New Jersey Comprehensive Waiver Demonstration
Section 1115 Quarterly Report
***Demonstration Year:* 3 (7/1/14-6/30/15)**
***Federal Fiscal Quarter:* 3 (4/1/15-6/30/15)**

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

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

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

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

II. Enrollment and Benefit Information

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

There have been no major changes in trends or issues related to eligibility, enrollment, disenrollment, access, and delivery network in the current quarter.

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

The State is currently discussing a proposed amendment to increase access to the Supports Program. The proposed amendment would include two new eligibility groups and allowing enrollees to access Private Duty Nursing Services through MLTSS. Discussions were held with CMS and the State completed the 30 day public comment period from June 30, 2015 through July 30, 2015. The public notice was published on June 30, 2015. The proposed amendment was submitted to CMS on July 24, 2015.

III. Enrollment Counts for Quarter

Demonstration Populations by MEG	Total Number of Demonstration participants Quarter Ending – 09/30	Total Number of Demonstration participants Quarter Ending – 12/31	Total Number of Demonstration participants Quarter Ending – 3/31	Total Number of Demonstration participants Quarter Ending – 06/30
Title XIX	711,606	720,818	734,185	720,094
ABD	278,904	275,683	273,301	266, 861
LTC	23,794	22,725		
HCBS - State plan	1,616	2,215	2,415	3,127
TBI – SP	n/a	n/a	n/a	n/a
ACCAP – SP	n/a	n/a	n/a	n/a
CRPD – SP	n/a	n/a	n/a	n/a
GO – SP	n/a	n/a	n/a	n/a
HCBS - 217-Like	9,938	10,467	10,082	10,217
TBI – 217-Like	n/a	n/a	n/a	n/a
ACCAP – 217-Like	n/a	n/a	n/a	n/a
CRPD – 217-Like	n/a	n/a	n/a	n/a
GO – 217-Like	n/a	n/a	n/a	n/a
SED - 217 Like	9	5	6	1
IDD/MI – (217 Like)	0	1	126	135
NJ Childless Adults	n/a	n/a	n/a	n/a
AWDC	n/a	n/a	n/a	n/a
New Adult Group	498,613	539,899	576,566	564,101

SED at Risk	2,797	2,997	2,921	3,248
MATI at Risk	0	0	0	0
Title XXI Exp Child				
NJFAMCAREWAIV-POP 1	n/a	n/a	n/a	n/a
NJFAMCAREWAIV-POP 2	n/a	n/a	n/a	n/a
XIX CHIP Parents	n/a	n/a	n/a	n/a

IV. Outreach/Innovative Activities to Assure Access

MLTSS

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

The MLTSS Steering Committee met on May 15, 2015 and will continue to meet at least quarterly through June 2017, with its representation from stakeholders, consumers, providers, MCOs and state staff members. The May meeting focused on gaining input from the Committee members on the major trends/operational issues and providing information specific to their special interests on quality measurements, dashboard data and provider relations.

The Office of Managed Health Care (OMHC), with its provider relations unit, has remained at the forefront in spearheading 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. OMHC updated the Frequently Asked Questions document and posted on the DHS website in June. New sections included information on the Assisted Living billing process if pending enrollment, the Enhanced At Risk Criteria Pre-Admission Screening (EARC PAS) Authorization, MCO Contract Parameters on Benefits Coordination with other Insurers, and MLTSS Patient Pay Liability/Cost Share.

The MLTSS website was completely revised for the general public and providers to reflect that the program has been operational for one year as of July 1. Initial rollout information was no longer relevant for consumers and needed to be redone to be current on the website. The Frequently Asked Questions (FAQs) were redone, both the consumer and provider versions. The FAQs for providers have been regularly revised about on a monthly basis with information on issues such as reimbursement, clinical and financial eligibility, and MCO contract parameters.

Presentations on MLTSS were done to a variety of statewide groups, including the Health Care Association of NJ's Assisted Living Conference and the NJ Foundation for Aging. MLTSS and its connection for persons with developmental disabilities was also the focus of a session at The Arc of NJ's annual conference. In addition, OMHC and DoAS staff participated in a major presentation to the nursing facilities that was held via a webinar on two dates. It was done by the State in collaboration with

the HealthCare Association of NJ, LeadingAge and the NJ Hospital Association. The presentation covered the identification of clinical needs and eligibility, care planning process, financial eligibility determination and the areas of provider responsibility.

ASD/ID/DD-MI/SED

The Department of Children and Families, Children's System of Care (CSOC) promotes their programs at their many community meetings throughout the state and continues to do so.

CSOC continues to work with DMAHS, DMAHS's fiscal agent, Molina, and CSOC's Contracted Systems Administrator on implementation activities to assure ease of enrollment for eligible individuals and so that providers can bill correctly.

Supports

During this quarter, the Division of Developmental Disabilities (DDD) has continued its preparation for enrolling the first group of individuals into the Supports Program July 2015. As part of this preparation, DDD has continued its efforts to assist individuals with Medicaid eligibility.

DDD provided an ongoing series of live webinars providing information about the system reform, Supports Program, and impact it will have on individuals/families that are newly entering DDD services and those individuals/families that are currently receiving services. Presentations, webinars, training regarding system reform and implementation of the Supports Program for individuals, families, providers, and schools were continued. DDD also recorded and archived a webinar explaining the NJ Comprehensive Assessment Tool (NJ CAT) for families.

An initial draft (in April) and second draft (in May) of the Supports Program Policies and Procedures Manual was released. Stakeholder comments was solicited and received for both drafts of the Policies and Procedures Manual.

During the quarter, DDD conducted outreach to recruit potential new providers in NJ and neighboring states through a welcome packet of information and webinar entitled "Providing Services in the NJ Developmental Disabilities System: A Primer for New Providers." DDD also held meetings with Supported Employment providers to assist them in preparation for becoming Medicaid providers, provide guidance regarding quality services/best practice related to Supported Employment, and build provider capacity.

To assist Support Coordinators, individuals, families, providers and others, DDD further developed the provider database for all providers who are approved in the new system. For families who have been utilizing Self-Directed Employees (SDE), also referred to as "self-hires", DDD met with these families to discuss mandatory training for these employees, the SDE hiring process, and policies related to SDEs.

DDD held Question and Answer sessions with the membership and workgroups/subcommittees of the trade organizations in its continued efforts to be inclusive of stakeholder input into the Support Program process and policies.

V. Collection and Verification of Encounter Data and Enrollment Data

Summary of Issues, Activities or Findings

The State has built and is currently in the process of refining various dashboards that will review encounters, claims, quality metrics and enrollment data for trends in the MLTSS program. New Jersey is using this information to aid in identifying issues and evaluating the overall success of the program. New Jersey is in discussion with its EQRO to begin encounter validation as well.

Rutgers Center for State Health Policy (CSHP) is responsible for the evaluation of the Waiver. CSHP delivered a report based on initial data to the State in early July. Greater discussion of CSHP's progress can be found in Section XII.

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

MLTSS

The Division of Medical Assistance and Health Services (DMAHS) convenes a weekly meeting with state staff from the various Divisions involved in MLTSS to discuss any issues to ensure that they are resolved timely and in accordance with the rules and laws that govern the Medicaid program. The state also continues to have weekly conference calls with the Managed Care Organizations (MCOs) to review statistics and discuss and create an action plan for any issues that either the State or the MCOs are encountering.

ASD/ID/DD-MI/SED

CSOC is continuing its effort to identify youth that is eligible for the ID/DD-MI and ASD pilot programs. As of 6/30/2015, there were 46 youth identified for the ASD pilot and 191 youth identified for the ID/DD-MI pilot. CSOC is continuing to work with DMAHS on the enrollment process for youth eligible for the SED waiver. The enrollment process for SED eligible youth is in the final stages and initial enrollment is forthcoming.

CSOC and DMAHS's fiscal agent, Molina have worked together to build the codes for the waiver services into the systems for providers to begin billing.

