New Jersey Comprehensive Waiver Demonstration
Section 1115 Quarterly Report
***Demonstration Year:* 5 (7/1/16-6/30/17)**
***Federal Fiscal Quarter:* Quarter 4 (7/1/17-9/30/17)**

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 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.

There are no anticipated changes in populations served or benefits.

III. Enrollment Counts for Quarter

Demonstration Populations by MEG	Total Number of Demonstration participants Quarter Ending – 12/16	Total Number of Demonstration participants Quarter Ending – 03/17	Total Number of Demonstration participants Quarter Ending – 06/17	Total Number of Demonstration participants Quarter Ending – 09/17
Title XIX	736,648	734,943	728,964	695,942
ABD	274,962	272,169	269,279	258,924
LTC				
HCBS - State plan	8,115	8,599	9,968	10,643
TBI – SP				
ACCAP – SP				
CRPD – SP				
GO – SP				
HCBS - 217-Like	12,295	12,419	12,550	12,703
TBI – 217-Like				
ACCAP – 217-Like				
CRPD – 217-Like				
GO – 217-Like				
SED - 217 Like	153	211	257	252
IDD/MI – (217 Like)	271	400	415	347
NJ Childless Adults				
AWDC	369,139	375,007	369,518	343,988
New Adult Group	204,246	204,410	202,155	192,568
SED at Risk	3,689	4,224	4,314	3,017
MATI at Risk				
Title XXI Exp Child				
NJFAMCAREWAIV-POP 1				

NJFAMCAREWAIV-POP 2	
XIX CHIP Parents	

IV. Outreach/Innovative Activities to Assure Access

MLTSS
The State has continued to maintain its efforts to ensure that consumers, stakeholders, Managed Care Organizations (MCO), 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 Department of Human Services (DHS) has continued to work with a quality subgroup of the MLTSS Steering Committee on a Nursing Facility (NF) quality initiative. With consensus from stakeholders, the DHS will use seven performance measures to establish a minimum threshold upon which MCOs will rely in narrowing their networks of NF providers. Those measures address antipsychotic medication, immunizations against influenza, pressure ulcers, physical restraints, falls with major injury, NF resident experience survey and tracking 30-day hospitalizations. The MLTSS Steering Committee met on September 28, 2017 with its representation from stakeholders, consumers, providers, MCOs and state staff members. The agenda included a report to the Committee, including these topics: 1115 Comprehensive Waiver Renewal Approval Highlights; the MLTSS Dashboard Indicators, NF Any Willing Qualified Provider Initiative Update, and the Medicaid Innovative Accelerator Program: Incentivizing Quality and Outcomes Technical Assistance Opportunities. The Office of Managed Health Care (OMHC), with its provider relations unit, has remained committed to its communications efforts to ensure access through its provider networks. Its provider-relations unit has continued to respond to inquiries through its email account on these issues among others: MCO contracting, credentialing, reimbursement, authorizations, appeals and complaint resolution. On June 8, 2017, in coordination with the Medicaid Fraud Division the Office of Managed Health Care provided Contract Guidance to MCOs and Providers regarding coordination of benefits for dually enrolled members and individuals with Third Party Liability Insurance. The Division of Medical Assistance and Health Services (DMAHS) worked closely with Stakeholders and Providers to prepare guidance in order to facilitate billing for ancillary services. As part of Traumatic Brain Injury (TBI) Workgroup, modifications have been made to the descriptions of MLTSS Waiver Services. OMHC, provider relations unit, is working directly with the individual Managed Care Organizations and the TBI Providers to insure that operational and billing issues that may have resulted from initial service definitions are addressed and TBI Providers are reimbursed in a timely manner for services rendered.
ASD/ID/DD-MI/SED
The Department of Children and Families (DCF), Children's System of Care (CSOC) promotes their program at their many meetings throughout the state and plans to continue to do so at community/stakeholder meetings.
Supports

During this quarter, the Division of Developmental Disabilities (DDD) continues enrollment of individuals into the Supports Program. As of the end of the reporting quarter, DDD enrolled 4,400 individuals in the Supports Program.

DDD began utilizing the newly awarded Fiscal Intermediary – Public Partnerships LLC (PPL) to provide payments for Self-Directed Employees (SDE) and business entities that are not required to become Medicaid/DDD approved providers due to the services they are offering. A pilot group of SDEs were part of this shift in order to identify and resolve issues as they occur.

DDD continues to assist individuals with Medicaid eligibility including assisting individuals in accessing Supports Program Only Medicaid.

DDD continues enrollment of individuals into Supports Program + Private Duty Nursing (PDN) and provided options counseling to individuals identified as needing PDN. In addition, DDD continues enrollment of individuals identified through Support Coordination Agencies as meeting the criteria for Supports Program enrollment.

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

DDD continues the identification of quality measures for the DDD system, providers, individuals, and services.

NJ CAT assessments, supplemental assessments, reassessments as needed and DDD continues to work through the process for Day Habilitation Certification. During this quarter, DDD released a revised (version 4.0) Supports Program Policies & Procedures Manual.

V. Collection and Verification of Encounter Data and Enrollment Data

Summary of Issues, Activities or Findings

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

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

MLTSS
DMAHS convenes a bi-weekly meeting with state staff from the various Divisions involved in MLTSS to discuss any issues to ensure that they are resolved timely and in accordance with the rules and laws that govern the Medicaid program. The state also continues to have bi-weekly conference calls with the MCOs to review statistics and discuss and create an action plan for any issues that either the State or the MCOs are encountering.
ASD/ID/DD-MI/SED
DCF, CSOC continues ongoing enrollment of youth in the Intellectual Disabilities/ Development Disabilities co-occurring Mental Illness Pilot (ID/DD-MI) and the Autism Spectrum Disorder (ASD) Pilot. As of September 30, 2017, there were 150 youth identified for the ASD pilot and 887 youth identified for the ID/DD-MI pilot. The SED Plan A coverage process was finalized with the Division of Medical Assistance and Health Services (DMAHS) and has been operationalized. As of September 30, 2017, 237 SED Plan A youth have been enrolled through the Serious Emotional Disturbance program. CSOC's Contracted Systems Administrator (CSA), and DMAHS's fiscal agent, Molina, continue to hold implementation meetings as needed. CSOC continues to build ASD, I/DD-MI and SED provider networks. A request for Intensive in-Home providers was posted this quarter. Technical assistance continues to be ongoing to assist and provide new ASD, ID/DD-MI providers related procedures and expectations. CSOC also provided technical assistance on the Medicaid enrollment process to ensure that providers receive Medicaid ID for billing and requisite provider enrollment.
Supports
During this quarter, DDD held the Family Advisory Council meeting. This group meets monthly to provide input and feedback on Division policies. No issues regarding the Supports Program were presented to the Division during this quarter. DDD held a Provider Leadership Meeting on September 25, 2017 where leadership from the provider membership trade organizations receive updates and provide comments/feedback on the DDD system. DDD also held the quarterly provider and family update meetings on September 27, 2017. At both of these meetings the Assistant Commissioner provided an update on DDD and answered questions DDD started conducting the Live Q&A Webinars for individuals, families, providers, and support coordinators held every other week. DDD provided training to staff at the Division of Vocational Rehabilitation Services (DVRS) regarding the Supports Program and how services and supports can be provided through DDD in order to assist individuals in employment. In addition, DDD provided training related to Supports Program + PDN for Managed Care Organization staff so t that they can better assist the individuals they serve in making choices between programs. DDD met individually with providers within our contract reimbursement system to determine readiness for the shift to the Supports Program and Fee-for-Service and answer questions. In addition, DDD also provided answers to and met with a variety of providers regarding various areas related to the Supports

Program.

DDD provided presentations at schools, trade organization membership meetings, conferences, family group/organization meetings and events, self-advocates, the transition coordinators network, etc.

IME

During the DY5, FF4 (July 1, 2017 to September 30, 2017): During this time period the IME received and responded to 15,889 calls to the call center from consumers and/or family members. These calls resulted in 2,700 direct referrals to treatment providers and 1,570 were sent to IME Care Coordination services to facilitate admission to treatment. As the IME continues to provide Utilization Management services for SUD treatment, they have provided 5,496 treatment authorization reviews to ensure admission to the right level of care for Medicaid recipients. In addition they have reviewed 4,114 requests by providers for continued treatment for Medicaid recipients based on medical necessity. The IME continues to support Providers by operating a provider assistance call line where they received and responded to 3,748 calls.

DSRIP

Quarterly Payment Reports – On August 1, 2017, CMS approved Federal drawdown by New Jersey of $3,809,552.56 for Quarter 4, Demonstration Year 5 for payments earned under Stage 1 and Stage 2 measures. On August 12, 2017, CMS approved Federal drawdown by New Jersey of $997,852.51 for Quarter 2, Demonstration Year 5 for payments earned under Stage 3 and Stage 4 measures. On August 17, 2017, CMS approved Federal drawdown by New Jersey of $3,809,552.56 for Quarter 3, Demonstration Year 5 for payments earned under Stage 1 and Stage 2 measures.

Progress in meeting DSRIP goals – CMS approved Final DY5 Payment Summary, Management Report and All Payment Summary documents (documents reflected DY4 appeal results).

Performance – DY5 Q3 and Q4 Progress Reports were reviewed and approved by CMS. DY4 Appeal Recommendations were agreed upon by CMS and New Jersey Derpartment Of Health.

Challenges – CMS and NJDOH continue discussions on the design of DY7 and DY8. CMS and NJ agreed that, for DY6 and forward, the state will utilize the national benchmark when possible, followed by the NJ statewide benchmark. NJ is awaiting a response from CMS regarding a question of possible duplicate funding issue for the CarePoint hospital system.

Mid-course corrections – CMS, NJDHS and NJDOH are holding weekly calls to discuss the 1115 Waiver renewal, including extending NJDSRIP under the 1115 Waiver Renewal. CMS and NJDOH are working together on a final version of the STCs for DY6.

Successes and evaluation – CMS issued and approved the Funding and Mechanics Protocol applicable to DY5 and was posted on the NJ DSRIP website. This protocol included the UPP Redesign and a calculation of DY4 payments based on adjudicated appeals with appeal adjustments made as part of DY5 payments. The September quarterly Learning Collaborative and QMC meetings were rescheduled for October 26, 2017.

Other

Managed Care Contracting:

There are no updates for this quarter.

Self-attestations:

There were a total of 90 self-attestations for the time period from July 1, 2017 to September 30, 2017. There was a significant decrease in self-attestation forms received this quarter due to education around the process to the plans on an individual basis.
MCO Choice and Auto-assignment:
The number of individuals who changed their MCO after auto-assignment is 5,193.
MLR:
MCO Medical Loss Ratios for the 12 month Period July 1, 2015 to June 30, 2016: Horizon NJ Health: 91.8% UnitedHealthcare: 87.8% Amerigroup: 83.5% WellCare: 89.4% Aetna: 97.5%

VII. Action Plan for Addressing Any Issues Identified

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

VIII. Financial/Budget Neutrality Development/Issues

Issues Identified:
Issues regarding the implementation of the new Fiscal Intermediary, PPL, have been identified this quarter. The main issues have been enrollment of providers and SDEs within the PPL system and timely payment of providers and SDEs who have rendered services. DDD staff have been meeting with PPL regularly to address these issues and have, in collaboration with PPL, established an escalation process to ensure these issues are addressed as they come to our attention.
Actions Taken to Address Issues:
Weekly meetings continue in order to solve these issues in the long-term.

IX. Member Month Reporting

A. For Use in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Title XIX				
ABD				
LTC (following transition to MLTSS)				
HCBS -State Plan				
TBI – SP				
ACCAP – SP				
CRPD – SP				
GO – SP				
HCBS -217 Like				
TBI – 217-Like				
ACCAP – 217-Like				
CRPD – 217-Like				
GO – 217-Like				
SED -217 Like				
IDD/MI -(217 Like)				
NJ Childless Adults				
New Adult Group				
Title XXI Exp Child				
XIX CHIP Parents				

X. Consumer Issues

Summary of Consumer Issues

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

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
1	Change PCP	Checking on status of authorization request	PCP change request	Medical Benefits	PPP status, payment or enrollment
2	Provider Search	Speak with or leave a message for their Care Manager	Request to speak with Care Manager	PCP Update	Request for services (new/additional)
3	Eligibility	Status of assessment	Request or check status of authorization	Request ID card	Request to speak with Care Manager
4		Questions regarding the PPP program.	Check benefit coverage	Eligibility Inquiry	Benefits questions

5			Request ID card		PCP Changes

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

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
1	Eligibility	Checking on status of authorization request	Request or check status of authorization	Eligibility Inquiry	Authorization inquires
2	Claims inquiries	Authorization updates due to change in member status	Claims inquiries	Claims inquiries	Claims inquiries
3	Authorization inquires	Status of assessment	Credentialing status	Authorization inquires	Incorrect denials
4	Requests to join network	Claims inquiries	Single case agreement requests	Incorrect cost share causing an increase in provider complaints	Single case agreement requests
5		Personal Pay deduction questions			

XI. Quality Assurance/Monitoring Activity

MLTSS:

MLTSS Claims Processing Information by MCO

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
# Claims Received	41,304	94,198	309,297	48,523	193,285
# Claims Paid	29,009	72,933	272,465	41,299	142,824
# Claims Denied	8,011	20,655	31,791	3,471	49,749
# Claims Pending	4,284	610	5,041	3,753	712
Average # days for adjudication	15	15	15	15	15

Top 5 Reasons for MLTSS Claims Denial by MCO

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare

1	Service denied because payment already made for same/similar procedure within set time frame	NetworX Std Fee Sched	Duplicate	Claim is a duplicate	No Authorization
2	Non-covered charge(s)	Disallow-not allowed under contract	Timely Filing	Dates of service matched	No Patient Responsibility
3	Procedure code incidental to primary procedure	Incorrect billing form/provider	Provider not eligible for code	Benefits Based on Admission Date	Timely Filing
4	Exact duplicate claim/service	Capitated Service	Provider not contracted	Medi Medi 2ndary Carrier	
5		Paid at contracted rate	No authorizaiton	No Authorization on file	

ASD/ID/DD-MI/SED

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

Supports:

The Department of Human Services Quality Management Unit (QMU) conducts an annual audit of the Supports Program. The unit began their annual audit in September of this year and will continue conducting this audit until the end of the calendar year.

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

DDD requires reporting on 86 distinct Unusual Incident Codes. At the end of this quarter there were 4,408 individuals on the Supports Program. From this group, there were 162 unusual incidents reported for 137 individuals (some individuals had more than 1 unusual incident report). Therefore, approximately 97% of individuals on the Supports Program during this quarter did not require an UIR. Some UIR codes, such as abuse, neglect, or exploitation require an investigation. If there were minor or no injuries then the provider agency is responsible to conduct an investigation and submit their findings/action plan for review by the Department of Human Services Critical Incident Management Unit. If there were moderate to major injuries then the Department of Human Services Special Response Unit will conduct an investigation. During this quarter the Special Response Unit was assigned 3 Unusual Incidents to investigate.

