New Jersey Comprehensive Waiver Demonstration
Section 1115 Quarterly Report
Demonstration Year: **3 (7/1/14-6/30/15)**
Federal Fiscal Quarter: **2 (1/1/15-3/31/15)**

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. New Jersey is waiting for guidance from CMS before submitting the amendment.

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 – MM/YY
Title XIX	710,515	715,577	701,657	
ABD	277,241	272,534	266,163	
LTC	23,794	22,725		
HCBS - State plan	1,610	2,220	2,423	
TBI – SP	n/a	n/a	n/a	
ACCAP – SP	n/a	n/a	n/a	
CRPD – SP	n/a	n/a	n/a	
GO – SP	n/a	n/a	n/a	
HCBS - 217-Like	9,794	10,366	9,975	
TBI – 217-Like	n/a	n/a	n/a	
ACCAP – 217-Like	n/a	n/a	n/a	
CRPD – 217-Like	n/a	n/a	n/a	
GO – 217-Like	n/a	n/a	n/a	
SED - 217 Like	9	5	1	
IDD/MI – (217 Like)	0	1	22	
NJ Childless Adults	n/a	n/a	n/a	
AWDC	n/a	n/a	n/a	
New Adult Group	493,152	528,280	525,039	

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

The MLTSS Steering Committee met on January 29, 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 next meeting in 2015 is set for May 14. The January meeting focused on hearing input from the Committee members on the major trends/operational issues on a macro level that they were seeing in the implementation of MLTSS: quality indicators, member profile highlights and dashboard data.

An MLTSS flier was created and is now available on the website at http://tinyurl.com/mp8r3fa. The four-page flier is in color and can be printed out for distribution. It includes basic MLTSS information: covered services and supports, qualifications for coverage and the application process. The 21 Area Agencies on Aging (AAAs) are using the brochure to explain MLTSS at health fairs and other similar events attended by older adults.

The State has established one toll free number – 1-844-646-5347 – to link six of its divisions together for all of its offerings in terms of long term services and supports, including MLTSS. The divisions include Medical Assistance and Health Services (DMAHS), Aging Services (DoAS), Disability Services (DDS), Developmental Disabilities (DDD), Family Development (DFD), and Mental Health and Addiction Services (DMHAS). The public can now make contact with any of the six divisions with the use of one master number.

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 been responding to inquiries through its email account on these issues among others: MCO contracting, credentialing, reimbursement, authorizations, appeals and complaint resolution. OMHC issued contract guidance in January 2015 on the coordination of benefits specifically related to dually eligible members and members with commercial coverage. In addition, the OMHC staff participated in statewide workshops on MLTSS in cooperation with the New Jersey Association of Health

Care Social Workers, Health Care Association of New Jersey, Leading Age New Jersey, and Health Research and Educational Trust of New Jersey.

ASD, ID/DD-MI, SED

The Department of Children and Families, Children's System of Care (CSOC) continues to hold community meetings where they discuss the programs offered and how to access them.

Supports

The Division of Developmental Disabilities (DDD) continued phase 2 of implementation of the Supports Program during this quarter. DDD has continued their education efforts, providing forums and webinars to provide information to families and other stakeholders regarding the implementation process and how the Supports Program can be accessed.

DDD has conducted NJ CAT assessments, supplemental assessments, and reassessments as needed in order to prepare individuals to be enrolled in the Supports program. DDD has also finalized the factors within the NJ CAT that will determine when an individual moves into an acuity-based tier. The provider database has been further developed to assist Support Coordinators, individuals, families, providers, etc. in searching for providers once they are approved in the new system.

DDD continues to assist individuals with Medicaid eligibility to assure eligibility for the Support Program. Presentations to providers and individuals on the tiers and how they will work have done. DDD has also provided "How is Case Management for DDD Services Changing? An overview of the Supports Coordination model in the New FFS System" for families and providers.

The certification process for Day Habilitation providers has been opened to begin enrolling providers into the network.

An initial draft of the "Supports Program Policies and Procedures Manual" will be released in April for stakeholder comment.

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, 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 has also begun discussions 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 has received some initial encounter data for the evaluation and is in the process of validating it. 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.