CSOC is continuing to build its provider networks for each of the waivers. Requests for Proposals (RFPs) have been posted to recruit agencies/providers that are able to provide services based on waiver expectations.

Technical assistance is continuing to be given by CSOC to providers for the ASD and ID/DD-MI programs as it relates to procedures and expectations. CSOC also provided technical assistance regarding the Medicaid enrollment process, ensuring that providers received Medicaid IDs for billing, and received requisite provider enrollment training. CSOC continued to train existing contracted agencies around the new service provisions and updated CYBER functions, and has scheduled and coordinated training specific to the new provider network.

Supports

During this quarter, DDD began identification of "Cohort 1" for enrollment into the Supports Program in July 2015. This is a small group of individuals who will be enrolled into the program and will allow DDD to troubleshoot and problems that may arise before enrolling another, larger, group of individuals.

As part of its continued work on preparing for the launch of the Support Program, DDD has Continued work on the next platform of iRecord (DDD's electronic health record). Training on the impending new version of iRecord for Support Coordinators – in person sessions were also made available through live webinars. A user guide for the new version of iRecord was developed and made available through the Division's website and iRecord itself.

DDD also provided training for Division personnel (primarily Case Managers) on the Person Centered Planning Tool (PCPT) and Individualized Service Plan (ISP) in preparation for shifting individuals currently receiving services into the Supports Program. The Division also held a meeting with key personnel to walk through the Supports Program – enrollment through disenrollment – for individuals and providers in order to identify areas that need to be addressed as implementation of the Supports Program comes closer.

DDD finalized a revised Memorandum of Understanding (MOU) with the Division of Vocational Rehabilitation Services (DVRS) and Commission for the Blind & Visually Impaired (CBVI) that incorporates employment services through the Supports Program and the Employment First Initiative.

DDD has continued to assist providers with the transition into the Supports Program. DDD met with day programs to assist in developing a crosswalk of current services they provide with those that will be available through the Supports Program, recorded and archived a webinar on completing the Provider Application, and arranged several "Understanding the Molina Medicaid Electronic Billing Process" training opportunities with Molina for providers. DDD has also provided Support Coordination Agencies with training on the Supports Program launch – in person and through a webinar archived on the College of Direct Support, and provided live Question and Answer webinar sessions for Support Coordination Agencies related to the Supports Program launch. DDD continued the Day Habilitation certification process.

To assist in preparation for the Medicaid-based, Fee-for-Service system, DDD continued meeting with trade organizations and individual providers. DDD also released a final "Quick Reference Guide" with the final standardized rates.

MBHO

In January 2015, Governor Chris Christie announced that the Department of Human Services is 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 that was established through a Memorandum of Understanding with the Division of Mental Health and Addiction Services. The IME went live on 7/1/15.

The IME serves as a single point of entry for those seeking treatment for substance use disorder services. The IME will ensure that individuals are receiving the right level of care for the right duration at the right intensity. This will allow the state to manage its resources that include 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 for state only funds; verifying eligibility for Medicaid; and, referral for the Medicaid member to appropriate Medicaid covered service and Medicaid providers.

DSRIP

Quarterly Payment Reports:

DY3 Q2

Progress Reports submitted from hospitals - 10/31/2014
Progress Reports submitted to CMS - 1/23/2015
Progress Reports final approval - 3/23/2015
DY3 Q2 program outcome: No funds forfeited

DY3 Q3

Progress Report submitted from hospitals - 2/6/2015
Progress Report submitted to CMS - 4/16/2015
Progress Reports final approval - 4/22/2015
DY3 Q3 program outcome: One hospital had funds forfeited for Stage I/II quarterly activity S1A13M1Q4.

DY3 Q4

Progress Report & Measure Workbooks submitted from hospitals - 4/30/2015
Progress Report & Measure Workbooks submitted to CMS - 6/1/2015
Progress Reports & Measure Workbooks final approval - July 2015
DY3 Q4 program outcome: Three hospitals had funds forfeited for one Stage I/II quarterly activity S1A14M1Q5. One hospital had funds forfeited for two Stage III measures. One hospital had funds forfeited for two Stage IV measures.

Progress in meeting goals:

One informational DSRIP webinar about April 30, 2015 reporting of baseline performance measures for hospitals was held in April 2015.

All hospitals continuing in the DSRIP program into DY4 submitted a progress report, standard reporting workbook and DY4 renewal application on April 30, 2015. 100% of hospitals continuing to DY4 submitted the Chart/EHR measures for the baseline reporting. 100% of hospitals submitted the MMIS measures acknowledgment on the web portal.

All hospitals completed the Stage 1 & 2 activities which were due for completion at the end of DY3. The remaining Stage 1 & 2 activities in the progress reports are quarterly activities.

CMS approved reducing the number of Stage 4 Universal measures by 12 measures. The measures will not be part of the DY3 Q4 quarterly payment of the first reporting of measures on April 30, 2015. Reduction in the number of measures was largely due to the recommendation of the TriChair hospital

associations that have been supporting the DSRIP program implementation.

Performance:
The DY4 Renewal Applications were submitted by all but one hospital that has decided not to continue with DY4 and DY5. The DY4 Renewal Applications included reporting by hospitals on the contingent approval improvement requirements included in the 'CMS Follow-up Issues' section of the DY2 application approvals due by the midpoint evaluation. DOH will include Follow-up Issues with the DY4 application approval letters sent out in July 2015 concerning inadequately meeting deliverables such as Learning Collaborative surveys, inadequate investment in the DSRIP program as a percentage of the original budget and low patient enrollment in the DSRIP project.

Challenges:
The measures calculated on behalf of the hospitals, the MMIS measures, require hospitals to detail how they verified the measures and attest to the verification beginning October 2015. The MMIS data is healthcare industry-wide and hospitals will not be able to derive the measures using the MMIS data because the data used to derive the measures is not limited to the DSRIP networks. Verification of the measure data will be completed by sharing with the hospitals at least the hospital network data.

The MMIS measure Improvement Target Goals (ITGs) were determined by the Quality and Measures Committee at the end of February 2015. CMS requested justification for the ITGs selected for 5 measures. The justifications for each measure were sent to CMS on March 31, 2015 in one document giving the rationale for each measure ITG selection, box plot graph of hospital percentiles, and hospital percentiles in list format. On June 11, 2015, the Quality and Measures Committee meeting maintained their ITG selections for MMIS measures for approval by CMS. The QMC also discussed setting the ITGs for the chart-based measures to be a 10 percent improvement above the baseline measurement. The ITGs for the MMIS and Chart/EHR measures will be expected by the hospitals before October 2015, when the hospitals report measures for the first pay-for-performance payment.

The DOH and CMS completed the review of the DY3 Q3 progress reports within 75 days. DOH approves the reports along with sending Requests For Information from hospitals on outstanding activities before obtaining CMS approval. The goal for the DY3 Q4 hospital submissions, progress report and measure workbook, was completion of the review by DOH and CMS within 51 days. The Q4 submission is different from the prior DSRIP program quarterly submissions in that it comprises three parts: the progress report, measures workbook and the renewal application. As of June 30, 2015, the progress reports and renewal applications had final approval and the measures workbooks were still under review.

DSRIP program activities have been largely focused on implementation stages of the projects. Additional requirements include maintaining updated protocols. The protocols need to be updated with changes made about the 8% gap reduction and the measure reduction.

Mid-course corrections:
CMS maintained the readmission measures specifications cannot be changed for the NJ DSRIP program to exclude two diagnostic categories.

CMS detailed the Quality and Measures Committee composition requirements. Changes will be made to the QMC to add a consumer and a community health center member.

The DSRIP program development phase from program start in the Special Terms and Conditions through the hospital project application approvals took a period of more than 1.5 years, from October 2012 to May 2014, and required an extension of the Subsidy fund. To prepare for the possible continuation of incentive payments in July 2017 without extension funds, DOH will begin to discuss improvements for another DSRIP program.