Other Quality/Monitoring Issues:

EQR PIP

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

The MCOs are also involved in a non-collaborative Prenatal QIP with the focus on Reduction of Preterm Births. The initial proposals were submitted by the MCOs in October 2014 for review by the EQRO. The individual proposals were approved and project activities were initiated by the plans in early 2015. The June interim reports included the 2014 baseline data. The September 2015 reports included an analysis of plan specific activities and any revisions for the upcoming year. Results of calendar year 2015 measures represented remeasurement year 1. January 2016 was the start of remeasurement year 2 for this QIP. All MCOs submitted a progress report in June 2016 which included remeasurement year 1 data, and were reviewed by the EQRO. All MCOs submitted a progress report update in September 2016 and were reviewed by the EQRO. January 2017 was the start of the sustainability year for the MCOs. In June 2017, all MCOs submitted a progress report which included the results of the remeasurement year 2 data and were reviewed by the EQRO. In the June 2017 report, one of the MCOs revised their Prenatal QIP aim statement and performance indicators, resulting in a new QIP cycle. For this MCO, 2016 is now the baseline data year for the project; results of calendar year 2017 will reflect remeasurement year 1 and results of calendar year 2018 will reflect remeasurement year 2. January 2019 will be the start of the sustainability year for this MCO. All MCOs submitted a progress report update in September 2017 and is currently being reviewed by the EQRO.

Additionally, the MCOs submitted individual QIP proposals with the focus on Developmental Screening and Early Intervention. The initial proposals were submitted by the MCOs in September 2017 and are currently being reviewed by the EQRO, awaiting approval.

Lastly, all MCOs submitted individual QIP proposals in September 2015 on Falls Prevention specific to

members receiving managed long term services and supports. The individual proposals were approved and project activities were initiated by the MCOs in early 2016. The MCOs submitted a progress report in June 2016 which included the 2015 baseline data. The MCOs submitted a progress report update in September 2016 and was reviewed by the EQRO. January 2017 was the start of remeasurement year 2 for this QIP. The MCOs submitted a progress report in June 2017 which included the results of the remeasurement year 1 data and were reviewed by the EQRO. The MCOs submitted a progress report update in September 2017 and is currently being reviewed by the EQRO.
State Sanctions against MCO, ASO, SNP or PACE Organization:
There were sanctions given to Amerigroup, UnitedHealthcare Community Plan, and Horizon NJ Health for failure to achieve EPSDT during this quarter.

XII. Demonstration Evaluation

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

A.	***Expanding Medicaid managed care to include long-term care services and supports will result in improved access to care and quality of care and reduced costs, and allow more individuals to live in their communities instead of institutions.***
	The Center for State Health Policy (CSHP) draft final evaluation report covering all findings related to this hypothesis was submitted to the State in June 2017. Our activities during the quarter starting July 1, 2017 included general monitoring of ongoing activities related to MLTSS. CSHP attended the MAAC meeting in July and the MLTSS Steering Committee Meeting on September 28th.
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.***
	CSHP draft final evaluation report covering all findings related to this hypothesis was submitted to the State in June 2017. No further activities related to this hypothesis were undertaken during the following quarter.
C.	***Utilizing a projected spend-down provision and eliminating the look back period at time of application for transfer of assets for applicants or beneficiaries seeking long term services and supports whose income is at or below 100% of the FPL will simplify Medicaid eligibility and enrollment processes without compromising program integrity.***
	CSHP draft final evaluation report covering all findings related to this hypothesis was submitted to the State in June 2017. No further activities related to this hypothesis were undertaken during the following quarter.
D.	***The Delivery System Reform Incentive Payment (DSRIP) Program will result in better care for individuals (including access to care, quality of care, health outcomes), better health for the population, and lower cost through improvement.***
	In preparation for CSHP summative evaluation of the DSRIP program, activities in the past quarter included work on both the quantitative and qualitative aspects of our evaluation plan. On the quantitative side, CSHP Medicaid claims database for 2016 was finalized, and CSHP began updating the following DSRIP metrics through the 2016 calendar year: Initiation and Engagement of Alcohol and Other Drug Treatment, Mental Health Utilization-Inpatient, and ED Visits for Asthma. CSHP additionally started updating other variables for the year 2016. CSHP requested and received the

	2017 ICD-10 compliant readmissions metric specifications and SAS Packs from the Yale Center for Outcomes Research, and placed a request with the State for hospitals' DY4 and DY5 performance results on selected Stage 4 quality metrics to be analyzed as part of the summative evaluation. CSHP also explored the feasibility of getting NJ hospital discharge data for 2015-2016 to calculate certain quality metrics for the all-payer population. However, the ICD-10 transition has delayed the release of the public-use state inpatient database through HCUP. On the qualitative side, CSHP obtained IRB approval for consent documents and an interview guide for our key informant interviews and began recruiting interview subjects. Interviews will be conducted next quarter and will be analyzed for a qualitative chapter in our summative evaluation and also utilized to construct the next hospital web survey. Finally, CSHP kept abreast of changes to the DSRIP databook and the Funding and Mechanics Protocol, as well as other updates posted to the NJ DSRIP website.

XIII. Enclosures/Attachments

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

XIV. State Contact(s)

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XV. Date Submitted to CMS
November 29, 2017

Federal Budget Neutrality Summary

SUBJECT TO PUBLIC COMMENT PROCESS

Room Under the Budget Neutrality Cap	**$ 31,406,324,065**

	Total				
State Fiscal Year	Date of Service Budget Neutrality Ceiling*	CMS 64 Waiver Date of Service Expenditures	BN Savings Phase-Down	DSRIP Expenditures	Variance
Initial Waiver Period					
SFY13 Actual	$ 6,657,226,210	$ 5,891,234,624			$ 765,991,586
SFY14 Actual	$ 9,551,505,260	$ 8,176,436,192			$ 1,375,069,068
SFY15 Actual	$ 10,115,539,330	$ 8,107,136,429			$ 2,008,402,901
SFY16 Actual	$ 10,687,255,927	$ 8,160,312,456			$ 2,526,943,471
SFY17 Actual	$ 11,145,351,553	$ 8,448,257,992			$ 2,697,093,562
SFY13-17	$ 48,156,878,279	$ 38,783,377,693	$ -	$ -	$ 9,373,500,587
First Waiver Extension Period					
SFY18 Projected	$ 11,882,440,668	$ 8,313,481,043			$ 3,568,959,625
SFY19 Projected	$ 12,670,438,538	$ 8,850,000,566			$ 3,820,437,972
SFY20 Projected	$ 13,513,019,727	$ 9,239,280,061			$ 4,273,739,666
SFY21 Projected	$ 14,414,135,160	$ 9,489,049,737			$ 4,925,085,423
SFY22 Projected	$ 15,378,033,655	$ 9,933,432,863			$ 5,444,600,793
SFY18-22	$ 67,858,067,748	$ 45,825,244,270			$ 22,032,823,478
Second Waiver Extension Period					
Total					**$ 31,406,324,065**

Budget Neutrality Monitoring Spreadsheet

Main Budget Neutrality Test

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

TOTAL COMPUTABLE

Waiver Year	1	2	3	4	5	***Demo***		6	7	8	9	10	***Renewal***
State Fiscal Year	2013	2014	2015	2016	2017	***Period 1***		2018	2019	2020	2021	2022	***Period 1***
NO WAIVER													
Title XIX	$ 1,888,003,055	$ 2,721,828,868	$ 3,190,622,964	$ 3,450,278,327	$ 3,618,285,034	**$ 14,869,018,248**		$ 3,929,974,862	$ 4,268,514,578	$ 4,636,217,112	$ 5,035,594,635	$ 5,469,375,725	$ 23,339,676,911
***ABD/LTC/HCBS State Plan**	$ 4,769,223,154	$ 6,829,676,392	$ 6,924,916,366	$ 7,236,977,599	$ 7,527,066,520	**$ 33,287,860,032**		$ 7,952,465,806	$ 8,401,923,960	$ 8,876,802,615	$ 9,378,540,525	$ 9,908,657,931	$ 44,518,390,837
	$ -	$ -	$ -	$ -	$ -	**$ -**		$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	**$ -**		$ -	$ -	$ -	$ -	$ -	$ -
NO WAIVER -TOTAL COMPUTABLE	**$ 6,657,226,210**	**$ 9,551,505,260**	**$ 10,115,539,330**	**$ 10,687,255,927**	**$ 11,145,351,553**	**$ 48,156,878,279**		**$ 11,882,440,668**	**$ 12,670,438,538**	**$ 13,513,019,727**	**$ 14,414,135,160**	**$ 15,378,033,655**	**$ 67,858,067,748**
WITH WAIVER													
Title XIX	$ 1,660,533,500	$ 2,401,028,803	$ 2,585,155,172	$ 2,542,349,561	$ 2,543,100,659	**$ 11,732,167,695**		$ 2,896,176,183	$ 3,145,661,408	$ 3,416,638,032	$ 3,710,957,388	$ 4,030,630,288	$ 17,200,063,301
****ABD/LTC/HCBS State Plan**	$ 4,009,676,348	$ 5,468,130,944	$ 5,219,407,337	$ 5,283,892,825	$ 5,508,360,696	**$ 25,489,468,150**		$ 5,209,108,223	$ 5,496,142,521	$ 5,614,445,392	$ 5,735,895,711	$ 5,860,605,937	$ 27,916,197,784
HCBS state plan	$ -	$ -	$ -	$ -	$ -	**$ -**		$ -	$ -	$ -	$ -	$ -	$ -
DDD Supports-PDN	$ -	$ -	$ -	$ -	$ -			$ -	$ -	$ -	$ -	$ -	$ -
DSRIP	$ 192,443,637	$ 266,607,552	$ 266,600,001	$ 293,872,727	$ 354,600,000	**$ 1,374,123,917**		$ 166,000,000	$ 166,000,000	$ 166,000,000	$ -	$ -	$ 498,000,000
CNOMS	$ 28,581,139	$ 40,668,893	$ 35,973,919	$ 40,197,343	$ 42,196,637	**$ 187,617,931**		$ 42,196,637	$ 42,196,637	$ 42,196,637	$ 42,196,637	$ 42,196,637	$ 210,983,185
WITH WAIVER - TOTAL COMPUTABLE	**$ 5,891,234,624**	**$ 8,176,436,192**	**$ 8,107,136,429**	**$ 8,160,312,456**	**$ 8,448,257,992**	**$ 38,783,377,693**		**$ 8,313,481,043**	**$ 8,850,000,566**	**$ 9,239,280,061**	**$ 9,489,049,737**	**$ 9,933,432,863**	**$ 45,825,244,270**
Difference	**$ 765,991,586**	**$ 1,375,069,068**	**$ 2,008,402,901**	**$ 2,526,943,471**	**$ 2,697,093,562**	**$ 9,373,500,587**		**$ 3,568,959,625**	**$ 3,820,437,972**	**$ 4,273,739,666**	**$ 4,925,085,423**	**$ 5,444,600,793**	***$ 22,032,823,478***

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

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

FEDERAL SHARE

Waiver Year	1	2	3	4	5	***Demo***		6	7	8	9	10	***Renewal***
State Fiscal Year	2013	2014	2015	2016	2017	***Period 1***		2018	2019	2020	2021	2022	***Period 1***
NO WAIVER													
Title XIX	$ 947,820,711	$ 1,506,507,404	$ 1,750,305,401	$ 1,750,856,075	$ 1,817,908,487	**$ 7,773,398,078**		$ 1,968,328,398	$ 2,137,886,057	$ 2,322,049,917	$ 2,522,078,199	$ 2,739,337,512	**$ 11,689,680,085**
***ABD/LTC/HCBS State Plan**	$ 2,391,868,093	$ 3,436,667,374	$ 3,480,683,737	$ 3,625,364,745	$ 3,766,466,934	**$ 16,701,050,884**		$ 3,979,639,438	$ 4,204,561,095	$ 4,442,203,898	$ 4,693,287,840	$ 4,958,573,694	**$ 22,278,265,966**
	$ -	$ -	$ -	$ -	$ -	**$ -**		$ -	$ -	$ -	$ -	$ -	**$ -**
	$ -	$ -	$ -	$ -	$ -	**$ -**		$ -	$ -	$ -	$ -	$ -	**$ -**
NO WAIVER - FEDERAL SHARE	**$ 3,339,688,804**	**$ 4,943,174,778**	**$ 5,230,989,138**	**$ 5,376,220,820**	**$ 5,584,375,421**	**$ 24,474,448,962**		**$ 5,947,967,836**	**$ 6,342,447,153**	**$ 6,764,253,816**	**$ 7,215,366,040**	**$ 7,697,911,206**	**$ 33,967,946,051**
WITH WAIVER													
Title XIX	$ 833,625,792	$ 1,328,947,500	$ 1,418,159,122	$ 1,290,124,376	$ 1,277,711,465	**$ 6,148,568,255**		$ 1,450,550,202	$ 1,575,504,908	$ 1,711,223,584	$ 1,858,633,470	$ 2,018,741,682	**$ 8,614,653,844**
****ABD/LTC/HCBS State Plan**	$ 2,011,078,841	$ 2,751,925,469	$ 2,624,022,315	$ 2,647,177,908	$ 2,756,310,228	**$ 12,790,514,762**		$ 2,606,687,350	$ 2,750,321,892	$ 2,809,515,744	$ 2,870,284,161	$ 2,932,683,391	**$ 13,969,492,538**
HCBS state plan	$ -	$ -	$ -	$ -	$ -	**$ -**		$ -	$ -	$ -	$ -	$ -	**$ -**
HOLD DDD Supports-PDN	$ -	$ -	$ -	$ -	$ -	**$ -**		$ -	$ -	$ -	$ -	$ -	**$ -**
DSRIP	$ 96,221,820	$ 149,756,377	$ 148,380,003	$ 168,585,269	$ 207,066,669	**$ 770,010,137**		$ 83,000,002	$ 83,000,002	$ 83,000,002	$ -	$ -	**$ 249,000,006**
CNOMS	$ 14,798,341	$ 21,084,004	$ 18,690,296	$ 20,299,658	$ 21,098,319	**$ 95,970,618**		$ 21,098,319	$ 21,098,319	$ 21,098,319	$ 21,098,319	$ 21,098,319	**$ 105,491,593**
WITH WAIVER - FEDERAL SHARE	**$ 2,955,724,794**	**$ 4,251,713,350**	**$ 4,209,251,736**	**$ 4,126,187,211**	**$ 4,262,186,680**	**$ 19,805,063,771**		**$ 4,161,335,872**	**$ 4,429,925,120**	**$ 4,624,837,648**	**$ 4,750,015,949**	**$ 4,972,523,391**	**$ 22,938,637,980**
	$ 2,011,069,653												
Difference	**$ 383,964,010**	**$ 691,461,428**	**$ 1,021,737,403**	**$ 1,250,033,609**	**$ 1,322,188,741**	**$ 4,669,385,191**		**1,786,631,964**	**1,912,522,033**	**2,139,416,167**	**2,465,350,091**	**2,725,387,816**	**11,029,308,070**

Notes:

