 30 days and establishment of services within 30 days. Three MCOs were more likely to show services established within 30 days than to complete care plans within 30 days, and the two MCOs exhibiting higher compliance with care plan completion were less likely than two of the less compliant plans to show services established within 30 days. It is important to note that some MLTSS-related services are state plan services (personal care assistance and adult medical daycare). Individuals who are enrolled in managed care prior to MLTSS may be getting these services already through their MCO. In addition, as we note in our report in stakeholder feedback on MLTSS (Farnham, Chakravarty & Lloyd, forthcoming), new Medicaid enrollees may enroll in state plan services on a fee-for-service basis prior to their MCO enrollment. If they do so, that could facilitate the MCO initiating services. Finally, MLTSS enrollees in assisted living or other community alternative residential settings who are new to Medicaid may be in their place of service prior to MLTSS enrollment, which facilitates the MCO establishing services quickly.

**Figure 7: Care plan completion and establishment of services in EQRO audits within 30 days\* of MLTSS enrollment, Year 2 (July 2015–June 2016)**



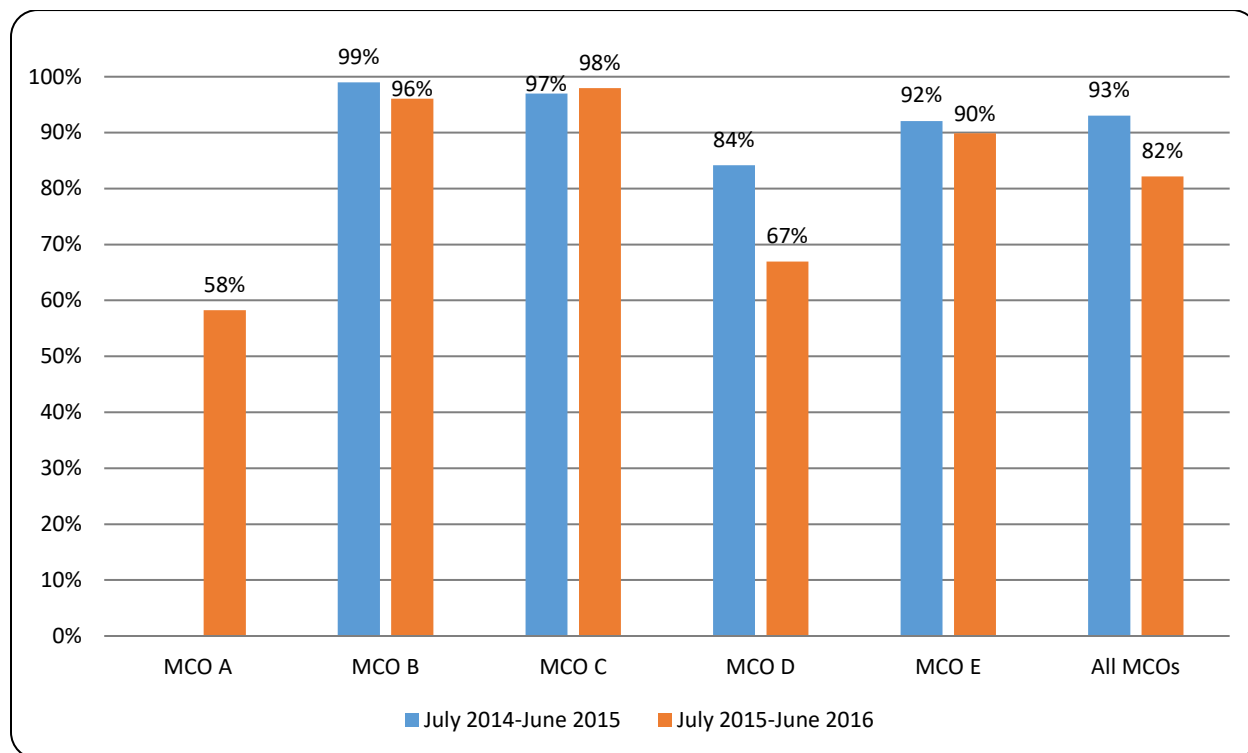
\*Excludes residential and vehicle modifications.

Sources: DMAHS, MLTSS Performance Measure Reports, Jan-Mar 2017; IPRO, MCO MLTSS Care Management Audits, June 2016.

*Aligned with Needs.* This measure looks at the percentage of plans of care that were aligned with assessment results of the NJ Choice<sup>33</sup> in type, scope, amount, frequency and duration. All MCOs met the 85% threshold in both years, and all increased from Year 1 to Year 2, as shown in Table 5. We do not have any further information about the ways in which care plans were aligned or not, or what this meant for consumers. Only files with both items present are included in the measure. Figure 8 shows the extent to which files could be included for this measure for Years 1 and 2. There was some variability by MCO—the EQRO was able to include 90% or more of files for MCOs B, C, and E in both periods. MCO A did not have data for the first period and the EQRO included 58% of its files in Year 2. MCO D declined from 84% in Year 1 to 67% in Year 2. Thus, while alignment of the NJ Choice with the plan of care is high in all MCOs, the extent to which such alignment can be measured differs across the MCOs. We do not know the potential explanatory factors for this.

<sup>33</sup> NJ Choice is an assessment tool used by OCCO and MCOs to determine whether a consumer meets a nursing facility level of care. See [http://www.state.nj.us/humanservices/dmahs/home/NJ\\_Level\\_of\\_Care\\_and\\_Assessment\\_Training.pdf](http://www.state.nj.us/humanservices/dmahs/home/NJ_Level_of_Care_and_Assessment_Training.pdf) for more details.

**Figure 8: MCO files in EQRO audits including both NJ Choice and plan of care, Years 1 and 2**



Source: DMAHS, MLTSS Performance Measure Reports (Oct-Dec 2015 and Jan-Mar 2017).

The EQRO also looks at the alignment of the PCA (personal care assistance) assessment with the NJ Choice, for members who are using that service. Those results by MCO were similar to the results for the alignment of the NJ Choice with the plan of care, with an overall value of 92% for all MCOs in Year 2 (versus 98% alignment for the plan of care with the NJ Choice).

*Person-Centered Principles.* This measure examines whether plans of care were developed using person-centered principles, which was determined by looking at the goals to see if they were member specific and demonstrating member involvement in their development and modification.<sup>34</sup> This measure showed a large range for individual MCOs in both audits, with a narrowing in Year 2 as the highest and lowest scoring MCOs came down and up, respectively. The overall rate declined from Year 1 to Year 2, with two MCOs (B and D) declining and two (C and E) increasing. None of the MCOs met the 85% standard for this measure.

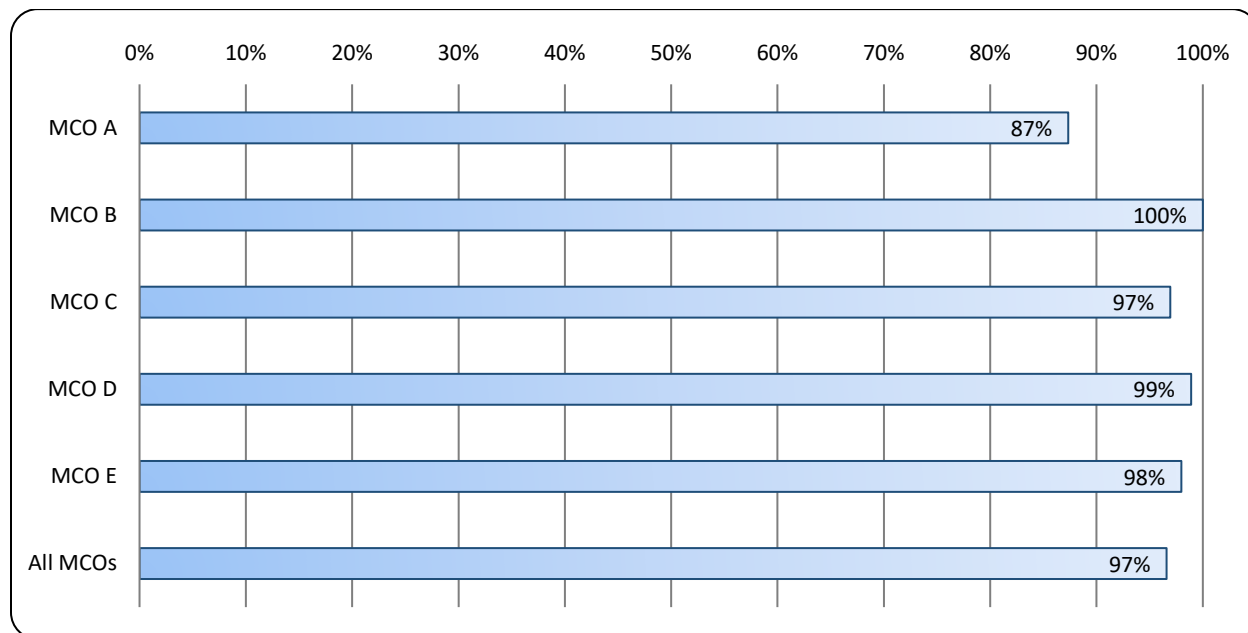
*Back-up Plan.* This measure documents the presence of a back-up plan (i.e., what happens if a home care aide is out sick for services delivered in a private home where there is no regularly

<sup>34</sup> Based on “NJ EQRO HMO Care Management Audit, Review of Care Management Files—Home Community Based Services (HCBS)” received from DMAHS personnel.

scheduled staff). As implemented in the initial audit, this was calculated for all files selected, rather than just those in an HCBS setting without regular staffing, so changes from Year 1 to Year 2 partially reflect differential file selection. In the Year 2 audit, there were 329 of 499 files selected (66%) for audit of this measure—for three of the plans (MCOs A, B and C), about 70% of their cases were audited for this measure; for MCO D, about 40% of its cases were included and for MCO E it was 86%. This may indicate some differences in the types of members served by different MCOs, which may be based somewhat on provider network relationships. Four of the plans achieved 84% or higher with this measure.

Care Management. Some stakeholders in our interviews raised questions about the quality of care management (Farnham et al., 2015 and forthcoming). We looked for information in the EQRO reports that might address these concerns. The EQRO looks at the extent to which documentation exists of initial face-to-face visits and whether they are timely. Timeliness is measured in a binary fashion where it is not possible to tell how late the visit was, or whether any delay was due to a consumer request or factor beyond the MCOs control, such as a hospitalization. Figure 9 shows the percent with any documented face-to-face initial visit (for new enrollees who had enrolled 6 months to 1 year prior to the audit). The average for all MCOs is 97%. Patterns were similar for MLTSS enrollees who were new to managed care as well as those who were existing MCO members, so they are combined in the figure. Only one MCO was below 97%, and that was the newest MCO for which this was the first audit, and represented 10 files. There is no information about the status of these 10 files to determine whether an enrollee was negatively affected by this or whether it was some kind of error (e.g., an enrollee who had passed away or was hospitalized, etc.).

**Figure 9: Percent of MCO files in EQRO audits with a documented face-to-face initial visit, Year 2**



Sources: IPRO, MCO MLTSS Care Management Audits, June 2016.

The EQRO looks at ongoing case management visits, but audits include members who are required to be visited every 90 days as well as every 180 days, making it difficult to interpret this measure. Those members required to be visited every 180 days might be very close to that window at the time of the audit.

The state Division of Aging Services generates a report for MCOs of any member who has not had an NJ Choice reassessment within the past 16 months and tracks to what extent the MCOs are able to conduct the reassessment or otherwise categorize the member. The most recent data from the report to CMS dated 1/1/2017-3/31/2017 noted that there were 627 members who had not had a reassessment in the past 16 months. We are not sure what kind of denominator to use for this—the MLTSS population was 16,596 in June of 2015 and 22,353 in December of 2015.<sup>35</sup> A conservative estimate would be that fewer than 6% of members have not had the required reassessment.<sup>36</sup> About 36% of the assessments were still outstanding, 51% had been done (though only 12% had been received in the state’s system) and 13% involved members who had passed away or were otherwise ineligible. There may be differences by MCO, but the measure is too newly reported for us to determine.

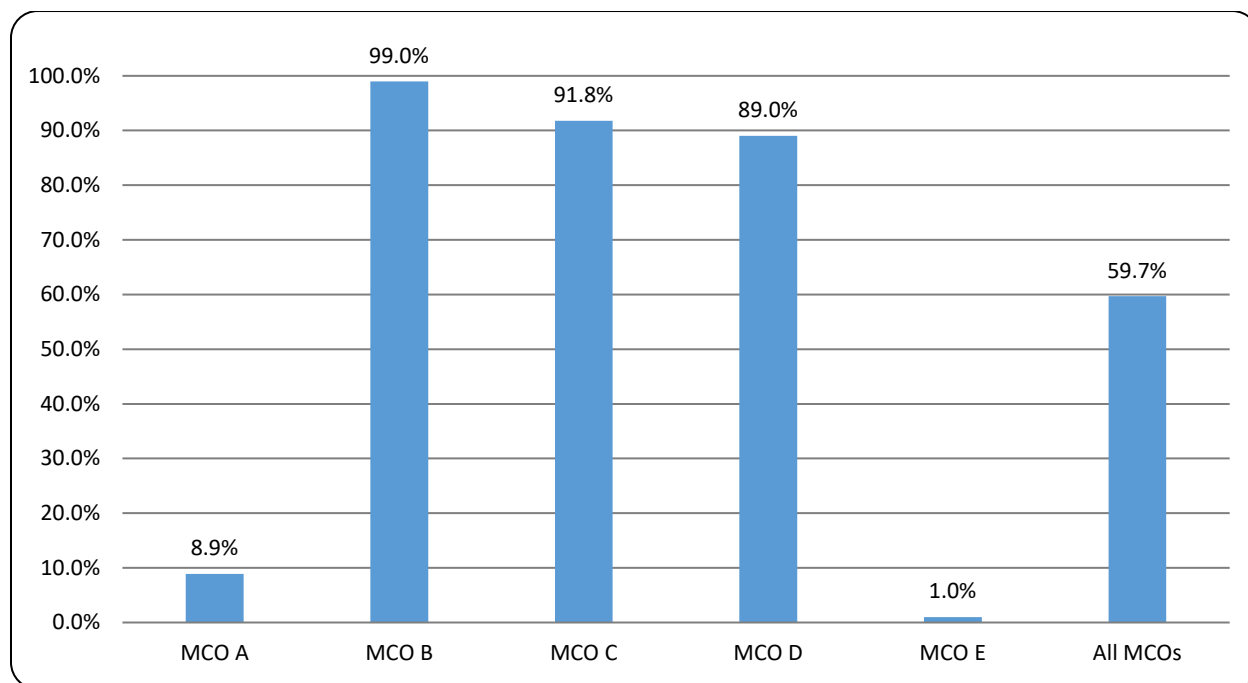
<sup>35</sup> MAAC Meeting Presentation January 23, 2017, slide 71.

<sup>36</sup> This takes the June 2015 figure and reduces it by the 32.3% no longer enrolled rate presented in slide 75 from the presentation above, which would give a denominator of 11,235 who were likely still enrolled, and a rate of 5.6% not having received a timely reassessment.

The EQRO looks at timely reassessments as well. They showed a rate of 91% timeliness, based on 35 cases (as few as 2 for one MCO). The denominator was the members who had a reassessment completed, rather than those who were required to have one. We were not sure if this would pick up a case where an assessment should have been done but wasn't, as opposed to measuring the timeliness of the reassessments that were done. Each MCO had, at most, one audited case that was not done in a timely manner (i.e., within 30 days after the redetermination date).

Critical Incident Training. The Year 2 EQRO audit included information on whether it was documented in the MCO file that the MLTSS member or authorized representative had received information and education on identifying and reporting abuse, neglect, and/or exploitation at least annually. MCOs were either high or low on this measure, as shown in Figure 10. Three of the MCOs met the 85% standard.

**Figure 10: Cases with evidence of critical incident training, Year 2**



Source: DMAHS, MLTSS Performance Measure Reports, Jan-Mar 2017

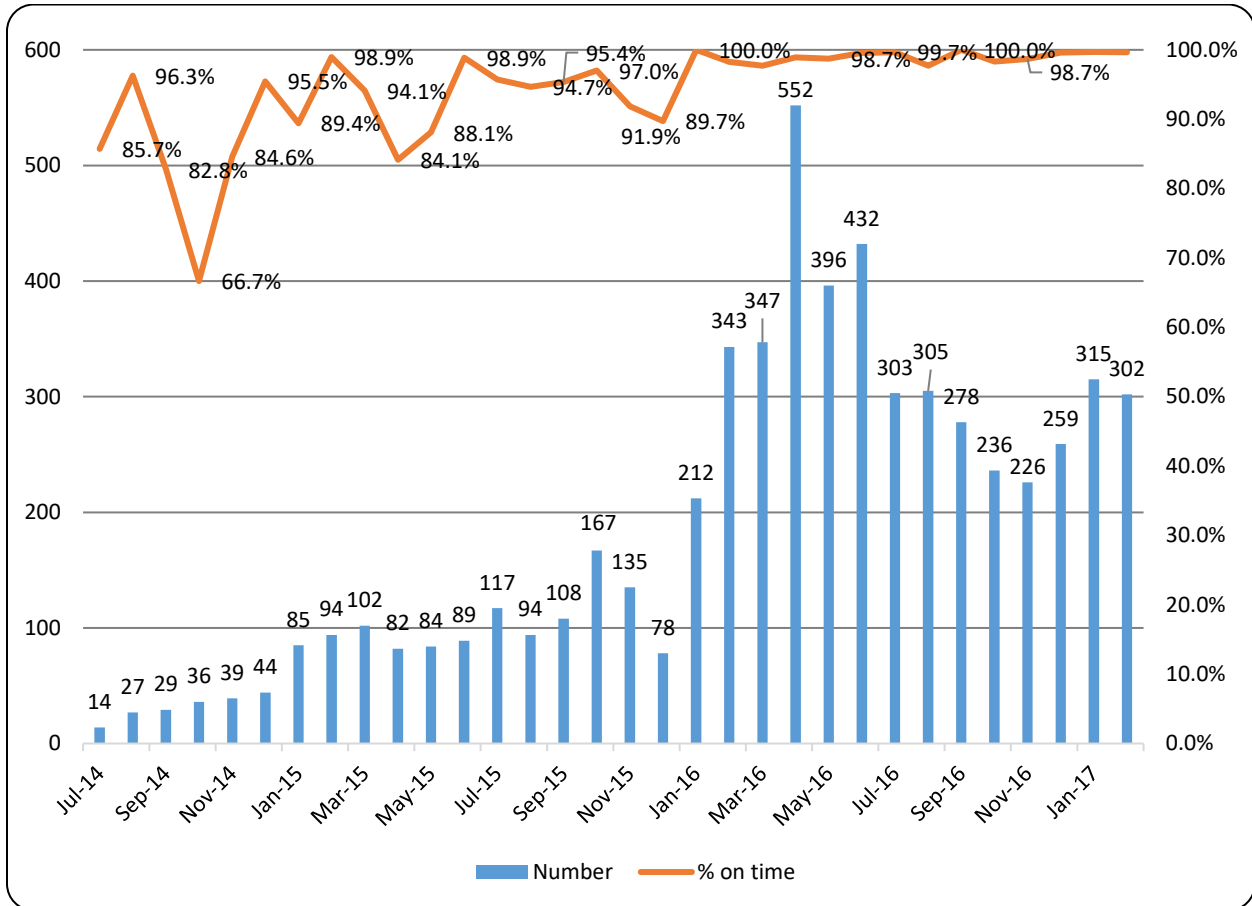
### **Critical Incidents**

Critical incidents are defined in the managed care contract as “an occurrence involving the care, supervision, or actions involving a Member that is adverse in nature or has the potential to have an adverse impact on the health, safety, and welfare of the Member or others. Critical incidents also include situations occurring with staff or individuals or affecting the operations of a



facility/institution/school.”<sup>37</sup> Figure 11 shows the number and timeliness<sup>38</sup> of reporting for critical incidents from July 2014 to February 2017. The monthly average for timeliness ranged from 67% in October 2014 to nearly 100% since early 2016. The smallest number of incidents (14) were reported in July 2014 and the largest number in April 2016 (552). The April number translates into about 2% of 24,979 MLTSS enrollees reported in March of 2016 (though one member may have multiple critical incidents).<sup>39</sup>

**Figure 11: Critical incident numbers and timeliness, July 2014–February 2017**



Sources: DMAHS, MLTSS Performance Measure Reports, combined measures 17 and 17a.

Table 6 details the categories of incidents in Year 1 and Year 2. The most common incidents are injuries or falls and medical or psychiatric emergencies (including harms from medication errors).

<sup>37</sup> Quote from Article 1, Page 8 of the Managed Care Contract, 01/2015 Accepted, accessed March 31, 2016 from <http://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-contract.pdf>.

MLTSS-related critical incidents are detailed in Article 9, Pages 55-56.

<sup>38</sup> Timeliness is defined as within one business day for unexpected deaths or media/potential media involvement and two business days otherwise.

<sup>39</sup> New Jersey Comprehensive Waiver Demonstration Section 1115 Annual Report, Demonstration Year 4: July 1, 2015–June 30, 2016.

Together, these account for more than half of incidents in Year 1 and more than three quarters in Year 2. Changes from Year 1 to Year 2 may include both changes in the extent to which reporting was completed as well as the frequency of the actual incidents reported.

**Table 6: Critical incident categories**

Critical Incident Categories	Year 1 (July 2014– June 2015)	Percent of total incidents	Year 2 (July 2015– June 2016)	Percent of total incidents
Severe injury/fall requiring treatment	262	36.7%	895	30.4%
Medical/psychiatric emergency	122	17.1%	1,425	48.5%
Missing/unable to contact or wandering from home/facility	70	9.8%	150	5.1%
Other/media involvement/medication error with serious consequences	59	8.3%	108	3.7%
Inappropriate conduct by provider	37	5.2%	60	2.0%
Theft/exploitation	35	4.9%	45	1.5%
Neglect/mistreatment, including self, caregiver overwhelmed, environmental	35	4.9%	74	2.5%
Abuse-suspected or evidenced	34	4.8%	43	1.5%
Backup plan failure	30	4.2%	20	0.7%
Eviction/utility cutoff	17	2.4%	50	1.7%
Unexpected death	13	1.8%	37	1.3%
Inaccessible for initial visit (partial 2016 only)			34	1.2%
Total	714		2,941	

Sources: DMAHS, MLTSS Performance Measure Reports, 7/1/14–6/30/15, 7/1/15–9/30/15 and 10/1/15–12/31/15, combined measures 17 and 17a.

There aren't many differences by MCO. There were two differences that we found notable in our interim report, but it appears they may be explained by the MCOs decision about how (and perhaps whether) to report when members are not accessible for the initial face to face meeting.<sup>40</sup>

### **Appeals, Grievances and Complaints**

MCOs are required to report Appeals, Grievances and Complaints for MLTSS members.<sup>41</sup> An appeal is a request for review of an action. A complaint is a protest regarding the MCO or contractor that could be resolved within five business days. A grievance is a complaint that could not be resolved within five business days.

<sup>40</sup> Based on reporting in the MLTSS Performance Measure Report, Annual (7/1/2015-6/30/16).

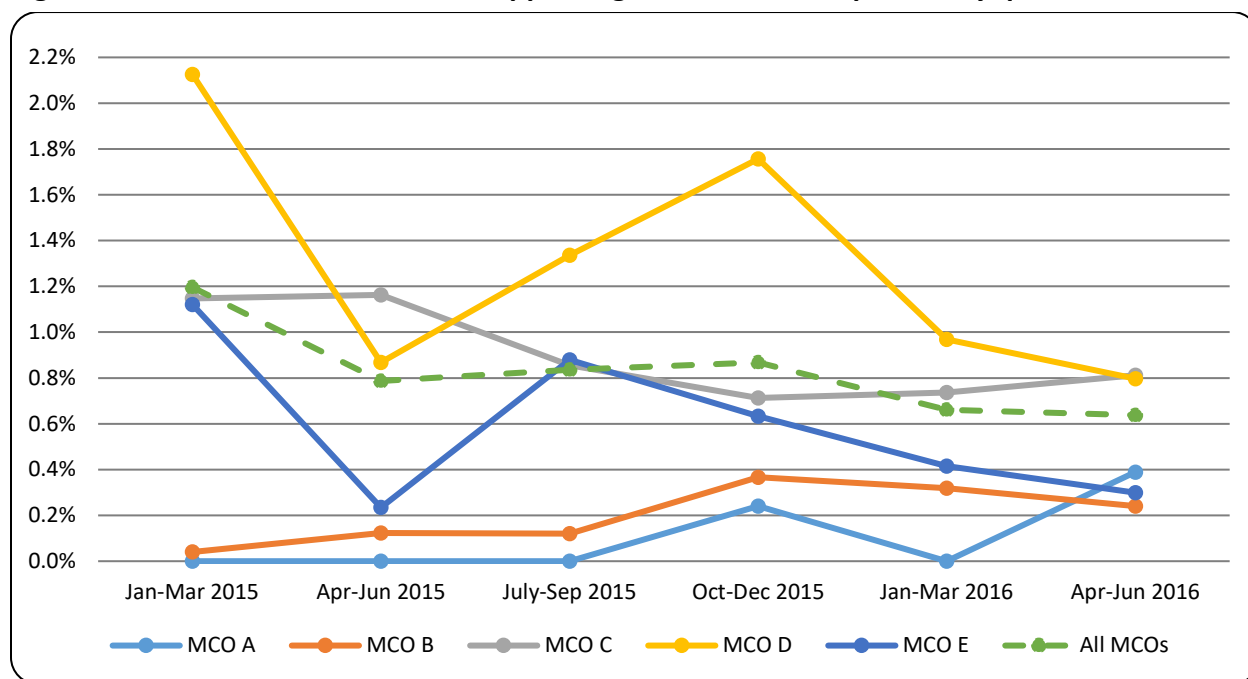
<sup>41</sup> See detailed definitions in Article 1 of the Managed Care Contract, 01/2015 Accepted, accessed March 31, 2016 from <http://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-contract.pdf>. Appeals in Article 1, p.2; Complaints in Article 1, p.6 and Grievances in Article 1, p.13.

It is important to note that there are nuances with this type of measure such that lower numbers or rates do not necessarily reflect positive member experiences relative to other organizations and higher numbers or rates may not always reflect relatively negative experiences. With respect to MCO reporting of appeals/grievances/complaints they receive, members must be able to reach the MCO, make the MCO understand that the member has an issue, and the MCO must then document and report the issue (and hopefully, address it). An MCO with fewer reported issues may actually have fewer issues, or there may be communication barriers within their organization such that they are not recognizing the issues that they have. In addition, some members are more likely to complain or to be able to complain, and this kind of reporting does not adjust for these factors.

Until January 2015, MCOs reported all Medicaid members together. As of January 2015, MLTSS members are reported as a separate category. Appeals and grievances are reported separately from complaints. Despite the five day language above, investigation is considered timely when complete within 30 days. A completed investigation does not mean that the matter has been resolved to the member's satisfaction, but rather that the MCO has considered the issue and rendered an opinion as to its merit. Timeliness for appeals, grievances and complaints is very high in all MCOs.

There were a total of 742 appeals, grievances and complaints reported by MCOs in 2015 (with as few as one per MCO to as many as 398) and a total of 887 in 2016 (with as few as 15 per MCO to as many as 505). Figure 12 shows the percent of each MCO's members with an appeal, grievance or complaint during each quarter from early 2015 through mid-2016. The average for all MCOs has declined from 1.2% to 0.6% during that time period. There is some variation by MCO, but in all cases MCOs report a small percentage of members with appeals, grievances or complaints.

**Figure 12: Percent of members with appeals, grievances or complaints, by quarter**



Sources: DMAHS, MLTSS Quarterly Performance Measure Reports.

### Outcome of Appeals

DMAHS examined not only the MCO-reported timeliness of appeal resolution (i.e., those investigated within 30 days) but also the MCO-reported outcome of appeals regarding denials of home health (215 appeals) and private duty nursing services (40 appeals) for 2015. With home health services, the MCO upheld 197 of the denials (92%) and overturned 18 (8%) in full or part. With private duty nursing, all but one of the denials were upheld.<sup>42</sup> In 2016, there were 185 home health appeals, of which 177 (96%) were upheld and 6 (3%) had mixed outcomes (not a full denial after the appeal). There were 36 private duty nursing appeals, of which 34 (94%) were upheld.<sup>43</sup>

### Relation of Appeals and Fair Hearings to Service Reductions

Service reductions and the extent to which they are associated with appeals or fair hearings has been reported publicly for one quarter, to our knowledge (Q2 of 2015).<sup>44</sup> MCOs reported one full reduction in physical therapy, one partial reduction in private duty nursing, 7 reductions in adult medical day (4 full; 3 partial) and 41 reductions in personal care assistance (9 full; 32 partial). There is no indication of the number or percentage of hours involved. The presentation noted that none of the 14 full reductions were appealed. Of the 36 partial reductions, 4 (11%) went to

<sup>42</sup> Calculated from data from MAAC\_Meeting\_Presentations\_4\_20\_16 (slides 28-30), which notes that the data is pending state and IPRO validation.

<sup>43</sup> Accessed May 30, 2017 from [http://www.state.nj.us/humanservices/dmahs/boards/maac/MAAC\\_Mtg\\_Minutes\\_1\\_23\\_17.pdf](http://www.state.nj.us/humanservices/dmahs/boards/maac/MAAC_Mtg_Minutes_1_23_17.pdf)

<sup>44</sup> Slide 8 in 9.24.15 Quality Slides for MLTSS Steering Committee.

a first level appeal, 1 (3%) went to a second level appeal and 1 (3%) went to a fair hearing. It is not clear whether service reductions have an effect on client outcomes. A lack of appeals and fair hearings cannot be assumed to indicate client satisfaction. Another presentation from this time period notes that there were a total of 10,866 MLTSS HCBS members in August of 2015, plus another 3,027 in Assisted Living.<sup>45</sup> This is the population to which reductions would apply. While these results are not audited, it would appear that reductions affected a small proportion of members in this quarter. Without information on other time periods, it is impossible to know how typical this quarter was.

### Fair Hearings

Another potential measure of member complaints is the extent to which members file Medicaid fair hearing requests with the Department of Human Services. The outcomes of fair hearing requests that proceed through to a final decision are posted on the Department of Human Services web site. It is not possible to determine the extent to which these decisions relate to members enrolled in MLTSS and often it is not possible to tell the ultimate outcome—i.e., often, the result is that the MCO is told to do a new assessment, and the reader cannot tell whether they ultimately approved the desired service. Table 7 shows the number of final agency decisions by MCO as well as the number of cases that DMAHS has transmitted to the Office of Administrative Law (OAL), along with information on the number of total Medicaid enrollees as well as MLTSS enrollees.<sup>46</sup> It is possible that some individuals are represented more than once in the fair hearing data. In addition, this table does not adjust for member factors that could affect the probability of filing a fair hearing request—that is, a larger number of final agency decisions could mean that an MCO is more likely to serve members that are more likely to file a fair hearing request as well as the more straightforward interpretation that larger numbers mean more members with disputes. In addition, MCOs inform their members of the right to file a request—while efforts are made by the state to ensure standard minimum language used in disclosures, it is possible that better efforts by an MCO to inform members could result in more requests.

All MCOs have small numbers of fair hearing outcomes relative to the size of their enrollment. United appears to have higher numbers than might be expected given their enrollment, but it is difficult to establish patterns with certainty given the small number of cases, potential for duplicate cases in the data, and other issues mentioned that could affect the number of cases filed. In the MAAC meeting in April of 2016, an advocate who files fair hearing requests on behalf of members noted that she had felt pressure at times from MCOs to withdraw cases before a final outcome would be posted—if there are differential efforts in this regard, that could affect

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<sup>45</sup> Slide 3 in MLTSS Presentation Steering Committee 9.24.15.

<sup>46</sup> See Department of Human Services, DMAHS Final Agency Decisions, accessed April 1, 2016 from <http://www.state.nj.us/humanservices/dmahs/info/fads.html>.

the numbers as well.<sup>47</sup> For 2016, the share of cases sent to OAL is very similar to the share of final agency decisions when broken out by MCO, which would appear to indicate that, for 2016, cases in each MCO were equally likely to proceed from a filing to a final decision.

The fair hearing results appear to match reasonably well with the pattern of MCO-reported appeals, complaints, and grievances discussed earlier, which reflects positively on the validity of the MCO reports. In general, and subject to all the caveats discussed above, an MCO reporting low numbers of member disputes but showing up with a high number of fair hearing requests could be discouraging or undercounting member disputes in some way, calling their reporting into question. Alternatively, an MCO with high levels of reported member disputes (particularly if they are not resolved to members' satisfaction) but no fair hearing requests may not be adequately informing members of their right to a fair hearing.

DMAHS presented information about fair hearing dispositions at the October 2016 and January 2017 MAAC meetings. From January through July of 2016, 592 of 3,069 fair hearing requests (19%) involved an adverse decision by an MCO (MLTSS or any other Medicaid program).<sup>48</sup> For the MCO-related hearings that are filed, 5% to 10% of cases proceed to an initial or final decision, 11% of the time people fail to appear (no reason why known), and 60% are withdrawn (no reason why known). The remaining percentage (19-24%) was not explained, and these cases were probably still pending.<sup>49</sup> From August through December of 2016, 370 of 1,934 fair hearing requests (19%) were MCO-related. As of mid-January of 2017, 4% had resulted in an initial or final decision, 8% involved failure to appear for the hearing, and 47% were withdrawn. Presumably the remaining 41% were still pending.<sup>50</sup>

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<sup>47</sup> See sheet 28, p.97, lines 6-13 in

[http://www.state.nj.us/humanservices/dmahs/boards/maac/MAAC\\_Mtg\\_Minutes\\_4\\_20\\_16.pdf](http://www.state.nj.us/humanservices/dmahs/boards/maac/MAAC_Mtg_Minutes_4_20_16.pdf) (accessed May 26, 2017).

<sup>48</sup> Most decisions that are appealed involve financial eligibility for Medicaid.

<sup>49</sup> These data are based on notes taken by J Farnham at the MAAC meeting on October 19, 2016. The presentation was verbal only by Carol Grant; some of the information is in the minutes at [http://www.state.nj.us/humanservices/dmahs/boards/maac/MAAC\\_Mtg\\_Minutes\\_10\\_19\\_16.pdf](http://www.state.nj.us/humanservices/dmahs/boards/maac/MAAC_Mtg_Minutes_10_19_16.pdf) (accessed May 25, 2017).

<sup>50</sup> Accessed May 30, 2017 from

[http://www.state.nj.us/humanservices/dmahs/boards/maac/MAAC\\_Mtg\\_Minutes\\_1\\_23\\_17.pdf](http://www.state.nj.us/humanservices/dmahs/boards/maac/MAAC_Mtg_Minutes_1_23_17.pdf).

**Table 7: Fair hearing information and enrollment by MCO**

MCO	# of DMAHS Final Agency Decisions				# Cases Sent to OAL		Average Total Medicaid Enrollees, 2015	Enrollees eligible to receive MLTSS Services, Jul 2015–June 2016
	2014	2015	2016	2017 (Jan–Mar)	Jan–July 2016	Aug–Dec 2016		
Aetna	0	0	0	0	*	2	8,512	890
Amerigroup	1	2	5	3	32	69	210,303	6,053
Horizon	1	11	40	11	340	542	833,872	16,227
United	4	27	28	13	220	346	492,951	7,177
WellCare	0	0	1	0	*	3	58,748	4,057
Total MCO	6	40	74	27	592	370	1,604,386	34,404

\*The source noted that there were a handful of cases for these MCOs, but they were not included in the total.

Sources: DMAHS Final Agency Decisions accessed May 26, 2017 from

<http://www.state.nj.us/humanservices/providers/rulefees/decisions/dmahs2014.html>,

[http://www.state.nj.us/humanservices/dmahs/info/fads\\_2015.html](http://www.state.nj.us/humanservices/dmahs/info/fads_2015.html) and

[http://www.state.nj.us/humanservices/dmahs/info/fads\\_2016.html](http://www.state.nj.us/humanservices/dmahs/info/fads_2016.html) . Cases sent to OAL accessed May 30, 2017 from

[http://www.state.nj.us/humanservices/dmahs/boards/maac/MAAC\\_Mtg\\_Minutes\\_1\\_23\\_17.pdf](http://www.state.nj.us/humanservices/dmahs/boards/maac/MAAC_Mtg_Minutes_1_23_17.pdf) and

[http://www.state.nj.us/humanservices/dmahs/boards/maac/MAAC\\_Mtg\\_Minutes\\_10\\_19\\_16.pdf](http://www.state.nj.us/humanservices/dmahs/boards/maac/MAAC_Mtg_Minutes_10_19_16.pdf). Total Medicaid enrollment

from NJ Department of Banking and Insurance, Carrier Enrollment Reports (Calculated from 2015 quarters), accessed April 18,

2016 from [http://www.state.nj.us/dobi/division\\_insurance/lhactuar.htm#HMORReports](http://www.state.nj.us/dobi/division_insurance/lhactuar.htm#HMORReports). MLTSS enrollment from MLTSS

Performance Measure Report, 1/1/2017–3/31/2017.

### Independent Health Care Appeals Program (IHCAP)

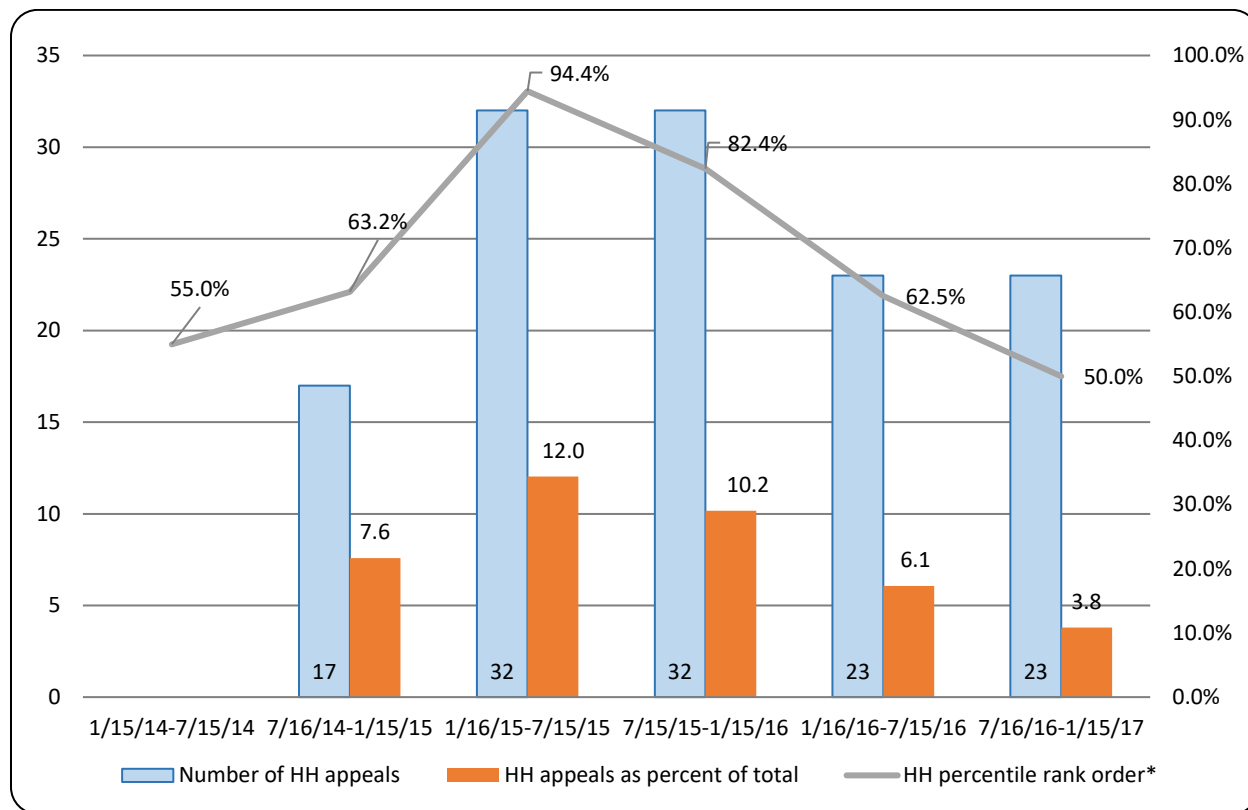
IHCAP<sup>51</sup> began in 1997 and is an external review program administered by the NJ Department of Banking and Insurance (DOBI) to review adverse determinations made by insurance carriers for any health benefit. DOBI contracts with multiple Independent Utilization Review Organizations (IURO) to perform reviews. Insurance carriers bear the costs even if they reverse their decision prior to the IURO rendering a decision, or the individual or health care provider withdraws the appeal. Since 1997, DOBI has issued semi-annual reports tracking appeals and their resolution. Reports do not break out results by type of product—thus, these data contain all lines of business for each carrier (Medicaid and commercial). Self-insured and Medicare Advantage plans are not included, nor is Medicare.

Advocates tell us that the only MLTSS service that is appealable through IHCAP is private duty nursing. It was only in early 2015 that DOBI began listing the services appealed with specific

<sup>51</sup> See [http://www.state.nj.us/dobi/division\\_insurance/managedcare/ihcp.htm](http://www.state.nj.us/dobi/division_insurance/managedcare/ihcp.htm).

frequency numbers. In the report for the first half of 2015, denial of home health care is the top category (32 appeals, 12% of the total), and the report notes “These denials involved the reduction of private duty nursing services by Medicaid HMOs.”<sup>52</sup> Figure 13 shows the number of home health appeals, their percentage of the total number of appeals, and the percentile of the rank order of home health appeals to give a sense of how this category has varied over time and how it compares with other categories over 6 semiannual periods. It appears from these data that there was an increase in these types of cases during 2015, but the frequency of cases to some degree and their share of total appeals to a greater degree seems to have decreased in 2016. According to authors’ calculations from Medicaid claims data, 343 individuals had at least one claim for private duty nursing services in 2015. The 64 IHCAP appeals during 2015 would correspond to about 19 percent of the population of individuals with one or more private duty nursing claims during that period. However, appeals may also be filed by individuals who believe they have a case for private duty nursing but who are ultimately denied without Medicaid ever paying for the service, so it is not possible to estimate an exact percentage.

**Figure 13: Home health IHCAP appeals by semiannual period**



\*This is calculated as the percent of categories ranked below home health. For the first period, home health ranked 9 out of 20 categories, the second—7<sup>th</sup> of 19, the third—1<sup>st</sup> of 18, the fourth—3<sup>rd</sup> of 17, the fifth—6<sup>th</sup> of 16, and the sixth—8<sup>th</sup> of 16.

Source: Semi-annual legislative reports (32<sup>nd</sup> through 37<sup>th</sup>), Independent Health Care Appeals Program, Department of Banking and Insurance, accessed May 30, 2017 from [http://www.state.nj.us/dobi/division\\_insurance/managedcare/ihcaperports.htm](http://www.state.nj.us/dobi/division_insurance/managedcare/ihcaperports.htm).

<sup>52</sup> See [http://www.state.nj.us/dobi/division\\_insurance/managedcare/omc/34thihcaprpt.pdf](http://www.state.nj.us/dobi/division_insurance/managedcare/omc/34thihcaprpt.pdf).



### **Transitions between Nursing Facility and Community**<sup>53</sup>

The reporting of member transitions between nursing facility and community settings is complicated by members who may pass away or switch between MCOs. It appears that some MCOs may interpret a requirement to report only continuously enrolled members somewhat differently, so we have not presented tables or figures for this section. The state is implementing a nursing facility transition incentive payment initiative that will require a minimum of 120 calendar days of residence in the community after the transition.

1. Transitions from Nursing Facility to Community and Back within 90 Days: MCOs report to the department the number of MLTSS members per quarter who have transitioned from a nursing facility to a community setting. There were 227 transitions out of nursing facilities in the first year of MLTSS and 371 in the second year. Fifteen of those transitioned in the first year of MLTSS and 17 of those transitioned during the second year returned to a nursing facility for more than 90 days.
2. Transitions from Community to Nursing Facility, Short-Term (less than or equal to 180 days) and Long-Term (greater than 180 days): In the first year of MLTSS, 1,199 consumers moved from HCBS settings to a nursing home, 43% for short-term stays of less than or equal to 180 days. In the second year of MLTSS, 962 consumers moved, 19% for short-term stays. Given the increase in the HCBS population, this may reflect success in keeping people in HCBS settings. There were some differences by MCO, which may result from differences in the population served given their geographic area or differing provider networks.

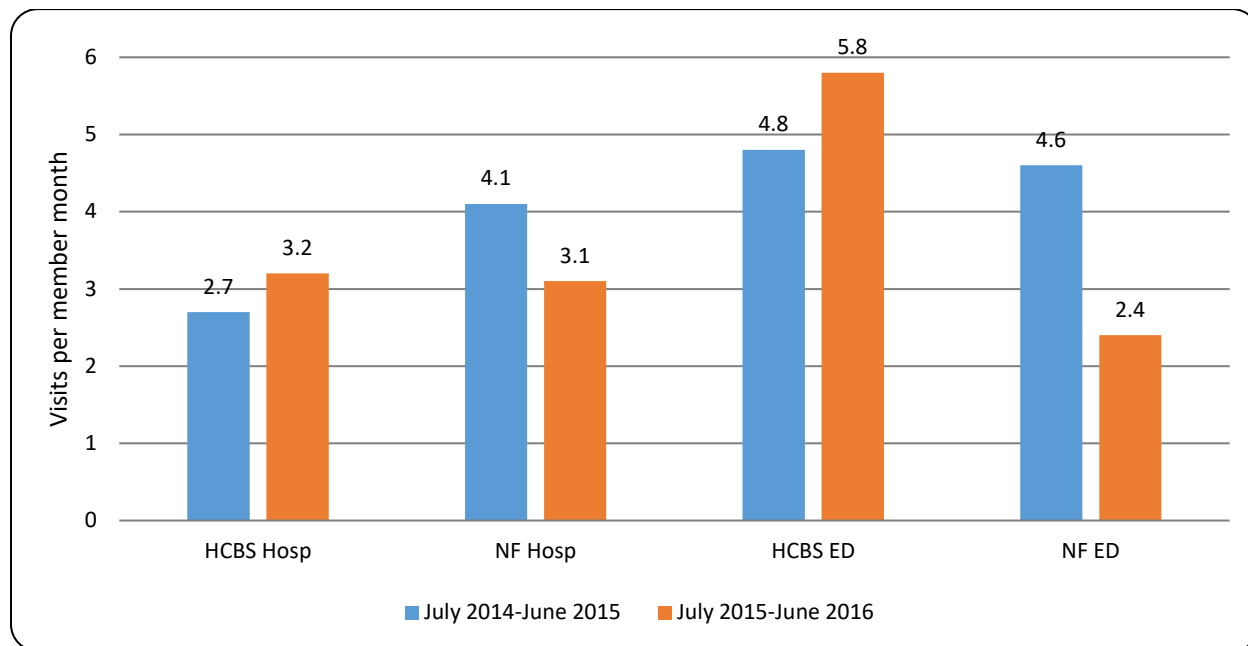
### **Hospital and Emergency Department Use**

As shown in Figure 14, hospital and ED use increased for the HCBS population from Year 1 to Year 2, while decreasing for the nursing facility population. During our interviews, stakeholders told us that the acuity of people in HCBS was increasing with a better ability to keep consumers in home and community settings. Some members make multiple visits—for example, one MCO reported to DMAHS that one member made 29 visits to the ED, 13 for alcohol use.

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<sup>53</sup> Sources for this section are DMAHS, MLTSS Performance Measure Reports dated 1/1/17-3/31/17 and 1/1/16-3/31/16.

**Figure 14: Rate of hospital and ED use among continuously enrolled MLTSS members, Years 1 and 2, by setting (nursing facility or HCBS)**



Sources: DMAHS, MLTSS Performance Measure Reports, 1/1/17-3/31/17 and 1/1/16-3/31/16. Members with more than one visit are counted more than once.

### **Network Adequacy**

The New Jersey Comprehensive Waiver Demonstration Section 1115 Annual Report for Demonstrations Year 3 (covering the period of July 1, 2014 to June 30, 2015) and Year 4 (July 1, 2015 to June 30, 2016) contain GeoAccess reports for 17 acute care provider types.<sup>54</sup> For MLTSS services, MCOs are required to have at least two providers for each home and community-based service (other than community-based residential alternatives)—for services provided in members’ residences, the provider does not need to be located in the member’s county but must be willing and able to serve residents of that county.<sup>55</sup> Presumably for this reason, GeoAccess reports are not available for MLTSS services. However, the annual report notes that MCOs submit network files (including MLTSS providers) on a quarterly basis to DMAHS, which reviews them for potential gaps in coverage. In addition, MCOs report any potential gaps in coverage and the action they are taking to mitigate impacts on members during regular conference calls with the State. According to the annual report, should there be a gap in services for a member, MCOs will

<sup>54</sup> See Section VII and Attachment D--for year 3, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nj/Comprehensive-Waiver/nj-1115-request-Annl-rpt-demo-yr3-11102015.pdf>; for year 4,

<https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nj/Comprehensive-Waiver/nj-1115-request-Annl-rpt-demo-yr4-12072016.pdf>.

<sup>55</sup> See Section 4.8.10 MLTSS Network Requirements (Article 4, p.101 of the 01/2015 Accepted contract), <http://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-contract.pdf>.

complete a single case agreement with a nonparticipating provider and/or arrange for transportation to a participating provider in a contiguous county.<sup>56</sup> We do not know how often this occurs. A summary of detailed grievance information reported by the MCOs covering the period of January to December 2015 showed 12 instances of difficulty obtaining access to MLTSS providers.<sup>57</sup> We are uncertain about the comprehensiveness of this number.

For the 17 acute care providers shown in the reports, there are some notable gaps in hospital participation in selected geographic areas for two MCOs in Year 4, which is noted in the DMAHS report. There are some differences in access to primary care providers (dentists, primary care doctors and pediatricians) by plan and by area, with 78.5% coverage being the lowest value in any area for any plan and many at 100%.

The accuracy of provider directories, on which these data are based, has been questioned nationally and in New Jersey. One examination notes that New Jersey is among the most strict group of states with respect to provider directory requirements.<sup>58</sup> It is unclear whether recent changes to requirements will be sufficient to overcome the problems found by the Mental Health Association in New Jersey in 2013 where researchers found that 33% of 525 psychiatrists had incorrect listings and that only 61% were able to provide information on their ability to accept new patients, many after multiple contact attempts.<sup>59</sup>

### **CAHPS® Survey**

In this section, we examine findings from the 2015 CAHPS® (Consumer Assessment of Healthcare Providers and Systems) survey for MLTSS, D-SNP, and all adult Medicaid beneficiaries. The CAHPS® assesses members' perceptions of the quality of care and services they receive in their Medicaid health plan. Our objective is to situate the experience of individuals enrolled in MLTSS alongside that of other individuals served by the same Medicaid health plans. We examine measures related to provider and plan satisfaction.

**Population Overview.** MLTSS enrollees have been assessed to be clinically eligible for nursing home care as well as financially eligible for Medicaid. In 2015, MLTSS enrollees were about 1% of the NJ FamilyCare population—by the end of 2015, there were about 22,000 MLTSS enrollees,

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<sup>56</sup> See Attachment E, PM#14 on p.8 <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nj/Comprehensive-Waiver/nj-1115-request-Ann1-rpt-demo-yr3-11102015.pdf>.

<sup>57</sup> MAAC Meeting Presentations 4 20 16, slide 28.

<sup>58</sup> Hoyt B. 2015. Provider Directories: Litigation, Regulatory, And Operational Challenges. Washington, DC: Berkeley Research Group. [http://www.thinkbrg.com/media/publication/579\\_Hoyt\\_DirectoryWhitePaper\\_032015\\_WEB.pdf](http://www.thinkbrg.com/media/publication/579_Hoyt_DirectoryWhitePaper_032015_WEB.pdf).

<sup>59</sup> Mental Health Association in New Jersey. July 2013. Managed Care Network Adequacy Report. <http://www.mhanj.org/wp-content/uploads/2014/09/Network-Adequacy-Report-Final.pdf>.

about 16,000 of whom lived in community settings (including assisted living).<sup>60</sup> D-SNP enrollees are dually eligible for both Medicaid and Medicare (meaning that they are either 65 or over, or permanently disabled). In addition, they have chosen a managed care plan to jointly administer their Medicaid and Medicare benefit. In 2014 there were about 22,000 D-SNP enrollees (Wood 2014), corresponding to roughly 10% of dual eligible individuals.<sup>61</sup> Adult Medicaid enrollees may be any age, though most are nonelderly. In November of 2015, about 70% of New Jersey's roughly 882,000 adult Medicaid enrollees were not disabled or age 65 or above. About 20% were disabled and about 10% were age 65 or above.<sup>62</sup> These populations are very different, as we note further below. However, it is the goal of Medicaid that they all be satisfied with their care.

CAHPS® Overview. The CAHPS® survey was administered between November 2015 and January 2016. There were 547 useable surveys collected for the MLTSS population (response rate 35.5%), 612 surveys for the D-SNP population (response rate 36.4%), and 1,632 surveys to characterize the overall adult NJ FamilyCare population (response rate 24.4%). Surveys were sent by mail with a follow-up mailing and phone call to those for whom a valid phone number was found. Phone surveys constituted 19% of the MLTSS surveys, 27% of the D-SNP surveys, and 25% of the adult FamilyCare surveys. Samples were drawn randomly, but there is always the chance that differential non-response can reduce the representativeness of survey estimates. MLTSS results were not shown by plan.

CAHPS® Findings. In demographics and health status, these populations differ in expected ways (data not shown). Compared to the D-SNP and Adult groups, almost half (48.8%) of MLTSS beneficiaries are 75 years of age or older.<sup>63</sup> The largest proportion of D-SNP beneficiaries are between the ages of 65 and 74, and the majority (60.5%) of the Adult group are between the

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<sup>60</sup> See slides 72 and 74 in of presentation to Medical Assistance Advisory Committee (MAAC) on January 23, 2017 [http://www.state.nj.us/humanservices/dmahs/boards/maac/MAAC\\_Meeting\\_Presentations\\_1\\_23\\_17.pdf](http://www.state.nj.us/humanservices/dmahs/boards/maac/MAAC_Meeting_Presentations_1_23_17.pdf) (accessed February 8, 2017).

<sup>61</sup> Estimate of number of dual eligible is from Kaiser State Health Facts, 2010, accessed May 16, 2017 from <http://kff.org/medicaid/state-indicator/dual-eligible-beneficiaries/?dataView=0&currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D> . This shows 208,300 dual eligibles in New Jersey, which seems to track reasonably well with the November 2015 Family Care enrollment report showing 265,000 ABD (aged, blind or disabled) enrollees. According to other Kaiser estimates from 2010, more than 90% of aged Medicaid enrollees are dually eligible, while about 40% of disabled Medicaid enrollees are--“Aged and Disabled Dual Eligibles as a Percent of Total Medicaid Beneficiaries,” accessed May 16, 2017 from <http://kff.org/medicaid/state-indicator/ageddisabled-medicaid-beneficiaries/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>.

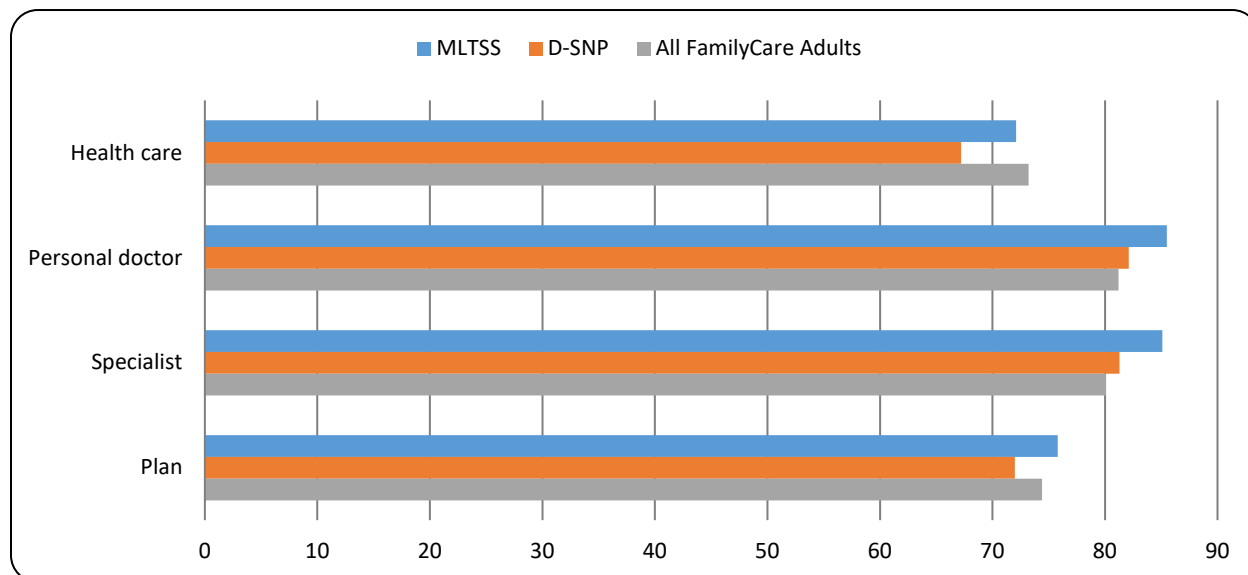
<sup>62</sup> NJ FamilyCare enrollment report, November, 2015. Accessed May 16, 2017 from [http://www.state.nj.us/humanservices/dmahs/news/reports/enrollment\\_2015.pdf](http://www.state.nj.us/humanservices/dmahs/news/reports/enrollment_2015.pdf)

<sup>63</sup> Data presented at the December 2015 MLTSS Steering Committee meeting showed that 59% of the MLTSS population was age 75 or older in September 2015. Thus, the very elderly may be slightly under-represented in the CAHPS® MLTSS survey.

ages of 18 and 54. The majority (78.2%) of MLTSS beneficiaries are not Hispanic or Latino and 61.1% identify as white. A greater proportion of the D-SNP respondents (41.4%) report they are Hispanic/Latino and the majority of both the D-SNP and overall adult Medicaid population identify as non-white. Only 12% of MLTSS beneficiaries rate their overall health as good or excellent, compared with 23.5% of D-SNP adults and 32.7% of adults overall. Ratings of overall mental or emotional health are similarly poorer among MLTSS beneficiaries. Only 26.6% consider their mental/emotional health to be excellent or good, whereas 36% of D-SNP beneficiaries and 46% of all FamilyCare adults rate their mental health as good or excellent.

Figure 15 shows the proportion of respondents with a positive rating of their health care, personal doctor, specialist, and health plan.<sup>64</sup> Individuals in MLTSS were no less likely (and often actually more likely) to positively rate these aspects of their care compared to the D-SNP and overall adult groups.

**Figure 15: Respondent rating of care, personal doctor, specialist and health plan (2015 CAHPS®)**



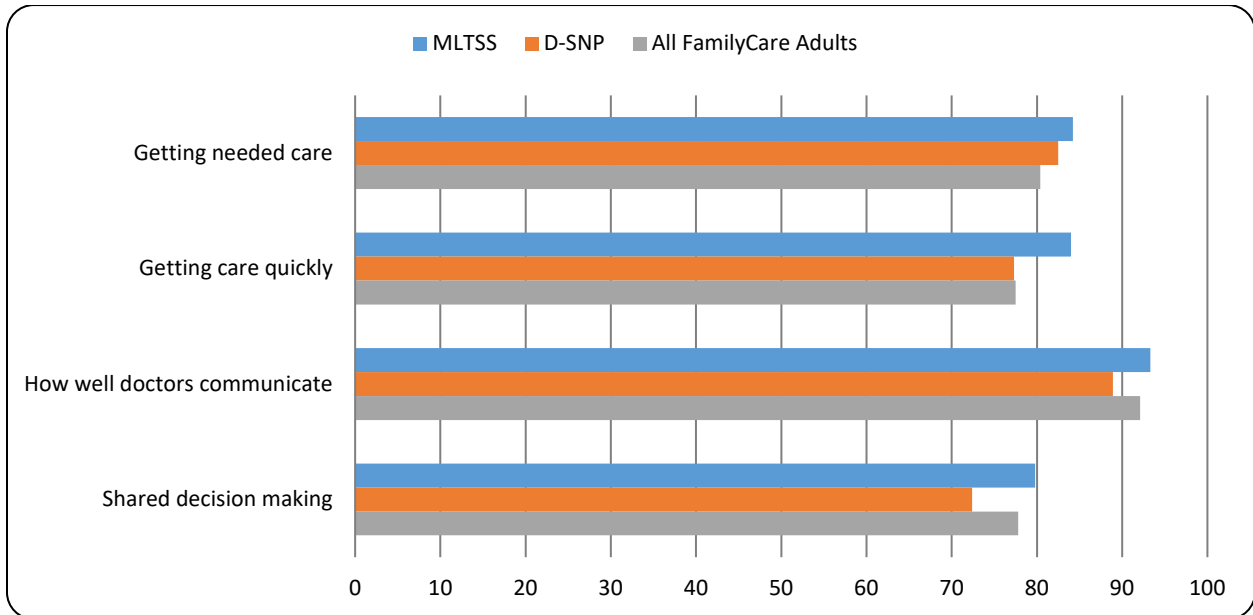
Sources: Adult Surveys (NJ FamilyCare, MLTSS, DSNP), CAHPS® 5.0H Reports, April 2016.

The same pattern of satisfaction is seen in Figure 16 which shows results for CAHPS® composite measures.<sup>65</sup> The experience of getting needed care, getting needed care quickly, having doctor(s) communicate well, and engaging in shared decision making with their doctors is as positive, and frequently more positive, for MLTSS beneficiaries as it is for the D-SNP and overall adult populations.

<sup>64</sup> Ratings of 8, 9, or 10 on a 10-point scale were considered positive.

<sup>65</sup> Composite measures group together questions on similar topics to simplify interpretation of the data and enhance the reliability of results.

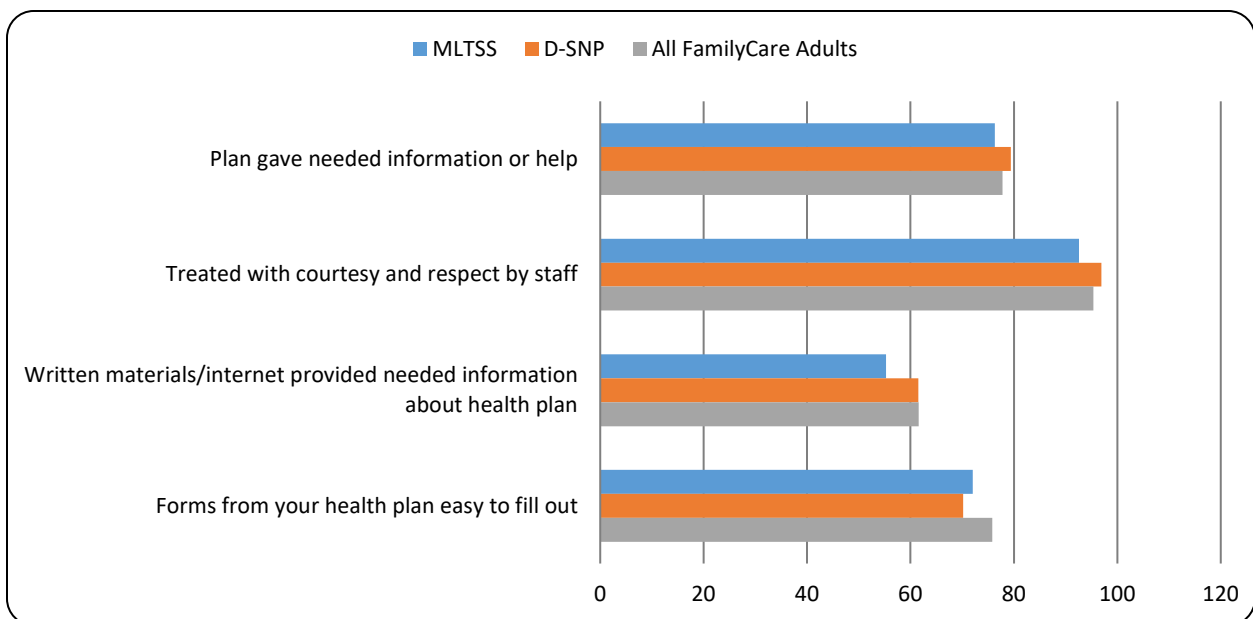
**Figure 16: CAHPS® composite measures (2015)**



Sources: Adult Surveys (NJ FamilyCare, MLTSS, DSNP), CAHPS® 5.0H Reports, April 2016.

Figure 17 shows the proportion of respondents reporting they usually or always had positive experiences with their health plan with respect to getting information, being treated courteously, and the ease of using forms from the plan. Here, results are slightly poorer for the MLTSS population.

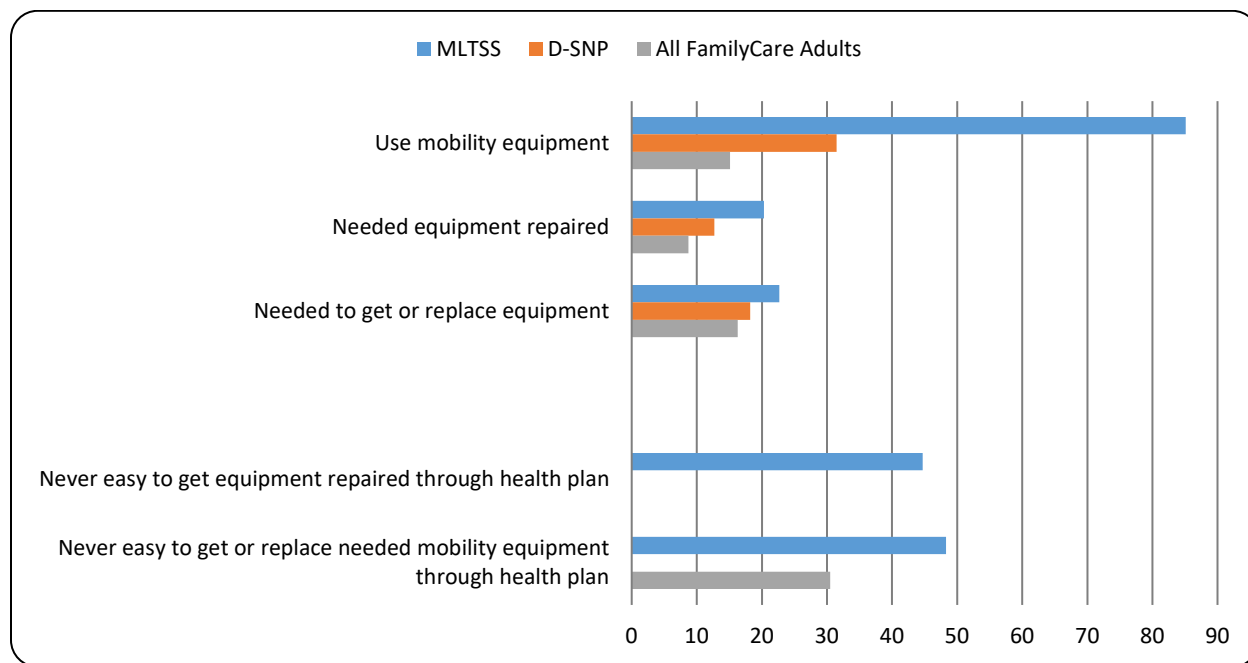
**Figure 17: Respondent experiences with health plan (2015 CAHPS®)**



Sources: Adult Surveys (NJ FamilyCare, MLTSS, DSNP), CAHPS® 5.0H Reports, April 2016.

Finally, Figure 18 shows respondents' experiences with their health plan in obtaining, replacing, or repairing mobility equipment. It is notable that 85% of those in MLTSS needed some type of mobility equipment (wheelchair, scooter, walker, or a cane). Less than a third of D-SNP respondents needed these devices, and only 15% of adult Medicaid beneficiaries overall needed them. Individuals in MLTSS also needed their equipment repaired or replaced more often than those in the comparison populations. Because this equipment is needed less among D-SNPs and all adults, and fewer in those samples faced the situation of needing the equipment repaired or replaced, there was not sufficient sample to show reliable estimates for some of these measures in the D-SNP and adult groups. More than 40% of individuals in MLTSS reported difficulty with their health plan getting, replacing, or repairing mobility equipment. State officials told us that frequently there is confusion about whether Medicare or Medicaid is the payer for such equipment. Most MLTSS enrollees are dual-eligible, and Medicaid requires that Medicare pay when required. In the NCI-AD™ survey (discussed later), New Jersey's MLTSS members were generally less likely to report needs for equipment than MLTSS recipients in four other states. So, while there is clearly room for improvement here, it does not appear that New Jersey is an outlier.

**Figure 18: Respondent experiences with mobility equipment (2015 CAHPS®)**



Sources: Adult Surveys (NJ FamilyCare, MLTSS, DSNP), CAHPS® 5.0H Reports, April 2016.

**CAHPS® Discussion.** Management of beneficiaries' acute and chronic health conditions, the dimensions of care predominantly tapped by CAHPS® questions, were not directly affected by the shift to MLTSS, as they were already included in Medicaid enrollees' benefit packages. Individuals in MLTSS are on par with non-MLTSS beneficiaries in overall satisfaction with their health care providers and access to care. When examining satisfaction with the administrative

responsiveness of their plan, MLTSS beneficiaries are slightly less satisfied. The move to MLTSS required health plans to build capacity and expertise in long-term care service delivery, contracting with long-term care providers and training customer service representatives on an entirely new suite of covered services. MLTSS enrollees interact with their health plan about this new group of services, while D-SNP and those in general Medicaid interact with plans about same services plans are more familiar with managing. This may explain the slightly lower results for MLTSS enrollees versus D-SNP and other adult Medicaid enrollees regarding administrative responsiveness. In terms of overall plan rating, MLTSS beneficiaries are equally or more satisfied as D-SNP enrollees and the general population of Medicaid adults.

### **NCI-AD (National Core Indicators, Aging and Disabilities™)**

The NCI-AD™ is a face-to-face survey with questions developed by experts in long-term care, carried out by the states that implement it. To conduct the survey, New Jersey utilized staff from the Department of Human Services for consumers enrolled in Medicaid and county staff for consumers not enrolled in Medicaid. There were 75 interviewers and 727 completed interviews, beginning in July 2015 and concluding in October 2015. All interviewers were trained with the involvement of the National Association of States United for Aging and Disabilities (NASUAD) and the Human Services Research Institute (HSRI).

New Jersey was one of the first cohort of six states to participate in the 2015 inception of the rapid-cycle data collection of the NCI-AD,™ an annual in-person survey addressing quality of life and care issues. A detailed report for New Jersey is available showing answers to all questions.<sup>66</sup> There is also a national report with results from 13 participating states.<sup>67</sup> We will discuss selected results here, focusing on areas where New Jersey's MLTSS results differed from other states, how MLTSS compared with other long term care programs in New Jersey, or where there was notable variation among individual New Jersey MCOs. The NCI-AD™ initial report includes only the four plans operating at the beginning of MLTSS: Amerigroup, Horizon NJ Health, United Healthcare, and WellCare. A sample of about 100 members receiving HCBS (not nursing facility) services was selected for each MCO. Proxies could respond for members if they desired a proxy or were unable to respond themselves. In New Jersey, about 25% of surveys for the overall sample were by proxy.<sup>68</sup> Fee-for-service nursing home residents were also included as a separate category in the NJ NCI-AD,™ as were Program of All-inclusive Care for the Elderly (PACE) participants and those receiving Older Americans Act HCBS services (at least one service--including adult day, chore, homemaker, personal care and/or home delivered meals--three or more times per week).

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<sup>66</sup> See <http://nci-ad.org/resources/reports/> (accessed June 5, 2017).

<sup>67</sup> See [http://nci-ad.org/upload/reports/NCI-AD\\_2015-2016\\_National\\_Report\\_FINAL.pdf](http://nci-ad.org/upload/reports/NCI-AD_2015-2016_National_Report_FINAL.pdf) (accessed June 6, 2017).

<sup>68</sup> [http://nci-ad.org/upload/reports/NCI-AD\\_2015-2016\\_National\\_Report\\_FINAL.pdf](http://nci-ad.org/upload/reports/NCI-AD_2015-2016_National_Report_FINAL.pdf) , p.250.