Success and evaluation:
NJ DSRIP obtained approval for the improvement target goals (ITG) of 13 measures on June 10, 2015.
NJ DSRIP obtained hospitals' updated project partner profiles by July 2015 to include hospitals that were able to obtain a project partner for the lower gap improvement requirement from a 10% reduction to an 8% reduction.

The DOH worked with the TriChair Hospital Association to invite America's Essential Hospitals to speak about DSRIP programs across other states during the June 2015 face-to-face learning collaborative. The presentation about other states' DSRIP programs highlighted several lessons: 1. Measures were difficult but necessary, 2. Patient activation and social determinants were inherent challenges, 3. Hospitals and project partners need to enhance communication, 4. Transformation is occurring, and 5. Leadership support and collaboration is crucial.

DSRIP program enrollment is low for some hospitals. The June 2015 learning collaborative provided information about patient engagement and provided a combined breakout session among all hospitals to share their efforts to increase enrollment. The DOH will be continuing to ask hospitals about their patient enrollment, including it in the DY4 Q1 progress reports.

Beginning with the July 2015 learning collaborative, hospitals will present on patient engagement, project partner collaboration and quality improvement and patient satisfaction improvement.

Other

Managed Care Contracting:

Nothing new to report.

Self-attestations:

There were 56 self-attestations completed from April 1, 2015 to June 30, 2015.

MCO Choice and Auto-assignment:

The number of individuals who chose an MCO during the period from April 1, 2015 through June 30, 2105 was 31,726. The number of individuals who changed MCO after auto-assignment was 7,476**.**

MLR:

<u>MCO MLR for the 12 month Period October 1, 2013 to September 30, 2014</u>
Horizon NJ Health: 90.9%
United Healthcare: 83.2%

Amerigroup: 77.3% HealthFirst (ended operating 6/30/14): 89.2% WellCare (began operating 7/1/14): 92.6% Plan Average: 86.6%

VII. Action Plan for Addressing Any Issues Identified

Issue Identified	Action Plan for Addressing Issue
None identified	Development: Implementation: Administration:

VIII. Financial/Budget Neutrality Development/Issues

Issues Identified:
None identified
Actions Taken to Address Issues:

IX. Member Month Reporting

A. For Use in Budget Neutrality Calculations

Member Months reporting can be found under Attachment A: Budget Neutrality Report.

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Title XIX				
ABD				
LTC (following transition to MLTSS)				
HCBS -State Plan				
TBI – SP				
ACCAP – SP				
CRPD – SP				
GO – SP				
HCBS -217 Like				
TBI – 217-Like				
ACCAP – 217-Like				

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

X. Consumer Issues

Summary of Consumer Issues

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

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
1	Member ID card	Assessment status	Care Manager inquiries	Medical Benefits	Questions about DME
2	Eligibility verification	Authorization status	Member inquiries about MLTSS covered benefits	PCP Update	Inquiry into status of authorizations
3	Benefit questions	Care Manager inquiries	Requests to speak with Clinical Care Coordinator	ID Card	Incorrect PCP on Member ID Cards
4	PCP change request		MLTSS members requesting assessment	Provider Search/Verification	PCP changes
5	Pharmacy benefit inquiry		MLTSS member inquiries with questions about their care plan	Eligibility Inquiry	Check on physician network status

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

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
1	Eligibility verification	Facility specific issues – living conditions	Increased NF rates - reprocessing these claims	Claims payment status	Claim inquiries
2	Claims payment status	Provider contract termination	Incorrect auths - re-educating.	Eligibility verification	EOB issues
3	Benefit questions	Claim coding issues	Claim denials	Authorization status	Authorization requests
4	NF/MCO PASSR coordination	EOB issues	EOB/TPL issues	Incorrectly processed claims	

5		Rate changes	Code confusion is being remediated via education	ICD 10 transition inquiries	

XI. Quality Assurance/Monitoring Activity

MLTSS:

New Jersey, led by the DMAHS MLTSS Quality Monitoring Unit, has continued work with NASUAD to participate in the NCI-AD survey. Representatives from NASUAD came to NJ to train staff to complete the surveys in March. Surveyors began scheduling appointments in June to complete surveys. NJ is looking to use this survey to compare the HCBS MLTSS population with the PACE, NF, and Older Americans Act (OAA) populations. Conference calls are scheduled bi-weekly with NASUAD to discuss the process and troubleshoot any issues the state might encounter.

MLTSS Claims Processing Information by MCO

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
# Claims Received	1,957	33,967	99,401	42,946	30,354
# Claims Paid	1,160	29,700	78,863	37,428	21,429
# Claims Denied	338	4,101	16,166	5,538	8,537
# Claims Pending	459	166	2,136	20	388
Average # days for adjudication	15	15	15	15	15

Top 5 Reasons for MLTSS Claims Denial by MCO

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
1	Member Not Eligible on date of Service	Definite Duplicate Claim	No Pre-certification /Authorization or Referral	No authorization on file	No Authorization
2	Duplicate Submission	Termination	Definite Duplicate Claim	Not on fee schedule	Timely Filing
3	EOB Required	Primary carrier info required	Invalid billing	Benefits based on admission date	PMT was included in allowance for another service
4	The procedure code is	Charges processed under		Send Primary Carrier's EOB	No Patient Responsibility

	inconsistent with the modifier used or a required modifier is missing	original submission			
5	Procedure code is inconsistent with modifier	Submitted after Plan Filing Limit		PCA Pend Override	

SED/ID/DD-MI/ASD:

The Department of Children and Families, Children's System of Care (CSOC) has continued to work with the Division of Medical Assistance and Health Services, Quality Monitoring Unit (QMU) to build the process to begin yearly audits of each of the waiver programs CSOC is responsible for.

CSOC has also continued working with its ASO, PerformCare to begin reporting the quality measures for CMS.

During the community meetings held this quarter, there were no comments or issues raised.

Supports:

During this quarter, DDD conducted quality monitoring of a sample of Support Coordination Agencies.

The Division also established a Supports Program Launch Workgroup consisting of individuals, family members, Support Coordination Agencies, Medicaid personnel, Molina personnel, and Division personnel. This group will hold conference calls every other week beginning July 1st in order to troubleshoot issues and identify solutions related to the launch of the Supports Program

Other Quality/Monitoring Issues:

EQR PIP

In December 2013, the MCOs, with the guidance of the EQRO, initiated a collaborative QIP with a focus on Identification and Management of Obesity in the Adolescent Population. The EQRO held regularly scheduled meetings with the MCOs to ensure a solid and consistent QIP foundation across all MCOs. Starting August 2015, MCOs will meet monthly, independent of the EQRO, for continued collaborative activities. The MCO's submitted their project update in June 2015 which includes quantitative results for the previous measurement year. In September 2015, the plans will submit a report to include a qualitative analysis of their recent activities and, based on the analysis, any revisions to the interventions for the upcoming year. The MCOs are expected to show improvement and sustainability of this collaborative QIP over the next 2 years.

The MCOs began 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 2015 interim reports include the 2014 Baseline Data. The next report submission in September 2015 is expected to include an analysis of plan specific activities.

Additionally, MCO's will be submitting individual QIP proposals in late 2015 on a topic specific to members receiving managed long term support services.

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

There were no state sanctions against an MCO, ASO or PACE Organization. One SNP organization has several Corrective Action Plans (CAPs) in place.