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

Budget Neutrality Monitoring Spreadsheet

Supplemental Test #1

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

TOTAL COMPUTABLE

Waiver Year	1	2	3	4	5	***Demo***		6	7	8	9	10	***Renewal***
State Fiscal Year	2013	2014	2015	2016	2017	***Period 1***		2018	2019	2020	2021	2022	***Period 1***
NO WAIVER													
HCBS 217-like	$ 217,434,338	$ 299,298,600	$ 296,727,244	$ 333,440,492	$ 383,231,508	**$ 1,530,132,182**		$ 404,705,927	$ 427,383,667	$ 451,332,156	$ 476,622,602	$ 503,330,200	**$ 2,263,374,552**
Adults w/o Depend. Children	$ 1,677,789	$ 798,912	$ -	$ -	$ -	**$ 2,476,701**		$ -	$ -	$ -	$ -	$ -	**$ -**
SED 217-like	$ 253,840	$ 345,267	$ 290,262	$ 256,844	$ 5,235,238	**$ 6,381,451**		$ 5,651,215	$ 6,100,246	$ 6,584,955	$ 7,108,177	$ 7,672,974	**$ 33,117,567**
Former XIX Chip Parents	$ -	$ 140,335,250	$ -	$ -	$ -	**$ 140,335,250**		$ -	$ -	$ -	$ -	$ -	**$ -**
IDD/MI	$ -	$ -	$ 6,423,263	$ 34,933,951	$ 44,272,008	**$ 85,629,222**		$ 47,789,742	$ 51,586,986	$ 55,685,948	$ 60,110,602	$ 64,886,828	**$ 280,060,106**
NO WAIVER -TOTAL COMPUTABLE	**$ 219,365,967**	**$ 440,778,028**	**$ 303,440,769**	**$ 368,631,287**	**$ 432,738,754**	**$ 1,764,954,806**		**$ 458,146,884**	**$ 485,070,898**	**$ 513,603,059**	**$ 543,841,382**	**$ 575,890,003**	**$ 2,576,552,224**
WITH WAIVER													
HCBS 217-like	$ 207,465,132	$ 278,302,398	$ 331,234,441	$ 375,718,137	$ 402,567,552	**$ 1,595,287,660**		$ 456,020,011	$ 481,573,141	$ 508,558,144	$ 537,055,254	$ 567,149,203	**$ 2,550,355,753**
Adults w/o Depend. Children	$ 1,529,772	$ 674,018	$ -	$ -	$ -	**$ 2,203,790**		$ -	$ -	$ -	$ -	$ -	**$ -**
SED 217-like	$ 83	$ 58,922	$ 27,837	$ 96,680	$ 12,116,668	**$ 12,300,190**		$ 13,079,426	$ 14,118,681	$ 15,240,514	$ 16,451,484	$ 17,758,674	**$ 76,648,778**
Former XIX Chip Parents	$ -	$ 126,863,607	$ -	$ -	$ -	**$ 126,863,607**		$ -	$ -	$ -	$ -	$ -	**$ -**
IDD/MI	$ -	$ -	$ 1,186,792	$ 7,798,525	$ 10,750,786	**$ 19,736,103**		$ 10,668,406	$ 11,516,088	$ 12,431,125	$ 13,418,869	$ 14,485,096	**$ 62,519,584**
WITH WAIVER - TOTAL COMPUTABLE	**$ 208,994,987**	**$ 405,898,945**	**$ 332,449,070**	**$ 383,613,342**	**$ 425,435,006**	**$ 1,756,391,350**		**$ 479,767,842**	**$ 507,207,911**	**$ 536,229,783**	**$ 566,925,607**	**$ 599,392,973**	**$ 2,689,524,116**
Difference	**$ 10,370,980**	**$ 34,879,083**	**$ (29,008,301)**	**$ (14,982,055)**	**$ 7,303,748**	**$ 8,563,456**		**$ (21,620,959)**	**$ (22,137,013)**	**$ (22,626,724)**	**$ (23,084,225)**	**$ (23,502,970)**	**$ (112,971,891)**

FEDERAL SHARE

Waiver Year	1	2	3	4	5	***Demo***		6	7	8	9	10	***Renewal***
State Fiscal Year	2013	2014	2015	2016	2017	***Period 1***		2018	2019	2020	2021	2022	***Period 1***
NO WAIVER													
HCBS 217-like	$ 110,183,049	$ 154,284,438	$ 152,379,548	$ 167,842,602	$ 191,637,762	**$ 776,327,399**		$ 202,360,417	$ 213,699,704	$ 225,674,390	$ 238,320,079	$ 251,674,370	**$ 1,131,728,959**
Adults w/o Depend. Children	$ 852,857	$ 408,324	$ -	$ -	$ -	**$ 1,261,182**		$ -	$ -	$ -	$ -	$ -	**$ -**
SED 217-like	$ -	$ 172,639	$ 145,397	$ 129,706	$ 2,617,619	**$ 3,065,361**		$ 2,825,608	$ 3,050,123	$ 3,292,477	$ 3,554,089	$ 3,836,487	**$ 16,558,783**
Former XIX Chip Parents	$ -	$ 71,621,870	$ -	$ -	$ -	**$ 71,621,870**		$ -	$ -	$ -	$ -	$ -	**$ -**
IDD/MI	$ -	$ -	$ 3,244,338	$ 17,467,007	$ 22,248,738	**$ 42,960,083**		$ 24,016,562	$ 25,924,853	$ 27,984,772	$ 30,208,366	$ 32,608,641	**$ 140,743,195**
NO WAIVER -TOTAL COMPUTABLE	**$ 111,035,906**	**$ 226,487,272**	**$ 155,769,283**	**$ 185,439,316**	**$ 216,504,118**	**$ 895,235,895**		**$ 229,202,587**	**$ 242,674,680**	**$ 256,951,639**	**$ 272,082,534**	**$ 288,119,498**	**$ 1,289,030,938**
WITH WAIVER													
HCBS 217-like	$ 105,131,236	$ 143,461,176	$ 170,100,169	$ 189,123,731	$ 201,306,894	**$ 809,123,206**		$ 228,018,404	$ 240,795,440	$ 254,288,438	$ 268,537,518	$ 283,585,046	**$ 1,275,224,845**
Adults w/o Depend. Children	$ 777,617	$ 344,491	$ -	$ -	$ -	**$ 1,122,108**		$ -	$ -	$ -	$ -	$ -	**$ -**
SED 217-like	$ -	$ 29,462	$ 13,944	$ 48,823	$ 6,058,334	**$ 6,150,563**		$ 6,539,713	$ 7,059,341	$ 7,620,257	$ 8,225,742	$ 8,879,337	**$ 38,324,389**
Former XIX Chip Parents	$ -	$ 64,746,447	$ -	$ -	$ -	**$ 64,746,447**		$ -	$ -	$ -	$ -	$ -	**$ -**
IDD/MI	$ -	$ -	$ 599,439	$ 3,899,270	$ 5,402,769	**$ 9,901,477**		$ 5,361,369	$ 5,787,369	$ 6,247,217	$ 6,743,604	$ 7,279,433	**$ 31,418,991**
WITH WAIVER - TOTAL COMPUTABLE	**$ 105,908,853**	**$ 208,581,576**	**$ 170,713,552**	**$ 193,071,824**	**$ 212,767,997**	**$ 891,043,802**		**$ 239,919,485**	**$ 253,642,149**	**$ 268,155,912**	**$ 283,506,864**	**$ 299,743,816**	**$ 1,344,968,226**
Difference	**$ 5,127,053**	**$ 17,905,696**	**$ (14,944,269)**	**$ (7,632,508)**	**$ 3,736,122**	**$ 4,192,094**		**$ (10,716,899)**	**$ (10,967,468)**	**$ (11,204,272)**	**$ (11,424,330)**	**$ (11,624,318)**	**$ (55,937,288)**

Budget Neutrality Monitoring Spreadsheet

Supplemental Test #2

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

TOTAL COMPUTABLE

Waiver Year	1	2	3	4	5	*Demo*		6	7	8	9	10	*Renewal*
State Fiscal Year	2013	2014	2015	2016	2017	*Period 1*		2018	2019	2020	2021	2022	*Period 1*
NO WAIVER													
New Adult Group	$ -	$ 655,329,429	$ 3,208,229,680	$ 3,490,111,740	$ 3,706,632,521	**$ 11,060,303,369**		$ 3,963,404,797	$ 4,237,964,648	$ 4,531,544,285	$ 4,845,461,280	$ 5,181,124,478	**$ 22,759,499,488**
NO WAIVER -TOTAL COMPUTABLE	**$ -**	**$ 655,329,429**	**$ 3,208,229,680**	**$ 3,490,111,740**	**$ 3,706,632,521**	$ 11,060,303,369		**$ 3,963,404,797**	**$ 4,237,964,648**	**$ 4,531,544,285**	**$ 4,845,461,280**	**$ 5,181,124,478**	**$ 22,759,499,488**
WITH WAIVER													
New Adult Group	$ -	$ 849,302,769	$ 2,859,089,720	$ 2,911,520,516	$ 3,101,628,329	**$ 9,721,541,334**		$ 3,306,350,982	$ 3,535,394,262	$ 3,780,304,225	$ 4,042,180,015	$ 4,322,196,920	**$ 18,986,426,404**
WITH WAIVER - TOTAL COMPUTABLE	**$ -**	**$ 849,302,769**	**$ 2,859,089,720**	**$ 2,911,520,516**	**$ 3,101,628,329**	$ 9,721,541,334		**$ 3,306,350,982**	**$ 3,535,394,262**	**$ 3,780,304,225**	**$ 4,042,180,015**	**$ 4,322,196,920**	**$ 18,986,426,404**
Difference	**$ -**	**$ (193,973,340)**	**$ 349,139,960**	**$ 578,591,224**	**$ 605,004,192**	**$ 1,338,762,035**		**$ 657,053,815**	**$ 702,570,386**	**$ 751,240,060**	**$ 803,281,265**	**$ 858,927,558**	**$ 3,773,073,084**

FEDERAL SHARE

Waiver Year	1	2	3	4	5	*Demo*		6	7	8	9	10	*Renewal*
State Fiscal Year	2013	2014	2015	2016	2017	*Period 1*		2018	2019	2020	2021	2022	*Period 1*
NO WAIVER													
New Adult Group	$ -	$ 655,312,015	$ 3,208,089,476	$ 3,488,602,179	$ 3,613,966,707	**$ 10,965,970,377**		$ 3,745,417,533	$ 3,962,496,946	$ 4,146,363,021	$ 4,360,915,152	$ 4,663,012,030	**$ 20,878,204,682**
NO WAIVER -TOTAL COMPUTABLE	**$ -**	**$ 655,312,015**	**$ 3,208,089,476**	**$ 3,488,602,179**	**$ 3,613,966,707**	$ 10,965,970,377		**$ 3,745,417,533**	**$ 3,962,496,946**	**$ 4,146,363,021**	**$ 4,360,915,152**	**$ 4,663,012,030**	**$ 20,878,204,682**
WITH WAIVER													
New Adult Group	$ -	$ 849,280,201	$ 2,858,964,774	$ 2,910,261,210	$ 3,024,087,621	**$ 9,642,593,806**		$ 3,124,501,678	$ 3,305,593,635	$ 3,458,978,366	$ 3,637,962,014	$ 3,889,977,228	$ 17,417,012,920
WITH WAIVER - TOTAL COMPUTABLE	**$ -**	**$ 849,280,201**	**$ 2,858,964,774**	**$ 2,910,261,210**	**$ 3,024,087,621**	$ 9,642,593,806		**$ 3,124,501,678**	**$ 3,305,593,635**	**$ 3,458,978,366**	**$ 3,637,962,014**	**$ 3,889,977,228**	**$ 17,417,012,920**
Difference	**$ -**	**$ (193,968,186)**	**$ 349,124,702**	**$ 578,340,969**	**$ 589,879,087**	**$ 1,323,376,572**		**$ 620,915,855**	**$ 656,903,311**	**$ 687,384,655**	**$ 722,953,138**	**$ 773,034,802**	**$ 3,461,191,762**

Notes:

1. Federal share is calculated using Composite Federal Share Ratios (source data is CMS 64 Schedule C as reported in QE Sept2017 with a run date of Nov 06, 2017).
2. Member-months based on MMIS report with last actual reported as of Sept 2017.
3. "With Waiver" pmpm's based on calculations using Sch C expenditures and MMIS eligibility actual member-months reported through Sept

Federal Budget Neutrality - Cap

TOTAL EXPENDITURES IN WAIVER	**$6,876,592,177**	**$10,647,612,717**	**$13,627,209,779**	**$14,545,998,954**	**$15,284,722,827**	**$60,982,136,454**		**$16,303,992,349**	**$17,393,474,083**	**$18,558,167,071**	**$19,803,437,822**	**$21,135,048,135**	**$93,194,119,460**	
														Original STC
Waiver Year	1	2	3	4	5	***Demo***		6	7	8	9	10	***Renewal***	Growth %'s
State Fiscal Year	2013	2014	2015	2016	2017	***Period 1***		2018	2019	2020	2021	2022	***Period 1***	used for
Member Months	*actual*	*actual*	*actual*	*actual*	*actual*			*projected*	*projected*	*projected*	*projected*	*projected*		BN
Title XIX	5,773,180	7,850,901	8,699,959	8,893,616	8,816,484			9,051,004	9,291,762	9,538,924	9,792,661	10,053,148		2.7%
***ABD/LTC/HCBS State Plan**	2,499,711	3,452,152	3,381,631	3,402,743	3,385,777			3,447,926	3,511,216	3,575,668	3,641,302	3,708,142		1.8%
														1.8%
														1.8%
Total Waiver Member Months	**8,272,891**	**11,303,053**	**12,081,590**	**12,296,359**	**12,202,261**			**12,498,930**	**12,802,978**	**13,114,592**	**13,433,964**	**13,761,290**		
Per Member Per Month														
Title XIX	$327.03	$346.69	$366.74	$387.95	$410.40			$434.20	$459.39	$486.03	$514.22	$544.05		5.8%
***ABD/LTC/HCBS State Plan**	$1,907.91	$1,978.38	$2,047.80	$2,126.81	$2,223.14			$2,306.45	$2,392.88	$2,482.56	$2,575.60	$2,672.14		3.75%
Total Expenditures (Member Months x PMPM)														
Title XIX	$1,888,003,055	$2,721,828,868	$3,190,622,964	$3,450,278,327	$3,618,285,034	**$14,869,018,248**		**$3,929,974,862**	**$4,268,514,578**	**$4,636,217,112**	**$5,035,594,635**	**$5,469,375,725**	**$23,339,676,911**	
***ABD/LTC/HCBS State Plan**	$4,769,223,154	$6,829,676,392	$6,924,916,366	$7,236,977,599	$7,527,066,520	**$33,287,860,032**		**$7,952,465,806**	**$8,401,923,960**	**$8,876,802,615**	**$9,378,540,525**	**$9,908,657,931**	**$44,518,390,837**	
Total Base Expenditures	**$6,657,226,210**	**$9,551,505,260**	**$10,115,539,330**	**$10,687,255,927**	**$11,145,351,553**	**$48,156,878,279**		**$11,882,440,668**	**$12,670,438,538**	**$13,513,019,727**	**$14,414,135,160**	**$15,378,033,655**	**$67,858,067,748**	
** ABD, LTC, and HCBS State Plan Member Months, PMPM, and Total Expenditures are combined in the WOW Cap Consolidated Calculation*														
Hypothetical Population Expenditures														
HCBS 217-Like	$217,434,338	$299,298,600	$296,727,244	$333,440,492	$383,231,508	**$1,530,132,182**		**$404,705,927**	**$427,383,667**	**$451,332,156**	**$476,622,602**	**$503,330,200**	**$2,263,374,552**	
***Adults w/o Dependent Children**	$1,677,789	$798,912	$0	$0	$0	**$2,476,701**		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	
SED 217-Like	$253,840	$345,267	$290,262	$256,844	$5,235,238	**$6,381,451**		**$5,651,215**	**$6,100,246**	**$6,584,955**	**$7,108,177**	**$7,672,974**	**$33,117,567**	
***XIX CHIP Parents**	$0	$140,335,250	$0	$0	$0	**$140,335,250**		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	
IDD/MI	$0	$0	$6,423,263	$34,933,951	$44,272,008	**$85,629,222**		**$47,789,742**	**$51,586,986**	**$55,685,948**	**$60,110,602**	**$64,886,828**	**$280,060,106**	
New Adult Group	$0	$655,329,429	$3,208,229,680	$3,490,111,740	$3,706,632,521	**$11,060,303,369**		**$3,963,404,797**	**$4,237,964,648**	**$4,531,544,285**	**$4,845,461,280**	**$5,181,124,478**	**$22,759,499,488**	
Total Hypothetical Expenditures	**$219,365,967**	**$1,096,107,457**	**$3,511,670,449**	**$3,858,743,027**	**$4,139,371,274**	**$12,825,258,175**		**$4,421,551,681**	**$4,723,035,546**	**$5,045,147,344**	**$5,389,302,662**	**$5,757,014,480**	**$25,336,051,712**	
** Adults w/o Dependent Chidren and Title XIX CHIP Parents are now in New Adult Group as of 1/1/14.*														