New Jersey MLTSS Compared with Other States.<sup>69</sup> Although there were 13 states in the first round of the NCI-AD™, only 5 included MLTSS programs: Delaware, Minnesota, New Jersey, Tennessee and Texas. Tennessee’s MLTSS results include nursing home residents. Many results are risk adjusted for age, gender, race, rurality, whether the person lives in his/her own home versus somewhere else, whether the person lives alone, mobility, assistance needed for everyday activity, assistance needed for self-care, overall health, and whether the Proxy version of the survey was used (NCI-AD™ 2015-2016 National, p.255). For most measures, New Jersey was somewhere in the middle. Margins of error for estimates were 2%-3% for Minnesota, Tennessee, and Texas; about 4% for New Jersey, and 9% for Delaware.<sup>70</sup>

*Member Differences.* There were several items that seemed to denote relevant differences between New Jersey MLTSS members and those in the 4 other states.

- Age - New Jersey serves a higher proportion of people who are age 90 and over (18% of NJ MLTSS versus 5%-14% for others, NCI-AD™ 2015-2016 National, Table 2).
- Family support - New Jersey MLTSS members were more likely than those in other states to say that a family member (paid or unpaid) was the person who helped them most (52% versus 32%-43% for others, NCI-AD™ 2015-2016 National, Table 50, risk adjusted).
- Comfort after hospital/rehab discharge – perhaps because of family support, or perhaps because of differences in coverage of hospital/rehab stays, New Jersey MLTSS members were more likely to report feeling comfortable and supported enough to go home after discharge from a hospital or rehabilitation facility in the past year (93%, versus 79%-89% for others, NCI-AD™ 2015-2016 National, Table 53, risk adjusted).
- Activities outside home - New Jersey MLTSS members were less likely than members in 3 other states to say that they were able to do things they enjoyed outside their home when and with whom they wanted (64%, versus 64%-78% for others, risk adjusted, NCI-AD™ 2015-2016 National, Table 23). The reasons why people were unable to participate were not broken down by program, but when comparing New Jersey with the other states having MLTSS programs, the only items New Jersey residents of all surveyed programs were more likely to cite than other states were transportation (49% versus 35%-45% for the 4 other states with MLTSS programs, NCI-AD™ 2015-2016 National, Table 24) and “other.” When MLTSS members were asked about transportation, New Jersey respondents were the 4<sup>th</sup> lowest (ahead of Texas) with respect to doing things outside the home (73% versus 76%-82% for the 3 highest (70% for TX), risk adjusted, NCI-AD 2015-2016 National, Table 57) and the lowest with respect to medical appointments (90% for NJ versus 92%-97% for others, risk adjusted, NCI-AD™ 2015-2016 National, Table 58). Transportation is an often cited complaint among stakeholders.

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<sup>69</sup> Page numbers and table references in this section refer to the NCI-AD 2015-2016 National Report.

<sup>70</sup> See p.55 in [http://nci-ad.org/upload/reports/NCI-AD\\_2015-2016\\_National\\_Report\\_FINAL.pdf](http://nci-ad.org/upload/reports/NCI-AD_2015-2016_National_Report_FINAL.pdf).

*Access to Primary Care and Equipment/Modifications.* New Jersey’s MLTSS members frequently reported better access to primary care and equipment than other states. Table 8 lists survey items where New Jersey appeared to be different from at least 3 other states (based on simple differences and not statistical testing). One exception to the generally positive pattern is the general “other” category of equipment, as noted below (NCI-AD™ 2015-2016 National, Tables 90 and 91). There were other relevant items where New Jersey was somewhere in the middle, and we did not include those here in the interest of space.

**Table 8: Access to primary care, equipment and modifications, MLTSS members, NCI-AD™ 2015–2016 National**

Survey Item	New Jersey	Range, other states	NCI-AD™ Table
Can get appointment with primary care doctor when needed	92%	81%-90%	103
Had physical exam/wellness visit in past year	89%	72%-86%	105
Discussed forgetfulness with doctor or nurse (if forgot things more often in past year)	70%	51%-58%	114
Know how to manage their chronic conditions (if present)	93%	86%-91%	56
Need grab bars	8%	9%-20%	60
Need bathroom modifications	5%	6%-16%	62
Need specialized bed	4%	5%-10%	64
Need walker upgrade	4%	4%-10%	75
Need scooter	4%	6%-16%	76
Need cane	1%	2%-5%	78
Need hearing aids	7%	7%-13%	82
Need communication device	2%	3%-5%	86
Need other device	9%	3%-9%	90
Need upgrade to other device	5%	1%-3%	91

Notes—included here are measures where New Jersey appeared different than other states (no statistical testing was done). Other states are DE, MN, TN, TX. The need questions specify that the consumer has an unmet need.

Source: Accessed June 6, 2017 from [http://nci-ad.org/upload/reports/NCI-AD\\_2015-2016\\_National\\_Report\\_FINAL.pdf](http://nci-ad.org/upload/reports/NCI-AD_2015-2016_National_Report_FINAL.pdf).

*Care Management/Services.* Table 9 notes several items relevant to MLTSS services and care management, which we know are of great interest to stakeholders. New Jersey did not differ from the other states with respect to services meeting needs or extent of self-direction. On most related measures, New Jersey was somewhere in the middle. However, New Jersey was the most positive with respect to the extent to which care managers discussed services to help with any unmet needs (and this was not due to NJ members having higher levels of unmet needs). On a

less positive note, NJ members were more likely to say that their paid support staff changed too often, and less likely than respondents in 3 other states to say that someone discussed job options with them (if a job was desired).

**Table 9: MLTSS services and care management, MLTSS members, NCI-AD™ 2015–2016 National**

Survey Item	New Jersey	Range, other states	NCI-AD™ Table
Services met all needs and goals	71%	62%-73%	45
Participating in self-directed option	11%	5%-41%	127
CM talked to person about services that might help with unmet needs and goals*	71%	42%-62%	47
Paid support staff change too often	43%	17%-36%	37
Someone talked to person about job options (if job wanted)*	8%	8%-25%	132

Notes—included here are measures where New Jersey appeared different than other states (no statistical testing was done). Other states are DE, MN, TN, TX.

\*These questions were asked of a selected sample of those who responded to a previous question in a certain way.

Source: Accessed June 6, 2017 from [http://nci-ad.org/upload/reports/NCI-AD\\_2015-2016\\_National\\_Report\\_FINAL.pdf](http://nci-ad.org/upload/reports/NCI-AD_2015-2016_National_Report_FINAL.pdf).

*Mental Health.* New Jersey was noticeably low in the proportion of MLTSS enrollees with a mental health-related diagnosis (27%, compared with 41%-55% for the others, not risk adjusted, NCI-AD™ 2015-2016 National, Table 16). New Jersey did not differ from other states in the extent to which MLTSS members took medications for sadness or depression (42%, versus 39%-43% for others, risk adjusted, NCI-AD™ 2015-2016 National, Table 115). However, NJ MLTSS members were less likely to say that they had discussed their depression with anyone else (49%, versus 65%-71% for others).<sup>71</sup> The others with whom they could discuss sadness or depression included friend, family member, doctor or nurse. Results for all program respondents for states with MLTSS programs showed that New Jersey lagged the four other states with respect to all potential confidant categories (NCI-AD™ 2015-2016 National, Table B57, not limited to MLTSS or risk adjusted): friends (5%, versus 8%-26% others), family (9%, versus 12%-28% others), and doctors/nurses (20%, versus 24%-49% others)

Differences among New Jersey’s Long-Term Care Programs. The national report offers the opportunity to compare MLTSS respondents as a group with those from New Jersey’s other long-term care programs, with risk adjustment for some measures. Our focus is on how MLTSS relates to other programs in key areas and where MLTSS differs from other programs—if a different program stands out, we generally do not discuss this. We should also note that, as we show in

<sup>71</sup> NJ MLTSS members were equally likely to say that they were lonely, said or depressed (risk adjusted, NCI-AD™ 2015-2016 National, Table 31, NJ 54%, others 50%-57%).

the next section, there is some variability by MCO (and probably in other ways as well) in participant profiles and experiences. This is undoubtedly true for the other categories as well—PACE may differ from site to site, as may the experiences of those in nursing homes or receiving Older Americans Act services.

In addition to about 100 members for each MCO enrolling MLTSS members, fee-for-service nursing home residents were also included as a separate category in the NJ NCI-AD™, as were (PACE) participants and those receiving Older Americans Act HCBS services (at least one service--including adult day, chore, homemaker, personal care and/or home delivered meals--three or more times per week). Margins of error for estimates are about 4% for MLTSS and about 9% for the other categories, which means that it is difficult to say that there is a true difference among categories unless it is a large difference.<sup>72</sup>

Table 10 shows the number of eligible participants and the number of surveys for each program type. Fee-for-service nursing home residents were the largest population, with Older Americans Act recipients not far behind. MLTSS participants are also numerous. PACE constitutes the smallest group at 840.

**Table 10: Eligible participants and NCI-AD™ 2015 surveys, by program (New Jersey)**

Program	Number of surveys	Number of eligible participants
MLTSS/HCBS (4 MCOs)	415	11,893
Older Americans Act	104	17,853
Program of All-Inclusive Care for the Elderly	101	840
Nursing Home Residents (FFS)	104	20,202
Total	727	50,788

Source: [http://nci-ad.org/upload/reports/NCI-AD\\_2015-2016\\_National\\_Report\\_FINAL.pdf](http://nci-ad.org/upload/reports/NCI-AD_2015-2016_National_Report_FINAL.pdf) p.42.

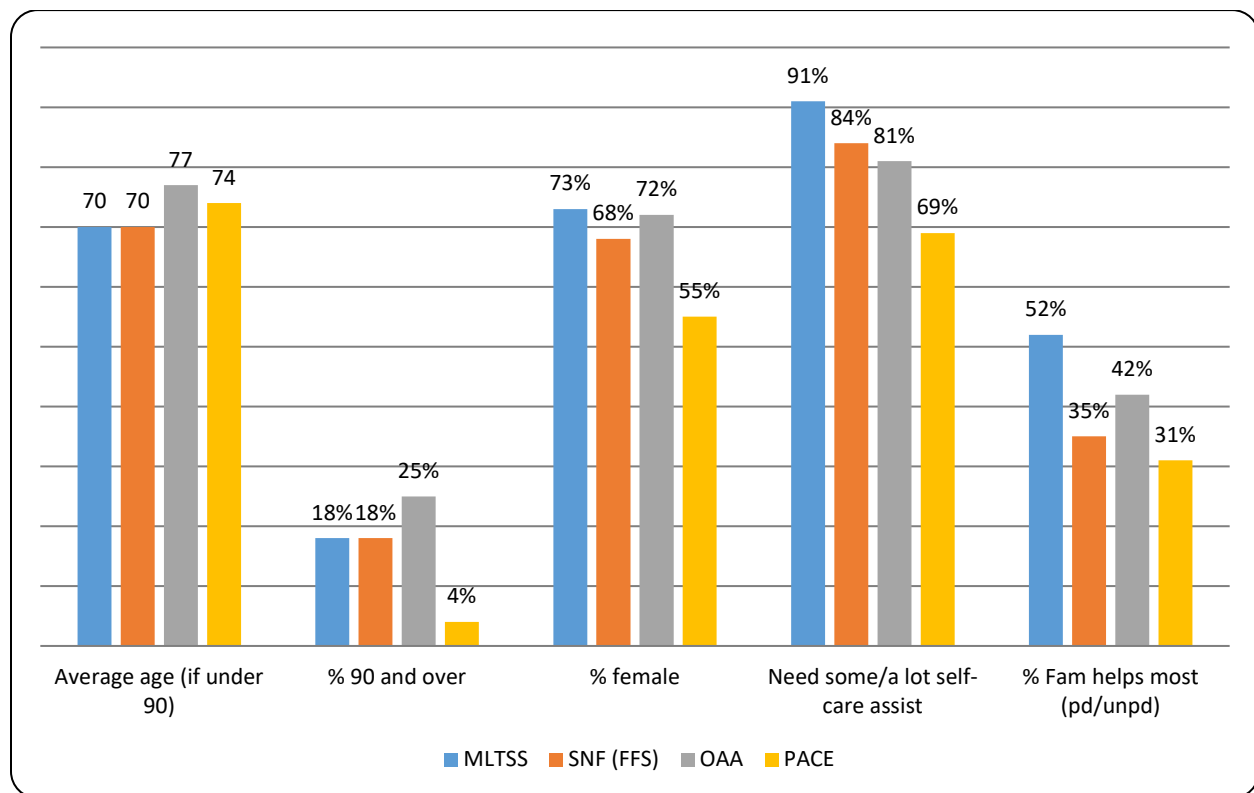
*Demographics, Assistance Needs, and Who Helps Participant.* As shown in Figure 19, Older Americans Act (OAA) recipients are a bit older than those in other programs. PACE has a lower percentage of participants who are 90 and over. PACE enrollees are more likely to be male compared with other programs. PACE also has a different racial/ethnic composition than the other programs--46% of PACE participants are Black or African/American, compared with 21% average overall (race/ethnicity not shown in figure). PACE also has a higher percentage of

<sup>72</sup> See p.55 in [http://nci-ad.org/upload/reports/NCI-AD\\_2015-2016\\_National\\_Report\\_FINAL.pdf](http://nci-ad.org/upload/reports/NCI-AD_2015-2016_National_Report_FINAL.pdf).

Hispanic or Latino participants than average (19% versus 8% average overall).<sup>73</sup> PACE also has fewer participants on Medicare than other programs (79%, compared with 93% overall, not shown in figure).<sup>74</sup>

MLTSS leads the group in the percent of members needing assistance with self-care (bathing, dressing, etc.), though it may differ only from PACE considering the estimated margins of error. Nearly all program participants needed help with everyday activities like preparing meals and housework, so we did not show that. MLTSS also leads with respect to the proportion of respondents for whom a family member (paid or unpaid) is the person providing the most help. It is important to keep in mind when reading about differences in experiences or outcomes by program that people are not randomly assigned to programs, and their characteristics influence what programs they choose.

**Figure 19: Age, percent female, need for self-care assistance, and extent to which family helps the most, by NJ program (NCI-AD™ 2015)**



Note: Self-care and source of help are risk-adjusted; others are not.

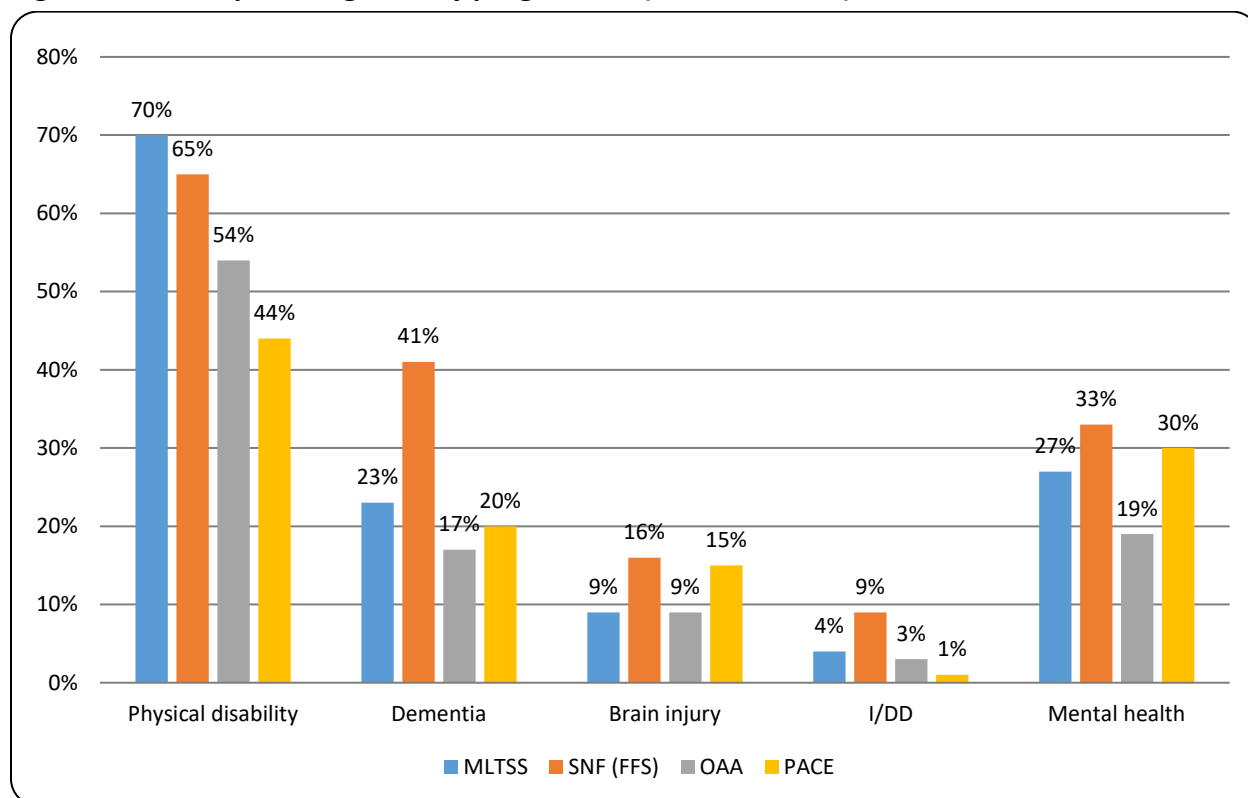
Source: Tables 1, 2, 3, 136 & 50 in [http://nci-ad.org/upload/reports/NCI-AD\\_2015-2016\\_National\\_Report\\_FINAL.pdf](http://nci-ad.org/upload/reports/NCI-AD_2015-2016_National_Report_FINAL.pdf).

<sup>73</sup> Overall race/ethnicity is from Table 4 in [http://nci-ad.org/upload/reports/NCI-AD\\_2015-2016\\_National\\_Report\\_FINAL.pdf](http://nci-ad.org/upload/reports/NCI-AD_2015-2016_National_Report_FINAL.pdf) ; PACE-specific numbers are from Table 4 in [http://nci-ad.org/upload/reports/NCI-AD\\_2015-2016\\_NJ\\_state\\_report.pdf](http://nci-ad.org/upload/reports/NCI-AD_2015-2016_NJ_state_report.pdf).

<sup>74</sup> Table 21 in [http://nci-ad.org/upload/reports/NCI-AD\\_2015-2016\\_National\\_Report\\_FINAL.pdf](http://nci-ad.org/upload/reports/NCI-AD_2015-2016_National_Report_FINAL.pdf).

*Diagnoses.* Figure 20 shows diagnoses of participants by program. MLTSS and nursing homes lead in the percentage of participants with a physical disability. Respondents with dementia were about twice as likely to be in a nursing home setting versus other programs. There were smaller differences for respondents with mental health, brain injuries and intellectual or developmental disabilities—with margins of error up to 9%, it’s harder to know if these are robust differences.

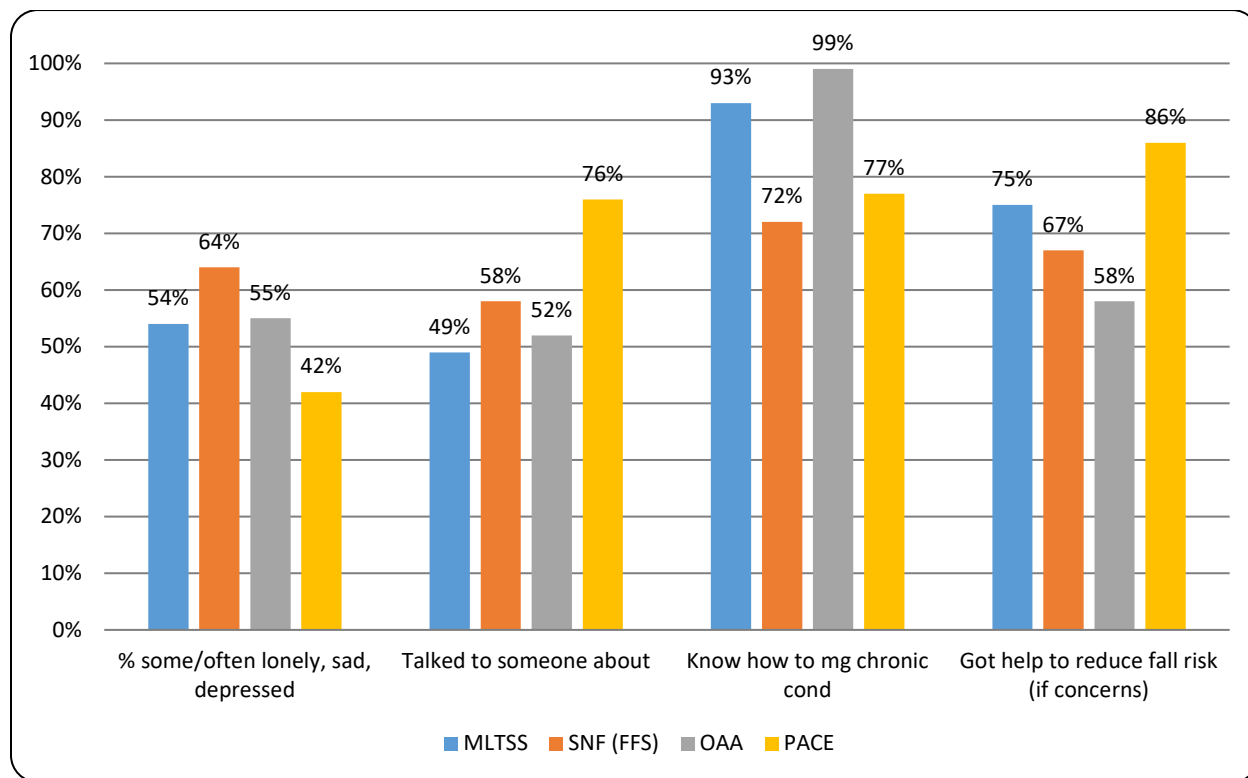
**Figure 20: Participant diagnosis by program, NJ (2015 NCI-AD™)**



Source: Tables 12-16, [http://nci-ad.org/upload/reports/NCI-AD\\_2015-2016\\_National\\_Report\\_FINAL.pdf](http://nci-ad.org/upload/reports/NCI-AD_2015-2016_National_Report_FINAL.pdf).

*Depression/Loneliness, Engagement in Care.* Figure 21 shows the extent to which participants are sometimes or often lonely, sad, or depressed; the extent to which they have talked to someone (friend, family, doctor or nurse) about their feelings; the extent to which they know how to manage chronic conditions, if they have them, and the extent to which they received help to reduce their risk of falling, if there was a concern about this.

**Figure 21: Depression/loneliness and engagement in care by NJ program (2015 NCI-AD™)**

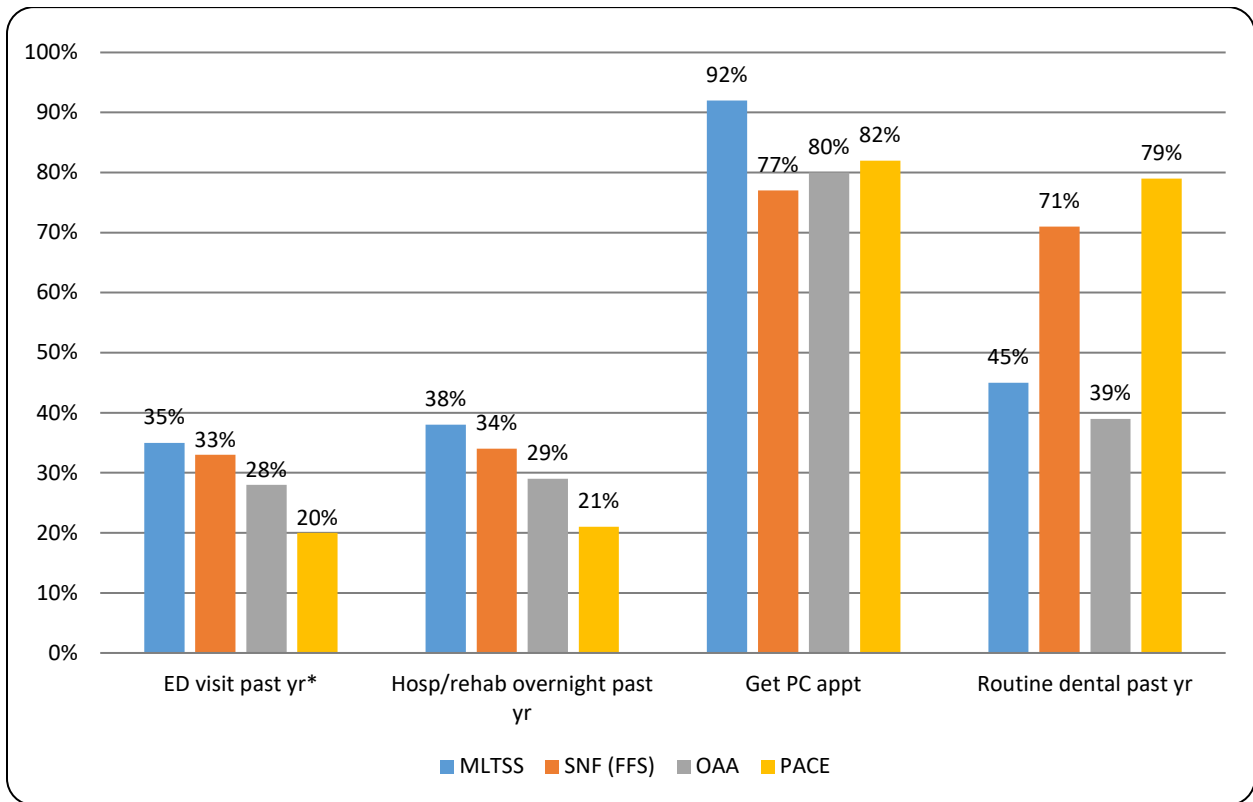


Source: Tables 31, 104, 56 & 97 in [http://nci-ad.org/upload/reports/NCI-AD\\_2015-2016\\_National\\_Report\\_FINAL.pdf](http://nci-ad.org/upload/reports/NCI-AD_2015-2016_National_Report_FINAL.pdf).  
 Note: Depression and knowledge of chronic condition management are risk adjusted; the others are not, though that they were only asked of people for whom the condition existed.

PACE respondents were less likely to know how to manage chronic conditions, but reported less depression and more engagement with respect to talking to someone if they were depressed or lonely, and were the most likely to get help to reduce risks of falling. MLTSS respondents were the second most likely to get help to reduce the risk of falling and more likely than PACE or nursing home respondents to know how to manage chronic conditions. Nursing home residents were the most likely to feel lonely or depressed, but were also a bit more likely to talk to someone about it than MLTSS or OAA respondents.

*ED/Hospital Utilization and Primary Care Access/Use.* As shown in Figure 22, MLTSS respondents were the most likely to visit the ED or have an overnight hospital or rehab stay in the past year—when taking into account the margin of error for these measures, the difference may be only with PACE, which was the lowest. These measures were risk-adjusted. MLTSS respondents were the most likely to report being able to get a primary care appointment if needed (all groups were very, and about equally, likely to have a primary care provider). However, MLTSS members were less likely than nursing home or PACE participants to have had a routine dental visit in the past year.

**Figure 22: ED/hospital/rehab visits and primary care access/use in past year, by NJ program (2015 NCI-AD™)**

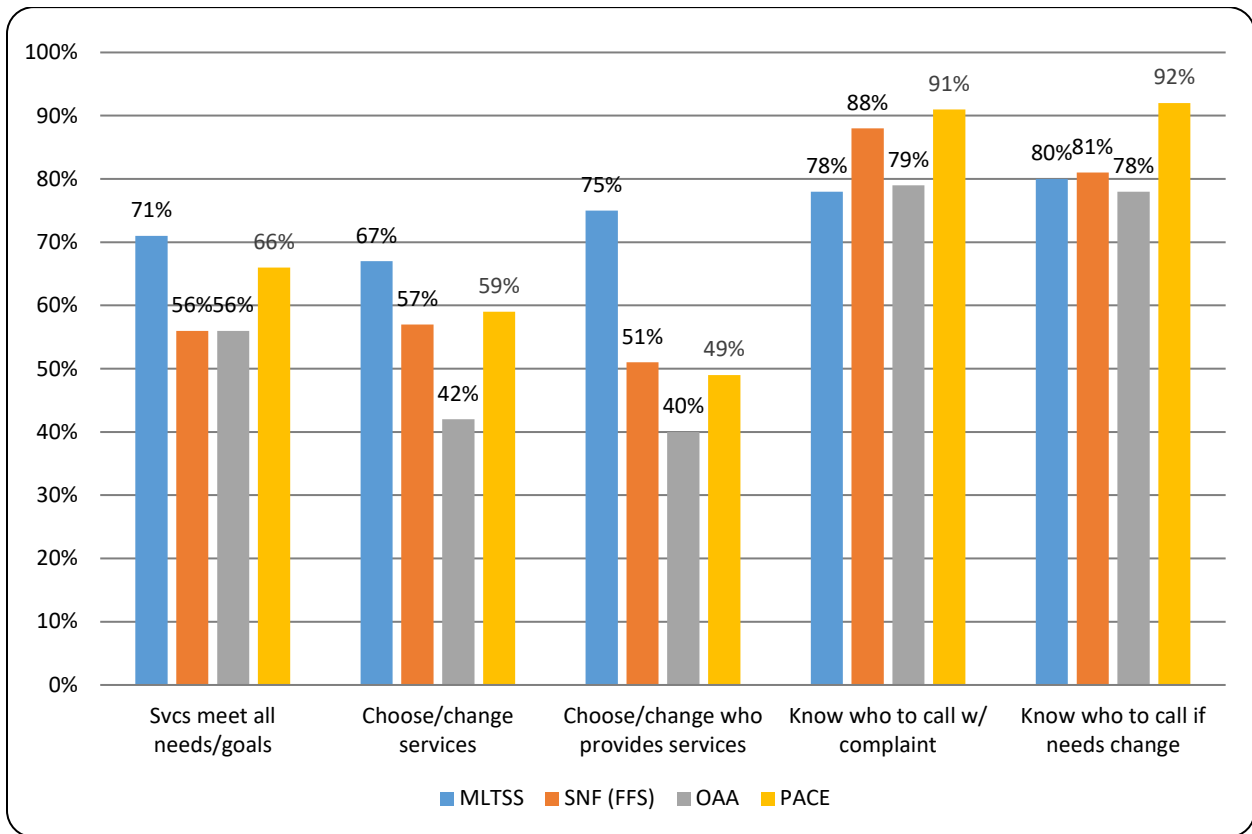


Source: Tables 101, 52, 103 & 109 from [http://nci-ad.org/upload/reports/NCI-AD\\_2015-2016\\_National\\_Report\\_FINAL.pdf](http://nci-ad.org/upload/reports/NCI-AD_2015-2016_National_Report_FINAL.pdf).  
 Note: ED and hospital measures are risk-adjusted.

*Service Adequacy, Choice, and Care Manager Accessibility.* As shown in Figure 23, MLTSS respondents were the most likely to say that their services met all their needs and goals (risk-adjusted)—with the margin of error, PACE and MLTSS may be equivalent. MLTSS respondents were also the most likely to report that they could choose or change their services or who provided the services. They were a bit less likely than respondents in PACE or nursing homes to know who to call with a complaint about their services, and less likely than PACE respondents to know who to call if their needs changed.



**Figure 23: Service adequacy, choice, and care manager accessibility, by NJ program (NCI-AD™ 2015)**

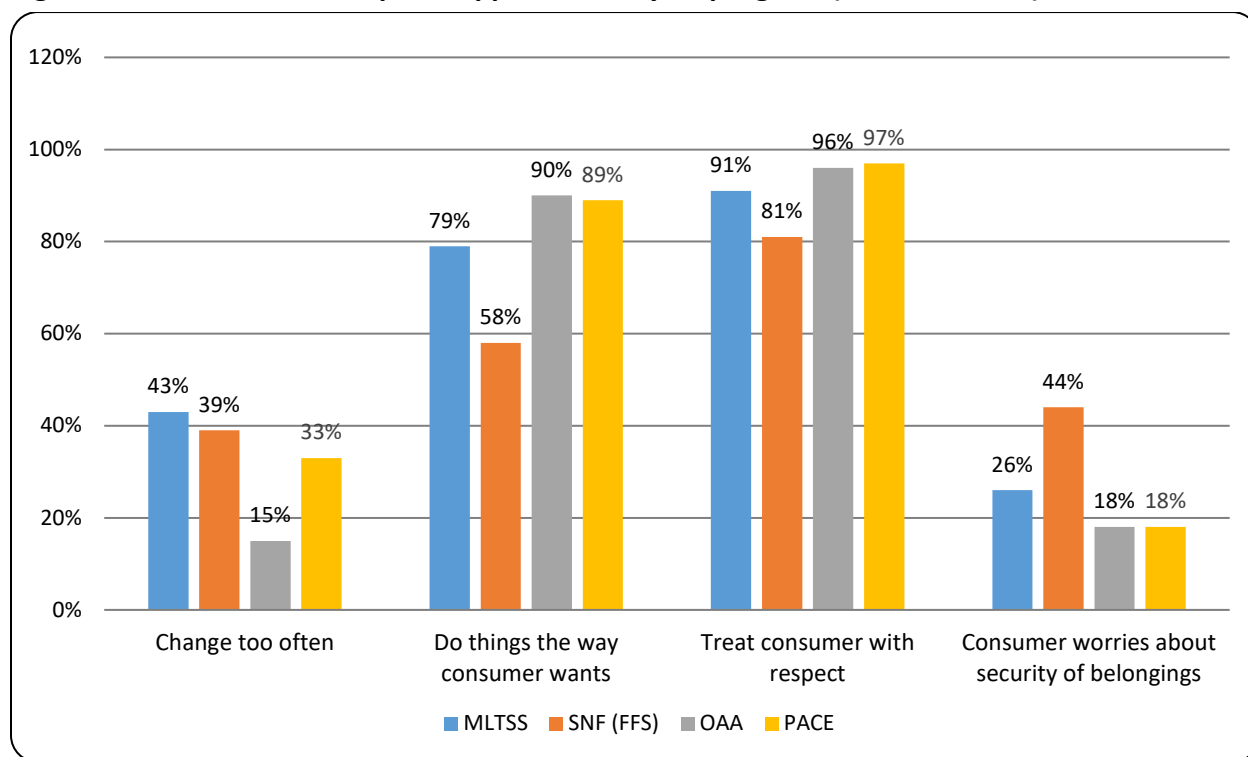


Note: only the first measure (services meet all needs/goals) is risk-adjusted.

Source: Tables 45, 128, 129, 39 & 40 in [http://nci-ad.org/upload/reports/NCI-AD\\_2015-2016\\_National\\_Report\\_FINAL.pdf](http://nci-ad.org/upload/reports/NCI-AD_2015-2016_National_Report_FINAL.pdf).

*Paid Support Staff.* As shown in Figure 24, MLTSS respondents were the most likely to say that their paid support staff changed too often (with margins of error, it may be a robust difference only with OAA respondents and a small difference with PACE). MLTSS respondents may be a bit less likely to feel that their paid support staff do things the way they want them to, or treat them with respect, compared with respondents in PACE or OAA, and a bit more likely to worry about the security of their belongings. However, they are more satisfied in all regards than nursing home respondents. These measures are not risk-adjusted.

**Figure 24: Satisfaction with paid support staff, by NJ program (2015 NCI-AD™)**



Source: Tables 37, 38, 118 & 94 in [http://nci-ad.org/upload/reports/NCI-AD\\_2015-2016\\_National\\_Report\\_FINAL.pdf](http://nci-ad.org/upload/reports/NCI-AD_2015-2016_National_Report_FINAL.pdf) (not risk adjusted).

Differences among New Jersey MCOs. Unlike in the national report, the detailed New Jersey report does not adjust any results for member characteristics. This makes it impossible to know whether differences between MCOs are due to the services provided by these programs or to characteristics of their members that are not under their control. While the NJ report does not mention margins of error, estimates from the national report would suggest that it is probably about 9% for the sample sizes for each plan. It is important to keep this in mind when viewing these estimates.

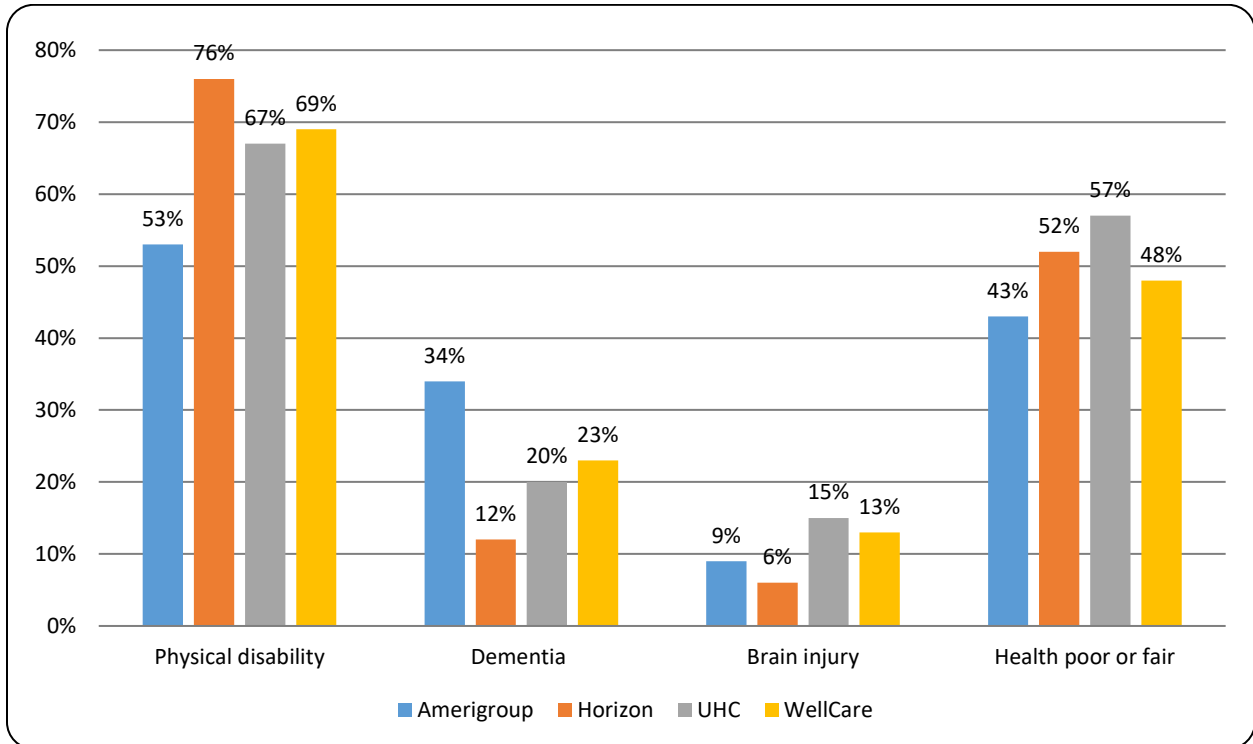
Despite these caveats, it appears that the member profile of the MCOs is different in many cases, and we wanted to show these differences. We also wanted to show that there was, in some cases, variability in how people experience MLTSS in New Jersey by plan—these differences in experience may or may not have to do with factors that are under the plan’s control.

*MCO Member Diagnoses, Health, and Functioning*

- There were some differences in member diagnoses by MCO, as shown in Figure 25. Amerigroup is more likely than the others to serve members with a dementia diagnosis and less likely to serve members with a physical disability diagnosis. United and WellCare were more likely to serve members with a brain injury (traumatic or acquired) diagnosis. United

members were the most likely and Amerigroup members the least likely to rate their health as poor or fair.

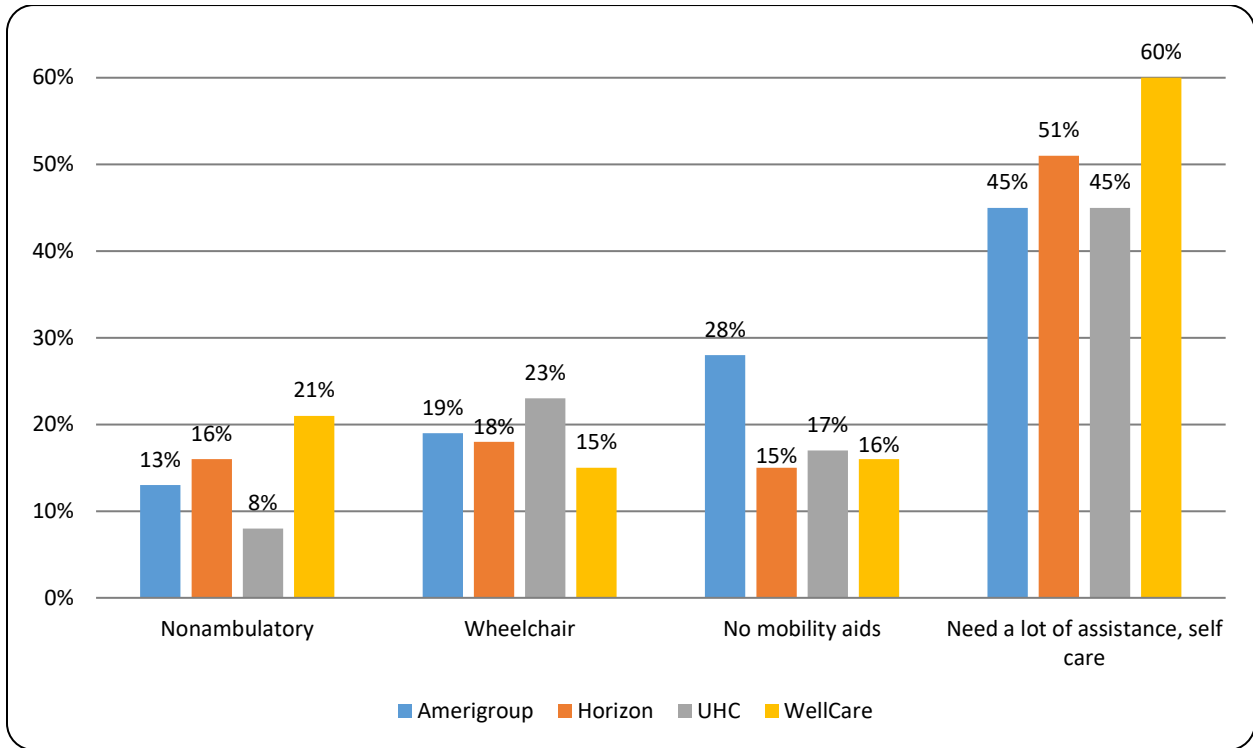
**Figure 25: Member diagnosis and health rating, by MCO (2015 NCI-AD™)**



Source: NCI-AD™ 2015 Survey (Tables 12, 13, 14 & 944), accessed June 5, 2017 from [http://nci-ad.org/upload/reports/NCI-AD\\_2015-2016\\_NJ\\_state\\_report.pdf](http://nci-ad.org/upload/reports/NCI-AD_2015-2016_NJ_state_report.pdf).

- There were some differences in member level of mobility, and need for a lot of assistance with activities (versus some or none) as shown in Figure 26. WellCare was somewhat more likely to have nonambulatory members than the other plans (21% versus 8%-16%). Amerigroup had more members who moved with no aids than the other plans (28% versus 15-17%). United was a little more likely to have members who used a wheelchair (23% versus 15%-19% for the others). WellCare members were more likely to say they needed a lot of assistance with self-care (60% versus 45-51% for the others). Patterns were similar for everyday activities (67% for WellCare versus 55-60% for the others, not shown).

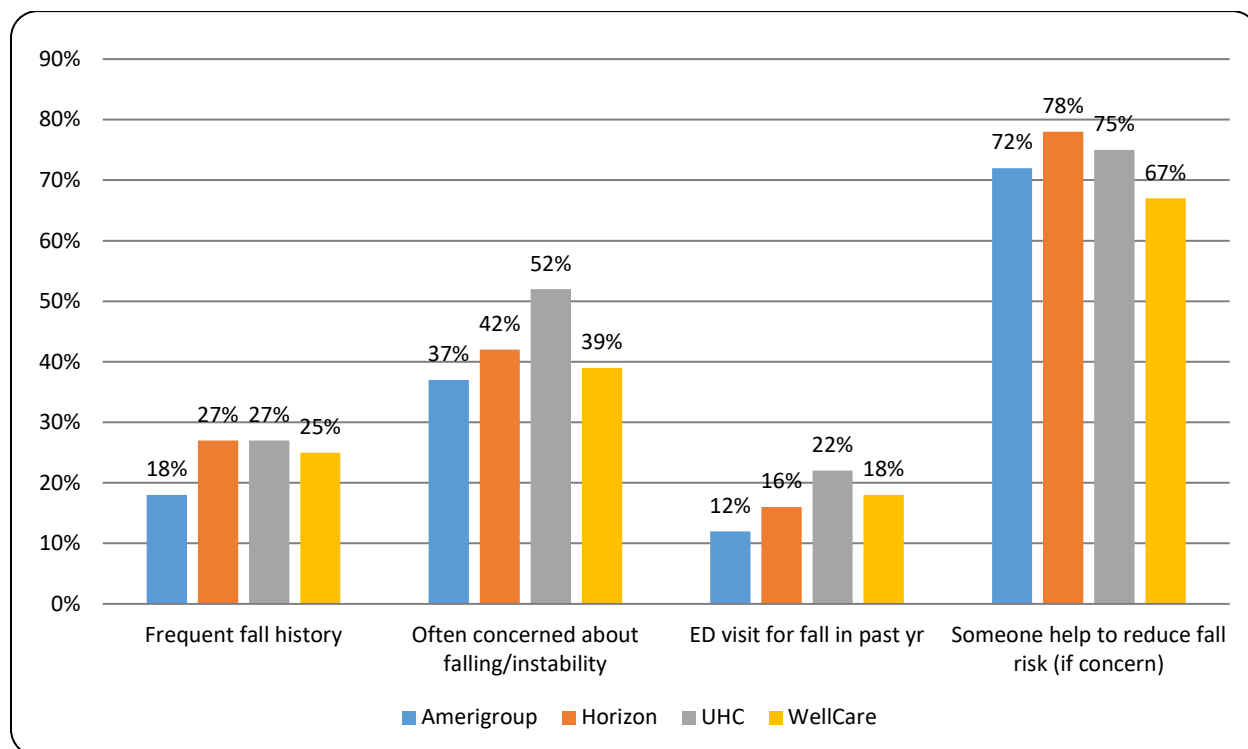
**Figure 26: Member mobility and need for assistance with self-care, by MCO (2015 NCI-AD™)**



Source: NCI-AD™ 2015 Survey (Tables 19 & 119), accessed June 5, 2017 from [http://nci-ad.org/upload/reports/NCI-AD\\_2015-2016\\_NJ\\_state\\_report.pdf](http://nci-ad.org/upload/reports/NCI-AD_2015-2016_NJ_state_report.pdf).

- There were differences in MCO members' history of frequent falls, current concerns about falling or instability, and having an ED visit in the past year after a fall, as shown in Figure 27. Amerigroup was a bit less likely to have members with a history of frequent falls (18% versus 25-27% for the others) and ED visits for falls (12% versus 16%-22% for the others), and United had a higher percentage of members who were often concerned about falling (52% versus 37%-42% for the others) and who had an ED visit after falling (22% vs 12%-18% for the others). Two-thirds or more of respondents from all plans reported that someone (not necessarily affiliated with the plan) had worked with them to reduce their risk of falling, if there were concerns about this.

**Figure 27: Member history of frequent falls, concern about falls/instability, ED visits for falls, and help to reduce fall risk (if a concern) by MCO (2015 NCI-AD™)**



Source: NCI-AD™ 2015 Survey (Tables 20, 79 & 83 and Graph 68), accessed June 5, 2017 from [http://nci-ad.org/upload/reports/NCI-AD\\_2015-2016\\_NJ\\_state\\_report.pdf](http://nci-ad.org/upload/reports/NCI-AD_2015-2016_NJ_state_report.pdf).

*MCO Member Social Context.* There are some differences among MCO members that may affect their experiences apart from their MCO membership. Notable differences included:

- A much higher percentage of members claiming Spanish as a primary language for WellCare (35%, versus 8%-12% for the other plans).
- WellCare’s members were much more likely to live in their own home or the home of a family member (88%, versus 67% for Horizon, 59% for Amerigroup and 56% for United). The other plans had higher percentages of members in assisted living or other group facilities such as group homes or adult foster homes.
- WellCare’s members were also more likely to live with a spouse or partner (30%, versus 11%-16% for the others).
- WellCare’s members were the least likely to be able to get to safety quickly in case of an emergency (76%), compared with 90% of UHC’s members and 80%-83% of the other MCOs.

There are other differences among MCO members that may reflect characteristics independent of their MCO, but could also be influenced by MCO care management.

- UHC members were less likely than respondents in any other setting (including nursing facilities) to say that they were able to do things they enjoyed outside their home when and

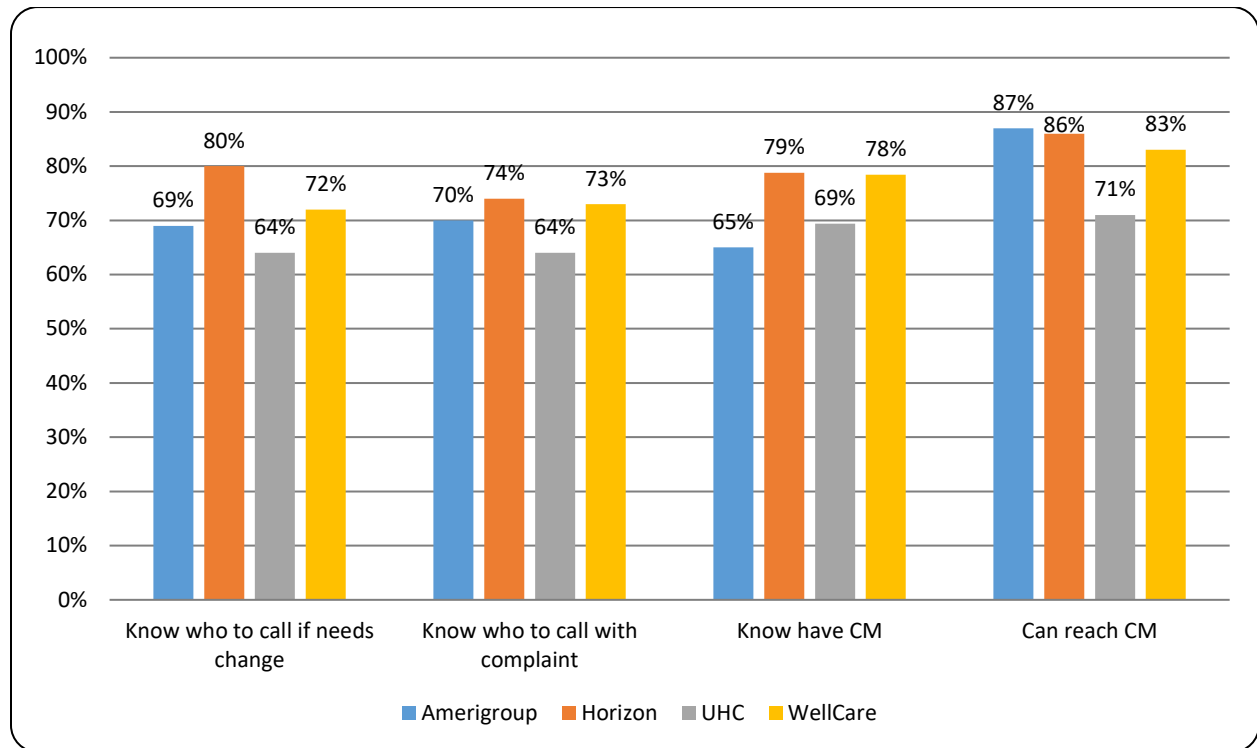
with whom they wanted to (44% said yes versus sometimes or no, compared with 54% of nursing facility residents and 59%-64% among other MCOs). UHC members also differed in several ways with respect to the reasons they chose regarding not being able to do things they enjoyed outside their home: 14% chose cost factors (versus 3%-6% among other MCOs), 11% chose accessibility/equipment (4%-7% among other MCOs), and 10% chose lack of information (versus 0%-2% among other MCOs). On the positive side, UHC members were the least likely to say they were sometimes or often lonely, sad or depressed (51% versus 56%-61% for other MCOs). They were also the least likely to be on medications for depression (36% versus 41%-49% for other MCOs), so the lack of reported depression was not due to being more likely to be taking medication. However, they were also the most likely to say that they did not feel in control of their life (19%, versus 7%-12% for other MCOs). They were the most likely to say that nobody provided support to them on a regular basis (21%, versus 9%-14% for other MCOs) and least likely to say that the person who helped them most often was an unpaid family member or spouse/partner (29%, versus 35%-46% for other MCOs)—they were also less likely to live with a spouse/partner (11%, compared with 15%-30% for other MCOs). Taken together, these factors may indicate a social support network that is less robust for these members.

*Access to Care Management.* Depending on their MCO (and possibly other factors such as their level of cognition and whether they had a knowledgeable caregiver), from 64%-80% of respondents knew who to contact if their needs changed and they needed different services or supports, and 64%-74% knew who to call if they had a complaint about their services. From 65%-79% of MLTSS respondents knew that they had a care manager.<sup>75</sup> Of those who knew they had a care manager, from 71%-87% were able to reach them if needed. See Figure 28 for a listing by MCO.

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<sup>75</sup> This is not a metric calculated by NCI-AD™ but can be deduced from the numbers of respondents overall (p.24) versus respondents listed in Table 40 regarding whether they are able to contact their case manager (p.139), which was only asked of people who said they had one. However, all MLTSS respondents have a case manager.

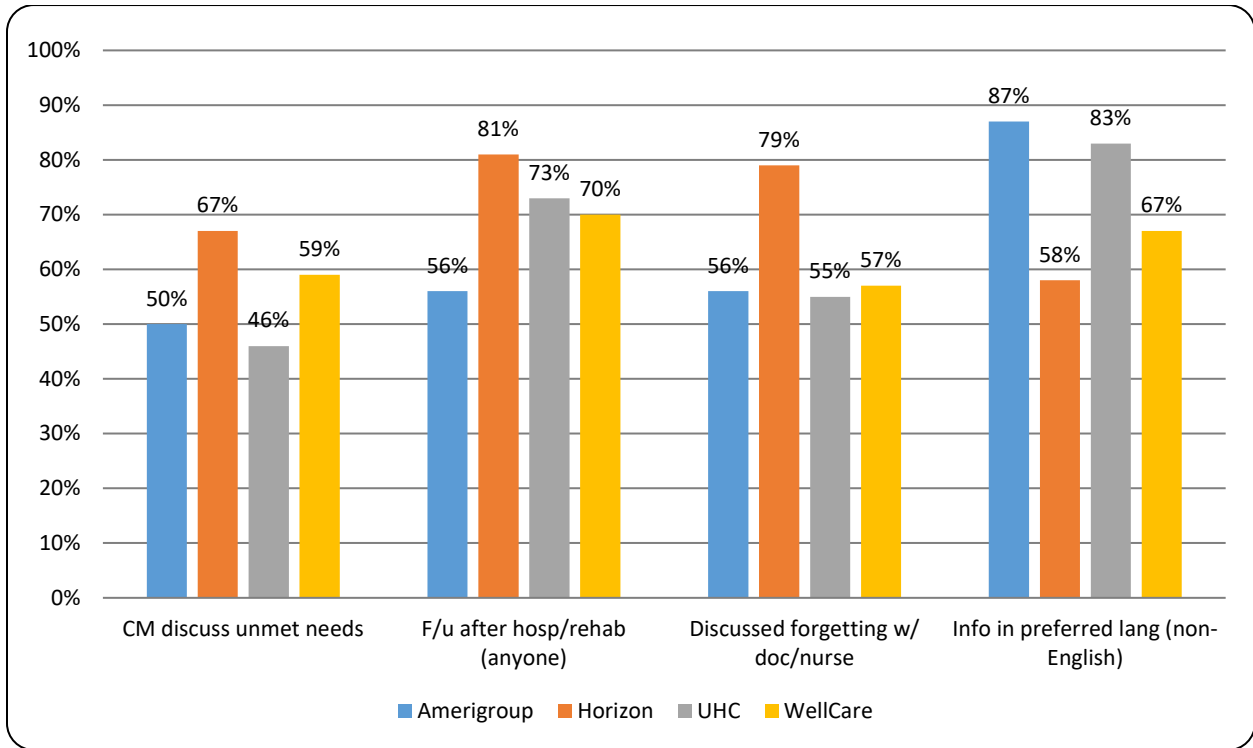
**Figure 28: Access to and knowledge of care manager, by MCO (2015 NCI-AD™)**



Source: NCI-AD™ 2015 Survey (Tables 38, 39, 40 and p.24 to get the % who know they have a care manager), accessed June 5, 2017 from [http://nci-ad.org/upload/reports/NCI-AD\\_2015-2016\\_NJ\\_state\\_report.pdf](http://nci-ad.org/upload/reports/NCI-AD_2015-2016_NJ_state_report.pdf).

*Member-Specific Needs.* Several measures (detailed in Figure 29) address what happens if members have specific needs. All of these measures are based on reduced numbers of between 23 and 54 respondents, so margins of error would be quite large here. While care manager discussion of unmet needs and getting information about services in the member’s preferred language refer to the MCO, the others (follow-up by someone after a hospitalization, and whether the member or someone has discussed their increased forgetfulness, if this is an issue, with a nurse or doctor) may refer to providers who are not employed directly by the MCO. Member or caregiver motivation/activation may play a role in some of these as well in terms of asking for assistance.

**Figure 29: Member-specific needs, by MCO (2015 NCI-AD™)**

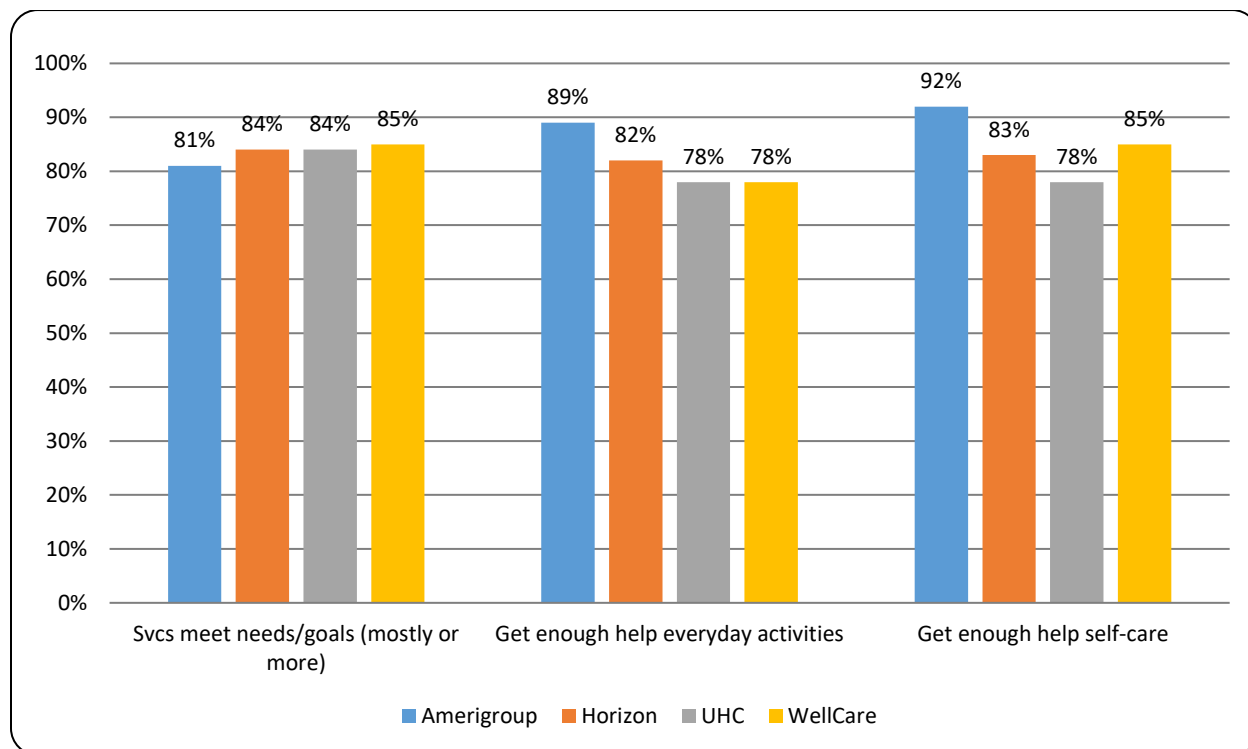


Source: NCI-AD™ 2015 Survey (Tables 47, 52 & 97 and Graph 30), accessed June 5, 2017 from [http://nci-ad.org/upload/reports/NCI-AD\\_2015-2016\\_NJ\\_state\\_report.pdf](http://nci-ad.org/upload/reports/NCI-AD_2015-2016_NJ_state_report.pdf).

*Service Adequacy.* More than 80% of respondents in all plans said that services mostly or completely met their needs and goals. They were asked separately whether they always got enough assistance with everyday activities and self-care (from paid or unpaid helpers). At least 78% said they always got enough help. Figure 30 shows these measures by plan—there aren't large differences here, given the margins of error.



**Figure 30: Adequacy of services and assistance to members, by MCO (2015 NCI-AD™)**



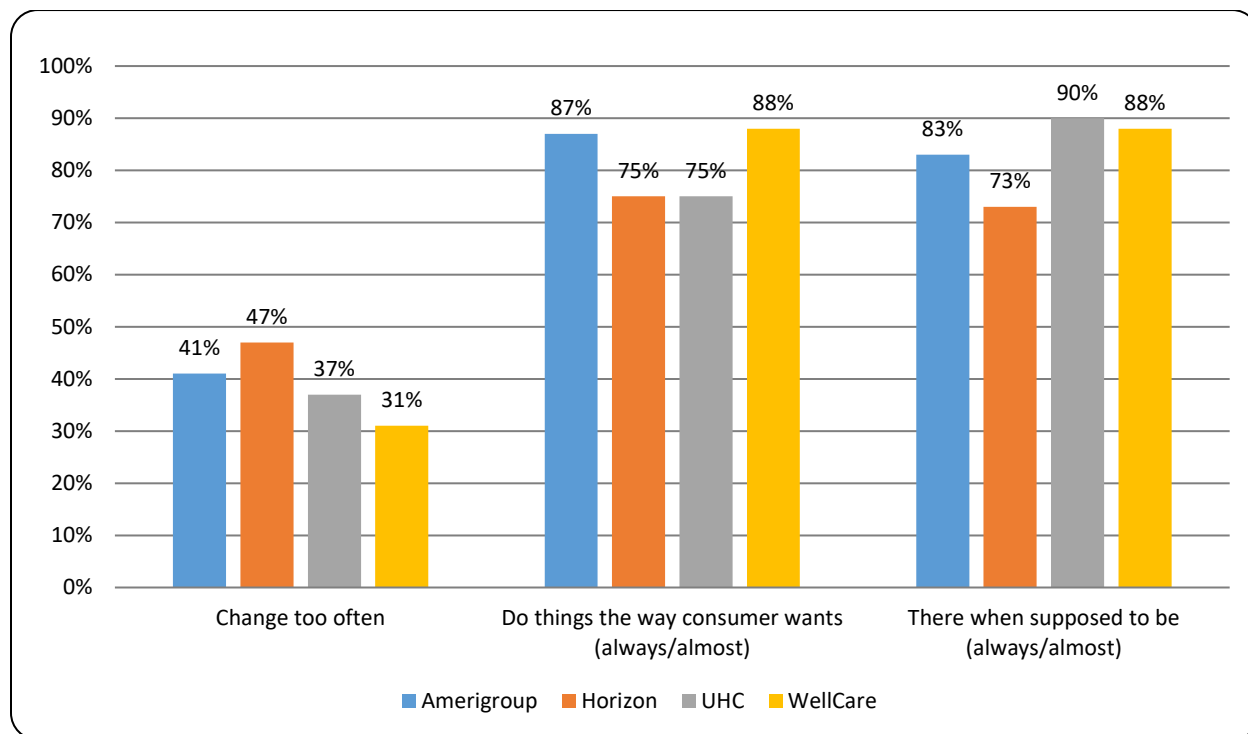
Source: NCI-AD™ 2015 Survey (Tables 44, 118 & 120), accessed June 5, 2017 from [http://nci-ad.org/upload/reports/NCI-AD\\_2015-2016\\_NJ\\_state\\_report.pdf](http://nci-ad.org/upload/reports/NCI-AD_2015-2016_NJ_state_report.pdf).

*Paid Support Staff.* Respondents were asked a number of questions about paid support staff—with respect to whether they changed too often, did things the way consumers wanted them done, arrived and left when they were supposed to, if consumers felt safe around them with respect to self and belongings, if consumers had money taken or used without permission, and if consumers were treated with respect. There weren’t large differences for the safety and respect questions by plan, so we did not create a figure for them. Ninety-two percent or more of MLTSS respondents felt safe around their paid support staff, and 89% felt treated with respect.<sup>76</sup> At least 70% never worried about the security of their personal belongings and at least 82% never had money taken or used without permission.<sup>77</sup> Figure 31 presents some areas where there were larger differences. Between 31% and 47% of respondents thought paid staff changed too often; 75%-88% felt paid support staff did things the way consumers wanted them done; and 73%-90% of respondents thought staff arrived and left when they were supposed to.

<sup>76</sup> See Tables 76 and 101 in [http://nci-ad.org/upload/reports/NCI-AD\\_2015-2016\\_NJ\\_state\\_report.pdf](http://nci-ad.org/upload/reports/NCI-AD_2015-2016_NJ_state_report.pdf).

<sup>77</sup> See Tables 77 and 78 in [http://nci-ad.org/upload/reports/NCI-AD\\_2015-2016\\_NJ\\_state\\_report.pdf](http://nci-ad.org/upload/reports/NCI-AD_2015-2016_NJ_state_report.pdf).

**Figure 31: Member ratings of paid support staff, by MCO (2015 NCI-AD™)**



Source: NCI-AD™ 2015 Survey (Graph 11 and Tables 37 & 41), accessed June 5, 2017 from [http://nci-ad.org/upload/reports/NCI-AD\\_2015-2016\\_NJ\\_state\\_report.pdf](http://nci-ad.org/upload/reports/NCI-AD_2015-2016_NJ_state_report.pdf).

## Discussion

The share of the Medicaid population receiving long-term services and supports in community settings has increased steadily since MLTSS implementation, and few individuals enrolled in former HCBS waiver programs who transitioned to MLTSS have moved to nursing homes.

Timeliness of clinical eligibility assessments for people enrolling into MLTSS as well as anyone at risk of entering a nursing home has shown improvement since the inception of MLTSS, but there is still room for improvement. Because nursing home stays tend to deplete people’s financial resources quickly, the state requires that clinical eligibility be established for all people who are expected to enter a nursing home, whether or not they are currently financially eligible for Medicaid. There are discussions about revising this quality metric to more closely track people who are enrolling into MLTSS.

External quality review audits show a mixed picture, with some improvements and some declines in the quality of audited files from Year 1 to Year 2 of MLTSS. It is not always obvious how audit benchmarks indicate quality as experienced by consumers.

Critical incidents, appeals/grievances/complaints, and fair hearings appear to affect relatively small numbers of enrollees. Critical incidents are reported in a timely fashion. Appeals/grievances and complaints filed internally with MCOs appear to be responded to in a timely way, but MCOs overwhelmingly uphold their original decisions (more than 90% of the time). Appeals by individuals using or requesting private duty nursing services may be more prevalent than other types of appeals, but it is not possible to calculate an exact percentage (see discussion on page 34).

Individuals transitioned out of nursing facilities to community settings seem able to stay in the community, and those who move from the community to nursing facilities seem to stay there long-term as well. Transitions between settings tend to be problematic for individuals' health, so this stability is positive from that perspective.

CAHPS® survey results show that MLTSS enrollees are similar to other adult enrollees in their ratings of their health plan and providers. This is reassuring given the variety of new processes and services that health plans have undertaken for this group of enrollees.

NCI-AD™ surveys among MLTSS enrollees in New Jersey and four other states found that New Jersey respondents were equally likely to report that their services met their needs and goals, were more likely to have a case manager to discuss unmet needs, and to report access to primary care services, equipment and modifications' MLTSS, but were also more likely to think that their paid support staff changed too often.

Within New Jersey's long-term care service programs, MLTSS members' responses to the NCI-AD™ showed that they perceived more choice in their services and were equally or more likely to think that their services met their needs. However, they were also the most likely to think that their paid support staff changed too often.

Comparing responses to the NCI-AD across MCOs showed some differences in the kinds of members served by MCOs, which may affect their experiences with MLTSS.

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# **Chapter 3: Analysis of Medicaid Claims Data to Examine Access to Care, Quality, and Cost of Care: Assessing Avoidable Hospital Use, Readmissions, Behavioral Health Care, and Ambulatory Visits in Managed Care and MLTSS**

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## **Introduction**

In this chapter, we assess the impact of the expansion of managed care to Long Term Services and Supports (LTSS) and behavioral health (for selected LTSS-eligible populations) by examining measures of access to care, quality of care, and cost of health care for NJ Medicaid beneficiaries calculated from Medicaid fee-for-service (FFS) claims and managed care encounter data over 2011-2015. We examine the effects of the policy change on the targeted LTSS-eligible population, and we also examine potential changes in the quality of care for the entire managed care population as a result of this expansion in the services. All effects are identified by examining changes in selected quality metrics from the pre- to the post-implementation period of the MLTSS program. Finally, we compare selected utilization trends in Medicaid to trends in New Jersey overall during the waiver demonstration period.

Our research strategy is guided by the Division of Medical Assistance and Health Services (DMAHS) Quality Strategy (DMAHS 2014b) which includes quality issues relevant to the expansion in managed care and more generally, guides the State's healthcare monitoring, assessment, and improvement efforts for all Medicaid managed care services. The following goals are put forth in the Quality Strategy:

- To improve timely, appropriate access to primary, preventive, and long term services and supports for adults and children;
- To improve the quality of care and services;
- To promote person-centered health care and social services and supports;
- To assure member satisfaction with services and improve quality of life.

These goals align with the specific evaluation hypothesis and research questions enumerated in the waiver Special Terms and Conditions document (CMS 2014) relating to the managed care

expansion. These evaluation aims guide our selection, analysis, and presentation of claims-based metrics in this chapter:<sup>78</sup>

**Hypothesis 1: "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.";**

**Research Question 1a: "What is the impact of the managed care expansion on access to care, the quality, efficiency, and coordination of care, and the cost of care for adults and children?"**

**Research Question 1b: "What is the impact of including long-term care services in the capitated managed care benefit on access to care, quality of care, and mix of care settings employed?"**

To answer and address these research questions, we examine changes over time of specific metrics for the overall Medicaid and Medicaid managed care populations. Examining potential changes across all managed care beneficiaries examines overall adherence to the Quality Strategy by Medicaid managed care organizations (MCOs) undertaking the MLTSS reforms and provide the evidence needed for answering Research Question 1a. These findings also supplement those presented in Chapter 1. We also examine selected metrics for specific groups of Medicaid beneficiaries targeted by the managed care expansion. These are groups of long-term care (LTC) beneficiaries meeting an institutional level of care and residing either in a nursing facility or in their homes and communities under the former §1915(c) waiver programs or, after July 1, 2014, under MLTSS. These subpopulation analyses supplement the findings presented in Chapter 2 and provide the evidence needed for answering Research Question 1b. Finally, exploring trends in metrics between Medicaid and NJ overall (based on all-payer data) helps put Medicaid findings in the context of broader health system patterns in the state. It informs us whether some of the observed changes are potentially due to broader policy changes beyond Medicaid in that their effects are reflected in both Medicaid and all-payer data. It also sheds light on whether quality trends among Medicaid patients are different from those having other insurance. This provides information that further informs our analyses around Research Question 1a with the caveat that these findings are not adjusted for patient or provider characteristics and do not exclusively relate to the managed care population.

In contrast to Chapters 1 and 2 where the data characterizing the Medicaid population come from secondary sources, here we calculate selected metrics using Medicaid claims data for populations of Medicaid beneficiaries, including the LTC population, and additionally those who

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<sup>78</sup> Separate from this report we have also presented findings from stakeholder interviews that sheds light on member satisfaction and potential provider and payer issues that may not be captured in some of the claims-based metrics. Member satisfaction related to the overall managed care population is also analyzed in Chapters 1.



had a behavioral health (BH) diagnosis. Stratification of quality metrics to these specific subpopulations contributes to answering Research Questions 1a and 1b and more generally, Hypothesis 1. These results thus examine any indirect effects of MLTSS implementation on the quality of care for the overall Medicaid managed care population, and additionally, the direct effects of the MLTSS policy on the LTSS-eligible population that includes effects from integration of physical, behavioral, and long-term care services under MCOs. Further, the findings reveal any early effects<sup>79</sup> of the reforms in behavioral health care delivery (for populations outside MLTSS) authorized under the Waiver and falling under the purview of Hypothesis 1.