During this quarter, in accordance with STC 71(c), the State developed and implemented an exceptions process for high need MLTSS enrollees whose costs exceed institutional care. The process was approved February 12, 2015 and was implemented within one week of approval.

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 3/31/2015, there were 35 youth identified for the ASD pilot and 111 youth identified for the ID/DD-MI pilot. CSOC is working with DMAHS on the enrollment process for youth eligible for the SED waiver.

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 has been 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

As part of phase 2 of the Supports program implementation, DDD Expanded Support Coordination Orientation to include a series of modules through the College of Direct Support required prior to attending the in person 2-day training provided by The Boggs Center (NJ's University Center for Excellence in Developmental Disabilities Education, Research, and Service). DDD developed eight modules on employment and added to the College of Direct Support for Support Coordinators. These

modules are mandated training designed to assist Support Coordinators in understanding the employment service system for people with disabilities and discuss options to encourage individuals to work.

Individual budget amounts for each acuity tier within the Supports Program were finalized.

DDD released a draft "Quick Reference Guide" with updated standardized rates and continued meeting with the providers and stakeholders to assist in preparation for the Medicaid Fee-for-Service system.

As part of the Statewide Transition Plan (STP), DDD has begun identifying areas that will be impacted within the Supports program.

MBHO

Medicaid addiction treatment payments will be increased to be equivalent to the current state reimbursement rates, concurrent with the NJ is launching an Interim Managing Entity (IME) through a MOA with Rutger's University Behavioral Health Care (UBHC) on July 1, 2015 to provide service administration for addiction services for both state only and Medicaid funded services. The IME will provide a 24 hour call center, a bed management system, utilization management and care coordination for adult addiction services in NJ. Beginning on July 1, the IME will begin taking calls and administrating prior authorizations for assessments and continued stay reviews for state only funded services. Beginning January 1, 2016, the IME will additionally be administering prior authorizations and continued stay review authorizations for Medicaid covered members utilizing addiction services.

At this time, the State has decided to not pursue an RFP for an Administrative Services Organization (ASO) and determined that we are going to pursue the IME, as mentioned above, to gauge utilization, to assess the practical application of best practices, and to monitor its outcomes. When New Jersey chose to expand Medicaid, which resulted in over 400,000 new enrollees, and to launch Managed Long Term Services and Supports (MLTSS), which includes a behavioral health benefit, options for the management and reimbursement of behavioral health services increased dramatically. The State will carefully consider other options of managing the behavioral health care system for the long term.

DSRIP

Quarterly Payment Reports:
For DY3 Q1, hospitals activity completion earned $16.4 million in state and federal DSRIP payments, approved on January 21, 2015. The Q1 payment summary had 1 (one) outstanding issue for one hospital, along with several hospital deferments for Activity 13 for Q1. For DY3 Q2, hospitals activity completion earned $36.2 million in state and federal DSRIP payments, approved April 2, 2015. The Q2 payment summary had 0 (zero) outstanding issues, action/milestone payment for the Q1 outstanding issue, adjustments for Activity 13 for hospitals which had pilot projects beginning Q2, several continued hospital deferments for Activity 13 for Q1 and Q2, and an adjustment for a hospital that earned payment on Activity 13 in Q1, but needs deferment of Q1 and Q2.

Progress in meeting goals:
The DY3 Q4 progress reports, covering the time period January through March 2015, are due April 30, 2015.

All but one hospital began the pilot project by January 2015; all hospitals began their pilot by March 2015.

The average overall estimated completion percentage for each hospital project's stage activities or performance measure data tracking/collection is:
Stage I – 98%, Stage II – 73%, Stage III – 51%, Stage IV – 40%, January 2015 survey (49 hospitals)
Stage I – 99%, Stage II – 81%, Stage III – 60%, Stage IV – 47%, February 2015 survey (50 hospitals)
Stage I – 98%, Stage II – 86%, Stage III – 59%, Stage IV – 51%, March 2015 survey (50 hospitals)

Performance:
The DY3 Q3 progress reports for the experience period October – December 2014 were due January 31, 2015. All hospitals submitted their progress reports by that date.