XII. Demonstration Evaluation

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

A.	***Expanding Medicaid managed care to include long-term care services and supports will result in improved access to care and quality of care and reduced costs, and allow more individuals to live in their communities instead of institutions.***
	During the quarter ending June 30, 2015, the Rutgers Center for State Health Policy (CSHP) continued our meetings/discussions with the state including, among other things, the monitoring of the managed care expansion as it relates to long-term services and supports. As mentioned in previous reports, these activities yield a great deal of contextual and procedural information that inform both our quantitative and qualitative evaluations. Some specific examples of activities this last quarter include, as in the previous ones: 1) monthly update calls with State Medicaid officials to discuss progress and ongoing developments related to waiver programs and services, 2) quarterly in-person meetings with the lead staff involved in implementing the waiver across various state departments, 3) attending and documenting relevant information at the May 2015 MLTSS Steering Committee meeting, 4) continued review of other documents including the MCO Contract and MLTSS Service Dictionary, MAAC meeting presentations and minutes, and communication materials directed to consumers and providers. CSHP completed our MLTSS interviews. By the end of the quarter CSHP completed a project total of 16 interviews with 34 stakeholders. CSHP completed their report on the stakeholder interviews and submitted it to the state just after the end of the quarter on July 1, 2015. In the quarter ending June 30, 2015, CSHP completed the majority of the data preparation and analysis for the second baseline report in the quantitative evaluation of the above hypothesis. A variety of quality metrics were tabulated for specific subpopulations of Medicaid beneficiaries for years 2011 and 2012: Medicaid overall, the Medicaid managed care population, specific eligibility groups, the long-term care population overall (excluding PACE), the nursing facility and HCBS subpopulations, and cohorts of beneficiaries having behavioral health conditions. Examples of some of the quality metrics calculated were ambulatory visits within 14 days of hospital discharge,

	avoidable hospital use (both inpatient and ED), and 30-day readmissions for heart failure, pneumonia, acute myocardial infarction, and for all causes. Tables presenting these data were generated and most sections of the report were drafted. This in-depth analytic work and the subsequent organization of this baseline report established the framework for answering the two research questions under this hypothesis in accordance with the evaluation plan.
B.	***Providing home and community-based services to Medicaid and CHIP beneficiaries and others with serious emotional disturbance, opioid addiction, pervasive developmental disabilities, or intellectual disabilities/developmental disabilities will lead to better care outcomes.***
	In April 2015, CSHP met with representatives from DDD and DCF overseeing the reforms in home and community-based services for special populations of children and adults with intellectual/developmental disabilities. CSHP received updates on the status of their initiatives and enrollment in the waiver demonstration programs.
C.	***Utilizing a projected spend-down provision and eliminating the look back period at time of application for transfer of assets for applicants or beneficiaries seeking long term services and supports whose income is at or below 100% of the FPL will simplify Medicaid eligibility and enrollment processes without compromising program integrity.***
	Stakeholder interview feedback on the elimination of the look back period was that not many consumers are affected, but that it does simplify the eligibility and enrollment process for these individuals. Stakeholder interview feedback on the Qualified Income Trusts was that they are positive with respect to allowing consumers to spend down in community settings in addition to nursing facilities, thus improving access to home and community-based services. However, there are questions of access to legal assistance for consumers who have few financial or social resources with respect to both drawing up the trust documents initially and finding someone to administer the trust over time.
D.	***The Delivery System Reform Incentive Payment (DSRIP) Program will result in better care for individuals (including access to care, quality of care, health outcomes), better health for the population, and lower cost through improvement.***
	Quantitative Evaluation: CSHP continued their analysis work in two main areas. The first related to metrics that CSHP would independently calculate to evaluate the DSRIP program based on Medicaid claims data. Second, CSHP utilized all-payer data to create the list of relevant hospitals for each NJ zip code and then create a measure of DSRIP exposure based on the proportion of hospitals that were participating in the DSRIP program.

XIII. Enclosures/Attachments

A. Budget Neutrality Report
B. MLTSS Performance Measure Report

XIV. State Contact(s)

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XV. Date Submitted to CMS

August 27, 2015

Budget Neutrality Monitoring Spreadsheet

QE June 2015 Report

Due to CMS: **9/1/2015**

TOTAL COMPUTABLE

Budget Neutrality Test	Authority Citation	Five Year Demonstration Forecasted Expenditures		Difference	
		No Waiver	With Waiver		
Main Test	STC #128	$ 47,883,913,195	$ 40,371,319,656	*$ 7,512,593,539*	a
Supplemental Test #1	STC #129	1,825,524,409	1,892,518,257	*(66,993,848)*	b
Supplemental Test #2	STC #129	11,090,379,567	9,099,244,877	*1,991,134,691*	c
				$ 7,445,599,691	d = a + b

Savings from Supp Test #2 cannot be used to offset Main Test

FEDERAL SHARE

Budget Neutrality Test	Authority Citation	Five Year Demonstration Forecasted Expenditures		Difference	
		No Waiver	With Waiver		
Main Test	STC #128	$ 24,682,310,658	$ 20,850,396,259	*$ 3,831,914,400*	a
Supplemental Test #1	STC #129	934,731,800	969,092,491	*(34,360,691)*	b
Supplemental Test #2	STC #129	11,001,613,042	9,027,257,106	*1,974,355,936*	c
				$ 3,797,553,709	d = a + b

Savings from Supp Test #2 cannot be used to offset Main Test

Budget Neutrality Monitoring Spreadsheet

Main Budget Neutrality Test

Budget Neutrality "Without Waiver" Caps as Established in STC #128

TOTAL COMPUTABLE

	DY1	DY2	DY3	DY4	DY5	5-Yr Demo Total
NO WAIVER						
Title XIX	1,888,003,055	2,721,798,359	3,180,728,190	3,454,183,159	3,751,269,683	*14,995,982,446*
ABD	2,303,770,824	3,339,472,169	3,493,430,312	3,685,423,618	3,888,015,464	*16,710,112,389*
LTC	2,432,436,621	3,333,367,293	3,164,934,248	3,348,683,718	3,543,103,179	*15,822,525,059*
HCBS state plan	30,677,444	44,273,219	57,678,284	82,346,590	85,772,311	*300,747,848*
Add'l DY4 GME				*27,272,727*	*27,272,727*	*54,545,454*
	$ 6,654,887,945	$ 9,438,911,041	$ 9,896,771,034	$ 10,597,909,812	$ 11,295,433,364	$ *47,883,913,195*

	DY1	DY2	DY3	DY4	DY5	*5-Yr Demo Total*
WITH WAIVER						
Title XIX	1,659,840,020	2,381,142,090	2,665,012,337	2,817,979,162	2,979,726,003	*12,503,699,612*
ABD/LTC	3,960,040,462	5,378,167,015	5,254,050,944	5,510,347,382	5,779,391,479	*25,881,997,282*
HCBS state plan	42,959,719	64,721,553	89,487,829	127,781,891	133,117,907	*458,068,899*
HOLD DDD Supports-PDN				23,684,294	27,772,568	*51,456,862*
Hospital Subsidies	192,443,637	266,607,552	266,600,000	293,872,727	293,872,727	*1,313,396,643*
CNOMS	28,436,213	27,079,508	29,552,610	38,816,014	38,816,014	*162,700,359*
	$ 5,883,720,051	$ 8,117,717,718	$ 8,304,703,719	$ 8,812,481,470	$ 9,252,696,698	$ *40,371,319,656*
Difference	**771,167,894**	**1,321,193,323**	**1,592,067,315**	**1,785,428,342**	**2,042,736,666**	***7,512,593,539***

Notes:

1. Federal share is calculated using Composite Federal Share Ratios (source data is CMS 64 Schedule C as reported in QE Mar 2015 with a run date of June 8, 2015).
2. "With Waiver" expenditures from CMS 64 Schedule C as reported in QE Mar 2015 with a run date of June 8, 2015
3. Member-months are reported from MMIS with last actual reported as of March 30, 2015.
4. "With Waiver" pmpm's calculated using Sch C expenditures and MMIS eligibility actual member-months reported through March 2015 as reported in June 2015.
5. CNOMs (costs not otherwise matchable) include Severe Emotionally Disturbed children (SED at risk), MATI population, DDD non-disabled adult children and CCW Supports Equalization
6. Additional GME (increase of $27.3m) is currently not included in PMPM caps per STC #128. On "With Waiver," $27.3M is included in the Hospital Subsidy line item
7. The DDD Supports-PDN population, pending waiver amendment approval, is represented as a separate line item