Broadly, this chapter is divided into three sections. Section A contains tables with annual estimates of selected quality metrics. Section B contains multivariate regression analyses that use statistical techniques such as Segmented Regression Analysis and Difference-in-Differences Modeling (see Methods section for details) to account for individual, geographic and provider characteristics while identifying the impacts of the managed care expansion under the Waiver. Section C descriptively compares trends of selected quality and utilization metrics for Medicaid and NJ overall.

## **Methods**

### **Data Sources**

The analyses in this chapter were generated using Medicaid FFS claims and managed care encounter data for January 1, 2011 through January 31, 2016. We used recipient and claims-level information to allow for stratification of quality metrics to relevant subpopulations. All utilization and spending estimates reflect claims adjustments and updates through a minimum of 6 months from the date of service. We also use the publically available New Jersey State Health Assessment Data (NJSHAD) query tool for estimates of statewide hospital utilization from 2011 to 2015 (OHCQA 2017).

### **Metrics**

The metrics in this chapter are monthly, quarterly or annual estimates over the period 2011–2015<sup>80</sup> and can be broadly organized into several categories of outcomes: avoidable hospital use reflecting inadequate quality of ambulatory care; hospital readmissions that may reflect inadequate inpatient and outpatient care as well as gaps in care coordination; and rates of follow-up care in the post-acute phase that may reveal gaps in care coordination or care transition. We also examine spending relating to hospital use overall, avoidable hospital use, and total spending

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<sup>79</sup> It was not until July 2015 when an Interim Managing Entity for addiction services was operationalized.

<sup>80</sup> While the waiver demonstration period starts on October 2012, our analytic findings here are based on full calendar years so that our estimates are not driven by seasonality differences.

by the LTSS-eligible population. We examine whether the share of this last category of spending between community-living beneficiaries and those staying in nursing facility changes over time focusing on specific components of spending such as those relating LTSS services and avoidable/preventable hospitalizations. These cost trends illustrate savings potentially realized from increased efficiencies in care delivery and assess progress in rebalancing spending from institutions to the community under MLTSS. Appendix A contains additional details on each of these measures.

Table A outlines the broad categories of metrics calculated using the Medicaid FFS claims and managed care encounter data. Metrics 1-4 are population-based and rates are assessed per unit population. Metrics 5-7, on the other hand, are based on index events that arise in a hospital setting. Metrics 8-11 measure costs and are assessed overall and per unit population.

**Table A: Metrics related to quantitative evaluation of Hypothesis 1**

	<b>Metrics</b>	<b>Description/Motivation</b>
	<b>Utilization</b>	
1	Prevention Quality Indicators (ages 18+)	Ambulatory care sensitive hospitalizations by adults that reflect inadequate community-level care.
2	Pediatric Quality Indicators (children 6-17)	Ambulatory care sensitive hospitalizations by children that reflect inadequate community-level care.
3	Avoidable emergency department (ED) visits (all ages)	ED visits that occur due to inadequate access to primary care.
4	Hospital utilization (all ages)	Inpatient and hospital emergency department utilization.
5	30-day readmissions (ages 18+)	All-cause unplanned readmissions following all hospital admissions and following hospital admissions specifically for heart failure, pneumonia, and acute myocardial infarction. All of these may reflect gaps in inpatient care and/or care coordination following discharge.
6	Follow-up after hospitalization for mental illness (ages 6+)	Follow-up with a mental health practitioner within 7 days and 30 days of an acute care hospitalization for mental illness.
7	Ambulatory visit 14 days after discharge (all ages)	Follow-up with a health practitioner after a hospital stay for medical reasons.
	<b>Cost/Spending</b>	
8	Cost related to avoidable hospitalizations and ED visits	Assesses potential savings by avoiding preventable hospital utilization.
9	Costs related to all inpatient hospitalizations and ED visits	Assess the effects of the managed care expansion on acute care spending overall.
10	Long-term care spending in community and nursing facilities	Spending ratio assesses whether there is rebalancing of resources from the institutional setting to the community.
11	Total spending	Assess any effects on spending including long-term care, non-long-term care, avoidable and non-avoidable.

Table B enumerates the populations for which the above metrics are calculated. It also provides a brief description of the purpose of each population stratification with additional details on definitions and motivations for the stratifications in the narrative below.

**Table B: Medicaid populations related to evaluation of Hypothesis 1**

<b>Populations</b>	<b>Purpose/Motivation for Inclusion</b>
All beneficiaries	Examine overall trends in quality and costs for the entire Medicaid population.
All managed care (MC) beneficiaries	Examine trends in quality and costs for all beneficiaries in managed care.
Specific Eligibility Categories Aged/Blind/Disabled (ABD), NJ FamilyCare, General Assistance (GA)	Eligibility categories offer a natural stratification for metrics based on disability-impacted health (e.g., ABD), or age and income (ABD, GA) for determining how trends vary based on these beneficiary characteristics.
Beneficiaries with behavioral health conditions	Examine quality of care for these beneficiaries since behavioral health care is carved into MCOs under MLTSS. Additionally, the demonstration plans to transition behavioral health services for all Medicaid beneficiaries out of FFS to management under an ASO.
Long-term care (LTC) beneficiaries	Examine quality and costs of care for beneficiaries directly impacted by the MLTSS demonstration program.
LTC beneficiaries residing in a nursing facility	Examine quality and costs of care for institutionalized long-term care beneficiaries undergoing a modified transition to MLTSS and remaining FFS until the transition is triggered.
LTC beneficiaries receiving home and community-based services (HCBS)	Examine quality and costs of care for community-residing beneficiaries transitioning to MLTSS under the Comprehensive Waiver. This population is comprised of the original §1915(c) waiver populations who had their acute care transitioned to MCOs in 2011 and any individuals joining MLTSS on or after July 1, 2014 and residing in their homes or in the community (assisted living).

**Population Definitions**

*Medicaid Eligibility:* Beneficiaries with any period of active enrollment in a particular year, as indicated by the effective dates of their Program Status Codes, made up the beneficiary cohort for that year. If there was any period during the year when the beneficiary had a managed care plan code, the beneficiary was considered part of the managed care population for that year. Assignment to eligibility categories was based on the protocol used for Medicaid’s monthly public reporting. Using the first program status code in the calendar year along with age and any concurrent special program codes, each beneficiary was assigned to one of the following categories: Aged/Blind/Disabled, NJ FamilyCare, Children’s Services, General Assistance,<sup>81</sup> and Other. Classification into these eligibility groups will allow us to consider differing beneficiary characteristics while assessing the impact of the Waiver on Medicaid beneficiaries overall during the demonstration period.

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<sup>81</sup> In 2014, adult beneficiaries enrolling as part of the statewide Medicaid expansion under the Affordable Care Act are classified in the General Assistance eligibility category.

*Long-Term Care Population:* The Waiver combined several §1915(c) waivers serving people in the community with care needs at an institutional level into MLTSS. The largest historical §1915(c) waiver, Global Options (GO), had served older adults, and three smaller waivers included or targeted younger individuals. The Traumatic Brain Injury (TBI) waiver included people diagnosed with acquired brain injury after age 21 but before age 65. Community Resources for People with Disabilities (CRPD) served individuals of any age, including children, and the AIDS Community Care Alternatives Program (ACCAP) waiver served individuals of any age with AIDS and children under the age of 13 who were HIV positive. In addition to bringing these populations under the MLTSS umbrella, the Waiver also required new entrants to nursing facilities to enroll in MLTSS (residents of nursing facilities at the time of MLTSS implementation remain in a fee-for-service arrangement unless they have a change in the status of their level of care).

We developed an algorithm for defining the LTC population and designating each LTC beneficiary as either part of the nursing facility or home and community-based LTC population.<sup>82</sup> This was done on both an annual and monthly basis. The annual assignment results in a more stably defined cohort<sup>83</sup> and is used in descriptive tables of metrics by year. The monthly assignment is more refined, capturing transitions between different statuses within a year and allowing a more granular categorizing of claims and associated spending for a beneficiary at the time of service delivery. The monthly assignment is used in statistical models. The algorithm for these assignments is detailed in Appendix D.

In both enrollment volume and beneficiary characteristics (e.g. age, health), the original §1915(c) waiver programs (CRPD, ACCAP, TBI, or GO) were distinct. While the original waiver under which HCBS beneficiaries were entitled to services could be identified in 2011-2013, these distinct categories ceased to exist when MLTSS went into effect on July 1, 2014. In order to examine whether there were different trajectories of quality or spending for these four original populations across the interim study period, we isolated a cohort of §1915(c) waiver enrollees by their status in January 2014 and present some metrics for all years for this cohort (as allowed by sample size).

*Behavioral Health Conditions:* In order to assess coordination of behavioral and physical health services occurring as part of the managed care expansion under the Waiver, we defined the cohort of beneficiaries in each year with a BH condition. Using the AHRQ clinical classifications software (CCS), we scanned all claims for a diagnosis of mental health condition or substance use

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<sup>82</sup> The LTC population evaluated in this report does not include PACE enrollees or individuals with developmental disabilities residing in developmental centers or receiving services under the Community Care Waiver, which was carved out of MLTSS. It includes only the MLTSS-eligible populations.

<sup>83</sup> This implies that a LTC-eligible beneficiary who received HCBS services for a small period during the year but was a NF resident for the most of the year would be designated NF resident for that year.

disorder (see Appendix A and Appendix E for additional details). Beneficiaries with any claim flagged using this methodology were considered part of the BH population in the year of the diagnosis.

### **Metric Definitions: Inclusion and Exclusion Criteria**

Each metric has inclusion and exclusion criteria specified by the measure steward. If not already part of the metric specification, we imposed on all metrics (except for total and LTSS/non-LTSS spending) the requirement that a claim was only counted if the beneficiary had been continuously enrolled in Medicaid for at least 30 days preceding the claim date. As stated in our evaluation plan, this criteria eliminates events which might precipitate Medicaid enrollment and confound the effect of the demonstration.

### **Transition to ICD-10 Coding**

Starting in October 2015, all ICD diagnosis and procedure codes transitioned to the ICD-10-CM/PCS coding system. We were able to use metric specifications accommodating the ICD-10 coding system when provided by the measure steward. For some metrics without updated specifications, we employed CMS's general equivalence mapping prepared by the National Bureau of Economic Research (2016). See Appendix A for further details.

### **Costs**

Data on costs come from the payment fields in the Medicaid claims data. We only tabulated costs to Medicaid and Medicaid HMOs incurred via direct payment for services. Payments made by Medicare or from any other source are not included. Capitation payments, which include costs for the organization and procurement of services, are also excluded from totals. Costs for hospital use only reflect facility charges and do not include any physician or lab charges associated with hospitalization or outpatient visits. All costs were inflation adjusted and expressed in year 2012 purchasing power using the Consumer Price Index for medical care from Table 1A (Crawford, Church, and Rippy 2013, 164; Crawford and Church 2014, 165; Crawford, Church, and Akin 2015, 165; Crawford, Church, and Akin 2015b, 145).

Costs for LTSS were collected from both FFS and encounter claims for beneficiaries included in the LTC population (as defined above) for the time of their LTC assignment (which may be monthly or annual depending on analysis). Facility costs were counted from NF FFS claims across the entire study period, and NF encounter claims with a specific custodial revenue code were counted after July 1, 2014. Costs for community-based LTSS were counted on claims having LTSS

service codes as described in the MLTSS Service Dictionary (DMAHS 2014a) and enumerated in the spreadsheet of uniform billing codes shared with us by DMAHS.<sup>84,85</sup>

### **Reporting Criteria**

For Metrics 1-4 and 8-11, which are population-based rates, denominators and estimates are not shown when the denominator for IP hospitalizations or ED visits is less than 50. For the remaining metrics (5-7), denominators and estimates are suppressed when denominators are less than 30.

### **Analytic Approach**

In Section A we calculated and present mostly annual estimates to examine time trends in utilization and spending-related metrics over the period 2011-2015. Specific metrics include annual rates of inpatient hospitalizations and ED visits, rates of avoidable/preventable hospitalizations and ED visits, readmission rates, rates of follow up and ambulatory visits after hospitalization. We also examine categories of spending including that associated with hospital encounters, avoidable/preventable hospitalizations and LTSS-related spending among the nursing facility residents, and community based long term care individuals receiving home and community-based services.

In addition to annual estimates, for examining changes in the share of spending by the LTSS-eligible population between HCBS and NF, we examined monthly estimates of overall spending, LTSS spending, and non-LTSS spending identifying the component related to avoidable/preventable hospital use.

In our discussion of descriptive findings we will focus on the 2015 annual estimates to examine the effect of the MLTSS program on LTSS-eligible beneficiaries or the overall managed care population. The subgroups of interest in regard to Research Questions 1 and 2 will be the overall group of managed care beneficiaries and the HCBS population that shifted to managed care for their long-term care services on July 2014.

It is important to note that for descriptive analyses, observed variation for the metrics between two points in time might sometimes be the result of outliers in the data, small sample sizes within certain subpopulations, or changes in characteristics of the beneficiary population.

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<sup>84</sup> A current version of this spreadsheet is included on the DMAHS website among its MLTSS Resources for Consumers, Providers, and Stakeholders.

[http://www.nj.gov/humanservices/dmahs/home/MLTSS\\_Code\\_Crosswalk\\_Old\\_to\\_New.pdf](http://www.nj.gov/humanservices/dmahs/home/MLTSS_Code_Crosswalk_Old_to_New.pdf).

<sup>85</sup> Medical day care and personal care assistance were both State plan long-term care services that remained unchanged under MLTSS and so were not included in the service code crosswalk spreadsheet. However, we did include costs for these services in our LTSS spending tabulations across the study period.

In Section B, we report findings from multivariate regression analysis conducted to isolate and identify the effect of the managed care expansion policy on the stated outcomes (after adjusting for patient, provider and area-level characteristics). We primarily utilize two statistical techniques, namely Segmented Regression Analysis (SRA) (Wagner et al. 2002) and Difference-in-Differences (DD) estimation (Chakravarty et al. 2015; Ashenfelter and Card 1985) to determine any statistically significant effect of these policies on outcomes. Each statistical technique is distinctively suited to answer one of the two research questions under Hypothesis 1. The SRA is utilized to examine Research Question 1a and the DD is utilized to examine Research Question 1b.

For examining the effect of the MLTSS program on the overall managed care population we utilize the SRA. Such a model assumes that the policy effect leads to a change in level, and also a change in the existing time trend of the metric measuring quality or any other relevant outcome of interest. For our analysis examining the effect of the MLTSS policy on the overall managed care population, we utilize the model described in equation (1)

$$\begin{aligned}
 Y_{it} = & \beta_0 + \beta_1(\text{time})_t + \beta_2(\text{waiver post})_t + \beta_3(\text{waiver time})_t \\
 & + \beta_4(\text{expansion post})_t + \beta_5(\text{expansion time})_t + \beta_6(\text{MLTSS post})_t \\
 & + \beta_7(\text{MLTSS time})_t + \gamma X_{it} + \varepsilon_{it}
 \end{aligned}
 \tag{1}$$

Here,  $Y_{it}$  reflects the outcome related to the  $i^{\text{th}}$  managed care enrollee or an index event at time  $t$ . On the right hand side of the equation, time is a continuous variable indicating time in months or calendar quarters from the start of the study period. The variables *waiver post*, *expansion post* and *MLTSS post* are indicator (0/1) variables for the period subsequent to these policy changes. The variables *waiver time*, *expansion time* and *MLTSS time*, are continuous variables equaling the number of months (or quarters) after the corresponding policy change. Coefficient  $\beta_0$  estimates the baseline level of the outcome at the first time period, and coefficient  $\beta_1$  indicates the baseline trend, i.e., the change in the outcome that occurs prior to the first policy change. Coefficients  $\beta_2$ ,  $\beta_4$  and  $\beta_6$  estimate the level changes after each of the policy changes i.e., start of the waiver, the Medicaid expansion, and the MLTSS implementation, in October 2012, January 2014 and July 2014 respectively. Similarly  $\beta_3$ ,  $\beta_5$ , and  $\beta_7$  estimate the change in trend in the outcome after each of these changes. The specification detailed above, while examining the change in outcome due to the MLTSS program, is able to identify changes in outcomes that may have occurred due to the waiver implementation or the Medicaid expansion and isolate those effects from that of MLTSS implementation.



In this model, the specific effect of the MLTSS program on the overall managed care population is given by the magnitude of  $\beta_6$  that gives the change in level and  $\beta_7$  that gives the change in trend after the MLTSS implementation and we further test whether these values are statistically significant. Accordingly in our results section, we report the magnitudes of these two coefficients and their joint statistical significance. Lack of significance will indicate that the effect of the MLTSS implementation while not necessarily zero in magnitude is not statistically significant. For interpretability purposes, we further compare predicted values of outcomes post-MLTSS with counterfactual values (that simulate a scenario where the MLTSS implementation did not occur by setting the MLTSS variables to zero in our regression analysis). The line graphs are reported for each of outcomes in the results section. We will see that each line graph bifurcates into two after June 2014, one providing the values with MLTSS implementation and the other for the counterfactual scenario without MLTSS implementation. We further compute whether this difference is statistically significant.

While examining these effects we adjust for patient characteristics that are represented by the variable  $X_{it}$ . We incorporate hospital fixed effects (to account for time-invariant differences across hospitals) for inpatient quality-based measures and zip code fixed effects (to account for time-invariant differences across geographic locations) for measures reflecting ambulatory care.  $\varepsilon_{it}$  is the random error term utilized in the regression representing the statistical distribution of the outcome variable.

For examining the effect of the MLTSS implementation on the community-based population receiving HCBS services and the nursing facility population,<sup>86</sup> we utilize the DD regression model. We define a comparison group to these populations comprised of individuals who are not LTC-eligible and are categorically eligible for Medicaid (i.e. Aged, Blind, or Disabled). The DD estimation process examines changes in outcome for the HCBS, and separately, the MLTSS NF population from the pre- to the post-MLTSS implementation period and compares this change to the comparison group. Such an estimation strategy is able to identify changes in outcomes that are due to program impact and distinct from secular trends. It accounts for the effect of unobserved factors, as long as their impact on one of the groups relative to the other do not change over time. Equations (2) and (3) illustrate the general DD specification.

$$Y_{it} = \beta_0 + \beta_1(HCBS)_i + \beta_2(post\ MLTSS)_t + \beta_3(HCBS_i * post\ MLTSS_t) + \gamma X_{it} + \varepsilon_{it} \quad (2)$$

$$Y_{jt} = \gamma_0 + \gamma_1(NF)_j + \gamma_2(post\ MLTSS)_t + \gamma_3(NF_j * post\ MLTSS_t) + \Omega X_{jt} + \varepsilon_{jt} \quad (3)$$

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<sup>86</sup> Existing NF residents continue to have their services covered by the FFS system until they experience specific triggers related to acute care events. New NF residents will be under MLTSS.

In the above equations, variables  $Y_{it}$  and  $Y_{jt}$  represent the utilization or cost-based outcomes enumerated in Table A for the patient  $i$  receiving community LTSS services or patient  $j$  residing in a nursing facility at time  $t$ . Post MLTSS is an indicator (0/1) variable that identifies the period starting July 2014. In equation (2), HCBS indicates if the individual was LTSS-eligible (due to requiring a NF level of care) and living in the community receiving HCBS services. In equation (3), NF indicates individuals who were NF residents prior to MLTSS and MLTSS NF residents in the post-MLTSS period. In these models,  $\beta_3$  and  $\gamma_3$  represent the two DD estimates measuring the program impact.  $X_{it}$ ,  $X_{jt}$  are vectors of other control variables relating to the patient, and  $\varepsilon_{it}$ ,  $\varepsilon_{jt}$  represent the random error terms.

It is important to mention that due to the phased out transition to MLTSS for NF residents, the estimation may be limited by small sample size in the months immediately after MLTSS implementation. This may affect the stability of the regression coefficients. As a result, for our discussions we will focus mainly on the effect of MLTSS on HCBS population.

The DD approach assumes that there are no unmeasured factors due to which the outcomes would change relatively between the intervention and comparison groups. If this assumption is not fulfilled and the two groups have differential trends, the effect size includes this difference over time. Accordingly, we test to see whether there existed significant differences in trends between the HCBS and comparison group prior to MLTSS implementation after adjusting for observed factors. If this difference is in the same direction of the DD estimate, and of comparable magnitude, that would imply that the DD model may be overestimating the effect.

As before, we incorporate hospital fixed effects for to account for differences in time invariant inpatient quality-based measures and zip code fixed effects for time-invariant reflecting ambulatory care. We also include indicator variables to distinguish the pre-implementation period into pre-waiver, post-waiver, and post Medicaid expansion periods.

In our findings section we first report the unadjusted DD estimate. This is based on the difference between the pre-post change in the HCBS population and the pre-post change in the comparison group. We follow this with the adjusted difference that estimates the policy effect after accounting for patient and provider or geographical characteristics. This corresponds to the coefficient of the regression interaction term between HCBS or NF indicator and post-MLTSS. The magnitude of this interaction term is reported along with its statistical significance. In the footnote to the table, we note if the pre-trends between the HCBS or NF and comparison group are significantly different.

For index-event based metrics, (Metrics 5-7) the vector of patient characteristics includes individual-level control variables such as beneficiary elderly status (age 65 and older), sex, and health status. For the non-readmission metrics in this group (*Follow-up after Hospitalization for Mental Illness* and *Ambulatory Visit 14 Days after Discharge*), the measure of health status used was a categorization of the diagnosis-based Chronic Illness and Disability Payment System (CDPS) risk score that measures disease diagnoses and burden of illness with higher values indicating greater disease burden. For readmission metrics we used the full set of risk-adjustment variables that are defined by the 2014 or 2016 (for pneumonia)<sup>87</sup> CMS methodology related to Risk Standardized Readmission Rates (QualityNet 2016). Appendix F lists all the risk-adjustment variables for each of the readmission outcomes.

When modeling population-based metrics (Metrics 1-4, and 8) at the person-quarter level, the vector of patient control variables includes beneficiary sex, elderly status (age 65 and older), and number of days enrolled in Medicaid during the quarter. We also account for any change in disease diagnoses and burden of illness over time within the analytic population by adjusting for the CDPS risk score category for each individual.

Our estimation procedures were conducted using STATA MP 14 or SAS Enterprise Guide 7.11 software.

In Section C, we compared the slope of linear trend lines for rates of avoidable hospitalizations and overall emergency department visits between Medicaid and NJ overall. The linear trend was fit to the average rate over the baseline years (2011-2012) and the annual estimates for each year of the demonstration period through 2015. We used only hospitalization rates for ACS conditions available statewide from the NJSHAD that approximated AHRQ's Prevention Quality Indicators.

## Results

### Section A

In this descriptive analysis section, we examine our quality measures for the overall group of Medicaid beneficiaries and specific subgroups related to eligibility or place of service. We will highlight notable differences in estimates over the years. Our primary focus will be on any substantive changes in these estimates during 2015, the first full year of MLTSS implementation, compared to previous years. Several significant changes in the composition of the populations we present should be kept in mind when considering the data shown. First, would be the

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<sup>87</sup> Due to variations in hospital coding practices, CMS expanded the pneumonia cohort for fiscal year 2017 reporting. Additional risk adjustment variables were added in this process.

Medicaid expansion effective in 2014 which brought several hundred thousand low-income beneficiaries into the Medicaid managed care population. Second, would be the rebalancing of the long-term care population which made it possible for more individuals at a nursing facility level of care to live in their homes and communities. Not only were former nursing facility residents moved back to the community under MLTSS, but more existing beneficiaries and new entrants were able to access long-term care services without having to be in a nursing facility. These demographic and associated risk profile shifts are not adjusted for in the descriptive results we present here. Therefore, the findings discussed in this section do not necessarily illustrate causal effects of waiver policies, but suggest areas of potential quality and cost improvement or deterioration over the first three waiver demonstration years. Our regression analysis in the next section adjusts for the demographic and risk factors associated with these populations.

Table 3A.1 reports the percentage of NJ Medicaid beneficiaries who were MC enrollees at some point during the calendar year. In 2014 and again in 2015, there is, as expected, a sharp increase in the number of beneficiaries of the General Assistance (GA) category that includes the Medicaid expansion population. The long-term care population receiving HCBS also grew over these years with the most growth occurring between 2014 and 2015. Mandatory enrollment into an MCO for acute care services became effective for the HCBS population (existing and new entrants) in late 2011. This is reflected in the higher percentage of managed care enrollment in this population in 2012 (93%) compared to the previous year. The nursing facility population declined from 2011 to 2015, but the share of the NF population in managed care climbed over 10 percentage points from 2014 to 2015, consistent with NF residents remaining exempt from managed care until the implementation of MLTSS in July 2014.

The children's service and the residual 'other' category comprising all other eligibility categories, accounted for less than three percent of the overall Medicaid population. Because of its small base which may lead to volatility in estimates, we will not show estimates for these categories in the remainder of this section.

Tables 3A.2-3A.5 report rates of avoidable inpatient hospitalizations and primary care avoidable/preventable ED visits per 10,000 population. Rates of hospitalizations per 10,000 population are reported for all Medicaid beneficiaries, the managed care population, the HCBS and NF populations, and beneficiaries with a behavioral health condition. Figure 3A.1 displays the trends in avoidable hospital use based on the data in these tables for the overall population of Medicaid managed care beneficiaries, the HCBS population, and the NF population.

For the managed care population, avoidable hospitalization rates are generally lower by 2015 than they were in the baseline period (Table 3A.2). This holds true for the ABD and NJ FamilyCare

populations overall, which were predominantly in managed care for all the study years shown. However, for the GA category overall, which experienced major changes in size and managed care composition, the rate of avoidable hospitalizations increased by 2015.

Also in 2015, avoidable inpatient hospitalization rates were the highest among those receiving HCBS (780 per 10,000 beneficiaries; Table 3A.3), and even higher among HCBS beneficiaries with a BH condition (1,142 per 10,000 beneficiaries; Table 3A.3). This rate had decreased from 2013 to 2014, but by 2015 was back at the level of the pre-waiver baseline years (2011-2012). In contrast, the rate of avoidable hospitalizations for the nursing facility population, overall and among those with a BH condition, has been steadily declining since 2011.

The GA and the ABD population in managed care had the highest rates of avoidable ED utilization. Avoidable ED rates among the LTC population were much lower, roughly half the overall Medicaid rate (Tables 3A.4 and 3A.5). Avoidable ED rates have fallen for the nursing facility population over the study years, but are at their highest by 2015 in the HCBS population.

Tables 3A.6-3A.7 report rates of pediatric avoidable hospitalizations. These are substantially lower than the rates among adults, with the pediatric rate equaling one-tenth of the adult rate for all Medicaid beneficiaries and Medicaid managed care beneficiaries. Avoidable pediatric hospitalizations in 2015 are at their lowest in the study period for all categories.

Tables 3A.8-3A.9 report inpatient and ED utilization rates per 10,000 beneficiaries. In 2015, the ABD group had the highest rates of inpatient and ED utilization among the different eligibility groups. The long term care population had a substantially higher rate of inpatient utilization compared to the overall Medicaid rate (2,903 versus 848 per 10,000 beneficiaries), but had a lower rate of ED utilization compared to Medicaid beneficiaries overall (3,707 versus 5,200 per 10,000 beneficiaries). There was a decreasing trend in inpatient utilization among Medicaid beneficiaries overall, those with managed care, and in the long term care population over 2011-2015 although rates increased slightly from 2014 to 2015 (except in the case of the managed care population).

Figure 3A.2 further exhibits the trends in these rates for the overall managed care population and separately, the HCBS and NF populations. As with avoidable inpatient and ED visits (Figure 3A.1), we see a sharp decrease in ED visit rates from 4,933 visits per 10,000 population in 2013 to 4,168 per 10,000 population in 2014 for the HCBS population, but then sharp increases in both inpatient stays and ED visits for this population in 2015. Rates for the managed care population overall and the NF population do not show this pattern.

Tables 3A.10-3A.12 report annual levels of avoidable and overall hospital spending per person, and also total spending per person for the years 2011-2015. The ABD eligibility group enrolled in managed care has the highest per-person avoidable spending (\$221) and also overall hospital spending (\$1350) in 2015 compared to the other categories, but the avoidable spending for this population was even higher prior to the waiver implementation (\$273 and \$1605, respectively in 2011). In contrast, avoidable and overall hospital spending has been increasing slightly for the NJ FamilyCare population during this time period. Also among managed care enrollees, the ABD category also has the highest overall per-person spending, \$14,493 per beneficiary in 2015, but this is again the lowest per person spending for that population since 2011.

Figure 3A.3 examines trends in different categories of hospital and overall spending over 2011-2015 among all Medicaid beneficiaries. We find that total spending per beneficiary decreased after 2013 from \$5,744 in 2013 to \$5,069 in 2015, but this is largely due to drops in non-hospital spending. Hospital-based spending per beneficiary actually ended up at a higher level in 2015 than in the baseline years primarily attributable to growth in ED costs. Hospital spending accounted for 13% of total spending in 2015.

Table 3A.13 examines avoidable hospital spending by LTC beneficiaries in NF and in the community receiving HCBS services. Around three quarters of total avoidable costs among the LTC population was incurred by NF residents in 2011-2014, but the growth in avoidable costs among the HCBS population, and decrease among the NF population after 2014 shifts this to a nearly even split between these two LTC populations by 2015. When considering per person costs, NF residents on average had higher avoidable costs per person in 2011 than the HCBS population (\$193 vs. \$145). This difference was almost non-existent in 2014 (\$130 vs. \$129) largely due to a steeper decline in avoidable costs per person for the NF population, and reversed by 2015 (\$104 vs. \$204) due to the increase between 2014 and 2015 in spending for the HCBS population. It should also be noted that overall avoidable hospital spending and per person avoidable spending was still lower for the LTC population during the waiver demonstration years than during the baseline period.

Table 3A.14 reports 30-day hospital-wide readmission rates as well as 30-day all-cause readmission rates after an index hospitalization for heart failure (HF), pneumonia (PN), and acute myocardial infarction (AMI) for Medicaid beneficiaries overall, for long term care eligible beneficiaries, and those with a behavioral health condition. Heart failure readmission rates were the highest among all readmission rates for every category and year except for the LTC population in 2014. In every category of readmission, and every year, beneficiaries with a BH condition had a higher readmission rate compared to those who were LTC-eligible and also Medicaid beneficiaries overall.

Tables 3A.15-3A.22 report these readmission rates for the different Medicaid eligibility groups and separately for NF residents and the beneficiaries receiving HCBS services among the LTC population. Figures 3A.4-3A.7 report trends in each type of readmission for the overall managed care population and the HCBS and NF populations. We compare the change in readmission rates from 2013 to 2015 to the underlying trend between 2012 and 2013. For the overall managed care population, we find an improvement in quality reflected through AMI readmission rates, but a worsening for HF readmission rates. For the HCBS population, all readmission rates exhibited a worsening except for AMI which had no clear trend. For the NF population, readmission rates indicate improvements in care except for HF readmission which increased between 2014 and 2015, consistent with the trends seen for the entire managed care and HCBS populations.

Tables 3A.23-24 report rates of follow-up visit during the seven and thirty-day period following a mental illness hospitalization for beneficiaries in different Medicaid eligibility categories and LTC beneficiaries. Separate estimates for this metric were not generated for beneficiaries in nursing facilities since these beneficiaries may have follow-up care provided within the facility itself. For Medicaid beneficiaries overall and in managed care, rates of follow-up seven days and thirty days after discharge from a mental illness hospitalization do not change very much over 2011-2015, but there is an indication of a slightly increasing trend starting in 2014 after slight declines from 2011-2013.

Tables 3A.25-26 report rates of ambulatory visit within 14 days of hospital discharge for these same beneficiary categories. Recognizing that ambulatory visit rates may vary depending on where the patient was discharged, rates of ambulatory visits are distinguished based on whether the patient was discharged to home, to a rehabilitation facility, or to another facility. Focusing on those who were discharged home, rates have declined since 2011 for managed care overall and for the ABD and NJ FamilyCare populations. They have also declined for the HCBS population through 2014, but then increase by 7.5 percentage points from 2014 to 2015.

Figure 3A.8 exhibits rates of these two types of follow-up for all managed care beneficiaries, overall, and additionally for the LTC HCBS population. The noticeable trend is a decrease in ambulatory visits for the managed care and HCBS populations over the period 2011-2014. However, this rate climbs back up in 2015 for the HCBS population, although not for managed care overall.

Figure 3A.9 displays the avoidable hospitalization rate, the 30-day hospital readmission rate, and the 30-day follow-up after hospitalization for mental illness rate for all Medicaid beneficiaries with a behavioral health condition, excluding those in MLTSS or served by DDD whose behavioral health benefit is administered by their MCO. This is the population of beneficiaries affected by

the transition of some aspects of BH management to the Interim Managing Entity in July 2015. During the first two quarters when the IME was operational, avoidable hospitalizations are lower than in prior years, but the declines were underway in 2013. Thirty-day readmission and mental health follow-up visits are not markedly different in the last two quarters of 2015 compared to the period prior to IME operation.

Table 3A.27 examines three quality metrics for a cohort of beneficiaries enrolled under each of the §1915(c) HCBS waivers in January 2014. Rates of avoidable hospitalizations and 30-day readmissions have not improved for those in the TBI waiver over the first three demonstration years compared to the pre-waiver period. Because children in the CRPD waiver often have private insurance, we may not be capturing all their hospitalizations in claims data. Qualifying index hospitalizations for mental illness are rare in these small cohorts, so trends in follow-up care cannot be examined through 2015.

Tables 3A.28 shows the total and per person LTSS, non-LTSS, and total spending for the LTC population. Total spending is higher for the NF population compared to the HCBS population and this is largely driven by their high LTSS spending, although that spending is at its lowest in 2015. The share of LTSS and total spending has shifted more towards the HCBS population by 2015 compared to 2011-2012. The average per person spending is also lower in 2015 than it was in 2011-2012, except for non-LTSS spending for the NF population. The per-capita differences in overall costs are lower than those in total costs demonstrating that a part of the cost differential between NF and HCBS is driven by a higher number of NF residents.

Figure 3A.10 shows the proportion of total Medicaid spending on the LTC population attributable to the HCBS and NF populations on a monthly basis over the study period. Here we observe that the majority of total spending over 2011-2015 is for individuals living in nursing facilities. The proportion of spending attributable to the NF population has declined from a high of 89% in January 2011 to 81% by December 2015. The greatest increases in the proportion of spending for the HCBS population occurred after implementation of MLTSS in July 2014.

Figure 3A.11 shows the inflation-adjusted amount (in millions of dollars) of total monthly spending for the NF and HCBS populations. Overall monthly spending has declined by about \$21 million over the study period mostly as a result of declines in the magnitude of spending for the NF population. That decline is evident prior to the MLTSS policy initiation. Spending for the HCBS population is at its highest in December 2015.

Figure 3A.12 shows the components of total spending by month over the study period for the NF and HCBS populations. Most of this spending is accounted for by NF LTSS (73.8% in December



2015). HCBS LTSS spending accounted for 13.3%. We see a decrease in the NF LTSS share and an increase in the HCBS LTSS share from 2014-2015. Spending related to avoidable hospitalizations accounted for less than 1% of overall spending.

**Table 3A.1: New Jersey Medicaid population total enrollment and percentage in managed care, 2011-2015**

	2011		2012		2013		2014		2015	
	Total	% MC	Total	% MC	Total	% MC	Total	% MC	Total	% MC
<b>All Medicaid Beneficiaries</b>	1,569,730	85%	1,581,262	87%	1,592,727	88%	1,954,216	89%	2,144,195	92%
Aged/Blind/Disabled	319,150	76%	327,344	81%	332,339	82%	331,784	85%	327,867	87%
NJ FamilyCare	1,120,576	94%	1,138,332	95%	1,153,344	95%	1,246,307	94%	1,321,238	95%
General Assistance	88,495	7%	76,637	6%	67,955	6%	335,282	78%	456,093	89%
Children's Service	34,519	65%	31,709	71%	31,959	70%	33,672	67%	33,342	68%
Other	6,990	3%	7,240	3%	7,130	2%	7,171	21%	5,655	13%
<b>Long-Term Care Beneficiaries</b>	49,912	22%	49,534	28%	49,337	30%	47,721	32%	47,573	43%
Nursing Facility	37,009	1%	36,011	4%	35,384	4%	34,373	6%	32,121	17%
HCBS	12,903	81%	13,523	93%	13,953	94%	13,348	98%	15,452	98%

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: MC=Managed Care; HCBS=Home and Community-Based Services.

**Table 3A.2: Rates of avoidable inpatient hospitalizations per 10,000 adults by Medicaid eligibility category and among adults with a behavioral health condition**

	2011		2012	2013	2014	2015	
	Population (N)	Rate	Rate	Rate	Rate	Population (N)	Rate
<b>Medicaid Overall</b>	786,549	229	228	196	145	1,269,215	147
Aged/Blind/Disabled	293,507	530	521	439	367	302,435	387
NJ FamilyCare	391,159	53	46	41	42	500,111	41
General Assistance	88,489	41	32	25	89	456,084	106
<b>Managed Care</b>	602,394	256	264	225	160	1,138,611	153
Aged/Blind/Disabled	231,027	566	565	471	387	264,177	409
NJ FamilyCare	360,855	57	50	44	45	464,307	43
General Assistance	6,861	363	339	296	104	405,836	113

	2011		2012	2013	2014	2015	
	Population (N)	Rate	Rate	Rate	Rate	Population (N)	Rate
<b>Medicaid Overall</b>							
Behavioral Health Condition	237,715	553	510	440	352	383,353	373

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: Rates are calculated per 10,000 adults age 18 and above.

**Table 3A.3: Rates of avoidable inpatient hospitalizations per 10,000 adults among LTC-eligible populations overall and with a behavioral health condition**

	2011		2012	2013	2014	2015	
	Population (N)	Rate	Rate	Rate	Rate	Population (N)	Rate
<b>Long-Term Care Population</b>	49,654	625	591	495	422	47,232	488
Nursing Facility	36,850	535	461	388	361	31,978	348
HCBS	12,804	886	938	767	581	15,254	780
<hr/>							
<b>With a Behavioral Health Condition</b>	2011		2012	2013	2014	2015	
	Population (N)	Rate	Rate	Rate	Rate	Population (N)	Rate
<b>Long-Term Care Population</b>	33,923	800	730	594	518	32,617	587
Nursing Facility	26,510	696	594	484	456	24,882	415
HCBS	7,413	1,170	1,174	966	744	7,735	1,142

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: Rates are calculated per 10,000 adults age 18 and above.

**Table 3A.4: Rates of avoidable emergency department visits per 10,000 population by Medicaid eligibility category**

	2011		2012	2013	2014	2015	
	Population (N)	Rate	Rate	Rate	Rate	Population (N)	Rate
<b>Medicaid Overall</b>	1,569,730	2,643	2,717	2,659	2,637	2,144,195	2,708
Aged/Blind/Disabled	319,150	3,308	3,334	3,146	2,973	327,867	3,090
NJ FamilyCare	1,120,576	2,677	2,745	2,703	2,658	1,321,238	2,644
General Assistance	88,495	458	387	313	2,388	456,093	2,731
<b>Managed Care</b>	1,347,033	2,995	3,032	2,936	2,869	1,977,817	2,894
Aged/Blind/Disabled	255,504	3,819	3,691	3,418	3,178	289,115	3,396
NJ FamilyCare	1,061,569	2,803	2,871	2,818	2,801	1,259,147	2,757
General Assistance	6,863	4,838	4,702	4,344	2,878	405,843	2,998

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

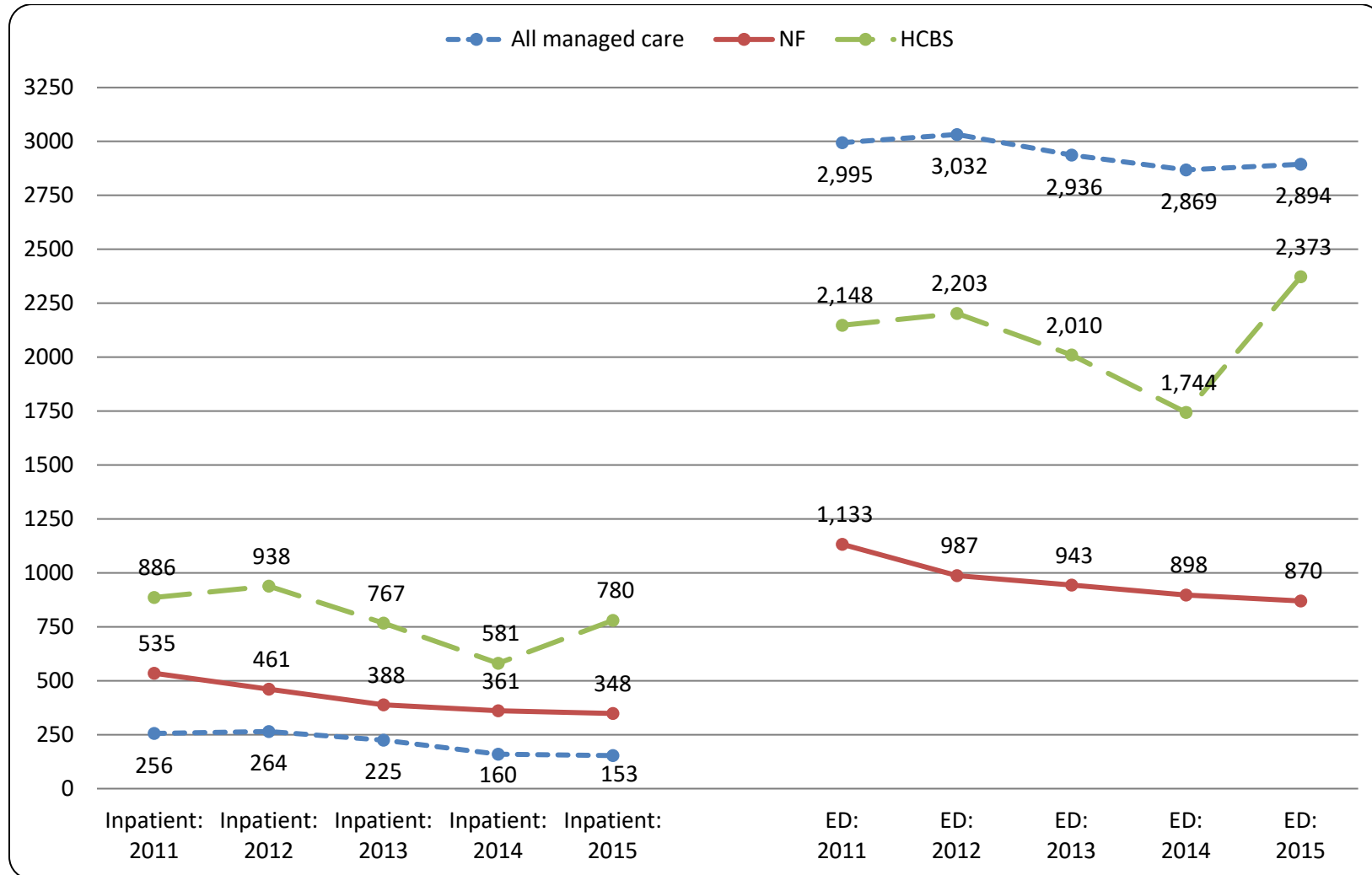
**Table 3A.5: Rates of avoidable emergency department visits per 10,000 population among LTC-eligible populations**

	2011		2012	2013	2014	2015	
	Population (N)	Rate	Rate	Rate	Rate	Population (N)	Rate
<b>Long-Term Care Population</b>	49,912	1,395	1,319	1,245	1,134	47,573	1,358
Nursing Facility	37,009	1,133	987	943	898	32,121	870
HCBS	12,903	2,148	2,203	2,010	1,744	15,452	2,373

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: HCBS=Home and Community-Based Services

**Figure 3A.1: Rates of avoidable hospital utilization per 10,000 beneficiaries for the Medicaid managed care and HCBS populations**



Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.  
 Notes: HCBS=Home and Community-Based Services; NF=Nursing Facility; ED=Emergency Department.

**Table 3A.6: Rates of avoidable pediatric hospitalizations per 10,000 children by Medicaid eligibility category**

	2011		2012	2013	2014	2015	
	Population (N)	Rate	Rate	Rate	Rate	Population (N)	Rate
<b>Medicaid Overall</b>	479,503	24	24	23	19	568,579	15
Aged/Blind/Disabled	20,985	73	79	78	76	21,253	52
NJ FamilyCare	435,687	22	22	21	17	524,014	14
General Assistance	*	*	*	*	*	*	*
<b>Managed Care</b>	456,961	25	25	24	20	547,473	16
Aged/Blind/Disabled	20,289	75	79	79	76	20,998	52
NJ FamilyCare	422,039	23	22	21	18	511,595	14
General Assistance	*	*	--	*	*	*	*

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: Rates calculated per 10,000 children ages 6 to 17.

\*Estimate suppressed due to insufficient sample size.

--population denominator equals 0.



**Table 3A.7: Rates of avoidable pediatric hospitalizations per 10,000 children among LTC-eligible populations**

	2011		2012	2013	2014	2015	
	Population (N)	Rate	Rate	Rate	Rate	Population (N)	Rate
<b>Long-Term Care Population</b>	152	329	190	179	58	203	0
Nursing Facility	102	294	288	92	101	98	0
HCBS	50	400	0	339	0	105	0

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: HCBS= Home and Community-Based Services.

Rates calculated per 10,000 children ages 6 to 17.

**Table 3A.8: Rates of inpatient and emergency department use per 10,000 population by Medicaid eligibility category**

	Inpatient Utilization Rate					Emergency Department Visit Rate				
	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015
<b>Medicaid Overall</b>	1,061	1,048	928	828	848	4,948	5,069	4,949	4,959	5,200
Aged/Blind/Disabled	2,814	2,811	2,407	2,094	2,167	7,053	7,048	6,708	6,404	6,726
NJ FamilyCare	643	614	563	520	496	4,741	4,858	4,762	4,688	4,757
General Assistance	358	297	236	781	965	892	777	619	4,760	5,553
<b>Managed Care</b>	1,067	1,084	962	860	853	5,556	5,625	5,440	5,375	5,533
Aged/Blind/Disabled	2,872	2,932	2,500	2,150	2,196	7,950	7,680	7,199	6,773	7,280
NJ FamilyCare	628	599	550	518	488	4,965	5,082	4,963	4,942	4,957
General Assistance	3,363	3,348	2,987	928	1,051	9,311	9,419	8,417	5,722	6,090

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

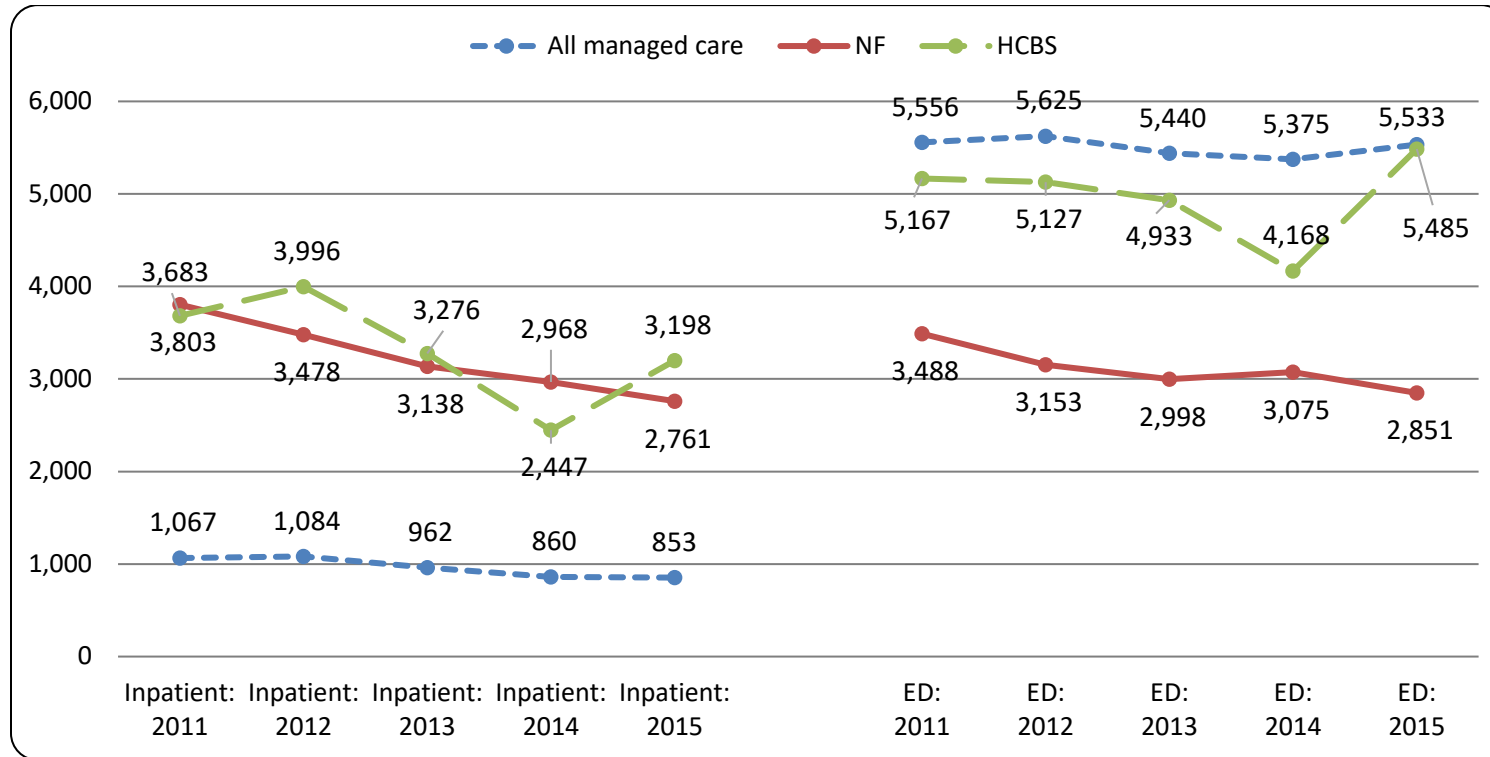
**Table 3A.9: Rates of inpatient and emergency department use per 10,000 population among LTC-eligible populations**

	Inpatient Utilization Rate					Emergency Department Visit Rate				
	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015
<b>Long-Term Care Population</b>	3,772	3,620	3,177	2,822	2,903	3,922	3,692	3,545	3,380	3,707
Nursing Facility	3,803	3,478	3,138	2,968	2,761	3,488	3,153	2,998	3,075	2,851
HCBS	3,683	3,996	3,276	2,447	3,198	5,167	5,127	4,933	4,168	5,485

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: HCBS=Home and Community-Based Services.

**Figure 3A.2: Rates of inpatient and emergency department use per 10,000 beneficiaries for the Medicaid managed care and HCBS populations**



Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.  
 Notes: HCBS=Home and Community-Based Services; NF=Nursing Facility; ED=Emergency Department.

**Table 3A.10: Spending per person associated with avoidable hospital use by Medicaid eligibility category**

	Per Person Avoidable Inpatient Spending					Per Person Avoidable ED Spending					Per Person All Avoidable Spending (IP+ED)				
	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015
<b>Medicaid Overall</b>	\$47	\$46	\$41	\$42	\$42	\$65	\$69	\$72	\$81	\$81	\$112	\$115	\$113	\$123	\$123
Aged/Blind/Disabled	\$178	\$176	\$154	\$147	\$134	\$68	\$65	\$66	\$77	\$70	\$245	\$241	\$220	\$223	\$204
NJ FamilyCare	\$12	\$11	\$11	\$11	\$11	\$69	\$75	\$78	\$85	\$83	\$82	\$87	\$89	\$96	\$94
General Assistance	\$29	\$26	\$20	\$57	\$68	\$14	\$12	\$10	\$77	\$86	\$43	\$38	\$31	\$134	\$154
<b>Managed Care</b>	\$49	\$49	\$44	\$45	\$43	\$74	\$77	\$79	\$88	\$87	\$122	\$126	\$123	\$133	\$130
Aged/Blind/Disabled	\$194	\$189	\$164	\$155	\$144	\$79	\$72	\$72	\$82	\$77	\$273	\$261	\$236	\$238	\$221
NJ FamilyCare	\$13	\$12	\$11	\$12	\$11	\$73	\$79	\$81	\$89	\$87	\$86	\$91	\$92	\$101	\$98
General Assistance	\$239	\$263	\$241	\$66	\$72	\$146	\$145	\$139	\$94	\$95	\$385	\$407	\$380	\$160	\$167

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: IP=Inpatient; ED=Emergency Department.

Avoidable hospital spending is tabulated for all ages.

All spending is in 2012 dollars.

**Table 3A.11: Spending per person associated with overall hospital use by Medicaid eligibility category**

	Per Person Inpatient Spending					Per Person ED Spending					Per Person All Hospital Spending				
	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015
<b>Medicaid Overall</b>	\$549	\$549	\$513	\$515	\$523	\$121	\$127	\$132	\$152	\$159	\$670	\$676	\$645	\$668	\$683
Aged/Blind/Disabled	\$1,346	\$1,349	\$1,261	\$1,247	\$1,120	\$145	\$138	\$141	\$163	\$156	\$1,491	\$1,486	\$1,402	\$1,410	\$1,276
NJ FamilyCare	\$351	\$346	\$323	\$312	\$307	\$122	\$133	\$138	\$150	\$153	\$473	\$478	\$461	\$462	\$460
General Assistance	\$316	\$270	\$229	\$581	\$744	\$28	\$25	\$20	\$157	\$186	\$344	\$295	\$249	\$737	\$930
<b>Managed Care</b>	\$570	\$577	\$539	\$544	\$539	\$136	\$141	\$146	\$166	\$170	\$706	\$718	\$684	\$710	\$709
Aged/Blind/Disabled	\$1,440	\$1,425	\$1,323	\$1,307	\$1,181	\$165	\$149	\$151	\$174	\$170	\$1,605	\$1,574	\$1,474	\$1,481	\$1,350
NJ FamilyCare	\$351	\$347	\$324	\$319	\$308	\$128	\$139	\$144	\$158	\$160	\$479	\$485	\$467	\$477	\$467
General Assistance	\$2,538	\$2,933	\$2,675	\$688	\$808	\$283	\$292	\$272	\$189	\$205	\$2,820	\$3,225	\$2,947	\$877	\$1,013

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: ED=Emergency Department.

Spending is tabulated for all ages.

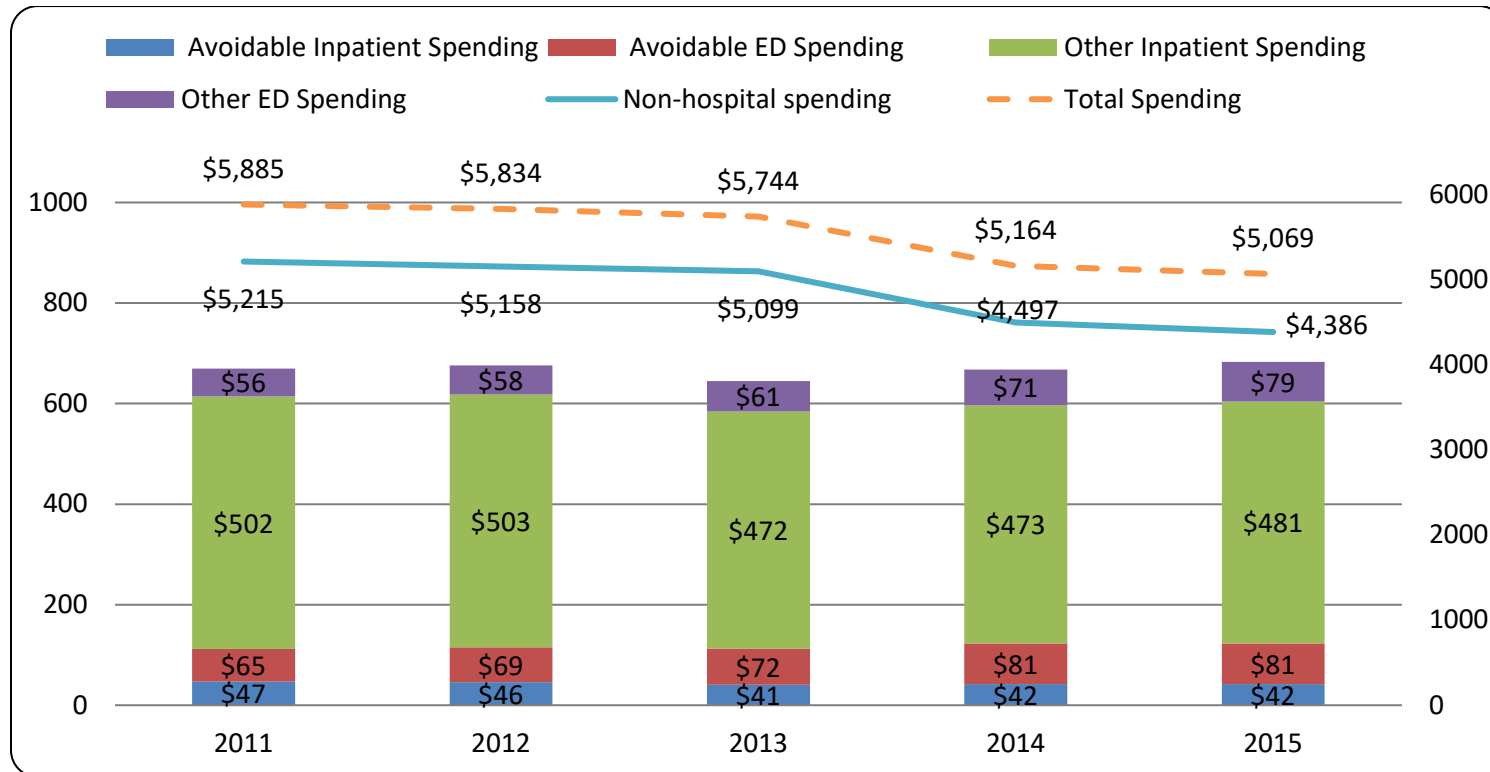
All spending is in 2012 dollars.

**Table 3A:12: Total spending per person by Medicaid eligibility category**

	2011	2012	2013	2014	2015
<b>Medicaid Overall</b>	\$5,885	\$5,834	\$5,744	\$5,164	\$5,069
Aged/Blind/Disabled	\$19,503	\$19,007	\$18,637	\$18,213	\$17,756
NJ FamilyCare	\$2,253	\$2,272	\$2,224	\$2,241	\$2,286
General Assistance	\$2,680	\$2,560	\$2,601	\$3,050	\$3,970
<b>Managed Care</b>	\$5,048	\$5,260	\$5,300	\$5,007	\$4,593
Aged/Blind/Disabled	\$15,865	\$16,038	\$16,207	\$16,246	\$14,493
NJ FamilyCare	\$2,300	\$2,326	\$2,273	\$2,323	\$2,342
General Assistance	\$10,341	\$11,292	\$10,754	\$3,607	\$4,276

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.  
Spending is tabulated for all ages.  
All spending is in 2012 dollars.

**Figure 3A.3: Trends in avoidable and overall hospital spending and total spending for the Medicaid population overall**



Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: ED=Emergency Department.

Spending is tabulated for all ages.

All spending is in 2012 dollars.



**Table 3A.13: Total and per person spending associated with avoidable hospital use among LTC-eligible populations**

	Total Avoidable Inpatient (IP) Spending										Per Person Avoidable Inpatient Spending				
	2011		2012		2013		2014		2015		2011	2012	2013	2014	2015
	<b>Long-Term Care Pop.</b>	\$7,879,992	100%	\$6,534,098	100%	\$5,781,438	100%	\$5,290,153	100%	\$5,456,735	100%	\$158	\$132	\$117	\$111
Nursing Facility	\$6,382,956	81%	\$4,836,681	74%	\$4,078,996	71%	\$3,862,378	73%	\$2,815,902	52%	\$172	\$134	\$115	\$112	\$88
HCBS	\$1,497,036	19%	\$1,697,418	26%	\$1,702,442	29%	\$1,427,775	27%	\$2,640,834	48%	\$116	\$126	\$122	\$107	\$171

	Total Avoidable Emergency Department (ED) Spending										Per Person Avoidable ED Spending				
	2011		2012		2013		2014		2015		2011	2012	2013	2014	2015
	<b>Long-Term Care Pop.</b>	\$1,118,722	100%	\$925,985	100%	\$893,851	100%	\$923,407	100%	\$1,041,756	100%	\$22	\$19	\$18	\$19
Nursing Facility	\$750,243	67%	\$683,925	74%	\$639,611	72%	\$622,896	67%	\$527,916	51%	\$20	\$19	\$18	\$18	\$16
HCBS	\$368,479	33%	\$242,061	26%	\$254,240	28%	\$300,510	33%	\$513,840	49%	\$29	\$18	\$18	\$23	\$33

	Overall Avoidable Hospital Spending (Inpatient + ED)										Per Person Total Avoidable Hospital Spending				
	2011		2012		2013		2014		2015		2011	2012	2013	2014	2015
	<b>Long-Term Care Pop.</b>	\$8,998,714	100%	\$7,460,084	100%	\$6,675,289	100%	\$6,213,559	100%	\$6,498,491	100%	\$180	\$151	\$135	\$130
Nursing Facility	\$7,133,200	79%	\$5,520,605	74%	\$4,718,607	71%	\$4,485,274	72%	\$3,343,818	51%	\$193	\$153	\$133	\$130	\$104
HCBS	\$1,865,515	21%	\$1,939,478	26%	\$1,956,682	29%	\$1,728,285	28%	\$3,154,674	49%	\$145	\$143	\$140	\$129	\$204

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: HCBS=Home and Community-Based Services; ED=Emergency Department.

All spending is in 2012 dollars.

**Table 3A.14: Thirty-day readmission rates among groups of Medicaid beneficiaries**

	2012			2013			2014			2015		
	Medicaid Overall	LTC	Behavioral Health	Medicaid Overall	LTC	Behavioral Health	Medicaid Overall	LTC	Behavioral Health	Medicaid Overall	LTC	Behavioral Health
<b>Hospital-Wide</b>	12.7%	10.9%	15.9%	11.7%	9.6%	14.9%	11.4%	8.6%	14.6%	11.1%	8.9%	13.9%
<b>Heart Failure</b>	18.7%	11.0%	23.5%	15.6%	11.7%	19.7%	15.4%	6.3%	18.8%	16.8%	11.3%	21.2%
<b>AMI</b>	11.4%	10.2%	12.0%	11.7%	6.8%	14.1%	9.4%	5.8%	11.4%	9.3%	3.4%	11.5%
<b>Pneumonia</b>	11.8%	10.7%	12.4%	10.0%	7.6%	10.7%	9.9%	9.0%	10.9%	9.8%	8.0%	11.0%

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: LTC=Long-Term Care; AMI=Acute Myocardial Infarction.

**Table 3A.15: Hospital-wide 30-day readmission rates by Medicaid eligibility category**

	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>
<b>Medicaid Overall</b>	12.7%	11.7%	11.5%	11.1%
Aged/Blind/Disabled	15.0%	13.7%	13.8%	12.7%
NJ FamilyCare	6.0%	6.3%	5.6%	6.1%
General Assistance	17.3%	17.5%	14.1%	13.4%
<b>Managed Care</b>	12.9%	11.9%	11.7%	11.4%
Aged/Blind/Disabled	15.6%	14.2%	14.3%	13.6%
NJ FamilyCare	6.0%	6.2%	5.6%	6.1%
General Assistance	15.0%	17.1%	14.1%	13.3%

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: Readmission rates are calculated for adults ages 18 and above.

**Table 3A.16: Hospital-wide 30-day readmission rates among LTC-eligible populations**

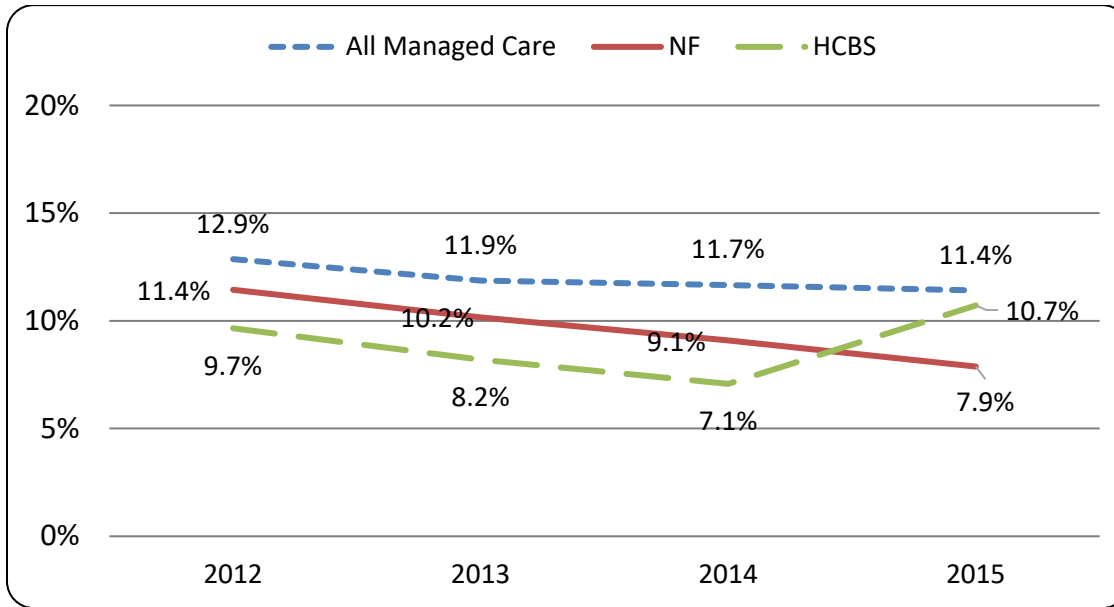
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>
<b>Long-Term Care Population</b>	10.9%	9.6%	8.6%	8.9%
Nursing Facility	11.4%	10.2%	9.1%	7.9%
HCBS	9.7%	8.2%	7.1%	10.7%

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: HCBS=Home and Community-Based Services.

Readmission rates are calculated for adults ages 18 and above.

**Figure 3A.4: Trends in hospital-wide readmission rates among the Medicaid managed care and HCBS populations**



Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: HCBS=Home and Community-Based Services.

Readmission rates are calculated for adults ages 18 and above.

**Table 3A.17: Heart failure 30-day readmission rates by Medicaid eligibility category**

	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>
<b>Medicaid Overall</b>	18.7%	15.6%	15.4%	16.8%
Aged/Blind/Disabled	18.8%	15.3%	15.1%	15.9%
NJ FamilyCare	15.2%	21.8%	16.2%	17.2%
General Assistance	*	*	21.6%	22.6%
<b>Managed Care</b>	19.2%	15.8%	15.8%	17.8%
Aged/Blind/Disabled	19.4%	15.7%	15.5%	17.0%
NJ FamilyCare	15.2%	20.4%	16.2%	17.2%
General Assistance	*	*	21.6%	22.6%

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: Readmission rates are calculated for adults ages 18 and above.

\*Estimate suppressed due to insufficient sample size.

**Table 3A.18: Heart failure 30-day readmission rates among LTC-eligible populations**

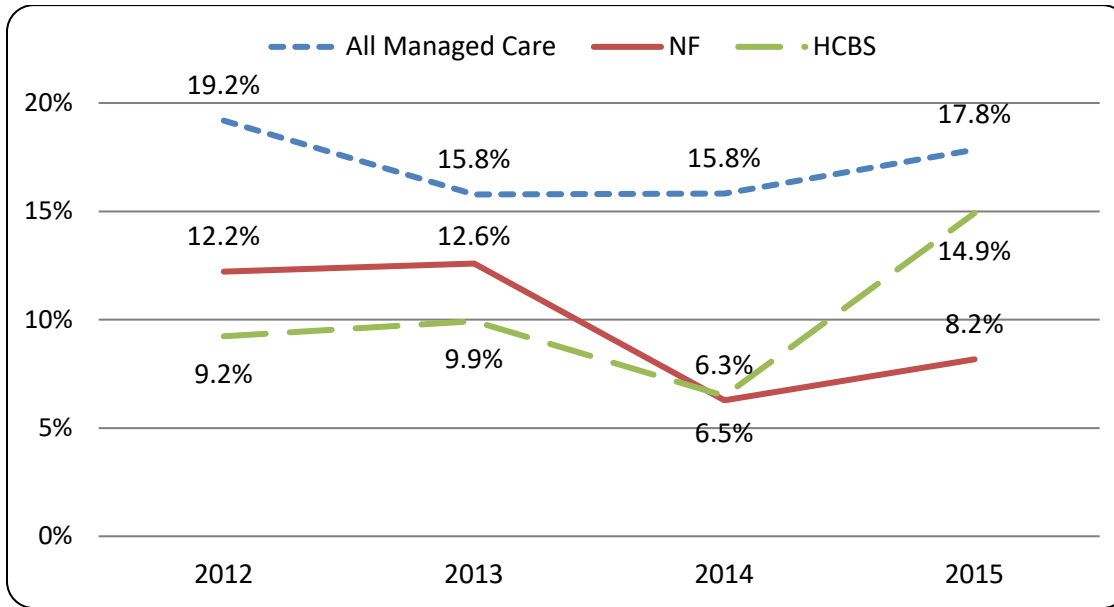
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>
<b>Long-Term Care Population</b>	11.0%	11.7%	6.3%	11.3%
Nursing Facility	12.2%	12.6%	6.3%	8.2%
HCBS	9.2%	9.9%	6.5%	14.9%

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: HCBS=Home and Community-Based Services.

Readmission rates are calculated for adults ages 18 and above.

**Figure 3A.5: Trends in heart failure readmission rates among the Medicaid managed care and HCBS populations**



Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: HCBS=Home and Community-Based Services.

Readmission rates are calculated for adults ages 18 and above.



**Table 3A.19: Pneumonia 30-day readmission rates by Medicaid eligibility category**

	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>
<b>Medicaid Overall</b>	11.8%	10.0%	9.9%	9.8%
Aged/Blind/Disabled	12.2%	10.0%	9.8%	9.4%
NJ FamilyCare	5.3%	7.9%	8.8%	8.0%
General Assistance	*	*	15.2%	13.3%
<b>Managed Care</b>	12.6%	10.6%	10.7%	11.1%
Aged/Blind/Disabled	13.3%	10.8%	10.6%	11.0%
NJ FamilyCare	5.3%	7.9%	8.8%	8.0%
General Assistance	*	*	15.2%	13.4%

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: Readmission rates are calculated for adults ages 18 and above.

\*Estimate suppressed due to insufficient sample size

**Table 3A.20: Pneumonia 30-day readmission rates among LTC-eligible populations**

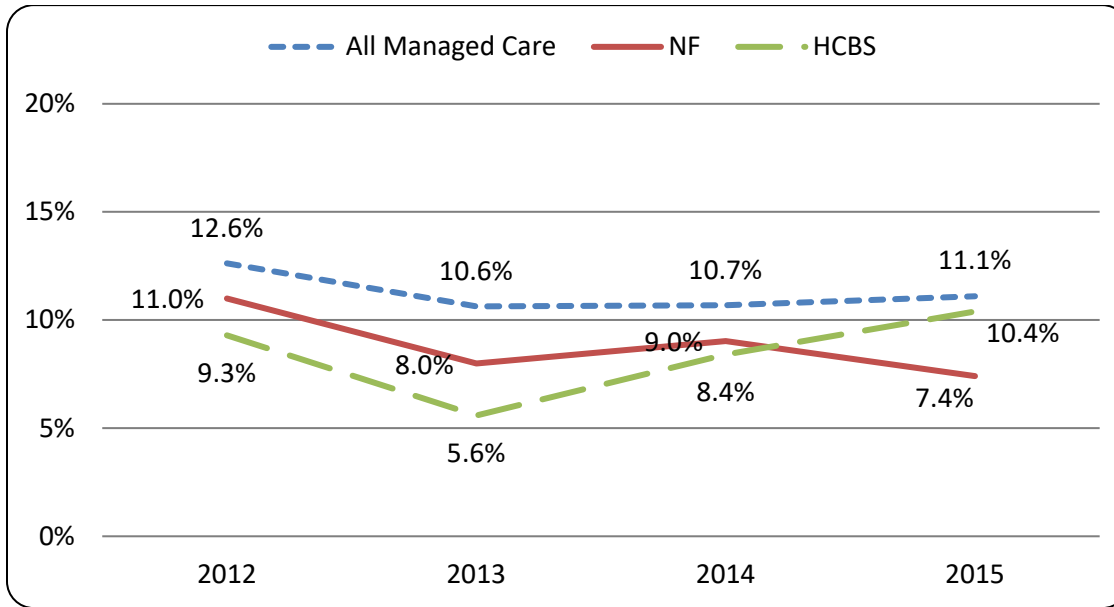
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>
<b>Long-Term Care Population</b>	10.7%	7.6%	9.0%	8.0%
Nursing Facility	11.0%	8.0%	9.0%	7.4%
HCBS	9.3%	5.6%	8.4%	10.4%

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: HCBS=Home and Community-Based Services.