The preliminary attribution rosters were sent to hospitals and their project partners on January 15, 2015.   Hospital patient preliminary patient roster matching had 72% (36 out of 50) of hospitals attempting to match the preliminary prospective attribution list.   Of these 36 hospitals that attempted to match their patient rosters, 31% matched at a rate of 90% or better, 33% matched at a rate of 75-89% and 36% matched at a rate of 0 – 74%. Final attribution patient rosters were sent to hospitals and their project partners on February 21, 2015, with additional support for hospitals to have a match rate of at least 90%.

The Quality and Measures Committee met to determine the Improvement Target Goals (ITGs) of the MMIS claims-based measures on February 25, 2015. The summary results were sent to CMS on March 6, 2015, and the rationales were sent on March 31, 2015.

The Databook, including measures specifications and the Standard Reporting Workbook, the measures reporting Excel document, were approved by CMS, with the first edition published to the website on January 30, 2015.

The hospitals identify their general progress in DSRIP along the Plan-Do-Study-Act Cycle.   The percentage of hospitals in each of the stages is reported below:
Plan – 2%, Do – 29%, Study – 29%, Act – 40%, February 2015 survey
Plan – 4%, Do – 33%, Study – 30%, Act – 33%, January 2015 survey
Plan – 2%, Do – 39%, Study – 43%, Act – 15%, December 2014 survey
Plan – 18%, Do – 48%, Study – 16%, Act – 12%, October 2014 survey

Two webinars were held with hospitals, one in January and one in February, in addition to the monthly Learning Collaborative. During these webinars additional updates were presented on the attribution patient rosters for hospitals matching and performance measures reporting.

Challenges:
The DOH and CMS will need to continue to negotiate programmatic changes as DSRIP is modified for State, CMS and Industry changes that may include updates to the Funding and Mechanics Protocol, Planning Protocol, and Toolkit.

For the DY4 progress report due in October 2015 for semi-annual measures reporting, following the baseline reporting in April 2015 of a DY3 progress report, the Funding and Mechanics Protocol requires hospitals to verify the state calculated claims-based MMIS measures, with an explanation of how they

verified the data, and provide an attestation of verification. While the DSRIP program and the DSRIP network have many features of an accountable care organization, including attribution of patients and coordination of care within partnerships, the DSRIP network is composed of a DSRIP hospital and the community based reporting partner (usually a primary care group), but is not extensive enough to include other healthcare providers. Given that the MMIS claims-based measures include providers and services beyond the DSRIP network, the MMIS data cannot be shared with the DSRIP hospital for their attributed patient population, and cannot be verified through access of the MMIS data and replication of the measure calculation algorithm. Another approach instead of requiring replication and verification of the measure calculation algorithm would be an acknowledgement of MMIS measures for all measures and an optional proxy measure data check with the DSRIP network data for those measures calculated using data outside the DSRIP network.

Hospitals have not been submitting learning collaborative surveys every month within one week following the learning collaborative, affecting the quality of summary data updates on hospitals' progress as a whole on the DSRIP program.

Time to review progress reports by the DOH and CMS has taken somewhat longer than the combined time allotted for review. The DY3 Q2 progress report review was delayed, though once begun, took approximately 30 days. Once submitted to CMS on January 23, 2015, CMS has not finalized review and approval for payment by March 31, 2015. The DY3 Q3 progress report was given a week extension of the deadline due to winter weather closings. For the DY3 Q3 progress reports, with the extension, the DOH designee completed all the progress report reviews within 30 days. CMS review has not begun for DY3 Q3 progress reports by March 31, 2015.

Mid-course corrections:
In accordance with the Funding and Mechanics Protocol, no payment was made for those activities targeted for completion in the hospital application (DY2 application) for the January – March 2014 period. Similarly, no Stage 3 or Stage 4 payment was made for measure level planning in the Data Reporting Plan submitted in October 2014.

Three hospitals submitted activity modification forms in January 2015. Conference calls were held with a hospital that had modifications that would change the hospital's DSRIP program from their application plan. If a plan modification was approved, it was incorporated into the following quarter's payment summary. One hospital submitted a plan modification with their DY3 Q3 progress report which was not approved because it would have significantly affected the DSRIP project from the DY2 hospital application plan.