With Waiver - Expenditures

TOTAL EXPENDITURES IN WAIVER	**$6,100,229,611**	**$9,431,637,906**	**$11,298,675,219**	**$11,455,446,314**	**$11,975,321,327**	**$50,261,310,377**		**$12,099,599,867**	**$12,892,602,739**	**$13,555,814,069**	**$14,098,155,359**	**$14,855,022,755**	**$67,501,194,789**	
														Original STC
Waiver Year	1	2	3	4	5	***Demo***		6	7	8	9	10	***Renewal***	Growth %'s
State Fiscal Year	2013	2014	2015	2016	2017	***Period 1***		2018	2019	2020	2021	2022	***Period 1***	used for
Member Months	*actual*	*actual*	*actual*	*actual*	*estimated*			*projected*	*projected*	*projected*	*projected*	*projected*		BN
Title XIX	5,773,180	7,850,901	8,699,959	8,893,616	8,816,484			9,051,004	9,291,762	9,538,924	9,792,661	10,053,148		2.7%
***ABD/LTC/HCBS State Plan**	2,499,711	3,361,590	3,381,631	3,401,925	3,357,056			3,046,489	3,102,410	3,159,358	3,217,351	3,276,409		1.8%
														1.8%
														1.8%
Total Waiver Member Months	**8,272,891**	**11,212,491**	**12,081,590**	**12,295,541**	**12,173,540**			**12,097,493**	**12,394,172**	**12,698,283**	**13,010,013**	**13,329,557**		
Per Member Per Month														
Title XIX	$287.63	$305.83	$297.15	$285.86	$302.44			$319.98	$338.54	$358.18	$378.95	$400.93		5.8%
***ABD/LTC/HCBS State Plan**	$1,604.06	$1,626.65	$1,543.46	$1,553.21	$1,609.12			$1,667.05	$1,727.06	$1,727.06	$1,727.06	$1,727.06		3.6%
														3.9%
														3.7%
Total Expenditures (Member Months x PMPM)														
Title XIX	$1,660,533,500	$2,401,028,803	$2,585,155,172	$2,542,349,561	$2,543,100,659	**$11,732,167,695**		$2,896,176,183	$3,145,661,408	$3,416,638,032	$3,710,957,388	$4,030,630,288	**$17,200,063,301**	
***ABD/LTC/HCBS State Plan**	$4,009,676,348	$5,468,130,944	$5,219,407,337	$5,283,892,825	$5,508,360,696	**$25,489,468,150**		$5,209,108,223	$5,496,142,521	$5,614,445,392	$5,735,895,711	$5,860,605,937	**$27,916,197,784**	
Total Base Actual Expenditures	**$5,670,209,848**	**$7,869,159,747**	**$7,804,562,509**	**$7,826,242,386**	**$8,051,461,355**	**$37,221,635,845**		**$8,105,284,406**	**$8,641,803,929**	**$9,031,083,424**	**$9,446,853,100**	**$9,891,236,226**	**$45,116,261,085**	
** ABD, LTC, and HCBS State Plan Member Months, PMPM, and Total Expenditures are combined in the Actuals Consolidated Calculation*														
Hypothetical Population Expenditures														
HCBS 217-Like	$207,465,132	$278,302,398	$331,234,441	$375,718,137	$402,567,552	**$1,595,287,660**		$456,020,011	$481,573,141	$508,558,144	$537,055,254	$567,149,203	**$2,550,355,753**	
****Adults w/o Dependent Children**	$1,529,772	$674,018	$0	$0	$0	**$2,203,790**		$0	$0	$0	$0	$0	**$0**	
SED 217-Like	$83	$58,922	$27,837	$96,680	$12,116,668	**$12,300,190**		$13,079,426	$14,118,681	$15,240,514	$16,451,484	$17,758,674	**$76,648,778**	
****XIX CHIP Parents**	$0	$126,863,607	$0	$0	$0	**$126,863,607**		$0	$0	$0	$0	$0	**$0**	
IDD/MI - 217-Like	$0	$0	$1,186,792	$7,798,525	$10,750,786	**$19,736,103**		$10,668,406	$11,516,088	$12,431,125	$13,418,869	$14,485,096	**$62,519,584**	
New Adult Group	$0	$849,302,769	$2,859,089,720	$2,911,520,516	$3,101,628,329	**$9,721,541,334**		$3,306,350,982	$3,535,394,262	$3,780,304,225	$4,042,180,015	$4,322,196,920	**$18,986,426,404**	
Total Hypothetical Expenditures	**$208,994,987**	**$1,255,201,714**	**$3,191,538,790**	**$3,295,133,858**	**$3,527,063,335**	**$11,477,932,684**		**$3,786,118,825**	**$4,042,602,173**	**$4,316,534,008**	**$4,609,105,622**	**$4,921,589,892**	**$21,675,950,519**	
*** Adults w/o Dependent Chidren and Title XIX CHIP Parents are now in New Adult Group as of 1/1/14.*														
Supports Program	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	
Hospital Subsidies														
HRSF & GME	$ 192,443,637	$ -	$ -	$ -	$ -	**$192,443,637**		$ -	$ -	$ -	$ -	$ -	**$0**	
HRSF Transition Payments	$ -	$ 83,302,681	$ -	$ -	$ -	**$83,302,681**							**$0**	
GME State Plan	-	100,000,001	100,000,000	127,272,727	188,000,000	**$515,272,728**		-	-	-	-	-	**$0**	
DSRIP	-	83,304,870	166,600,001	166,600,000	166,600,000	**$583,104,871**		166,000,000	166,000,000	166,000,000	-	-	**$498,000,000**	
Hospital Subsidies Expenditures	**$ 192,443,637**	**$ 266,607,552**	**$ 266,600,001**	**$ 293,872,727**	**$ 354,600,000**	**$1,374,123,917**		**$ 166,000,000**	**$ 166,000,000**	**$ 166,000,000**	**$ -**	**$ -**	**$498,000,000**	
Costs Otherwise Not Matchable (CNOMs)														
SED at Risk	$ 24,511,364	$ 37,239,735	$ 35,973,919	$ 40,197,343	$ 42,196,637	**$180,118,998**		$ 42,196,637	$ 42,196,637	$ 42,196,637	$ 42,196,637	$ 42,196,637	**$210,983,185**	
MATI at Risk	4,069,775	3,429,158	-	-	-	**$7,498,933**		-					**$0**	
DDD non-Disabled Adult Children	-	-	-											
DDD Community / Supports Equalizatior	-	-	-											
CNOM Expenditures	***$ 28,581,139***	***$ 40,668,893***	***$ 35,973,919***	***$ 40,197,343***	***$ 42,196,637***	**$187,617,931**		***$ 42,196,637***	***$ 42,196,637***	***$ 42,196,637***	***$ 42,196,637***	***$ 42,196,637***	**$210,983,185**	

Federal Budget Neutrality - Cap

TOTAL EXPENDITURES IN WAIVER	**$6,876,592,177**	**$10,647,612,717**	**$13,627,209,779**	**$14,545,998,954**	**$15,284,722,827**	**$60,982,136,454**		**$16,303,992,349**	**$17,393,474,083**	**$18,558,167,071**	**$19,803,437,822**	**$21,135,048,135**	**$93,194,119,460**	
														Original STC
Waiver Year	1	2	3	4	5	***Demo***		6	7	8	9	10	***Renewal***	Growth %'s
State Fiscal Year	2013	2014	2015	2016	2017	***Period 1***		2018	2019	2020	2021	2022	***Period 1***	used for
Member Months	*actual*	*actual*	*actual*	*actual*	*estimated*			*projected*	*projected*	*projected*	*projected*	*projected*		BN
Title XIX	5,773,180	7,850,901	8,699,959	8,893,616	8,816,484			9,051,004	9,291,762	9,538,924	9,792,661	10,053,148		2.7%
ABD	2,204,173	3,060,786	2,994,122	2,983,807	2,929,087			2,982,853	3,037,606	3,093,364	3,150,146	3,207,970		1.8%
LTC	281,944	372,506	361,853	359,894	358,389			364,968	371,667	378,489	385,437	392,512		1.8%
HCBS State Plan	13,594	18,860	25,656	59,042	98,301			100,105	101,943	103,814	105,720	107,660		1.8%
Total Waiver Member Months	**8,272,891**	**11,303,053**	**12,081,590**	**12,296,359**	**12,202,261**			**12,498,930**	**12,802,978**	**13,114,592**	**13,433,964**	**13,761,290**		
Per Member Per Month														
Title XIX	$327.03	$346.69	$366.74	$387.95	$410.40			$434.20	$459.39	$486.03	$514.22	$544.05		5.8%
ABD	$1,045.04	$1,124.49	$1,164.91	$1,206.78	$1,250.17			$1,295.18	$1,341.80	$1,390.11	$1,440.15	$1,492.00		3.6%
LTC	$8,636.81	$8,975.89	$9,325.83	$9,689.41	$10,067.17			$10,459.79	$10,867.72	$11,291.56	$11,731.93	$12,189.48		3.9%
HCBS State Plan	$2,256.69	$2,347.84	$2,434.29	$2,523.94	$2,616.93			$2,713.76	$2,814.17	$2,918.29	$3,026.27	$3,138.24		3.7%
Total Expenditures (Member Months x PMPM)														
Title XIX	$1,888,003,055	$2,721,828,868	$3,190,622,964	$3,450,278,327	$3,618,285,034	**$14,869,018,248**		**$3,929,974,862**	**$4,268,514,578**	**$4,636,217,112**	**$5,035,594,635**	**$5,469,375,725**	**$23,339,676,911**	
ABD	$2,303,448,952	$3,441,823,249	$3,487,882,659	$3,600,798,611	$3,661,856,695	**$16,495,810,166**		**$3,863,320,154**	**$4,075,867,477**	**$4,300,108,464**	**$4,536,686,462**	**$4,786,280,212**	**$21,562,262,769**	
LTC	$2,435,096,759	$3,343,572,880	$3,374,579,563	$3,487,160,523	$3,607,962,989	**$16,248,372,714**		**$3,817,483,963**	**$4,039,172,201**	**$4,273,734,278**	**$4,521,917,801**	**$4,784,513,793**	**$21,436,822,036**	
HCBS State Plan	$30,677,444	$44,280,262	$62,454,144	$149,018,465	$257,246,836	**$543,677,152**		**$271,661,690**	**$286,884,282**	**$302,959,873**	**$319,936,262**	**$337,863,925**	**$1,519,306,032**	
Total Base Expenditures	**$6,657,226,210**	**$9,551,505,260**	**$10,115,539,330**	**$10,687,255,927**	**$11,145,351,553**	**$48,156,878,279**		**$11,882,440,668**	**$12,670,438,538**	**$13,513,019,727**	**$14,414,135,160**	**$15,378,033,655**	**$67,858,067,748**	
Hypothetical Population Expenditures														
HCBS 217-Like	$217,434,338	$299,298,600	$296,727,244	$333,440,492	$383,231,508	**$1,530,132,182**		**$404,705,927**	**$427,383,667**	**$451,332,156**	**$476,622,602**	**$503,330,200**	**$2,263,374,552**	
***Adults w/o Dependent Children**	$1,677,789	$798,912	$0	$0	$0	**$2,476,701**		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	
SED 217-Like	$253,840	$345,267	$290,262	$256,844	$5,235,238	**$6,381,451**		**$5,651,215**	**$6,100,246**	**$6,584,955**	**$7,108,177**	**$7,672,974**	**$33,117,567**	
***XIX CHIP Parents**	$0	$140,335,250	$0	$0	$0	**$140,335,250**		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	
IDD/MI	$0	$0	$6,423,263	$34,933,951	$44,272,008	**$85,629,222**		**$47,789,742**	**$51,586,986**	**$55,685,948**	**$60,110,602**	**$64,886,828**	**$280,060,106**	
New Adult Group	$0	$655,329,429	$3,208,229,680	$3,490,111,740	$3,706,632,521	**$11,060,303,369**		**$3,963,404,797**	**$4,237,964,648**	**$4,531,544,285**	**$4,845,461,280**	**$5,181,124,478**	**$22,759,499,488**	
Total Hypothetical Expenditures	**$219,365,967**	**$1,096,107,457**	**$3,511,670,449**	**$3,858,743,027**	**$4,139,371,274**	**$12,825,258,175**		**$4,421,551,681**	**$4,723,035,546**	**$5,045,147,344**	**$5,389,302,662**	**$5,757,014,480**	**$25,336,051,712**	
** Adults w/o Dependent Chidren and Title XIX CHIP Parents are now in New Adult Group as of 1/1/14.*														