Readmission rates are calculated for adults ages 18 and above.

**Figure 3A.6: Trends in pneumonia readmission rates among the Medicaid managed care and HCBS populations**



Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: HCBS=Home and Community-Based Services.

Readmission rates are calculated for adults ages 18 and above.

**Table 3A.21: Acute myocardial infarction 30-day readmission rates by Medicaid eligibility category**

	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>
<b>Medicaid Overall</b>	11.4%	11.7%	9.4%	9.3%
Aged/Blind/Disabled	11.5%	11.0%	10.8%	8.6%
NJ FamilyCare	9.9%	16.3%	3.9%	12.1%
General Assistance	*	*	3.4%	9.5%
<b>Managed Care</b>	11.3%	12.0%	9.5%	9.6%
Aged/Blind/Disabled	11.5%	11.3%	11.1%	9.1%
NJ FamilyCare	9.9%	16.3%	3.9%	12.1%
General Assistance	*	*	3.4%	9.5%

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy

Notes: Readmission rates are calculated for adults ages 18 and above.

\*Estimate suppressed due to insufficient sample size.

**Table 3A.22: Acute myocardial infarction 30-day readmission rates among LTC- eligible populations**

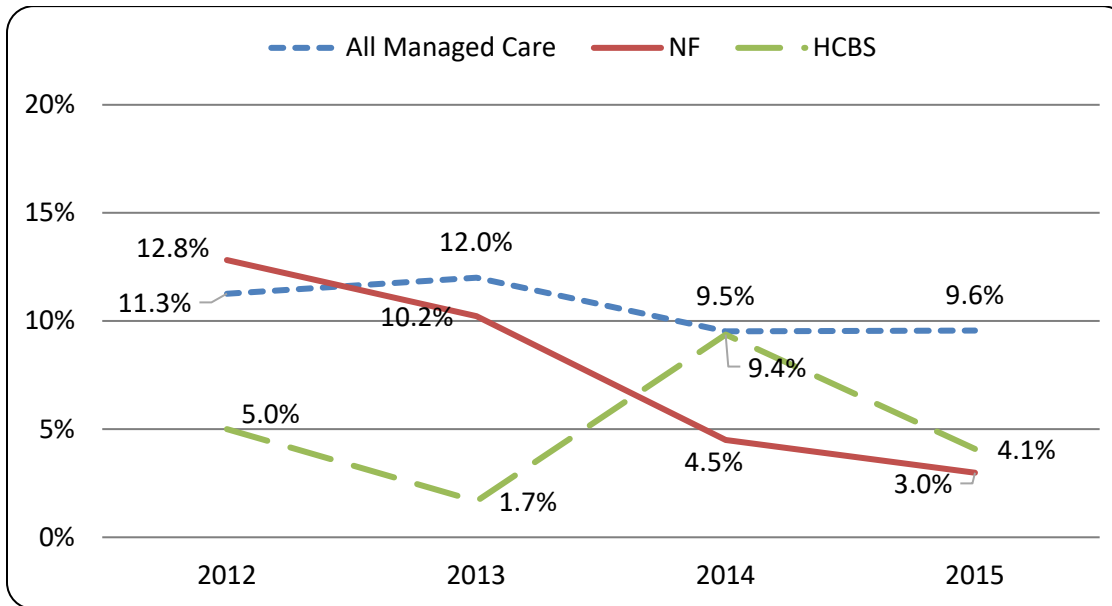
	<b>2012</b>	<b>2013</b>	<b>2014</b>	<b>2015</b>
<b>Long-Term Care Population</b>	10.2%	6.8%	5.8%	3.4%
Nursing Facility	12.8%	10.2%	4.5%	3.0%
HCBS	5.0%	1.7%	9.4%	4.1%

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: HCBS=Home and Community-Based Services.

Readmission rates are calculated for adults ages 18 and above.

**Figure 3A.7: Trends in acute myocardial infarction readmission rates among the Medicaid managed care and HCBS populations**



Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: HCBS=Home and Community-Based Services.

Readmission rates are calculated for adults ages 18 and above.

**Table 3A.23: Follow-up after hospitalization for mental illness by Medicaid eligibility category**

	7-Day Follow-up					30-Day Follow-up				
	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015
<b>Medicaid Overall</b>	29.7%	28.9%	28.3%	30.4%	31.3%	54.7%	53.9%	54.0%	55.0%	56.9%
Aged/Blind/Disabled	26.6%	25.8%	24.1%	26.0%	27.7%	50.8%	49.6%	48.8%	49.7%	53.4%
NJ FamilyCare	36.5%	36.6%	36.7%	37.8%	37.5%	62.6%	63.9%	64.1%	66.7%	64.9%
General Assistance	25.3%	27.7%	20.7%	30.4%	30.6%	52.0%	46.7%	48.3%	51.2%	54.3%
<b>Managed Care</b>	30.0%	29.2%	28.5%	30.7%	31.6%	55.3%	54.5%	54.3%	55.6%	57.2%
Aged/Blind/Disabled	26.6%	26.0%	24.1%	26.1%	27.8%	51.4%	50.1%	48.9%	49.8%	53.5%
NJ FamilyCare	36.6%	36.9%	36.8%	38.0%	37.7%	62.7%	64.3%	64.3%	67.0%	65.1%
General Assistance	32.2%	33.8%	21.6%	31.5%	31.1%	55.4%	51.9%	48.6%	53.2%	54.8%

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: Follow-up after hospitalization for mental illness is calculated for the population ages 6 and older.

**Table 3A.24: Follow-up after hospitalization for mental illness among LTC-eligible populations**

	7-Day Follow-up					30-Day Follow-up				
	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015
<b>Long-Term Care Population</b>										
HCBS	25.0%	30.4%	17.0%	*	*	40.6%	52.2%	29.8%	*	*

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: Follow-up after hospitalization for mental illness is calculated for the population ages 6 and older.

Estimates not calculated for the nursing facility population since follow-up visits must occur in the community to meet metric specifications.

\*Estimate suppressed due to insufficient sample size.



**Table 3A.25: Ambulatory visit within 14 days of discharge by Medicaid eligibility category**

	All Discharges					Discharged Home				
	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015
<b>Medicaid Overall</b>	33.0%	34.2%	33.1%	30.1%	30.5%	38.5%	39.5%	38.2%	33.7%	33.7%
Aged/Blind/Disabled	25.0%	26.4%	24.7%	22.2%	23.1%	31.5%	32.8%	30.7%	27.4%	27.9%
NJ FamilyCare	50.2%	49.9%	49.3%	46.5%	45.2%	50.6%	50.3%	49.7%	46.9%	45.7%
General Assistance	23.5%	23.2%	21.7%	26.1%	28.5%	24.5%	24.8%	24.3%	26.6%	29.4%
<b>Managed Care</b>	36.6%	36.7%	34.8%	31.5%	32.3%	40.0%	40.6%	39.0%	34.7%	34.4%
Aged/Blind/Disabled	28.8%	29.2%	26.5%	23.4%	25.5%	33.0%	33.9%	31.5%	28.0%	28.7%
NJ FamilyCare	50.6%	50.3%	49.6%	46.9%	45.6%	51.0%	50.7%	50.0%	47.4%	46.1%
General Assistance	27.8%	29.9%	25.5%	27.8%	29.2%	29.2%	32.3%	28.7%	28.4%	30.1%

	Discharged to Facility-based Rehabilitation					Discharged to Other Facility				
	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015
<b>Medicaid Overall</b>	5.2%	5.1%	5.4%	5.1%	6.4%	11.7%	16.8%	14.2%	15.9%	17.7%
Aged/Blind/Disabled	5.1%	5.0%	5.4%	4.7%	5.9%	8.0%	14.6%	11.1%	12.3%	14.5%
NJ FamilyCare	12.5%	16.7%	16.1%	8.9%	11.9%	34.9%	33.8%	32.2%	29.7%	26.6%
General Assistance	11.5%	8.5%	0.0%	11.8%	10.7%	*	*	*	20.3%	20.8%
<b>Managed Care</b>	6.1%	5.8%	5.9%	5.0%	7.2%	17.1%	20.4%	15.9%	17.5%	19.0%
Aged/Blind/Disabled	5.9%	5.6%	5.8%	4.6%	6.4%	12.2%	18.1%	12.5%	13.9%	15.9%
NJ FamilyCare	12.8%	16.9%	16.7%	8.1%	12.3%	35.1%	33.8%	32.4%	30.0%	26.8%
General Assistance	13.3%	11.5%	0.0%	12.3%	11.1%	*	*	*	20.5%	21.1%

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: Only one hospitalization per person is randomly chosen in each year to be an index hospitalization.

\*Estimate suppressed due to insufficient sample size.

**Table 3A.26: Ambulatory visit within 14 days of discharge among LTC-eligible populations**

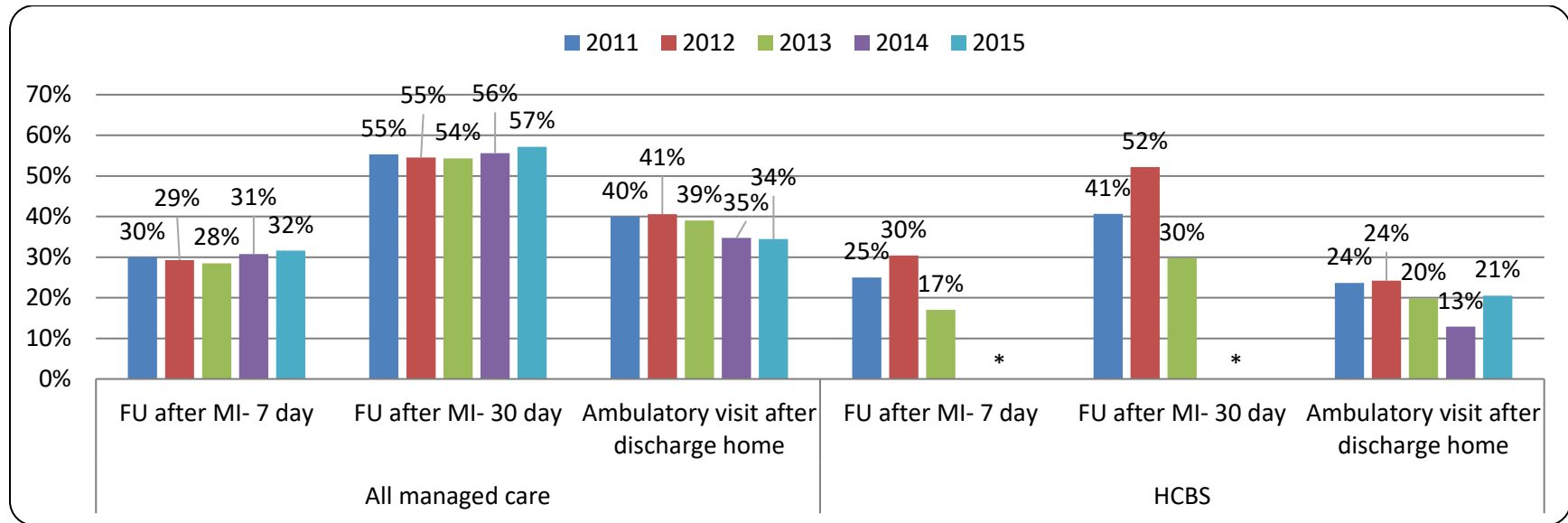
	All Discharges					Discharged Home				
	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015
<b>Long-Term Care Population</b>										
HCBS	18%	19.4%	15.7%	9.7%	16.4%	23.6%	24.2%	19.8%	12.9%	20.5%
	Discharged to Facility-Based Rehabilitation					Discharged to Other Facility				
	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015
<b>Long-Term Care Population</b>										
HCBS	4.9%	4.9%	4.5%	2.0%	4.9%	9.6%	14.4%	6.5%	1.9%	3.3%

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: Only one hospitalization per person is randomly chosen in each year to be an index hospitalization.

Estimates not calculated for the nursing facility population since follow-up visits must occur in the community to meet metric specifications.

**Figure 3A.8: Rates of follow-up and ambulatory visits after hospitalization among the Medicaid managed care and HCBS populations**

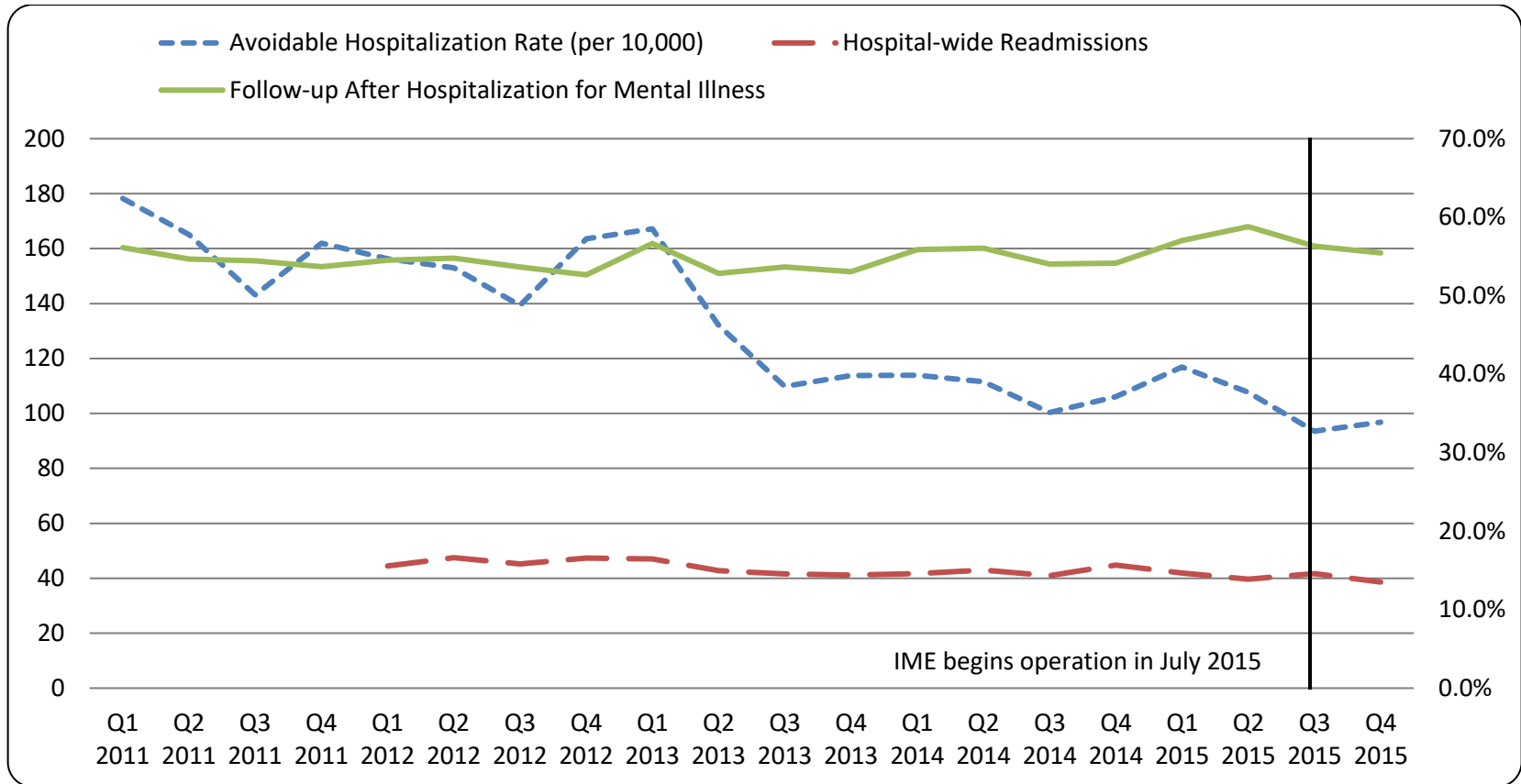


Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: HCBS=Home and Community-Based Services; FU=Follow-up; MI=Mental Illness.

\*Estimates for 2014 and 2015 suppressed due to insufficient sample size.

**Figure 3A.9: Selected quality metrics for the overall Medicaid population without managed behavioral health and having a behavioral health condition**



Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.  
 Notes: The DDD and MLTSS populations are excluded since their behavioral health care is managed by their MCO.

**Table 3A.27: Selected quality metrics for a cohort of HCBS beneficiaries by pre-MLTSS §1915(c) waiver program**

	Hospital-Wide 30-Day Readmission Rate				Avoidable Hospitalizations (per 10,000 beneficiaries)				
	2012	2013	2014	2015	2011	2012	2013	2014	2015
<b>1915(c) Enrollees</b>	9.1%	6.9%	7.4%	6.4%	738	788	686	609	714
CRPD	15.9%	15.9%	2.4%	7.3%	526	358	479	208	161
ACCAP	13.3%	6.7%	*	15.6%	387	449	179	298	189
TBI	4.9%	8.1%	16.0%	14.0%	135	132	225	257	329
GO	8.9%	6.6%	7.3%	6.1%	777	830	713	636	753

	Follow-up After Hospitalization for Mental Illness									
	7-day					30-Day				
	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015
<b>1915(c) Enrollees</b>	26.3%	38.9%	13.3%	*	*	50.0%	61.1%	28.9%	*	*
CRPD	--	--	--	--	--	--	--	--	--	--
ACCAP	--	*	*	--	--	--	*	*	--	--
TBI	*	*	*	--	*	*	*	*	--	*
GO	25.0%	40.0%	4.9%	*	*	50.0%	60.0%	12.2%	*	*

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: HCBS=Home and Community-Based Services.

\*Estimate suppressed due to insufficient sample size.

--No qualifying index admission in this category.

**Table 3A.28: Total and per person spending for LTSS and non-LTSS services among LTC-eligible populations**

	LTSS Spending (in millions of dollars)										LTSS Spending per LTC Person				
	2011		2012		2013		2014		2015		2011	2012	2013	2014	2015
<b>Long-Term Care Pop.</b>	\$2,012	100%	\$1,927	100%	\$1,900	100%	\$1,839	100%	\$1,721	100%	\$40,304	\$38,904	\$38,505	\$38,544	\$36,178
Nursing Facility	\$1,805	90%	\$1,707	89%	\$1,672	88%	\$1,628	88%	\$1,482	86%	\$48,773	\$47,412	\$47,262	\$47,353	\$46,152
HCBS	\$207	10%	\$220	11%	\$227	12%	\$212	12%	\$239	14%	\$16,012	\$16,247	\$16,296	\$15,860	\$15,444

	Non-LTSS Spending (in millions of dollars)										Non-LTSS Spending per LTC Person				
	2011		2012		2013		2014		2015		2011	2012	2013	2014	2015
<b>Long-Term Care Pop.</b>	\$253	100%	\$250	100%	\$249	100%	\$244	100%	\$244	100%	\$5,071	\$5,057	\$5,055	\$5,118	\$5,119
Nursing Facility	\$171	68%	\$162	65%	\$159	64%	\$168	69%	\$150	62%	\$4,634	\$4,487	\$4,493	\$4,882	\$4,670
HCBS	\$82	32%	\$89	35%	\$90	36%	\$76	31%	\$94	38%	\$6,327	\$6,574	\$6,479	\$5,726	\$6,052

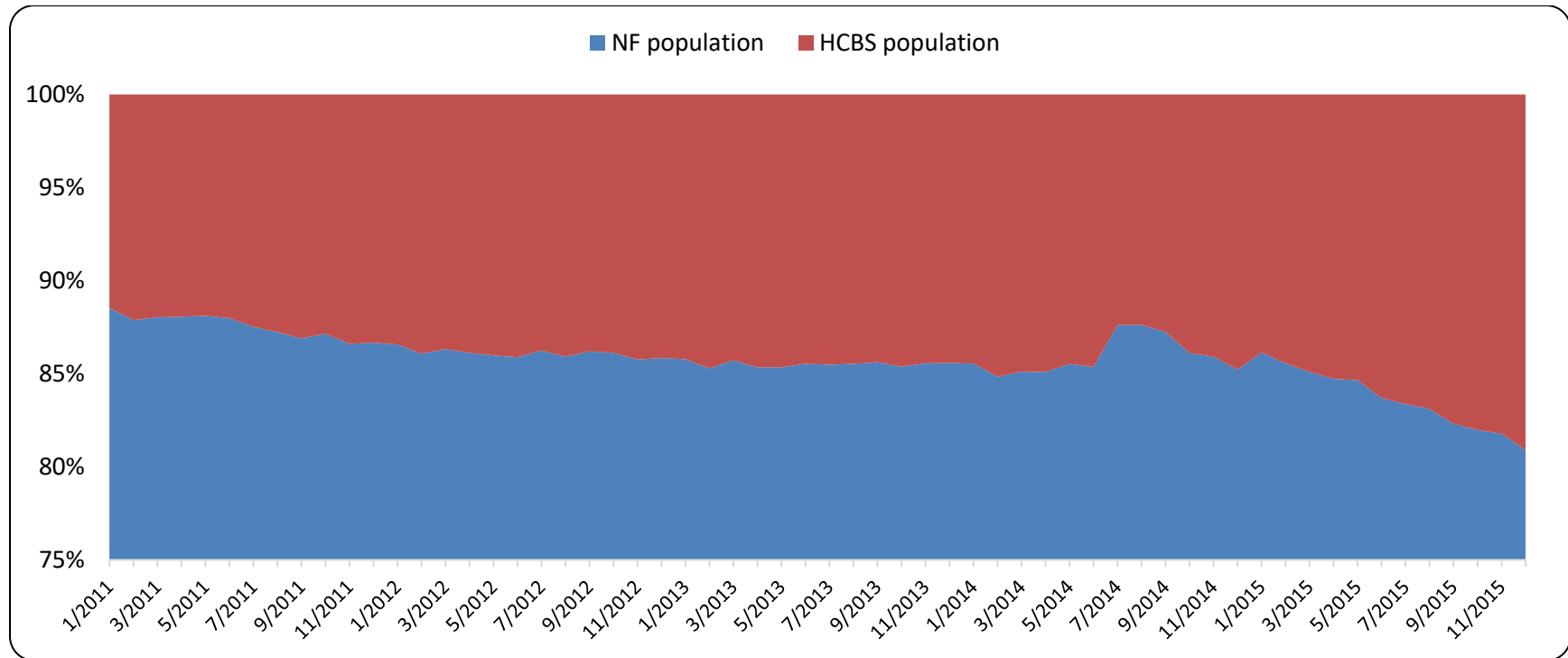
	Total Spending (in millions of dollars)										Total Spending per LTC Person				
	2011		2012		2013		2014		2015		2011	2012	2013	2014	2015
<b>Long-Term Care Pop.</b>	\$2,265	100%	\$2,178	100%	\$2,149	100%	\$2,084	100%	\$1,965	100%	\$45,375	\$43,961	\$43,559	\$43,662	\$41,297
Nursing Facility	\$1,977	87%	\$1,869	86%	\$1,831	85%	\$1,795	86%	\$1,632	83%	\$53,407	\$51,899	\$51,755	\$52,234	\$50,822
HCBS	\$288	13%	\$309	14%	\$318	15%	\$288	14%	\$332	17%	\$22,339	\$22,821	\$22,775	\$21,587	\$21,496

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: LTSS=Long-term services and supports; LTC=Long-term care; HCBS=Home and Community-Based Services.

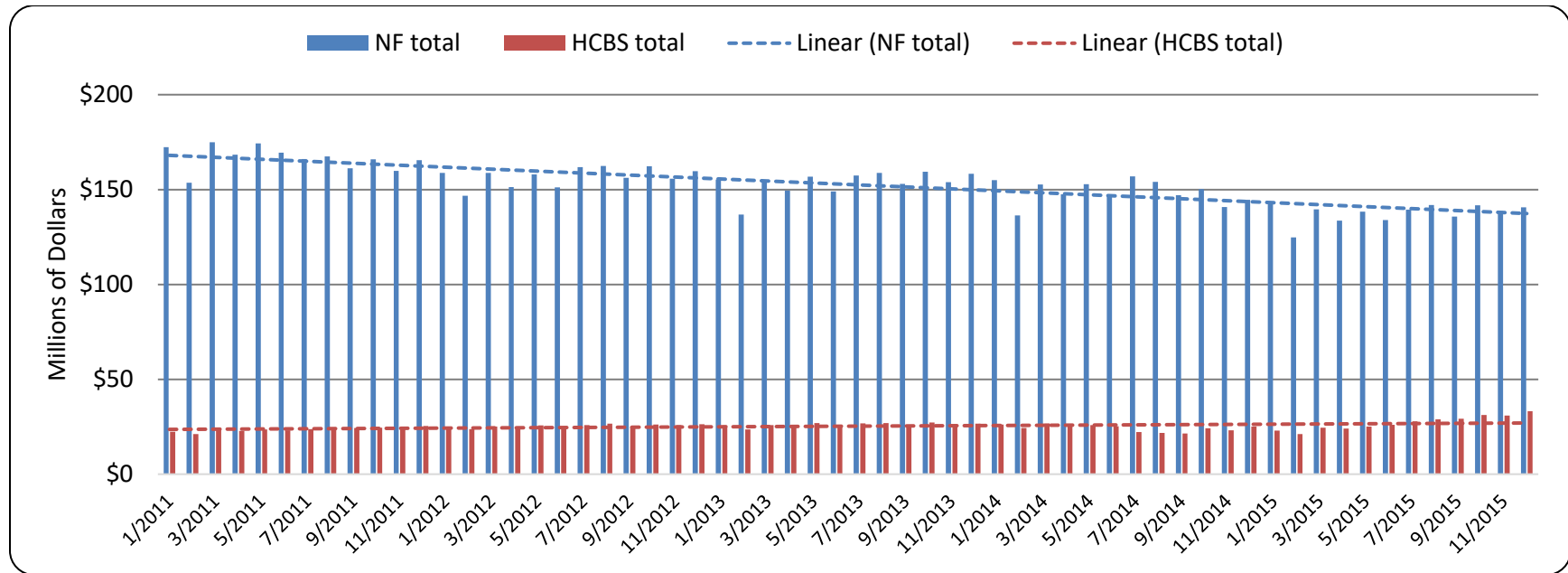
All spending is in 2012 dollars.

**Figure 3A.10: Share of total spending for the nursing facility and HCBS populations**



Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.  
 Notes: NF=Nursing Facility; HCBS=Home and Community-Based Services.  
 Vertical axis begins at 75%.

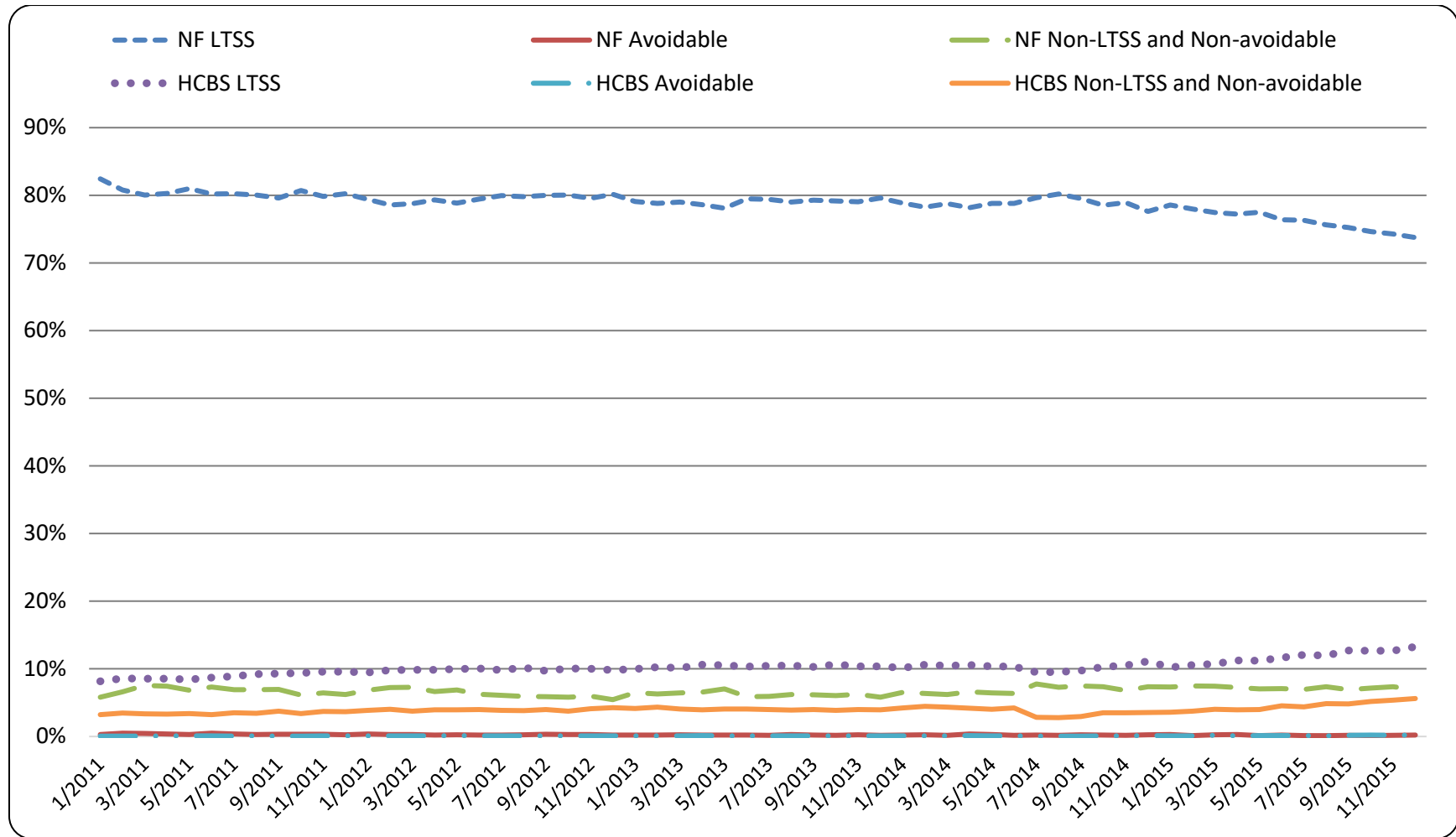
**Figure 3A.11: Total spending for the nursing facility and HCBS populations**



Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.  
 Notes: NF=Nursing Facility; HCBS=Home and Community-Based Services.  
 All spending is in 2012 dollars.



**Figure 3A.12: Shares of different components of spending for the NF and HCBS populations**



Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: NF=Nursing Facility; HCBS=Home and Community-Based Services; LTSS=Long-Term Services and Supports.

All spending is in 2012 dollars.

## **Section B**

*Avoidable Inpatient Hospitalizations, ED Visit Rates, and Associated Costs:* Table 3B.1 reports the Segmented Regression Analysis-based effect of the MLTSS program on the overall managed care population reflected in potential changes in rates of avoidable inpatient hospitalizations and ED visits among the universe of managed care enrollees. There is no significant impact of MLTSS on avoidable inpatient utilization, but we observe significant effects on avoidable ED utilization. While there is a statistically significant increase in avoidable ED visits immediately following the implementation of MLTSS, there is also a significant decrease in the trend over the subsequent six quarters. The magnitude of these changes are two or less visits per 1,000 managed care beneficiaries per quarter. By the end of 2015 that amounts to 11 ( $=1000 \times -0.01097$ ) fewer avoidable ED visits per 1,000 beneficiaries than there would have been without MLTSS. The corresponding change in terms of avoidable hospitalizations is 1 additional outcome per 10,000 beneficiaries, but this is not statistically significant.

Figures 3B.1 and 3B.2 provide graphical interpretations of the *net changes* reported in Table 3B.1 by line graphs denoting probability of avoidable utilization based on the regression modeling. In the post-implementation period spanning July-December 2015, the solid line graph gives the values taking into account the MLTSS implementation, and the dotted line graph gives counterfactual values without MLTSS implementation. The difference between the two line graphs gives the effect of the MLTSS program. Specifically, if at any point of time the dotted line is above the solid line (implying that the counterfactual value is higher than the MLTSS-based value) this reflects a decrease in avoidable utilizations signifying a positive effect on ambulatory/primary care-related quality. It is important to note that this difference may change over the post-implementation period. Table 3B.1 above provided the difference at the end of the study period, i.e., at the sixth quarter, post MLTSS implementation.

Table 3B.2 provides the unadjusted DD estimate based on the observed rates of the two types of avoidable events separately for the HCBS population, the NF population, and the comparison group in the pre- and post-MLTSS period. Table 3B.3 reports the adjusted effects based on the DD estimation comparing changes over time in the HCBS population relative to the comparison group, and separately, for the MLTSS NF population compared to the comparison group. We observe no statistically significant impact of MLTSS on avoidable inpatient utilization by the HCBS or NF population. The avoidable ED impact estimate, however, indicates the MLTSS implementation increased the rate of avoidable ED visits over a quarter by 13 per 1,000 HCBS beneficiaries and this change was statistically significant. The effect for the nursing facility population over a quarter was a decline of 5 per 1,000 beneficiaries and this effect was only marginally significant ( $p < 0.1$ ). There was a statistically significant difference in avoidable ED visit trends between HCBS and the comparison group prior to MLTSS, and this trend was in the same

direction of the estimated effect which results in the statistical model overestimating the true effect. That said, the overestimation was less than one-tenth the magnitude of the reported DD-estimated effect size and does not necessitate modification of our inferred policy effect.

Table 3B.4 reports per person, per quarter costs associated with avoidable inpatient hospitalizations or ED visits for the HCBS, NF, and comparison group for the pre- and post-MLTSS periods. This table further reports the ratio of ratios (ROR) of these costs where a magnitude greater than one reflects a positive association between the policy and avoidable costs. Table 3B.5 reports a similar ROR estimate that is calculated using a gamma regression with a log link that adjusts for patient and area level characteristics. We find that the MLTSS policy significantly increases avoidable IP costs for the HCBS population, but not the NF population. It also significantly decreases avoidable ED costs in the NF population, but does not have a significant impact on avoidable ED costs for the HCBS population.

*Hospital Readmissions:* Table 3B.6 reports the SRA-based effect of the MLTSS program on the overall managed care population reflected in potential changes in readmission rates among the universe of managed care enrollees. The coefficients corresponding to the variable *MLTSS post* give the change in the *level* of readmission likelihood immediately after the MLTSS implementation, and we find mixed results depending on the type of admission. The level change in 30-day readmission likelihood is positive for hospital-wide and heart failure admissions and negative for AMI and pneumonia admissions. None of the level changes are statistically significant. The change in trend given by the coefficients corresponding to *MLTSS time* are negative for all readmission metrics we examined and only significant for hospital-wide readmissions. We assess the joint statistical significant of these effects and find that there is a significant negative effect ( $p < 0.05$ ) on hospital-wide readmissions. This can be interpreted as an improvement in readmission related quality for the Medicaid managed care population as a whole. Specifically this represents a decrease in the likelihood of readmission by 4.6 pp by the last month of 2015.

As explained above, Figures 3B.3-3B.6 compare the MLTSS rates to the counterfactual rate for the four readmission metrics. While the distance between bifurcating lines represent the effect of the MLTSS program, only that relating to hospital wide readmissions represents a statistical significant effect.

Table 3B.7 provides the unadjusted DD estimate capturing the effect of the MLTSS implementation on the HCBS and NF populations that is based on the observed readmission rates for the HCBS, NF, and comparison population in the pre- and post-MLTSS implementation period. While these estimates do not take into account the differing beneficiary and provider

characteristics that are important to account for while examining the policy effect, they are informative since in addition to providing a starting estimate, they further demonstrate the way DD estimates are computed. Taking the case of pneumonia readmissions among the HCBS population, the unadjusted DD estimate is the change in readmission rate for the HCBS population from pre to post-MLTSS implementation period less the change for the comparison group over the same period. The difference in these two differences reflects the unadjusted policy effect, in this case a 6.1 percentage point (pp) increase in readmissions following hospitalization for pneumonia among the HCBS population.

Table 3B.8 reports the adjusted effects that take into account differences in patient and provider characteristics. These may be different from the unadjusted estimates and are relevant for estimating the true policy effect. Across all readmission metrics, estimated effects are positive indicating increases in the probability of hospital readmission for the HCBS and NF populations in MLTSS, but these increases are only statistically significant at the 5% level or less in two cases. Among the MLTSS NF population, the adjusted effect size was 0.0865. This should be interpreted as an 8.7 pp increase in hospital-wide 30-day readmissions due to MLTSS implementation for the NF population. We observe a 1.2 pp increase for the HCBS population, but this was only marginally significant ( $p < 0.1$ ). The other strongly significant finding was for pneumonia readmissions, where the adjusted effect size for the HCBS population indicates a 6.1 pp increase in pneumonia readmission rates due to the MLTSS implementation (in this case, unchanged from the unadjusted estimate). Due to small numbers of MLTSS NF residents with a qualifying heart failure or AMI index hospitalization in the post-MLTSS period, there are statistical issues with the reliability of the results of these two models.

Table 3B.9 shows the SRA-based effect of the MLTSS policy on hospital-wide readmissions among Medicaid managed care beneficiaries with a behavioral health condition. Similar to the findings for the entire managed care population, there was no statistically significant impact of MLTSS on the level, but the 0.3 pp decline each month of MLTSS in the probability of readmission for this population was statistically significant at the 5% level. The combined effect of both the level and trend changes was also significant. By December 2015, hospital-wide readmissions were 5.2 pp lower for the managed care population with a BH condition than they would have been without MLTSS. Figure 3B.7 depicts the probability of readmission for a managed care beneficiary with a behavioral health condition with the MLTSS effect and alongside, the calculated counterfactual.

Table 3B.10 provides the unadjusted DD estimate based on the observed rates of hospital-wide readmission for the HCBS population with a behavioral health condition, the NF population with a BH condition, and the comparison group in the pre- and post-MLTSS periods. The unadjusted difference in the differences is a 3.2 pp increase in the readmission rate among the HCBS

population with a BH condition in the post-MLTSS period and a 7.3 pp increase in the rate for the NF population with a BH condition during that period. Table 3B.11 reports the adjusted effects based on the DD estimation comparing changes over time of hospital-wide readmissions for the HCBS population with a BH condition compared to that in the comparison group. Based on these estimates, the increased probability of a readmission for the HCBS population after adjustment is a 1.5 pp increase that is only marginally significant. In contrast, the adjusted effect for the NF population is 0.09, meaning the MLTSS implementation increased the hospital-wide readmission rate among the NF population with a BH condition by 9 pp. The effect is statistically significant.

*Follow-up after Hospitalization for Mental Illness:* Table 3B.12 reports the SRA-based effect of the MLTSS program on the overall managed care population reflected in potential changes in follow-up after hospitalizations for mental illness among the universe of managed care enrollees. Residents of nursing facilities or intermediate care facilities were excluded in the regression model since follow-up care provided in the facility might not be captured in claims data. There are decreases in level and also the trend in follow up rates within 7 and 30 days of hospitalization as indicated by the coefficients of *MLTSS post* and *MLTSS time*. Figure 3B.8 shows the rates after MLTSS are lower than the calculated counterfactual rates. These decreases are not statistically significant.

Table 3B.13 provides the unadjusted estimates based on the observed rates of follow up for the HCBS population and the comparison group in the pre- and post-MLTSS period. Due to small numbers of qualifying mental illness index hospitalizations for the HCBS population post-MLTSS, estimates of the follow-up visit rates could not be reported. Table 3B.14 reports the adjusted effects based on the DD estimation comparing changes over time in the HCBS population compared to that in the comparison group. Residents of intermediate care facilities were excluded from the comparison population in the regression model since follow-up care provided in the facility might not be captured in claims data. Based on these estimates, the MLTSS implementation increased the follow up rate within 7 days of a mental illness hospitalization by 6.7 pp, but decreased the follow-up within 30 days by 3.1 pp. Neither effect is statistically significant, and, due to small numbers of HCBS beneficiaries with a qualifying mental illness index hospitalization in the post-MLTSS period, there are statistical issues with the reliability of these results.

*Ambulatory Visit after Hospitalization:* Table 3B.15 reports the SRA-based effect of the MLTSS program on the overall managed care population reflected in potential changes in ambulatory visit rates after discharge home from hospitalization among the universe of managed care enrollees. Residents of nursing facilities or intermediate care facilities were excluded in the regression model since follow-up care provided in the facility might not be captured in claims

data. The increases in the level and also the trend of such visits as indicated by the coefficients of *MLTSS post* and *MLTSS time* respectively are positive. The level estimate shows a 1.4 pp increase in the probability of an ambulatory visit following discharge home and this is statistically significant. The trend effect is less than one-hundredth of a pp and is not statistically significant. Figure 3B.9 demonstrates that the rates based on MLTSS are higher than the calculated counterfactual rates. In December 2015, the likelihood of an ambulatory visit was 1.6 pp higher due to MLTSS though the effect was statistically significant at only 10% level.

Table 3B.16 provides the unadjusted DD estimate based on the observed rates of post-discharge ambulatory visits for the HCBS population and the comparison group in the pre- and post-MLTSS period. Table 3B.17 reports the adjusted effects based on the DD estimation comparing changes over time in the HCBS population compared to the comparison group. Residents of intermediate care facilities were excluded from the comparison population in the regression model since follow-up care provided in the facility might not be captured in claims data, and this outcome was not modeled for the NF population for the same reason. Based on this estimate, the MLTSS implementation increased the probability of an ambulatory visit 14 days following discharge from a medical hospitalization by 0.6 pp. This effect is not statistically significant.

*Racial/Ethnic Disparities in Avoidable Inpatient Hospitalizations and Hospital-Wide Readmissions:* Table 3B.18 provides the race-specific unadjusted DD estimates based on the observed rates of avoidable inpatient hospitalizations and observed hospital-wide readmission rates separately for the HCBS population, the NF population, and the comparison group in the pre- and post-MLTSS period. It then shows the difference between these unadjusted DD estimates for black, Hispanic, and beneficiaries of other race/ethnicity compared to whites. Taking the black HCBS population and avoidable hospitalizations as an example, the unadjusted disparity effect of 0.16 indicates that the change in the probability of an avoidable hospitalization after MLTSS was 0.16 pp higher for black individuals receiving HCBS than for white HCBS recipients. This reflects a worsening in readmission care for blacks relative to whites. Table 3B.19 reports the adjusted effects based on the DD estimation comparing changes over time in the HCBS population relative to the comparison group, and separately, for the MLTSS NF population compared to the comparison group. We observe no statistically significant racial/ethnic disparities in the impact of MLTSS on avoidable hospitalizations. We do observe a statistically significant increase in the probability of hospital readmissions for black individuals receiving HCBS. This should be interpreted as a 4.4 pp greater increase in the readmission rate for blacks compared to whites after MLTSS implementation.

**Table 3B.1: MLTSS impact on avoidable hospitalizations and ED visits among the Medicaid managed care population**

<b>MLTSS Impact Estimates (n=28,728,949)</b>	<b>Avoidable Inpatient Utilization</b>	<b>Avoidable ED Utilization</b>
mltss_post	-0.00005 (0.00005)	0.00126** (0.00061)
mltss_quarter	0.00003 (0.00005)	-0.00204*** (0.00057)
Overall statistical significance		***
Net change as of Dec. 2015	0.00011	-0.01097***

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: ED=Emergency Department.

Person-quarter level segmented regression analysis with zip code fixed effects.

Avoidable inpatient utilization rate denotes the likelihood of at least one avoidable hospitalization by a Medicaid beneficiary during the quarter. Avoidable ED utilization rate denotes the sum total of ED visits by a person during a quarter.

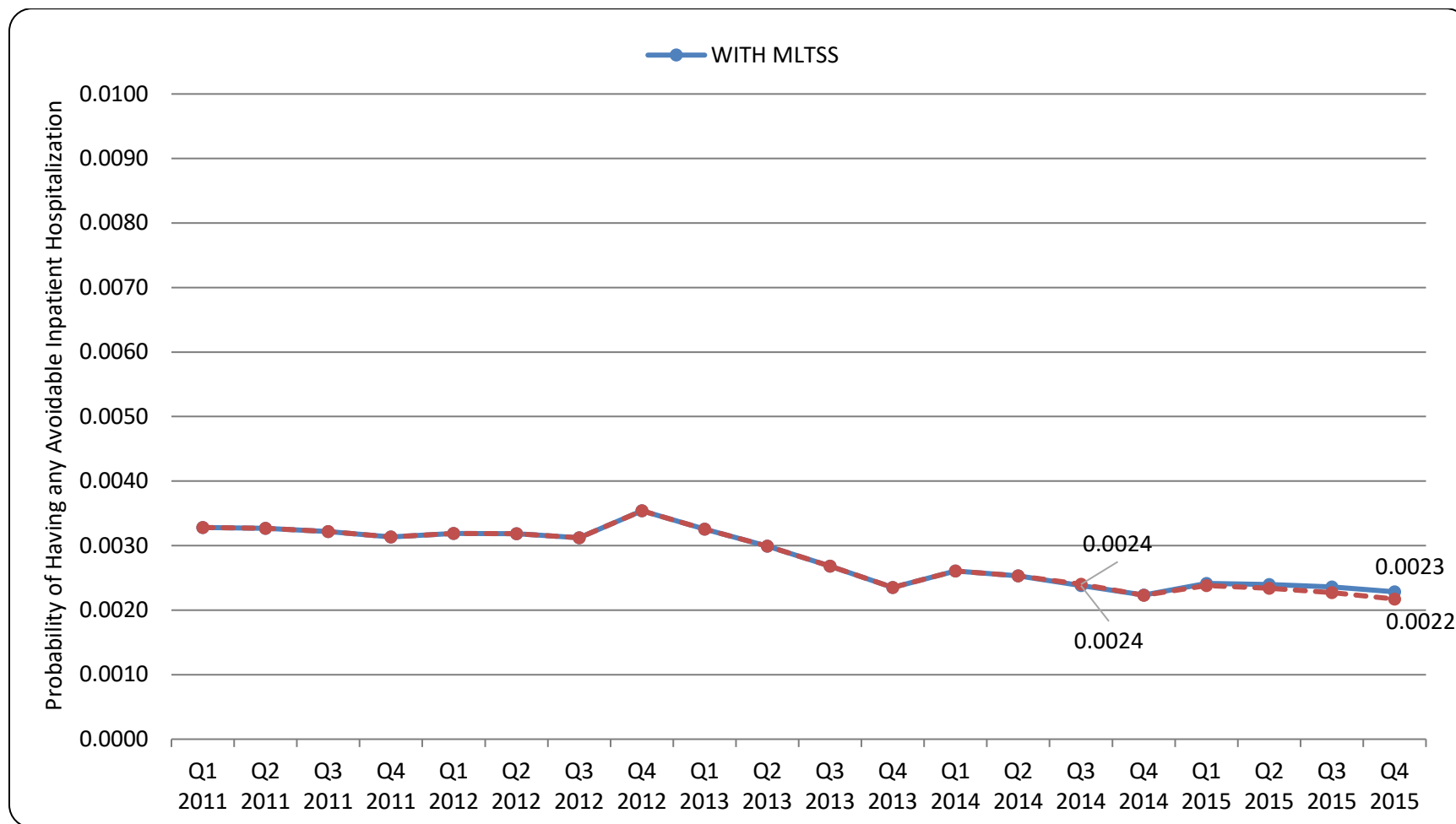
Models adjusted for sex, elderly status, quarterly time trends, waiver initiation, Medicaid expansion, CDPS risk category, and enrollment days per quarter.

Overall statistical significance is noted as n.s. (not significant) if the joint effect of mltss\_post and mltss\_quarter was not significant.

Robust standard errors in parentheses.

\*\*\* p<0.01, \*\* p<0.05, \* p<0.1

**Figure 3B.1: Regression-based rates of avoidable inpatient hospitalizations with and without MLTSS effect among the Medicaid managed care population**

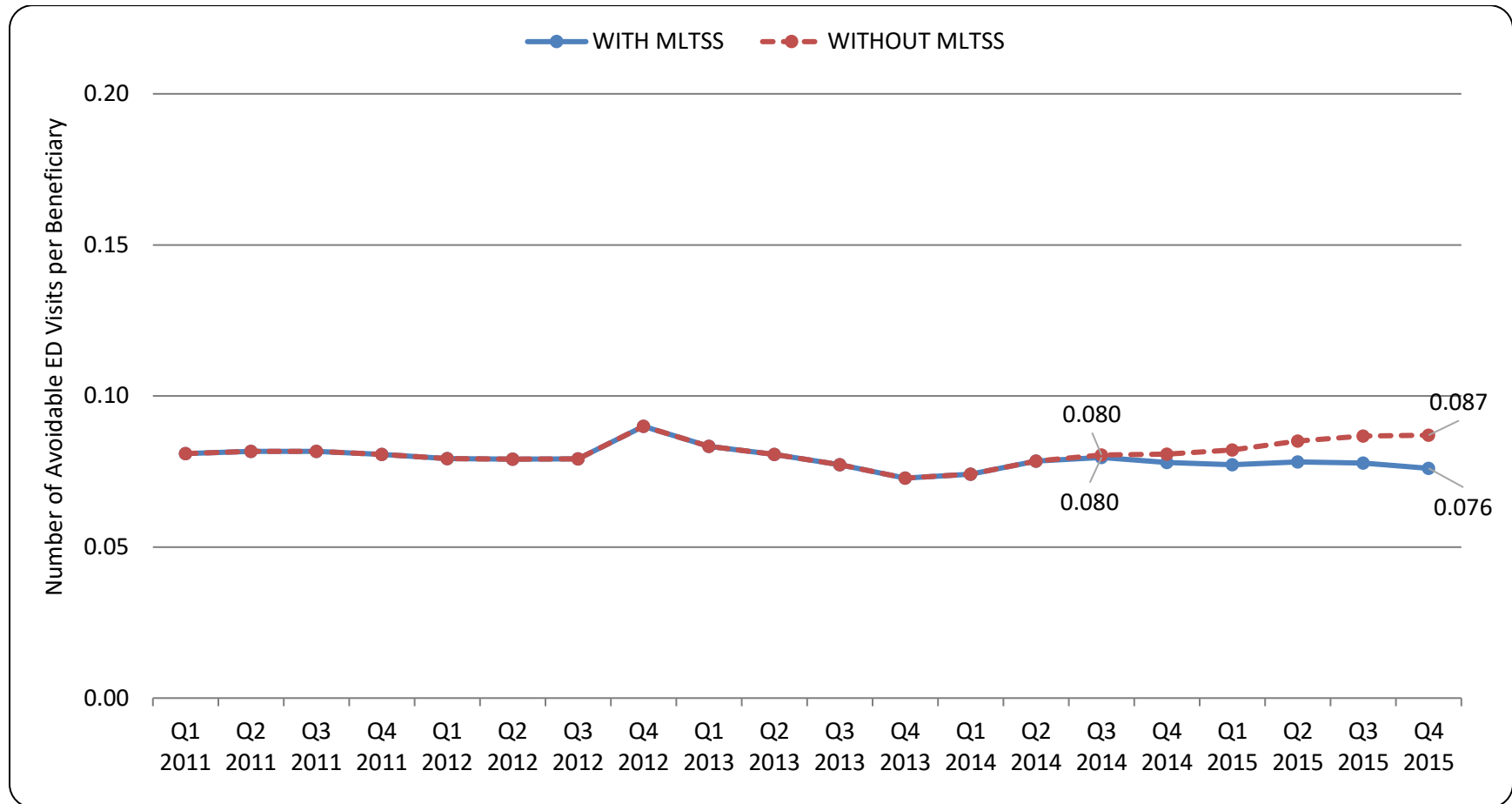


Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: The vertical axis denotes the numerical probability of hospitalization. This ranges from zero to a maximum of 1 denoting 100% probability. Here, the probability of an avoidable inpatient hospitalization is <1% in every quarter.



**Figure 3B.2: Regression-based rates of avoidable ED visits with and without MLTSS effect among the Medicaid managed care population**



Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.  
 Notes: ED=Emergency Department.

**Table 3B.2: Unadjusted MLTSS impact on avoidable hospitalizations and ED visit rates among the HCBS and NF populations**

	non-LTC ABD		HCBS			NF		
	pre-MLTSS (a)	post-MLTSS (b)	pre-MLTSS (c)	post-MLTSS (d)	Unadjusted DD <sup>a</sup>	pre-MLTSS (e)	post-MLTSS (f)	Unadjusted DD <sup>b</sup>
Average rate of avoidable IP hospitalizations per quarter	1.0%	0.8%	2.2%	1.7%	-0.2	1.2%	1.2%	0.3
Average number of avoidable ED visits per quarter	0.10	0.09	0.06	0.06	0.01	0.03	0.03	0.01

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: HCBS=Home and Community-Based Services; LTC=Long-term Care; ABD=Aged/Blind/Disabled; DD=Difference in Differences; IP=Inpatient; ED=Emergency Department; NF=Nursing Facility.

Avoidable inpatient utilization rate denotes the average likelihood of at least one avoidable hospitalization by a Medicaid beneficiary during the quarter.

Avoidable ED utilization rate denotes the sum total of ED visits by a person during a quarter.

Not adjusted for beneficiary or area characteristics.

For avoidable inpatient hospitalizations the unadjusted difference in differences is a percentage point change.

<sup>a</sup>Calculated as  $[d-c]-[b-a]$

<sup>b</sup>Calculated as  $[f-e]-[b-a]$

**Table 3B.3: Adjusted MLTSS impact on avoidable inpatient hospitalizations and ED visit rates among the HCBS and NF populations**

MLTSS Impact Estimates	Avoidable Inpatient Utilization	Avoidable ED Utilization
<i>(n=5,472,818)</i>		
HCBS * Post-MLTSS	0.00041 (0.00064)	0.01335*** (0.00223)
<i>(n=5,670,368)</i>		
NF * Post-MLTSS	0.00041 (0.00095)	-0.00538* (0.003)

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: ED=Emergency Department; HCBS=Home and Community-Based Services; NF=Nursing Facility.

Person-quarter level difference-in-differences regression analysis with zip code fixed effects.

Models adjusted for sex, elderly status, quarterly time trends, waiver initiation, Medicaid expansion, CDPS risk category, and enrollment days per quarter.

Significant difference in avoidable ED pre-trends between HCBS and comparison group equaling 0.00065.

Robust standard errors in parentheses.

\*\*\* p<0.01, \*\* p<0.05, \* p<0.1

**Table 3B.4: Unadjusted MLTSS impact on average per person, per quarter costs related to avoidable inpatient hospitalizations and ED visits among the HCBS and NF populations**

	non-LTC ABD		HCBS			NF		
	pre-MLTSS <i>(a)</i>	post-MLTSS <i>(b)</i>	pre-MLTSS <i>(c)</i>	post-MLTSS <i>(d)</i>	Unadjusted Ratio of Ratios <sup>a</sup>	pre-MLTSS <i>(e)</i>	post-MLTSS <i>(f)</i>	Unadjusted Ratio of Ratios <sup>b</sup>
Avoidable IP cost	\$47.19	\$36.14	\$35.34	\$37.78	1.40	\$38.50	\$44.57	1.51
Avoidable ED cost	\$20.60	\$21.20	\$6.32	\$8.22	1.26	\$5.48	\$5.20	0.92

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: IP=Inpatient; ED=Emergency Department; HCBS=Home and Community-Based Services; LTC=Long-term Care; ABD=Aged/Blind/Disabled; NF=Nursing Facility.

Unadjusted observed costs calculated by dividing total costs relating to a group by the number of person-quarters in the period.

Not adjusted for beneficiary or area characteristics.

<sup>a</sup>Calculated as  $[d/c]/[b/a]$

<sup>b</sup>Calculated as  $[f/e]/[b/a]$

**Table 3B.5: Adjusted MLTSS impact on avoidable inpatient and avoidable ED costs among the HCBS and NF populations**

MLTSS Impact Estimates	Avoidable Inpatient Costs	Avoidable ED Costs
<i>(n=5,472,818)</i>		
HCBS * Post-MLTSS	2.3274*** (0.450)	.9418 (0.0543)
<i>(n=5,670,368)</i>		
NF * Post-MLTSS	1.3596 (0.269)	.6817*** (0.0682)

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: ED=Emergency Department; HCBS=Home and Community-Based Services; NF=Nursing Facility. Person-quarter level gamma regression analysis with log link and zip code fixed effects. Table reports the exponentiated coefficient of the interaction term giving the ratio of the two ratios as described in Table 3B.4, but after adjusting for patient and geographic factors.

Models adjusted for sex, elderly status, CDPS risk category, and enrollment days per quarter.

Robust standard errors in parentheses.

\*\*\* p<0.01, \*\* p<0.05, \* p<0.1

**Table 3B.6: MLTSS impact on hospital readmissions among the Medicaid managed care population**

<b>MLTSS Impact Estimates</b>	<b>Hospital-Wide</b> <i>(n=283,930)</i>	<b>Heart Failure</b> <i>(n=8,573)</i>	<b>AMI</b> <i>(n=3,450)</i>	<b>Pneumonia</b> <i>(n=8,297)</i>
mltss_post	0.00089 (0.00394)	0.02243 (0.02418)	-0.04616 (0.03422)	-0.00738 (0.02751)
mltss_time	-0.00261*** (0.00101)	-0.00588 (0.00673)	-0.01396 (0.00933)	-0.00396 (0.00539)
Overall statistical significance	***	n.s.	n.s.	n.s.
Net change as of Dec. 2015	-0.04617**	-0.08334	-0.29736	-0.07866

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: AMI=Acute Myocardial Infarction.

Hospital readmissions for initial index hospitalizations that may be all-cause or related to heart failure, AMI, or pneumonia.

Discharge-level segmented regression analysis with hospital fixed effects.

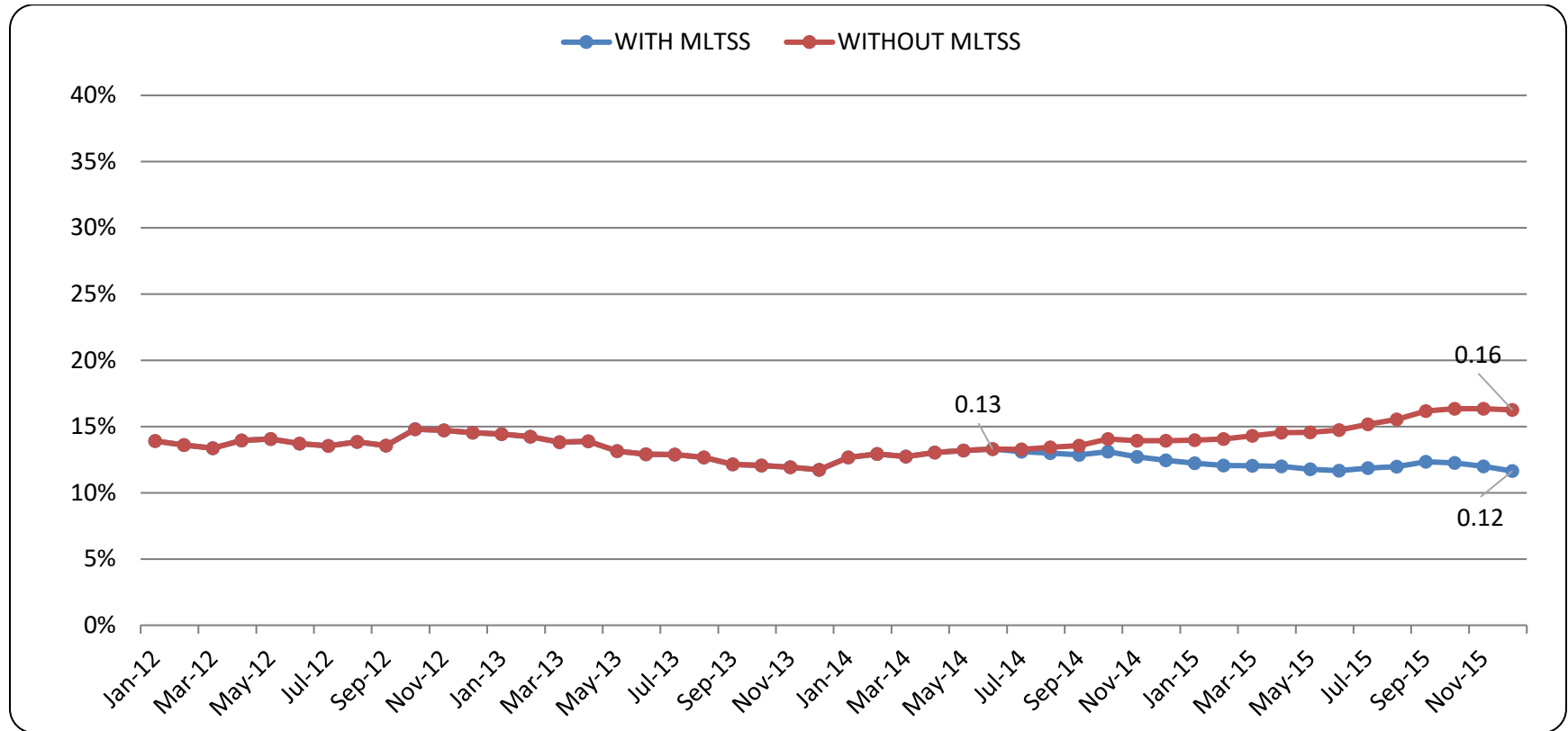
Models adjusted for sex, elderly status, monthly time trends, waiver initiation, Medicaid expansion, and all condition-specific risk factors listed in Appendix F.

Overall statistical significance is noted as n.s. (not significant) if the joint effect of mltss\_post and mltss\_time was not significant.

Robust standard errors in parentheses.

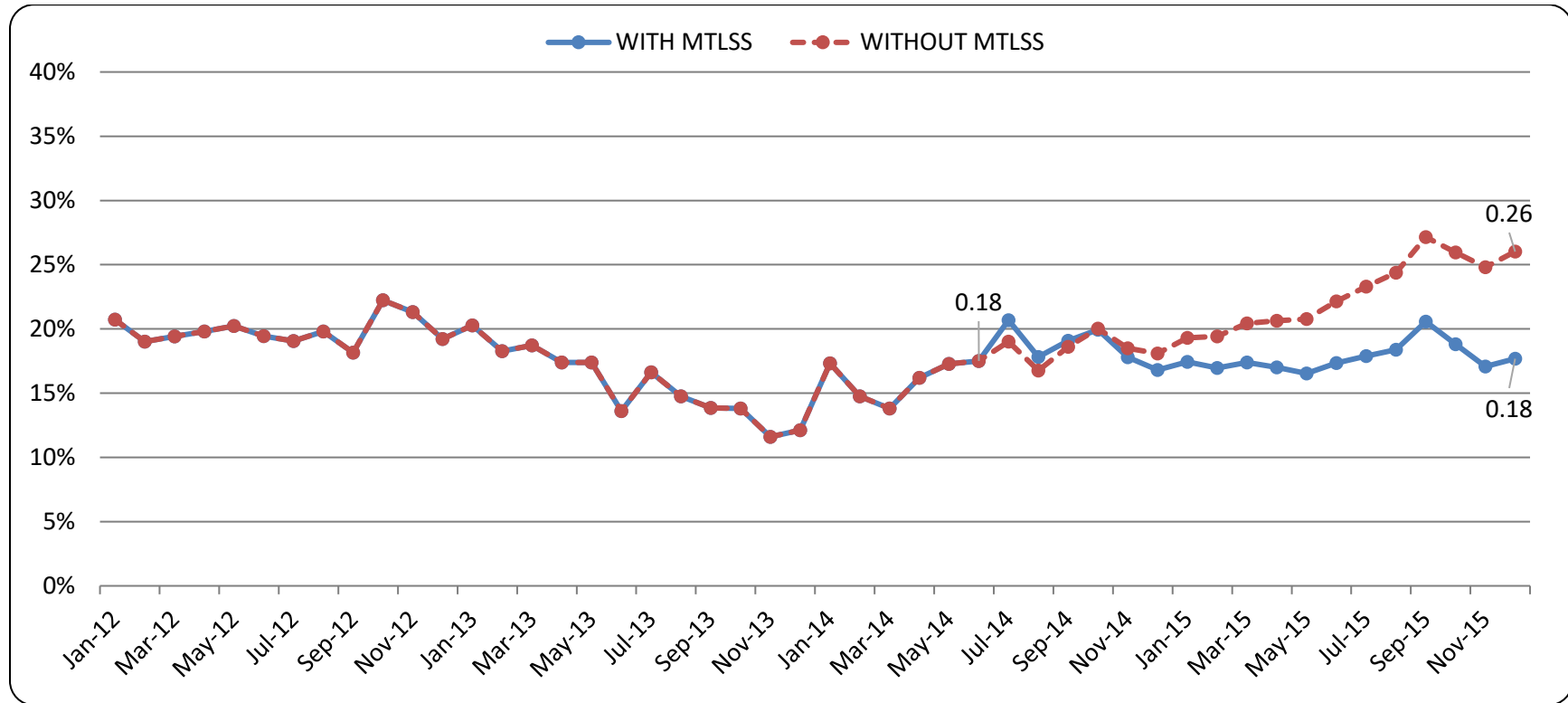
\*\*\* p<0.01, \*\* p<0.05, \* p<0.1

**Figure 3B.3: Regression-based probability of 30-day readmission following all-cause hospitalizations with and without MLTSS effect among the Medicaid managed care population**



Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

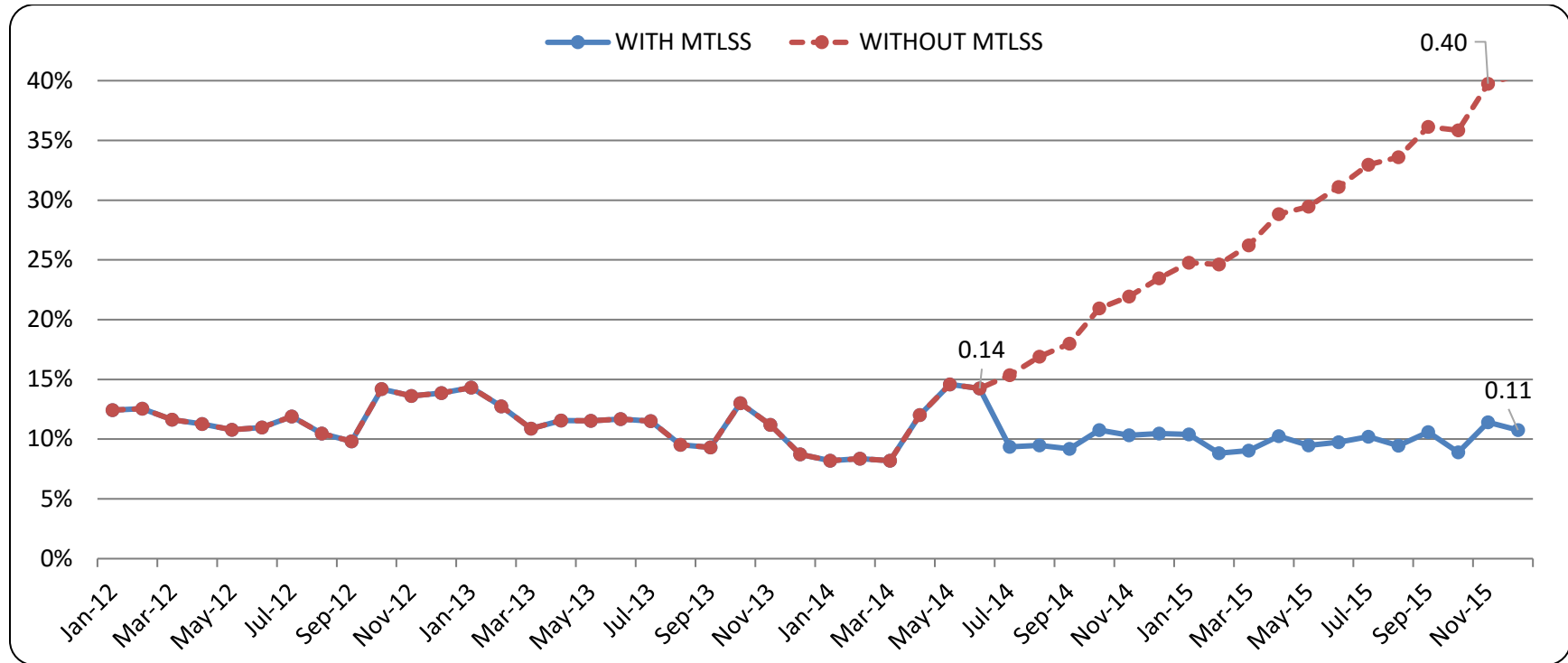
**Figure 3B.4: Regression-based probability of 30-day readmission following heart failure hospitalizations with and without MLTSS effect among the Medicaid managed care population**



Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

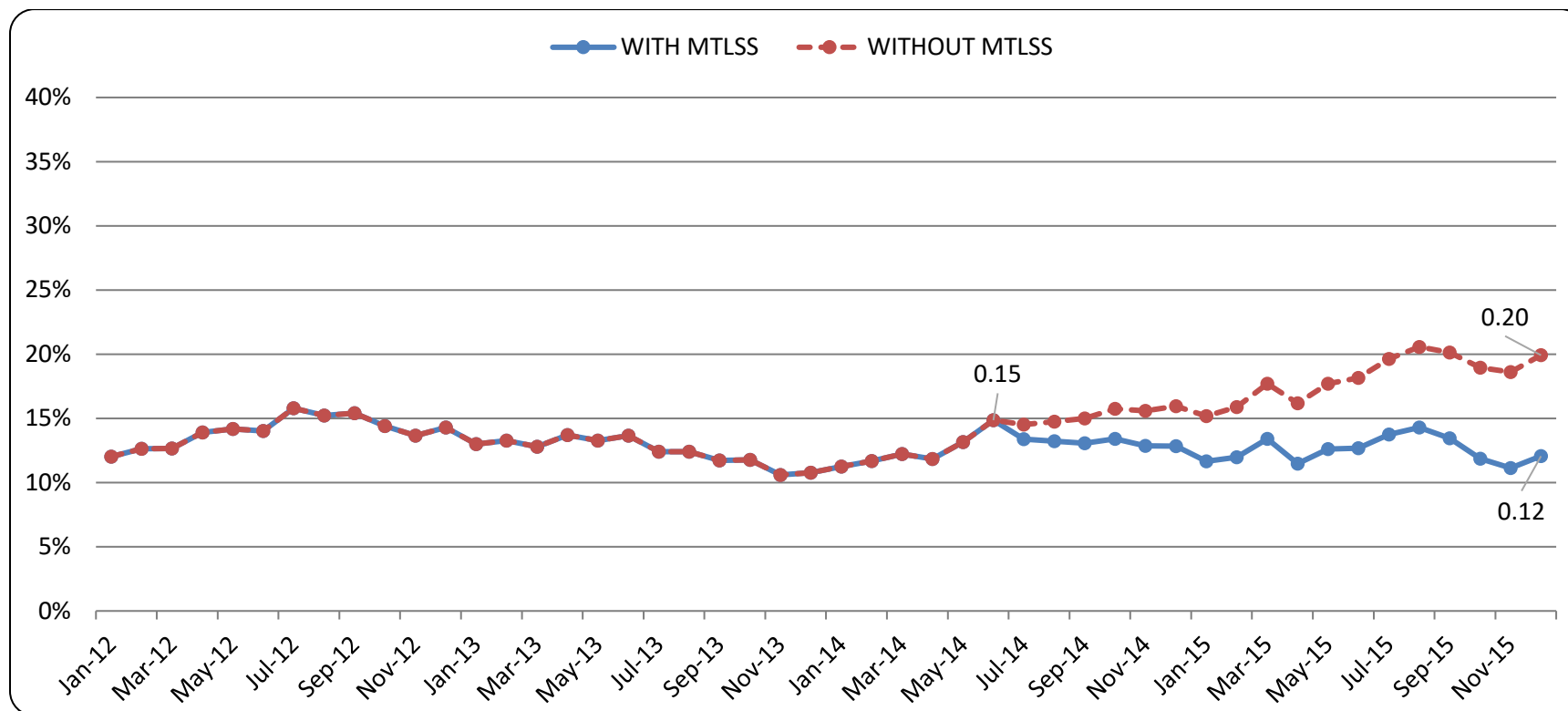


**Figure 3B.5: Regression-based probability of 30-day readmission following acute myocardial infarction hospitalizations with and without MLTSS effect among the Medicaid managed care population**



Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

**Figure 3B.6: Regression-based probability of 30-day readmission following pneumonia hospitalizations with and without MLTSS effect among the Medicaid managed care population**



Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

**Table 3B.7: Unadjusted MLTSS impact on 30-day hospital readmission rates among the HCBS and NF populations**

Readmission Type	non-LTC ABD		HCBS			NF		
	pre-MLTSS (a)	post-MLTSS (b)	pre-MLTSS (c)	post-MLTSS (d)	Unadjusted DD <sup>a</sup>	pre-MLTSS (e)	post-MLTSS (f)	Unadjusted DD <sup>b</sup>
Hospital-Wide	15.4%	14.3%	8.8%	9.8%	2.2	10.3%	15.9%	6.8
Heart Failure	18.3%	17.2%	8.7%	11.7%	4.2	10.3%	*	*
AMI	12.4%	10.0%	4.5%	5.9%	3.8	7.7%	*	*
Pneumonia	11.9%	10.6%	7.0%	11.7%	6.1	9.6%	12.2%	3.9

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: HCBS=Home and Community-Based Services; LTC=Long-term Care; ABD=Aged/Blind/Disabled; NF=Nursing Facility; DD= Difference in Differences; AMI=Acute Myocardial Infarction.