Additional guidance was provided on measures reporting, specifically (a) October 2015 reporting for the substitution measures and (b) inclusion of patients if they did not have Medicaid/CHIP/Charity Care for the entire duration of the performance period. If a hospital were to have to select a substitution measure, the first reporting for the substitute measures would not be April 2015. The substitutions measures would be first reported with the semi-annual measures in October 2015. Only matchable patients to the retrospective reporting plan are able to be included in the measures. If a patient is on the attribution list, then the patient is eligible for inclusion in the measure pool during the performance period, even if the patient had changed to a payer other than Medicaid, CHIP and Charity Care during the performance period.

Streamlining the progress report review began with the DY3 Q2 progress report, where CMS reviews

were conducted on hospitals receiving the top 75% of funding. The DY3 Q2 progress report review had much improvement over the Q1 progress report review with quick resolution of the activities under dispute which fell into agreement with the department's review. The DOH has suggested using the department's designee as the single DSRIP reviewer for the department and CMS, a recommendation over a concurrent review as a plan of action by the fiscal year end Q4 progress reports review period.

Success and evaluation:
The DSRIP program has led to the development or purchase and use of patient education materials and better care coordination with external partners for patients. For reporting of the outpatient measures, hospitals will be working with community reporting partners or enhanced reporting partners, with whom they must develop a data use agreement by June 2015 for the DSRIP program. Other accomplishments of the DSRIP program are as follows:

- The learning collaborative has been so well received that groups of hospitals are meeting to discuss their projects and project improvement outside of the learning collaborative.
- NJ has successfully used the NJ attribution model to assign patients to hospitals and project partners.
- NJ has developed improvement target goals and baseline thresholds for all 50 participating hospitals and for all 18 MMIS measures.
- Hospital industry thinking has evolved to the industry wanting to engage NJ in discussions on the design of the next DSRIP demonstration program because they see DSRIP as an important initiative for the future.

NJ DOH reviewed the National Academy for State Health Policy DSRIP report, and noted that NJ was distinct from other states which do not have the entire DSRIP payment allotted distributable to the applicants. The NJ DSRIP program distributes the funding entirely, and stands as a successful exception to other states that do not have a funding mechanism to distribute all the funds.

Section XII. D. below contains the update for the DSRIP portion of the waiver evaluation.

Other
Self-attestations:
There were 54 self-attestations completed.
MCO Choice and Auto-assignment:
The number of individuals who chose an MCO: 22,279
The number of individuals who changed MCO after auto-assignment: 7,118
MLR:
The State calculates the Medical Loss Ratio (MLR) at the end of each State Fiscal Year (SFY) in accordance with the MCO contract. The current information available is for the period July 1, 2013 through June 30, 2014. The next MLR report will be for SFY 15 (July 1, 2014 through June 30, 2015). The

minimum MLR requirement for acute care services is 80%.

Beginning July 1, 2014 in relation to MLTSS members, a temporary MLR rate of 85% for HCBS services and 90% for nursing facilities was required until additional historical cost data under managed care can be ascertained.

The MLR for each MCO for the 12 month Period July 1, 2013 through June 30, 2014 is as follows:

Horizon NJ Health: 91.5% MLR
United Health Care: 84.3% MLR
Amerigroup: 79.2% MLR
HealthFirst: 87.5% MLR

WellCare and Aetna Better Health are not included in the current MLR report as both were not active Medicaid Managed Care Organizations until after July 1, 2014.

VII. Action Plan for Addressing Any Issues Identified

Issue Identified	Action Plan for Addressing Issue
HCBS Setting Rule	The New Jersey Department of Human Services (DHS), working with the Department of Children and Families and the Department of Health, publicly released New Jersey's draft Statewide Transition Plan (STP) on January 26, 2015. The public comment period closed on February 27, 2015. Over 1,000 public comments were received in the form of letters, emails, phone calls and testimony at the two public input sessions on February 4 and 19, 2015. The draft STP produced strong emotional and operations-based opposition. It opened up an important dialogue and resulted in constructive and useful feedback. Because of the public's commitment to the issues and willingness to engage in the public input process, an important dialogue developed and resulted in constructive and useful feedback that is being incorporated into the revised plan. DHS Acting Commissioner Connolly requested from CMS a 30-day extension to the March 17th submission deadline. A revised version was submitted to CMS on April 17, 2015.