FEDERAL SHARE

	DY1	DY2	DY3	DY4	DY5	5-Yr Demo Total
NO WAIVER						
Title XIX	947,821,008	1,507,616,068	1,789,447,974	1,863,552,631	2,023,832,602	*8,132,270,283*
ABD	1,155,317,847	1,680,171,312	1,755,987,120	1,851,641,404	1,953,428,197	*8,396,545,881*
LTC	1,219,842,447	1,677,099,798	1,590,867,222	1,682,455,550	1,780,136,349	*7,950,401,366*
HCBS state plan	15,580,961	22,836,074	29,620,511	42,195,551	43,950,939	*154,184,037*
Add'l DY4 GME				*13,636,364*	*13,636,364*	*27,272,728*
Enhanced GME Revenue			22,250,000	21,636,364	21,636,364	*65,522,727*
	$ 3,338,562,264	$ 4,887,723,252	$ 5,165,922,828	$ 5,453,481,501	$ 5,836,620,814	$ *24,682,310,658*

	DY1	DY2	DY3	DY4	DY5	*5-Yr Demo Total*
WITH WAIVER						
Title XIX	833,277,910	1,318,925,064	1,499,311,052	1,520,316,741	1,607,580,137	*6,779,410,903*
ABD/LTC	1,985,920,376	2,705,889,276	2,640,970,325	2,768,524,984	2,903,698,913	*13,005,003,873*
HCBS state plan	21,819,084	33,383,301	45,956,209	65,477,238	68,211,488	*234,847,320*
HOLD DDD Supports-PDN				11,842,147	13,886,284	*25,728,431*
Hospital Subsidies	96,221,820	133,303,778	133,300,005	146,936,369	146,936,369	*656,698,341*
CNOMS	14,725,869	14,081,343	15,367,358	19,602,086	19,408,007	*83,184,663*
Enhanced GME Revenue	-	-	22,250,000	21,636,364	21,636,364	*65,522,727*
	$ 2,951,965,059	$ 4,205,582,762	$ 4,357,154,948	$ 4,554,335,929	$ 4,781,357,561	$ *20,850,396,259*
Difference	**386,597,205**	**682,140,490**	**808,767,880**	**899,145,572**	**1,055,263,254**	***3,831,914,400***

Notes:

8. Beginning DY3 (June'15), the State began claiming enhanced FFP on GME, which is the federal share % equivalent of MCO payments on the CMS64. GME is technically a Managed Care payment, originally certified in all capitation rate cells, including the Medicaid Expansion population.

Budget Neutrality Monitoring Spreadsheet

Supplemental Test #1

Budget Neutrality "Without Waiver" Caps as Established in STC #129

TOTAL COMPUTABLE

	DY1	DY2	DY3	DY4	DY5	5-Yr Demo Total
NO WAIVER						
HCBS 217-like	217,434,338	299,270,518	297,462,343	424,753,712	442,490,384	1,681,411,294
Adults w/o Depend. Children	1,677,789	798,912	-	-	-	2,476,701
SED 217-like	253,840	345,267	216,371	233,564	252,122	1,301,164
Former XIX Chip Parents	-	140,335,250	-	-	-	140,335,250
IDD/MI	-	-	-	-	-	-
	$ 219,365,967	$ 440,749,946	$ 297,678,714	$ 424,987,276	$ 442,742,506	$ 1,825,524,409

	DY1	DY2	DY3	DY4	DY5	5-Yr Demo Total
WITH WAIVER						
HCBS 217-like	207,393,155	277,666,552	329,338,863	464,888,095	484,188,181	1,763,474,846
Adults w/o Depend. Children	1,529,772	674,018	-	-	-	2,203,790
SED 217-like	-	-	-	-	-	-
Former XIX Chip Parents	-	126,839,621	-	-	-	126,839,621
IDD/MI	-	-	-	-	-	-
	$ 208,922,927	$ 405,180,191	$ 329,338,863	$ 464,888,095	$ 484,188,181	$ 1,892,518,257
Difference	**10,443,040**	**35,569,755**	**(31,660,148)**	**(39,900,819)**	**(41,445,675)**	**(66,993,848)**

Notes:

1. Federal share is calculated using Composite Federal Share Ratios (source data is CMS 64 Schedule C as reported in QE March 2015 with a run date of
2. "With Waiver" expenditures from CMS 64 Schedule C as reported in QE March 2015 with a run date of June 8, 2015
3. Member-months are reported from MMIS with last actual reported as of June 2015.
4. "With Waiver" pmpm's calculated using Sch C expenditures and MMIS eligibility actual member-months reported through March 2015 as reported in June 2015.

FEDERAL SHARE

	DY1	DY2	DY3	DY4	DY5	5-Yr Demo Total
NO WAIVER						
HCBS 217-like	110,182,650	154,277,034	152,764,519	217,446,909	226,526,958	861,198,070
Adults w/o Depend. Children	852,857	408,324	-	-	-	1,261,182
SED 217-like	126,920	172,633	108,186	116,782	126,061	650,582
Former XIX Chip Parents	-	71,621,966	-	-	-	71,621,966
IDD/MI	-	-	-	-	-	-
	$ 979,777	$ 72,202,924	$ 108,186	$ 116,782	$ 126,061	$ 934,731,800

	DY1	DY2	DY3	DY4	DY5	5-Yr Demo Total
WITH WAIVER						
HCBS 217-like	105,094,382	143,139,967	169,134,999	237,993,163	247,873,581	903,236,091
Adults w/o Depend. Children	777,617	344,491	-	-	-	1,122,108
SED 217-like	-	-	-	-	-	-
Former XIX Chip Parents	-	64,734,292	-	-	-	64,734,292
IDD/MI	-	-	-	-	-	-
	$ 105,871,999	$ 208,218,750	$ 169,134,999	$ 237,993,163	$ 247,873,581	$ 969,092,491
Difference	**(104,892,222)**	**(136,015,826)**	**(169,026,813)**	**(237,876,381)**	**(247,747,520)**	**(34,360,691)**

Budget Neutrality Monitoring Spreadsheet

Supplemental Test #2

Budget Neutrality "Without Waiver" Caps as Established in STC #129

TOTAL COMPUTABLE

	DY1	DY2	DY3	DY4	DY5	5-Yr Demo Total
NO WAIVER						
New Adult Group	$ -	$ 1,113,566,583	$ 3,105,523,276	$ 3,320,628,680	$ 3,550,661,029	$ 11,090,379,567
WITH WAIVER						
New Adult Group	$ -	$ 857,234,945	$ 2,617,249,151	$ 2,745,249,949	$ 2,879,510,833	$ 9,099,244,877
Difference	**-**	**256,331,638**	**488,274,126**	**575,378,731**	**671,150,196**	**1,991,134,691**

Notes:

1. Federal share is calculated using Composite Federal Share Ratios (source data is CMS 64 Schedule C as reported in QE Sept 2014 with a run date of Oct 30, 2014).
2. "With Waiver" expenditures from CMS 64 Schedule C as reported in QE June 2014 with a run date of Oct 30, 2014
3. Member-months are reported from MMIS with last actual reported as of September 2014.
4. "With Waiver" pmpm's calculated using Sch C expenditures and MMIS eligibility actual member-months reported through June 2014 as reported in September 2014.