With Waiver - Expenditures

TOTAL EXPENDITURES IN WAIVER	**$6,100,227,468**	**$9,442,488,618**	**$11,297,320,773**	**$11,437,497,403**	**$12,005,158,050**	**$50,282,692,312**		**$12,044,101,459**	**$12,833,033,560**	**$13,491,860,168**	**$14,029,478,279**	**$14,781,257,604**	**$67,179,731,070**	
														Original STC
Waiver Year	1	2	3	4	5	***Demo***		6	7	8	9	10	***Renewal***	Growth %'s
State Fiscal Year	2013	2014	2015	2016	2017	***Period 1***		2018	2019	2020	2021	2022	***Period 1***	used for
Member Months	*actual*	*actual*	*actual*	*actual*	*estimated*			*projected*	*projected*	*projected*	*projected*	*projected*		BN
Title XIX	5,773,180	7,850,901	8,699,959	8,893,999	8,785,836			9,019,541	9,259,462	9,505,765	9,758,620	10,018,201		2.7%
***ABD**	2,486,117	3,342,730	3,355,975	3,342,883	3,258,769			2,946,398	3,000,482	3,055,559	3,111,646	3,168,764		1.8%
***LTC**														1.8%
HCBS State Plan	13,594	18,860	25,656	59,042	98,287			100,091	101,928	103,799	105,705	107,645		1.8%
Total Waiver Member Months	**8,272,891**	**11,212,491**	**12,081,590**	**12,295,924**	**12,142,892**			**12,066,029**	**12,361,872**	**12,665,123**	**12,975,971**	**13,294,610**		
Per Member Per Month														
Title XIX	$287.63	$305.59	$296.85	$284.99	$301.52			$319.01	$337.51	$357.09	$377.80	$399.71		5.8%
***ABD**	$1,595.54	$1,616.41	$1,525.65	$1,508.82	$1,563.14			$1,619.41	$1,677.71	$1,677.71	$1,677.71	$1,677.71		3.6%
***LTC**														3.9%
HCBS State Plan	$3,162.12	$3,441.37	$3,872.47	$4,066.37	$4,216.83			$4,372.85	$4,534.64	$4,702.43	$4,876.42	$5,056.84		3.7%
Total Expenditures (Member Months x PMPM)														
Title XIX	$1,660,532,120	$2,399,180,142	$2,582,613,493	$2,534,724,200	$2,649,124,657	**$11,826,174,612**		$2,877,328,130	$3,125,189,727	$3,394,402,860	$3,686,806,812	$4,004,399,310	**$17,088,126,839**	
***ABD**	$3,966,690,442	$5,403,226,627	$5,120,055,291	$5,043,806,205	$5,093,901,545	**$24,627,680,110**		$4,771,424,809	$5,033,933,470	$5,126,336,408	$5,220,435,488	$5,316,261,845	**$25,468,392,019**	
***LTC**	$0	$0	$0	$0	$0	**$0**		$0	$0	$0	$0	$0	**$0**	
HCBS State Plan	$42,985,906	$64,904,317	$99,352,046	$240,086,620	$414,459,151	**$861,788,040**		$437,683,414	$462,209,051	$488,108,984	$515,460,224	$544,344,093	**$2,447,805,765**	
Total Base Actual Expenditures	**$5,670,208,468**	**$7,867,311,086**	**$7,802,020,830**	**$7,818,617,025**	**$8,157,485,353**	**$37,315,642,762**		**$8,086,436,352**	**$8,621,332,248**	**$9,008,848,252**	**$9,422,702,523**	**$9,865,005,247**	**$45,004,324,623**	
** ABD and LTC Member Months, PMPM, and Total Expenditures are combined in the Actual Detail Calculation*														
Hypothetical Population Expenditures														
HCBS 217-Like	$207,464,369	$278,302,398	$331,117,748	$375,476,571	$430,061,851	**$1,622,422,937**		$454,160,413	$479,609,340	$506,484,301	$534,865,203	$564,836,432	**$2,539,955,689**	
****Adults w/o Dependent Children**	$1,529,772	$674,018	$0	$0	$0	**$2,203,790**		$0	$0	$0	$0	$0	**$0**	
SED 217-Like	$83	$58,922	$27,837	$96,680	$6,135,308	**$6,318,830**		$6,622,803	$7,149,033	$7,717,076	$8,330,254	$8,992,153	**$38,811,319**	
****XIX CHIP Parents**	$0	$126,863,607	$0	$0	$0	**$126,863,607**		$0	$0	$0	$0	$0	**$0**	
IDD/MI - 217-Like	$0	$0	$1,186,792	$7,795,679	$9,058,086	**$18,040,557**		$9,777,817	$10,554,736	$11,393,387	$12,298,675	$13,275,894	**$57,300,509**	
New Adult Group	$0	$862,002,142	$2,860,394,406	$2,901,491,432	$3,068,397,436	**$9,692,285,416**		$3,280,956,785	$3,508,240,914	$3,751,269,863	$4,011,134,335	$4,289,000,589	**$18,840,602,486**	
Total Hypothetical Expenditures	**$208,994,224**	**$1,267,901,087**	**$3,192,726,783**	**$3,284,860,362**	**$3,513,652,681**	**$11,468,135,137**		**$3,751,517,818**	**$4,005,554,023**	**$4,276,864,626**	**$4,566,628,466**	**$4,876,105,068**	**$21,476,670,002**	
*** Adults w/o Dependent Chidren and Title XIX CHIP Parents are now in New Adult Group as of 1/1/14.*														
Supports Program	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**		**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	
Hospital Subsidies														
HRSF & GME	$ 192,443,637	$ -	$ -	$ -	$ -	**$192,443,637**		$ -	$ -	$ -	$ -	$ -	**$0**	
HRSF Transition Payments	-	83,302,681	-	-	-	**$83,302,681**							**$0**	
GME State Plan	-	100,000,001	100,000,000	127,272,727	127,272,727	**$454,545,455**		-	-	-	-	-	**$0**	
DSRIP	-	83,304,870	166,600,001	166,600,000	166,600,000	**$583,104,871**		166,000,000	166,000,000	166,000,000	-	-	**$498,000,000**	
Hospital Subsidies Expenditures	**$ 192,443,637**	**$ 266,607,552**	**$ 266,600,001**	**$ 293,872,727**	**$ 293,872,727**	**$1,313,396,644**		**$ 166,000,000**	**$ 166,000,000**	**$ 166,000,000**	**$ -**	**$ -**	**$498,000,000**	
Costs Otherwise Not Matchable (CNOMs)														
SED at Risk	$ 24,511,364	$ 37,239,735	$ 35,973,159	$ 40,147,289	$ 40,147,289	**$178,018,836**		$ 40,147,289	$ 40,147,289	$ 40,147,289	$ 40,147,289	$ 40,147,289	**$200,736,445**	
MATI at Risk	4,069,775	3,429,158	-	-	-	**$7,498,933**		-					**$0**	
DDD non-Disabled Adult Children	-	-	-											
DDD Community / Supports Equalizatior	-	-	-											
CNOM Expenditures	***$ 28,581,139***	***$ 40,668,893***	***$ 35,973,159***	***$ 40,147,289***	***$ 40,147,289***	**$185,517,769**		***$ 40,147,289***	***$ 40,147,289***	***$ 40,147,289***	***$ 40,147,289***	***$ 40,147,289***	**$200,736,445**	

Hypotheticals: Enrollment and PMPM's															
Waiver Year		1	2	3	4	5	***Demo***		6	7	8	9	10	***Renewal***	Growth %'s
State Fiscal Year		2013	2014	2015	2016	2017	***Period 1***		2018	2019	2020	2021	2022	***Period 1***	
WOW-CAP															
HCBS 217-Like	Enrollment	96,351	127,895	122,272	132,498	146,850			149,546	152,291	155,086	157,933	160,832		1.8%
	PMPM	$2,256.69	$2,340.19	$2,426.78	$2,516.57	$2,609.68			$2,706.24	$2,806.37	$2,910.20	$3,017.88	$3,129.54		3.7%
Adults w/o DC	Enrollment	6,057	2,774	3,870,426	4,240,639	4,406,230			4,406,230	4,406,230	4,406,230	4,406,230	4,406,230		
	PMPM	$277.00	$288.00						$0.00	$0.00	$0.00	$0.00	$0.00		
SED 217-Like	Enrollment	113	145	115	96	1,846			1,880	1,914	1,950	1,985	2,022		1.8%
	PMPM	$2,246.37	$2,381.15	$2,524.02	$2,675.46	$2,835.99			$3,006.15	$3,186.52	$3,377.71	$3,580.37	$3,795.19		6.0%
XIX Chip Parents	Enrollment	0	456,761	0	0	0			0	0	0	0	0		
	PMPM		$307.24						$0.00	$0.00	$0.00	$0.00	$0.00		
IDD/MI	Enrollment	0	0	581	2,981	3,564			3,629	3,696	3,764	3,833	3,903		1.8%
	PMPM	$9,839.39	$10,429.75	$11,055.53	$11,718.87	$12,422.00			$13,167.32	$13,957.36	$14,794.80	$15,682.49	$16,623.44		6.0%
New Adult Group	Enrollment	0	1,408,947	6,541,000	6,776,916	6,854,614			6,980,437	7,108,569	7,239,054	7,371,933	7,507,252		1.8%
	PMPM		$465.12	$490.48	$515.00	$540.75			$567.79	$596.18	$625.99	$657.29	$690.15		5.0%
ACTUALS															
HCBS 217-Like	Enrollment	96,351	127,895	122,272	132,498	146,850			149,546	152,291	155,086	157,933	160,832		1.8%
	PMPM	$2,153.22	$2,176.02	$2,709.00	$2,835.65	$2,940.57			$3,049.37	$3,162.20	$3,279.20	$3,400.53	$3,526.35		3.7%
Adults w/o DC	Enrollment	6,057	2,774	3,870,426	4,240,639	4,406,230			4,406,230	4,406,230	4,406,230	4,406,230	4,406,230		
	PMPM	$252.56	$242.98						$0.00	$0.00	$0.00	$0.00	$0.00		
SED 217-Like	Enrollment	113	145	115	96	1,846			1,880	1,914	1,950	1,985	2,022		1.8%
	PMPM	$0.73	$406.36	$242.06	$1,007.08	$6,563.74			$6,957.57	$7,375.02	$7,817.52	$8,286.57	$8,783.77		6.0%
***XIX CHIP Parents**	Enrollment	0	456,761	0	0	0									
	PMPM		$277.75												
IDD/MI - 217-Like	Enrollment	0	0	581	2,981	3,564			3,629	3,696	3,764	3,833	3,903		1.8%
	PMPM	$0.00	$0.00	$2,042.67	$2,616.08	$2,773.04			$2,939.42	$3,115.79	$3,302.74	$3,500.90	$3,710.95		6.0%
New Adult Group	Enrollment	0	1,186,513	6,541,000	6,776,916	6,854,614			6,980,437	7,108,569	7,239,054	7,371,933	7,507,252		1.8%
	PMPM		$715.80	$437.10	$429.62	$451.10			$473.66	$497.34	$522.21	$548.32	$575.74		5.0%

Hospital Subsidy Summary

Waiver Year	1	2	3	4	5	***Demo***		6	7	8	9	10	***Renewal***
State Fiscal Year	2013	2014	2015	2016	2017	***Period 1***		2018	2019	2020	2021	2022	***Period 1***
TOTAL COMPUTABLE													
HRSF & GME	$ 192,443,637	$ -	$ -	$ -	$ -	**$ 192,443,637**		$ -	$ -	$ -	$ -	$ -	**$ -**
HRSF Transition Payments	-	83,302,681	-	-	-	**$ 83,302,681**							**$ -**
GME State Plan	-	100,000,001	100,000,000	127,291,443	188,000,000	**$ 515,291,444**		-	-	-	-	-	**$ -**
DSRIP	-	83,304,870	166,600,001	166,600,000	166,600,000	**$ 583,104,871**		166,000,000	166,000,000	166,000,000	-	-	**$ 498,000,000**
TOTAL COMPUTABLE	**$ 192,443,637**	**$ 266,607,552**	**$ 266,600,001**	**$ 293,891,443**	**$ 354,600,000**	**$ 1,374,142,633**		**$ 166,000,000**	**$ 166,000,000**	**$ 166,000,000**	**$ -**	**$ -**	**$ 498,000,000**
Composite Federal Share Percentage													
HRSF & GME	50.00%	0.00%	0.00%	0.00%	0.00%								
HRSF Transition Payments	0.00%	50.00%	0.00%	0.00%	0.00%			0.00%	0.00%	0.00%	0.00%	0.00%	
GME State Plan	0.00%	66.45%	65.08%	67.00%	65.83%			64.83%	64.50%	63.83%	63.33%	63.33%	
DSRIP	0.00%	50.00%	50.00%	50.00%	50.00%			50.00%	50.00%	50.00%	50.00%	50.00%	
FEDERAL SHARE													
HRSF & GME	$ 96,221,820	$ -	$ -	$ -	$ -	**$ 96,221,820**		$ -	$ -	$ -	$ -	$ -	**$ -**
HRSF Transition Payments	$ -	$ 41,651,341	$ -	$ -	$ -	**$ 41,651,341**		-	-	-	-	-	**$ -**
GME State Plan	$ -	$ 66,452,600	$ 65,080,000	$ 85,285,267	$ 123,766,667	**$ 340,584,533**		-	-	-	-	-	**$ -**
DSRIP	$ -	$ 41,652,436	$ 83,300,003	$ 83,300,002	$ 83,300,002	**$ 291,552,443**		83,000,002	83,000,002	83,000,002	-	-	**$ 249,000,006**
FEDERAL SHARE	**$ 96,221,820**	**$ 149,756,377**	**$ 148,380,003**	**$ 168,585,269**	**$ 207,066,669**	**$ 770,010,137**		**$ 83,000,002**	**$ 83,000,002**	**$ 83,000,002**	**$ -**	**$ -**	**$ 249,000,006**

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

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

Costs Otherwise Not Matchable (CNOM) Summary

Waiver Year	1	2	3	4	5	***Demo***		6	7	8	9	10	***Renewal***	Growth %
State Fiscal Year	2013	2014	2015	2016	2017	***Period 1***		2018	2019	2020	2021	2022	***Period 1***	
TOTAL COMPUTABLE														
SED at Risk	$ 24,511,364	$ 37,239,735	$ 35,973,919	$ 40,197,343	$ 42,196,637	$ 180,118,998		$ 42,196,637	$ 42,196,637	$ 42,196,637	$ 42,196,637	$ 42,196,637	$ 210,983,185	
MATI at Risk	$ 4,069,775	$ 3,429,158	$ -	$ -	$ -	$ 7,498,933		$ -	$ -	$ -	$ -	$ -	$ -	
DDD non-Disabled Adult Children	$ -	$ -	$ -			$ -		$ -	$ -	$ -	$ -	$ -	$ -	3.00%
DDD Community / Supports Equalization	$ -	$ -	$ -			$ -								3.00%
TOTAL COMPUTABLE	**$ 28,581,139.00**	**$ 40,668,893.00**	**$ 35,973,919.00**	**$ 40,197,343.00**	**$ 42,196,637.00**	**$ 187,617,931**		**$ 42,196,637**	**$ 42,196,637**	**$ 42,196,637**	**$ 42,196,637**	**$ 42,196,637**	**$ 210,983,185**	
Composite Federal Share Percentage														
SED at Risk	51.99%	51.83%	51.96%	50.50%	50.00%			50.00%	50.00%	50.00%	50.00%	50.00%		
MATI at Risk	50.50%	52.00%	0.00%	0.00%	0.00%			0.00%	0.00%	0.00%	0.00%	0.00%		
DDD non-Disabled Adult Children				50.00%	50.00%			50.00%	50.00%	50.00%	50.00%	50.00%		
DDD Community / Supports Equalization				50.00%	50.00%			50.00%	50.00%	50.00%	50.00%	50.00%		
FEDERAL SHARE														
SED at Risk	$ 12,743,019	$ 19,300,842	$ 18,690,296	$ 20,299,658	$ 21,098,319	$ 92,132,134		$ 21,098,319	$ 21,098,319	$ 21,098,319	$ 21,098,319	$ 21,098,319	$ 105,491,593	
MATI at Risk	$ 2,055,322	$ 1,783,162	$ -	$ -	$ -	$ 3,838,484		$ -	$ -	$ -	$ -	$ -	$ -	
DDD non-Disabled Adult Children	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	$ -	
DDD Community / Supports Equalization	$ -	$ -	$ -	$ -	$ -	$ -		$ -	$ -	$ -	$ -	$ -	$ -	
FEDERAL SHARE	**$ 14,798,341**	**$ 21,084,004**	**$ 18,690,296**	**$ 20,299,658**	**$ 21,098,319**	**$ 95,970,618**		*$ 21,098,319*	*$ 21,098,319*	*$ 21,098,319*	*$ 21,098,319*	*$ 21,098,319*	**$ 105,491,593**	