VIII. Financial/Budget Neutrality Development/Issues

Issues 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 requests	Assessment Status	Requests to speak with Care	Medical benefits	Incorrect PCP on Member ID

			Manager		Card
2	Eligibility verification	Authorization Status	Authorization inquiries	PCP update	Inquiry into status of authorizations
3	Address changes	Care Manager Inquiry	Eligibility inquiries	ID Card updates	Questions about DME
4	Medicare primary, Part D assistance	DSNP transitions	DME	Provider search	Requesting services
5	Provider inquiries	Care Manger call transfers	PCP changes	Provider verification	Enrollment inquiries

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

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
1	Eligibility verification	EOB inquiries	DME	Authorizations	Claims inquiries
2	Prior authorizations	DME	Prior authorizations	Eligibility verification	Participation status
3	Pharmacy benefits	Prior authorizations	Claims payment concerns	Claim inquiries	Authorizations
4		Claims Inquiries	Referrals		Rate questions
5			Billing questions		

XI. Quality Assurance/Monitoring Activity

MLTSS:

The DMAHS MLTSS Quality Monitoring Unit has worked diligently with the MCOs over the past several months to outline uniform reporting guidelines and timeframes for the quality metrics spelled out in the Managed Care Quality Strategy. The State has also begun discussions with NASUAD to participate in the NCI-AD survey. 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.

The MLTSS Quality Metrics are currently under review by the MLTSS Quality Monitoring Unit and will be reported when review is complete.

MLTSS Claims Processing Information by MCO

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare

# Claims Received	113	24,719	221,325	44,838	24,474
# Claims Paid	95	2,1276	139,341	38,532	16,471
# Claims Denied	17	3,399	65,587	6343	8,083
# Claims Pending	1	44	16,397	87	1045
Average # days for adjudication	15	15	15	15	15

*In FFQ2, there is a large increase in numbers of claims paid from the previous quarter for some plans while there is not for others. This is likely due to the clean-up of historical claims related to Assisted Living, Personal Preference Program and Explanation Of Benefits related to guidance from the state.

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 - cert/Authorization or Referral	No authorization on file	No Authorization
2	Duplicate Submission	Charges processed under original submission	Definite Duplicate Claim	Fee Schedule	No Patient Responsibility
3	EOB Required	Primary carrier info required	Invalid billing	Benefits based on admission date	Timely Filing
4	The procedure code is inconsistent with the modifier used or a required modifier is missing	Termination		Send Primary Carrier's EOB	PMT was included in allowance for another service
5		Network Standard Fee Schedule		Code not payable per provider specialty	Member not eligible on date of service

Critical Incidents:

Amerigroup Critical Incidents reported Jan. 1- Mar. 31, 2015
Total 17, 11 filed in allowable time period filed, 6 filed late (> than 2 business days) than reporting time permits

Incident Type

Abuse: total 1, 1 reported late
Physical Abuse (Including Seclusion and Restraints - Both Physical and Chemical) - 0
Psychological/Verbal Abuse (Including Seclusion and Restraints - Physical & Chemical) – 1, 1 reported late
Sexual Abuse or Suspected Sexual Abuse - 0

Neglect/Mistreatment: total 3, 1 reported late
Caregiver - 0
Caregiver Overwhelmed - 0
Environment - 0
Medical - 0
Service Provider - 0
Self - 1
Other – 2, 1 reported late

Exploitation: total 1, 1 reported late
Financial - 0
Theft with Law Enforcement Involvement – 0
Destruction of Property - 0
Other – 1, 1 reported late