FEDERAL SHARE

	DY1	DY2	DY3	DY4	DY5	5-Yr Demo Total
NO WAIVER						
New Adult Group	$ -	$ 1,113,566,583	$ 3,105,523,276	$ 3,320,628,680	$ 3,461,894,503	$ 11,001,613,042
WITH WAIVER						
New Adult Group	$ -	$ 857,234,945	$ 2,617,249,151	$ 2,745,249,949	$ 2,807,523,062	$ 9,027,257,106
Difference	**-**	**256,331,638**	**488,274,126**	**575,378,731**	**654,371,441**	**1,974,355,936**

		DY1	DY2	DY3	DY4	DY5	Demo Period			
Title XIX	MMs	5,773,180	7,850,813	8,672,979	8,903,681	9,140,521		2.7%		
	Pmpm	$287.51	$303.30	$307.28	$316.50	$325.99		5.8%		
	Spend	$1,659,840,020	$2,381,142,090	$2,665,012,337	$2,817,979,162	$2,979,726,003	**$12,503,699,612**			
ABD	MMs	2,486,117	3,341,135	3,338,257	3,399,126	3,461,252		1.8%	11546743	
	Pmpm	$1,592.86	$1,609.68	$1,573.89	$1,621.11	$1,669.74		3.6%	-2.02%	
	Spend	$3,960,040,462	$5,378,167,015	$5,254,050,944	$5,510,347,382	$5,779,391,479	**$25,881,997,282**		-233244.2	6874696
										6,860,378
LTC	MMs	0	0					1.8%		
	Pmpm	$0.00	$0.00		$0.00	$0.00		3.9%	-0.21%	
	Spend	$0	$0	$0	$0	$0	**$0**		-24048.89	
HCBS State Plan	MMs	13,594	18,857	23,694	32,626	32,776		1.8%		
	Pmpm	$3,160.20	$3,432.23	$3,776.80	$3,916.54	$4,061.45		3.7%		
	Spend	$42,959,719	$64,721,553	$89,487,829	$127,781,891	$133,117,907	**$458,068,899**			

		DY1	DY2	DY3	DY4	DY5	Demo Period	
HCBS 217-Like	MMs	96,351	127,883	122,575	166,851	167,577		1.8%
	Pmpm	$2,152.48	$2,171.25	$2,686.84	$2,786.25	$2,889.34		3.7%
	Spend	$207,393,155	$277,666,552	$329,338,863	$464,888,095	$484,188,181	**$1,763,474,846**	
AWDC	MMs	6,057	2,774	0	0	0		
	Pmpm	$252.56	$242.98					
	Spend	$1,529,772	$674,018	$0	$0	$0	**$2,203,790**	
SED 217-Like	MMs	113	145	86	87	89		1.8%
	Pmpm	$0.00	$0.00					6.0%
	Spend	$0	$0	$0	$0	$0	**$0**	
XIX Chip Parents	MMs	0	456,761	0	0	0		
	Pmpm		$277.69					
	Spend	$0	$126,839,621	$0	$0	$0	**$126,839,621**	
IDD/MI	MMs	0	0	508	0	0		1.8%
	Pmpm	$0.00	$0.00	$0.00	$0.00	$0.00		6.0%
	Spend	$0	$0	$0	$0	$0	**$0**	
New Adult Group	MMs	0	2,394,149	6,331,600	6,447,823	6,566,179		1.8%
	Pmpm		$358.05	$413.36	$425.76	$438.54		5.0%
	Spend	$0	$857,234,945	$2,617,249,151	$2,745,249,949	$2,879,510,833	**$9,099,244,877**	

		DY1	DY2	DY3	DY4	DY5	Demo Period	
Title XIX	MMs	5,773,180	7,850,813	8,672,979	8,903,681	9,140,521		2.7%
	Pmpm	$327.03	$346.69	$366.74	$387.95	$410.40		5.8%
	Spend	$1,888,003,055	$2,721,798,359	$3,180,728,190	$3,454,183,159	$3,751,269,683	**$14,995,982,446**	
ABD	MMs	2,204,481	2,969,766	2,998,884	3,053,932	3,109,989		1.8%
	Pmpm	$1,045.04	$1,124.49	$1,164.91	$1,206.78	$1,250.17		3.6%
	Spend	$2,303,770,824	$3,339,472,169	$3,493,430,312	$3,685,423,618	$3,888,015,464	**$16,710,112,389**	
LTC	MMs	281,636	371,369	339,373	345,602	351,946		1.8%
	Pmpm	$8,636.81	$8,975.89	$9,325.83	$9,689.41	$10,067.17		3.9%
	Spend	$2,432,436,621	$3,333,367,293	$3,164,934,248	$3,348,683,718	$3,543,103,179	**$15,822,525,059**	
HCBS State Plan	MMs	13,594	18,857	23,694	32,626	32,776		1.8%
	Pmpm	$2,256.69	$2,347.84	$2,434.29	$2,523.94	$2,616.93		3.7%
	Spend	$30,677,444	$44,273,219	$57,678,284	$82,346,590	$85,772,311	**$300,747,848**	

		DY1	DY2	DY3	DY4	DY5	Demo Period	
HCBS 217-Like	MMs	96,351	127,883	122,575	168,783	169,557		1.8%
	Pmpm	$2,256.69	$2,340.19	$2,426.78	$2,516.57	$2,609.68		3.7%
	Spend	$217,434,338	$299,270,518	$297,462,343	$424,753,712	$442,490,384	**$1,681,411,294**	
AWDC	MMs	6,057	2,774	0	0	0		
	Pmpm	$277.00	$288.00					
	Spend	$1,677,789	$798,912	$0	$0	$0	**$2,476,701**	
SED 217-Like	MMs	113	145	86	87	89		1.8%
	Pmpm	$2,246.37	$2,381.15	$2,524.02	$2,675.46	$2,835.99		6.0%
	Spend	$253,840	$345,267	$216,371	$233,564	$252,122	**$1,301,164**	
XIX Chip Parents	MMs	0	456,761	0	0	0		
	Pmpm		$307.24					
	Spend	$0	$140,335,250	$0	$0	$0	**$140,335,250**	
IDD/MI	MMs	0	0	0	0	0		1.8%
	Pmpm	$9,839.39	$10,429.75	$11,055.53	$11,718.87	$12,422.00		6.0%
	Spend	$0	$0	$0	$0	$0	**$0**	
New Adult Group	MMs	0	2,394,149	6,331,600	6,447,823	6,566,179		1.8%
	Pmpm		$465.12	$490.48	$515.00	$540.75		5.0%
	Spend	$0	$1,113,566,583	$3,105,523,276	$3,320,628,680	$3,550,661,029	**$11,090,379,567**	

ORIGINAL STC APPROVED GROWTH PERCENTAGES FOR BUDGET NEUTRALITY

Schedule C
CMS 64 Waiver Expenditure Report
Cumulative Data Ending Quarter/Year : 2/2015

State: New Jersey

Summary of Expenditures by Waiver Year
Summary of Expenditures by Waiver Year
Waiver: 11W00279

MAP Waivers

Total Computable

Waiver Name	A	01	02	03
ABD	0	3,960,040,462	5,378,167,015	3,502,700,629
ACCAP – 217 Like	0	630,539	880,454	0
ACCAP – SP	0	900,000	966,297	0
AWDC	0	1,529,772	674,018	0
Childless Adults	0	27,844,394	48,216,389	0
CRPD – 217 Like	0	11,803,536	16,894,842	0
CRPD –SP	0	10,672,842	15,247,535	0
DSRIP	0	0	83,304,870	54,606,972
GME State Plan	0	0	100,000,001	75,000,015
GO – 217 Like	0	181,068,236	221,682,839	0
GO – SP	0	23,869,092	33,606,671	0
HCBS – 217 Like	0	216,912	20,770,166	247,004,147
HCBS – State Plan	0	60,671	5,536,122	67,115,872
HRSF & GME	0	192,443,637	0	0
HRSF Transition Payments	0	0	83,302,681	0
MATI at Risk	0	4,069,775	3,429,158	0
New Adult Group	0	7,171,980	857,234,945	1,853,884,815
SED at Risk	0	24,366,438	23,650,350	19,701,740
TBI – 217 Like	0	13,673,932	17,438,251	0
TBI – SP	0	7,457,114	9,364,928	0
Title XIX	0	1,659,840,020	2,381,142,090	1,776,674,891
XIX CHIP Parents	0	0	126,839,621	0
Total	**0**	**6,127,659,352**	**9,428,349,243**	**7,596,689,081**