Not adjusted for beneficiary or provider characteristics.

Units of unadjusted difference in differences is a percentage point change.

<sup>a</sup>Calculated as  $[d-c]-[b-a]$

<sup>b</sup>Calculated as  $[f-e]-[b-a]$

\*Estimate suppressed due to insufficient sample size.

**Table 3B.8: Adjusted MLTSS impact on hospital readmission rates among the HCBS and NF populations**

MLTSS Impact Estimates	Hospital-Wide	Heart Failure	AMI	Pneumonia
	HCBS (n=173,272) NF (n=181,619)	HCBS (n=7,852) NF (n=7,933)	HCBS (n=2,698) NF (n=2,735)	HCBS (n=7,571) NF (n=9,350)
HCBS * Post-MLTSS	0.01162* (0.00686)	0.03055 (0.02855)	0.02551 (0.02990)	0.06072** (0.02404)
NF * Post-MLTSS	0.08650*** (0.02522)	0.12381* (0.07120)	0.05237 (0.05150)	0.03930 (0.05315)

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: AMI=Acute Myocardial Infarction; HCBS=Home and Community-Based Services; NF=Nursing Facility.

Hospital readmissions for initial index hospitalizations that may be all-cause or related to heart failure, AMI, or pneumonia.

Discharge level difference-in-differences regression analysis with hospital fixed effects.

Models adjusted for sex, elderly status, monthly time trends, waiver initiation, Medicaid expansion, and all condition-specific risk factors listed in Appendix F.

Shaded estimates are based on small sample sizes that may affect the reliability of these estimates.

Robust standard errors in parentheses.

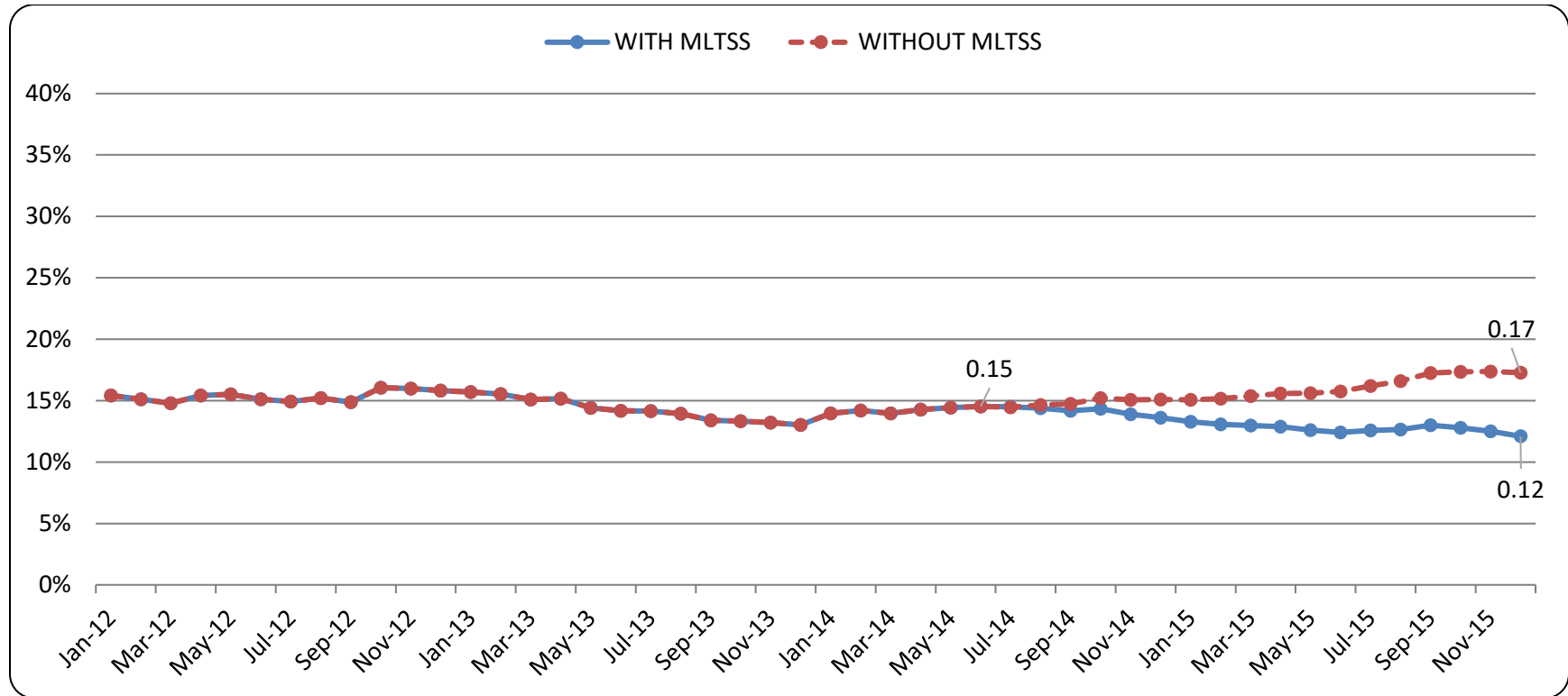
\*\*\* p<0.01, \*\* p<0.05, \* p<0.1

**Table 3B.9: MLTSS impact on hospital-wide readmissions among the Medicaid managed care population with a behavioral health condition**

MLTSS Impact Estimates	Hospital-Wide ( <i>n=179,182</i> )
mltss_post	0.00365 (0.00577)
mltss_time	-0.00308** (0.00149)
Overall statistical significance	**
Net change as of Dec. 2015	-0.05176*

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.  
 Discharge-level segmented regression analysis with hospital fixed effects.  
 Models adjusted for sex, elderly status, monthly time trends, waiver initiation, Medicaid expansion, and all condition-specific risk factors listed in Appendix F.  
 Robust standard errors in parentheses.  
 \*\*\*  $p < 0.01$ , \*\*  $p < 0.05$ , \*  $p < 0.1$

**Figure 3B.7: Regression-based probability of 30-day readmission following all-cause hospitalizations with and without MLTSS effect for the Medicaid managed care population with a behavioral health condition**



Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

**Table 3B.10: Unadjusted MLTSS impact on 30-day hospital-wide readmission rates among the HCBS and NF populations with a behavioral health condition**

	non-LTC ABD with a BH condition		HCBS with a BH condition			NF with a BH condition		
	pre-MLTSS <i>(a)</i>	post-MLTSS <i>(b)</i>	pre-MLTSS <i>(c)</i>	post-MLTSS <i>(d)</i>	Unadjusted DD <sup>a</sup>	pre-MLTSS <i>(e)</i>	post-MLTSS <i>(f)</i>	Unadjusted DD <sup>b</sup>
Hospital-Wide Readmissions	18.4%	16.8%	10.3%	12.0%	3.2	10.3%	16.0%	7.3

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: HCBS=Home and Community-Based Services; LTC=Long-term Care; ABD=Aged/Blind/Disabled; NF=Nursing Facility; BH=Behavioral Health; DD= Difference in Differences. Not adjusted for beneficiary or provider characteristics.

Units of unadjusted difference in differences is a percentage point change.

<sup>a</sup>Calculated as  $[d-c]-[b-a]$

<sup>b</sup>Calculated as  $[f-e]-[b-a]$

**Table 3B.11: Adjusted MLTSS impact on hospital-wide readmission rates among the HCBS and NF populations with a behavioral health condition**

MLTSS Impact Estimate	Hospital-Wide Readmissions
<i>(n=122,877)</i>	
HCBS * Post-MLTSS	0.01459* (0.00813)
<i>(n=133,138)</i>	
NF * Post-MLTSS	0.09008*** (0.02581)

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: HCBS=Home and Community-Based Services; NF=Nursing Facility.

Discharge level difference-in-differences regression analysis with hospital fixed effects.

Models adjusted for sex, elderly status, monthly time trends, waiver initiation, Medicaid expansion, and all condition-specific risk factors listed in Appendix F.

Robust standard errors in parentheses.

\*\*\* p<0.01, \*\* p<0.05, \* p<0.1



**Table 3B.12: MLTSS impact on follow-up after mental illness hospitalization among the Medicaid managed care population**

MLTSS Impact Estimates ( <i>n</i> =44,821)	Follow-up within 7 days	Follow-up within 30 days
mltss_post	-0.01132 (0.01407)	-0.01852 (0.01667)
mltss_time	-0.00026 (0.00402)	-0.00271 (0.00447)
Overall statistical significance	n.s.	n.s.
Net change as of Dec. 2015	-0.01597	-0.06729

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: Discharge-level segmented regression analysis with hospital fixed effects.

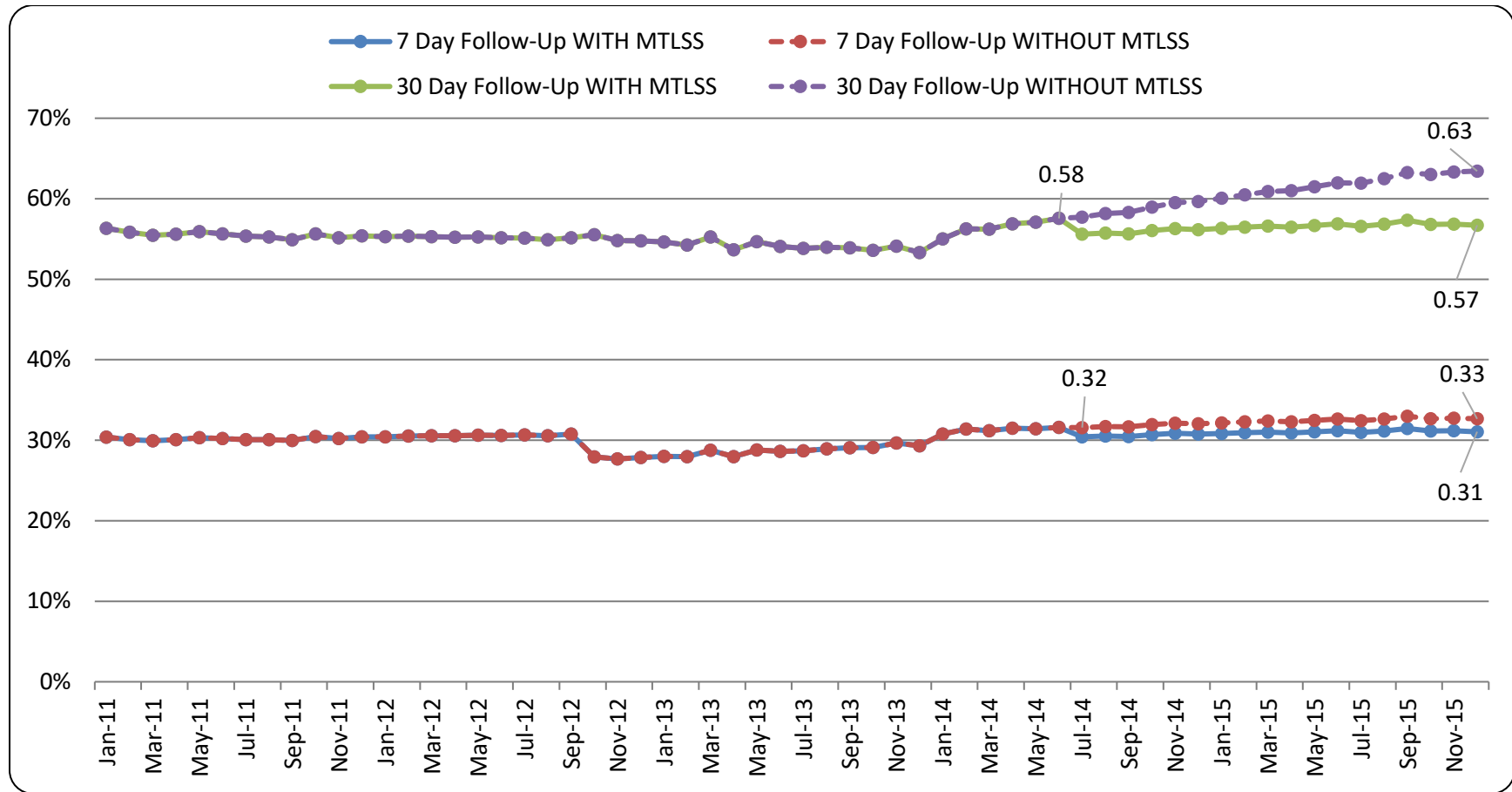
Models adjusted for sex, elderly status, monthly time trends, waiver initiation, Medicaid expansion, and CDPS risk score category.

Overall statistical significance is noted as n.s. (not significant) if the joint effect of mltss\_post and mltss\_time was not significant.

Robust standard errors in parentheses.

\*\*\*  $p < 0.01$ , \*\*  $p < 0.05$ , \*  $p < 0.1$

**Figure 3B.8: Regression-based rates of follow-up after mental illness hospitalization with and without MLTSS effect**



Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

**Table 3B.13: Unadjusted MLTSS impact on follow-up after mental illness hospitalization among the HCBS population**

	non-LTC ABD		HCBS		Unadjusted Difference in Differences <sup>a</sup>
	pre-MLTSS (a)	post-MLTSS (b)	pre-MLTSS (c)	post-MLTSS (d)	
Follow-up within 7 days	25.6%	27.0%	23.6%	*	*
Follow-up within 30 days	49.8%	52.1%	40.7%	*	*

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: HCBS=Home and Community-Based Services; LTC=Long-term Care; ABD=Aged/Blind/Disabled.

Not adjusted for beneficiary and provider characteristics.

<sup>a</sup>Calculated as  $[d-c]-[b-a]$ ; Units of unadjusted difference in differences is a percentage point change.

\*Estimate suppressed due to insufficient sample size.

**Table 3B.14: Adjusted MLTSS impact on follow-up after mental illness hospitalization among the HCBS population**

<b>MLTSS Impact Estimates (n=24,594)</b>	<b>Follow-up within 7 days</b>	<b>Follow-up within 30 days</b>
HCBS * Post-MLTSS	0.06752 (0.11585)	-0.03100 (0.12018)

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: HCBS=Home and Community-Based Services.

Discharge level difference-in-differences regression analysis with hospital fixed effects.

Models adjusted for sex, elderly status, monthly time trends, waiver initiation, Medicaid expansion, and CDPS risk score category.

Shaded estimates are based on small sample sizes that may affect the reliability of these estimates.

Robust standard errors in parentheses.

\*\*\* p<0.01, \*\* p<0.05, \* p<0.1

**Table 3B.15: MLTSS impact on 14-day ambulatory visit rates after hospitalization among the Medicaid managed care population**

MLTSS Impact Estimates	Ambulatory Visit 14 Days After Discharge Home <i>(n=252,000)</i>
mltss_post	0.01423** (0.00684)
mltss_time	0.00009 (0.00253)
Overall statistical significance	*
Net change as of Dec. 2015	0.01579*

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015;

Analysis by Rutgers Center for State Health Policy.

Discharge-level segmented regression analysis with hospital fixed effects.

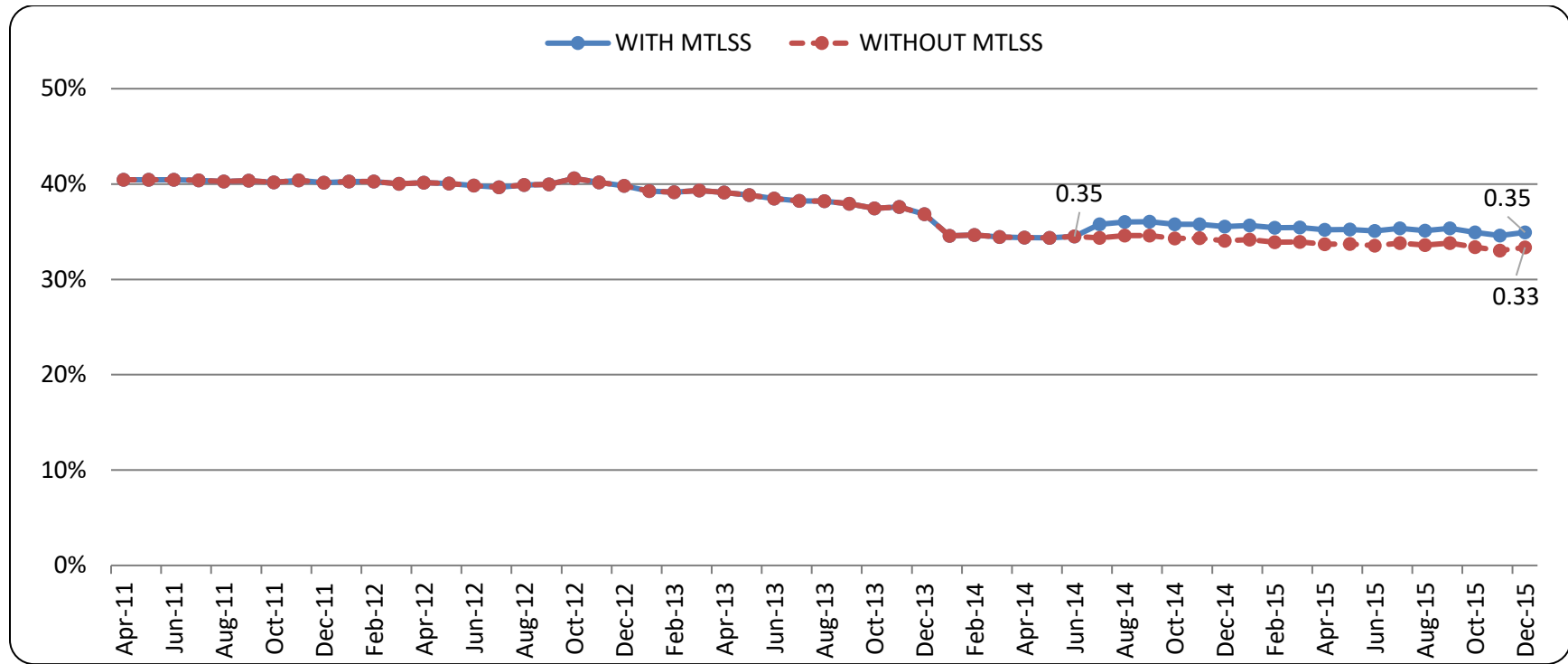
Models adjusted for sex, elderly status, monthly time trends, waiver initiation,

Medicaid expansion, and CDPS risk score category.

Robust standard errors in parentheses.

\*\*\* p<0.01, \*\* p<0.05, \* p<0.1

**Figure 3B.9: Regression-based 14-day ambulatory visit rates after hospitalization with and without MLTSS effect**



Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

**Table 3B.16: Unadjusted MLTSS impact on 14-day ambulatory visit rates after hospitalization among the HCBS population**

	non-LTC ABD		HCBS		Unadjusted Difference in Differences <sup>a</sup>
	pre-MLTSS (a)	post-MLTSS (b)	pre-MLTSS (c)	post-MLTSS (d)	
<b>Ambulatory visit 14 days after discharge home</b>	32.4%	29.2%	21.4%	18.6%	0.4

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: HCBS=Home and Community-Based Services; LTC=Long-term Care; ABD=Aged/Blind/Disabled.

Not adjusted for beneficiary and provider characteristics.

<sup>a</sup>Calculated as  $[d-c]-[b-a]$ ; Units of unadjusted difference in differences is a percentage point change.

**Table 3B.17: Adjusted MLTSS impact on ambulatory visit rates after hospitalization among the HCBS population**

MLTSS Impact Estimates	Ambulatory Visit 14 Days After Discharge Home <i>(n=131,149)</i>
HCBS * Post-MLTSS	0.00588 (0.01049)

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015;  
Analysis by Rutgers Center for State Health Policy.

Notes: HCBS=Home and Community-Based Services.

Discharge level difference-in-differences regression analysis with hospital fixed effects.

Models adjusted for sex, elderly status, monthly time trends, waiver initiation, Medicaid expansion,  
and CDPS risk score category.

Robust standard errors in parentheses.

\*\*\* p<0.01, \*\* p<0.05, \* p<0.1



**Table 3B.18: Unadjusted MLTSS impact on racial/ethnic disparities in avoidable hospitalizations and hospital-wide readmissions among the HCBS and NF populations**

Average rate of avoidable IP hospitalizations per quarter	non-LTC ABD		HCBS				NF			
	pre-MLTSS (a)	post-MLTSS (b)	pre-MLTSS (c)	post-MLTSS (d)	Unadjusted DD <sup>a</sup> (e)	Unadjusted Disparity Effect <sup>c</sup>	pre-MLTSS (f)	post-MLTSS (g)	Unadjusted DD <sup>b</sup> (h)	Unadjusted Disparity Effect <sup>d</sup>
(1) White	0.9%	0.7%	2.0%	1.5%	-0.3		1.0%	1.0%	0.3	
(2) Black	1.3%	1.0%	2.9%	2.4%	-0.1	0.16	1.6%	1.5%	0.2	-0.04
(3) Hispanic	1.0%	0.7%	2.6%	1.9%	-0.4	-0.14	1.9%	2.6%	1.0	0.71
(4) Other	0.9%	0.6%	2.4%	1.8%	-0.4	-0.06	1.6%	1.3%	-0.1	-0.38
<b>Hospital-wide Readmissions</b>										
(1) White	13.6%	12.4%	7.5%	5.8%	-0.6		7.9%	14.1%	7.3	
(2) Black	19.4%	19.1%	11.1%	16.0%	5.2	5.76	14.4%	19.0%	4.9	-2.40
(3) Hispanic	13.3%	10.9%	8.2%	10.8%	5.0	5.62	9.6%	18.6%	11.5	4.15
(4) Other	12.9%	10.8%	12.0%	11.6%	1.8	2.34	12.4%	15.0%	4.7	-2.56

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: HCBS=Home and Community-Based Services; LTC=Long-term Care; ABD=Aged/Blind/Disabled; NF=Nursing Facility.

Not adjusted for beneficiary and provider characteristics.

Units of unadjusted difference in differences and unadjusted disparity effects are a percentage point change.

<sup>a</sup>Calculated as  $[d-c]-[b-a]$

<sup>b</sup>Calculated as  $[g-f]-[b-a]$

<sup>c</sup>Calculated as  $[e-e(1)]$

<sup>d</sup>Calculated as  $[h-h(1)]$

**Table 3B.19: Adjusted MLTSS impact on racial/ethnic disparities in avoidable hospitalizations and hospital-wide readmissions among the HCBS and NF populations**

MLTSS Disparity Effect Estimates	Avoidable Inpatient Utilization	Hospital-wide Readmissions
	HCBS (n=5,466,537) NF (n=5,663,924)	HCBS (n=173,028) NF (n=181,366)
Black * HCBS * Post-MLTSS	0.00097 (0.00188)	0.04352** (0.01910)
Hispanic * HCBS * Post-MLTSS	-0.00219 (0.00185)	0.03727 (0.02327)
Other * HCBS * Post-MLTSS	-0.00211 (0.00246)	0.02223 (0.02855)
Black * NF * Post-MLTSS	0.00160 (0.00244)	-0.02908 (0.04562)
Hispanic * NF * Post-MLTSS	0.00830 (0.00520)	0.07200 (0.04663)
Other * NF * Post-MLTSS	-0.00136 (0.00282)	0.02867 (0.05332)

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: HCBS=Home and Community-Based Services; NF=Nursing Facility.

Discharge level difference-in-differences regression analysis with hospital fixed effects.

Avoidable inpatient hospitalization models adjusted for sex, elderly status, quarterly time trends, waiver initiation, Medicaid expansion, CDPS risk category, and enrollment days per quarter.

Hospital-wide readmission models adjusted for sex, elderly status, monthly time trends, waiver initiation,

Medicaid expansion, and all condition-specific risk factors listed in Appendix F.

Robust standard errors in parentheses.

\*\*\* p<0.01, \*\* p<0.05, \* p<0.1

## **Section C**

In this descriptive analysis section, we examine rates of admissions for ambulatory care sensitive (ACS) conditions and overall emergency department visits for all Medicaid beneficiaries compared to similar rates for the entire NJ population based on all-payer data. These findings explore whether hospital utilization trends differ or are similar between Medicaid and other payers, thus putting the Medicaid-specific results discussed in sections A and B in the context of broader health system performance. It is important to note that the inclusion and exclusion criteria for the ACS conditions are not identical between the data used to generate all-payer rates and the methodology we employed for calculating ACS rates in the Medicaid claims data. However, comparing the trends for each group over time can be illustrative, and we focus on the slope of the linear trend from the baseline average through 2015 as the relevant indicator of the similarity or difference in utilization trends. The noted comparisons have not been tested for statistical significance.

Figures 3C.1 and 3C.2 show trends in ACS hospitalizations for diabetes-related conditions. Admissions for short-term diabetes complications have grown more rapidly among Medicaid beneficiaries during the waiver demonstration period than in New Jersey overall (0.55 vs. 0.10, respectively). The linear trend for uncontrolled diabetes over this period is nearly identical between Medicaid and NJ overall, although between 2014 and 2015 there was a marked increase in such admissions for Medicaid beneficiaries.

Figures 3C.3 and 3C.4 display trends in avoidable admissions for COPD and asthma. The trend has been declining in NJ and Medicaid overall, but for older adults (age 40+), the rate of these admissions declined more rapidly in the Medicaid population over the waiver demonstration period. For younger adults (age 18-39), the Medicaid trend has been more volatile and declining only slightly more rapidly overall than for all of New Jersey's young adults.

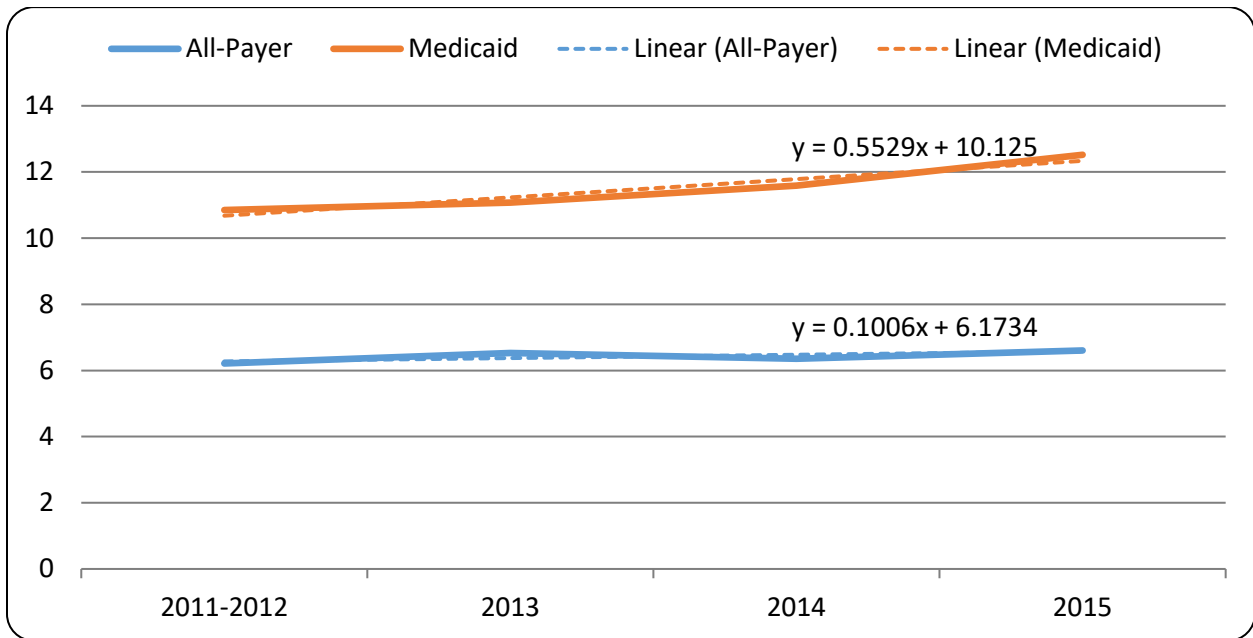
Figure 3C.5 has trends in preventable hospitalizations for hypertension. These have been declining at a similar rate for both Medicaid beneficiaries and NJ adults overall. For preventable heart failure admissions, Figure 3C.6 shows a more rapid decline for the Medicaid population than in NJ overall, but that declining trend reverses between 2014 and 2015. In Figure 3C.7, rates of avoidable admissions for angina are also declining more rapidly for the Medicaid population than in NJ overall, but this measure is not available for the Medicaid population in 2015 to determine whether that trend continues.

Turning to figures 3C.8 and 3C.9 which show avoidable admissions for two acute conditions, bacterial pneumonia and kidney/urinary tract infections, we again see the more rapidly declining

trend in these admissions among Medicaid beneficiaries compared to NJ overall, but a leveling out occurring Medicaid between 2014-2015 that does not occur for NJ overall.

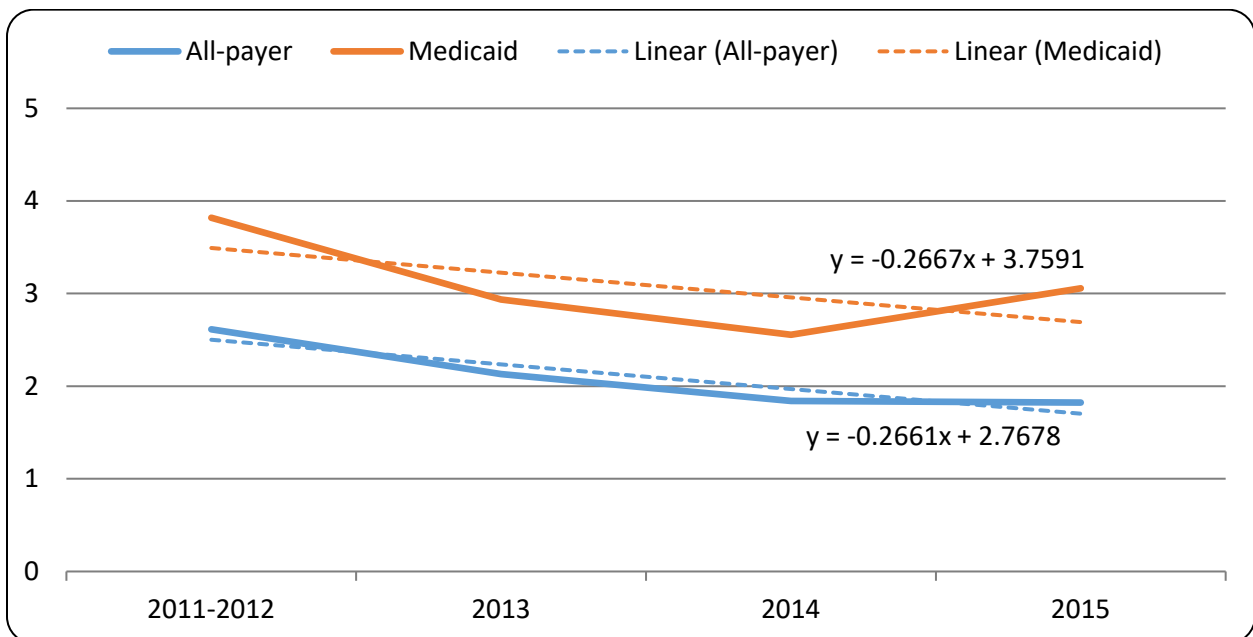
Finally in Figure 3C.10 we see rates of emergency department visits. The rate of ED visits has climbed slightly during the waiver demonstration period for both Medicaid beneficiaries and NJ overall. The degree of increase has been a little higher in the Medicaid population (58.6 vs. 45.6).

**Figure 3C.1: Rates of diabetes short-term complications admissions per 10,000 adults for the NJ all-payer and overall Medicaid populations**



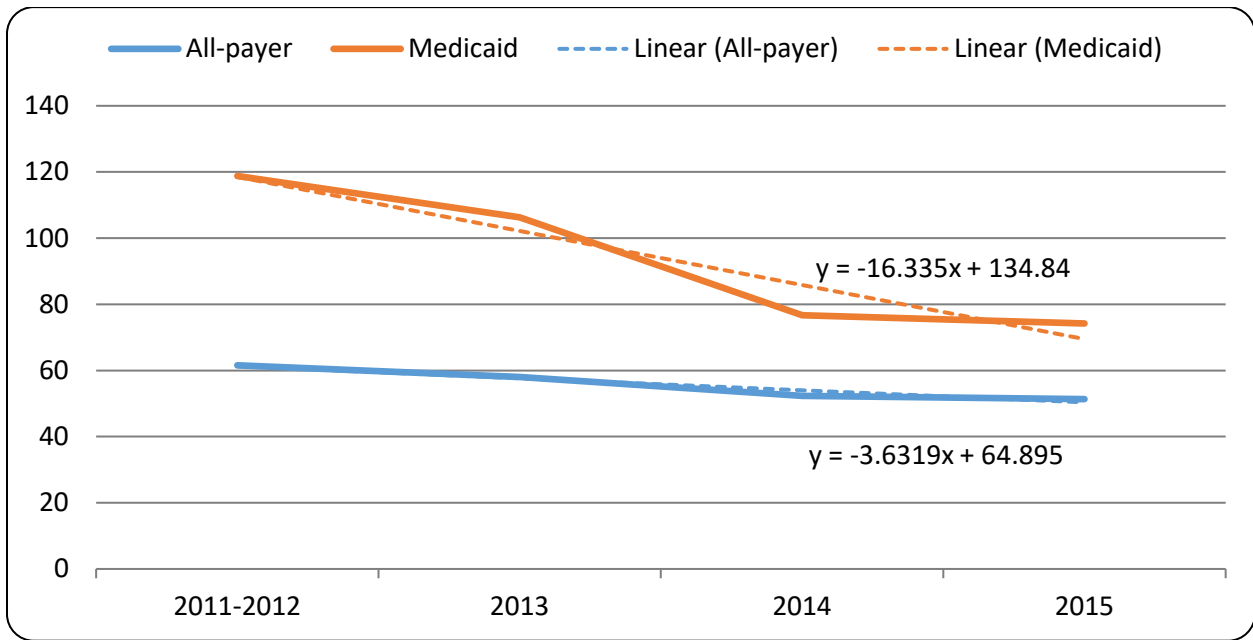
Source: NJSHAD Hospitalization Data and Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

**Figure 3C.2: Rates of uncontrolled diabetes admissions per 10,000 adults for the NJ all-payer and overall Medicaid populations**



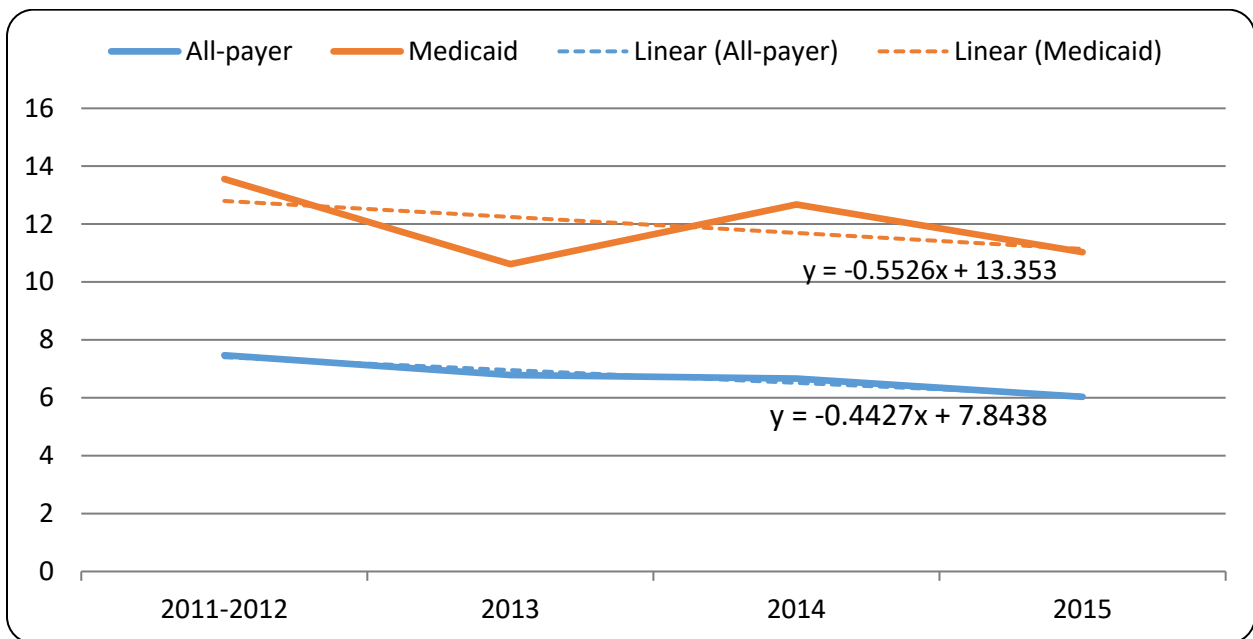
Source: NJSHAD Hospitalization Data and Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

**Figure 3C.3: Rates of COPD and asthma admissions per 10,000 older adults for the NJ all-payer and overall Medicaid populations**



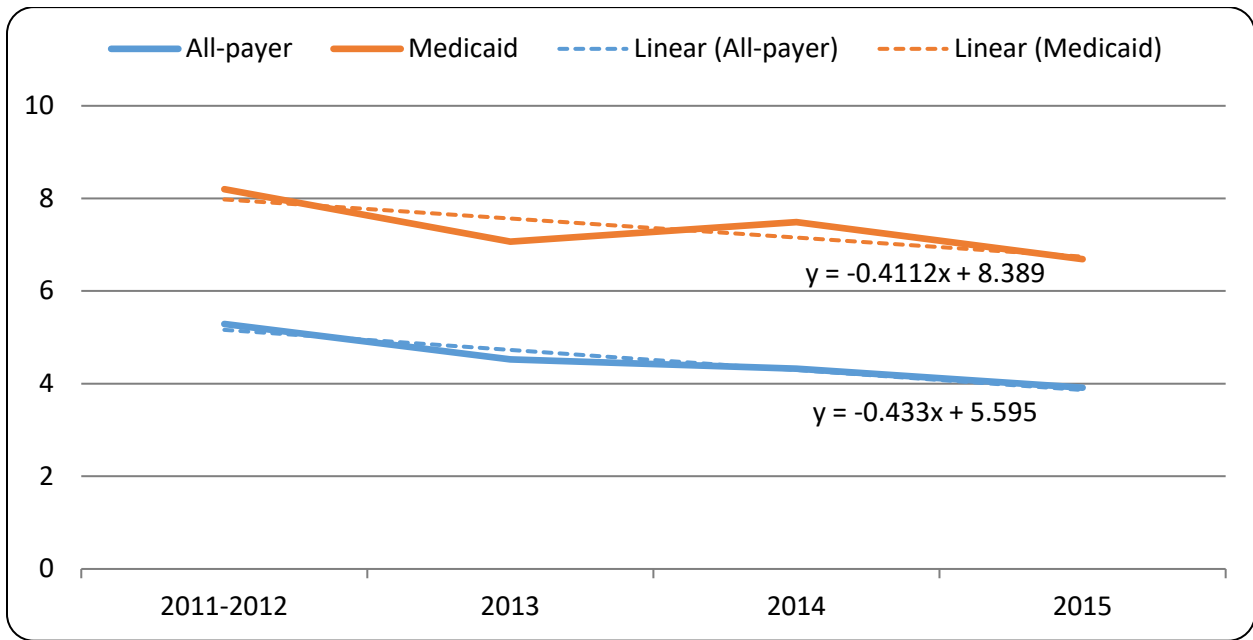
Source: NJSHAD Hospitalization Data and Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

**Figure 3C.4: Rates of asthma admissions per 10,000 young adults for the NJ all-payer and overall Medicaid populations**



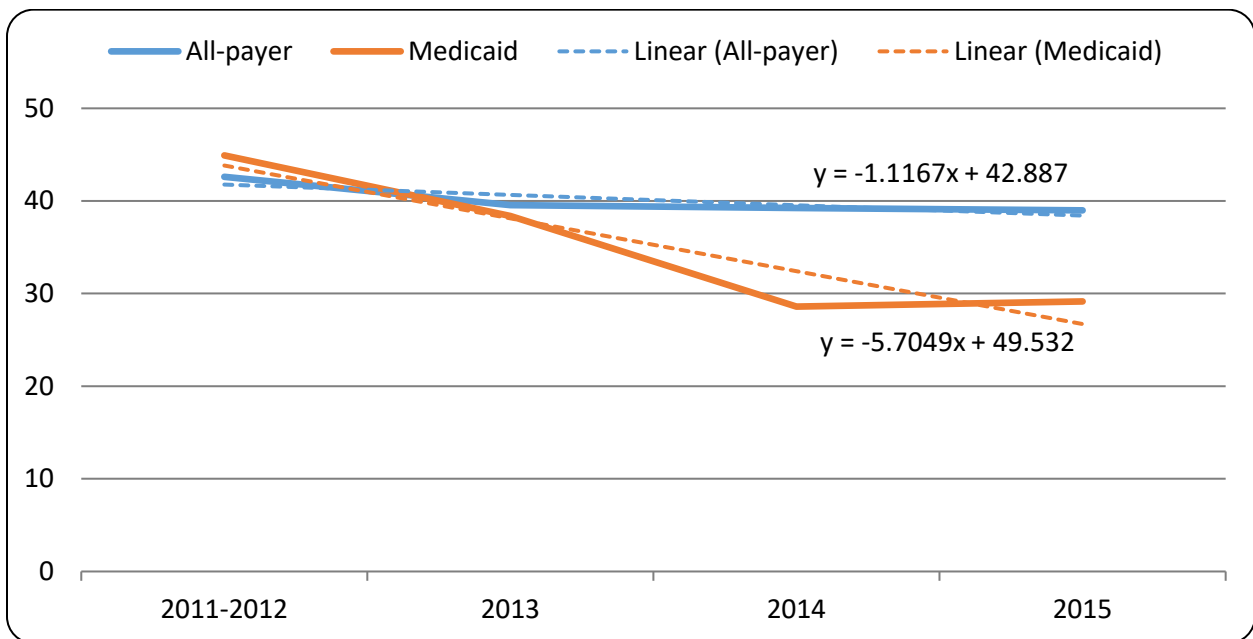
Source: NJSHAD Hospitalization Data and Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

**Figure 3C.5: Rates of hypertension admissions per 10,000 adults for the NJ all-payer and overall Medicaid populations**



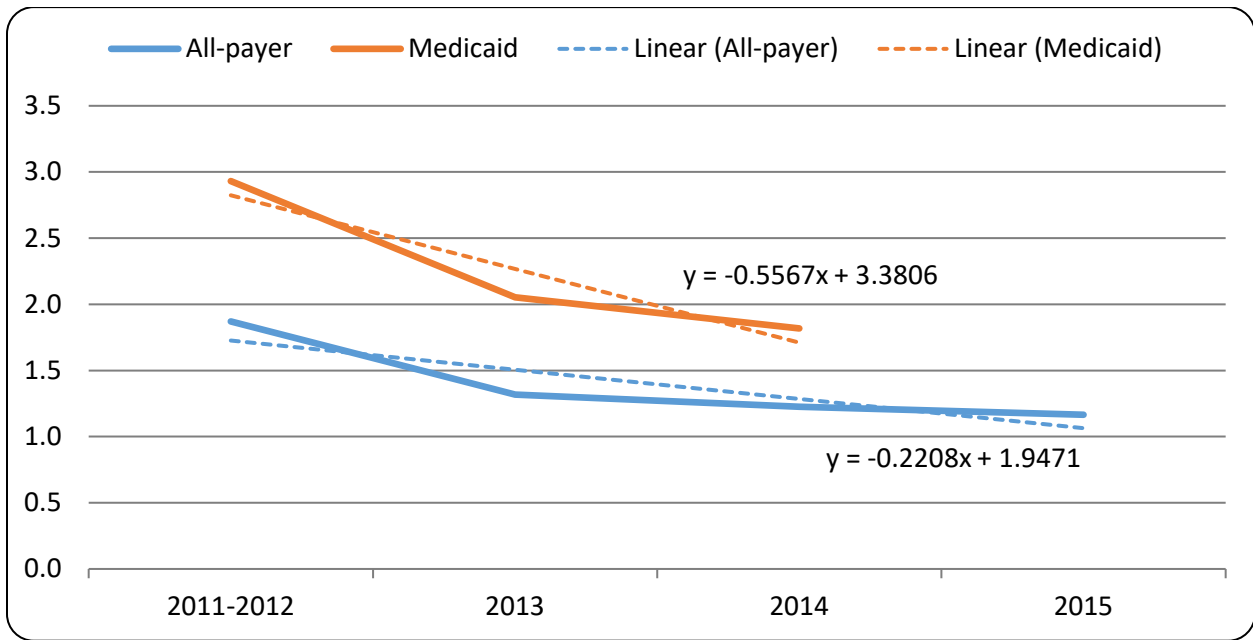
Source: NJSHAD Hospitalization Data and Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

**Figure 3C.6: Rates of heart failure admissions per 10,000 adults for the NJ all-payer and overall Medicaid populations**



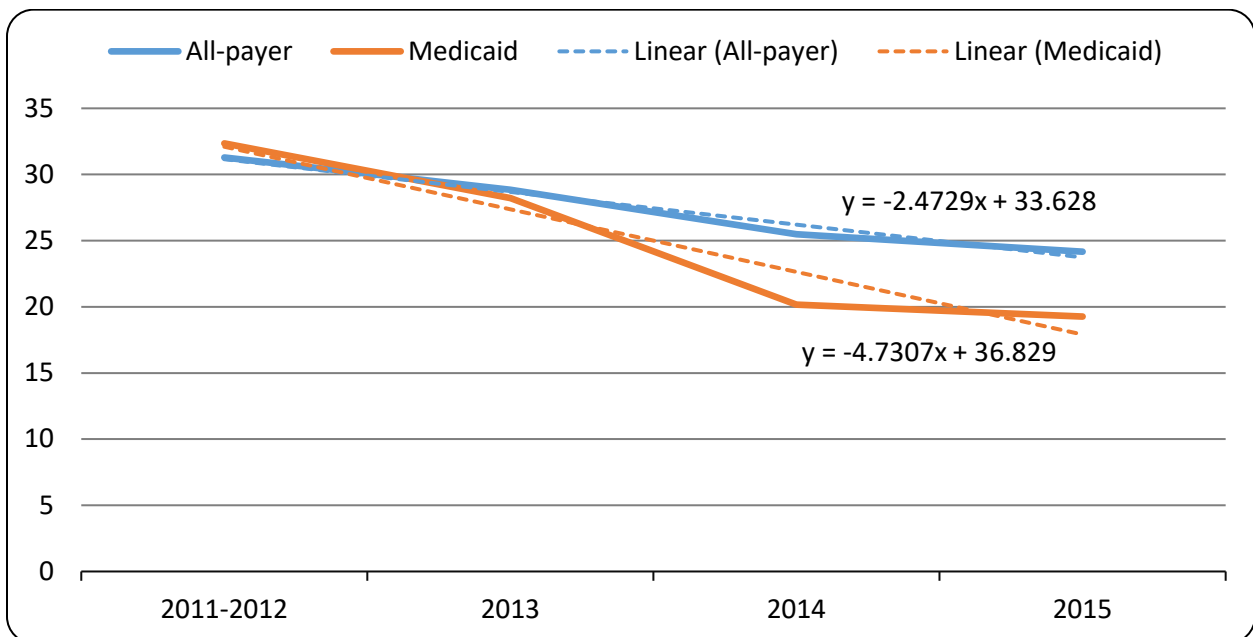
Source: NJSHAD Hospitalization Data and Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

**Figure 3C.7: Rates of angina admissions per 10,000 adults for the NJ all-payer and overall Medicaid populations**



Source: NJSHAD Hospitalization Data and Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

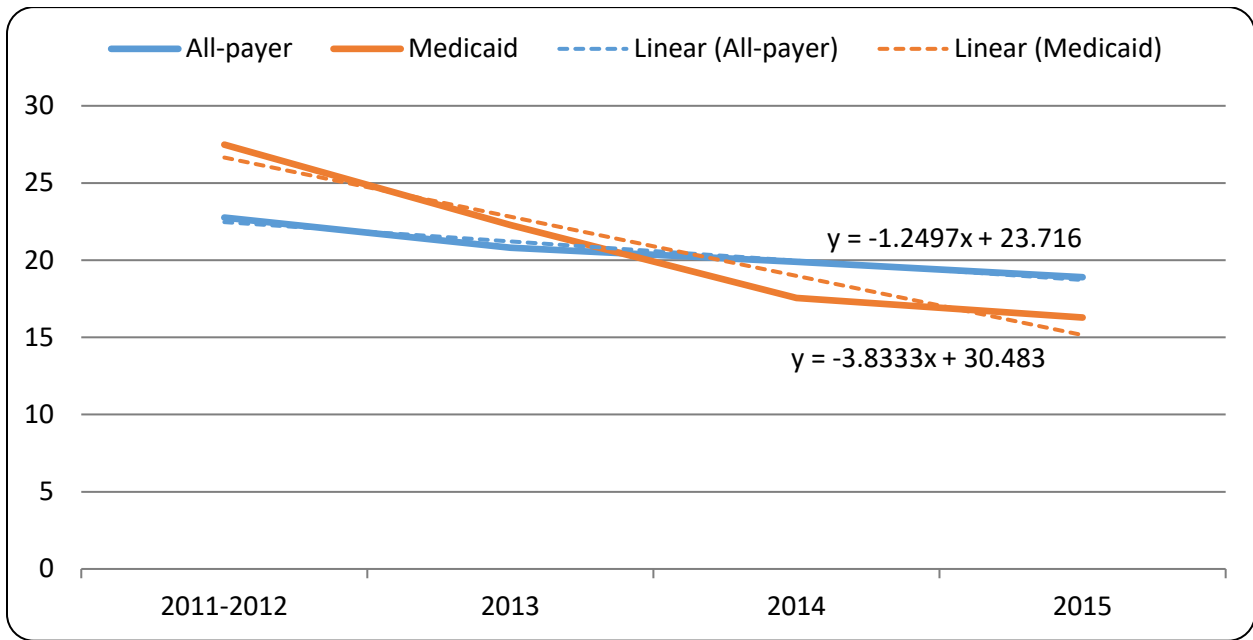
**Figure 3C.8: Rates of bacterial pneumonia admissions per 10,000 adults for the NJ all-payer and overall Medicaid populations**



Source: NJSHAD Hospitalization Data and Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

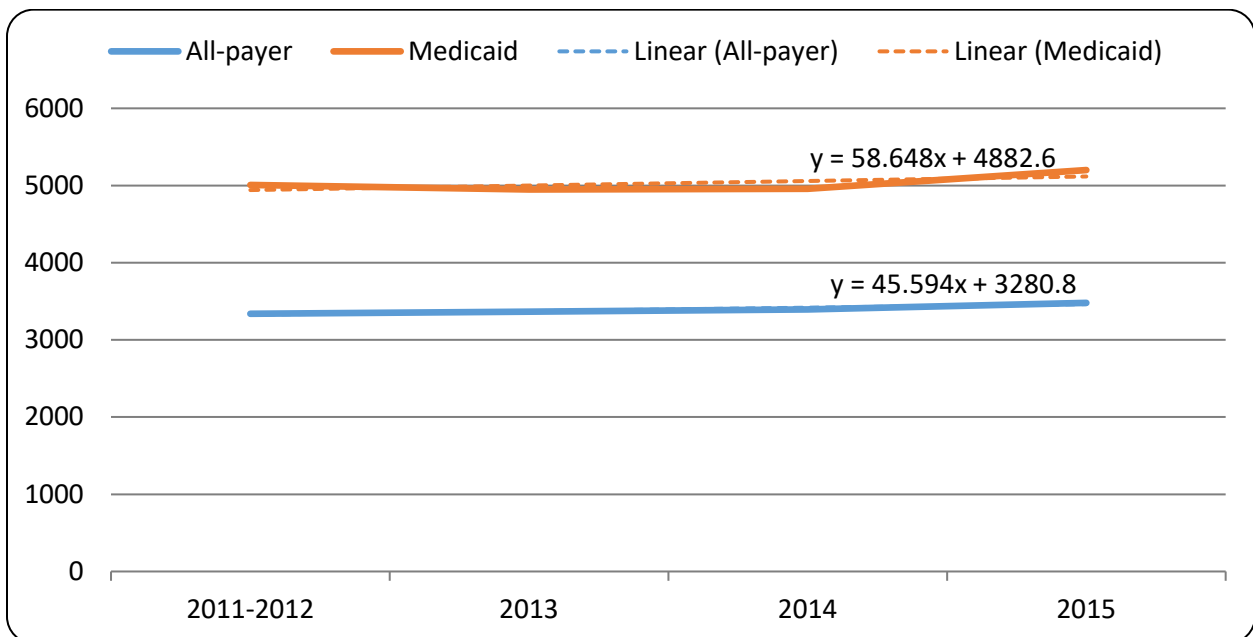


**Figure 3C.9: Rates of kidney and/or urinary tract infection admissions per 10,000 adults for the NJ all-payer and overall Medicaid populations**



Source: NJSHAD Hospitalization Data and Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

**Figure 3C.10: Rates of emergency department visits per 10,000 population for the NJ all-payer and overall Medicaid populations**



Source: NJSHAD Hospitalization Data and Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

## Discussion

In this chapter, we utilized Medicaid claims data to calculate a set of metrics relevant for evaluating the transition to Managed Long-term Service and Supports under the Waiver. These metrics include avoidable inpatient hospitalizations and ED visits that arise due to inadequate ambulatory or primary care in the community; hospital readmissions overall and for specific diseases that reflect potentially inadequate inpatient care and lack of care coordination; follow-up after mental illness hospitalizations that examines similar issues specifically for individuals with behavioral health conditions; and ambulatory visit rates that reflect the quality of care transitions. We also constructed several spending-related measures to see potential changes in distribution of spending over time and across places-of-care. Finally, we compared trends in avoidable inpatient hospitalizations and ED visits between Medicaid recipients and NJ patients overall, using all-payer information.

We will distill the many results presented in this chapter down to the key points relevant for answering the two research questions under our first evaluation hypothesis. First we discuss findings for the entire managed care population over the baseline and demonstration period. Then we comment on the evidence for rebalancing of spending from the nursing facility to the community. And finally, we summarize the direct impact of MLTSS on those long-term care beneficiaries enrolled in the program.

### **Overall Managed Care Population**

The pattern in the descriptive trends for avoidable hospital use and ED visits that we observe in all-payer data for NJ overall, and in claims data for Medicaid and Medicaid managed care overall, reveal that the most notable trend differences occur starting in 2014 when both the Medicaid expansion and MLTSS commenced. This suggests that controlling for the impact of the Medicaid expansion is essential to isolating any potential influence of MLTSS on outcomes for the overall managed care population. Thus, we emphasize here the results of our adjusted regression analyses of the findings related to the first evaluation research question.

We find no significant impact of MLTSS on avoidable inpatient visits for the managed care population overall. We do estimate significant changes in avoidable ED visits when MLTSS was in effect, but the magnitude of such changes, while favorable, are small. By the end of 2015 there were 11 fewer avoidable ED visits per 1,000 beneficiaries than there would have been without MLTSS. It is also important to note that descriptive trends show avoidable inpatient and avoidable ED use for the Medicaid managed care population to be slightly decreasing, in line with overall inpatient and ED use.

For all four types of hospital readmissions, there is a declining trend in readmission rates associated with MLTSS, but that decline is only significant for hospital-wide readmissions, both for the overall managed care population (a 4.6 pp decline by December 2015,  $p < 0.05$ ) and for the subset with a diagnosed BH condition (5.2 pp decline by December 2015,  $p < 0.1$ ). Examination of follow-up after hospitalizations yielded mixed results. Despite the slight improvements we see in the descriptive unadjusted rates of follow-up after hospitalization for mental illness from baseline through 2015, our regression models estimate a decrease in these 7 and 30-day follow up rates post-MLTSS. However, these decreases are not significant. There is a small (1.6 percentage point) and significant ( $p < 0.10$ ) increase in ambulatory visits 14 days after discharge home.

Overall, there were no negative effects on the quality, efficiency, and coordination of care for the managed care population during the first 18 months of MLTSS implementation.

### **Rebalancing**

The bulk of spending related to the LTC population across 2011-2015 is accounted for by the NF LTSS spending. Shifting spending away from facility care when possible is a promising strategy to control costs, and MLTSS has helped accelerate this rebalancing. Overall annual spending for the HCBS and NF populations has declined by about \$300 million over 2011-2015, mostly as a result of declines in the magnitude of spending for the NF population. The greatest increases in the proportion of spending for the HCBS population occurred after implementation of MLTSS in July 2014.

We examined the effect of the MLTSS policy on the HCBS and NF populations that transitioned to managed care for their long-term care services on July 1, 2014. Our difference-in-differences analyses used the non-LTC ABD population as a comparison group to identify the extent to which differences in outcomes over time could be attributed to the effect of MLTSS. Thus, while descriptive results demonstrate overall changes in outcomes for the HCBS or NF populations, our regression analyses statistically estimates changes in outcomes associated with MLTSS.

### **HCBS Population**

Descriptive results show increases in inpatient utilization and ED visits rates and commensurate increases in avoidable inpatient and ED use between 2014 and 2015 for the HCBS population. There is also an increase in avoidable hospital spending for the HCBS population. The increases in avoidable ED visits and avoidable inpatient spending persist in adjusted regression analyses and are statistically significant.

Hospital-wide, heart failure, and pneumonia readmission rates are all higher in 2015 than they were at baseline for the HCBS population, sometimes with pronounced increases between 2014 and 2015. Our adjusted DD estimate for all four readmission metrics also indicate increases in readmissions for the HCBS population, but only the increases in readmissions following hospitalization for pneumonia are statistically significant at the 5% level. The adjusted effect size for the HCBS population indicates a 6.1 pp increase in pneumonia readmission rates due to the MLTSS implementation. We also observe a 1.2 pp increase for the HCBS population in hospital-wide readmissions, but this was only marginally significant ( $p < 0.1$ ).

Regression analyses of follow-up after mental illness hospitalizations showed mixed results with an increase in 7 day follow ups and a decrease in 30 day follow ups. No effects were statistically significant, and the small sample for this analysis may limit the reliability of this finding. This small sample size limitation reduces our ability to assess the impact of the behavioral health integration under managed care which was also part of MLTSS. In descriptive analyses of avoidable hospitalizations, we do observe sharp increases among those HCBS beneficiaries with a BH condition between 2014 and 2015. Further, our regression analysis indicates a marginally significant increase (1.5 pp,  $p < 0.10$ ) in the likelihood of readmissions among the HCBS population with a BH problem. There thus does not appear to be any evidence of improvements in behavioral health care under MLTSS so far.

Total spending per person for the HCBS population did not increase over the waiver demonstration period. LTSS spending per HCBS person decreased, and avoidable hospital spending (both inpatient and ED) increased. Other non-LTSS, non-avoidable hospital spending also exhibited some growth during the MLTSS months, which is consistent with the increases in ED utilization and readmissions we observe for the HCBS population.

We examined whether there was worsening of racial and ethnic disparities in care by comparing changes in rates of avoidable inpatient hospitalizations and hospital wide readmission rates in minority population groups compared to whites. The only significant result was an increase in hospital wide readmission rates by black HCBS beneficiaries relative to white beneficiaries.

In summary, during the first 18 months of MLTSS, there was a worsening of several of the outcomes we examined in the HCBS population. These findings are largely consistent between our descriptive results and our adjusted regression results.

### **NF Population**

The majority of the nursing facility population remained outside of MLTSS during the demonstration period, only transitioning when certain triggers, like a change in level of care,

were experienced. Our descriptive analyses show trends for the entire NF population in the baseline and demonstration years, while our adjusted regression analyses focus on outcomes only for those NF residents who switched into MLTSS. Therefore, the findings between the two approaches may not be concordant. Also, although we do adjust for an annual measure of health risk in our regressions, the fact that the NF residents who become MLTSS are those going through changes in condition or setting of care could still cause outcomes measured subsequent to these periods of short-term vulnerability look different when compared to the entire, more stable NF population pre-MLTSS. Finally, the smaller sample creates more instability in estimates for the NF population. Our NF findings are thus subject to these important caveats and it is important not to overemphasize them.

Descriptive analyses show steady or declining overall inpatient, ED, avoidable inpatient, avoidable ED, and spending related to avoidable hospital use between 2014 and 2015 for the entire NF population. In adjusted regression analyses, the decline in avoidable ED visits and associated spending persist as statistically significant effects (although only at the 10% level for avoidable ED visits) of MLTSS on NF residents in the program. Avoidable inpatient visits and associated spending for the NF population in MLTSS is estimated to be increasing in our DD model, but this was not statistically significant.

While we observe declines in hospital-wide, AMI, and pneumonia readmission rates for the NF population overall between 2014 and 2015 in descriptive analyses, in the regression analyses, there is evidence of net increases in all readmission rates for the MLTSS NF population relative to the comparison population. Only the increase of 8.7 percentage points in hospital-wide readmissions (and 9 percentage points among the NF residents in MLTSS with a BH condition) is significant, however.

We did not detect changes in racial and ethnic disparities among the NF population as a consequence of MLTSS.

### **Conclusions**

The analyses in this chapter provide evidence that quality of care for the entire Medicaid managed care population has not suffered during the waiver demonstration period, but the transition to MLTSS for the HCBS population has been accompanied by increases in types of utilization such as avoidable ED visits and hospital readmissions. There was a slight decrease in avoidable ED visits and avoidable ED visit related costs for NF population. Data are not yet robust enough to determine the impact of MLTSS on the NF population.

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## Appendix A: Description of Measures

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*Inpatient Utilization and Emergency Department Visits:* These measures assess the extent to which individuals receive inpatient hospital treatment or seek ambulatory care in the emergency department because of pregnancy and childbirth, for surgery, or for nonsurgical medical treatment. These measures of service use gather information about the provision of care to individuals and how organizations managing that care use and allocate resources. Use of inpatient and emergency department services is affected by many member characteristics such as age, sex, health, and socioeconomic status.

Our preparation of these metrics considers utilization at any general acute care hospital, inside or outside NJ. The costs associated with all identified inpatient and emergency department visits are also aggregated by beneficiary.

*Ambulatory Care Sensitive (ACS) Inpatient Hospitalizations and Avoidable/Preventable Emergency Department Visits:* We calculate rates of ACS inpatient (IP) hospitalizations and avoidable treat-and-release ED visits that may occur due to inadequate ambulatory/primary care within communities. Avoidable hospitalizations have been widely used in previous research to measure access to primary care, and disparities in health outcomes (Basu, Friedman, and Burstin 2004; Billings et al. 1993; Bindman et al. 1995; Howard et al. 2007). The federal Agency for Healthcare Research and Quality (AHRQ) provides validated programming algorithms to calculate rates of avoidable ACS hospitalizations which are used in this analysis. These are known as the Prevention Quality Indicators (PQI) for adults (ages 18 and above) and Pediatric Quality Indicators for children (ages 6-17). The latest version (version 6.0) of AHRQ's quality indicators software accommodates ICD-10 codes and was used for calculating PQIs and PDIs from October through December 2015. Other updates and enhancements made to the version 6.0 software, such as the exclusion of one very low prevalence component indicator, were thus also applied to these three months of data (AHRQ 2016). Appendix B gives a list of ACS conditions that constitute a composite index that measures the overall rate of avoidable IP hospitalizations per unit of population. Appendix B also lists the constituents of the two other composite indicators (based on acute and chronic conditions).

We also calculate avoidable treat-and-release ED visits based on the methodology provided by the New York University, Center for Health and Public Service Research (Billings, Parikh, and Mijanovich 2000), which are part of AHRQ's Safety Net Monitoring Toolkit. These comprise three categories of avoidable ED visits that could have been treated in an outpatient primary care setting or could have been prevented with timely access to primary care. Detailed definitions of

these classifications are provided with examples in Appendix C. ICD-10 versions of diagnosis codes for this metric were provided on New York University website.<sup>88</sup>

Our preparation of these metrics considers utilization at any general acute care hospital, inside or outside NJ. The costs associated with all identified avoidable inpatient and emergency department visits are also aggregated by beneficiary.

*Readmissions:* Because hospital readmissions can result from poor quality of care or inadequate transitional care, 30-day readmissions metrics are used to broadly measure the quality of care delivered by hospitals (Benbassat and Taragin 2000; Jencks, Williams, and Coleman 2009). Such ‘potentially preventable’ readmissions are defined as readmission for any cause within 30 days of the discharge date for the index hospitalization, excluding a specified set of planned readmissions. While readmissions rates have been most heavily utilized to assess quality for the Medicare population, calculating these measures among the Medicaid population has received growing attention (Trudnak et al. 2014). The readmissions metrics we calculate are endorsed by the National Quality Forum (NQF) and are adapted from the 2014 (for hospital-wide, heart failure, and acute myocardial infarction) and 2016 (for pneumonia) Centers for Medicare and Medicaid Services methodology available at QualityNet.<sup>89</sup> To accommodate the transition in October 2015 to the ICD10-CM coding system, diagnoses on claims from this last quarter of 2015 were mapped back to the ICD9-CM system using crosswalks from CMS’s general equivalence mappings prepared by the National Bureau of Economic Research (2016).

We consider index admissions and readmissions at any general acute care hospital, inside or outside NJ. In accordance with specifications for all Centers for Medicare and Medicaid Services (CMS) readmissions metrics, we required that the beneficiary be enrolled for 12 months prior to the index hospitalization (ignoring gaps of 45 days or less) to allow for sufficient claims history for risk-adjustment. Therefore, estimates for year 2011 could not be calculated due to this restriction.

*Follow-up after Hospitalization for Mental Illness:* Following an acute hospitalization for mental illness, it is recommended that patients have an outpatient visit with a mental health practitioner to ensure appropriate and regular follow-up therapy and medication monitoring. This measure is used to assess the percentage of discharges for members hospitalized for the treatment of selected mental health disorders that were followed by a qualifying visit with a mental health practitioner within 7 and 30 days. Our preparation of this measure considers index admissions at any general acute care hospital or short-term psychiatric hospital, inside or outside NJ. This

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<sup>88</sup> <http://wagner.nyu.edu/faculty/billings/nyued-background>.

<sup>89</sup> <https://www.qualitynet.org>.

measure is endorsed by the NQF and is part of the Medicaid Adult Core and Child Core Sets of Health Care Quality Measures.

We followed the National Committee of Quality Assurance's specifications for the calculation of this metric (NCQA 2014) using value sets from the 2016 specifications (NCQA 2016) only when necessary for accommodating the ICD-10 transition and crosswalks from the New Jersey Department of Health to identify mental health practitioners and place of service codes (NJDOH 2017). We also modified the metric slightly by identifying follow-up visits for hospital discharges through December 31 of the calendar year (instead of through December 1) in order to support time series regression analyses.

Finally, since patients residing in medical facilities, such as a nursing homes, may have follow-up care provided within the facility itself, metrics relating to post-acute ambulatory care cannot be accurately calculated for this population if follow-up services are not billed separately within these facilities. Specifically, some care provided by physicians to NF residents in NJ are included in the facility per diem rate and thus claims are not generated for these services. Therefore, populations in nursing facilities or intermediate care facilities were excluded from the analytic population when conducting regression analyses on this metric.

*Ambulatory Care Visit 14 Days after Discharge:* Motivated by research showing that readmissions and ED visits are less likely to occur if patients are seen by a primary clinician or specialist shortly after discharge, this measure assesses the frequency of clinician follow-up visits within 14 days after patients are discharged from the hospital for medical conditions. It was developed by the Dartmouth Atlas Project for use in the Medicare population. Using their methodology and adapting it for the Medicaid claims data, access to ambulatory care is assessed among all discharges and then separately for discharges home (with or without home health services), to facility-based rehabilitation (SNFs, inpatient rehabilitation facilities, long-term acute care hospitals), and to other facilities (such as an intermediate care facility) (Goodman, Fisher, and Chang 2011).

In our preparation of this measure, we consider discharges from only general acute care hospitals in NJ. Hospitalizations outside NJ could not be included because this measure requires identification of medical discharges from AP-DRG billing codes. Hospitals in other states may use different DRG systems to which our crosswalk would not apply. Also, this measure requires a negative 90-day hospitalization history. Our claims database begins on January 1, 2011 so this negative history could not be established for hospitalizations in the first three months of 2011. Therefore, this metric was only based on April through December in year 2011.

Finally, since patients residing in medical facilities, such as nursing homes, may have follow-up care provided within the facility itself, metrics relating to post-acute ambulatory care cannot be accurately calculated for this population if follow-up services are not billed separately within these facilities. Specifically, some care provided by physicians to NF residents in NJ are included in the facility per diem rate and thus claims are not generated for these services. Therefore, populations in nursing facilities or intermediate care facilities were excluded from the analytic population when conducting regression analyses on this metric.

*Behavioral Health Comorbidities:* Behavioral health comprises two mutually exclusive categories: problems related to mental health (MH) and substance use disorders/substance abuse (SA). We adapt the Agency for Health Care Research and Quality (AHRQ) Clinical Classification Software (CCS) to identify BH problems among Medicaid beneficiaries. The software uses information from ICD-9 and ICD-10 diagnosis and procedure codes to classify hospital discharges into a number of clinically meaningful disease categories (HCUP 2015, 2017). Mental health conditions include mood disorders; schizophrenia; anxiety disorder; delirium; dementia and substance abuse includes alcohol and substance-related disorders (See Appendix E for details).

## Appendix B: AHRQ Prevention Quality Indicators and Pediatric Quality Indicators – Composites and Constituents

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### Overall Composite (PQI #90)

PQI #01 Diabetes Short-Term Complications Admission Rate	PQI #11 Bacterial Pneumonia Admission Rate
PQI #03 Diabetes Long-Term Complications Admission Rate	PQI #12 Urinary Tract Infection Admission Rate
PQI #05 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	PQI #13 Angina without Procedure Admission Rate <sup>90</sup>
PQI #07 Hypertension Admission Rate	PQI #14 Uncontrolled Diabetes Admission Rate
PQI #08 Congestive Heart Failure (CHF) Admission Rate	PQI #15 Asthma in Younger Adults Admission Rate
PQI #10 Dehydration Admission Rate	PQI #16 Rate of Lower-Extremity Amputation Among Patients With Diabetes

### Acute Composite (PQI #91)

PQI #10 Dehydration Admission Rate	PQI #12 Urinary Tract Infection Admission Rate
PQI #11 Bacterial Pneumonia Admission Rate	

### Chronic Composite (PQI #92)

PQI #01 Diabetes Short-Term Complications Admission Rate	PQI #13 Angina without Procedure Admission Rate <sup>13</sup>
PQI #03 Diabetes Long-Term Complications Admission Rate	PQI #14 Uncontrolled Diabetes Admission Rate
PQI #05 Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	PQI #15 Asthma in Younger Adults Admission Rate
PQI #07 Hypertension Admission Rate	PQI #16 Rate of Lower-Extremity Amputation Among Patients With Diabetes
PQI #08 Congestive Heart Failure (CHF) Admission Rate	

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Source: Prevention Quality Indicators Technical Specifications - Version 5.0, March 2015;  
[http://www.qualityindicators.ahrq.gov/Modules/PQI\\_TechSpec.aspx](http://www.qualityindicators.ahrq.gov/Modules/PQI_TechSpec.aspx).

<sup>90</sup> This component was retired in Version 6.0 of the PQI software which accommodated ICD-10 coding. This software version was used for generating the overall composite indicator in October-December 2015.

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**Overall Composite (PDI #90)**

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PDI #14 Asthma Admission Rate

PDI #15 Diabetes Short-Term Complications Admission Rate

PDI #16 Gastroenteritis Admission Rate

PDI #18 Urinary Tract Infection Admission Rate

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Source: Pediatric Quality Indicators Technical Specifications - Version 5.0, March 2015;  
[http://www.qualityindicators.ahrq.gov/modules/PDI\\_TechSpec.aspx](http://www.qualityindicators.ahrq.gov/modules/PDI_TechSpec.aspx).