Notes: SED at Risk and MATI at Risk

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

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

Notes: DDD programs

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

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

Budgent Neutrality Monitoring Sheet Notes

Enrollment Trends

No Waiver Spending

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

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

With Waiver Spending

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

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

BN caps should be as of 3-27-14

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

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

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

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

Schedule C

CMS 64 Waiver Expenditure Report

Cumulative Data Ending Quarter/Year : 4/2017

State: New Jersey

Summary of Expenditures by Waiver Year

Waiver: 11W00279

MAP Waivers

Total Computable

Waiver Name	A	01	02	03	04	05	06
ABD	0	3,968,034,154	5,408,209,012	5,120,732,991	5,069,232,397	5,151,218,116	1,026,837,926
ACCAP – 217 Lil	0	630,539	880,454	0	0	0	0
ACCAP – SP	0	900,000	966,297	0	0	0	0
AWDC	0	1,529,772	674,018	0	0	0	0
Childless Adults	0	27,844,394	48,216,389	0	0	0	0
CRPD – 217 Like	0	11,803,536	16,894,842	0	0	0	0
CRPD –SP	0	10,672,842	15,247,535	0	0	0	0
DSRIP	0	0	83,304,870	166,600,001	166,600,000	166,600,000	0
GME State Plan	0	0	100,000,001	100,000,000	127,291,443	188,000,000	54,499,992
GO – 217 Like	0	181,068,236	221,682,839	0	0	0	0
GO – SP	0	23,869,092	33,606,671	0	0	0	0
HCBS – 217 Like	0	288,889	21,406,012	331,234,441	375,718,137	402,567,552	158,880,182
HCBS – State Pl	0	86,858	5,718,886	99,376,696	240,131,569	364,974,816	150,998,102
HRSF & GME	0	192,443,637	0	0	0	0	0
HRSF Transitior	0	0	83,302,681	0	0	0	0
IDD/MI – 217 Li	0	0	0	1,186,792	7,798,525	10,750,786	2,765,861
MATI at Risk	0	4,069,775	3,429,158	0	0	0	0
New Adult Grou	0	7,940,104	849,302,769	2,859,089,720	2,911,520,516	3,101,628,329	745,509,023
SED – 217 Like	0	83	58,922	27,837	96,680	12,116,668	3,922,140
SED at Risk	0	24,511,364	37,239,735	35,973,919	40,197,343	42,196,637	5,931,962
TBI – 217 Like	0	13,673,932	17,438,251	0	0	0	0
TBI – SP	0	7,457,114	9,364,928	0	0	0	0
Title XIX	0	1,660,533,500	2,401,028,803	2,585,155,172	2,542,349,561	2,543,100,659	517,416,609
XIX CHIP Parent	0	0	126,863,607	0	0	0	0
Total	**0**	**6,137,357,821**	**9,484,836,680**	**11,299,377,569**	**11,480,936,171**	**11,983,153,563**	**2,666,761,797**

Federal Share

Waiver Name	A	01	02	03	04	05	06
ABD	0	1,989,920,458	2,720,956,589	2,573,335,580	2,539,175,066	2,577,677,321	513,872,076
ACCAP – 217 Li	0	319,151	446,869	0	0	0	0
ACCAP – SP	0	454,312	489,362	0	0	0	0
AWDC	0	777,617	344,491	0	0	0	0
Childless Adults	0	14,715,147	24,778,164	0	0	0	0
CRPD – 217 Like	0	6,026,151	8,740,654	0	0	0	0
CRPD –SP	0	5,447,877	7,899,121	0	0	0	0
DSRIP	0	0	41,652,435	83,300,003	83,300,002	83,300,002	0
GME State Plan	0	0	55,642,502	66,797,499	84,588,472	122,350,400	35,076,195
GO – 217 Like	0	91,709,982	114,209,771	0	0	0	0
GO – SP	0	12,108,906	17,304,835	0	0	0	0
HCBS – 217 Like	0	147,458	11,076,822	170,100,169	189,123,731	201,306,894	79,443,017
HCBS – State Pl	0	44,439	2,963,002	51,039,962	120,761,409	182,561,934	75,508,625
HRSF & GME	0	96,221,820	0	0	0	0	0
HRSF Transitior	0	0	41,651,341	0	0	0	0
IDD/MI – 217 Li	0	0	0	599,439	3,903,695	5,375,473	1,382,933
MATI at Risk	0	2,055,322	1,783,162	0	0	0	0
New Adult Grou	0	7,938,698	849,280,201	2,858,964,774	2,910,261,210	3,018,922,205	708,233,572
SED – 217 Like	0	42	29,462	13,944	48,354	6,059,317	1,961,635
SED at Risk	0	12,743,019	19,300,842	18,690,296	20,590,547	21,593,131	2,965,981
TBI – 217 Like	0	6,928,494	8,987,060	0	0	0	0
TBI – SP	0	3,776,704	4,819,278	0	0	0	0
Title XIX	0	833,625,792	1,328,947,500	1,418,159,122	1,290,124,376	1,277,711,465	259,148,173
XIX CHIP Parent	0	0	64,746,447	2,148	0	0	0
Total	**0**	**3,084,961,389**	**5,326,049,910**	**7,241,002,936**	**7,241,876,862**	**7,496,858,142**	**1,677,592,207**

Created On: Monday, November 6, 2017 9:15 AM

DY1 & DY2 HCBS expen

	DY1	DY2
	total computable	
HCBS – 217 Like	207,465,132	278,302,398
HCBS – State Plan	42,985,906	64,904,317
	Federal share	
HCBS – 217 Like	105,131,236	143,461,176
HCBS – State Plan	21,832,238	33,475,598

Composite Federal Share Percentages

Waiver Name	01	02	03	04	05	06	07	08	09	10
ABD	50.15%	50.31%	50.25%	50.09%	50.04%	50.04%	50.04%	50.04%	50.04%	50.04%
AWDC	50.83%	51.11%								
Childless Adults	52.85%	51.39%								
DSRIP		50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%
GME State Plan		66.45%	65.08%	*67.00%*	*65.83%*	*64.83%*	*64.50%*	*63.83%*	*63.33%*	*63.33%*
HCBS – 217 Like	50.67%	51.55%	51.35%	50.34%	50.01%	50.00%	50.00%	50.00%	50.00%	50.00%
HCBS – State Pl	50.79%	51.58%	51.36%	50.29%	50.02%	50.01%	50.01%	50.01%	50.01%	50.01%
HRSF & GME	50.00%									
HRSF Transitior		50.00%								
IDD/MI – 217 Li			50.51%	50.00%	50.25%	50.25%	50.25%	50.25%	50.25%	50.25%
MATI at Risk	50.50%	52.00%								
New Adult Grou	99.98%	100.00%	100.00%	99.96%	97.50%	94.50%	93.50%	91.50%	90.00%	90.00%
SED – 217 Like		50.00%	50.09%	50.50%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%
SED at Risk	51.99%	51.83%	51.96%	50.50%	50.00%	50.00%	50.00%	50.00%	50.00%	50.00%
Title XIX	50.20%	55.35%	54.86%	50.75%	50.24%	50.09%	50.09%	50.09%	50.09%	50.09%
XIX CHIP Parent		51.04%								

	CMS 64 - MEDICAID ELIGIBILITY GROUPS AS OF JUNE 2014																						
								final dec 13 rpt	final feb 14 rpt	final mar 14 rpt	final apr14 rpt	final may 14 rpt	final jun 14 rpt	final jul 14 rpt	final aug 14 rpt	final sep14 rpt	final oct 14 rpt	final nov 14 rpt	final dec 14 rpt	final jan 15 rpt	final feb 15 rpt	final mar 15 rpt	final apr 15 rpt	final may 15 rpt	final jun 15 rpt
		Actuals through 9/30/2015 (as of 12/31/2015)																							
	DEFINITIONS:	**DY1**	**DY2**	**DY3**	**DY4**	**DY5**		**Oct-12**	**Nov-12**	**Dec-12**	**Jan-13**	**Feb-13**	**Mar-13**	**Apr-13**	**May-13**	**Jun-13**	**Jul-13**	**Aug-13**	**Sep-13**	**Oct-13**	**Nov-13**	**Dec-13**	**Jan-14**	**Feb-14**	**Mar-14**
1	TITLE XIX	5,773,180	7,850,901	8,699,959	8,893,616	8,816,484		643,208	641,115	641,945	643,840	643,718	645,054	645,116	635,183	634,001	633,251	632,536	631,012	628,743	625,874	623,702	663,241	667,292	678,653
2	ABD (Excluding HCBS and LTC SPC 61)	2,486,117	3,342,730	3,355,975	3,343,701	3,287,476		274,854	274,540	274,471	275,897	276,304	276,808	277,259	277,750	278,234	278,390	278,697	279,521	279,906	279,461	278,818	276,842	277,127	278,134
3	Childless Adults	385,740	225,208	-	-	-		45,455	44,363	43,494	43,024	42,618	42,563	41,976	41,588	40,659	39,738	39,242	38,278	37,737	34,678	35,535			
4	Adults W/O Dependent Children	6,057	2,774	3,870,426	4,240,639	4,406,230		772	750	713	682	670	663	644	610	553	503	491	460	453	442	425	145,207	160,725	203,473
5	SED	26,729	43,160	38,453	43,795	46,906		2,560	2,618	2,677	2,907	3,029	3,110	3,181	3,313	3,334	3,271	3,291	3,154	3,364	3,566	3,531	3,769	3,856	4,162
6	HCBS (State Plan)	13,594	18,860	25,656	59,042	98,301		1,518	1,520	1,504	1,467	1,474	1,493	1,511	1,543	1,564	1,553	1,555	1,540	1,567	1,586	1,586	1,596	1,583	1,580
7	HCBS (217 Like)	96,351	127,895	122,272	132,498	146,850		11,219	11,225	11,221	10,428	10,396	10,420	10,456	10,480	10,506	10,556	10,577	10,645	10,726	10,752	10,751	10,758	10,742	10,606
8	LTC																						0	0	0
9	SED (217 Like)	113	145	115	96	1,846		15	13	14	15	15	10	7	9	15	14	11	15	15	16	13	9	9	11
10	IDD/MI (217 Like)	-	-	581	2,981	3,564																			0
11	XIX CHIP Parents *(10/01/2013 - 12/31/2013 Only)*		456,761	-	-	-														152,428	152,087	152,246			
12	New Adult Group *(01/01/2014 Onwards)*		1,183,739	2,670,574	2,536,277	2,448,384																	181,112	186,389	198,362
	Source = CMS64 MEG report from Dec 2015																								

		final jul 15 rpt	final aug 15 rpt	final sept 15 rpt	final Oct 15 rpt	final Nov 15 rpt	final Dec 15 rpt																			
	DEFINITIONS:	**Apr-14**	**May-14**	**Jun-14**	**Jul-14**	**Aug-14**	**Sep-14**	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**	**Apr-15**	**May-15**	**Jun-15**	**Jul-15**	**Aug-15**	**Sep-15**	**Oct-15**	**Nov-15**	**Dec-15**	**Jan-16**	**Feb-16**	**Mar-16**	**Apr-16**	**May-16**	**Jun-16**
1	TITLE XIX	683,673	689,180	693,744	698,873	705,756	712,044	716,443	718,070	721,307	726,830	732,311	736,730	740,261	744,442	746,892	744,994	744,692	744,034	744,176	741,195	739,809	741,320	741,240	740,227	739,262	737,369	735,298
2	ABD (Excluding HCBS and LTC SPC 61)	278,326	278,535	278,973	280,262	280,382	280,535	280,359	280,294	278,829	279,154	279,165	279,205	279,364	279,287	279,139	279,313	279,789	278,996	278,966	278,024	279,820	278,974	278,024	278,259	278,098	277,601	277,837
3	Childless Adults																											
4	Adults W/O Dependent Children	221,698	235,947	248,452	261,467	275,824	285,009	293,647	303,733	320,267	332,291	348,973	355,792	362,664	364,468	366,291	362,228	357,424	350,616	345,857	342,309	345,701	353,211	354,296	355,355	357,219	357,319	359,104
5	SED	4,191	3,551	3,454	3,185	3,028	2,810	2,886	2,923	3,039	3,164	3,262	3,413	3,522	3,637	3,584	3,438	3,182	3,107	3,201	3,431	3,581	3,756	3,875	3,959	4,033	4,148	4,084
6	HCBS (State Plan)	1,576	1,573	1,565	1,492	1,546	1,624	1,821	2,011	2,162	2,163	2,265	2,349	2,496	2,703	3,024	3,360	3,715	3,972	4,158	4,528	4,751	5,067	5,310	5,531	5,797	6,263	6,590
7	HCBS (217 Like)	10,604	10,577	10,601	9,863	9,920	9,994	10,300	10,490	10,467	10,246	10,156	10,149	10,181	10,224	10,282	10,517	10,584	10,701	10,734	10,837	11,028	11,081	11,205	11,255	11,380	11,474	11,702
8	LTC	0	0	0	24,537	24,150	23,794	23,313	22,974	22,725																		
9	SED (217 Like)	15	10	7	14	18	11	6	8	9	9	5	7	9	11	8	11	8	7	8	9	7	9	4	7	12	9	5
10	IDD/MI (217 Like)	0	0	0	0	0	0	0	0	0	0	0	113	133	145	190	205	220	244	271	275	285	262	269	274	230	222	224
11	XIX CHIP Parents *(10/01/2013 - 12/31/2013 Only)*																											
12	New Adult Group *(01/01/2014 Onwards)*	203,220	205,870	208,786	211,485	214,061	216,647	218,794	220,090	225,796	225,810	228,275	228,919	227,858	226,725	226,114	223,139	219,467	215,942	213,041	209,178	207,478	207,706	208,078	208,765	208,497	207,899	207,087
	Source = CMS64 MEG report from Dec 2015																											

	DEFINITIONS:	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17
1	TITLE XIX	734,757	736,857	737,591	735,985	736,021	736,648	736,407	735,129	734,943	731,877	731,305	728,964	723,181	714,777	695,942
2	ABD (Excluding HCBS and LTC SPC 61)	277,679	277,578	277,295	277,229	276,175	274,962	273,999	273,094	272,169	270,755	269,279	267,262	265,052	262,388	258,924
3	Childless Adults															
4	Adults W/O Dependent Children	358,260	359,657	357,531	356,075	363,353	369,139	375,232	374,545	375,007	374,260	373,653	369,518	361,673	355,081	343,988
5	SED	3,854	3,608	3,448	3,467	3,603	3,689	3,898	3,992	4,224	4,342	4,467	4,314	3,901	3,465	3,017
6	HCBS (State Plan)	6,848	7,074	7,245	7,429	7,674	8,115	8,311	8,419	8,599	9,082	9,537	9,968	10,318	10,484	10,643
7	HCBS (217 Like)	11,818	11,872	11,904	12,032	12,164	12,295	12,444	12,380	12,419	12,477	12,495	12,550	12,656	12,659	12,703
8	LTC															
9	SED (217 Like)	1	50	82	116	132	153	178	196	211	225	245	257	264	263	252
10	IDD/MI (217 Like)	207	194	175	155	135	271	387	404	400	409	412	415	410	394	347
11	XIX CHIP Parents *(10/01/2013 - 12/31/2013 Only)*															
12	New Adult Group *(01/01/2014 Onwards)*	205,668	205,206	203,978	203,061	203,499	204,246	204,906	204,372	204,410	203,711	203,172	202,155	200,265	197,214	192,568
	Source = CMS64 MEG report from Dec 2015															

RUN DATE: 11/6/17

MMX Member Mo	Count(dist) Recip Idn
10/1/2012	29,433.
11/1/2012	29,367.
12/1/2012	29,283.
1/1/2013	29,180.
2/1/2013	28,845.
3/1/2013	28,869.
4/1/2013	28,803.
5/1/2013	28,701.
6/1/2013	28,754.
7/1/2013	28,869.
8/1/2013	29,047.
9/1/2013	29,081.
10/1/2013	29,126.
11/1/2013	29,167.
12/1/2013	29,217.
1/1/2014	29,089.
2/1/2014	28,868.
3/1/2014	28,900.
4/1/2014	28,830.
5/1/2014	28,813.
6/1/2014	28,782.
7/1/2014	29,252.
8/1/2014	29,150.
9/1/2014	29,007.
10/1/2014	28,813.
11/1/2014	28,548.
12/1/2014	28,375.
1/1/2015	28,365.
2/1/2015	28,076.
3/1/2015	27,871.
4/1/2015	27,799.
5/1/2015	27,747.
6/1/2015	27,940.
7/1/2015	27,981.
8/1/2015	28,164.
9/1/2015	28,224.
10/1/2015	28,328.
11/1/2015	28,506.
12/1/2015	28,542.
1/1/2016	28,516.
2/1/2016	28,449.
3/1/2016	28,519.
4/1/2016	28,464.
5/1/2016	28,633.
6/1/2016	28,678.
7/1/2016	28,710.
8/1/2016	28,845.
9/1/2016	28,790.
10/1/2016	28,934.
11/1/2016	28,762.
12/1/2016	28,603.
1/1/2017	28,470.
2/1/2017	28,199.
3/1/2017	28,014.
4/1/2017	27,933.
5/1/2017	27,791.
6/1/2017	27,638.
7/1/2017	27,357.
8/1/2017	26,946.
9/1/2017	26,454.
10/1/2017	24,677.
11/1/2017	24,548.