Federal Share

Schedule C

CMS 64 Waiver Expenditure Report

Cumulative Data Ending Quarter/Year : 2/2015

Waiver Name	A	01	02	03
ABD	0	1,985,920,376	2,705,889,276	1,760,646,883
ACCAP – 217 Like	0	319,151	446,869	0
ACCAP – SP	0	454,312	489,362	0
AWDC	0	777,617	344,491	0
Childless Adults	0	14,715,147	24,778,164	0
CRPD – 217 Like	0	6,026,151	8,740,654	0
CRPD –SP	0	5,447,877	7,899,121	0
DSRIP	0	0	41,652,435	27,303,487
GME State Plan	0	0	50,000,002	37,500,009
GO – 217 Like	0	91,709,982	114,209,771	0
GO – SP	0	12,108,906	17,304,835	0
HCBS – 217 Like	0	110,604	10,755,613	126,851,249
HCBS – State Plan	0	31,285	2,870,705	34,467,157
HRSF & GME	0	96,221,820	0	0
HRSF Transition Payments	0	0	41,651,341	0
MATI at Risk	0	2,055,322	1,783,162	0
New Adult Group	0	7,171,980	857,234,945	1,853,884,815
SED at Risk	0	12,670,547	12,298,181	10,244,905
TBI – 217 Like	0	6,928,494	8,987,060	0
TBI – SP	0	3,776,704	4,819,278	0
Title XIX	0	833,277,910	1,318,925,064	999,540,701
XIX CHIP Parents	0	0	64,734,292	0
Total	**0**	**3,079,724,185**	**5,295,814,621**	**4,850,439,206**

CMS 64 - MEDICAID ELIGIBILITY GROUPS AS OF JUNE, 2014

	DEFINITIONS:	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
1	TITLE XIX	699,149	705,108	711,606	716,105	717,767	720,818	726,122	730,903	734,185	734,074	732,115	720,094
2	ABD (Excluding HCBS and LTC SPC 61)	279,229	279,081	278,904	278,346	277,844	275,683	275,365	274,503	273,301	272,091	270,198	266,861
3	Childless Adults												
4	Adults W/O Dependent Children	259,190	273,441	282,660	291,343	301,228	317,432	329,043	344,923	350,143	354,275	353,356	346,724
5	SED	3,184	3,027	2,806	2,878	2,911	3,026	3,157	3,248	3,390	3,485	3,532	3,248
6	HCBS (State Plan)	1,485	1,535	1,616	1,823	2,014	2,215	2,204	2,323	2,415	2,575	2,778	3,127
7	HCBS (217 Like)	9,827	9,877	9,938	10,261	10,433	10,467	10,196	10,123	10,082	10,089	10,122	10,217
8	LTC	24,537	24,150	23,794	23,313	22,974	22,725						
9	SED (217 Like)	14	18	11	5	7	9	9	4	6	5	2	1
10	IDD/MI (217 Like)	0	0	0	0	0	0	0	0	111	126	136	135
11	XIX CHIP Parents *(10/01/2013 - 12/31/2013 Only)*												
12	New Adult Group *(01/01/2014 Onwards)*	211,055	213,447	215,953	218,051	219,257	222,467	224,515	226,437	226,423	224,255	221,480	217,377

Source = CMS64 MEG report from Jun 2015

Deliverables due during MLTSS 3rd Quarter (1/1/2015 – 3/31/2015)

Each performance measure identifies its measurement period; however, depending on the source for the numerator/denominator the due date for reporting on a particular measure may have a lag time to allow for collection of the information. Several measures rely on claims data; therefore, a lag of 180 days must be built into the due date to allow for the MCO to receive the claims and process the data. Each of the measures will reflect the measurement period and reporting period. This report reflects the performance measures with a reporting period for the third quarter of MLTSS.

The following measures are not included in this report for the stated reason:

- Annual Measurement Period: PMs #5, 22, 32, 35, 36, 37, 38, 39, and 40.
- Lag Measurement Period: PMs #20, 24, 25, 26, 27, 28, 29, 30, 31, 33, 34, and 41.
- New Jersey's EQRO/IPRO is performing various reviews including the Annual Assessment, MLTSS Care Management Reviews, etc. to provide the data for the following measures: 8, 9, 9A, 10, 11, 12, 13, 15*, 15A*, 16 (*Data will be obtained during the IPRO Annual Assessment). These elements are collected annually but will have a lag reporting time.

PM: #2	#2 – Nursing Facility Level of Care assessment conducted prior to enrollment into MLTSS
Numerator:	# of members in the denominator that started receiving MLTSS services after the LOC approved/authorized date
Denominator:	All MLTSS level of care assessments with "approved" or "authorized" date within the measurement month
Data Source:	DoAS
Measurement Period:	Monthly with a three month lag report – Due 15th of the month following the 3 month lag

Measurement Period	09/2014	10/2014	11/2014
Numerator	**O/D**	**O/D**	**O/D**
Denominator	**O/D**	**O/D**	**O/D**
%	**O/D**	**O/D**	**O/D**

O/D = overdue and not available at this time, will include in next report

PM #3	Nursing Facility level of care authorized by Office of Community Choice Options (OCCO) for MCO referred members
Numerator:	# of MLTSS level of care assessment outcomes in the denominator that were "authorized" or "approved" by OCCO
Denominator:	Total number of MLTSS level of care assessments that were "authorized", "approved" or "denied" by OCCO during the measurement month
Data Source:	DoAS
Measurement Period:	Monthly – Due the 15th of the following month

N = Numerator D = Denominator % = Percentage O/D = Over due

Deliverables due during MLTSS 3rd Quarter (1/1/2015 – 3/31/2015)

Measurement period	12/2014	01/2015	02/2015
Numerator	**1355**	**O/D**	**O/D**
Denominator	**1368**	**O/D**	**O/D**
%	**99**		

O/D = overdue and not available at this time, will include in next report

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PM #4	Timeliness of nursing facility level of care assessment by MCO
Numerator:	The number of assessments in the denominator where the MCO assessment/ determination date is less than 30 days from the referral date to MLTSS
Denominator:	Number of level of care assessments conducted by MCO in the measurement month
Data Source:	MCO
Measurement Period:	Monthly – Due 15th of the 2nd month (lag report) following reporting period

January 2015*	A	B	C	D	E	TOTAL
Numerator	**1**	**81**	**84**	**4**	**18**	**188**
Denominator	**1**	**89**	**84**	**73**	**27**	**274**
%	**100**	**91**	**100**	**5.4**	**67**	**69**

MCOs began collecting this data in January 2015 and the first reporting date was 3/15/15. Not all of the MCOs were able to create a retrospective report for the first 6 months of MLTSS as each MCO needed system development to capture these data elements.