## Appendix C: Classification of Emergency Department Visits

Type Description	Diagnoses
<b>Non-Emergent:</b> The patient's initial complaint, presenting symptoms, vital signs, medical history, and age indicated that immediate medical care was not required within 12 hours.	Headache, Dental disorder, Types of migraine
<b>Emergent, Primary Care Treatable:</b> Conditions for which treatment was required within 12 hours, but care could have been provided effectively and safely in a primary care setting. The complaint did not require continuous observation, and no procedures were performed or resources used that are not available in a primary care setting (e.g., CAT scan or certain lab tests)	Acute bronchitis, Painful respiration, etc.
<b>Emergent, ED Care Needed, Preventable/Avoidable:</b> Emergency department care was required based on the complaint or procedures performed/resources used, but the emergent nature of the condition was potentially preventable/avoidable if timely and effective ambulatory care had been received during the episode of illness	Flare-ups of asthma, diabetes, congestive heart failure, etc.
<b>Emergent, ED Care Needed, Not Preventable/Avoidable:</b> Emergency department care was required and ambulatory care treatment could not have prevented the condition	Trauma, appendicitis, myocardial infarction

The first three categories are considered to be avoidable/preventable.

Type descriptions taken from <http://wagner.nyu.edu/faculty/billings/nyued-background.php>.

## Appendix D: Long-Term Care Assignment Algorithms

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*Monthly Assignment:* For every month in which a beneficiary had at least one day of active enrollment as determined by the effective dates of the Program Status Code, assignment to one of the following categories was implemented hierarchically: facility, home and community-based services (HCBS), or other. The rules for assignment were: If at least one claim showed up for a nursing facility (Category of Service=07) in the month or the post-MLTSS Special Program Code (SPC) for facility resident (61,63-67) was effective at least one day in the month, the month was assigned as NF (nursing facility). For the remaining beneficiary-months, if there was ever an active pre-MLTSS SPC in the month indicating the beneficiary was in one of the §1915(c) waiver programs (3,4,6=CRPD, 5=ACCAP, 17=TBI, 32,33=GO) or an active post-MLTSS SPC code in the month indicating home or community-based residence (60=community, 62=assisted living), the month was designated as HCBS. The remaining months fell into the 'Other' category. Any month classified as facility or HCBS was a long-term care month (LTC). Months in the 'Other' category were non-LTC.

*Quarterly Assignment:* For any beneficiary ever having at least one day of active enrollment in the quarter as determined by the effective dates of the Program Status Code, a quarterly assignment to either NF, HCBS, or non-LTC was implemented using the monthly assignment and a majority rule. In cases where there was no majority, assignment was hierarchical based on the order: NF, HCBS, non-LTC.

*Annual Assignment:* For any beneficiary ever having at least one day of active enrollment in the calendar year as determined by the effective dates of the Program Status Code, 'X' was the number of months designated as facility months in the monthly assignment. 'Y' was the number of months designated HCBS. If at least half of the beneficiary's enrolled months during that year had one of these LTC designations then the beneficiary was classified as part of the LTC population for that year. If less than half, then the beneficiary was non-LTC. Within the LTC population, 'X' and 'Y' were compared to make an annual assignment to either the facility or community. If 'X' was greater than or equal to 'Y' then the beneficiary was in the facility population for the entire year. If 'X' was less than 'Y' then the beneficiary was designated as being a LTC HCBS recipient.



## Appendix E: Definition of Mental Health and Substance Abuse

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<b>Mental Health</b>	
5.1	Adjustment disorders [650]
5.2	Anxiety disorders [651]
5.3	Attention deficit conduct and disruptive behavior disorders [652]
5.4	Delirium dementia and amnesic and other cognitive disorders [653]
5.5	Developmental disorders [654]
5.6	Disorders usually diagnosed in infancy childhood or adolescence [655]
5.7	Impulse control disorders not elsewhere classified [656]
5.8	Mood disorders [657]
5.9	Personality disorders [658]
5.10	Schizophrenia and other psychotic disorders [659]
5.13	Suicide and intentional self-inflicted injury [662]
5.14	Screening and history of mental health codes [663]
5.15	Miscellaneous mental disorders [670]
<b>Substance Abuse</b>	
5.11	Alcohol-related disorders [660]
5.12	Substance-related disorders [661]
5.14	Screening and history of substance abuse codes [663]

Source: AHRQ Clinical Classification Software (CCS). Numbers in the first column denote multi-level CCS diagnostic categories. Numbers in the second column denote single-level categories.

## Appendix F: Risk-Adjustment Variables for Readmissions Metrics

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For the 30-day readmission metrics, control variables for health status come from a full year of data prior to the index admission date and encompass clinically relevant comorbidities (not complications) that have strong relationships with readmission for the specific condition being analyzed.

### Heart Failure Readmissions

<ul style="list-style-type: none"> <li>• Age</li> <li>• Sex</li> <li>• History of Coronary Artery Bypass Graft</li> <li>• History of Percutaneous Transluminal Coronary Angioplasty</li> <li>• Diabetes Mellitus (DM) or DM Complications</li> <li>• Disorders of Fluid/Electrolyte/Acid-Base</li> <li>• Iron Deficiency or Other Unspecified Anemias and Blood Disease</li> <li>• Cardio-Respiratory Failure or Shock</li> <li>• Congestive Heart Failure</li> <li>• Vascular or Circulatory Disease</li> <li>• Chronic obstructive pulmonary disease</li> <li>• Pneumonia</li> <li>• Renal Failure</li> <li>• Other Urinary Tract Disorders</li> <li>• Decubitus Ulcer or Chronic Skin Ulcer</li> <li>• Other Gastrointestinal Disorders</li> <li>• Acute Coronary Syndrome</li> <li>• Valvular or Rheumatic Heart Disease</li> </ul>	<ul style="list-style-type: none"> <li>• Specified Arrhythmias</li> <li>• Asthma</li> <li>• Peptic Ulcer, Hemorrhage, Other Specified Gastrointestinal Disorders</li> <li>• Cancer</li> <li>• Drug/Alcohol Abuse/Dependence/Psychosis</li> <li>• Major Psychiatric Disorders</li> <li>• End-Stage Renal Disease or Dialysis</li> <li>• Severe Hematological Disorders</li> <li>• Nephritis</li> <li>• Liver or Biliary Disease</li> <li>• Metastatic Cancer or Acute Leukemia</li> <li>• Stroke</li> <li>• Dementia or Other Specified Brain Disorders</li> <li>• Coronary Atherosclerosis or Angina</li> <li>• Other or Unspecified Heart Disease</li> <li>• Other Psychiatric Disorders</li> <li>• Fibrosis of Lung or Other Chronic Lung Disorders</li> <li>• Hemiplegia, Paraplegia, Paralysis, Functional Disability</li> <li>• Depression</li> </ul>
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### Acute Myocardial Infarction (AMI) Readmissions

<ul style="list-style-type: none"> <li>• Age</li> <li>• Sex</li> <li>• History of Coronary Artery Bypass Graft</li> <li>• History of Percutaneous Transluminal Coronary Angioplasty</li> </ul>	<ul style="list-style-type: none"> <li>• Vascular or Circulatory Disease</li> <li>• Disorders of Fluid/Electrolyte/Acid-Base</li> <li>• Coronary Atherosclerosis</li> <li>• History of infection</li> <li>• Cerebrovascular Disease</li> </ul>
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**Acute Myocardial Infarction (AMI) Readmissions (continued)**

<ul style="list-style-type: none"> <li>• Diabetes Mellitus (DM) or DM Complications</li> <li>• Iron Deficiency or Other Unspecified Anemias and Blood Disease</li> <li>• Congestive Heart Failure</li> <li>• Valvular or Rheumatic Heart Disease</li> <li>• Chronic obstructive pulmonary disease</li> <li>• End-Stage Renal Disease or Dialysis</li> <li>• Other Urinary Tract Disorders</li> <li>• Specified Arrhythmias</li> <li>• Pneumonia</li> <li>• Renal Failure</li> </ul>	<ul style="list-style-type: none"> <li>• Metastatic Cancer or Acute Leukemia</li> <li>• Cancer</li> <li>• Decubitus Ulcer or Chronic Skin Ulcer</li> <li>• Dementia or Other Specified Brain Disorders</li> <li>• Angina Pectoris/Old Myocardial Infarction</li> <li>• Stroke</li> <li>• Asthma</li> <li>• Acute Coronary Syndrome</li> <li>• Hemiplegia, Paraplegia, Paralysis, Functional Disability</li> <li>• Protein-Calorie Malnutrition;</li> <li>• Anterior Myocardial Infarction</li> <li>• Other Location of Myocardial Infarction</li> </ul>
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**Pneumonia Readmissions**

<ul style="list-style-type: none"> <li>• Age</li> <li>• Sex</li> <li>• History of Coronary Artery Bypass Graft</li> <li>• History of infection</li> <li>• Septicemia/Shock</li> <li>• Metastatic Cancer or Acute Leukemia</li> <li>• Lung, Upper Digestive Tract, and Other Severe Cancers</li> <li>• Other Major Cancers</li> <li>• Diabetes Mellitus (DM) or DM Complications</li> <li>• Protein-calorie malnutrition</li> <li>• Disorders of Fluid/Electrolyte/Acid-Base</li> <li>• Other Gastrointestinal Disorders</li> <li>• Severe Hematological Disorders</li> <li>• Iron Deficiency or Other Unspecified Anemias and Blood Disease</li> <li>• Dementia or Other Specified Brain Disorders</li> <li>• Drug/Alcohol Abuse/Dependence/Psychosis</li> <li>• Major Psychiatric Disorders</li> <li>• Other Psychiatric Disorders</li> <li>• Hemiplegia, Paraplegia, Paralysis, Functional Disability</li> </ul>	<ul style="list-style-type: none"> <li>• Cardio-Respiratory Failure or Shock</li> <li>• Congestive Heart Failure</li> <li>• Acute Coronary Syndrome</li> <li>• Chronic Atherosclerosis or Angina</li> <li>• Valvular or Rheumatic Heart Disease</li> <li>• Specified Arrhythmias</li> <li>• Stroke</li> <li>• Vascular or Circulatory Disease</li> <li>• Chronic obstructive pulmonary disease</li> <li>• Fibrosis of Lung or Chronic Lung Disorders</li> <li>• Asthma</li> <li>• Pneumonia</li> <li>• Pleural Effusion/Pneumothorax</li> <li>• Other Lung Disorders</li> <li>• Dialysis Status</li> <li>• Renal Failure</li> <li>• Urinary Tract Infection</li> <li>• Other Urinary Tract Disorders</li> <li>• Decubitus Ulcer or Chronic Skin Ulcer</li> <li>• Vertebral fractures</li> <li>• Other Injuries</li> <li>• Respirator dependence/tracheostomy status</li> </ul>
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## Hospital-Wide Readmissions

<ul style="list-style-type: none"> <li>• Age</li> <li>• Metastatic cancer/acute leukemia</li> <li>• Severe Cancer</li> <li>• Other Cancers</li> <li>• Severe Hematological Disorders</li> <li>• Coagulation Defects and Other Specified Hematological Disorders</li> <li>• Iron Deficiency or Other Unspecified Anemia and Blood Disease</li> <li>• End-stage Liver Disease</li> <li>• Pancreatic Disease</li> <li>• Dialysis Status</li> <li>• Acute Renal Failure</li> <li>• Transplants</li> <li>• Severe Infection</li> <li>• Other Infectious Diseases and Pneumonias</li> <li>• Septicemia/Shock</li> <li>• Congestive Heart Failure</li> <li>• Polyneuropathy</li> <li>• Congestive Heart Failure</li> <li>• Chronic Atherosclerosis or Angina, Cerebrovascular Disease</li> </ul>	<ul style="list-style-type: none"> <li>• Specified Arrhythmias</li> <li>• Cardio-respiratory Failure or Cardio-respiratory Shock</li> <li>• Chronic Obstructive Pulmonary Disease</li> <li>• Fibrosis of Lung or Other Chronic Lung Disorders</li> <li>• Protein-calorie Malnutrition</li> <li>• Disorders of Fluid, Electrolyte, Acid-Base</li> <li>• Rheumatoid Arthritis and Inflammatory Connective Tissue Disease</li> <li>• Diabetes Mellitus</li> <li>• Decubitus Ulcer or Chronic Skin Ulcer</li> <li>• Hemiplegia, Paraplegia, Paralysis, Functional Disability</li> <li>• Seizure Disorders and Convulsions</li> <li>• Respirator Dependence/Tracheostomy Status</li> <li>• Drug and Alcohol Disorders</li> <li>• Psychiatric Comorbidity</li> <li>• Hip Fracture/Dislocation</li> </ul>
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# Chapter 4: Examining Care Outcomes for Populations of Children and Youth Eligible for Targeted Home and Community-Based Services

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## Introduction

In this chapter, we present metrics calculated from Medicaid claims and managed care encounter data for the baseline (2011-2012) and demonstration period (2013-2015) for several populations of children targeted for additional home and community-based services (HCBS) under the Waiver. Specifically, the Waiver authorizes the NJ Department of Children and Families' Division of Children's System of Care (DCF's CSOC)<sup>91</sup> to coordinate new supportive services for children with Autism Spectrum Disorder (ASD), co-occurring intellectual/developmental disabilities and mental illness (ID-DD/MI), and Serious Emotional Disturbance (SED). The Waiver also expands Medicaid eligibility for children with SED.

Our selection, analysis, and presentation of quality metrics in this report is guided by the following evaluation hypothesis and research questions in the waiver Special Terms and Conditions document (CMS 2014) relating to this expansion in targeted home and community-based services.

**Hypothesis 2: "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."**

**Research Question 2a: "What is the impact of providing additional home and community-based services to Medicaid and CHIP beneficiaries with serious emotional disturbance, autism spectrum disorder, or intellectual disabilities/developmental disabilities?"**

**Research Question 2b: "What is the impact of the program to provide a safe, stable, and therapeutically supportive environment for children from age 5 up to age 21 with serious emotional disturbance who have, or who otherwise would be at risk for, institutionalization?"**

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<sup>91</sup> By January of 2013, DCF assumed responsibility for all children previously managed by the Division of Developmental Disabilities (DDD).

All metrics in this chapter are calculated for the calendar years of the waiver baseline period, (2011-2012)<sup>92</sup> and the first three years of the demonstration period (2013-2015). All of the services authorized under the Waiver for the DCF populations started being offered during calendar year 2014 or later, limiting the data on the post-implementation period available for this final report.

## Background

A brief background on the service packages and target populations for each of the DCF CSOC waiver initiatives is provided here as context for the analytic methods and quantitative findings on quality of care we present in this chapter.

### ASD

The services provided through the ASD pilot program are evidence-based habilitative services often covered under private insurance that improve adaptive behavior, language, and cognitive outcomes. The new components of the ASD service package authorized under the Waiver are:

- Behavior Consultative Supports
- Individual Behavior Supports

Up to 200 children under 13 years of age with ASD who are Medicaid/CHIP eligible and who have a functional behavioral assessment indicating their condition is of high or moderate acuity are eligible for these behavioral therapies through the ASD pilot program. This program became operational in the spring of 2014 with enrollment ongoing as newly eligible children were identified.<sup>93</sup>

### ID-DD/MI

The pilot program for children with ID-DD/MI provides intensive in-home and out-of-home services that help to stabilize children in the least restrictive setting. There are seven services in the ID-DD/MI package authorized under the Waiver:

- Case/Care Management
- Individual Supports
- Natural Supports Training
- Intensive In-Community Services – Habilitation
- Respite

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<sup>92</sup> While the waiver demonstration period starts on October 2012, our analytic findings here are based on full calendar years so that our estimates are not driven by seasonality differences.

<sup>93</sup> Service codes for the new behavioral therapies were not built into the administrative claims system of the State's fiscal agent (Molina) at the time the pilot program began. Claims were handled manually until March 2015 when the service codes become operational.

- Non-medical Transportation
- Interpreter Services

Children ages 5-20 years old with dual diagnoses of ID-DD/MI, Medicaid/CHIP eligible, who meet the level of care criteria, and are involved with a Care Management Organization, are eligible for these services through the ID-DD/MI pilot program.<sup>94</sup> Two services, case management and intensive in-community services, started in March 2015. Individual Supports began in June 2015, respite was operationalized in January 2016, and interpreter services were offered beginning in January 2017. Natural supports and non-medical transportation were not yet operational as of the writing of this report.

### **SED**

The SED component of the Waiver (1) expands Medicaid/CHIP eligibility to youth with SED who are at-risk for hospitalization or who require a hospital level of care regardless of parental income, (2) federalizes general behavioral health services paid for on the state dollar for all SED children in Medicaid/CHIP, and (3) provides three new behavioral health services shown to be critical in supporting children with serious emotional disturbance in the community:

- Transitioning Youth Life Skill Building (ages 16-20)
- Youth Support and Training (ages 5-16)
- Non-medical Transportation

The expansion in eligibility for CSOC services (including new waiver services) to youth with SED, and the federalization of these behavioral health services became effective immediately after approval of the Waiver in October 2012. The expansion granting youth at a hospital-level of care Medicaid State Plan eligibility began in July 2016. The new waiver services are targeted at children with SED ages 5-20 years old who are involved with a Care Management Organization. The Transitioning Youth Life Skill Building and Youth Support and Training services were operationalized in the fall of 2015.

## **Methods**

### **Data Sources**

The analyses in this chapter were generated using Medicaid fee-for-service (FFS) claims and managed care encounter data for January 1, 2011 through December 31, 2015. We used recipient-level program enrollment information through September 2015 to allow for stratification of quality metrics to relevant subpopulations.

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<sup>94</sup> The services are delivered on a FFS basis as part of the Individual Service Plan implemented by the child's Care Management Organization.

## **Metrics**

The metrics in this chapter span the baseline period (2011-2012) and first three years of the Waiver demonstration period (2013-2015).<sup>95</sup> They are intended to examine health care outcomes and associated spending for specific subpopulations of children directly affected by the changes implemented under the Waiver. The metrics we utilize are based on specific types of hospital utilization that reflect quality of care in the community and therefore, are applicable only to children also receiving acute care services under Medicaid such that their hospital utilization is reflected in claims data. We examine inpatient (IP) utilization overall and for mental illness, avoidable hospital admissions, emergency department (ED) visits, and hospital readmissions or ED visits following an initial hospitalization (all-cause or specifically for mental illness). We also calculate annual spending relating to hospital use overall. This metric illustrates potential savings to be realized from the improved home and community-based support provided to children through waiver services. For children with SED, we separately examine rates of placement in residential treatment facilities.

Table A outlines the planned metrics calculated using the Medicaid FFS claims and managed care encounter data. Due to identification and accuracy concerns, only those metrics where the denominator criterion is fulfilled (see Reporting Criteria below) are reported. The facility type(s) included in the calculation are also noted. Metrics 1-8 and 12 are population-based and rates are assessed per unit population. Metrics 9-11, on the other hand, are based on index events that arise in a hospital setting. Our purpose was to capture aspects of utilization relevant to the populations being evaluated and potentially impacted by changes under the Waiver. To achieve this, several of these metrics are adaptations of existing metrics. Appendix A contains additional details on each of these measures.

**Table A: Metrics related to quantitative evaluation of Hypothesis 2**

	<b>Metrics</b>	<b>Description</b>	<b>Facility Type(s)</b>
	Utilization		
1	Pediatric Quality Indicators (children 6-17)	Ambulatory care sensitive hospitalizations by children that reflect inadequate community-level care.	General acute care hospitals
2	Inpatient hospital utilization (all ages)	Admissions to general acute care hospitals.	General acute care hospitals
3	Inpatient days (all ages)	Total duration of hospital stays.	General acute care hospitals
4	Mental illness admissions (ages 6+)	Discharges from an acute inpatient facility with a primary admitting diagnosis of mental illness.	General acute care hospitals

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<sup>95</sup> While the waiver demonstration period starts on October 2012, our analytic findings here are based on full calendar years so that our estimates are not driven by seasonality differences.



	<b>Metrics</b>	<b>Description</b>	<b>Facility Type(s)</b>
5	Severe mental illness admissions (ages 6+)	Discharges from an acute inpatient facility with a primary admitting diagnosis of severe mental illness.*	General acute care hospitals
6	Psychiatric hospital utilization (all ages)	Discharges from psychiatric hospitals.	Short-term and long-term psychiatric hospitals
7	Emergency department utilization (all ages)	Visits to emergency departments.	General acute care hospitals
8	Residential treatment facility admissions (all ages)	Admissions to a residential treatment facility	Residential treatment facilities
<b>Post-Acute Care</b>			
9	All-cause: 30-day readmissions or 30-day post-discharge ED visits (all ages)	All-cause unplanned readmissions or ED visit(s) during a 30-day period following an initial hospital admission. These may reflect post-discharge gaps in inpatient care and/or care coordination following discharge.	General acute care hospitals and short-term psychiatric hospitals
10	Mental illness: 30-day readmissions or 30-day post-discharge ED visits (age 6+)	All-cause unplanned readmissions or ED visit(s) during a 30-day period following an initial hospital admission for mental illness. These may reflect post-discharge gaps in inpatient care and/or care coordination specific to patients with mental illness.	General acute care hospitals and short-term psychiatric hospitals
11	Severe mental illness: 30-day readmissions or 30-day post-discharge ED visits (ages 6+)	All-cause unplanned readmissions or ED visit(s) during a 30-day period following an initial hospital admission for severe mental illness (SMI). These may reflect post-discharge gaps in inpatient care and/or care coordination for patients with SMI.	General acute care hospitals and short-term psychiatric hospitals
<b>Spending</b>			
12	Spending related to all inpatient hospitalizations and ED visits	Assess the effects of the targeted HCBS on acute care spending overall.	General acute care hospitals

\* This metric is assessed only among hospitalizations for beneficiaries meeting the criteria for a mental illness admission (metric 4). Therefore, admissions for some of the diagnoses falling within the severe mental illness designation but outside of the HEDIS mental illness designation, specifically those related to substance abuse, are not included in this metric. See Appendix C for the diagnosis codes included in the definition of severe mental illness used in this chapter.

If not already part of the metric specification, an inclusion criteria imposed on all metrics was the requirement that a claim for utilization was only counted if the beneficiary had been continuously enrolled in Medicaid for at least 30 days preceding the claim date. As stated in our evaluation plan, this criteria eliminates events which might precipitate Medicaid enrollment and confound the effect of the demonstration.

### **Mental Illness Designations**

We used information from the primary diagnosis code present on inpatient claims to identify hospitalizations for mental illness and severe mental illness. Specifically, we used the National

Committee for Quality Assurance's 2014 HEDIS Mental Illness Value Set to identify hospitalizations for mental illness (NCQA 2014). To accommodate the transition in October 2015 to the ICD10-CM coding system, diagnoses on claims from this last quarter of 2015 were mapped back to the ICD9-CM system using crosswalks from CMS's general equivalence mappings prepared by the National Bureau of Economic Research (2016). Within this universe of designated mental illness hospitalizations we further identified those hospitalizations which were for severe mental illness conditions based on findings from the national comorbidity survey – replication (Kessler et al. 2005) and subsequent work by Coffey et al. (2011) at the Agency for Health Care Research and Quality (AHRQ). Appendix C lists the diagnosis codes included in the definition of severe mental illness used in this chapter.

### **Spending**

Data on spending come from the payment fields in the Medicaid claims data. We only tabulated spending by Medicaid and Medicaid HMOs incurred via direct payment for services to providers. Payments made by Medicare or from any other source are not included. Spending for hospital use only reflect facility charges and do not include any physician or lab charges associated with hospitalization or outpatient visits. All spending was inflation adjusted and expressed in year 2012 purchasing power using the Consumer Price Index for medical care from Table 1A (Crawford, Church, and Rippey 2013, 164; Crawford and Church 2014, 165; Crawford, Church, and Akin 2015a, 145; Crawford, Church, and Akin 2015b, 165).

### **Population Definitions**

*Medicaid Youth:* Beneficiaries, ages 0-20, with any period of active enrollment in a particular calendar year, as indicated by the effective dates of their Program Status Codes, made up the Medicaid youth cohort for that year. Metrics are presented for this population to capture any trends in quality metrics that impact all Medicaid children and youth.

*ASD:* The cohort of children enrolled in the ASD pilot program was identified starting with recipient-level program and waiver enrollment data extending through September 2015. Any child with an active 'Special Program Code' (SPC) of 48 (indicating ASD moderate acuity) or 49 (indicating ASD high acuity) was included in the ASD cohort. All children in this cohort who were identified in years 2011-2015, as indicated by their presence in the respective Medicaid youth eligibility cohort, made up the ASD study population for each of these years.

*ID-DD/MI:* The cohort of children enrolled in the ID-DD/MI pilot program was identified starting with recipient-level program and waiver enrollment data extending through September 2015. Any child with an active SPC of 38 was included in the ID-DD/MI cohort. All children in this cohort

who were identified in years 2011-2015, as indicated by their presence in the respective Medicaid youth eligibility cohort, made up the ID-DD/MI study population for each of these years.

*SED*: The cohort of children with SED and eligible to receive waiver services was identified starting with recipient-level data from September 2015. Any child age 5-20, with a SPC of 37 and a concurrently active Program Status Code of 641 was included in the SED cohort. All children in this cohort who were identified in years 2011-2015, as indicated by their presence in the respective Medicaid youth eligibility cohort, made up the SED population for each of these years.

As of March 31, 2017, 170 youth have been identified for the ASD pilot and 736 youth have been identified for the ID-DD/MI pilot. The SED demonstration had 3,641 SED at-risk youth participating and 179 youth with SED at a hospital-level of care receiving waiver and State Plan services. Table B shows the number of children identified in each cohort using enrollment data and special program codes from the period(s) available in our claims data over 2011-2015 when the new waiver services were operational and attrition of those population totals as enrollment was tracked back to the years in the study period. Children with SED newly enrolled as a result of the eligibility expansion under the Waiver would not be in the recipient-level data in the baseline years unless they qualified under pre-waiver eligibility criteria at that time, thus explaining the larger declines in the SED population.

**Table B: Population totals for cohorts of children and youth eligible for home and community-based waiver services**

	2015	2014	2013	2012	2011
<b>ASD</b>	54	54	52	49	40
<b>ID-DD/MI</b>	220	219	202	187	180
<b>SED*</b>	2,780	1,369	767	546	507

\*Only enrollment in September 2015, when waiver services for this population were operationalized, was considered when identifying the SED cohort.

**Reporting Criteria**

For Metrics 1-8 and 12, which are population-based rates, estimates are not shown when the denominator for IP hospitalizations or ED visits is less than 50. For the remaining three metrics, denominators and estimates are suppressed when denominators are less than 30. We calculated annual estimates over 2011-2015.

While we have already suppressed estimates based on small denominators, it is important to note due to small numbers of children in the ASD and ID-DD/MI cohorts, the observed variation for the metrics between years might be the result of outliers in the data or random events. Estimates based on small samples should be interpreted with this caveat. Additionally, the

expansion SED at-risk population was eligible for only CSOC and waiver services starting in October 2012. Hospitalizations and emergency department use for these individuals would only be present in our claims data if the child happened to be eligible for and enrolled to receive State Plan services under pre-waiver eligibility criteria during the years prior to 2015 when we identified the cohort. The population of children with SED eligible for waiver services and also legacy eligible for State Plan services was not sufficient to meet our reporting criteria threshold. Thus, metrics reflecting rates of acute care utilization are not shown for the SED cohort. These legacy children were, however, included in the estimates of post-acute care following hospitalization for the combined waiver cohorts since there is no denominator eligibility issue for metrics based on index hospital events.

### **Data Analysis**

Where sample size was sufficient, we conducted statistical testing on utilization rates, comparing estimates for 2015 to the year prior to waiver service initiation; The comparison year was therefore 2013 for the ASD cohort and 2014 for the ID-DD/MI and SED cohorts. We calculated the ratio of the utilization rate in 2015 to that in the comparison year and calculated the 95% confidence interval for this ratio using established methods (Breslow and Day 1987; NYSDH 2011; WSDH 2012). If the confidence interval included one then we inferred that the rates of utilization did not change significantly from the period prior to delivery of waiver services to the period after; otherwise there was a statistically significant change ( $p < 0.05$ ).

## **Results**

### **ASD and ID-DD/MI**

Tables 4.1 and 4.2 show rates of hospital utilization, overall, and those related to pediatric ambulatory care sensitive conditions or mental health conditions for the ASD and ID-DD/MI cohorts of Medicaid youth eligible for home and community-based waiver services, and for all Medicaid youth.<sup>96</sup> Our sample was insufficient to present some of these rates for the ASD waiver population.

*Avoidable Inpatient Hospitalizations:* In general, rates of avoidable hospitalizations were very low (Table 4.1). There were 0.2 avoidable hospitalizations per 100 Medicaid youth in four out of five years during the study period. The rate was higher in the ID-DD/MI cohort through 2014, reaching 1.8 per 100 ID-DD/MI youth in 2013, but dropping down to zero in 2015.

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<sup>96</sup> It is important to note that rates are consistently presented as events per 100 population, however, the relevant denominators related to some of the presented statistics are sometimes less than 100.

*Hospitalization Rates and Inpatient Days:* We observe a slight downward trend in hospital utilization for Medicaid youth overall over 2011-2015 which is seen in the ID-DD/MI as well as the ASD cohort (See Table 4.1). However, none of these declines are statistically significant. The number of inpatient days did significantly decline between 2015 and 2013 for the ASD and ID-DD/MI cohorts. We observe declines in inpatient days for Medicaid youth overall as well, though not as steep.

*ED Visits:* The emergency department visit rate for all cohorts increased between 2014 and 2015 following a steady or declining trend in the preceding year(s). These increases, from 53.8 ED visits per 100 youth to 94.4 visits per 100 ASD youth in 2015, and 60.4 to 89.5 visits per 100 youth with ID-DD/MI, were statistically significant.

*Hospital Per-capita Spending:* This was generally greater for the ID-DD/MI cohort in all years compared to the ASD and all-Medicaid cohorts, reflecting their higher rates of inpatient stays. The overall trend in declining inpatient use and duration of stay in the ASD cohort may be responsible for the general decline in hospital spending per beneficiary despite increases in ED use. Per capita spending for the ASD and the ID-DD/MI cohorts were statistically significantly lower in 2015 versus the year preceding waiver service initiation ((\$644 vs. \$954 and \$856 vs. \$2,847, respectively).

*Inpatient Hospital Use for Mental Health Conditions:* Table 4.2 demonstrates that all the three rates for Medicaid youth overall were steady over the study period. For the ASD cohort, the rates could either be not reported because of small samples, or were zero, except for a rate of 1.9 mental illness hospitalizations per 100 youth in 2015. Rates of MI hospitalizations for the ID-DD/MI cohort dropped to their lowest level of 2.8 per 100 youth in 2015, although this decline was not statistically significant. Admissions to either long-term or short-term psychiatric hospitals for children in the ID-DD/MI cohort reached their highest in 2015 at 4.1 per 100 youth, but this was not a statistically significant increase.

## **SED**

*Admission to Residential Treatment Facilities:* Table 4.3 shows rates of admission to residential treatment facilities for the cohort of children with SED at-risk for, or having, an institutional level of care. In 2011, 1 in every 100 children with SED had at least one admission to a residential treatment facility. The corresponding rate climbed to 1.7 per 100 children in 2013 and was down to 0.4 per 100 children in 2015 having at least one admission for treatment in a residential facility. The decline from 2014 to 2015 was statistically significant.

### **Combined Cohorts**

Table 4.4 presents 30-day readmission rates and rates of ED treat-and-release visits within 30 days of discharge for different types of hospitalizations occurring in 2012 through 2015. These estimates are presented for the cohorts of children combined to ensure the minimum denominator of 30 index hospitalizations. In the one baseline year (2012), nearly 6% of hospitalizations among all children eventually eligible for waiver home and community-based services were followed by a readmission within 30 days. Eleven percent were followed by an ED visit within the same window resulting in 14% being followed by either one or both of these outcomes. These rates were generally better (lower) than the corresponding rates for all Medicaid youth. However, in the early demonstration years (2013-2014) this pattern inverts. Readmission and ED visits post-discharge improve slightly (reflected in lower percentages) among Medicaid youth overall, but appear to worsen among the combined ASD, ID-DD/MI, and SED cohort. By 2015, there is an improvement from 2014 rates for the waiver cohorts, but these changes are not statistically significant. The infrequency of mental illness and serious mental illness hospitalizations in these cohorts prevent us from assessing their trends in the first three demonstration years.

**Table 4.1: Overall hospital utilization rates (per 100 population) and spending per beneficiary for Medicaid youth eligible for home and community-based waiver services**

Overall Hospital Utilization	ASD					ID-DD/MI					Medicaid Youth				
	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015
Avoidable pediatric hospitalizations	*	*	*	*	0.0	1.4	0.0	1.8	0.6	0.0	0.2	0.2	0.2	0.2	0.1
Hospital utilization	*	*	15.4	9.3	11.1	16.7	13.9	11.9	11.9	10.0	3.6	3.4	3.1	2.8	2.5
Inpatient days	*	*	46.2	25.9	24.1 <sup>†</sup>	71.1	43.3	57.4	158.0	45.5 <sup>†</sup>	13.6	13.3	12.8	11.7	11.1
Emergency department visits	*	*	53.8	44.4	94.4 <sup>†</sup>	73.9	59.9	60.4	61.2	89.5 <sup>†</sup>	43.1	44.2	43.9	42.8	43.3
Hospital spending per beneficiary	*	*	\$954	\$656	\$644 <sup>†</sup>	\$1,118	\$1,085	\$903	\$2,847	\$856 <sup>†</sup>	\$337	\$350	\$352	\$350	\$342

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011–2015; Analysis by Rutgers Center for State Health Policy.

Notes: ASD=Autism Spectrum Disorder; ID-DD/MI=Co-occurring intellectual/developmental disability and mental illness; ED=Emergency Department.

Rates are per 100 population; Medicaid youth includes all beneficiaries ages 0–20.

\*Estimate suppressed due to insufficient sample size.

† Difference from 2013 estimate (ASD) or 2014 estimate (ID-DD/MI) is significant at the 5% level.

Cohort Sizes	ASD					ID-DD/MI					Medicaid Youth				
	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015
Avoidable hospitalizations	15	23	35	43	51	143	153	169	173	176	479,503	497,129	512,211	539,136	568,579
Hospital utilization	40	49	52	54	54	180	187	202	219	220	868,829	886,595	897,412	941,512	982,818
Inpatient days	40	49	52	54	54	180	187	202	219	220	868,829	886,595	897,412	941,512	982,818
Emergency department visits	40	49	52	54	54	180	187	202	219	220	868,829	886,595	897,412	941,512	982,818
Hospital spending per beneficiary	40	49	52	54	54	180	187	202	219	220	868,829	886,595	897,412	941,512	982,818

Notes: These Ns reflect relevant denominators for rates reported in the top panel.

See Appendix A for details on inclusion/exclusion criteria resulting in eligible population for each metric.

**Table 4.2: Mental health inpatient utilization rates (per 100 population) for Medicaid youth eligible for home and community-based waiver services**

Inpatient Hospital Utilization for Mental Health Conditions	ASD					ID-DD/MI					Medicaid Youth				
	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015
Mental Illness hospitalizations	*	*	*	*	1.9	6.3	3.1	4.2	4.8	2.8	0.4	0.4	0.4	0.4	0.4
SMI hospitalizations	*	*	*	*	0.0	0.7	0.6	0.0	1.0	0.0	0.2	0.2	0.3	0.3	0.3
Hospitalizations at psych. hospitals	*	*	0.0	0.0	0.0	1.7	2.1	1.5	1.8	4.1	0.2	0.1	0.1	0.1	0.2

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011–2015; Analysis by Rutgers Center for State Health Policy.

Notes: ASD=Autism Spectrum Disorder; ID-DD/MI=Co-occurring intellectual/developmental disability and mental illness; SMI=Severe Mental Illness.

Rates are per 100 population; Medicaid youth includes all beneficiaries ages 0–20.

\*Estimate suppressed due to insufficient sample size.

Cohort Sizes	ASD					ID-DD/MI					Medicaid Youth				
	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015	2011	2012	2013	2014	2015
Mental Illness hospitalizations	15	23	35	44	52	143	162	189	207	218	565,150	581,855	596,448	637,731	676,417
SMI hospitalizations	15	23	35	44	52	143	162	189	207	218	565,150	581,855	596,448	637,731	676,417
Hospitalizations at psych. hospitals	40	49	52	54	54	180	187	202	219	220	868,829	886,595	897,412	941,512	982,818

Notes: These Ns reflect relevant denominators for rates reported in the top panel.

See Appendix A for details on inclusion/exclusion criteria resulting in eligible population for each metric.



**Table 4.3: Residential treatment facility admission rates for Medicaid youth with serious emotional disturbance eligible for home and community-based waiver services**

	SED				
	2011	2012	2013	2014	2015
Residential Treatment Facility Admissions	1.0	0.7	1.7	1.0	0.4 <sup>†</sup>

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015;

Analysis by Rutgers Center for State Health Policy.

Notes: SED=Serious Emotional Disturbance.

Rates are per 100 population.

<sup>†</sup> Difference from 2014 estimate is significant at the 5% level.

<b>Cohort Sizes</b>	SED				
	2011	2012	2013	2014	2015
Residential Treatment Facility Admissions	516	556	767	1369	2776

Notes: These Ns reflect relevant denominators for rates reported in the top panel.

See Appendix A for details on inclusion/exclusion criteria resulting in eligible population for each metric.

**Table 4.4: Post-acute care following hospitalization of Medicaid youth eligible for home and community-based waiver services**

Post-Acute Care Following Types of Hospitalizations	Combined Waiver Populations (ASD, ID-DD/MI, SED)				Medicaid Youth			
	2012	2013	2014	2015	2012	2013	2014	2015
All-Cause Hospitalizations								
Readmission within 30 days	5.7%	9.8%	16.1%	6.3%	8.5%	8.2%	7.1%	7.3%
ED Visit within 30 days	11.4%	14.6%	19.4%	18.8%	14.1%	13.8%	14.0%	14.9%
Either of above	14.3%	22.0%	25.8%	21.9%	19.6%	19.0%	18.6%	19.7%
Mental Illness Hospitalizations								
Readmission within 30 days	*	*	*	*	11.6%	10.7%	10.8%	10.8%
ED Visit within 30 days	*	*	*	*	21.0%	18.8%	20.5%	22.4%
Either of above	*	*	*	*	25.8%	23.1%	23.8%	25.7%
Severe Mental Illness Hospitalizations								
Readmission within 30 days	*	*	*	*	11.3%	11.6%	11.7%	11.6%
ED Visit within 30 days	*	*	*	*	20.6%	19.3%	21.3%	23.7%
Either of above	*	*	*	*	24.9%	24.0%	25.2%	27.3%

Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Notes: ASD=Autism Spectrum Disorder; ID-DD/MI=Co-occurring intellectual/developmental disability and mental illness; SED=Serious Emotional Disturbance; ED=Emergency Department.

Medicaid youth includes all beneficiaries ages 0-20.

\*Estimate suppressed due to insufficient sample size.

## Discussion

This chapter presents estimates for the baseline and first three waiver demonstration years for the metrics we proposed to assess the impact of expanded home and community-based services authorized under the Comprehensive Medicaid Waiver for children with autism spectrum disorder, co-occurring intellectual disabilities/developmental disabilities and mental illness, and serious emotional disturbance. With respect to the waiver services for children with ASD and ID-DD/MI, it is worth noting that DCF delivers these services to more children than just those enrolled in the pilot programs established by the Waiver. Thus, while the scope of our evaluation is limited to the cohorts meeting the inclusion criteria for the pilot programs, and our analysis is structured to that end, it will not fully reflect the impact of these supportive home and community-based services on all children receiving them.

Below we highlight some key takeaway points from this chapter's findings. Due to small sample sizes in the ASD cohort and because waiver services for the other two cohorts were not delivered until 2015, we have limited data for assessing the full impact of these new services on health outcomes for these populations of children. We noted differences between estimates for individual years or between populations, but these should be interpreted with the caveat that the differences discussed have not been adjusted for patient and provider characteristics and can be influenced by outlier events in small populations. Making those adjustments would require regression analyses which are not feasible due to the small sample sizes.

Among children with ASD and ID-DD/MI enrolled in the waiver pilot program any time up through September 2015, there is a mixed trend in outcomes for overall hospital use, with frequency and duration of inpatient stays declining but rates of ED visits increasing. Because the same trends are observed in Medicaid youth overall, this may not be related to waiver services provided in the pilot programs. Children in the ASD cohort barely ever had inpatient utilization for mental illness, prior to or after the pilot program began. There were different trends in utilization between inpatient facility types for the ID-DD/MI cohort, with increasing rates of utilization at short-term and long-term psychiatric hospitals and declines in hospitalizations at general acute care facilities. This is relevant to consider given the goal of expanded home and community-based services in maintaining children in their own homes. However, these observed changes were not statistically significant between 2014 and 2015 when some of the waiver services began for this population of children and youth. Thus, there is no net positive or negative impact on acute care utilization outcomes that we can attribute to these additional waiver services for children in the ASD or ID-DD/MI pilot programs.

It may be that more proximal behavioral health outcomes reflect early impacts of these waiver services. Data from secondary sources extending further out than our claims analysis are suggestive that the pilots are being implemented successfully. According to the annual report for demonstration year 4 prepared by the State (DMAHS 2016), all of the children in the ASD and ID-DD/MI programs were identified as at-risk for out-of-home placement, but less than 5% of children participating in the pilots had to be placed out-of-home. This is suggestive that the waiver services provided were successful at maintaining a majority of children in their homes. Moreover, review of case files and administrative data undertaken as part of CSOC's Quality Strategy show very close to or at 100% achievement of process measures reflecting quality of life, appropriateness of level and plan of care procedures, and use of qualified service providers for the children enrolled in these pilot programs. Measures related to health and welfare and financial accountability are still in development. These findings supplement those from our hospital based quality metrics.

The statistically significant decline in the number of children with SED ever being admitted to a residential treatment facility in 2015 is also a positive finding, but there would be, at most, three months of exposure to the new waiver services for this cohort of children in 2015. So while the declining trend is promising, it is not conclusive regarding the impact of these new services on reducing the need for out-of-home placement in a residential treatment facility for children with SED. Finally the metrics calculated for the combined cohorts shed light on specific domains of quality for the overall HCBS waiver populations.

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## Appendix A: Description of Measures

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*Inpatient Utilization and Emergency Department Visits:* These measures assess the extent to which individuals receive inpatient hospital treatment or care in the emergency department. These measures of acute care and emergency medical utilization shed light on overall health of individuals and capture potential policy impact on health and healthcare. It is however important to remember that use of inpatient and emergency department services is affected by many member characteristics such as age, sex, health, and socioeconomic status.

Our preparation of these measures consider utilization at any general acute care hospital, inside or outside NJ, by members of our defined child cohorts (ASD, ID-DD/MI, and Youth). The days associated with all identified inpatient hospitalizations, and the spending associated with all identified inpatient and emergency department visits are also aggregated over cohort members.

*Ambulatory Care Sensitive (ACS) Inpatient Hospitalizations:* We calculate rates of ACS inpatient (IP) hospitalizations that may occur due to inadequate quality of ambulatory/primary care within communities. Avoidable hospitalizations have been widely used in previous research to measure access to primary care, and disparities in health outcomes (Basu, Friedman, and Burstin 2004; Billings et al. 1993; Bindman et al. 1995; Howard et al. 2007). The federal Agency for Healthcare Research and Quality (AHRQ) provides validated programming algorithms to calculate rates of avoidable ACS hospitalizations which are used in this analysis. These are known as the Pediatric Quality Indicators for children (ages 6-17). Appendix B gives a list of ACS conditions that constitute a composite index that measures the overall rate of avoidable IP hospitalizations per unit of population.

Our preparation of this metric considers avoidable hospitalizations occurring at any general acute care hospital, inside or outside NJ, by members of our defined child cohorts (ASD, ID-DD/MI, and Youth).

*Mental Illness Admissions:* This measure of inpatient utilization assesses the extent to which individuals receive inpatient hospital treatment for mental illness. Like general measures of hospital utilization, this measure of service use gathers information about the provision of care to individuals and how organizations managing that care use and allocate resources. Use of inpatient services is affected by many member characteristics such as age, sex, health, and socioeconomic status.

This metric was adapted from the National Committee of Quality Assurance's Follow-up after Hospitalization for Mental Illness (FUH) metric which is endorsed by NQF. Our preparation of this metric considers hospitalizations for mental illness occurring at any general acute care hospital, inside or outside NJ, by members of our defined child cohorts (ASD, ID-DD/MI, and Youth). In accordance with the metric specification for FUH, index hospitalizations for mental illness were only identified for the population age 6 and older.

*Severe Mental Illness Admissions:* Preparation of this metric followed the same specifications as Mental Illness Admissions. The only difference was that the admissions counted were a subset of the mental illness admissions, defined as those admissions with a diagnosis qualifying as severe mental illness. Therefore, admissions for some of the diagnoses falling within the severe mental illness designation but outside of the HEDIS Mental Illness Value Set, specifically those related to substance abuse, are not included in this metric. See Appendix C for the list of diagnosis codes designated as severe mental illness in this report.

*Admissions to Psychiatric Hospitals:* This measures assesses the extent to which individuals receive inpatient treatment at a short-term or long-term psychiatric hospital. Our preparation of this metric considers utilization at any psychiatric hospital, inside or outside NJ, by members of our defined child cohorts (ASD, ID-DD/MI, and Youth).

*Admissions to Residential Treatment Facilities:* This measure assesses the extent to which children with SED received treatment in a residential facility. Returning for treatment after a leave was not counted as a separate admission. Our preparation of this metric considers utilization at any Joint Commission-accredited residential treatment facility, inside or outside NJ, by members of our defined SED cohort.

*Readmissions:* Thirty-day readmissions metrics are used to broadly measure the quality of care delivered by hospitals (Benbassat and Taragin 2000; Jencks, Williams, and Coleman 2009) and post-discharge care coordination. Such 'potentially preventable' readmissions are defined as readmission for any cause within 30 days of the discharge date for the index hospitalization, excluding a specified set of planned readmissions. While readmissions rates have been most heavily utilized to assess quality for the Medicare population, calculating these measures among the Medicaid population has received growing attention (Trudnak et al. 2014).

We prepared readmission metrics considering hospitalizations at acute inpatient facilities, both general acute care hospitals and short-term psychiatric hospitals, inside or outside NJ, by members of our defined child cohorts (ASD, ID-DD/MI, SED, and Youth). In accordance with specifications for all Centers for Medicare and Medicaid Services (CMS) readmissions metrics, we



required that the beneficiary be enrolled for 12 months prior to the index hospitalization (ignoring gaps of 45 days or less) to allow for sufficient claims history if risk-adjustment were to be undertaken. While estimates presented in this chapter are not risk-adjusted, estimates for year 2011 could not be calculated due to this restriction.

*Hospital-Wide All-Cause Unplanned Readmissions:* This readmission metric is endorsed by the National Quality Forum (NQF) and it was calculated by adapting the federal CMS methodology available at QualityNet<sup>97</sup> to the Medicaid FFS claims and encounter data. It was calculated for children ages 0-17 so it could be used to assess quality for the populations of children affected by the Waiver policies, and, additionally, we included index admissions with a principal psychiatric diagnosis.

*Readmission Following Hospitalization for Mental Illness:* We adapted the National Committee of Quality Assurance's 'Follow up after hospitalization' (FUH) specifications for the identification of a hospitalization for mental illness in the calculation of this metric (NCQA 2014). For this metric, we considered admissions to any general acute care hospital or short-term psychiatric hospital with a diagnosis of mental illness. In accordance with the metric specification for FUH, index hospitalizations for mental illness were only identified for the population age 6 and older.

*Readmission Following Hospitalization for Severe Mental Illness:* Preparation of this metric followed the same specifications as *Readmission Following Hospitalization for Mental Illness*. The only difference was that the universe of index admissions considered was a subset of the mental illness index admissions defined as those admissions with a diagnosis qualifying as severe mental illness. Therefore, admissions for some of the diagnoses falling within the severe mental illness designation but outside of the HEDIS mental illness designation, specifically those related to substance abuse, are not included in this metric. See Appendix C for the list of diagnosis codes designated as severe mental illness.

*Emergency Department Visits within 30 Days of Discharge:* Return visits to the ED after a hospital discharge can be an important indicator of inadequate post-discharge follow-up and care coordination. Although not a validated quality metric, research on this topic is growing (DeLia et al. 2014). For each of the index admission universes identified for the readmission metrics described above, we also flagged whether there was an ED treat-and-release visit at any general acute care hospital inside or outside NJ within 30 days of discharge.

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<sup>97</sup> <https://www.qualitynet.org>.

## Appendix B: AHRQ Pediatric Quality Composite Indicator – Constituents

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### Overall Composite (PDI #90)

PDI #14 Asthma Admission Rate

PDI #15 Diabetes Short-Term Complications Admission Rate

PDI #16 Gastroenteritis Admission Rate

PDI #18 Urinary Tract Infection Admission Rate

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Source: Pediatric Quality Indicators Technical Specifications - Version 5.0, March 2015;  
[http://www.qualityindicators.ahrq.gov/Archive/PDI\\_TechSpec\\_V45.aspx](http://www.qualityindicators.ahrq.gov/Archive/PDI_TechSpec_V45.aspx).

## Appendix C: Severe Mental Illness Diagnoses

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Severe Mental Illness ICD9-CM Diagnoses	
295, 297, 298	Psychotic disorders
296.00-06, 296.10-16, 296.40-46, 296.50-56, 296.60-66, 296.7, 296.80-82, 296.89, 296.90, 296.99	Bipolar disorders
300.3	Obsessive compulsive disorder
300.4, 309.1, 301.11-12	Dysthymia (chronic depression)
313.81	Oppositional defiant disorder
296.20, 296.23, 296.24, 296.30, 296.33, 296.34	Depressive disorders
301.20	Personality disorder
312.03, 312.13, 312.21	Conduct disorder

Note: To accommodate the transition in October 2015 to the ICD10-CM coding system, diagnoses on claims from this last quarter of 2015 were mapped back to the ICD9-CM system using crosswalks from CMS's general equivalence mappings prepared by the National Bureau of Economic Research (2016).

# Chapter 5: Impact of Administrative Simplifications to Streamline Medicaid Eligibility Processes

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## Introduction

In this chapter, we examine the reforms under the Medicaid Comprehensive Waiver intended to streamline eligibility processes for new applicants and existing beneficiaries in need of long-term care services. The following evaluation hypothesis and research questions in the waiver Special Terms and Conditions document (CMS 2014) are addressed:<sup>98</sup>

**Hypothesis 3: “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.”**

**Research Question 3a: “What is the impact of the projected spend-down provision on the Medicaid eligibility and enrollment process? What economies or efficiencies were achieved, and if so, what were they? Was there a change in the number of individuals or on the mix of individuals qualifying for Medicaid due to this provision?”**

**Research Question 3b: “What is the impact of eliminating the transfer of assets look-back period for long term care and home and community based services for individuals who are at or below 100% of the FPL? Was there a change in the number of individuals or in the mix of individuals qualifying for Medicaid due to this provision?”**

To evaluate these reforms we draw on statistics from administrative records provided to us by State officials or available in public reports and presentations. We also rely on audit data collected by the State’s Bureau of Quality Control (BQC) and contextual information on the audit process and findings from direct communications with State officials.

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<sup>98</sup> The hypothesis and associated research questions enumerated here reflect the wording used in the waiver Special Terms and Conditions document as approved by CMS (CMS 2014). The projected spend-down provision originally proposed in the Waiver was not implemented since the State chose to adopt Qualified Income Trusts (QITs), and we assess the impact of QIT implementation

## **Background**

### **Transfer of Assets Self-Attestation**

Medicaid eligibility for long-term care services requires that applicants have not transferred any assets or resources for less than fair market value during the five years preceding their date of application. If an initial check using an asset verification system (AVS) shows questionable activity, applicants are often required to furnish bank statements and financial documents proving compliance with this requirement before eligibility can be granted. If a transfer of assets did occur then a penalty period is imposed delaying eligibility for long-term care services.

Under the Waiver, individuals with income at or below 100% of the Federal Poverty Level (FPL) applying for institutional or home and community-based services are permitted to self-attest that they have made no disqualifying asset transfers during the past five years. This attestation is a sworn statement documented on an addendum to the Medicaid application used by County Welfare Agencies (CWAs) for new entrants, or collected during the clinical eligibility determination conducted by Managed Care Organizations (MCOs) for existing beneficiaries moving into Managed Long-term Services and Supports (MLTSS) after July 1, 2014. This form, which was approved for use in December 2012 for CWAs and in 2016 for MCOs, eliminates the need for the time intensive five-year lookback process, and was intended to expedite eligibility approvals for very low-income applicants (Harr 2012, Harr 2013, Harr 2016).

### **Qualified Income Trusts**

The adoption of Qualified Income Trusts (QITs) in December 2014 (Harr 2014) replaced the hypothetical spend-down provision for community-residing individuals having a nursing facility level-of-care which was originally proposed in the Waiver. QITs allow clinically eligible individuals whose monthly income is above 300% of the Supplemental Security Income rate (recently \$2,205) to have excess income disregarded in determining Medicaid eligibility. Income above the threshold is deposited in a separate bank account which is dedicated exclusively to approved uses such as Medicaid cost-sharing expenses (which could include long-term services and supports delivered in their homes/communities or in a nursing facility), personal or medical needs allowances, or uncovered medical costs. Prior to the Waiver, a spend-down provision for higher income applicants was only available for nursing facility residents through a Medically Needy designation, which may have led people with income higher than the eligibility threshold to choose nursing facilities at a higher cost to the state. QITs effectively create a new eligibility pathway for long-term care services in home and community settings for such individuals. The introduction of the QIT mechanism required discontinuing the Medically Needy program, which could have posed a disadvantage to existing enrollees residing in nursing facilities since the resource limits for eligibility are lowered to the community levels (\$2,000 for an individual or

\$3,000 for a couple). However, the State grandfathered all individuals enrolled in the Medically Needy program prior to December 2014 so they could maintain their Medicaid eligibility under the old resource limits (\$4,000 for an individual or \$6,000 for a couple).

## **Methods**

### **Data Sources**

In this section, we use statistics collected by the State for public- and CMS-reporting purposes as well as data collected by the Bureau of Quality Control specifically for evaluation of the self-attestation policy. We also use Medicaid fee-for-service (FFS) claims and managed care encounter data for January 1, 2011 through December 31, 2015.

### **Measures**

Drawing from quarterly reports from DMAHS to CMS, we present counts of self-attestation forms received by the State. We also report the error rate of audited self-attestations resulting from the BQC's review process as reported to us by the State. Using data from the Department of Human Services' response to the Office of Legislative Services on the budget (state fiscal years 2015-2016 and 2016-2017), we present here the count of applicants using QITs, reported approval rates, and the our estimated number of community-residing long-term care Medicaid beneficiaries enrolled because of the QIT mechanism. Finally, we present trends in settings of care (HCBS v Nursing Facility) for long-term care beneficiaries calculated from Medicaid claims data.

### **Quality Control Review of Transfer of Assets Self-Attestation**

In July through September 2015, the BQC piloted a review protocol to measure the accuracy and effectiveness of the transfer of assets self-attestation procedure. Completed self-attestations provided to BQC each quarter from the Office of Eligibility were sampled for detailed review. First a random sample of 30 forms from each batch was selected, and then 8 of the 30 were randomly selected. The 8 applications then underwent an audit process. In this process, electronic asset verification was conducted. If any questionable activity was detected, applicants would be contacted and asked to provide a representative sample of financial documents (i.e. information on bank accounts, properties, investments, and any other resource or asset) for up to five years prior to the time of application in order to determine whether any assets had been transferred for less than fair market value. Any finding on the sample of 8 would trigger a review of all 30 of the sampled cases. The error rate was calculated as the percentage of all reviewed cases having a positive finding, meaning a transfer penalty would have been imposed under a pre-waiver financial eligibility determination.

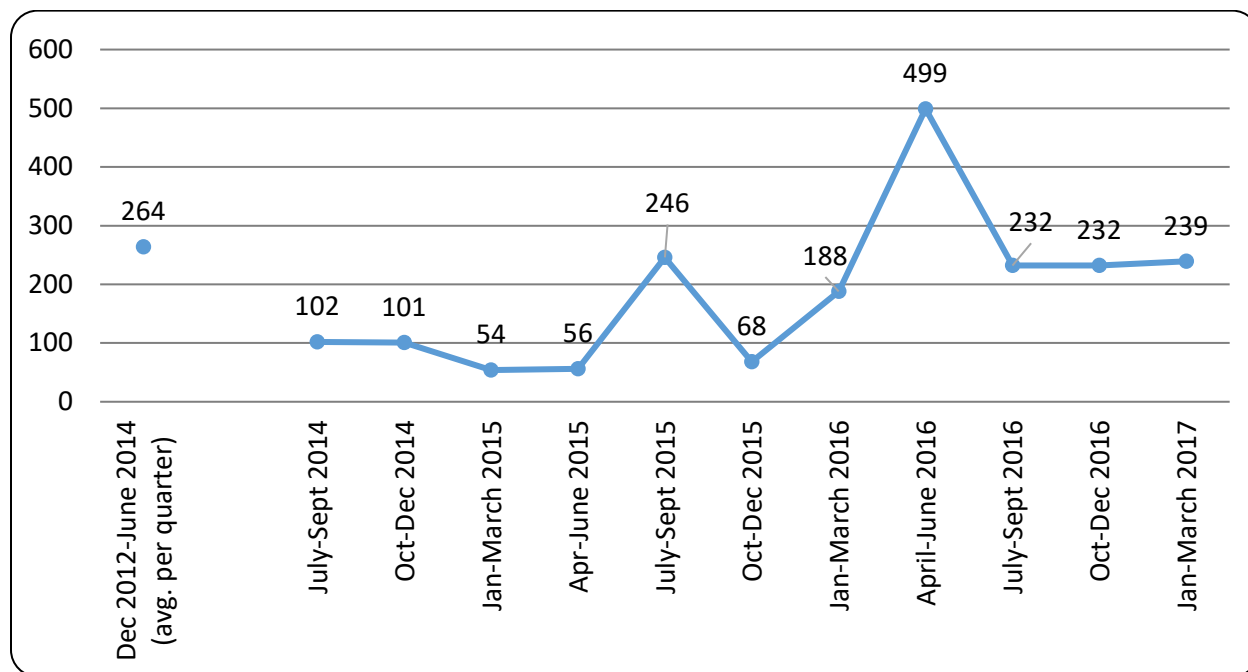
The BQC was unable to provide the average time from application to approval in each quarter for all cases reviewed in the audit process due to concerns about the accuracy of the measure. This information routes through county welfare agencies (CWAs) and MCOs, depending on the application pathway, which poses difficulty for collecting the information in a standardized way. Moreover, delays by applicants in providing other documentation requested by the CWA, as well as delays in determination of clinical eligibility, could all prolong the time from application to approval. Therefore, we are unable to provide data for this proposed evaluation outcome.

## Results

### Transfer of Assets Self-Attestation

Figure 5.1 shows the number of self-attestations collected during each quarter after MLTSS implementation in July 2014. Prior to MLTSS, 1,670 self-attestations were collected from CWAs and this is presented as an average per quarter on the chart. Post-MLTSS, until March 2017, another 2,017 self-attestations were collected.

**Figure 5.1: Quarterly number of self-attestation forms received from Medicaid long-term care applicants, December 2012 to March 2017**



Source: DMAHS, Quarterly reports to CMS.

Table 5.1 shows results of BQC’s self-attestation review process for each quarter between October 2015 and December 2016. The error rate on the eight sampled applicants in each quarter was 0%.

**Table 5.1: Error rate and time to approval from quality control review of self-attestation forms**

Quarter	Self-attestations received	Number reviewed	Error rate
Oct-Dec 2015	67	8	0%
Jan-March 2016	183	8	0%
April-June 2016	499	8	0%
July-Sept 2016	232	8	0%
Oct-Dec 2016	232	8	0%
Jan-March 2017	239	*	*

Source: DMAHS, Communication from Bureau of Quality Control shared in October 2016 and March 2017.

\*Data being collected, but unavailable for this report.

### **Qualified Income Trusts**

During fiscal year 2015,<sup>99</sup> 544 QIT applications were approved out of the 1,800 received (30%). Projections made by the State for fiscal years 2016 and 2017 show similar rates of approval (36% and 33%, respectively; DHS 2016, p.23).

Table 5.2 shows the number of Medicaid Only beneficiaries with QITs in different settings from December 2014 until March 1, 2016. During that period, there were 1,054 QIT users, of whom 72% were in nursing facilities, 21% were in Assisted Living (considered a community setting) and 7% were living at home. These data show that at least 291 people have been able to enroll in MLTSS and stay in the community that would not have been able to without the QIT mechanism. In addition, these data, along with a report of QIT application counts from December 1, 2014 through March 1, 2015 (DHS 2015, p.42) show that around 25% of QIT applications are for community-residing individuals seeking long-term care services.

**Table 5.2: Cumulative amount of individuals eligible for Medicaid Only using a QIT from December 1, 2014 to March 1, 2016**

Setting	Number	Percent
Nursing Facility	763	72%
Assisted Living	218	21%
Living at Home	73	7%
<b>Total</b>	<b>1054</b>	<b>100%</b>

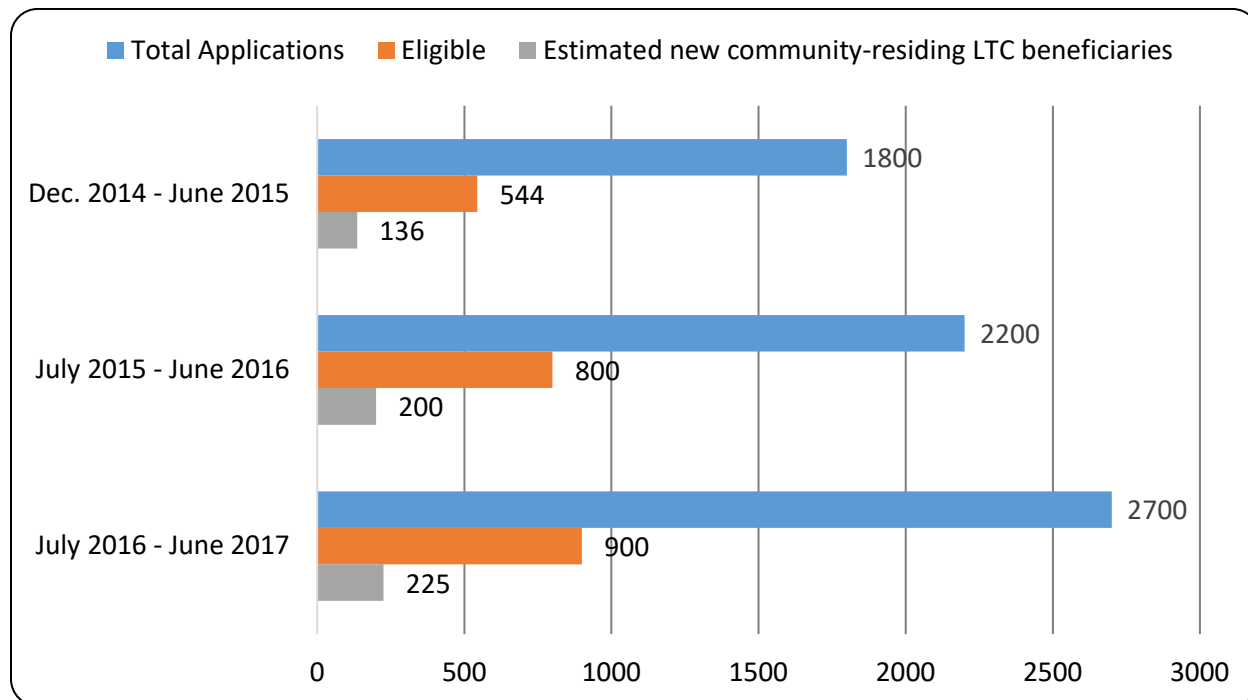
Source: Department of Human Services response to Office of Legislative Services, State Fiscal Year 2016-2017.

<sup>99</sup> July 1, 2014 through June 30, 2015 (QIT applications were accepted beginning December 1, 2014).



Figure 5.2 uses the application counts and (actual and projected) eligibility rates reported by the State along with the distribution of QIT applicant living arrangements to estimate the number of individuals given a pathway into MLTSS HCBS by the use of QITs through June 30, 2017.

**Figure 5.2: Number of QIT applications received, determined eligible, and the estimated number of new MLTSS community-residing beneficiaries from December 2014 to June 2017**

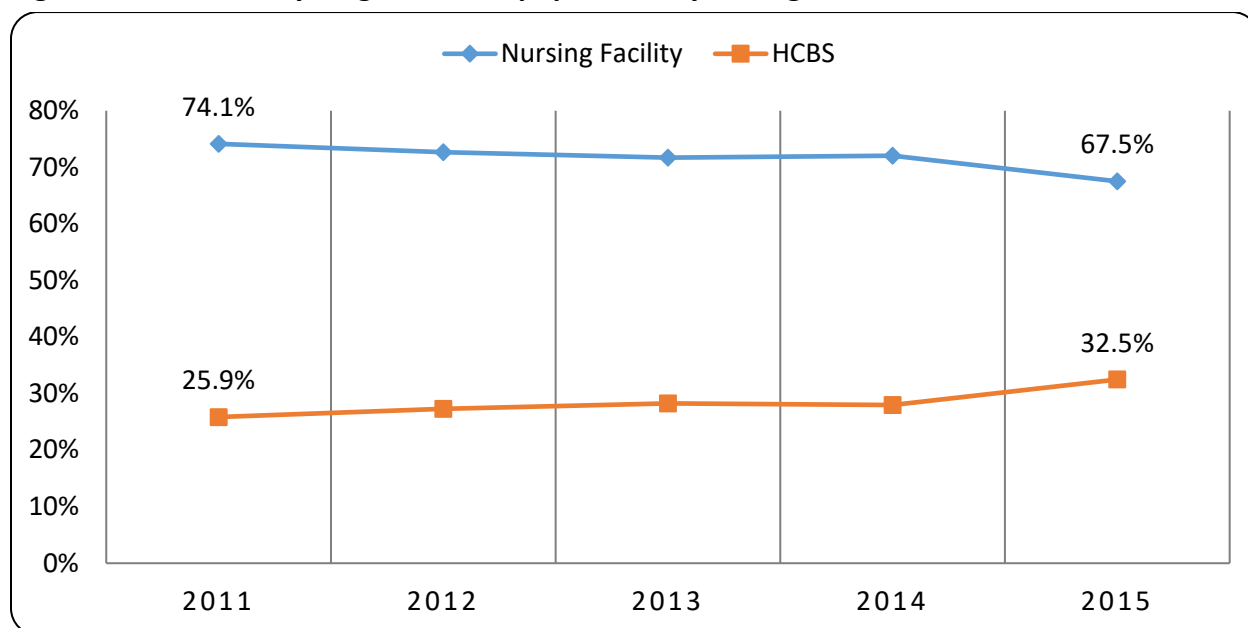


Source: QIT application count and number determined eligible from Department of Human Services response to Office of Legislative Services, State Fiscal Years 2015-2016 and 2016-2017; Estimates of new community-residing beneficiaries calculated using the assumption that 25% of approved QIT applications are for individuals residing in the community.

Figure 5.3 shows the percentage of long-term care (LTC) designated<sup>100</sup> recipients receiving services in nursing facilities or in their homes and communities (which includes assisted living) from 2011-2015. The proportion of all LTC recipients in community settings increases after the Waiver was approved (2013-2015) compared to the baseline period (2011-2012). While our analysis of Medicaid claims data for this final evaluation did not extend beyond 2015, data from secondary sources presented in Figure 1, Chapter 2 of this report shows a continuing increase in the percentage of LTC beneficiaries receiving HCBS through the beginning of 2017. As of March 2017, 43% of the long-term care population receives home and community-based services (HCBS), and 56% resides in nursing facilities.

<sup>100</sup> See Chapter 3 for definition of the long-term care assignment algorithm used in analysis of Medicaid claims data.

**Figure 5.3: New Jersey long-term care population by setting of care, 2011–2015**



Source: Medicaid Fee-for-Service Claims & Managed Care Encounter Data, 2011-2015; Analysis by Rutgers Center for State Health Policy.

Note: HCBS=Home and Community-Based Services.

## Discussion

This chapter presents findings to date on the administrative simplifications approved under the Waiver and designed to ease the application and approval process for existing beneficiaries and new applicants in need of an institutional level of care. These new processes are being used and monitored, and they very likely have expanded and streamlined the eligibility process for a number of Medicaid applicants. With regards to self-attestation for transfer of assets, a 0% error rate on audited cases is promising evidence that the often burdensome five year lookback process can be safely eliminated for many low-income applicants. As of March 2016, it is known that the availability of QITs has allowed 291 new applicants to qualify for Medicaid home and community-based services who would have otherwise been ineligible at their current income level. We estimate at least a couple hundred more have gained eligibility because of the QIT pathway since then, assuming initial trends did not change substantially.

There are many different reasons why nearly two-thirds of QIT applications are not approved. Some applications are denied because they remain incomplete even after the CWA has requested the missing information from the applicant. These requests could be for documentation of an individual's resources for the last five years, information on other trusts held by the applicant, or proof of citizenship or identity. Applications could also be denied if the applicant's income is over the average price of paying privately for long-term care in NJ (\$9,300 per month in a nursing

home and about \$6,000 in assisted living). Some proportion of received applications will also be in a pending status, for instance, if there is an issue with the trust and the trustee is working through the issue with the CWA. Finally, some applications could be withdrawn. We do not know the reasons for this, but in the first few months when QITs were available, 19 of the 460 received applications were withdrawn (DHS 2015, p.42).

Whether these new processes are being used uniformly and equitably is not clear. The BQC has noted that, although all CWAs have been provided with the self-attestation form, the counties drawn in the early samples were not representative of the distribution of the Medicaid population in the state, suggesting that some counties may not be regularly using the form. This would mean some applicants who should get the benefit of self-attestation may not be, depending on county-specific practices. In audits for more recent quarters, the BQC reports that the sample is more diverse, but there are other reasons why not all counties are adequately represented. It could be because not all counties are sending their self-attestation forms in to BQC, or the number received in a less populated county is so small that only one or two forms show up in their samples. The small sample of reviewed cases and uncertainty around its uniform use also mean the error rate may not be representative of the statewide error rate. With regard to QITs, stakeholders have expressed concerns about access to legal assistance for consumers with limited financial or social resources at a disadvantage for drawing up the trust documents and designating a representative to administer the trust over time. The State has informed the CWAs to reach out if they encounter these situations, but as of April 2017, only one or two such cases have been brought to the State's attention and they have been resolved.

The existence of these new avenues into the Medicaid long-term care system, particularly the establishment of QITs, has the potential to impact the number and mix of individuals in the MLTSS program. While self-attestation could potentially increase the number of eligible beneficiaries by streamlining the process, establishment of QITs would potentially increase the share of beneficiaries in the community. This motivates our examination of the percentage of long-term care beneficiaries receiving HCBS. This shift does appear to be taking place, and although we cannot directly attribute all of this shift to these administrative changes implemented under the Waiver, it is reasonable to conclude that they have created an easier pathway into home and community-based long-term care services.