	MMs
DY1	261,235.
DY2	347,789.
DY3	340,943.
DY4	341,004.
DY5	340,689.
DY6	129,982.

MMX Member Month Date	Count(dist) Recip Idn
10/1/2012	2,376.
11/1/2012	2,353.
12/1/2012	2,332.
1/1/2013	2,323.
2/1/2013	2,302.
3/1/2013	2,291.
4/1/2013	2,270.
5/1/2013	2,242.
6/1/2013	2,220.
7/1/2013	2,195.
8/1/2013	2,177.
9/1/2013	2,157.
10/1/2013	2,130.
11/1/2013	2,109.
12/1/2013	2,076.
1/1/2014	2,048.
2/1/2014	2,032.
3/1/2014	2,017.
4/1/2014	1,970.
5/1/2014	1,930.
6/1/2014	1,876.
7/1/2014	1,845.
8/1/2014	1,823.
9/1/2014	1,811.
10/1/2014	1,791.
11/1/2014	1,769.
12/1/2014	1,744.
1/1/2015	1,724.
2/1/2015	1,712.
3/1/2015	1,695.
4/1/2015	1,679.
5/1/2015	1,666.
6/1/2015	1,651.
7/1/2015	1,639.
8/1/2015	1,632.
9/1/2015	1,612.
10/1/2015	1,585.
11/1/2015	1,587.
12/1/2015	1,578.
1/1/2016	1,571.
2/1/2016	1,557.
3/1/2016	1,548.
4/1/2016	1,541.
5/1/2016	1,525.
6/1/2016	1,515.
7/1/2016	1,507.
8/1/2016	1,505.
9/1/2016	1,501.
10/1/2016	1,495.
11/1/2016	1,485.
12/1/2016	1,482.
1/1/2017	1,470.
2/1/2017	1,465.
3/1/2017	1,460.
4/1/2017	1,453.
5/1/2017	1,443.
6/1/2017	1,434.
7/1/2017	1,424.
8/1/2017	1,416.
9/1/2017	1,088.

	MMs
DY1	20,709.
DY2	24,717.
DY3	20,910.
DY4	18,890.
DY5	17,700.

Deliverables due during MLTSS 1st quarter (7/1/2017 - 9/30/2017)

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

This quarterly report reflects the performance measures (PM) that were reported by the MCOs and the Division of Aging Services (DoAS) to the Office of MLTSS/QM during the first quarter of MLTSS (7/1/17 – 9/30/17). Each performance measure identifies its measurement period; however, depending on the source for the numerator/denominator the due date for reporting on a particular measure may have a lag time to allow for collection of the information. Several measures rely on claims data; therefore, a lag of 180 days must be built into the due date to allow for the MCO to receive the claims and process the data. This report reflects the performance measures data the Office of MLTSS/QM should have received during the fourth year, first quarter (7/1/17 – 9/30/17) of MLTSS program.

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

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

Deliverables due during MLTSS 1st quarter (7/1/2017 - 9/30/2017)

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

Measurement period	**06/2017**
Numerator	1241
Denominator	1261
%	98.4

Beginning 7/1/2017, PM #03 has been revised and a lag time of three months has been added to this measure to allow for reassessment by OCCO. PM #03 for July 2017 is due 11/15/17. DoAS reports that the rate has been as expected.

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

May 2017	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	39	214	357	75	205	890
Denominator	41	218	379	81	223	942
%	95.1	98.1	94.2	92.6	91.9	94.4

June 2017	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	29	162	418	58	141	808
Denominator	38	164	439	62	153	856
%	76.3	98.8	95.2	93.6	92.2	94.3

Deliverables due during MLTSS 1st quarter (7/1/2017 - 9/30/2017)

July 2017	A	B	C	D	E	TOTAL
Numerator	22	85	324	48	126	605
Denominator	33	101	348	54	131	667
%	66.7	84.1	93.1	88.9	96.2	90.7

The MCOs are monitoring the timeliness of level of care (LOC) assessments and have identified that some of the delays include: delayed at the request of the NF, member hospitalization, staff illness, member dis-enrolled, delay in clinical outreach, members requested appointments beyond the 30 day limit, unable to contact and schedule the initial visit, county reassignment, member rescheduled the original appointment beyond the 30 day limit, Care Manager not performing timely outreach, and PASSR delay. MCO A reports they recognize a decline in the timeliness of level of care (LOC) assessments and identified that this decline was related to staffing issues. MCO A reports that they had an assessor who was unexpectedly hospitalized and although assignments were rescheduled urgently there were delays due to geographical challenges experienced by the remaining assessors. Additionally, MCO A reports that all of the late assessments were completed within 33 to 43 days from the referrals. In one reporting period MCO E reports that 13 members referred for MLTSS eligibility were nursing facility residents and 11 were FIDE-SNP. Additionally, MCO E reports that the remaining NJ Family Care members were referred by the UM/CM staff due to utilization trends or by the assessors who identified members meeting eligibility criteria for MLTSS during the assessment process for utilization services, such as PCA or MDC. The MCOs continue improvement procedures such as monitoring the referral and submission process for all completed assessments, ensuring NF residents have custodial authorizations in place, evaluating the performance of the Rapid Assessment model, and ongoing monitoring of the plan's referral queues with increased oversight of the referral and assessment process.

PM # 04a	Timeliness of nursing facility level of care assessment
Numerator:	The number of assessments in the denominator where the OCCO/ADRC assessment/determination date is less than 30 days from the referral date
Denominator (WYE 2017):	Number of level of care assessments conducted by OCCO in the measurement month
Denominator (WYE 2018):	Number of new MLTSS enrollees within the reporting month with an assessment completed by OCCO/ADRC
Data Source:	DoAS

Measurement Period	05/2017	06/2017	07/2017
Numerator	504	834	660
Denominator	780	1317	1105
%	64.6	64.6	59.7

DoAS reports that OCCO staffing and workload has been variable from reporting period to reporting period. OCCO staff is not limited to assessing the MLTSS population. As a result, their rate of compliance has varied between 53% - 64%. Beginning with the measurement period July 2017, the denominator for PM #04a was revised to better report on the MLTSS population.

N = Numerator D = Denominator % = Percentage N/A = Not Available O/D = Over due

Deliverables due during MLTSS 1st quarter (7/1/2017 - 9/30/2017)

PM # 05	Timeliness of nursing facility level of care re-determinations
Numerator:	Total number of MLTSS enrollees in the denominator who are confirmed as being appropriate for continued enrollment and have no assessment conducted within 13 months
Denominator:	Total number of MLTSS enrollees with no assessment conducted within the last 16 months as per "16 month report"
Data Source:	DoAS
Measurement Period:	Quarterly

Beginning 7/1/2017, the measurement period for PM #05 was changed to quarterly. The first report for WYE2018 is due 12/30/17.

PM # 06	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	06/2017
Numerator	1256
Denominator	1256
%	100

The completion of the IPOC is included in the electronic data exchange with the NJ Choice Assessment, the tool used to determine NF LOC eligibility. The IPOC completion should always be 100% since the data exchange will not accept an incomplete record. This measure has been deleted effective measurement period beginning 7/1/2017. This is the final report for PM #06.

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

N = Numerator D = Denominator % = Percentage N/A = Not Available O/D = Over due

Deliverables due during MLTSS 1st quarter (7/1/2017 - 9/30/2017)

Measurement Period	06/2017	07/2017	08/2017
Numerator	1015	927	948
Denominator	1256	1172	1171
%	80.8	79.1	81.0

DoAS noted significant overall improvement from four of the five plans, resulting in a six percentage point increase from the prior measurement period. This improvement has been attributed to compliance rate reports sent to each MCO in April and retraining of assessors in June. MCOs are instructed to ensure assessor staff is continually updated on the coding requirements to ensure choice of settings is documented on the IPOC as a result of the Options Counseling session.

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

Measurement Period	06/2017	07/2017	08/2017
Numerator	300	292	290
Denominator	301	292	291
%	99.7	100	99.6

DoAS reports that the reporting from the plans is uniform for this measure at this time based on their monitoring of the timeliness of CI reporting. Any response that falls below 100% will require the MCO to identify what actions they are taking to improve timeliness. Two MCOs fell below this threshold during this reporting period and they have provided DoAS with acceptable action plans to address their delays.

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

Deliverables due during MLTSS 1st quarter (7/1/2017 - 9/30/2017)

Measurement Period	06/2017	07/2017	08/2017
Numerator	5	4	5
Denominator	5	4	5
%	100	100	100

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

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

Table 3A Appeals and Grievances

4/1/17-6/30/17	A	B	C	D	E	TOTAL
Numerator	1	17	79	38	16	151
Denominator	1	17	79	38	16	151
%	100	100	100	100	100	100

Table 3B Complaints

4/1/17-6/30/17	A	B	C	D	E	TOTAL
Numerator	23	53	109	7	4	196
Denominator	23	53	109	7	4	196
%	100	100	100	100	100	100

All MCOs reported that timelines for investigation of complaints, appeals, and grievances were completed within 30 days.

Deliverables due during MLTSS 1st quarter (7/1/2017 - 9/30/2017)

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

10/1/16 – 12/31/16	A	B	C	D	E	TOTAL
Numerator	829	3575	11835	5528	2825	24592
Denominator	1149	4221	15498	6900	4938	32706
%	72.1	84.7	76.4	80.1	57.2	75.1

The MCOs continue to claim under reporting for this measure. MCOs report that there are members receiving services but the MCO had not yet received a claim as some providers are not submitting, and or delaying the submission of claims for services. MCO A reported LTC accounts for 86% (713 members) of those 829 members receiving MLTSS services and 6.7% (56) reside in Assisted Living facilities. Additionally, MCO A reported that 9% had Personal Emergency Response Services (PERS) and 8% had Home Delivered Meals. MCO C reported that of the members that did not have MLTSS claims, 5% were receiving Hospice services and 50% had paid PCA/MDC claims. Additionally, MCO C reported that denied claims review identified the top denial reasons: member not eligible on date of service, untimely submission of claim, provider not contracted for service, and lack of authorization. MCO E reported they identified 408 members had no claims for services at all during the measurement period and 270 of those members are currently still enrolled in the plan. Additionally, MCO E reported that 22% of members without services were identified as being newly enrolled in the plan. Furthermore, MCO E plans for re-training staff on services available under the benefit, adding review of MLTSS services to their current audit tool and including those findings in quarterly audit, monitoring MLTSS specific service utilization monthly through the authorization report and sharing with senior leadership. Other analyses and discoveries reported include: unable to contact, members refusing services, or members that were enrolled and disenrolled within the same quarter, provider not contracted for service, expiration of previous authorization and recertification of services, inpatient admission/sub-acute rehab, or member initiating delay in initial face to face visit.

Deliverables due during MLTSS 1st quarter (7/1/2017 - 9/30/2017)

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

4/1/17-6/30/17	A	B	C	D	E	TOTAL
Numerator	3	22	104	41	10	180
Denominator	1150	5710	14389	6451	4894	32594
%	0.3	0.4	0.7	0.6	0.2	0.5

7/1/16-6/30/17	A	B	C	D	E	TOTAL
Numerator	9	30	130	183	27	379
Denominator	579	3378	9644	4469	2974	21044
%	1.5	0.89	1.3	4.09	0.9	1.8

The MCOs continue to report that as they continue to work with approved programs such as Money Follows the Person to identify appropriate NF transitions to the community, there have been increases in the number of MLTSS members transitioning from the NF to the community. MCO A reported in the quarterly measure that two members who transitioned were elderly and disabled. Furthermore, both discharged home and had PCA and other support services arranged. Additionally, MCO A reports a third member diagnosed with a Traumatic Brain Injury who was not eligible for MFP program (Money Follows the Person) was successfully transitioned with collaboration between the care manager, MLTSS Member representative, NF Transition Liaison, NF team, and various providers. MCO B reported that they identified an error in the logic used to develop their quarterly measure and code has been adjusted and data has been rerun to capture the correct logic. MCO B identified this data is under reported for the following reasons: incorrect documentation of setting dates and no plan of care completed timely for new members who transition into an HCBS setting immediately upon MLTSS enrollment. Additionally, MCO B reports that they continue to reeducate CM staff on the importance of living arrangement accuracy and has added process improvement initiatives to identify discrepancies more timely. MCO C reports that for the quarterly measure 26% transitioned to an Assisted Living setting and 4% transitioned to a TBI CRS. Additionally, MCO C reports that the age range of members was 28 to 97, and ages of 54 - 64 had the highest number of transitions at 37%. MCO D reports for their annual measurement the average length of stay in the NF for members who transitioned this year was 123 days and the number of short NF stays prior to transition are decreasing. MCO E reports for their annual measure that of the 27 transitions meeting criteria for inclusion, 8 were facilitated by the NF transition team through the MFP program and 19 were for non-MFP transitions. Additionally, MCO E reported the actual number of MFP transitions was 32 but only 8 met criteria for continuous enrollment and there were no FIDE-SNP members identified. The MCOs continue to track and trend NF to community transitions and assist with identifying members that may be candidates for transition.

PM # 22	New NF living arrangement for MLTSS members
Numerator:	Cases in the Denominator with a NF living arrangement status at any time during the reporting year. (Cases should be counted only once).
Denominator:	Unique count of members continuously enrolled with the same MLTSS MCO from date of initial enrollment in MLTSS during the measurement year
Data Source:	MCO – living arrangement file, prior auth. and/or client tracking system.
Measurement Period:	Annually – Due 30 days after year

7/1/16 -6/30/17	A	B	C	D	E	TOTAL
Numerator	66	2635	1767	1767	121	6356
Denominator	547	6346	3957	3226	5249	19325
%	12.1	41.5	44.7	54.8	2.3	32.8

The number of MLTSS members that are residing in a nursing facility has gradually increased over the past year. Any new admissions to a nursing facility for custodial care must be enrolled in MLTSS; therefore it is expected that this number will continue to grow. The MCO's report they continue to support membership in whatever setting is most appropriate and least restrictive. One MCO reports they will continue to support members in the least restrictive environment and that some members decline in cognitive or functional abilities and that the safest place for them is in a Nursing Facility. All MCOs report they continue to support NF transitions to the community and ensure members are in the appropriate care setting.

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

1/1/17-3/31/17	A	B	C	D	E	TOTAL
Numerator	3	0	15	5	0	23
Denominator	4	12	114	34	4	168
%	75.0	0.0	13.2	14.7	0.0	13.6

The MCO's are continuing to track and trend members returning to the NF within 90 days. MCO C reported that 47% (7) of the members returned due to a functional decline, 27% (4) returned due to lack of informal supports/needs not met in the community, 13% (2) returned due to a safety risk

and 13% (2) returned at the member or family request. Additionally, MCO C reported two members originally refused to stay in the nursing facility and returned due to a functional decline. MCO A reported that three members returned to the NF within 90 days: one after 2 days, one after 70 days, and the third after 83 days from the date of discharge and these members ranged in age from 55 to 73, and all three discharged home with family. MCO E reported a change in the care management assignment process building a team of care managers who will be exclusively working with NF population to identify more appropriate members and continue to coordinate services and transitions wherever members' desires are to return to an HCBS setting.