Unexpected Deaths - 1

Elopement/Wandering from Home or Facility - 0

Other Reportable Events: total 11, 3 reported late
Cancellation of Utilities - 0
Eviction/Loss of Home - 1
Facility Closure with Direct Impact to a Member's Health and Welfare - 0
Failure of Member's Back Up Plan - 0
Severe Injury or Fall Resulting in the Need for Medical Treatment – 0
Medical or Psychiatric Emergency, including Suicide Attempt - 0
Media Involvement or Potential Involved - 0
Medication Error Resulting in Serious Consequences - 0
Missing Person/Unable to Contact - 2
Natural Disaster with Direct Impact to Member's Health and Welfare - 0
Other – 8, 3 reported late

Horizon Critical Incidents reported Jan. 1- Mar. 31, 2015
Total 189, 184 filed in allowable time period, 5 filed late (> than 2 business days) than reporting time permits

Incident Type
Abuse: total 11
Physical Abuse (Including Seclusion and Restraints - Both Physical and Chemical) - 9
Psychological/Verbal Abuse (Including Seclusion and Restraints - Physical & Chemical) - 2
Sexual Abuse or Suspected Sexual Abuse - 0

Neglect/Mistreatment: total 11
Caregiver - 1
Caregiver Overwhelmed - 2
Environment – 1
Medical - 1
Service Provider – 3
Self - 1
Other - 2

Exploitation: total 8
Financial – 5
Theft with Law Enforcement Involvement - 2
Destruction of Property - 0
Other - 1

Unexpected Deaths – 3

Elopement/Wandering from Home or Facility – 1, 1 reported late

Other Reportable Events: total 155
Cancellation of Utilities - 0
Eviction/Loss of Home - 2
Facility Closure with Direct Impact to a Member's Health and Welfare - 0
Failure of Member's Back Up Plan – 11, 1 reported late
Severe Injury or Fall Resulting in the Need for Medical Treatment – 106, 3 reported late
Medical or Psychiatric Emergency, including Suicide Attempt - 30
Media Involvement or Potential Involved - 1
Medication Error Resulting in Serious Consequences - 1
Missing Person/Unable to Contact - 2
Natural Disaster with Direct Impact to Member's Health and Welfare - 0
Other – 2

<u>**United Critical Incidents reported Jan. 1- Mar. 31, 2015**</u>
Total 63, 58 filed in required time period, 5 filed late (> than 2 business days) than reporting time permits

Incident Type
Abuse: total 3
Physical Abuse (Including Seclusion and Restraints - Both Physical and Chemical) - 2
Psychological/Verbal Abuse (Including Seclusion and Restraints - Physical & Chemical) - 0
Sexual Abuse or Suspected Sexual Abuse - 1

Neglect/Mistreatment: total 2, 1 reported late
Caregiver - 0
Caregiver Overwhelmed - 0
Environment - 0
Medical - 0
Service Provider - 1

Self – 0
Other - 1

Exploitation: total 3
Financial - 0
Theft with Law Enforcement Involvement - 2
Destruction of Property - 1
Other - 0

Unexpected Deaths - 0

Elopement/Wandering from Home or Facility - 1

Other Reportable Events: total 54, 4 reported late
Cancellation of Utilities - 0
Eviction/Loss of Home – 0
Facility Closure with Direct Impact to a Member's Health and Welfare - 0
Failure of Member's Back Up Plan - 0
Severe Injury or Fall Resulting in the Need for Medical Treatment – 11, 1 reported late
Medical or Psychiatric Emergency, including Suicide Attempt – 15, 3 reported late
Media Involvement or Potential Involved - 0
Medication Error Resulting in Serious Consequences - 0
Missing Person/Unable to Contact - 26
Natural Disaster with Direct Impact to Member's Health and Welfare - 0
Other - 2

WellCare Critical Incidents reported Jan. 1- Mar. 31, 2015
Total 1, 0 filed in required time period, 1 filed late (> than 2 business days) than reporting time permits

Incident Type
Abuse: total 0
Physical Abuse (Including Seclusion and Restraints - Both Physical and Chemical) - 0
Psychological/Verbal Abuse (Including Seclusion and Restraints - Physical & Chemical) - 0
Sexual Abuse or Suspected Sexual Abuse - 0