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ENCOUNTER PAYMENTS, SERVICE UNITS, AND CLAIM COUNT FOR JULY 1, 2016 THROUGH MARCH 31, 2017 FOR MLTSS WAIVER RECIPIENTS

Clin Proc Curr Layman Name	Clin Proc Code	Claim Payment Amt	Clin Service Units Qty	Count Distinct Claims
ADULT DAYCARE SERVICES 15MIN	S5100	5	234	64
MEDICAL DAY CARE	S5102	468,315	37,393,783	473,083
TEAM EVALUATION & MANAGEMENT	T1024	354	101,495	354
<b>MDC Total</b>		<b>468,674</b>	<b>37,495,511</b>	<b>473,501</b>
ADULT DAYCARE SERVICES 15MIN	S5100	41,265	2,916,698	804,029
ADULT FOSTER CARE PER DIEM	S5140	192	206,308	4,028
ALCOHOL AND/OR DRUG SERVICES	H0004	1,832	190,535	5,962
ASSIST LIVING WAIVER/DIEM	T2031	88,724	44,561,954	841,956
CHORE SERVICES PER 15 MIN	S5120	83	3,568	1,024
CHORE SERVICES PER DIEM	S5121	22	8,971	81
COMM TRANS WAIVER/SERVICE	T2038	87	88,862	87
DAY HABIL WAIVER PER 15 MIN	T2021	145	5,114	1,037
DEVELOP COGNITIVE SKILLS	97532	20,568	3,126,174	98,296
HOMAKER SERVICE NOS PER 15M	S5130	72,069	5,039,917	1,324,591
HOME ENVIRONMENT ASSESSMENT	T1028	234	21,310	234
HOME MEALS PER MEAL	S5170	455,922	5,906,688	829,960
HOME MODIFICATIONS PER MONTH	S5165	316	790,634	318
LPN/LVN SERVICES UP TO 15MIN	T1003	41,639	15,952,156	1,631,555
MED REMINDER SERV PER MONTH	S5185	299	14,299	299
MEDICAL DAY CARE	S5102	11,318	366,405	12,221
P. T. THER PROC.1 OR MORE AREAS	97110	14,314	1,482,055	45,529
PERS INSTAL & EQUIP	S5160	1,109	58,743	1,109
PERS MONTHLY FEE	S5161	61,100	1,766,053	61,194
PRIVATE DUTY/INDEP NURS SERV	T1000	3,060	1,209,042	116,450
RES, NOS WAIVER PER DIEM	T2033	52,766	10,096,940	54,845
RESPIRE CARE SERVICE 15 MIN	T1005	2,141	256,072	112,937
RN SERVICES UP TO 15 MINUTES	T1002	15,579	6,455,396	541,561
SELF CARE MANAGEMENT TRAINING	97535	13,828	1,570,260	53,317
SPEECH LANGUAGE HEARING THERAP	92507	4,888	655,590	5,439
SPEECH,LANGUAGE/HEARING THERAP	92508	3,186	302,592	3,781
UNSKILLED RESPIRE CARE /DIEM	S5151	236	79,505	569
VEHICLE MOD WAIVER/SERVICE	T2039	9	92,123	9
ELEC MED COMP DEV, NOC	T1505	28	1,630	28
OTHER MLT		508	861,782	5,310
<b>MLT Total</b>		<b>907,467</b>	<b>104,087,376</b>	<b>6,557,756</b>
CUSTODIAL NURSING FACILITY	(blank)	100,469	505,910,917	2,812,659
<b>NFC Total</b>		<b>100,469</b>	<b>505,910,917</b>	<b>2,812,659</b>
PERSONAL CARE SER PER 15 MIN	T1019	1,823,992	121,961,143	32,548,357
PERSONAL CARE SER PER DIEM	T1020	10	-	46
<b>PCA Total</b>		<b>1,824,002</b>	<b>121,961,143</b>	<b>32,548,403</b>
ALCOHOL AND/OR DRUG SERVICES	H0019	1,505	482,032	2,311
ALCOHOL AND/OR DRUG SERVICES	H0020	10	644	162
E/M EST PT MINIMAL PROBLEM(S)	99211	2	16	2
E/M OFFICE/OP - ESTABLISHED PT	99212	27	1,037	27
E/M OFFICE/OP ESTAB PATIENT	99213	60	2,517	60
E/M OFFICE/OP ESTAB PT VISIT	99215	1	73	1
E/M OFFICE/OP ESTABLISHED PT	99214	10	346	10
GROUP MEDICAL PSYCHOTHERAPY...	90853	366	3,809	492
GRP PSYCH PARTIAL HOSP 45-50	G0410	85	2,340	158
HEALTH & BEHAV INTERVEN INDIV	96152	8	1,789	29
HOSPITAL OUTPT CLINIC VISIT	G0463	119	1,097	119
PSYCH DIAG EVAL W/MED SRVCS	90792	547	20,046	547
PSYCH DIAGNOSTIC EVALUATION	90791	404	12,237	404
PSYTX COMPLEX INTERACTIVE	90785	2	-	2
PSYTX PT&/FAM W/E&M 30 MIN	90833	182	1,377	182
PSYTX PT&/FAM W/E&M 45 MIN	90836	52	381	52
PSYTX PT&/FAMILY 30 MINUTES	90832	3,188	31,082	3,208
PSYTX PT&/FAMILY 45 MINUTES	90834	2,615	33,236	2,621
SPECIAL FAMILY THERAPY	90847	93	547	93
PSYTX PT&/FAMILY 60 MINUTES	90837	31	357	31
PSYTX CRISIS INITIAL 60 MIN	90839	4	104	4
PSYTX CRISIS EA ADDL 30 MIN	90840	3	75	8
NEUROPSYCH TST BY PSYCH/PHYS	96118	5	724	32
HEALTH & BEHAV ASSESS INIT	96150	2	482	8
MH PARTIAL CARE	H0035	2,447	202,099	10,617
PARTIAL HOSP LESS INTENSE	OP912	7	509	35
INTENSIVE OUTPATIENT PSYCHIA	S9480	5	371	5
BEHAVIORAL HEALTH HOME-ACTIVE	H0046	10	-	10
PHARMACOLOGIC MGMT W/PSYTX	90863	2	-	4
HEALTH & BEHAV INTERVEN FAMILY	96154	1	441	6
OPPS/PHP;ACTIVITY THERAPY	G0176	4	-	4
ALCOHOL AND/OR DRUG ASSESS	H0003	10	23	10
PSYCHI/PSYCHOLO SERV, GROUP THE	OP915	7	-	27
OTHER MENTAL HEALTH	various	15,737	2,473,879	123,569
<b>Behavioral Health Total</b>		<b>27,551</b>	<b>3,273,668</b>	<b>144,850</b>
<b>Total Long Term Care and Home and Community Based Services for MLTSS Wai</b>		<b>3,300,612</b>	<b>769,454,947</b>	<b>42,392,319</b>
<b>Grand Total MLTSS or LTC Encounter Services, including Behavioral Health</b>		<b>3,328,163</b>	<b>772,728,615</b>	<b>42,537,169</b>

Notes:

Service from dates for claims span July 1, 2016 through March, 31, 2017 and were paid from July 1, 2016 and September 29, 2017. Only non-voided, paid claims are reflected in the data. Medical Day Care, Managed Long Term Supports, Personal Care Assistant Services (not including self-directed Personal Care), and Nursing Facility claims and services are defined using the Encounter Category of Service and a waiver Special Program Code on the claim. Behavioral Health claims have been pulled with a combination of primary diagnosis code, procedure code, revenue code, or DRG related to a behavioral health need, with the exclusion of diagnoses which are categorized as altering the mental status of an individual but are of organic origin, as specified by Section 4.1.2b of the current State Managed Care Contract. For claims fitting multiple categories, the hierarchy applied for categorization is as follows: Managed Long Term Services and Supports, Custodial Nursing Facility, Medical Day Care Personal Care Assistance, and Behavioral Health. Existing issues with encounter data submission by the Managed Care Organization (e.g. span dates for services not matching service unit counts) are not corrected in the data provided.

FEE FOR SERVICE PAYMENTS, SERVICE UNITS, AND CLAIM COUNT FOR JULY 1, 2016 THROUGH MARCH 31, 2017 FOR MLTSS WAIVER RECIPIENTS

Clm Proc Curr Layman Name	Clm Proc Code	Claim Payment Amt	Clm Service Units Qty	Count Distinct Claims
CUSTODIAL NURSING HOME		18,174,930	99,396	3,598
MEDICAL DAY CARE	S5102	43,803	558	558
HHA/CNA PER HR WEEKDAY	S9122	110,195	6,524	1,488
NURSING ASSESSMENT/EVALUATN	T1001	385	11	11
PERSONAL CARE ASSISTANT VISIT{	Z1611	216	24	24
PPP MONTHLY CASH GRANT	Y9833	26,259	15	15
ADULT MH REHAB LEV AT GRP HOME	Z7333	15,862	59	30
PERSONAL CARE ASSISTANT VISIT	Z1605	106	9	9
PERSONAL CARE ASSISTANT VISIT	Z1616	60	5	5
ALR DAILY RATE	Y9633	2,103,556	42,637	1,624
CPCH DAILY RATE	Y7574	314,617	7,300	256
<b>Grand Total</b>		<b>20,789,989</b>	<b>156,538</b>	<b>7,618</b>
<b>Behavioral Health Total</b>		<b>3,255,452</b>	<b>42,509</b>	<b>15,463</b>
<b>Grand Total MLTSS or LTC Fee for Service, including Behavioral Health</b>		<b>24,045,442</b>	<b>199,047</b>	<b>23,081</b>

Notes:

Service from dates for claims span July 1, 2016 through March, 31, 2017 and were paid from July 1, 2016 and September 29, 2017. Only non-voided, paid claims are reflected in the data. Medical Day Care, Managed Long Term Supports, Personal Care Assistant Services (not including self-directed Personal Care), and Nursing Facility claims and services are defined using the Fee for Service Category of Service and a waiver Special Program Code on the claim.



FEE FOR SERVICE PAYMENTS, SERVICE UNITS, AND CLAIM COUNT FOR JULY 1, 2016 THROUGH MARCH 31, 2017 FOR ASD, IDD-MI, AND SED FEDERALLY MATCHED WAIVER SERVICES

Waiver Category and Proc Name	Proc Code	Proc Mod 1	Proc Mod 2	Prov Type	Prov Spec Cde	Claim Payment	Service Units	Sum of Net Paid
						Amt	Qty	Claims
<b>ASD</b>						<b>1,436,112</b>	<b>109,746</b>	<b>6,247</b>
COMM BASED WRAP AROUND SERV(II HABIL	T2021	HA	HO	44	826	446,663	21,420	1,751
COMM BASED WRAP AROUND(II HABILITATI	T2021	HA	HN	44	826	63,829	3,485	300
COMP COMM SUPP SERV(INDIV SUPPORTS)	H2015	HA	HN	44	826	39,475	6,414	350
COMP COMM SUPP SERV(INDIV SUPPORTS)	H2016					872,126	78,142	3,809
MENTAL HEALTH ASSESSMENT(BCBA)	H0031	HA	22	44	826	11,560	165	26
MENTAL HEALTH ASSESSMENT(FUNCT BEHAV	H0031	HA	-	44	826	1,695	84	8
MENTAL HEALTH ASSESSMENT, BY NON-PHY	H0031	HA	HN	44	826	765	36	3
<b>IDD/MI</b>						<b>3,631,908</b>	<b>276,399</b>	<b>16,285</b>
COMM BASED WRAP AROUND SERV(II HABIL	T2021	HA	HO	44	826	589,251	27,974	2,407
COMM BASED WRAP AROUND(II HABILITATI	T2021	HA	HN	44	826	46,819	2,503	229
COMMUN BASED WRAP AROUND SERV(II HAB	T2021	HA	22	44	826	10,085	361	27
COMP COMM SUPP SERV(HAB IN HOME)	H2016					706,725	62,914	3,674
COMP COMM SUPP SERV(INDIV SUPPORTS)	H2015	HA	HN	44	826	38,075	6,092	354
COMP COMM SUPP SERV(INDIV SUPPORTS)	H2016					1,364,208	121,870	5,361
COMP COMMUN SUPP SERV(IND SUPPORTS)	H2015	HA	HO	44	826	35,506	5,739	394
DAY HABILITATION, WAIVER; PER 15 MIN	T2021	22	HA	44	826	314,215	11,231	1,139
DAY HABILITATION, WAIVER; PER 15 MIN	T2021	52	HO	44	826	209,000	9,900	994
HABILITATION RES(DDD OUT OF HOME SER	T2016	HA	U1	44	825	12,526	82	82
HABILITATION RES(DDD OUT OF HOME SER	T2016	HA	U2	44	825	71,727	201	169
HABILITATION RES(DDD OUT OF HOME SER	T2016	HA	U3	44	825	14,697	62	2
MENTAL HEALTH ASSESSMENT(BCBA)	H0031	HA	22	44	826	49,619	632	145
MENTAL HEALTH ASSESSMENT(FUNCT BEHAV	H0031	HA	-	44	826	3,105	50	12
MENTAL HEALTH ASSESSMENT, BY NON-PHY	H0031	HA	HN	44	826	765	36	3
MENTAL HEALTH ASSESSMENT, BY NON-PHY	H0031	HA	HO	44	826	-	-	-
RESPIRE CARE IN HOME (PER 15 MINS)	S9125	HA	52	44	865	164,599	26,594	1,287
RESPIRE, DAILY,	S9125	52	HA	44	865	988	158	6
<b>SED</b>						<b>31,208,041</b>	<b>595,318</b>	<b>108,356</b>
BEHAV ASSIST SERV BY DYFS PROV/15 MI	H2019	UC	-	44	903	9,500	250	30
BEHAV ASSIST SERV BY DYFS PROV/15 MI	H2019	-	-	44	903	9,348	246	38
BEHAVIORAL ASSIST SERVICES EA 15 MIN	H2014	TJ	U1	44	903	16,142	1,669	207
BEHAVIORAL ASSIST SERVICES EA 15 MIN	H2014	TJ	U2	44	903	195	20	2
CSOCI CARE MANAGEMENT (CMO) SERVICES	Z5008	-	-	44	901	11,079,200	20,144	20,233
IIC ASSESSMENT-CLIN LICENSED PRACT	H0018	TJ	U1	44	902	33,900	300	100
INDIVID BEHAVIOR ASSIST SERV 15 MIN	H2014	TJ	-	44	903	1,027,141	105,692	11,921
INTENS IN-COM INDIV CLIN LEVEL SERV	H0036	TJ	U1	44	902	8,357,456	297,242	37,710
INTENS IN-COMM PROF IND SERV MASTERS	H0036	TJ	U2	44	902	2,904,633	137,110	17,372
MEN HLTH REHAB GROUP HOME/DYFS	Y9935	-	-	44	896	14,268	89	26
MEN HLTH REHAB GROUP HOME/DYFS	Y9935	-	-	44	897	192,034	1,158	927
MEN HLTH REHAB GROUP HOME/DYFS	Y9935	-	-	44	899	260,643	1,475	472
MEN HLTH REHAB JCAHO RTC/DYFS	Y9948	-	-	44	897	195,244	367	417
MEN HLTH REHAB JCAHO RTC/DYFS	Y9948	-	-	44	898	60,116	113	167
MEN HLTH REHAB JCAHO RTC/DYFS	Y9948	-	-	59	896	90,300	210	210
MH RHAB NON-RTC COMM PSYCH RESI/DMHS	Y9933	-	-	44	896	74,527	225	228
MH RHAB NON-RTC COMM PSYCH RESI/DMHS	Y9933	-	-	44	898	518,706	1,566	1,662
MH RHAB TRANSITIONAL LIVNG HOME/DYFS	Y9936	-	-	44	899	178,567	818	818
MH RHB NON-RTC RESIDENTIAL CARE/DYFS	Y9943	-	-	44	896	1,701,686	5,392	3,980
MH RHB NON-RTC RESIDENTIAL CARE/DYFS	Y9943	-	-	44	899	18,249	79	13
MOBILE RESPONSE - INITIAL	S9485	TJ	-	44	894	4,260,986	3,134	3,141
MOBILE RESPONSE - STABILIZATION MNGT	H0032	TJ	-	44	894	151,583	17,524	8,473
MULTISYSTEMIC THERAPY FOR JUVENILES,	H2033	-	-	44	902	12,238	211	50
MULTISYSTEMIC THERAPY FOR JUVENILES,	H2033	-	-	44	903	5,278	91	18
THERAPEUTIC LEAVE JCAHO RTC/DYFS	Y9951	-	-	44	897	23,408	44	44
INTENSIVE IN COMMUN SERV PER 15 MIN	H0036	U1	TJ	44	902	283	10	1
MEN HLTH REHAB TREATMENT HOME/DMHS	Y9938	-	-	44	897	11,421	87	87
INTENS IN-COM GRP CLIN LEV 2 CHLD	H0036	UN	U1	44	902	988	52	9
<b>Grand Total</b>						<b>36,276,061</b>	<b>981,463</b>	<b>130,888</b>

Notes:

Service from dates for claims span July 1, 2016 through March, 31, 2017 and were paid from July 1, 2016 and October 11, 2017. Only non-voided, paid claims are reflected in the data. ASD, IDD-MI, and SED wavier services are defined by CCB295, Appendix A "New Services", for procedures marked as Matchable for SPC 37 under SED, Matchable for SPC 38 for IDD/MI, and Matchable for SPC 47, 48, 49 under ASD Waiver. Fields to be matched include procedure code, modifiers 1 and 2, provider type, provider specialty code, and CSOCI enrolled indicator. Report categorizes claims as a ASD, IDD-MI, or SEDS claim only if ALL criteria are satisfied. ORIG FFP<>0

## DDD Supports Waiver - July 1, 2016 through March 31, 2017

Clm Proc Curr Layman Name	Clm Proc Code	Claim Payments	Service Units Quantity	Net Paid Claims
ALCOHOL AND/OR DRUG SERVICES	H0004	\$69,271	6,264	678
BEHAV ASSISTANCE SERVICES IND	H2014	\$66,939	5,055	1,802
COM WRAP-AROUND SV, 15 MIN	H2021	\$1,200,091	153,385	6,563
COMP COMM SUPP SVC, 15 MIN	H2015	\$128,652	28,341	1,240
DAY HABIL WAIVER PER 15 MIN	T2021	\$6,711,448	1,157,938	45,819
HABIL PREVOC WAIVER PER HR	T2015	\$702,187	138,792	9,600
NON-EMERG.TRANSP./MILE VOL.INT	A0090	\$342,102	464,595	6,141
RESPIRE CARE SERVICE 15 MIN	T1005	\$111,670	23,416	1,397
SERV ASMNT/CARE PLAN WAIVER	T2024	\$1,584,202	16,079	6,610
SPEECH LANGUAGE HEARING THERAP	92507	\$2,139	113	56
HABIL SUP EMPL WAIVER 15MIN	T2019	\$206,714	19,229	1,423
SPECIAL SUPPLY, NOS WAIVER	T2028	\$2,750	3	3
<b>Grand Total</b>		<b>\$11,128,165</b>	<b>2,013,210</b>	<b>81,332</b>

*Notes:*

*Service from dates for claims span July 1, 2016 through March, 31, 2016 and were paid from July 1, 2016 and October 10, 2017.*

*Only non-voided, paid claims are reflected in the data.*

*Waiver services are defined as procedures directed toward dedicated appropriation code 140057 where Special Program on Claim in list ('45')*



	Atlantic County 2017 3Q	Bergen County 2017 3Q	Burlington County 2017 3Q	Camden County 2017 3Q	Cape May County 2017 3Q	Cumberland County 2017 3Q	Essex County 2017 3Q	Gloucester County 2017 3Q	Hudson County 2017 3Q
<b>Dentist (PCDs)</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 15 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>
Dentist	83.8%	99.0%	79.5%	96.8%	93.4%	92.7%	100.0%	89.0%	100.0%
<b>PCPs</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 15 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>
PCP	96.9%	100.0%	97.6%	99.9%	100.0%	93.8%	100.0%	94.5%	100.0%
Pediatric PCPs	92.7%	100.0%	93.7%	100.0%	100.0%	94.8%	100.0%	95.4%	100.0%
<b>Specialist (13 Dobi)</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>
Cardiologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Dermatologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Endocrinologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
ENT	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
General surgeon	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Neurologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Obstetrician/gynecologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Oncologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Ophthalmologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Oral surgeon	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Orthopedist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Psychiatrist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Urologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
<b>Hospitals</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>
Hospital	94.1%	100.0%	97.2%	100.0%	97.6%	98.3%	100.0%	98.6%	100.0%

Hunterdon County 2017 3Q	Mercer County 2017 3Q	Middlesex County 2017 3Q	Monmouth County 2017 3Q	Morris County 2017 3Q	Ocean County 2017 3Q	Passaic County 2017 3Q	Somerset County 2017 3Q	Sussex County 2017 3Q	Union County 2017 3Q	Warren County 2017 3Q
<b>2 in 15 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 15 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 15 Miles</b>
99.2%	95.5%	97.6%	94.7%	85.1%	91.9%	97.5%	89.8%	70.6%	99.5%	94.9%
<b>2 in 15 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 15 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 15 Miles</b>
60.6%	96.2%	100.0%	97.2%	95.9%	87.4%	99.6%	96.9%	100.0%	100.0%	54.9%
82.4%	99.8%	100.0%	99.4%	96.0%	94.9%	99.9%	99.5%	100.0%	100.0%	64.8%
<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.0%	100.0%	81.2%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>
25.0%	99.9%	100.0%	100.0%	100.0%	87.1%	99.8%	99.9%	68.1%	100.0%	53.8%

	Atlantic County 2017 3Q	Bergen County 2017 3Q	Burlington County 2017 3Q	Camden County 2017 3Q	Cape May County 2017 3Q	Cumberland County 2017 3Q	Essex County 2017 3Q	Gloucester County 2017 3Q	Hudson County 2017 3Q
<b>Dentist (PCDs)</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 15 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>
Dentist	94.3%	100.0%	92.0%	99.0%	100.0%	53.8%	100.0%	89.7%	100.0%
<b>PCPs</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 15 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>
PCP	96.1%	100.0%	98.7%	100.0%	100.0%	91.5%	100.0%	95.0%	100.0%
Pediatric PCPs	90.8%	100.0%	98.7%	100.0%	100.0%	96.0%	100.0%	96.7%	100.0%
<b>Specialist (13 Dobi)</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>
Cardiologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Dermatologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Endocrinologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
ENT	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
General surgeon	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Neurologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Obstetrician/gynecologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Oncologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Ophthalmologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Oral surgeon	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Orthopedist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Psychiatrist	100.0%	100.0%	100.0%	100.0%	100.0%	99.6%	100.0%	100.0%	100.0%
Urologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
<b>Hospitals</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>
Hospital	90.0%	100.0%	96.0%	99.9%	98.0%	0.8%	100.0%	97.8%	100.0%

Hunterdon County 2017 3Q	Mercer County 2017 3Q	Middlesex County 2017 3Q	Monmouth County 2017 3Q	Morris County 2017 3Q	Ocean County 2017 3Q	Passaic County 2017 3Q	Salem County 2017 3Q	Somerset County 2017 3Q	Sussex County 2017 3Q	Union County 2017 3Q
<b>2 in 15 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 15 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 15 Miles</b>	<b>2 in 6 Miles</b>
100.0%	99.3%	99.8%	98.4%	91.8%	99.2%	93.9%	100.0%	93.0%	95.9%	100.0%
<b>2 in 15 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 15 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 15 Miles</b>	<b>2 in 6 Miles</b>
100.0%	100.0%	100.0%	98.1%	97.3%	98.3%	100.0%	100.0%	99.9%	99.5%	100.0%
100.0%	100.0%	100.0%	98.6%	98.1%	99.2%	98.1%	100.0%	100.0%	96.2%	100.0%
<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	98.4%	100.0%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>
96.4%	99.9%	99.0%	96.3%	99.3%	99.8%	93.9%	94.7%	99.8%	67.6%	100.0%

<b>Warren County 2017 3Q</b>
<b>2 in 15 Miles</b>
97.3%
<b>2 in 15 Miles</b>
100.0%
98.0%
<b>1 in 45 Miles</b>
100.0%
100.0%
100.0%
100.0%
100.0%
100.0%
100.0%
100.0%
100.0%
100.0%
100.0%
99.6%
100.0%
100.0%
<b>1 in 15 Miles</b>
96.5%



	Atlantic County 2017 3Q	Bergen County 2017 3Q	Burlington County 2017 3Q	Camden County 2017 3Q	Cape May County 2017 3Q	Cumberland County 2017 3Q	Essex County 2017 3Q	Gloucester County 2017 3Q	Hudson County 2017 3Q
<b>Dentist (PCDs)</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 15 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>
Dentist	88.4%	98.8%	98.3%	99.5%	100.0%	95.4%	100.0%	91.6%	100.0%
<b>PCPs</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 15 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>
PCP	99.3%	100.0%	97.8%	100.0%	100.0%	94.8%	100.0%	95.3%	100.0%
Pediatric PCPs	99.5%	100.0%	97.4%	100.0%	100.0%	96.0%	100.0%	95.5%	100.0%
<b>Specialist (13 Dobi)</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>
Cardiologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Dermatologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Endocrinologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
ENT	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
General surgeon	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Neurologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Obstetrician/gynecologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Oncologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Ophthalmologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Oral surgeon	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Orthopedist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Psychiatrist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Urologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
<b>Hospitals</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>
Hospital	94.4%	100.0%	99.7%	99.9%	100.0%	95.9%	100.0%	95.0%	100.0%

Hunterdon County 2017 3Q	Mercer County 2017 3Q	Middlesex County 2017 3Q	Monmouth County 2017 3Q	Morris County 2017 3Q	Ocean County 2017 3Q	Passaic County 2017 3Q	Salem County 2017 3Q	Somerset County 2017 3Q	Sussex County 2017 3Q	Union County 2017 3Q
<b>2 in 15 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 15 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 15 Miles</b>	<b>2 in 6 Miles</b>
100.0%	100.0%	98.6%	98.1%	93.5%	97.8%	98.3%	100.0%	100.0%	95.9%	100.0%
<b>2 in 15 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 15 Miles</b>	<b>2 in 6 Miles</b>	<b>2 in 15 Miles</b>	<b>2 in 6 Miles</b>
100.0%	100.0%	100.0%	97.6%	98.6%	97.6%	100.0%	100.0%	100.0%	100.0%	100.0%
100.0%	100.0%	100.0%	98.7%	100.0%	97.0%	100.0%	100.0%	100.0%	100.0%	100.0%
<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>	<b>1 in 45 Miles</b>
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>	<b>1 in 15 Miles</b>
100.0%	100.0%	100.0%	100.0%	100.0%	99.1%	99.4%	100.0%	100.0%	61.2%	100.0%

<b>Warren County 2017 3Q</b>
<b>2 in 15 Miles</b>
100.0%
<b>2 in 15 Miles</b>
100.0%
100.0%
<b>1 in 45 Miles</b>
100.0%
100.0%
100.0%
100.0%
100.0%
100.0%
100.0%
100.0%
100.0%
100.0%
100.0%
100.0%
100.0%
<b>1 in 15 Miles</b>
97.5%

**Division of Medical Assistance and Health Services (DMAHS) - Quality Management Unit (QMU)**  
**2015 Final Report of Comprehensive Audit**  
**Audit Period March 1, 2015 thru December 31, 2015**

**Division of the Children’s System of Care (CSOC)**  
**Level of Care - Corrective Action Plan**

<b>ASSURANCE II: LEVEL OF CARE (LOC Determination)</b>	
<b>Sub Assurance c.):</b>	<b>QMU Findings:</b>
<i>c) The processes and instruments described in the approved waiver are applied appropriately and according to the approved description to determine participant level of care.</i>	QMU expects the new process in place for annual reevaluation of youth engaged with CMOs will be reflected in the next audit. Please confirm date of implementation for the new process of LOC determination in the Corrective Action Plan.
<b>CSOC Corrective Action</b>	
A new process was put in place to assure that for all youth engaged with CMO’s, the level of care is more clearly documented annually. Primarily, the process, Annual Review, allows the Child Family Team (CFT) to review the youth & family vision, strengths & needs, and progress towards identified goals over the course of both the most recent 90 days as well as over the past year. The outcome of this review process is documented in the youth’s EHR. “CMO authorization brought up to date” will no longer be utilized to determine a youth’s level of care. We anticipate that this will be in place by September 2017.	

**Division of the Children’s System of Care (CSOC)**  
**Plan of Care - Corrective Action Plan**

<b>ASSURANCE III: PLAN OF CARE</b>	
<b>Sub Assurance d.):</b>	<b>QMU Findings:</b>
d) Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan.	QMU found that there were services wherein the amount of services provided exceeded the amount listed in the Treatment Plans although the submission of pre-authorized services to Molina happens automatically after CSOC’s CSA/ASO approves the Treatment Plan as described in the Treatment Plan Approval process. QMU supports CSOC’s QA study to ensure that the treatment plan process is being completed properly.
<b>CSOC Corrective Action</b>	
All service planning is family/youth driven. There is a formal child family team process (CFT) that includes a discussion on services requested by the youth and family. These services are required to be included in the youth’s plan of care (service plan) and submitted for clinical review. If the services are found to be clinically appropriate, they are prior authorized as documented in the plan of care. On occasion, the authorization may include a number of units that does not match what was requested in the plan of care. This can be the result of the CMO not accurately requesting the number of units associated with the service and/or the request may have exceeded the maximum allowed for a given period. Please note that there are a variety of mechanisms that are used to add services as needed in the EHR. It will be communicated to the CMOs that in the interim, annual reviews must reflect all current services. CSOC will take steps to ensure that the treatment plan process is being completed properly and that service requests by CMOs use the proper process whenever services are modified so that all services and the maximum units authorized are consistent. CSOC is also working to enhance the EHR so reduce human error, where applicable, in authorization of these services. The target date is not easily defined. CSOC is in the middle of redesigning the care plan in the EHR. Part of this is to reflect accurately in the EHR, all the services provided to the youth. The redesign of the care plan is a priority for the CSOC but time for development and implementation needs to be taken into consideration. In the interim, CSOC will continue to communicate to the CMO’s, best practice how to document services in the current treatment plan. This communication is targeted by November 2017.	

**Division of Medical Assistance and Health Services (DMAHS) - Quality Management Unit (QMU)  
2015 Final Report of Comprehensive Audit  
Audit Period March 1, 2015 thru December 31, 2015**

**Division of the Children’s System of Care (CSOC)  
Health and Welfare - Corrective Action Plan**

<b>ASSURANCE V: HEALTH AND WELFARE</b>	
<b>Sub Assurance b.):</b>	<b>QMU Findings:</b>
<p><i>b) The State demonstrates that an incident management system is in place that effectively resolves those incidents and prevents further similar incidents to the extent possible.</i></p>	<p>QMU cited two cases as reportable UIRs based upon Administrative Order 2:05 and Policy and Procedure #DCBHS-013:</p> <ul style="list-style-type: none"> <li>• Unusual incident is an occurrence involving the care supervision or actions of a service recipient that is adverse in nature or has the potential to have an adverse impact on the health, safety and welfare of the service recipient and others. Examples include but are not limited to allegations of abuse and neglect, service recipient to service recipient assault, and medication errors.</li> <li>• The first duty of individuals involved is to ensure the health and safety of the child/youth/young adult. Unusual incidents shall be reported as quickly as safety allows; however, it is the responsibility of all employees of DCSOC, DCSOC-related entities, community-based service providers certified by DCSOC and agencies under contract with DCSOC to report unusual incidents within the time frames established within this policy.</li> </ul> <p>Although follow up was appropriate, the two cases (Z.S and G.M) were not initially reported as UIRs. A UIR was completed and submitted on G.M.’s case after CSOC’s clarification. QMU did not cite the incident wherein youth’s eyes were bruised.</p>
<b>CSOC Corrective Action</b>	
<p>Unusual Incident Report (UIR) reporting for CSOC is what is required under Administrative Order (AO) 2:05 and the DCBHS policy referenced in the report is an outdated policy no longer in practice at CSOC. The practice for reporting CSOC UIRs is to continue using the Department of Human Services Administrative Order which can be found at <a href="http://www.state.nj.us/humanservices/staff/opia/cimu/AO2_05.doc">www.state.nj.us/humanservices/staff/opia/cimu/AO2_05.doc</a> and its addendum <a href="http://www.state.nj.us/humanservices/staff/opia/cimu/AO2_05Addendum.doc">www.state.nj.us/humanservices/staff/opia/cimu/AO2_05Addendum.doc</a>.</p> <p>CSOC will provide reinforcement on the appropriate syntax to be used in EHR progress notes and the UIR reporting protocol. CSOC will take steps to assure that EHR is not being misused as a UIR reporting tool and that CSOC policy and procedures related to reporting UIRs are being completed appropriately so that the appropriate follow up and steps are documented. CSOC is also working on a revision to the AO 2:05 and streamlining the UIR reporting process and will provide instruction to the community providers once this is completed. To address this corrective action, DCF/CSOC will communicate UIR reporting protocols as they currently exist no later than September 2017.</p>	

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

- **ID/DD –MI and ASD Pilots**
- **Measurement period 7/1/2016 – 6/30/2017**

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

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

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

- **ID/DD –MI and ASD Pilots**
- **Measurement period 7/1/2016 – 6/30/2017**

<b>#2 Quality of Life Sub Assurance</b>	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.	
<b>Data Source</b>	Review of Child and Adolescent Needs and Strengths scores Contracted System Administrator (CSA) Data Data report: CSA NJ1225 Strengths & Needs Assessment – Post SPC Start	
<b>Sampling Methodology</b>	100% New youth enrolled in the waiver	
<b>Waiver</b>	<b>ID/DD –MI</b>	<b>ASD</b>
<b>Numerator:</b> Number of youth receiving Child and Adolescent Needs	770	115

and Strengths (CANS) assessment		
<b>Denominator :</b> Total number of new enrollees	770	115
<b>Percentage</b>	100%	100%

CSOC conducted a review of the data for all the youth enrolled during the reporting period under the ID/DD – MI and ASD waivers. For all the youth added during the waiver period the record contained strength and needs assessment. CSOC will continue to conduct ongoing monitoring for this sub assurance.

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

- **ID/DD –MI and ASD Pilots**
- **Measurement period 7/1/2016 – 6/30/2017**

<b>#3 Quality of Life Sub Assurance</b>	80% of youth should show improvement in Child and Adolescent Needs and Strengths composite rating within a year	
<b>Data Source</b>	CSA Data on CANS Initial and Subsequent Assessments. Data report: CSA NJ2021CANS Waiver Outcome	
<b>Sampling Methodology</b>	Number of youth enrolled in the waiver for at least 1 year.	
<b>Waiver</b>	<b>ID/DD –MI</b>	<b>ASD</b>
<b>Numerator:</b> Number of youth who improved within one year of admission	836	185
<b>Denominator:</b> Number of youth with Child and Adolescent Needs and Strengths assessments conducted 1 year from admission or last CANS conducted	900	193
<b>Percentage</b>	93%	96%

CSOC conducted a review of the Care and Associated Needs Assessments (CANS) for all youth during the reporting period served under the ID/DD – MI and ASD waivers. For the youth served under the ASD waiver, 96% of the youth achieved improvement, an increase from the same period last year, in the CANS rating. CSOC will continue to monitor this area to make sure that we maintain an 80% or higher outcome for this indicator.

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

- **IDD –MI and ASD Pilots**
- **Measurement period 7/1/2016 – 6/30/2017**

<b>#4 Level of Care Sub Assurance</b>	CSOC’s Contracted System Administrator (CSA), conducts an initial Level of Care assessment (aka Intensity of Services (IOS) prior to enrollment for all youth.	
<b>Data Source</b>	CSA Data. Data report: CSA NJ1218 New Enrollees, Quarterly Count and IOS Completed	
<b>Sampling Methodology</b>	100% new youth enrolled in the waiver	
<b>Waiver</b>	<b>ID/DD –MI</b>	<b>ASD</b>
<b>Numerator:</b> Number of youth receiving initial level of care determination prior to enrollment	770	115
<b>Denominator:</b> Number of new enrollees	770	115
<b>Percentage</b>	100%	100%

CSOC reviewed all new enrollees for the ID/DD – MI and ASD waivers. During the reporting period all the youth met the sub assurance.

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

- **IDD –MI and ASD Pilots**
- **Measurement period 7/1/2016 – 6/30/2017**

<b>#5 Plan of Care Sub Assurance</b>	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	
<b>Data Source</b>	CSA Data on Plans of Care completions. Data report: CSA NJ1219 Follow – Up Treatment Plan and Associated SNA	
<b>Sampling Methodology</b>	100% of youth enrolled during the measurement period.	
<b>Waiver</b>	<b>ID/DD –MI</b>	<b>ASD</b>
<b>Numerator:</b> Number of Plans of Care that address youth’s	770	115



assessed needs		
<b>Denominator:</b> Number of Plans of Care reviewed	770	115
<b>Percentage</b>	100%	100%

CSOC conducted a review of the data for the youth enrolled during the reporting period under the ID/DD – MI and ASD waivers. During the reporting period all the youth met the sub assurance.

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

- **IDD –MI and ASD Pilots**
- **Measurement period 7/1/2016 – 6/30/2017**

<b>#6 Plan of Care Sub Assurance</b>	Plan of Care (ISP) is updated at least annually or as the needs of the youth changes	
<b>Data Source</b>	CSA Data Report : CSA NJ1289 Waiver ISP Aggregate Report All Youth	
<b>Sampling Methodology</b>	100% of youth enrolled during the measurement period.	
<b>Waiver</b>	<b>ID/DD –MI</b>	<b>ASD</b>
<b>Numerator:</b> Number of current Plans of Care updated at least annually	243	86
<b>Denominator:</b> Number of Plans of Care reviewed	245	86
<b>Percentage</b>	99.2%	100%

CSOC conducted a review of the data for all youth during the reporting period served under the ID/DD – MI and ASD waivers that have been in the waiver for at least a year. There were two youth that lacked an annual plan of care update. CSOC will continue to monitor this indicator and work with our system partners to ensure ongoing monitoring so all youth’s plan of care are updated at least annually.

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

- **IDD –MI and ASD Pilots**
- **Measurement period 7/1/2016 – 6/30/2017**

<b>#7 Plan of Care Sub Assurance</b>	Services are authorized in accordance with the approved plan of care (ISP). Data Report: CSA NJ1220 Waiver Services Provided	
<b>Data Source</b>	CSA Data Report of Authorizations	
<b>Sampling Methodology</b>	100% of youth enrolled during the measurement period.	
<b>Waiver</b>	<b>ID/DD –MI</b>	<b>ASD</b>
<b>Numerator:</b> Number of plans of care that had services authorized based on the plan of care	770	115
<b>Denominator:</b> Number of plans of care reviewed	770	115
<b>Percentage</b>	100%	100%

CSOC conducted a review of the data for the youth enrolled during the reporting period under the ID/DD – MI and ASD waivers. During the reporting period all the youth met the sub assurance.

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

- **IDD –MI and ASD Pilots**
- **Measurement period 7/1/2016 – 6/30/2017**

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

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

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

- **IDD –MI and ASD Pilots**
- **Measurement period 7/1/2016 – 6/30/2017**

<b>#9 Plan of Care Sub Assurance</b>	Youth/Families are provided a choice of providers, based on the available qualified provider network.	
<b>Data Source</b>	CSA Data Report	
<b>Sampling Methodology</b>	Random sample representing a 95% confidence level	
<b>Waiver</b>	<b>ID/DD –MI</b>	<b>ASD</b>
<b>Numerator:</b> Number of youth/families given a choice of providers as indicated in Child Family Team (CFT) meeting	1769	442
<b>Denominator:</b> Number of Initial and 90 Days Plans	2240	610

<b>Percentage</b>	79%	73%
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This process was implemented recently. CSOC will refine the parameters with system partners to ensure that information is consistently completed and captured in the electronic health record.

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

- **IDDD –MI and ASD Pilots**
- **Measurement period 7/1/2016 – 6/30/2017**

<b>#10 Qualified Providers Sub Assurance</b>	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.	
<b>Data Source</b>	Record review	
<b>Sampling Methodology</b>	100% Agency	
<b>Waiver</b>	<b>ID/DD –MI</b>	<b>ASD</b>
<b>Numerator:</b> Number of new providers that met the qualifying standards prior to furnishing waiver services	10	0
<b>Denominator:</b> Total number of new providers	10	0
<b>Percentage</b>	100%	0%

The providers’ credentials and qualifications for respite were established as part of the RFQ and a review of submitted material was conducted during this process. CSOC’s evaluation of the information provided from applicants established that only qualified providers (seven new providers) would be allowed to provide the service; whose qualifications were verified during the RFQ.

Until CSOC establishes our own provider network, CSOC is utilizing providers qualified by the Department of Human Services, Division of Developmental Disabilities (three new providers).

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

- **ID/DD –MI and ASD Pilots**
- **Measurement period 7/1/2016 – 6/30/2017**

<b># 11 Qualified Providers Sub Assurance</b>	Children’s System of Care verifies that providers of waiver services continually meet required qualified status, including any applicable licensure and/or certification standards.	
<b>Data Source</b>	Provider HR Record Review	
<b>Sampling Methodology</b>	100% Agency	
<b>Waiver</b>	<b>ID/DD –MI</b>	<b>ASD</b>
<b>Numerator:</b> Number of providers that meet the qualifying standards –applicable Licensures/certification	In Development	In Development
<b>Denominator:</b> Total number of providers that initially met the qualified status	In Development	In Development
<b>Percentage</b>	In Development	In Development

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

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

- **IDD –MI and ASD Pilots**
- **Measurement period 7/1/2016 – 6/30/2017**

<b># 12 Qualified Providers Sub Assurance</b>	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.	
<b>Data Source</b>	Record Review	
<b>Sampling Methodology</b>	100% Community Provider Agencies	
<b>Waiver</b>	<b>ID/DD –MI</b>	<b>ASD</b>
<b>Numerator:</b> Number of providers that have been trained and are qualified to provide waiver services	10	0
<b>Denominator:</b> Total number of providers that provide waiver services	10	0

<b>Percentage</b>	100%	0%
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As was indicated on item #10 above the credentials and qualifications for providers were verified initially during the RFQ process. The RFQ was CSOC’s process to verify providers (ten new providers) to deliver the services. CSOC and the individual providers offer related training development to individuals providing the waiver service.

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

- **IDD –MI and ASD Pilots**
- **Measurement period 7/1/2016 – 6/30/2017**

<b># 13 Health and Welfare Sub Assurance</b>	The State, demonstrates on an on-going basis, that it identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation.	
<b>Data Source</b>	Review of Unusual Incident Reporting database and child abuse/neglect database and Administrative policies & procedures	
<b>Sampling Methodology</b>	100% of youth enrolled for the reporting period	
<b>Waiver</b>	<b>ID/DD –MI</b>	<b>ASD</b>
<b>Numerator:</b> Total number of UIRs submitted timely according to State policies	In Development	In Development
<b>Denominator:</b> Number of UIRs submitted involving enrolled youth	In Development	In Development
<b>Percentage</b>	In Development	In Development

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

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

- **IDD –MI and ASD Pilots**
- **Measurement period 7/1/2016 – 6/30/2017**

<b># 14 Health and Welfare Sub Assurance</b>	The State incorporates an unusual incident management reporting system, as articulated in Administrative Order 2:05, which reviews incidents and develops policies to prevent further similar incidents (i.e., abuse, neglect and missing), as well as utilizes a child abuse/neglect database to report on this data.
<b>Data Source</b>	Review of databases and Administrative policies & procedures

<b>Sampling Methodology</b>	100% of youth enrolled for the reporting period	
<b>Waiver</b>	<b>ID/DD –MI</b>	<b>ASD</b>
<b>Numerator:</b> The number of incidents that were reported through UIRMS and had required follow up	In Development	In Development
<b>Denominator:</b> Total number of incidents reported that required follow up	In Development	In Development
<b>Percentage</b>	In Development	In Development

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

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

- **IDDD –MI and ASD Pilots**
- **Measurement period 7/1/2016 – 6/30/2017**

<b># 15 Health and Welfare Sub Assurance</b>	The State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed.	
<b>Data Source</b>	Review of databases and Administrative policies & procedures	
<b>Sampling Methodology</b>	100% of all allegations of restrictive interventions reported	
<b>Waiver</b>	<b>ID/DD –MI</b>	<b>ASD</b>
<b>Numerator:</b> Number of unusual incidents reported involving restrictive interventions that were remediated in accordance to policies and procedures	In Development	In Development
<b>Denominator:</b> Total number of unusual incidents reported involving restrictive interventions	In Development	In Development
<b>Percentage</b>	In Development	In Development

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

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

- **IDD –MI and ASD Pilots**
- **Measurement period 7/1/2016 – 6/30/2017**

<b># 16 Health and Welfare Sub Assurance</b>	The State establishes overall healthcare standards and monitors those standards based on the NJ established EPSDT periodicity schedule for well visits.	
<b>Data Source</b>	MMIS Claims/Encounter Data	
<b>Sampling Methodology</b>	100% of youth enrolled for the reporting period	
<b>Waiver</b>	<b>ID/DD –MI</b>	<b>ASD</b>
<b>Numerator:</b> Number of youth enrolled that received a well visit	In Development	In Development
<b>Denominator:</b> Total number of youth enrolled	In Development	In Development
<b>Percentage</b>	In Development	In Development

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

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

- **IDD –MI and ASD Pilots**
- **Measurement period 7/1/2016 – 6/30/2017**

<b># 17 Financial Accountability Sub Assurance</b>	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.	
<b>Data Source</b>	Claims Data, Plans of Care, Authorizations	
<b>Sampling Methodology</b>	100% of youth enrolled for the reporting period	
<b>Waiver</b>	<b>ID/DD –MI</b>	<b>ASD</b>
<b>Numerator:</b> The number of claims there were paid according to code within youth’s centered plan authorization	In Development	In Development
<b>Denominator:</b> Total number of claims submitted	In Development	In Development
<b>Percentage</b>	In Development	In Development

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





The Office of Managed Long-Term Services and Supports Quality Monitoring (MLTSS/QM) is involved in multiple activities associated with the quality oversight of the managed care organizations and their relation to the MLTSS population. IPRO, the External Quality Review Organization for the State, (EQRO), on behalf of the State of New Jersey, conducts the mandatory CMS activities of the Assessment of Compliance with Medicaid Managed Care Regulations, Validation of Measures Reported by the MCO, and Validation of Performance Improvement Projects.

The Annual Assessment of MCO Operations reviews compliance for contractual Federal and State operational and quality requirements. MCOs demonstrating compliance at or above eighty-five percent (85%) receive a partial review every other year of only those elements that are “Not Met” or “N/A” during the comprehensive review. MLTSS elements are subject to review each year regardless of their compliance determination in the prior year. The 2016 review included full reviews for 2 MCOs and partial reviews for 3 MCOs. Corrective Action Plans were requested from the MCOs for any elements that received recommendations for deficiencies.

The NJ FamilyCare Managed Care Contract article 9.11.E requires NJ FamilyCare MCOs to report on Performance Measures for the MLTSS program. The EQRO works with the State to validate the MLTSS Performance Measures. The EQRO, with the participation of the State, conducted both calls and onsite visits to review and refine data descriptions and source codes, to align the MCOs performance measure specifications for consistent approaches in data reporting. Technical assistance calls were held as needed for the MCOs.

All 5 MCOs submitted updates for their current Falls Prevention Quality Improvement Projects in both the Fall of 2016 and in June 2017. The June submissions are used for scoring in the Annual Assessment under element Quality Management (QM) 11.

The EQRO also performs voluntary CMS activities inclusive of the conducting focused studies such MLTSS Care Management audits and the Calculation of Performance Measures.

Two separate MLTSS Care Management audits, one for Home and Community Based Services, and one for Nursing Facilities were conducted by the EQRO to evaluate the effectiveness of each MCO’s contractually-required MLTSS care management program. Audit activities included an evaluation of the following metrics: identification, outreach, face-to-face visits, initial plan of care, ongoing care management, and gaps in care. Based on the findings, the MCOs were required to submit work plans to the State addressing the EQRO’s recommendations. (Reports available on request)

The EQRO assesses the MCOs processes for calculating performance measures using the data from the annual assessment, focus studies, and MLTSS care management (CM) audits to calculate certain MLTSS performance measures. The results of the MLTSS performance measures calculated by the EQRO are included in the State’s quarterly/annual reports to CMS for the respective deliverable periods.

The EQRO initially was tasked with assessing the feasibility of performing the focus study of Performance Measure #13 – MLTSS/HCBS Services are delivered in accordance with the plan of care, including the type, scope, amount, frequency, and duration, using administrative data rather than care management record review. However, the results of the preliminary claims/authorization comparison and findings demonstrated that the administrative methodology was not a viable substitute for a comparison of claims against care management records. Therefore, the EQRO conducted a study comparing claims against care management records including the member’s plan of care. The final results of this study were submitted to the State in September 2017 and will be included in the next Annual Report.

The Office of MLTSS QM is also involved in multiple initiatives consisting of workgroups, committees, meetings, and surveys aimed to enhance the health and safety of the MLTSS population. These include but are not limited to: the MLTSS / MCO Quality Workgroup, National Core Indicators – Aging and Disabilities Survey, Annual MCO/ MLTSS Quality Status Meetings, and the MLTSS Steering Committee Meetings.

The MLTSS / MCO Quality Workgroup with representation from each of the MCOs, DoAS, and DMAHS meets on a monthly basis and primarily focuses on the MLTSS performance measures and other MLTSS Contract required reports. These meetings facilitate the discussion of reporting elements that may present challenges to the MCOs in reporting and a consensus is developed on how to address these issues so that the data received from each MCO can be aggregated and representative of the overall MLTSS program.

National Core Indicators – Aging and Disabilities (NCI-AD) Survey is a collaborative effort between the National Association of States United for Aging and Disabilities (NASUAD), Human Services Research Institute (HSRI), and the National Association of State Directors of Developmental Disabilities Services (NASDDDS). The NCI-AD's primary aim is to collect and maintain valid and reliable data that give states a broad view of how publicly-funded services impact the quality of life and outcomes of service recipients. New Jersey participated in this initiative to examine their funded long-term services and supports (LTSS) programs regardless of funding source (NJ FamilyCare/Medicaid; PACE; or Older Americans Act).

The DMAHS’ Office of MLTSS Quality Monitoring conducted an annual MCO / MLTSS Quality Status meeting in June with each MCO to discuss the status of the MCO’s self-reported MLTSS Performance Measure data submissions, Quarterly MLTSS Care Management Audits, Care Management Program Description, and Care Management Program Evaluation.

The MLTSS Steering Committee was established to provide stakeholder input and advice regarding the implementation of the MLTSS program. Today, DMAHS and DoAS continue to conduct quarterly Steering Committee meetings to ensure that consumers, stakeholders, managed care organizations, providers, and other community-based organizations are informed, and to solicit public input on MLTSS programs.

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*MLTSS Performance Measure Data Report – corrections to previously submitted data*  
 (Red font denotes the corrected data received as of 9/1/17)

The Office of MLTSS/QM reviews the data, analysis, discovery, and action taken for the MLTSS Performance Measures that were developed in response to the Special Terms and Conditions of the 1115 Comprehensive Medicaid Waiver. Through a continuous improved understanding of processes, the MCOs and DoAS submit corrected reports to the Office of MLTSS/QM. All corrections received by the respective specified data source (DoAS, MCOs, EQRO, or DDS) are used in this Annual Report to reconcile and correct enumerations to CMS in New Jersey’s 1115 Comprehensive Medicaid Waiver’s Quarterly Report submissions. As a process, only results of corrected MLTSS Performance Measures will be disclosed. Any corrections received as of September 1, 2017 are contained in the following tables. Additionally, as a result of measures involved in review from New Jersey’s EQRO, PMs #21, #35, #36, #37 and #38 are included in this annual report. Data presented in red font are indicative of a change to the data was previously reported for MLTSS program year ending 2017 and black font is indicative of data remained the same as previously reported or is being reported for the first time.

<b>PM: #2</b>	MLTSS recipients accessing services within 9 months of eligibility date.
<b>Numerator:</b>	Number of members in the denominator that had received MLTSS services within the first 9 months as evidenced by a paid claim.
<b>Denominator:</b>	Members new to MLTSS within the measurement month.
<b>Data Source:</b>	DoAS
<b>Measurement Period:</b>	Monthly with a nine month lag – Due the 15 <sup>th</sup> of the month following the 9 month lag

Measurement period	7/2016	8/2016	9/2016
<b>Numerator</b>	924	838	788
<b>Denominator</b>	1242	1095	1026
<b>%</b>	74.4	76.5	76.8

During the process of revising PM #2, DoAS has worked with Optum to develop the means of collecting data to monitor utilization of MLTSS services for new MLTSS enrollees. As previously reported, the DoAS revised PM #2 to evaluate the percentage of MLTSS members who have received MLTSS specific services within the first nine months of MLTSS enrollment as evidenced by encounters. Due to this revision, a lag time of nine months was added to allow for receipt of encounters. The State is eliminating this performance measure effective July 1, 2017.

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**Deliverables due during MLTSS Year Three (7/1/16 - 6/30/17)**

Following the analysis of the early data, DoAS reported that the percentages for services received within the first 9 months of enrollment have increased over time from a low of 55% to an average of 76.8% for September 2016. As per the MLTSS contract, MLTSS services are not provided prior to enrollment. Individuals enrolled in an MCO without MLTSS enrollment are receiving state plan services through the continuity of care requirement. Additionally, services determined medically necessary are provided regardless of MLTSS enrollment. Individuals with MLTSS specific service needs who may be awaiting enrollment may be identified through the MCO or other stakeholder and referred for expedited enrollment if necessary to facilitate access to services. Care management is received by all MLTSS enrollees, however, is not captured as a billable and reportable MLTSS service.

This is a gross utilization measure and does not measure program effectiveness. This measure has been eliminated effective with the July 2017 contract. Though still a requirement, due to the lag time in the data, it is the recommendation of DoAS to discontinue reporting PM #2 effective with the first quarter of program year ending 2018 (measurement period October 2016 and forward).

<b>PM # 5</b>	Timeliness of nursing facility level of care re-determinations
<b>Numerator:</b>	Total number of MLTSS enrollees in the denominator who are confirmed as being appropriate for continued enrollment and have no assessment conducted within 13 months
<b>Denominator:</b>	Total number of MLTSS enrollees with no assessment conducted within the last 16 months as per "16 month report"
<b>Data Source:</b>	DoAS
<b>Measurement Period:</b>	Beginning 7/1/2017, this is a quarterly report – due 3 months after the 16-month report is run

PM #5 MCO	SEP 2016/OCT 2016		DEC 2016/JAN 2017		MAY 2017	
	Report Total	*Priority Group	Report Total	*Priority Group	Report Total	*Priority Group
A	117	23	167	2	57	1
B	156	35	165	15	136	6
C	279	29	219	10	169	4
D	379	99	351	25	189	3
E	200	15	262	6	138	3
<b>TOTAL</b>	<b>1131</b>	<b>201</b>	<b>1164</b>	<b>58</b>	<b>689</b>	<b>17</b>
<i>* Priority Group is defined as those MLTSS members who did not have a LOC reassessment since 2014 at the time the report was run</i>						

As previously reported DoAS was unable to track the numerator and denominator as initially defined for PM #5. To identify MLTSS members who did not have an annual LOC

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reassessment, DoAS began generating reports of those MLTSS members without an assessment in the prior 16 month period. These reports are sent to the MCOs, who must respond to DoAS to report their findings and actions taken for each member on the report.

From September 2016 to January 2017, DoAS engaged with the MCOs to refine the 16-month report process, identify trends, and create policies to address the challenges reported by the MCOs. In response to some of the challenges, a voluntary withdrawal and unable to contact process were developed to enable disenrollment as appropriate.

From February to April 2017, the State began to outline a policy/process and contract language for involuntary disenrollment in response to an identified trend that some MLTSS members were not willing to participate in LOC reassessments and were refusing to be voluntarily disenrolled.

In March 2017, DoAS finalized a quarterly schedule for the 16 month report, requiring close out by the MCOs within 8 weeks. The processes for Voluntary Disenrollment and Involuntary Disenrollment were also finalized. DoAS provided training for the MCOs regarding streamlined assessment review; disenrollment; 16 month report process and timelines; and requirement for a Corrective Action Plan if all cases are not closed out or an extension requested within 30 days of receipt of report.

As of 7/1/2017, the revised definition for PM #05 is: Timeliness of nursing facility level of care re-determinations. The numerator is the total number of MLTSS enrollees in the denominator who are confirmed as being appropriate for continued enrollment and have no assessment conducted within 13 months. The denominator is the total number of MLTSS enrollees with no assessment conducted within the last 16 months as per "16 month report". The first report using the new guidelines is due 12/30/17.

In the early test runs of the data for PM #05, it was discovered that there was a group of MLTSS members without a LOC assessment since 2014 or before. These members were sent to the MCOs as the priority group for LOC reassessments.

From September/October 2016 to the next report run in December/January, the overall number of MLTSS members without a LOC reassessment in the previous 16 months showed no significant change, but the priority group dropped 71%, from 201 to 58. The next set of data in May 2017 showed a significant drop in both the overall number of MLTSS members without a LOC reassessment and the priority group.

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**Deliverables due during MLTSS Year Three (7/1/16 - 6/30/17)**

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

7/1/2016-9/30/2016	A	B	C	D	E	TOTAL
<b>Numerator</b>	5	7	85	41	9	147
<b>Denominator</b>	767	4471	12464	5636	3606	26944
<b>%</b>	0.7	0.16	0.68	0.7	0.3	0.55

10/1/2016-12/31/2016	A	B	C	D	E	TOTAL
<b>Numerator</b>	5	25	81	37	17	165
<b>Denominator</b>	892	4838	13067	5915	3973	28685
<b>%</b>	0.6	0.52	0.62	0.6	0.4	0.58

1/1/2017-3/31/2017	A	B	C	D	E	TOTAL
<b>Numerator</b>	4	15	73	34	14	140
<b>Denominator</b>	1012	5205	13603	6242	4554	30616
<b>%</b>	0.4	0.29	0.54	0.5	0.3	0.46

As previously reported, the State worked with their EQRO in refining the specifications for the Performance Measures. It was discovered late in the program year that the specifications for this measure’s denominator captured the entire MLTSS population, both HCBS and NF. This was a change from prior program years that reported on the number of members that were residing in a nursing home and transferred to the community. This change results in the number of members enrolled in MLTSS (not limited to NF) and transition to the community. It is not an accurate reflection of movement from nursing home to the community. The State recognized this change and has revised the specifications for program year beginning 7/1/17. Due to the specification changes for 7/1/16 – 6/30/17 the MCOs had to revise their coding which impacted their report submission. Contained in this report are the results that were received during the program year. Quarter four and annual results will be reported in the first quarterly report for MLTSS program year beginning 7/1/17.

**Deliverables due during MLTSS Year Three (7/1/16 - 6/30/17)**

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

7/1/16-9/30/16	A	B	C	D	E	TOTAL
<b>Numerator</b>	0	0	10	1	0	11
<b>Denominator</b>	3	8	110	49	3	173
<b>%</b>	0.0	0.0	10.0	2.0	0.0	6.4

In reanalyzing their data, MCO E reported that the revised criteria for inclusion were a total of 3 members identified as transitioning from NF to HCBS. MCO E reports that the absence of NF return can be attributed to the close monitoring and post discharge follow up by staff to ensure a safe transition from nursing facilities. Additionally, MCO E reports that staff will continue to identify members who can safely transition into the community and educate members on the use of services available to them such as their Community Advocacy Program.

<b>PM # 35</b>	Follow-up after mental health hospitalization for HCBS MLTSS members: 7 day follow-up.
<b>Numerator:</b>	Per Administrative Specifications, the unique count of visits (Not unique members) who received face-to-face follow up with a mental health professional within seven days of hospitalization following an acute inpatient discharge with a principal diagnosis of mental illness.
<b>Denominator:</b>	Using administrative specifications, the unique count of acute inpatient discharges (Not unique members) of eligible MLTSS HCBS members with a principal diagnosis of mental illness during measurement year. The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges
<b>Data Source:</b>	MCO – paid claims
<b>Measurement Period:</b>	Quarterly and Annually

N = Numerator    D = Denominator    % = Percentage    N/A = Not Available    O/D = Over due  
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**Deliverables due during MLTSS Year Three (7/1/16 - 6/30/17)**

7/1/16-9/30/16	A	B	C	D	E	TOTAL
<b>Numerator</b>	0	1	4	1	3	9
<b>Denominator</b>	0	4	14	1	9	28
<b>%</b>	0	25.0	28.6	100	33.3	32.1

MCOs are reporting some challenges in obtaining this data due to dual eligible members and limited access to Medicare claims. MCO C reports that of the 10 members that did not have a face-to-face follow-up with a mental health professional within 7 days of an acute inpatient hospitalization with mental illness, one member refused and two members started attending partial day care programs after discharge and received follow up through partial care programs. MCO E reported that there were a total of 9 hospitalizations for HCBS members with a primary mental illness diagnosis identified during the measurement period none of which were FIDE-SNP members and all 9 hospitalizations were for unique members. Additionally, MCO E reported that 5 of the 9 members were over 65 years of age and the diagnoses reported were: schizophrenia (unspecified and chronic paranoid type, paranoid) (3), bipolar disorder (1), schizoaffective disorder unspecified (1), and major depressive disorder (4). MCO B reports using the Innovator system to develop reporting around the follow-up after mental health hospitalization measures while still reviewing data to improve follow-up visits post mental health hospitalization. MCOs report they are continuing to monitor.

<b>PM # 36</b>	Follow-up after mental health hospitalization for HCBS MLTSS members: 30 day follow-up.
<b>Numerator:</b>	Per Administrative Specifications, the unique count of visits (Not unique members) who received face-to-face follow up with a mental health professional within thirty days of hospitalization following an acute inpatient discharge with a principal diagnosis of mental illness.
<b>Denominator:</b>	Using administrative specifications, the unique count of acute inpatient discharges (Not unique members) of eligible MLTSS HCBS members with a principal diagnosis of mental illness during measurement year. The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges.
<b>Data Source:</b>	MCO – paid claims
<b>Measurement Period:</b>	Quarterly and Annually

**Deliverables due during MLTSS Year Three (7/1/16 - 6/30/17)**

7/1/16-9/30/16	A	B	C	D	E	TOTAL
<b>Numerator</b>	0	1	9	1	5	16
<b>Denominator</b>	0	4	14	1	9	28
<b>%</b>	0	25.0	64.3	100	56.0	57.1

MCOs are reporting some challenges in obtaining this data due to dual eligible members and limited access to Medicare claims. There were five members that MCO C reported as not receiving follow-up with a mental health professional after acute inpatient hospitalization discharge with a principal diagnosis of mental illness. Of these, MCO C noted that two members refused follow-up; however, one received weekly supportive counseling. Additionally, one member was discharged to an Inpatient Psychiatric setting, another member was discharged to an Assisted Living Facility where they received follow up, and the MCO was unable to identify the reason for lack of follow-up for the remaining member. MCO E reported that all 9 hospitalizations were for unique members and 5 of the 9 members were over 65 years of age. The diagnoses reported were: schizophrenia (unspecified and chronic paranoid type, paranoid) (3), bipolar disorder (1), schizoaffective disorder unspecified (1), and major depressive disorder (4). Four of the nine members did not have an authorization request or authorization on file for the admission. As such, the Care Manager was not alerted to the admission in 45% of these cases. The MCO reported that because most Behavioral Health providers are new to working with MCOs, they are unclear on how and when to request authorizations for MLTSS members. Another 45% of the members who did not have a 7 day post discharge follow up appointment were not in Behavioral Health Care Management at the time of admission. Additionally MCO E reported that the Behavioral Health team will continue to monitor and review the Inpatient BH admission queue for notification and member follow up. MCOs report they are continuing to monitor and some are working with their behavior health administrator and staff to track hospital admissions and to ensure follow-up care.

<b>PM # 37</b>	Follow-up after mental health hospitalization for NF MLTSS members: 7 day follow up.
<b>Numerator:</b>	Per Administrative Specifications, the unique count of visits (Not unique members) who received face-to-face follow up with a mental health professional within seven days of hospitalization following an acute inpatient discharge with a principal diagnosis of mental illness.
<b>Denominator:</b>	Using administrative specifications, the unique count of acute inpatient discharges (Not unique members) of eligible MLTSS NF members with a principal diagnosis of mental illness during measurement year. The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges.
<b>Data Source:</b>	MCO – paid claims
<b>Measurement Period:</b>	Quarterly and Annually

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**Deliverables due during MLTSS Year Three (7/1/16 - 6/30/17)**

7/1/16-9/30/16	A	B	C	D	E	TOTAL
<b>Numerator</b>	0	0	2	0	0	2
<b>Denominator</b>	2	1	3	2	1	9
<b>%</b>	0	0	66.7	0	0	22.2

MCOs are reporting some challenges in obtaining this data are due to dual eligible members and limited access to Medicare claims. MCO A reported that the two inpatient psychiatric admission diagnoses were schizoaffective disorder (bipolar type) and major depressive disorder (recurrent moderate). Additionally, MCO A reported that due to the outcome results, the MLTSS manager will re-educate all staff on the importance of identifying if any of their members has had a recent discharge from an acute care hospital and that any inpatient psychiatric stay must have a followed up outpatient visit to a behavioral health provider within 7 days of discharge. MCO C reported that the member that did not have follow up within 7 days was discharged to a rehab nursing facility where they received medication management. MCO E reports that the admitting diagnosis for their member was identified as major depressive disorder single episode and upon discharge from the acute psychiatric unit; the member was transferred to an intermediate unit at another psychiatric facility where he remained until discharged to a SERV group home for adult mental health rehabilitation. MCOs report they are continuing to monitor and some are working with their behavioral health administrator and staff to track hospital admissions and to ensure follow-up care.

<b>PM # 38</b>	Follow-up after mental health hospitalization for NF MLTSS members: 30 day follow up.
<b>Numerator:</b>	Per Administrative Specifications, the unique count of visits (Not unique members) who received face-to-face follow up with a mental health professional within thirty days of hospitalization following an acute inpatient discharge with a principal diagnosis of mental illness.
<b>Denominator:</b>	Using administrative specifications, the unique count of acute inpatient discharges (Not unique members) of eligible MLTSS NF members with a principal diagnosis of mental illness during measurement year. The denominator for this measure is based on discharges, not on members. If members have more than one discharge, include all discharges.
<b>Data Source:</b>	MCO – paid claims
<b>Measurement Period:</b>	Quarterly and Annually

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**Deliverables due during MLTSS Year Three (7/1/16 - 6/30/17)**

<b>7/1/16-9/30/16</b>	<b>A</b>	<b>B</b>	<b>C</b>	<b>D</b>	<b>E</b>	<b>TOTAL</b>
<b>Numerator</b>	0	0	3	0	1	4
<b>Denominator</b>	2	1	3	2	1	9
<b>%</b>	0	0	100	0	100	44.4

MCOs are reporting some challenges in obtaining this data due to dual eligible members and limited access to Medicare claims. MCO A reports that they continue to reinforce with the care management staff the necessity to follow up with members who have any inpatient stay. For those with psychiatric stays, they will reinforce that timeframes must be maintained and follow up with the nursing facility to expedite BH referrals. Additionally, MCO C reports that they continue staff education on the requirements of follow up visits post discharge. MCOs report they are continuing to monitor and some are working with their behavioral health administrator and staff to track hospital admissions and to ensure follow-up care.