PM # 4a	Timeliness of nursing facility level of care assessment
Numerator:	The number of assessments in the denominator where the OCCO assessment/ determination date is less than 30 days from the referral date to OCCO
Denominator:	Number of level of care assessments conducted by OCCO in the measurement month
Data Source:	DoAS
Measurement Period:	Monthly – Due 15th of the 2nd month (lag report) following reporting period

Measurement Period	11/2014	12/2014	01/2015
Numerator	**363**	**470**	**O/D**
Denominator	**712**	**898**	**O/D**
%	**51**	**52**	**O/D**

O/D = overdue and not available at this time, will include in next report

N = Numerator D = Denominator % = Percentage O/D = Over due

Deliverables due during MLTSS 3rd Quarter (1/1/2015 – 3/31/2015)

PM # 6	Interim Plan of Care (IPOC) Completed (Options Counseling)
Numerator:	Number of assessments in the denominator with an Interim Plan of Care (IPOC) completed
Denominator:	Total number of NJ Choice assessments tagged as "authorized", "approved" or "denied" within the measurement month
Data Source:	DoAS
Measurement Period:	Monthly – Due the 15th of the following month

Measurement Period	11/2014	12/2014	01/2015
Numerator	**2474**	**1368**	**O/D**
Denominator	**2474**	**1368**	**O/D**
%	100	100	**O/D**

O/D = overdue and not available at this time, will include in next report

PM # 7	Members offered a choice between institutional and HCBS settings
Numerator:	Number of assessments in the denominator with an indicator showing choice of setting within the IPOC
Denominator:	Number of level of care assessments with a completed Interim Plan of Care (IPOC)
Data Source:	DoAS
Measurement Period:	Monthly – Due the 15th of the following month

Measurement Period	12/2014	01/2015	02/2015
Numerator	**1148**	**O/D**	**O/D**
Denominator	**1188**	**O/D**	**O/D**
%	**97**	**O/D**	**O/D**

O/D = overdue and not available at this time, will include in next report

PM # 17	Timeliness of Critical Incident (CI) reported to DoAS for measurement month
Numerator:	#CI reported in writing to DoAS within 2 business days
Denominator:	Total # of CI reported to DoAS for measurement month
Data Source:	DoAS

N = Numerator D = Denominator % = Percentage O/D = Over due

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

10/1/2014 – 12/31/14	A	B	C	D	E	TOTAL
Numerator	**0**	**10**	**52**	**30**	**3**	**95**
Denominator	**0**	**20**	**57**	**31**	**3**	**111**
%	**0**	**50**	**91**	**97**	**100**	**86**

Data was reported quarterly not monthly as stipulated in the measure. DoAS was notified that this data is to be reported on a monthly basis. Future reports will reflect the monthly data.

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

10/1/2014 – 12/31/2014	A	B	C	D	E	TOTAL
Numerator	**0**	**0**	**0**	**0**	**0**	**0**
Denominator	**0**	**0**	**0**	**0**	**0**	**0**
%	**0**	**0**	**0**	**0**	**0**	**0**

Data reported did not reflect incidents that were required to be reported within 1 business day. All reported incidents were required to be reported within 2 business days and was captured in #17.

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

Prior to the 1/1/15 MCO Contract Amendment, the MLTSS member and State Plan member data was co-mingled in a single report. Therefore, the first measurement period for this data was 1/1/15-3/31/15 with the report due in May 2015. This data will be submitted in the next report submission**.**

N = Numerator D = Denominator % = Percentage O/D = Over due

Deliverables due during MLTSS 3rd Quarter (1/1/2015 – 3/31/2015)

PM # 21	MLTSS members transitioned from NF to Community
Numerator:	# of MLTSS NF (SPC 61, 63, 64) members identified in the denominator who transitioned from a NF to the community (SPC 60, 62) at any time during the measurement period
Denominator:	# of MLTSS members with the living arrangement of NF (SPC 61, 63, 64) at any time during the measurement period (quarter or annual) and continuously enrolled in MCO.
Data Source:	MCO – living arrangement file and client tracking system
Measurement Period:	Quarterly/Annually – Due: 30 days after the quarter and year

10/1/14 – 12/31/14	A	B	C	D	E	TOTAL
Numerator	**0**	**3**	**0**	**9**	**0**	**12**
Denominator	**0**	**92**	**293**	**201**	**11**	**597**
%	**0**	**3**	**0**	**4**	**0**	**2**

PM # 23	MLTSS members transitioned from NF to the community at any point during the preceding quarter who returned to the NF within 90 days
Numerator:	# of MLTSS members in the denominator who transitioned from NF to the community who then returned to the NF within 90 days or less from transition during the measurement period
Denominator:	Quarterly: Total # of unique MLTSS members who transitioned from NF to the community during the measurement quarter Annually: Total # of unique MLTSS members who transitioned from NF to the community during state fiscal year 7/1-6/30
Data Source:	MCO – Living arrangement file, CM tracking and prior auth. System (r/o respite/rehab). MCO to identify how the dates were calculated.
Measurement Period:	Quarterly Lag Report/ Annually; each report is a unique run

7/1/14 – 9/30/14	A	B	C	D	E	TOTAL
Numerator	**0**	**0**	**0**	**0**	**0**	**0**
Denominator	**0**	**0**	**0**	**0**	**0**	**0**
%	**0**	**0**	**0**	**0**	**0**	**0**

PM # 18	Quarterly and Annual Critical Incident reporting for abuse, neglect and exploitation
Numerator:	# of critical incidents per category
Denominator:	Total # of critical incidents reported for measurement period (quarter or annual)
Data Source:	MCO
Measurement Period:	Quarterly/Annually – Due 30 days after quarter and year

N = Numerator D = Denominator % = Percentage O/D = Over due

Deliverables due during MLTSS 3rd Quarter (1/1/2015 – 3/31/2015)

Measurement Period: 10/1/14 – 12/31/14.

	MCO	A			B			C			D			E			TOTAL		
	Participant Safeguards:	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**	**N**	**D**	**%**
18	Critical Incident (CI) reporting Types:	0	0	0	37	37	100	60	60	100	47	47	100	3	3	100	147	147	100
a	Unexpected death a member	0	0	0	0	37	0%	1	60	2	0	47	0	0	0	0	1	147	0.7
b	Missing person of Unable to Contact	0	0	0	0	37	0%	1	60	2	23	47	49	0	0	0	24	147	16.3
c	Theft with law enforcement involvement	0	0	0	3	37	0%	3	60	5	0	47	0	0	0	0	6	147	4.0
d	Severe injury or fall resulting in the need of medical treatment	0	0	0	7	37	11%	17	60	28	16	47	34	0	0	0	40	147	27.2
e	Medical or psychiatric emergency, including suicide attempt	0	0	0	1	37	0%	9	60	15	0	47	0	0	0	0	10	147	6.8
f	Medication error resulting in serious consequences	0	0	0	0	37	0%	0	60	0	0	47	0	1	3	33.3	1	147	0.7
g	Inappropriate or unprofessional conduct by a provider involving member	0	0	0	4	37	22%	1	60	2	1	47	2	0	0	0	6	147	4.0
h	Suspected or evidenced physical or mental abuse (including seclusion and restraints)	0	0	0	0	37	33%	2	60	3	2	47	4	0	0	0	4	147	2.7
i	Sexual abuse and/or suspected sexual abuse	0	0	0	1	37	0%	0	60	0	1	47	2	0	0	0	2	147	1.4
j	Neglect/Mistreatment, including self-neglect, caregiver overwhelmed, environmental	0	0	0	1	37	11%	8	60	13	2	47	4	0	0	0	11	147	7.5
k	Exploitation, including financial, theft, destruction of property	0	0	0	2	37	0%	1	60	2	0	47	0	0	0	0	3	147	2.0
l	Failure of member's Back-up Plan	0	0	0	0	37	0%	9	60	15	0	47	0	1	3	33.3	10	147	6.8
m	Elopement/Wandering from home or facility	0	0	0	1	37	0%	0	60	0	0	47	0	0	0	0	1	147	0.7

N = Numerator D = Denominator % = Percentage

Deliverables due during MLTSS 3rd Quarter (1/1/2015 – 3/31/2015)

n	Eviction /loss of home	0	0	0	0	37	11%	5	60	8	0	47	0	0	0	0	5	147	3.4
o	Facility closure, with direct impact to member's health and welfare	0	0	0	0	37	0%	0	60	0	0	47	0	0	0	0	0	147	0
p	Media involvement or the potential for media involvement	0	0	0	1	37	11%	2	60	3	0	47	0	0	0	0	3	147	2.0
q	Cancellation of utilities	0	0	0	0	37	0%	1	60	2	0	47	0	1	3	33.3	2	147	1.4
r	Natural disaster, with direct impact to member's health and welfare	0	0	0	0	37	0%	0	60	0	0	47	0	0	0	0	0	147	0
s	Other	0	0	0	16	37	0%	0	60	0	2	47	4	0	0	0	18	147	12.2

N = Numerator D = Denominator % = Percentage O/D = Over due