Neglect/Mistreatment: total 0
Caregiver - 0
Caregiver Overwhelmed - 0
Environment - 0
Medical - 0
Service Provider - 0
Self – 0
Other - 0

Exploitation: total 0
Financial - 0
Theft with Law Enforcement Involvement - 0

Destruction of Property - 0
Other - 0

Unexpected Deaths - 0

Elopement/Wandering from Home or Facility - 0

Other Reportable Events, total 1, 1 reported late
Cancellation of Utilities - 0
Eviction/Loss of Home – 0
Facility Closure with Direct Impact to a Member's Health and Welfare - 0
Failure of Member's Back Up Plan - 0
Severe Injury or Fall Resulting in the Need for Medical Treatment – 0
Medical or Psychiatric Emergency, including Suicide Attempt – 1, 1 reported late
Media Involvement or Potential Involved - 0
Medication Error Resulting in Serious Consequences - 0
Missing Person/Unable to Contact - 0
Natural Disaster with Direct Impact to Member's Health and Welfare - 0
Other - 0

Aetna Critical Incidents reported Jan. 1- Mar. 31, 2015
Total 2, 2 filed in required time period, 0 filed late (> than 2 business days) than reporting time permits

Incident Type
Abuse: total 0
Physical Abuse (Including Seclusion and Restraints - Both Physical and Chemical) - 0
Psychological/Verbal Abuse (Including Seclusion and Restraints - Physical & Chemical) - 0
Sexual Abuse or Suspected Sexual Abuse - 0

Neglect/Mistreatment: total 0
Caregiver - 0
Caregiver Overwhelmed - 0
Environment - 0
Medical - 0
Service Provider - 0
Self – 0
Other - 0

Exploitation: total 0
Financial - 0
Theft with Law Enforcement Involvement - 0
Destruction of Property - 0
Other - 0

Unexpected Deaths - 1

Elopement/Wandering from Home or Facility - 0

Other Reportable Events, total 1
Cancellation of Utilities - 0
Eviction/Loss of Home – 0
Facility Closure with Direct Impact to a Member's Health and Welfare - 0
Failure of Member's Back Up Plan - 0
Severe Injury or Fall Resulting in the Need for Medical Treatment – 0
Medical or Psychiatric Emergency, including Suicide Attempt - 0
Media Involvement or Potential Involved - 0
Medication Error Resulting in Serious Consequences - 0
Missing Person/Unable to Contact - 1
Natural Disaster with Direct Impact to Member's Health and Welfare - 0
Other – 0

SED/IDD/ASD:

The Department of Children and Families, Children's System of Care (CSOC) has begun 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 is also 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. DDD also held a quarterly meeting with Support Coordination Supervisors to provide updates and solicit feedback. A demonstration of the next platform of iRecord (the electronic case management system) was provided.

DDD held focus groups for self-advocates families, and providers on the Quality Strategy. The Quality Strategy was submitted to CMS March 4, 2015.

Feedback was received from public forums held by DHS to solicit comment on the Statewide Transition Plan (STP) for the HCBS Final Rule. DDD reviewed the feedback received from stakeholders regarding their programs and revised the STP based on the feedback.

Other Quality/Monitoring Issues:
EQR PIP

In September of 2014, the New Jersey Managed Care Organizations (MCOs) submitted final updates to 4 Medicaid Quality Improvement Projects (QIPs), three of which focused on Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services including: Well Child Visits, Immunizations and Initial Lead Screening. The fourth QIP focused on Prenatal/Postpartum Care. These projects have been evaluated and scored by the External Quality Review Organization (EQRO) with the expectation that the MCOs will continue to internally address these areas using the feedback from the EQRO to enhance their activities.

Starting in 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 initially held biweekly meetings with the MCOs to ensure a solid and consistent QIP foundation across all MCOs. The MCOs submitted their new project proposals in December 2013, followed by the updated project baseline report in June of 2014, then a September 2014 project year one update. The EQRO and MCOs now meet monthly for continued collaborative activities. The MCOs are expected to show improvement and sustainability over the next 2 years.

Additionally, the MCOs are beginning 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 proposals were approved and project activities were initiated by the plans in early 2015. The plans will submit an interim report in June 2015 that will include the 2014 Baseline Data, followed by an update report in September.