**Federal Budget Neutrality Summary**

*SUBJECT TO PUBLIC COMMENT PROCESS*

**Room Under the Budget Neutrality Cap \$ 31,406,324,065**

State Fiscal Year	Total				
	Date of Service Budget Neutrality Ceiling*	CMS 64 Waiver Date of Service Expenditures	BN Savings Phase-Down	DSRIP Expenditures	Variance
<b>Initial Waiver Period</b>					
SFY13 Actual	\$ 6,657,226,210	\$ 5,891,234,624			\$ 765,991,586
SFY14 Actual	\$ 9,551,505,260	\$ 8,176,436,192			\$ 1,375,069,068
SFY15 Actual	\$ 10,115,539,330	\$ 8,107,136,429			\$ 2,008,402,901
SFY16 Actual	\$ 10,687,255,927	\$ 8,160,312,456			\$ 2,526,943,471
SFY17 Actual	\$ 11,145,351,553	\$ 8,448,257,992			\$ 2,697,093,562
SFY13-17	\$ 48,156,878,279	\$ 38,783,377,693	\$ -	\$ -	\$ 9,373,500,587
<b>First Waiver Extension Period</b>					
SFY18 Projected	\$ 11,882,440,668	\$ 8,313,481,043			\$ 3,568,959,625
SFY19 Projected	\$ 12,670,438,538	\$ 8,850,000,566			\$ 3,820,437,972
SFY20 Projected	\$ 13,513,019,727	\$ 9,239,280,061			\$ 4,273,739,666
SFY21 Projected	\$ 14,414,135,160	\$ 9,489,049,737			\$ 4,925,085,423
SFY22 Projected	\$ 15,378,033,655	\$ 9,933,432,863			\$ 5,444,600,793
SFY18-22	\$ 67,858,067,748	\$ 45,825,244,270			\$ 22,032,823,478
<b>Second Waiver Extension Period</b>					
<b>Total \$ 31,406,324,065</b>					

Budget Neutrality Monitoring Spreadsheet												
Main Budget Neutrality Test												
Budget Neutrality "Without Waiver" Caps based on Current Demo caps Established in STC #128												
TOTAL COMPUTABLE												
Waiver Year	1	2	3	4	5	Demo	6	7	8	9	10	Renewal
State Fiscal Year	2013	2014	2015	2016	2017	Period 1	2018	2019	2020	2021	2022	Period 1
<b>NO WAIVER</b>												
Title XIX	\$ 1,888,003,055	\$ 2,721,828,868	\$ 3,190,622,964	\$ 3,450,278,327	\$ 3,618,285,034	\$ 14,869,018,248	\$ 3,929,974,862	\$ 4,268,514,578	\$ 4,636,217,112	\$ 5,035,594,635	\$ 5,469,375,725	\$ 23,339,676,911
<b>*ABD/LTC/HCBS State Plan</b>	\$ 4,769,223,154	\$ 6,829,676,392	\$ 6,924,916,366	\$ 7,236,977,599	\$ 7,527,066,520	\$ 33,287,860,032	\$ 7,952,465,806	\$ 8,401,923,960	\$ 8,876,802,615	\$ 9,378,540,525	\$ 9,908,657,931	\$ 44,518,390,837
	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>NO WAIVER - TOTAL COMPUTABLE</b>	<b>\$ 6,657,226,210</b>	<b>\$ 9,551,505,260</b>	<b>\$ 10,115,539,330</b>	<b>\$ 10,687,255,927</b>	<b>\$ 11,145,351,553</b>	<b>\$ 48,156,878,279</b>	<b>\$ 11,882,440,668</b>	<b>\$ 12,670,438,538</b>	<b>\$ 13,513,019,727</b>	<b>\$ 14,414,135,160</b>	<b>\$ 15,378,033,655</b>	<b>\$ 67,858,067,748</b>
<b>WITH WAIVER</b>												
Title XIX	\$ 1,660,533,500	\$ 2,401,028,803	\$ 2,585,155,172	\$ 2,542,349,561	\$ 2,543,100,659	\$ 11,732,167,695	\$ 2,896,176,183	\$ 3,145,661,408	\$ 3,416,638,032	\$ 3,710,957,388	\$ 4,030,630,288	\$ 17,200,063,301
<b>**ABD/LTC/HCBS State Plan</b>	\$ 4,009,676,348	\$ 5,468,130,944	\$ 5,219,407,337	\$ 5,283,892,825	\$ 5,508,360,696	\$ 25,489,468,150	\$ 5,209,108,223	\$ 5,496,142,521	\$ 5,614,445,392	\$ 5,735,895,711	\$ 5,860,605,937	\$ 27,916,197,784
HCBS state plan	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
DDD Supports-PDN	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
DSRIP	\$ 192,443,637	\$ 266,607,552	\$ 266,600,001	\$ 293,872,727	\$ 354,600,000	\$ 1,374,123,917	\$ 166,000,000	\$ 166,000,000	\$ 166,000,000	\$ -	\$ -	\$ 498,000,000
CNOMS	\$ 28,581,139	\$ 40,668,893	\$ 35,973,919	\$ 40,197,343	\$ 42,196,637	\$ 187,617,931	\$ 42,196,637	\$ 42,196,637	\$ 42,196,637	\$ 42,196,637	\$ 42,196,637	\$ 210,983,185
<b>WITH WAIVER - TOTAL COMPUTABLE</b>	<b>\$ 5,891,234,624</b>	<b>\$ 8,176,436,192</b>	<b>\$ 8,107,136,429</b>	<b>\$ 8,160,312,456</b>	<b>\$ 8,448,257,992</b>	<b>\$ 38,783,377,693</b>	<b>\$ 8,313,481,043</b>	<b>\$ 8,850,000,566</b>	<b>\$ 9,239,280,061</b>	<b>\$ 9,489,049,737</b>	<b>\$ 9,933,432,863</b>	<b>\$ 45,825,244,270</b>
<b>Difference</b>	<b>\$ 765,991,586</b>	<b>\$ 1,375,069,068</b>	<b>\$ 2,008,402,901</b>	<b>\$ 2,526,943,471</b>	<b>\$ 2,697,093,562</b>	<b>\$ 9,373,500,587</b>	<b>\$ 3,568,959,625</b>	<b>\$ 3,820,437,972</b>	<b>\$ 4,273,739,666</b>	<b>\$ 4,925,085,423</b>	<b>\$ 5,444,600,793</b>	<b>\$ 22,032,823,478</b>
<i>* ABD, LTC, and HCBS State Plan Member Months, PMPM, and Total Expenditures are combined in the WOW Cap Consolidated Calculation</i>												
<i>** ABD, LTC, and HCBS State Plan Member Months, PMPM, and Total Expenditures are combined in the Actuals Consolidated Calculation</i>												
FEDERAL SHARE												
Waiver Year	1	2	3	4	5	Demo	6	7	8	9	10	Renewal
State Fiscal Year	2013	2014	2015	2016	2017	Period 1	2018	2019	2020	2021	2022	Period 1
<b>NO WAIVER</b>												
Title XIX	\$ 947,820,711	\$ 1,506,507,404	\$ 1,750,305,401	\$ 1,750,856,075	\$ 1,817,908,487	\$ 7,773,398,078	\$ 1,968,328,398	\$ 2,137,886,057	\$ 2,322,049,917	\$ 2,522,078,199	\$ 2,739,337,512	\$ 11,689,680,085
<b>*ABD/LTC/HCBS State Plan</b>	\$ 2,391,868,093	\$ 3,436,667,374	\$ 3,480,683,737	\$ 3,625,364,745	\$ 3,766,466,934	\$ 16,701,050,884	\$ 3,979,639,438	\$ 4,204,561,095	\$ 4,442,203,898	\$ 4,693,287,840	\$ 4,958,573,694	\$ 22,278,265,966
	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
<b>NO WAIVER - FEDERAL SHARE</b>	<b>\$ 3,339,688,804</b>	<b>\$ 4,943,174,778</b>	<b>\$ 5,230,989,138</b>	<b>\$ 5,376,220,820</b>	<b>\$ 5,584,375,421</b>	<b>\$ 24,474,448,962</b>	<b>\$ 5,947,967,836</b>	<b>\$ 6,342,447,153</b>	<b>\$ 6,764,253,816</b>	<b>\$ 7,215,366,040</b>	<b>\$ 7,697,911,206</b>	<b>\$ 33,967,946,051</b>
<b>WITH WAIVER</b>												
Title XIX	\$ 833,625,792	\$ 1,328,947,500	\$ 1,418,159,122	\$ 1,290,124,376	\$ 1,277,711,465	\$ 6,148,568,255	\$ 1,450,550,202	\$ 1,575,504,908	\$ 1,711,223,584	\$ 1,858,633,470	\$ 2,018,741,682	\$ 8,614,653,844
<b>**ABD/LTC/HCBS State Plan</b>	\$ 2,011,078,841	\$ 2,751,925,469	\$ 2,624,022,315	\$ 2,647,177,908	\$ 2,756,310,228	\$ 12,790,514,762	\$ 2,606,687,350	\$ 2,750,321,892	\$ 2,809,515,744	\$ 2,870,284,161	\$ 2,932,683,391	\$ 13,969,492,538
HCBS state plan	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
HOLD DDD Supports-PDN	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
DSRIP	\$ 96,221,820	\$ 149,756,377	\$ 148,380,003	\$ 168,585,269	\$ 207,066,669	\$ 770,010,137	\$ 83,000,002	\$ 83,000,002	\$ 83,000,002	\$ -	\$ -	\$ 249,000,006
CNOMS	\$ 14,798,341	\$ 21,084,004	\$ 18,690,296	\$ 20,299,658	\$ 21,098,319	\$ 95,970,618	\$ 21,098,319	\$ 21,098,319	\$ 21,098,319	\$ 21,098,319	\$ 21,098,319	\$ 105,491,593
<b>WITH WAIVER - FEDERAL SHARE</b>	<b>\$ 2,955,724,794</b>	<b>\$ 4,251,713,350</b>	<b>\$ 4,209,251,736</b>	<b>\$ 4,126,187,211</b>	<b>\$ 4,262,186,680</b>	<b>\$ 19,805,063,771</b>	<b>\$ 4,161,335,872</b>	<b>\$ 4,429,925,120</b>	<b>\$ 4,624,837,648</b>	<b>\$ 4,750,015,949</b>	<b>\$ 4,972,523,391</b>	<b>\$ 22,938,637,980</b>
	\$ 2,011,069,653											
<b>Difference</b>	<b>\$ 383,964,010</b>	<b>\$ 691,461,428</b>	<b>\$ 1,021,737,403</b>	<b>\$ 1,250,033,609</b>	<b>\$ 1,322,188,741</b>	<b>\$ 4,669,385,191</b>	<b>1,786,631,964</b>	<b>1,912,522,033</b>	<b>2,139,416,167</b>	<b>2,465,350,091</b>	<b>2,725,387,816</b>	<b>11,029,308,070</b>
Notes:												
1. Member-months based on MMIS report with last actual reported as of June 30, 2017.												
2. "With Waiver" pmpm's based on calculations using Sch C expenditures and MMIS eligibility actual member-months reported through June 2017												
3. CNOMS (costs not otherwise matchable) include Severe Emotionally Disturbed children (SED at risk), MATI population, DDD non-disabled adult children and CCW Supports Equalization												

Budget Neutrality Monitoring Spreadsheet												
Supplemental Test #1												
Budget Neutrality "Without Waiver" Caps based on Current Demo caps Established in STC #129												
TOTAL COMPUTABLE												
Waiver Year	1	2	3	4	5	Demo	6	7	8	9	10	Renewal
State Fiscal Year	2013	2014	2015	2016	2017	Period 1	2018	2019	2020	2021	2022	Period 1
<b>NO WAIVER</b>												
HCBS 217-like	\$ 217,434,338	\$ 299,298,600	\$ 296,727,244	\$ 333,440,492	\$ 383,231,508	\$ 1,530,132,182	\$ 404,705,927	\$ 427,383,667	\$ 451,332,156	\$ 476,622,602	\$ 503,330,200	\$ 2,263,374,552
Adults w/o Depend. Children	\$ 1,677,789	\$ 798,912	\$ -	\$ -	\$ -	\$ 2,476,701	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
SED 217-like	\$ 253,840	\$ 345,267	\$ 290,262	\$ 256,844	\$ 5,235,238	\$ 6,381,451	\$ 5,651,215	\$ 6,100,246	\$ 6,584,955	\$ 7,108,177	\$ 7,672,974	\$ 33,117,567
Former XIX Chip Parents	\$ -	\$ 140,335,250	\$ -	\$ -	\$ -	\$ 140,335,250	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
IDD/MI	\$ -	\$ -	\$ 6,423,263	\$ 34,933,951	\$ 44,272,008	\$ 85,629,222	\$ 47,789,742	\$ 51,586,986	\$ 55,685,948	\$ 60,110,602	\$ 64,886,828	\$ 280,060,106
<b>NO WAIVER - TOTAL COMPUTABLE</b>	<b>\$ 219,365,967</b>	<b>\$ 440,778,028</b>	<b>\$ 303,440,769</b>	<b>\$ 368,631,287</b>	<b>\$ 432,738,754</b>	<b>\$ 1,764,954,806</b>	<b>\$ 458,146,884</b>	<b>\$ 485,070,898</b>	<b>\$ 513,603,059</b>	<b>\$ 543,841,382</b>	<b>\$ 575,890,003</b>	<b>\$ 2,576,552,224</b>
<b>WITH WAIVER</b>												
HCBS 217-like	\$ 207,465,132	\$ 278,302,398	\$ 331,234,441	\$ 375,718,137	\$ 402,567,552	\$ 1,595,287,660	\$ 456,020,011	\$ 481,573,141	\$ 508,558,144	\$ 537,055,254	\$ 567,149,203	\$ 2,550,355,753
Adults w/o Depend. Children	\$ 1,529,772	\$ 674,018	\$ -	\$ -	\$ -	\$ 2,203,790	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
SED 217-like	\$ 83	\$ 58,922	\$ 27,837	\$ 96,680	\$ 12,116,668	\$ 12,300,190	\$ 13,079,426	\$ 14,118,681	\$ 15,240,514	\$ 16,451,484	\$ 17,758,674	\$ 76,648,778
Former XIX Chip Parents	\$ -	\$ 126,863,607	\$ -	\$ -	\$ -	\$ 126,863,607	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
IDD/MI	\$ -	\$ -	\$ 1,186,792	\$ 7,798,525	\$ 10,750,786	\$ 19,736,103	\$ 10,668,406	\$ 11,516,088	\$ 12,431,125	\$ 13,418,869	\$ 14,485,096	\$ 62,519,584
<b>WITH WAIVER - TOTAL COMPUTABLE</b>	<b>\$ 208,994,987</b>	<b>\$ 405,898,945</b>	<b>\$ 332,449,070</b>	<b>\$ 383,613,342</b>	<b>\$ 425,435,006</b>	<b>\$ 1,756,391,350</b>	<b>\$ 479,767,842</b>	<b>\$ 507,207,911</b>	<b>\$ 536,229,783</b>	<b>\$ 566,925,607</b>	<b>\$ 599,392,973</b>	<b>\$ 2,689,524,116</b>
<b>Difference</b>	<b>\$ 10,370,980</b>	<b>\$ 34,879,083</b>	<b>\$ (29,008,301)</b>	<b>\$ (14,982,055)</b>	<b>\$ 7,303,748</b>	<b>\$ 8,563,456</b>	<b>\$ (21,620,959)</b>	<b>\$ (22,137,013)</b>	<b>\$ (22,626,724)</b>	<b>\$ (23,084,225)</b>	<b>\$ (23,502,970)</b>	<b>\$ (112,971,891)</b>
FEDERAL SHARE												
Waiver Year	1	2	3	4	5	Demo	6	7	8	9	10	Renewal
State Fiscal Year	2013	2014	2015	2016	2017	Period 1	2018	2019	2020	2021	2022	Period 1
<b>NO WAIVER</b>												
HCBS 217-like	\$ 110,183,049	\$ 154,284,438	\$ 152,379,548	\$ 167,842,602	\$ 191,637,762	\$ 776,327,399	\$ 202,360,417	\$ 213,699,704	\$ 225,674,390	\$ 238,320,079	\$ 251,674,370	\$ 1,131,728,959
Adults w/o Depend. Children	\$ 852,857	\$ 408,324	\$ -	\$ -	\$ -	\$ 1,261,182	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
SED 217-like	\$ -	\$ 172,639	\$ 145,397	\$ 129,706	\$ 2,617,619	\$ 3,065,361	\$ 2,825,608	\$ 3,050,123	\$ 3,292,477	\$ 3,554,089	\$ 3,836,487	\$ 16,558,783
Former XIX Chip Parents	\$ -	\$ 71,621,870	\$ -	\$ -	\$ -	\$ 71,621,870	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
IDD/MI	\$ -	\$ -	\$ 3,244,338	\$ 17,467,007	\$ 22,248,738	\$ 42,960,083	\$ 24,016,562	\$ 25,924,853	\$ 27,984,772	\$ 30,208,366	\$ 32,608,641	\$ 140,743,195
<b>NO WAIVER - TOTAL COMPUTABLE</b>	<b>\$ 111,035,906</b>	<b>\$ 226,487,272</b>	<b>\$ 155,769,283</b>	<b>\$ 185,439,316</b>	<b>\$ 216,504,118</b>	<b>\$ 895,235,895</b>	<b>\$ 229,202,587</b>	<b>\$ 242,674,680</b>	<b>\$ 256,951,639</b>	<b>\$ 272,082,534</b>	<b>\$ 288,119,498</b>	<b>\$ 1,289,030,938</b>
<b>WITH WAIVER</b>												
HCBS 217-like	\$ 105,131,236	\$ 143,461,176	\$ 170,100,169	\$ 189,123,731	\$ 201,306,894	\$ 809,123,206	\$ 228,018,404	\$ 240,795,440	\$ 254,288,438	\$ 268,537,518	\$ 283,585,046	\$ 1,275,224,845
Adults w/o Depend. Children	\$ 777,617	\$ 344,491	\$ -	\$ -	\$ -	\$ 1,122,108	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
SED 217-like	\$ -	\$ 29,462	\$ 13,944	\$ 48,823	\$ 6,058,334	\$ 6,150,563	\$ 6,539,713	\$ 7,059,341	\$ 7,620,257	\$ 8,225,742	\$ 8,879,337	\$ 38,324,389
Former XIX Chip Parents	\$ -	\$ 64,746,447	\$ -	\$ -	\$ -	\$ 64,746,447	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
IDD/MI	\$ -	\$ -	\$ 599,439	\$ 3,899,270	\$ 5,402,769	\$ 9,901,477	\$ 5,361,369	\$ 5,787,369	\$ 6,247,217	\$ 6,743,604	\$ 7,279,433	\$ 31,418,991
<b>WITH WAIVER - TOTAL COMPUTABLE</b>	<b>\$ 105,908,853</b>	<b>\$ 208,581,576</b>	<b>\$ 170,713,552</b>	<b>\$ 193,071,824</b>	<b>\$ 212,767,997</b>	<b>\$ 891,043,802</b>	<b>\$ 239,919,485</b>	<b>\$ 253,642,149</b>	<b>\$ 268,155,912</b>	<b>\$ 283,506,864</b>	<b>\$ 299,743,816</b>	<b>\$ 1,344,968,226</b>
<b>Difference</b>	<b>\$ 5,127,053</b>	<b>\$ 17,905,696</b>	<b>\$ (14,944,269)</b>	<b>\$ (7,632,508)</b>	<b>\$ 3,736,122</b>	<b>\$ 4,192,094</b>	<b>\$ (10,716,899)</b>	<b>\$ (10,967,468)</b>	<b>\$ (11,204,272)</b>	<b>\$ (11,424,330)</b>	<b>\$ (11,624,318)</b>	<b>\$ (55,937,288)</b>

Budget Neutrality Monitoring Spreadsheet												
Supplemental Test #2												
Budget Neutrality "Without Waiver" Caps based on Current Demo caps Established in STC #129												
TOTAL COMPUTABLE												
Waiver Year	1	2	3	4	5	Demo	6	7	8	9	10	Renewal
State Fiscal Year	2013	2014	2015	2016	2017	Period 1	2018	2019	2020	2021	2022	Period 1
<b>NO WAIVER</b>												
New Adult Group	\$ -	\$ 655,329,429	\$ 3,208,229,680	\$ 3,490,111,740	\$ 3,706,632,521	\$ 11,060,303,369	\$ 3,963,404,797	\$ 4,237,964,648	\$ 4,531,544,285	\$ 4,845,461,280	\$ 5,181,124,478	\$ 22,759,499,488
<b>NO WAIVER - TOTAL COMPUTABLE</b>	\$ -	\$ 655,329,429	\$ 3,208,229,680	\$ 3,490,111,740	\$ 3,706,632,521	\$ 11,060,303,369	\$ 3,963,404,797	\$ 4,237,964,648	\$ 4,531,544,285	\$ 4,845,461,280	\$ 5,181,124,478	\$ 22,759,499,488
<b>WITH WAIVER</b>												
New Adult Group	\$ -	\$ 849,302,769	\$ 2,859,089,720	\$ 2,911,520,516	\$ 3,101,628,329	\$ 9,721,541,334	\$ 3,306,350,982	\$ 3,535,394,262	\$ 3,780,304,225	\$ 4,042,180,015	\$ 4,322,196,920	\$ 18,986,426,404
<b>WITH WAIVER - TOTAL COMPUTABLE</b>	\$ -	\$ 849,302,769	\$ 2,859,089,720	\$ 2,911,520,516	\$ 3,101,628,329	\$ 9,721,541,334	\$ 3,306,350,982	\$ 3,535,394,262	\$ 3,780,304,225	\$ 4,042,180,015	\$ 4,322,196,920	\$ 18,986,426,404
<b>Difference</b>	\$ -	\$ (193,973,340)	\$ 349,139,960	\$ 578,591,224	\$ 605,004,192	\$ 1,338,762,035	\$ 657,053,815	\$ 702,570,386	\$ 751,240,060	\$ 803,281,265	\$ 858,927,558	\$ 3,773,073,084
FEDERAL SHARE												
Waiver Year	1	2	3	4	5	Demo	6	7	8	9	10	Renewal
State Fiscal Year	2013	2014	2015	2016	2017	Period 1	2018	2019	2020	2021	2022	Period 1
<b>NO WAIVER</b>												
New Adult Group	\$ -	\$ 655,312,015	\$ 3,208,089,476	\$ 3,488,602,179	\$ 3,613,966,707	\$ 10,965,970,377	\$ 3,745,417,533	\$ 3,962,496,946	\$ 4,146,363,021	\$ 4,360,915,152	\$ 4,663,012,030	\$ 20,878,204,682
<b>NO WAIVER - TOTAL COMPUTABLE</b>	\$ -	\$ 655,312,015	\$ 3,208,089,476	\$ 3,488,602,179	\$ 3,613,966,707	\$ 10,965,970,377	\$ 3,745,417,533	\$ 3,962,496,946	\$ 4,146,363,021	\$ 4,360,915,152	\$ 4,663,012,030	\$ 20,878,204,682
<b>WITH WAIVER</b>												
New Adult Group	\$ -	\$ 849,280,201	\$ 2,858,964,774	\$ 2,910,261,210	\$ 3,024,087,621	\$ 9,642,593,806	\$ 3,124,501,678	\$ 3,305,593,635	\$ 3,458,978,366	\$ 3,637,962,014	\$ 3,889,977,228	\$ 17,417,012,920
<b>WITH WAIVER - TOTAL COMPUTABLE</b>	\$ -	\$ 849,280,201	\$ 2,858,964,774	\$ 2,910,261,210	\$ 3,024,087,621	\$ 9,642,593,806	\$ 3,124,501,678	\$ 3,305,593,635	\$ 3,458,978,366	\$ 3,637,962,014	\$ 3,889,977,228	\$ 17,417,012,920
<b>Difference</b>	\$ -	\$ (193,968,186)	\$ 349,124,702	\$ 578,340,969	\$ 589,879,087	\$ 1,323,376,572	\$ 620,915,855	\$ 656,903,311	\$ 687,384,655	\$ 722,953,138	\$ 773,034,802	\$ 3,461,191,762
<b>Notes:</b>												
1. Federal share is calculated using Composite Federal Share Ratios (source data is CMS 64 Schedule C as reported in QE Sept2017 with a run date of Nov 06, 2017).												
2. Member-months based on MMIS report with last actual reported as of Sept 2017.												
3. "With Waiver" pmpm's based on calculations using Sch C expenditures and MMIS eligibility actual member-months reported through Sept												



Federal Budget Neutrality - Cap													
TOTAL EXPENDITURES IN WAIVER	\$6,876,592,177	\$10,647,612,717	\$13,627,209,779	\$14,545,998,954	\$15,284,722,827	\$60,982,136,454	\$16,303,992,349	\$17,393,474,083	\$18,558,167,071	\$19,803,437,822	\$21,135,048,135	\$93,194,119,460	
Waiver Year	1	2	3	4	5	Demo	6	7	8	9	10	Renewal	Original STC
State Fiscal Year	2013	2014	2015	2016	2017	Period 1	2018	2019	2020	2021	2022	Period 1	Growth %'s used for
Member Months	actual	actual	actual	actual	actual		projected	projected	projected	projected	projected		BN
Title XIX	5,773,180	7,850,901	8,699,959	8,893,616	8,816,484		9,051,004	9,291,762	9,538,924	9,792,661	10,053,148		2.7%
*ABD/LTC/HCBS State Plan	2,499,711	3,452,152	3,381,631	3,402,743	3,385,777		3,447,926	3,511,216	3,575,668	3,641,302	3,708,142		1.8%
													1.8%
													1.8%
<b>Total Waiver Member Months</b>	<b>8,272,891</b>	<b>11,303,053</b>	<b>12,081,590</b>	<b>12,296,359</b>	<b>12,202,261</b>		<b>12,498,930</b>	<b>12,802,978</b>	<b>13,114,592</b>	<b>13,433,964</b>	<b>13,761,290</b>		
<b>Per Member Per Month</b>													
Title XIX	\$327.03	\$346.69	\$366.74	\$387.95	\$410.40		\$434.20	\$459.39	\$486.03	\$514.22	\$544.05		5.8%
*ABD/LTC/HCBS State Plan	\$1,907.91	\$1,978.38	\$2,047.80	\$2,126.81	\$2,223.14		\$2,306.45	\$2,392.88	\$2,482.56	\$2,575.60	\$2,672.14		3.75%
<b>Total Expenditures (Member Months x PMPM)</b>													
Title XIX	\$1,888,003,055	\$2,721,828,868	\$3,190,622,964	\$3,450,278,327	\$3,618,285,034	\$14,869,018,248	\$3,929,974,862	\$4,268,514,578	\$4,636,217,112	\$5,035,594,635	\$5,469,375,725	\$23,339,676,911	
*ABD/LTC/HCBS State Plan	\$4,769,223,154	\$6,829,676,392	\$6,924,916,366	\$7,236,977,599	\$7,527,066,520	\$33,287,860,032	\$7,952,465,806	\$8,401,923,960	\$8,876,802,615	\$9,378,540,525	\$9,908,657,931	\$44,518,390,837	
<b>Total Base Expenditures</b>	<b>\$6,657,226,210</b>	<b>\$9,551,505,260</b>	<b>\$10,115,539,330</b>	<b>\$10,687,255,927</b>	<b>\$11,145,351,553</b>	<b>\$48,156,878,279</b>	<b>\$11,882,440,668</b>	<b>\$12,670,438,538</b>	<b>\$13,513,019,727</b>	<b>\$14,414,135,160</b>	<b>\$15,378,033,655</b>	<b>\$67,858,067,748</b>	
<i>* ABD, LTC, and HCBS State Plan Member Months, PMPM, and Total Expenditures are combined in the WOW Cap Consolidated Calculation</i>													
<b>Hypothetical Population Expenditures</b>													
HCBS 217-Like	\$217,434,338	\$299,298,600	\$296,727,244	\$333,440,492	\$383,231,508	\$1,530,132,182	\$404,705,927	\$427,383,667	\$451,332,156	\$476,622,602	\$503,330,200	\$2,263,374,552	
*Adults w/o Dependent Children	\$1,677,789	\$798,912	\$0	\$0	\$0	\$2,476,701	\$0	\$0	\$0	\$0	\$0	\$0	
SED 217-Like	\$253,840	\$345,267	\$290,262	\$256,844	\$5,235,238	\$6,381,451	\$5,651,215	\$6,100,246	\$6,584,955	\$7,108,177	\$7,672,974	\$33,117,567	
*XIX CHIP Parents	\$0	\$140,335,250	\$0	\$0	\$0	\$140,335,250	\$0	\$0	\$0	\$0	\$0	\$0	
IDD/MI	\$0	\$0	\$6,423,263	\$34,933,951	\$44,272,008	\$85,629,222	\$47,789,742	\$51,586,986	\$55,685,948	\$60,110,602	\$64,886,828	\$280,060,106	
New Adult Group	\$0	\$655,329,429	\$3,208,229,680	\$3,490,111,740	\$3,706,632,521	\$11,060,303,369	\$3,963,404,797	\$4,237,964,648	\$4,531,544,285	\$4,845,461,280	\$5,181,124,478	\$22,759,499,488	
<b>Total Hypothetical Expenditures</b>	<b>\$219,365,967</b>	<b>\$1,096,107,457</b>	<b>\$3,511,670,449</b>	<b>\$3,858,743,027</b>	<b>\$4,139,371,274</b>	<b>\$12,825,258,175</b>	<b>\$4,421,551,681</b>	<b>\$4,723,035,546</b>	<b>\$5,045,147,344</b>	<b>\$5,389,302,662</b>	<b>\$5,757,014,480</b>	<b>\$25,336,051,712</b>	
<i>* Adults w/o Dependent Children and Title XIX CHIP Parents are now in New Adult Group as of 1/1/14.</i>													

With Waiver - Expenditures													
<b>TOTAL EXPENDITURES IN WAIVER</b>	<b>\$6,100,229,611</b>	<b>\$9,431,637,906</b>	<b>\$11,298,675,219</b>	<b>\$11,455,446,314</b>	<b>\$11,975,321,327</b>	<b>\$50,261,310,377</b>	<b>\$12,099,599,867</b>	<b>\$12,892,602,739</b>	<b>\$13,555,814,069</b>	<b>\$14,098,155,359</b>	<b>\$14,855,022,755</b>	<b>\$67,501,194,789</b>	
Waiver Year	1	2	3	4	5	<i>Demo</i>	6	7	8	9	10	<i>Renewal</i>	Original STC
State Fiscal Year	2013	2014	2015	2016	2017	<i>Period 1</i>	2018	2019	2020	2021	2022	<i>Period 1</i>	Growth %'s
<b>Member Months</b>	<i>actual</i>	<i>actual</i>	<i>actual</i>	<i>actual</i>	<i>estimated</i>		<i>projected</i>	<i>projected</i>	<i>projected</i>	<i>projected</i>	<i>projected</i>		used for
<b>Title XIX</b>	5,773,180	7,850,901	8,699,959	8,893,616	8,816,484		9,051,004	9,291,762	9,538,924	9,792,661	10,053,148		BN
<b>*ABD/LTC/HCBS State Plan</b>	2,499,711	3,361,590	3,381,631	3,401,925	3,357,056		3,046,489	3,102,410	3,159,358	3,217,351	3,276,409		2.7%
													1.8%
													1.8%
<b>Total Waiver Member Months</b>	<b>8,272,891</b>	<b>11,212,491</b>	<b>12,081,590</b>	<b>12,295,541</b>	<b>12,173,540</b>		<b>12,097,493</b>	<b>12,394,172</b>	<b>12,698,283</b>	<b>13,010,013</b>	<b>13,329,557</b>		
<b>Per Member Per Month</b>													
<b>Title XIX</b>	\$287.63	\$305.83	\$297.15	\$285.86	\$302.44		\$319.98	\$338.54	\$358.18	\$378.95	\$400.93		5.8%
<b>*ABD/LTC/HCBS State Plan</b>	\$1,604.06	\$1,626.65	\$1,543.46	\$1,553.21	\$1,609.12		\$1,667.05	\$1,727.06	\$1,727.06	\$1,727.06	\$1,727.06		3.6%
													3.9%
													3.7%
<b>Total Expenditures (Member Months x PMPM)</b>													
<b>Title XIX</b>	\$1,660,533,500	\$2,401,028,803	\$2,585,155,172	\$2,542,349,561	\$2,543,100,659	<b>\$11,732,167,695</b>	\$2,896,176,183	\$3,145,661,408	\$3,416,638,032	\$3,710,957,388	\$4,030,630,288	<b>\$17,200,063,301</b>	
<b>*ABD/LTC/HCBS State Plan</b>	\$4,009,676,348	\$5,468,130,944	\$5,219,407,337	\$5,283,892,825	\$5,508,360,696	<b>\$25,489,468,150</b>	\$5,209,108,223	\$5,496,142,521	\$5,614,445,392	\$5,735,895,711	\$5,860,605,937	<b>\$27,916,197,784</b>	
<b>Total Base Actual Expenditures</b>	<b>\$5,670,209,848</b>	<b>\$7,869,159,747</b>	<b>\$7,804,562,509</b>	<b>\$7,826,242,386</b>	<b>\$8,051,461,355</b>	<b>\$37,221,635,845</b>	<b>\$8,105,284,406</b>	<b>\$8,641,803,929</b>	<b>\$9,031,083,424</b>	<b>\$9,446,853,100</b>	<b>\$9,891,236,226</b>	<b>\$45,116,261,085</b>	
<i>* ABD, LTC, and HCBS State Plan Member Months, PMPM, and Total Expenditures are combined in the Actuals Consolidated Calculation</i>													
<b>Hypothetical Population Expenditures</b>													
<b>HCBS 217-Like</b>	\$207,465,132	\$278,302,398	\$331,234,441	\$375,718,137	\$402,567,552	<b>\$1,595,287,660</b>	\$456,020,011	\$481,573,141	\$508,558,144	\$537,055,254	\$567,149,203	<b>\$2,550,355,753</b>	
<b>**Adults w/o Dependent Children</b>	\$1,529,772	\$674,018	\$0	\$0	\$0	<b>\$2,203,790</b>	\$0	\$0	\$0	\$0	\$0	<b>\$0</b>	
<b>SED 217-Like</b>	\$83	\$58,922	\$27,837	\$96,680	\$12,116,668	<b>\$12,300,190</b>	\$13,079,426	\$14,118,681	\$15,240,514	\$16,451,484	\$17,758,674	<b>\$76,648,778</b>	
<b>**XIX CHIP Parents</b>	\$0	\$126,863,607	\$0	\$0	\$0	<b>\$126,863,607</b>	\$0	\$0	\$0	\$0	\$0	<b>\$0</b>	
<b>IDD/MI - 217-Like</b>	\$0	\$0	\$1,186,792	\$7,798,525	\$10,750,786	<b>\$19,736,103</b>	\$10,668,406	\$11,516,088	\$12,431,125	\$13,418,869	\$14,485,096	<b>\$62,519,584</b>	
<b>New Adult Group</b>	\$0	\$849,302,769	\$2,859,089,720	\$2,911,520,516	\$3,101,628,329	<b>\$9,721,541,334</b>	\$3,306,350,982	\$3,535,394,262	\$3,780,304,225	\$4,042,180,015	\$4,322,196,920	<b>\$18,986,426,404</b>	
<b>Total Hypothetical Expenditures</b>	<b>\$208,994,987</b>	<b>\$1,255,201,714</b>	<b>\$3,191,538,790</b>	<b>\$3,295,133,858</b>	<b>\$3,527,063,335</b>	<b>\$11,477,932,684</b>	<b>\$3,786,118,825</b>	<b>\$4,042,602,173</b>	<b>\$4,316,534,008</b>	<b>\$4,609,105,622</b>	<b>\$4,921,589,892</b>	<b>\$21,675,950,519</b>	
<i>** Adults w/o Dependent Children and Title XIX CHIP Parents are now in New Adult Group as of 1/1/14.</i>													
<b>Supports Program</b>	\$0	\$0	\$0	\$0	\$0	<b>\$0</b>	\$0	\$0	\$0	\$0	\$0	<b>\$0</b>	
<b>Hospital Subsidies</b>													
<b>HRSF &amp; GME</b>	\$ 192,443,637	\$ -	\$ -	\$ -	\$ -	<b>\$192,443,637</b>	\$ -	\$ -	\$ -	\$ -	\$ -	<b>\$0</b>	
<b>HRSF Transition Payments</b>	\$ -	\$ 83,302,681	\$ -	\$ -	\$ -	<b>\$83,302,681</b>	\$ -	\$ -	\$ -	\$ -	\$ -	<b>\$0</b>	
<b>GME State Plan</b>	-	100,000,001	100,000,000	127,272,727	188,000,000	<b>\$515,272,728</b>	-	-	-	-	-	<b>\$0</b>	
<b>DSRIP</b>	-	83,304,870	166,600,001	166,600,000	166,600,000	<b>\$583,104,871</b>	166,000,000	166,000,000	166,000,000	-	-	<b>\$498,000,000</b>	
<b>Hospital Subsidies Expenditures</b>	<b>\$ 192,443,637</b>	<b>\$ 266,607,552</b>	<b>\$ 266,600,001</b>	<b>\$ 293,872,727</b>	<b>\$ 354,600,000</b>	<b>\$1,374,123,917</b>	<b>\$ 166,000,000</b>	<b>\$ 166,000,000</b>	<b>\$ 166,000,000</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$498,000,000</b>	
<b>Costs Otherwise Not Matchable (CNOMs)</b>													
<b>SED at Risk</b>	\$ 24,511,364	\$ 37,239,735	\$ 35,973,919	\$ 40,197,343	\$ 42,196,637	<b>\$180,118,998</b>	\$ 42,196,637	\$ 42,196,637	\$ 42,196,637	\$ 42,196,637	\$ 42,196,637	<b>\$210,983,185</b>	
<b>MATI at Risk</b>	4,069,775	3,429,158	-	-	-	<b>\$7,498,933</b>	-	-	-	-	-	<b>\$0</b>	
<b>DDD non-Disabled Adult Children</b>	-	-	-	-	-		-	-	-	-	-		
<b>DDD Community / Supports Equalization</b>	-	-	-	-	-		-	-	-	-	-		
<b>CNOM Expenditures</b>	<b>\$ 28,581,139</b>	<b>\$ 40,668,893</b>	<b>\$ 35,973,919</b>	<b>\$ 40,197,343</b>	<b>\$ 42,196,637</b>	<b>\$187,617,931</b>	<b>\$ 42,196,637</b>	<b>\$ 42,196,637</b>	<b>\$ 42,196,637</b>	<b>\$ 42,196,637</b>	<b>\$ 42,196,637</b>	<b>\$210,983,185</b>	

Federal Budget Neutrality - Cap													
TOTAL EXPENDITURES IN WAIVER													
Waiver Year	1	2	3	4	5	Demo	6	7	8	9	10	Renewal	Original STC
State Fiscal Year	2013	2014	2015	2016	2017	Period 1	2018	2019	2020	2021	2022	Period 1	Growth %'s used for
Member Months	actual	actual	actual	actual	estimated		projected	projected	projected	projected	projected		BN
Title XIX	5,773,180	7,850,901	8,699,959	8,893,616	8,816,484		9,051,004	9,291,762	9,538,924	9,792,661	10,053,148		2.7%
ABD	2,204,173	3,060,786	2,994,122	2,983,807	2,929,087		2,982,853	3,037,606	3,093,364	3,150,146	3,207,970		1.8%
LTC	281,944	372,506	361,853	359,894	358,389		364,968	371,667	378,489	385,437	392,512		1.8%
HCBS State Plan	13,594	18,860	25,656	59,042	98,301		100,105	101,943	103,814	105,720	107,660		1.8%
<b>Total Waiver Member Months</b>	<b>8,272,891</b>	<b>11,303,053</b>	<b>12,081,590</b>	<b>12,296,359</b>	<b>12,202,261</b>		<b>12,498,930</b>	<b>12,802,978</b>	<b>13,114,592</b>	<b>13,433,964</b>	<b>13,761,290</b>		
Per Member Per Month													
Title XIX	\$327.03	\$346.69	\$366.74	\$387.95	\$410.40		\$434.20	\$459.39	\$486.03	\$514.22	\$544.05		5.8%
ABD	\$1,045.04	\$1,124.49	\$1,164.91	\$1,206.78	\$1,250.17		\$1,295.18	\$1,341.80	\$1,390.11	\$1,440.15	\$1,492.00		3.6%
LTC	\$8,636.81	\$8,975.89	\$9,325.83	\$9,689.41	\$10,067.17		\$10,459.79	\$10,867.72	\$11,291.56	\$11,731.93	\$12,189.48		3.9%
HCBS State Plan	\$2,256.69	\$2,347.84	\$2,434.29	\$2,523.94	\$2,616.93		\$2,713.76	\$2,814.17	\$2,918.29	\$3,026.27	\$3,138.24		3.7%
Total Expenditures (Member Months x PMPM)													
Title XIX	\$1,888,003,055	\$2,721,828,868	\$3,190,622,964	\$3,450,278,327	\$3,618,285,034	\$14,869,018,248	\$3,929,974,862	\$4,268,514,578	\$4,636,217,112	\$5,035,594,635	\$5,469,375,725	\$23,339,676,911	
ABD	\$2,303,448,952	\$3,441,823,249	\$3,487,882,659	\$3,600,798,611	\$3,661,856,695	\$16,495,810,166	\$3,863,320,154	\$4,075,867,477	\$4,300,108,464	\$4,536,686,462	\$4,786,280,212	\$21,562,262,769	
LTC	\$2,435,096,759	\$3,343,572,880	\$3,374,579,563	\$3,487,160,523	\$3,607,962,989	\$16,248,372,714	\$3,817,483,963	\$4,039,172,201	\$4,273,734,278	\$4,521,917,801	\$4,784,513,793	\$21,436,822,036	
HCBS State Plan	\$30,677,444	\$44,280,262	\$62,454,144	\$149,018,465	\$257,246,836	\$543,677,152	\$271,661,690	\$286,884,282	\$302,959,873	\$319,936,262	\$337,863,925	\$1,519,306,032	
<b>Total Base Expenditures</b>	<b>\$6,657,226,210</b>	<b>\$9,551,505,260</b>	<b>\$10,115,539,330</b>	<b>\$10,687,255,927</b>	<b>\$11,145,351,553</b>	<b>\$48,156,878,279</b>	<b>\$11,882,440,668</b>	<b>\$12,670,438,538</b>	<b>\$13,513,019,727</b>	<b>\$14,414,135,160</b>	<b>\$15,378,033,655</b>	<b>\$67,858,067,748</b>	
Hypothetical Population Expenditures													
HCBS 217-Like	\$217,434,338	\$299,298,600	\$296,727,244	\$333,440,492	\$383,231,508	\$1,530,132,182	\$404,705,927	\$427,383,667	\$451,332,156	\$476,622,602	\$503,330,200	\$2,263,374,552	
*Adults w/o Dependent Children	\$1,677,789	\$798,912	\$0	\$0	\$0	\$2,476,701	\$0	\$0	\$0	\$0	\$0	\$0	
SED 217-Like	\$253,840	\$345,267	\$290,262	\$256,844	\$5,235,238	\$6,381,451	\$5,651,215	\$6,100,246	\$6,584,955	\$7,108,177	\$7,672,974	\$33,117,567	
*XIX CHIP Parents	\$0	\$140,335,250	\$0	\$0	\$0	\$140,335,250	\$0	\$0	\$0	\$0	\$0	\$0	
IDD/MI	\$0	\$0	\$6,423,263	\$34,933,951	\$44,272,008	\$85,629,222	\$47,789,742	\$51,586,986	\$55,685,948	\$60,110,602	\$64,886,828	\$280,060,106	
New Adult Group	\$0	\$655,329,429	\$3,208,229,680	\$3,490,111,740	\$3,706,632,521	\$11,060,303,369	\$3,963,404,797	\$4,237,964,648	\$4,531,544,285	\$4,845,461,280	\$5,181,124,478	\$22,759,499,488	
<b>Total Hypothetical Expenditures</b>	<b>\$219,365,967</b>	<b>\$1,096,107,457</b>	<b>\$3,511,670,449</b>	<b>\$3,858,743,027</b>	<b>\$4,139,371,274</b>	<b>\$12,825,258,175</b>	<b>\$4,421,551,681</b>	<b>\$4,723,035,546</b>	<b>\$5,045,147,344</b>	<b>\$5,389,302,662</b>	<b>\$5,757,014,480</b>	<b>\$25,336,051,712</b>	
* Adults w/o Dependent Children and Title XIX CHIP Parents are now in New Adult Group as of 1/1/14.													

With Waiver - Expenditures														
<b>TOTAL EXPENDITURES IN WAIVER</b>	<b>\$6,100,227,468</b>	<b>\$9,442,488,618</b>	<b>\$11,297,320,773</b>	<b>\$11,437,497,403</b>	<b>\$12,005,158,050</b>	<b>\$50,282,692,312</b>		<b>\$12,044,101,459</b>	<b>\$12,833,033,560</b>	<b>\$13,491,860,168</b>	<b>\$14,029,478,279</b>	<b>\$14,781,257,604</b>	<b>\$67,179,731,070</b>	
Waiver Year	1	2	3	4	5	<b>Demo</b>		6	7	8	9	10	<b>Renewal</b>	Original STC
State Fiscal Year	2013	2014	2015	2016	2017	<b>Period 1</b>		2018	2019	2020	2021	2022	<b>Period 1</b>	Growth %'s
<b>Member Months</b>	<i>actual</i>	<i>actual</i>	<i>actual</i>	<i>actual</i>	<i>estimated</i>			<i>projected</i>	<i>projected</i>	<i>projected</i>	<i>projected</i>	<i>projected</i>		used for
<b>Title XIX</b>	5,773,180	7,850,901	8,699,959	8,893,999	8,785,836			9,019,541	9,259,462	9,505,765	9,758,620	10,018,201		BN
<b>*ABD</b>	2,486,117	3,342,730	3,355,975	3,342,883	3,258,769			2,946,398	3,000,482	3,055,559	3,111,646	3,168,764		2.7%
<b>*LTC</b>														1.8%
<b>HCBS State Plan</b>	13,594	18,860	25,656	59,042	98,287			100,091	101,928	103,799	105,705	107,645		1.8%
<b>Total Waiver Member Months</b>	<b>8,272,891</b>	<b>11,212,491</b>	<b>12,081,590</b>	<b>12,295,924</b>	<b>12,142,892</b>			<b>12,066,029</b>	<b>12,361,872</b>	<b>12,665,123</b>	<b>12,975,971</b>	<b>13,294,610</b>		
<b>Per Member Per Month</b>														
<b>Title XIX</b>	\$287.63	\$305.59	\$296.85	\$284.99	\$301.52			\$319.01	\$337.51	\$357.09	\$377.80	\$399.71		5.8%
<b>*ABD</b>	\$1,595.54	\$1,616.41	\$1,525.65	\$1,508.82	\$1,563.14			\$1,619.41	\$1,677.71	\$1,677.71	\$1,677.71	\$1,677.71		3.6%
<b>*LTC</b>														3.9%
<b>HCBS State Plan</b>	\$3,162.12	\$3,441.37	\$3,872.47	\$4,066.37	\$4,216.83			\$4,372.85	\$4,534.64	\$4,702.43	\$4,876.42	\$5,056.84		3.7%
<b>Total Expenditures (Member Months x PMPM)</b>														
<b>Title XIX</b>	\$1,660,532,120	\$2,399,180,142	\$2,582,613,493	\$2,534,724,200	\$2,649,124,657	<b>\$11,826,174,612</b>		\$2,877,328,130	\$3,125,189,727	\$3,394,402,860	\$3,686,806,812	\$4,004,399,310	<b>\$17,088,126,839</b>	
<b>*ABD</b>	\$3,966,690,442	\$5,403,226,627	\$5,120,055,291	\$5,043,806,205	\$5,093,901,545	<b>\$24,627,680,110</b>		\$4,771,424,809	\$5,033,933,470	\$5,126,336,408	\$5,220,435,488	\$5,316,261,845	<b>\$25,468,392,019</b>	
<b>*LTC</b>	\$0	\$0	\$0	\$0	\$0	<b>\$0</b>		\$0	\$0	\$0	\$0	\$0	<b>\$0</b>	
<b>HCBS State Plan</b>	\$42,985,906	\$64,904,317	\$99,352,046	\$240,086,620	\$414,459,151	<b>\$861,788,040</b>		\$437,683,414	\$462,209,051	\$488,108,984	\$515,460,224	\$544,344,093	<b>\$2,447,805,765</b>	
<b>Total Base Actual Expenditures</b>	<b>\$5,670,208,468</b>	<b>\$7,867,311,086</b>	<b>\$7,802,020,830</b>	<b>\$7,818,617,025</b>	<b>\$8,157,485,353</b>	<b>\$37,315,642,762</b>		<b>\$8,086,436,352</b>	<b>\$8,621,332,248</b>	<b>\$9,008,848,252</b>	<b>\$9,422,702,523</b>	<b>\$9,865,005,247</b>	<b>\$45,004,324,623</b>	
<i>* ABD and LTC Member Months, PMPM, and Total Expenditures are combined in the Actual Detail Calculation</i>														
<b>Hypothetical Population Expenditures</b>														
<b>HCBS 217-Like</b>	\$207,464,369	\$278,302,398	\$331,117,748	\$375,476,571	\$430,061,851	<b>\$1,622,422,937</b>		\$454,160,413	\$479,609,340	\$506,484,301	\$534,865,203	\$564,836,432	<b>\$2,539,955,689</b>	
<b>**Adults w/o Dependent Children</b>	\$1,529,772	\$674,018	\$0	\$0	\$0	<b>\$2,203,790</b>		\$0	\$0	\$0	\$0	\$0	<b>\$0</b>	
<b>SED 217-Like</b>	\$83	\$58,922	\$27,837	\$96,680	\$6,135,308	<b>\$6,318,830</b>		\$6,622,803	\$7,149,033	\$7,717,076	\$8,330,254	\$8,992,153	<b>\$38,811,319</b>	
<b>**XIX CHIP Parents</b>	\$0	\$126,863,607	\$0	\$0	\$0	<b>\$126,863,607</b>		\$0	\$0	\$0	\$0	\$0	<b>\$0</b>	
<b>IDD/MI - 217-Like</b>	\$0	\$0	\$1,186,792	\$7,795,679	\$9,058,086	<b>\$18,040,557</b>		\$9,777,817	\$10,554,736	\$11,393,387	\$12,298,675	\$13,275,894	<b>\$57,300,509</b>	
<b>New Adult Group</b>	\$0	\$862,002,142	\$2,860,394,406	\$2,901,491,432	\$3,068,397,436	<b>\$9,692,285,416</b>		\$3,280,956,785	\$3,508,240,914	\$3,751,269,863	\$4,011,134,335	\$4,289,000,589	<b>\$18,840,602,486</b>	
<b>Total Hypothetical Expenditures</b>	<b>\$208,994,224</b>	<b>\$1,267,901,087</b>	<b>\$3,192,726,783</b>	<b>\$3,284,860,362</b>	<b>\$3,513,652,681</b>	<b>\$11,468,135,137</b>		<b>\$3,751,517,818</b>	<b>\$4,005,554,023</b>	<b>\$4,276,864,626</b>	<b>\$4,566,628,466</b>	<b>\$4,876,105,068</b>	<b>\$21,476,670,002</b>	
<i>** Adults w/o Dependent Children and Title XIX CHIP Parents are now in New Adult Group as of 1/1/14.</i>														
<b>Supports Program</b>	\$0	\$0	\$0	\$0	\$0	<b>\$0</b>		\$0	\$0	\$0	\$0	\$0	<b>\$0</b>	
<b>Hospital Subsidies</b>														
<b>HRSF &amp; GME</b>	\$ 192,443,637	\$ -	\$ -	\$ -	\$ -	<b>\$192,443,637</b>		\$ -	\$ -	\$ -	\$ -	\$ -	<b>\$0</b>	
<b>HRSF Transition Payments</b>	-	83,302,681	-	-	-	<b>\$83,302,681</b>		-	-	-	-	-	<b>\$0</b>	
<b>GME State Plan</b>	-	100,000,001	100,000,000	127,272,727	127,272,727	<b>\$454,545,455</b>		-	-	-	-	-	<b>\$0</b>	
<b>DSRIP</b>	-	83,304,870	166,600,001	166,600,000	166,600,000	<b>\$583,104,871</b>		166,000,000	166,000,000	166,000,000	-	-	<b>\$498,000,000</b>	
<b>Hospital Subsidies Expenditures</b>	<b>\$ 192,443,637</b>	<b>\$ 266,607,552</b>	<b>\$ 266,600,001</b>	<b>\$ 293,872,727</b>	<b>\$ 293,872,727</b>	<b>\$1,313,396,644</b>		<b>\$ 166,000,000</b>	<b>\$ 166,000,000</b>	<b>\$ 166,000,000</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$498,000,000</b>	
<b>Costs Otherwise Not Matchable (CNOMs)</b>														
<b>SED at Risk</b>	\$ 24,511,364	\$ 37,239,735	\$ 35,973,159	\$ 40,147,289	\$ 40,147,289	<b>\$178,018,836</b>		\$ 40,147,289	\$ 40,147,289	\$ 40,147,289	\$ 40,147,289	\$ 40,147,289	<b>\$200,736,445</b>	
<b>MATI at Risk</b>	4,069,775	3,429,158	-	-	-	<b>\$7,498,933</b>		-	-	-	-	-	<b>\$0</b>	
<b>DDD non-Disabled Adult Children</b>	-	-	-	-	-	<b>\$-</b>		-	-	-	-	-	<b>\$-</b>	
<b>DDD Community / Supports Equalization</b>	-	-	-	-	-	<b>\$-</b>		-	-	-	-	-	<b>\$-</b>	
<b>CNOM Expenditures</b>	<b>\$ 28,581,139</b>	<b>\$ 40,668,893</b>	<b>\$ 35,973,159</b>	<b>\$ 40,147,289</b>	<b>\$ 40,147,289</b>	<b>\$185,517,769</b>		<b>\$ 40,147,289</b>	<b>\$ 40,147,289</b>	<b>\$ 40,147,289</b>	<b>\$ 40,147,289</b>	<b>\$ 40,147,289</b>	<b>\$200,736,445</b>	

<b>Hypotheticals: Enrollment and PMPM's</b>															
Waiver Year		1	2	3	4	5	<i>Demo</i>		6	7	8	9	10	<i>Renewal</i>	Growth %'s
State Fiscal Year		2013	2014	2015	2016	2017	<i>Period 1</i>		2018	2019	2020	2021	2022	<i>Period 1</i>	
<b>WOW-CAP</b>															
<b>HCBS 217-Like</b>	Enrollment	96,351	127,895	122,272	132,498	146,850			149,546	152,291	155,086	157,933	160,832		1.8%
	PMPM	\$2,256.69	\$2,340.19	\$2,426.78	\$2,516.57	\$2,609.68			\$2,706.24	\$2,806.37	\$2,910.20	\$3,017.88	\$3,129.54		3.7%
<b>Adults w/o DC</b>	Enrollment	6,057	2,774	3,870,426	4,240,639	4,406,230			4,406,230	4,406,230	4,406,230	4,406,230	4,406,230		
	PMPM	\$277.00	\$288.00						\$0.00	\$0.00	\$0.00	\$0.00	\$0.00		
<b>SED 217-Like</b>	Enrollment	113	145	115	96	1,846			1,880	1,914	1,950	1,985	2,022		1.8%
	PMPM	\$2,246.37	\$2,381.15	\$2,524.02	\$2,675.46	\$2,835.99			\$3,006.15	\$3,186.52	\$3,377.71	\$3,580.37	\$3,795.19		6.0%
<b>XIX Chip Parents</b>	Enrollment	0	456,761	0	0	0			0	0	0	0	0		
	PMPM		\$307.24						\$0.00	\$0.00	\$0.00	\$0.00	\$0.00		
<b>IDD/MI</b>	Enrollment	0	0	581	2,981	3,564			3,629	3,696	3,764	3,833	3,903		1.8%
	PMPM	\$9,839.39	\$10,429.75	\$11,055.53	\$11,718.87	\$12,422.00			\$13,167.32	\$13,957.36	\$14,794.80	\$15,682.49	\$16,623.44		6.0%
<b>New Adult Group</b>	Enrollment	0	1,408,947	6,541,000	6,776,916	6,854,614			6,980,437	7,108,569	7,239,054	7,371,933	7,507,252		1.8%
	PMPM		\$465.12	\$490.48	\$515.00	\$540.75			\$567.79	\$596.18	\$625.99	\$657.29	\$690.15		5.0%
<b>ACTUALS</b>															
<b>HCBS 217-Like</b>	Enrollment	96,351	127,895	122,272	132,498	146,850			149,546	152,291	155,086	157,933	160,832		1.8%
	PMPM	\$2,153.22	\$2,176.02	\$2,709.00	\$2,835.65	\$2,940.57			\$3,049.37	\$3,162.20	\$3,279.20	\$3,400.53	\$3,526.35		3.7%
<b>Adults w/o DC</b>	Enrollment	6,057	2,774	3,870,426	4,240,639	4,406,230			4,406,230	4,406,230	4,406,230	4,406,230	4,406,230		
	PMPM	\$252.56	\$242.98						\$0.00	\$0.00	\$0.00	\$0.00	\$0.00		
<b>SED 217-Like</b>	Enrollment	113	145	115	96	1,846			1,880	1,914	1,950	1,985	2,022		1.8%
	PMPM	\$0.73	\$406.36	\$242.06	\$1,007.08	\$6,563.74			\$6,957.57	\$7,375.02	\$7,817.52	\$8,286.57	\$8,783.77		6.0%
<b>*XIX CHIP Parents</b>	Enrollment	0	456,761	0	0	0									
	PMPM		\$277.75												
<b>IDD/MI - 217-Like</b>	Enrollment	0	0	581	2,981	3,564			3,629	3,696	3,764	3,833	3,903		1.8%
	PMPM	\$0.00	\$0.00	\$2,042.67	\$2,616.08	\$2,773.04			\$2,939.42	\$3,115.79	\$3,302.74	\$3,500.90	\$3,710.95		6.0%
<b>New Adult Group</b>	Enrollment	0	1,186,513	6,541,000	6,776,916	6,854,614			6,980,437	7,108,569	7,239,054	7,371,933	7,507,252		1.8%
	PMPM		\$715.80	\$437.10	\$429.62	\$451.10			\$473.66	\$497.34	\$522.21	\$548.32	\$575.74		5.0%

<b>Hospital Subsidy Summary</b>												
Waiver Year	1	2	3	4	5	<i>Demo</i>	6	7	8	9	10	<i>Renewal</i>
State Fiscal Year	2013	2014	2015	2016	2017	<i>Period 1</i>	2018	2019	2020	2021	2022	<i>Period 1</i>
<b>TOTAL COMPUTABLE</b>												
HRSF & GME	\$ 192,443,637	\$ -	\$ -	\$ -	\$ -	\$ 192,443,637	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
HRSF Transition Payments	-	83,302,681	-	-	-	\$ 83,302,681						\$ -
GME State Plan	-	100,000,001	100,000,000	127,291,443	188,000,000	\$ 515,291,444	-	-	-	-	-	\$ -
DSRIP	-	83,304,870	166,600,001	166,600,000	166,600,000	\$ 583,104,871	166,000,000	166,000,000	166,000,000	-	-	\$ 498,000,000
<b>TOTAL COMPUTABLE</b>	<b>\$ 192,443,637</b>	<b>\$ 266,607,552</b>	<b>\$ 266,600,001</b>	<b>\$ 293,891,443</b>	<b>\$ 354,600,000</b>	<b>\$ 1,374,142,633</b>	<b>\$ 166,000,000</b>	<b>\$ 166,000,000</b>	<b>\$ 166,000,000</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 498,000,000</b>
<b>Composite Federal Share Percentage</b>												
HRSF & GME	50.00%	0.00%	0.00%	0.00%	0.00%							
HRSF Transition Payments	0.00%	50.00%	0.00%	0.00%	0.00%		0.00%	0.00%	0.00%	0.00%	0.00%	
GME State Plan	0.00%	66.45%	65.08%	67.00%	65.83%		64.83%	64.50%	63.83%	63.33%	63.33%	
DSRIP	0.00%	50.00%	50.00%	50.00%	50.00%		50.00%	50.00%	50.00%	50.00%	50.00%	
<b>FEDERAL SHARE</b>												
HRSF & GME	\$ 96,221,820	\$ -	\$ -	\$ -	\$ -	\$ 96,221,820	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
HRSF Transition Payments	\$ -	\$ 41,651,341	\$ -	\$ -	\$ -	\$ 41,651,341	-	-	-	-	-	\$ -
GME State Plan	\$ -	\$ 66,452,600	\$ 65,080,000	\$ 85,285,267	\$ 123,766,667	\$ 340,584,533	-	-	-	-	-	\$ -
DSRIP	\$ -	\$ 41,652,436	\$ 83,300,003	\$ 83,300,002	\$ 83,300,002	\$ 291,552,443	83,000,002	83,000,002	83,000,002	-	-	\$ 249,000,006
<b>FEDERAL SHARE</b>	<b>\$ 96,221,820</b>	<b>\$ 149,756,377</b>	<b>\$ 148,380,003</b>	<b>\$ 168,585,269</b>	<b>\$ 207,066,669</b>	<b>\$ 770,010,137</b>	<b>\$ 83,000,002</b>	<b>\$ 83,000,002</b>	<b>\$ 83,000,002</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ 249,000,006</b>
DY6-10: Total Computable amounts tie to the amounts budgeted in SFY2016.												
DY6-10: Federal Share amounts = Total Computable amounts multiplied by the Federal Composite Share Percentage (estimate for DY4/DY5)												

<b>Costs Otherwise Not Matchable (CNOM) Summary</b>													
Waiver Year State Fiscal Year	1 2013	2 2014	3 2015	4 2016	5 2017	<b>Demo Period 1</b>	6 2018	7 2019	8 2020	9 2021	10 2022	<b>Renewal Period 1</b>	Growth %
<b>TOTAL COMPUTABLE</b>													
SED at Risk	\$ 24,511,364	\$ 37,239,735	\$ 35,973,919	\$ 40,197,343	\$ 42,196,637	\$ 180,118,998	\$ 42,196,637	\$ 42,196,637	\$ 42,196,637	\$ 42,196,637	\$ 42,196,637	\$ 210,983,185	
MATI at Risk	\$ 4,069,775	\$ 3,429,158	\$ -	\$ -	\$ -	\$ 7,498,933	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
DDD non-Disabled Adult Children	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	3.00%
DDD Community / Supports Equalization	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	3.00%
<b>TOTAL COMPUTABLE</b>	<b>\$ 28,581,139.00</b>	<b>\$ 40,668,893.00</b>	<b>\$ 35,973,919.00</b>	<b>\$ 40,197,343.00</b>	<b>\$ 42,196,637.00</b>	<b>\$ 187,617,931</b>	<b>\$ 42,196,637</b>	<b>\$ 42,196,637</b>	<b>\$ 42,196,637</b>	<b>\$ 42,196,637</b>	<b>\$ 42,196,637</b>	<b>\$ 210,983,185</b>	
<b>Composite Federal Share Percentage</b>													
SED at Risk	51.99%	51.83%	51.96%	50.50%	50.00%		50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	
MATI at Risk	50.50%	52.00%	0.00%	0.00%	0.00%		0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
DDD non-Disabled Adult Children				50.00%	50.00%		50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	
DDD Community / Supports Equalization				50.00%	50.00%		50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	
<b>FEDERAL SHARE</b>													
SED at Risk	\$ 12,743,019	\$ 19,300,842	\$ 18,690,296	\$ 20,299,658	\$ 21,098,319	\$ 92,132,134	\$ 21,098,319	\$ 21,098,319	\$ 21,098,319	\$ 21,098,319	\$ 21,098,319	\$ 105,491,593	
MATI at Risk	\$ 2,055,322	\$ 1,783,162	\$ -	\$ -	\$ -	\$ 3,838,484	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
DDD non-Disabled Adult Children	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
DDD Community / Supports Equalization	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
<b>FEDERAL SHARE</b>	<b>\$ 14,798,341</b>	<b>\$ 21,084,004</b>	<b>\$ 18,690,296</b>	<b>\$ 20,299,658</b>	<b>\$ 21,098,319</b>	<b>\$ 95,970,618</b>	<b>\$ 21,098,319</b>	<b>\$ 21,098,319</b>	<b>\$ 21,098,319</b>	<b>\$ 21,098,319</b>	<b>\$ 21,098,319</b>	<b>\$ 105,491,593</b>	
<b>Notes: SED at Risk and MATI at Risk</b>													
DY6-10: Total Computable = DY5 estimate in the QE Dec 15 Report for current demonstration													
DY6-10 Federal Share amounts = Total Computable amounts multiplied by the Federal Composite Share Percentage in accordance with current STC #130													
<b>Notes: DDD programs</b>													
DY6-10: Total Computable = DY5 estimate in the QE Dec 15 Report for current demonstration increased by 3% annually													
DY6-10: Federal Share amounts = Total Computable amounts multiplied by the Federal Composite Share Percentage (estimate for DY4/DY5)													

## Budget Neutrality Monitoring Sheet Notes

### Enrollment Trends

### No Waiver Spending

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

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

### With Waiver Spending

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

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



BN caps should be as of 3-27-14

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

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

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

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

Schedule C									
CMS 64 Waiver Expenditure Report									
Cumulative Data Ending Quarter/Year : 4/2017									
State: New Jersey									
Summary of Expenditures by Waiver Year									
Waiver: 11W00279									
MAP Waivers									
Total Computable									
Waiver Name	A	01	02	03	04	05	06		
ABD	0	3,968,034,154	5,408,209,012	5,120,732,991	5,069,232,397	5,151,218,116	1,026,837,926		
ACCAP – 217 Like	0	630,539	880,454	0	0	0	0		
ACCAP – SP	0	900,000	966,297	0	0	0	0		
AWDC	0	1,529,772	674,018	0	0	0	0		
Childless Adults	0	27,844,394	48,216,389	0	0	0	0		
CRPD – 217 Like	0	11,803,536	16,894,842	0	0	0	0		
CRPD –SP	0	10,672,842	15,247,535	0	0	0	0		
DSRIP	0	0	83,304,870	166,600,001	166,600,000	166,600,000	0		
GME State Plan	0	0	100,000,001	100,000,000	127,291,443	188,000,000	54,499,992		
GO – 217 Like	0	181,068,236	221,682,839	0	0	0	0		
GO – SP	0	23,869,092	33,606,671	0	0	0	0		
HCBS – 217 Like	0	288,889	21,406,012	331,234,441	375,718,137	402,567,552	158,880,182		
HCBS – State Plan	0	86,858	5,718,886	99,376,696	240,131,569	364,974,816	150,998,102		
HRSF & GME	0	192,443,637	0	0	0	0	0		
HRSF Transition	0	0	83,302,681	0	0	0	0		
IDD/MI – 217 Like	0	0	0	1,186,792	7,798,525	10,750,786	2,765,861		
MATI at Risk	0	4,069,775	3,429,158	0	0	0	0		
New Adult Growth	0	7,940,104	849,302,769	2,859,089,720	2,911,520,516	3,101,628,329	745,509,023		
SED – 217 Like	0	83	58,922	27,837	96,680	12,116,668	3,922,140		
SED at Risk	0	24,511,364	37,239,735	35,973,919	40,197,343	42,196,637	5,931,962		
TBI – 217 Like	0	13,673,932	17,438,251	0	0	0	0		
TBI – SP	0	7,457,114	9,364,928	0	0	0	0		
Title XIX	0	1,660,533,500	2,401,028,803	2,585,155,172	2,542,349,561	2,543,100,659	517,416,609		
XIX CHIP Parent	0	0	126,863,607	0	0	0	0		
<b>Total</b>	<b>0</b>	<b>6,137,357,821</b>	<b>9,484,836,680</b>	<b>11,299,377,569</b>	<b>11,480,936,171</b>	<b>11,983,153,563</b>	<b>2,666,761,797</b>		

Federal Share								Composite Federal Share Percentages										
Waiver Name	A	01	02	03	04	05	06	Waiver Name	01	02	03	04	05	06	07	08	09	10
ABD	0	1,989,920,458	2,720,956,589	2,573,335,580	2,539,175,066	2,577,677,321	513,872,076	ABD	50.15%	50.31%	50.25%	50.09%	50.04%	50.04%	50.04%	50.04%	50.04%	50.04%
ACCAP – 217 Like	0	319,151	446,869	0	0	0	0											
ACCAP – SP	0	454,312	489,362	0	0	0	0											
AWDC	0	777,617	344,491	0	0	0	0	AWDC	50.83%	51.11%								
Childless Adults	0	14,715,147	24,778,164	0	0	0	0	Childless Adults	52.85%	51.39%								
CRPD – 217 Like	0	6,026,151	8,740,654	0	0	0	0											
CRPD – SP	0	5,447,877	7,899,121	0	0	0	0											
DSRIP	0	0	41,652,435	83,300,003	83,300,002	83,300,002	0	DSRIP		50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%
GME State Plan	0	0	55,642,502	66,797,499	84,588,472	122,350,400	35,076,195	GME State Plan		66.45%	65.08%	67.00%	65.83%	64.83%	64.50%	63.83%	63.33%	63.33%
GO – 217 Like	0	91,709,982	114,209,771	0	0	0	0											
GO – SP	0	12,108,906	17,304,835	0	0	0	0											
HCBS – 217 Like	0	147,458	11,076,822	170,100,169	189,123,731	201,306,894	79,443,017	HCBS – 217 Like	50.67%	51.55%	51.35%	50.34%	50.01%	50.00%	50.00%	50.00%	50.00%	50.00%
HCBS – State Plan	0	44,439	2,963,002	51,039,962	120,761,409	182,561,934	75,508,625	HCBS – State Plan	50.79%	51.58%	51.36%	50.29%	50.02%	50.01%	50.01%	50.01%	50.01%	50.01%
HRSF & GME	0	96,221,820	0	0	0	0	0	HRSF & GME	50.00%									
HRSF Transition	0	0	41,651,341	0	0	0	0	HRSF Transition		50.00%								
IDD/MI – 217 Like	0	0	0	599,439	3,903,695	5,375,473	1,382,933	IDD/MI – 217 Like			50.51%	50.00%	50.25%	50.25%	50.25%	50.25%	50.25%	50.25%
MATI at Risk	0	2,055,322	1,783,162	0	0	0	0	MATI at Risk	50.50%	52.00%								
New Adult Group	0	7,938,698	849,280,201	2,858,964,774	2,910,261,210	3,018,922,205	708,233,572	New Adult Group	99.98%	100.00%	100.00%	99.96%	97.50%	94.50%	93.50%	91.50%	90.00%	90.00%
SED – 217 Like	0	42	29,462	13,944	48,354	6,059,317	1,961,635	SED – 217 Like		50.00%	50.09%	50.50%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%
SED at Risk	0	12,743,019	19,300,842	18,690,296	20,590,547	21,593,131	2,965,981	SED at Risk	51.99%	51.83%	51.96%	50.50%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%
TBI – 217 Like	0	6,928,494	8,987,060	0	0	0	0											
TBI – SP	0	3,776,704	4,819,278	0	0	0	0											
Title XIX	0	833,625,792	1,328,947,500	1,418,159,122	1,290,124,376	1,277,711,465	259,148,173	Title XIX	50.20%	55.35%	54.86%	50.75%	50.24%	50.09%	50.09%	50.09%	50.09%	50.09%
XIX CHIP Parent	0	0	64,746,447	2,148	0	0	0	XIX CHIP Parent		51.04%								
<b>Total</b>	<b>0</b>	<b>3,084,961,389</b>	<b>5,326,049,910</b>	<b>7,241,002,936</b>	<b>7,241,876,862</b>	<b>7,496,858,142</b>	<b>1,677,592,207</b>											
Created On: Monday, November 6, 2017 9:15 AM																		
<b>DY1 &amp; DY2 HCBS expenses</b>	<b>DY1</b>	<b>DY2</b>																
	total computable																	
HCBS – 217 Like	207,465,132	278,302,398																
HCBS – State Plan	42,985,906	64,904,317																
	Federal share																	
HCBS – 217 Like	105,131,236	143,461,176																
HCBS – State Plan	21,832,238	33,475,598																

CMS 64 - MEDICAID ELIGIBILITY GROUPS AS OF JUNE 2014																									
Actuals through 9/30/2015 (as of 12/31/2015)						final dec-13 rpt	final feb-14 rpt	final mar-14 rpt	final apr-14 rpt	final may-14 rpt	final jun-14 rpt	final jul-14 rpt	final aug-14 rpt	final sept-14 rpt	final oct-14 rpt	final nov-14 rpt	final dec-14 rpt	final jan-15 rpt	final feb-15 rpt	final mar-15 rpt	final apr-15 rpt	final may-15 rpt	final jun-15 rpt		
DEFINITIONS:	DY1	DY2	DY3	DY4	DY5	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14		
1 TITLE XIX	5,773,180	7,850,901	8,699,959	8,893,616	8,816,484	643,208	641,115	641,945	643,840	643,718	645,054	645,116	635,183	634,001	633,251	632,536	631,012	628,743	625,874	623,702	663,241	667,292	678,653		
2 ABD (Excluding HCBS and LTC SPC 61)	2,486,117	3,342,730	3,355,975	3,343,701	3,287,476	274,854	274,540	274,471	275,897	276,304	276,808	277,259	277,750	278,234	278,390	278,697	279,521	279,906	279,461	278,818	276,842	277,127	278,134		
3 Childless Adults	385,740	225,208	-	-	-	45,455	44,363	43,494	43,024	42,618	42,563	41,976	41,588	40,659	39,738	39,242	38,278	37,737	34,678	35,535					
4 Adults W/O Dependent Children	6,057	2,774	3,870,426	4,240,639	4,406,230	772	750	713	682	670	663	644	610	553	503	491	460	453	442	425	145,207	160,725	203,473		
5 SED	26,729	43,160	38,453	43,795	46,906	2,560	2,618	2,677	2,907	3,029	3,110	3,181	3,313	3,334	3,271	3,291	3,154	3,364	3,566	3,531	3,769	3,856	4,162		
6 HCBS (State Plan)	13,594	18,860	25,656	59,042	98,301	1,518	1,520	1,504	1,467	1,474	1,493	1,511	1,543	1,564	1,553	1,555	1,540	1,567	1,586	1,586	1,596	1,583	1,580		
7 HCBS (217 Like)	96,351	127,895	122,272	132,498	146,850	11,219	11,225	11,221	10,428	10,396	10,420	10,456	10,480	10,506	10,556	10,577	10,645	10,726	10,752	10,751	10,758	10,742	10,606		
8 LTC																					0	0	0		
9 SED (217 Like)	113	145	115	96	1,846	15	13	14	15	15	10	7	9	15	14	11	15	15	16	13	9	9	11		
10 IDD/MI (217 Like)	-	-	581	2,981	3,564																		0		
11 XIX CHIP Parents (10/01/2013 - 12/31/2013 Only)		456,761	-	-	-													152,428	152,087	152,246					
12 New Adult Group (01/01/2014 Onwards)		1,183,739	2,670,574	2,536,277	2,448,384																181,112	186,389	198,362		
Source = CMS64 MEG report from Dec 2015																									





RUN DATE: 11/6/17

MMX Member Mc	Count(dist Recip Idn)
10/1/2012	29,433.
11/1/2012	29,367.
12/1/2012	29,283.
1/1/2013	29,180.
2/1/2013	28,845.
3/1/2013	28,869.
4/1/2013	28,803.
5/1/2013	28,701.
6/1/2013	28,754.
7/1/2013	28,869.
8/1/2013	29,047.
9/1/2013	29,081.
10/1/2013	29,126.
11/1/2013	29,167.
12/1/2013	29,217.
1/1/2014	29,089.
2/1/2014	28,868.
3/1/2014	28,900.
4/1/2014	28,830.
5/1/2014	28,813.
6/1/2014	28,782.
7/1/2014	29,252.
8/1/2014	29,150.
9/1/2014	29,007.
10/1/2014	28,813.
11/1/2014	28,548.
12/1/2014	28,375.
1/1/2015	28,365.
2/1/2015	28,076.
3/1/2015	27,871.
4/1/2015	27,799.
5/1/2015	27,747.
6/1/2015	27,940.
7/1/2015	27,981.
8/1/2015	28,164.
9/1/2015	28,224.
10/1/2015	28,328.
11/1/2015	28,506.
12/1/2015	28,542.
1/1/2016	28,516.
2/1/2016	28,449.
3/1/2016	28,519.
4/1/2016	28,464.
5/1/2016	28,633.
6/1/2016	28,678.
7/1/2016	28,710.
8/1/2016	28,845.
9/1/2016	28,790.
10/1/2016	28,934.
11/1/2016	28,762.
12/1/2016	28,603.
1/1/2017	28,470.
2/1/2017	28,199.
3/1/2017	28,014.
4/1/2017	27,933.
5/1/2017	27,791.
6/1/2017	27,638.
7/1/2017	27,357.
8/1/2017	26,946.
9/1/2017	26,454.
10/1/2017	24,677.
11/1/2017	24,548.

	MMs
DY1	261,235.
DY2	347,789.
DY3	340,943.
DY4	341,004.
DY5	340,689.
DY6	129,982.

MMX Member Month Date	Count(dist) Recip Idn
10/1/2012	2,376.
11/1/2012	2,353.
12/1/2012	2,332.
1/1/2013	2,323.
2/1/2013	2,302.
3/1/2013	2,291.
4/1/2013	2,270.
5/1/2013	2,242.
6/1/2013	2,220.
7/1/2013	2,195.
8/1/2013	2,177.
9/1/2013	2,157.
10/1/2013	2,130.
11/1/2013	2,109.
12/1/2013	2,076.
1/1/2014	2,048.
2/1/2014	2,032.
3/1/2014	2,017.
4/1/2014	1,970.
5/1/2014	1,930.
6/1/2014	1,876.
7/1/2014	1,845.
8/1/2014	1,823.
9/1/2014	1,811.
10/1/2014	1,791.
11/1/2014	1,769.
12/1/2014	1,744.
1/1/2015	1,724.
2/1/2015	1,712.
3/1/2015	1,695.
4/1/2015	1,679.
5/1/2015	1,666.
6/1/2015	1,651.
7/1/2015	1,639.
8/1/2015	1,632.
9/1/2015	1,612.
10/1/2015	1,585.
11/1/2015	1,587.
12/1/2015	1,578.
1/1/2016	1,571.
2/1/2016	1,557.
3/1/2016	1,548.
4/1/2016	1,541.
5/1/2016	1,525.
6/1/2016	1,515.
7/1/2016	1,507.
8/1/2016	1,505.
9/1/2016	1,501.
10/1/2016	1,495.
11/1/2016	1,485.
12/1/2016	1,482.
1/1/2017	1,470.
2/1/2017	1,465.
3/1/2017	1,460.
4/1/2017	1,453.
5/1/2017	1,443.
6/1/2017	1,434.
7/1/2017	1,424.
8/1/2017	1,416.
9/1/2017	1,088.

	MMs
DY1	20,709.
DY2	24,717.
DY3	20,910.
DY4	18,890.
DY5	17,700.