State Sanctions against MCO, ASO, SNP or PACE Organization:
There were no State Sanctions against a MCO, ASO, SNP or PACE Organization.

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 period ending March 31, 2015, the Rutgers Center for State Health Policy (CSHP) continued our 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 will inform both our quantitative and qualitative evaluations. Some specific examples of activities this last quarter include: 1) monthly update calls with State Medicaid officials to discuss progress and new 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 January 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 finalized the MLTSS interview questions and began outreach and completion of interviews. By the end of the quarter CSHP completed seven interviews with eleven stakeholders. CSHP is planning for about eight additional interviews in the next quarter for our initial stakeholder summary.

Activities to support the quantitative evaluation of the above hypothesis in the last quarter were centered on validating the corrected Medicaid Fee-For-Service Claims and Managed Care Encounter datasets received in February 2015 (more details in section D below), operationalizing metric definitions in the claims data, and calculation of metrics specified in the evaluation plan. Additionally, CSHP continued discussions with representatives from Medicaid familiar with the claims data to specify the best methodology for identifying subpopulations of beneficiaries in the baseline period, specifically, the nursing facility population, former 1915(c) waiver populations, dual eligibles, and an approach for creating general groupings of Medicaid beneficiaries: ABD, children, and adults, in anticipation of the adjustments we will need to do for analyses using data from the post-expansion years. |
|---|---|
| **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 January 2015, we 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.*** |
| | There were no specific activities related to evaluation of this hypothesis in the quarter ending March 31, 2015. |
| **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.*** |
| | Three main activities relating to the evaluation of the DSRIP program, specifically the midpoint evaluation report are the following:

Calculation of metrics from the Medicaid Fee-for-Service and Managed Care Encounter data:
As mentioned previously, validation of the corrected Medicaid claims dataset that CSHP received in February 2015 was conducted. CSHP used uniform billing hospital discharge data to benchmark counts of inpatient and ED visits in the claims data. CSHP spoke to Medicaid representatives as needed to understand claims structure and key variables. CSHP completed the majority of the |

programming for DSRIP metrics in the most recent quarter. CSHP followed technical specifications for year 2014 from the applicable measure stewards (National Quality Forum, Joint Commission, etc.). Finalizing covariates and DSRIP exposure variables to create analytic datasets is underway, and refinement of the modeling approach continues.

DSRIP Key Informant Interviews: CSHP completed four additional DSRIP stakeholder interviews in this period, bringing our total to twelve. The members of the evaluation team separately identified themes from the interviews and discussed any differences in emphasis. CSHP wrote up our methods and our findings in a summary report that will be a component of the midterm evaluation.

Hospital Web Survey: The hospital midpoint web survey was designed by CSHP staff in January and February, 2015. It was informed by the key informant telephone interviews conducted earlier and also the material discussed at learning collaborative meetings. The final version of the questionnaire was programmed into *Survey Monkey* and pretested by Rutgers CSHP staff. Several minor programming revisions were performed following pretesting.

On March 3, 2015, an advance endorsement letter from the New Jersey Department of Health was emailed by Rutgers CSHP personnel to the DSRIP contact person for each DSRIP-eligible hospital in New Jersey. The letters were tailored slightly for the hospitals that were participating in DSRIP, non-participating, or withdrawn from the program, and encouraged the hospitals to provide feedback on the program via the survey. In some cases further follow-up was required related to the email contacts.

On March 12, 2015, another email was sent to all NJDSRIP-eligible hospitals containing informed consent information and a link to the web survey. On March 23, 2015, a reminder email with the consent information and survey link was sent to all eligible hospitals. On March 31, 2015, a second reminder email with the consent information and survey link was sent to all eligible hospitals.

Around the time of the writing of this report, on April 15, 2015, a final email reminder with the consent information and survey link was sent to those eligible hospitals who had not completed the web survey. The survey field period was completed on April 24, 2015.

XIII. Enclosures/Attachments

A. Budget Neutrality Report

XIV. State Contact(s)

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XV. Date Submitted to CMS

May 22, 2015