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

10/1/16 – 12/31/16	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	5	22	136	63	2	228
Denominator	5	23	144	67	2	241
%	100	95.7	94.4	94.0	100	94.6

The MCO's are continuing to track and trend members returning to the NF for greater than 180 days. MCO B reports the average time in NF setting at the time of the data run is 256.55 days and 12 members remained in the community for over one year before transitioning to the NF setting. Additionally, MCO B reports that they developed a process to complete comprehensive review of all members showing a change in setting and case managers are completing a NF screening tool on all NF members to review eligible candidates for NF to HCBS transition. MCO C reports that the top referral source for the NF admit was the family members with 24% (33 referrals) and the second highest was the Facility referrals with 15% (21 referrals). Furthermore, MCO C reports that they are reviewing transitions from HCBS to NF to identify reason for members to return to the community. MCOs will continue to monitor.

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

10/1/16 – 12/31/16	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	0	1	8	4	0	13
Denominator	5	23	144	67	2	241
%	0.0	4.4	5.6	6.0	0.0	5.3

MCOs report they are continuing to monitor and work with community and family supports to prevent hospitalizations and institutionalization. MCO D reports they continue to rapidly assess new members in nursing facilities as they are identified. As changes were made to the process, expedited NF designation on the data exchange has sped up proper plan code assignments. Additionally, MCO D reported they utilize findings for care manager training and follow the NF Diversion protocol to ensure proper transitions. MCO A reports that four of the five members transitioned from the home setting with family and extensive services and supports in the home, and the fifth member resided in Assisted Living prior to institutionalization. Additionally, MCO A reports that they are working to finalize a refrigerator magnet which advises members to call the care manager with any ER or inpatient visit, any critical incident, or any needs that might arise.

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

10/1/16 – 12/31/16	A	B	C	D	E	TOTAL
Numerator	70	357	1354	187	484	2452
Denominator	1222	9073	24643	10814	10047	55799
%	5.7	3.9	4.9	1.7	4.8	4.3

Data for this measure is captured on a monthly basis and the numerators are added together and the denominators are added together to report quarterly data reflecting the number of hospitalizations that occurred per member month. It is based on hospital events and not unduplicated members. The top diagnosis for hospital admission include: COPD, osteomyelitis, chemotherapy, respiratory failure, kidney disease, sepsis, non-ST elevation myocardial infarction, acute kidney failure, muscle weakness, essential hypertension, cellulitis of abdominal wall, CHF, pneumonia, GI bleed, and fractures. MCO D reports two members with multiple admissions during the quarter; one member was admitted 3 times during the quarter for complications from Congestive Heart Failure and one was admitted 4 times with complications of Diabetes Mellitus. MCO A reports that one member had a total of 7 admissions during the quarter with 4 admitting diagnosis of COPD and 3 for osteomyelitis. Additionally, MCO A reports that the member has left the hospital against medical advice, which increases the likelihood of readmissions.

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

10/1/16 – 12/31/16	A	B	C	D	E	TOTAL
Numerator	76	256	609	79	148	1168
Denominator	1810	6926	14935	8223	3047	34941
%	4.2	3.7	4.0	1.0	4.9	3.3

Data for this measure is captured on a monthly basis and the numerators are added together and the denominators are added together to report quarterly data reflecting the number of hospitalizations that occurred per member month. It is based on hospital events and not unduplicated members. Some of the reported diagnoses were related to cholecystitis, sepsis, acute kidney failure, UTI, essential hypertension, unspecified dementia, unspecified bacterial pneumonia, sepsis, ostomy/catheter complications, GI bleed, and CHF. MCO D reports one member was admitted three times for unspecified dementia without behavioral disturbance.

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

10/1/16 – 12/31/16	A	B	C	D	E	TOTAL
Numerator	23	90	144	25	83	365
Denominator	59	477	1314	189	410	2449
%	39	18.9	10.9	13.2	20.2	14.9

Data for this measure is captured on a monthly basis and the numerators are added together and the denominators are added together to report quarterly data reflecting the number of hospitalizations that occurred per member month. It is based on hospital events and not unduplicated members. Some of the reported diagnoses include congestive heart failure, gastrointestinal disorders such as GI bleeding, diverticulosis, intestinal obstruction, sepsis, cellulitis, schizophrenia, renal failure, CVA, UTI, fracture, metabolic imbalance, epilepsy, displacement of catheter, acute respiratory failure, COPD, chemotherapy, and chronic pain. MCO A reports they continue to monitor members for admissions and continues to encourage members, family and hospitals to report any admissions to the care manager. MCO B reports they have a dedicated team of acute care RNs devoted to member discharge planning and is using data to identify opportunities to prevent and/or minimize readmissions.

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

Deliverables due during MLTSS 1st quarter (7/1/2017 - 9/30/2017)

10/1/16 – 12/31/16	A	B	C	D	E	TOTAL
Numerator	6	0	294	8	13	321
Denominator	58	305	1473	79	93	2008
%	10.3	0.0	20.0	10.0	14.0	15.9

Data for this measure is captured on a monthly basis and the numerators are added together and the denominators are added together to report quarterly data reflecting the number of hospitalizations that occurred per member month. It is based on hospital events and not unduplicated members. MCO E reports that the most frequent diagnoses were sepsis with 8 reported events followed by pneumonitis with 2 events. Additionally, MCO E reports other diagnoses as anemia, congestive heart failure, and gastrointestinal hemorrhage. MCO D reported that leading re-admissions were made up of 2 unique members that were readmitted greater than one time, one member had the same readmission diagnoses each time of unspecified bacterial pneumonia and one member had the same readmission diagnoses of cerebral palsy, unspecified. Additionally, MCO D reports they support continuity of care by following up with members post discharge, ensuring that the member and care providers understand the discharge plan, ensuring follow up appointments are scheduled and making changes to the care plan if a change in condition is observed.

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

10/1/16 – 12/31/16	A	B	C	D	E	TOTAL
Numerator	127	106	2488	555	792	4068
Denominator	1216	9073	28054	10814	9903	59060
%	10.4	1.2	8.9	5.1	8.0	6.8

Data for this measure is captured on a monthly basis and the numerators are added together and the denominators are added together to report quarterly data reflecting the number of ER utilizations that occurred per member month. It is based on ER utilization events and not unduplicated members. MCO C reports the top three diagnoses as urinary tract infection, other chest pain unspecified, and chest pain, unspecified. Additionally, MCO C reports that they continue to track and trend and are in the process of including diagnostic groupings. MCO A reports the most frequent diagnoses were head injury, chest pain, and COPD and one member had 7 ER visits for COPD. The member was referred to the MLTSS supervisor so information can be shared with the member's Care Manager to facilitate and identify any member specific needs or obstacles to care.

Additionally, MCO A reports they continue to track ED utilization and will continue to work with their Informatics team to develop a database that will trend and identify individual member's ED patterns of utilization overtime.

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

10/1/16 – 12/31/16	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	87	31	555	196	138	1007
Denominator	1798	6926	15260	8220	3055	35259
%	4.8	0.5	3.6	2.4	4.5	2.8

MCOs are monitoring their respective data to identify patterns, trends, and frequency. MCO E reports there were one hundred unique members that were identified in the numerator with no FIDE-SNP enrollees and eighty of the 100 members were 65 years of age or older. Additionally, MCO E reports that they track and trend facilities with the highest utilization among this population and discovered Palisades Medical Center as having the highest number at 12 events.

PM # 32	# of MLTSS HCBS members using unduplicated Self Directed Services
Numerator:	Total # of MLTSS HCBS members using a least one self-directed service during the measurement period
Denominator:	Total # of MLTSS HCBS members eligible anytime during the measurement period
Data Source:	Division of Disability Services
Measurement Period:	Annual – Due 30 days after end of measurement year

7/1/16 – 6/30/17	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	16	129	427	152	103	827
Denominator	539	3215	8812	2933	4168	19667
%	2.9	4.0	4.8	5.1	2.4	4.2

The above data reflects the number of MLTSS members per MCO who are or have self-directed at least one service during the measurement period (numerator) in comparison to the number of MCO

members per MCO who are enrolled in self-direction for the measurement period (denominator). The above data does NOT reflect total number of MLTSS HCBS enrolled members. As of the end of the reporting period, there continue to be a total of 728 MLTSS members that remain active on the program.

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

10/1/16 – 12/31/16	A	B	C	D	E	TOTAL
Numerator	104	230	1857	323	561	3075
Denominator	519	2271	15498	4267	3733	26288
%	20.0	10.1	12.0	7.6	15.0	11.7

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

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

10/1/16 – 12/31/16	A	B	C	D	E	TOTAL
Numerator	13	98	173	48	503	835
Denominator	519	2271	15498	4267	3733	26288
%	2.5	4.3	1.1	1.1	13.5	3.1

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

Deliverables due during MLTSS 1st quarter (7/1/2017 - 9/30/2017)

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

10/1/16 – 12/31/16	A	B	C	D	E	TOTAL
Numerator	134	1168	1490	537	585	3914
Denominator	495	3334	9913	3753	3666	21161
%	27.1	35.0	15.0	14.3	16.0	18.5

MCOs report they used claims payment systems based on the claims submitted/received by the MCO.

MCO A reports that the most frequently occurring diagnosis was major depression 53%. The second most frequent diagnosis was adjustment disorder 8.9%, third was schizophrenic related disorder 8.2% and bipolar disorder 8.2%. The remaining 21.7% were various mental illness and substance abuse diagnoses. MCO A reports results are shared with the Behavioral Health Administrator in order to ensure the members with behavioral health needs are monitored and appropriate assessments and interventions are in place. Difficult or high intensity cases will be discussed utilizing a multidisciplinary team approach to determine appropriate services. In addition, MCO A reports that a crosswalk is being developed between the NJ Choice Assessment and the behavioral health screeners to improve the identification of members who may have behavioral health needs. MCO D reports that the top 3 disorders based on claims data were major depressive disorder, single episode, unspecified; bipolar disorder, unspecified; and major depressive disorder, recurrent, unspecified. Additionally, MCO D reports a Behavioral Health Administrator who works collaboratively with an interdisciplinary team ensures members diagnosed with a mental illness or a substance abuse disorder are connected to appropriate behavioral health services. MCO E reports eleven members were FIDE-SNP MLTSS and 68% were 65 years of age or older. Additionally MCO E reports the top 5 diagnosis identified were depression/depressive disorder (318 members), schizophrenia (58 members), bipolar disorders, and adjustment disorders (41 members each) and dysthymic disorder with 33 members. The MCOs will continue to monitor the data for trends.

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

10/1/16 – 12/31/16	A	B	C	D	E	TOTAL
Numerator	5	69	139	40	36	289
Denominator	495	3334	9913	3753	3666	21161
%	1.0	2.1	1.4	1.1	1.0	1.3

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

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

10/1/16 – 12/31/16	A	B	C	D	E	TOTAL
Numerator	121	973	1250	476	536	3356
Denominator	495	3334	9913	3753	3666	21161
%	24.4	29.2	12.6	12.7	14.6	15.8

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

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

10/1/16 – 12/31/16	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	8	126	101	21	13	269
Denominator	495	3334	9913	3753	3666	21161
%	1.6	3.8	1.0	0.6	0.4	1.2

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

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

10/1/16 – 12/31/16	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	337	1264	1661	1069	402	4733
Denominator	654	2624	5585	3050	1125	13038
%	51.5	48.2	29.7	35.1	35.7	36.3

MCOs report they used claims payment system based on the claims submitted/received by the MCO. MCO E reports that there of the 402 members identified, only 309 remain active with the Plan (300 in a NF, 5 have transitioned to the community, 3 reside in an ALF, and 1 member is now living in a SCNF. The top 5 diagnoses identified were major depression, adjustment disorder, schizophrenia, bipolar disorder and psychosis/psychotic disorder. Additionally, MCO E reports they have recently trained a new BH CM in an effort to best meet the needs of this population and

will continue to closely monitor findings and continue to recruit BH specialty staff to best manage the care for this population as indicated. MCO C reported that of the 1,661 members with a Behavioral Health diagnosis 4% (70) had a substance abuse diagnosis, 91% (1,506) had a mental illness and 5% (85) had both mental illness and substance abuse diagnoses. MCO B reports that the top diagnoses amongst this population are major depressive disorder, bipolar disorder and schizophrenia. MCO A reports that 58% had the diagnosis of major depression and the second most frequent diagnosis was adjustment disorder at 11%. Additionally, MCO A reported that remaining diagnoses included substance abuse, schizoaffective disorder and bipolar disorder. MCOs will continue to monitor.

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

10/1/16 – 12/31/16	A	B	C	D	E	TOTAL
Numerator	8	21	70	35	7	141
Denominator	654	2624	5585	3050	1125	13038
%	1.2	0.8	1.3	1.2	0.6	1.0

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

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

10/1/16 – 12/31/16	A	B	C	D	E	TOTAL
Numerator	319	1176	1506	1004	388	4393
Denominator	654	2624	5585	3050	1125	13038
%	48.8	44.8	27.0	32.9	34.5	33.6

N = Numerator D = Denominator % = Percentage N/A = Not Available O/D = Over due

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

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

10/1/16 – 12/31/16	A	B	C	D	E	TOTAL
Numerator	10	67	85	30	7	199
Denominator	654	2624	5585	3050	1125	13038
%	1.5	2.6	1.5	1.0	0.6	1.5

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

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

10/1/16 – 12/31/16	A	B	C	D	E	TOTAL
Numerator	22	112	416	445	565	1560
Denominator	519	2271	15498	4267	3733	26288
%	4.2	4.9	2.7	10.4	15.1	5.9

MCO A reported that all of their members continue to meet Nursing facility level of care due to cognitive or functional disabilities and most have supportive family caregivers who provide meals and overnight monitoring. As a result, the members may decline any HDM or PERS services. The MCOs will continue to monitor this data for trends, etc.

Deliverables due during MLTSS 1st quarter (7/1/2017 - 9/30/2017)

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

	MCO	MCO A		MCO B		MCO C		MCO D		MCO E		TOTAL	
18	**Critical Incident (CI) reporting types:**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
a	Unexpected death of a member	0	0	2	1.8	5	0.8	2	2.1	0	0	**9**	**1**
b	Media involvement or the potential for media involvement	0	0	2	1.8	1	0.2	1	1	0	0	**4**	**0.5**
c	Physical abuse (including seclusion and restraints both physical and chemical)	2	15.4	4	3.7	11	1.8	2	2.1	0	0	**19**	**2.2**
d	Psychological / Verbal abuse	0	0	0	0	3	0.5	1	1	0	0	**4**	**0.5**
e	Sexual abuse and/or suspected sexual abuse	0	0	2	1.8	0	0	0	0	0	0	**2**	**0.2**
f	Fall resulting in the need for medical treatment	4	30.8	55	51	167	28	48	50	26	47	**300**	**34**
g	Medical emergency resulting in need for medical treatment	3	23.1	4	3.7	295	49	10	10	14	26	**326**	**37**
h	Medication error resulting in serious consequences	0	0	0	0	2	0.3	0	0	0	0	**2**	**0.2**
i	Psychiatric emergency resulting in need for medical treatment	0	0	3	2.8	20	3.3	0	0	7	13	**30**	**3.4**
j	Severe injury resulting in the need for medical treatment	0	0	2	1.8	11	1.8	2	2.1	2	3.6	**17**	**1.9**
k	Suicide attempt resulting in the need for medical attention	0	0	0	0	0	0	0	0	0	0	**0**	**0**
l	Neglect/Mistreatment, caregiver (paid or unpaid)	1	7.7	8	7.3	3	0.5	3	3.1	1	1.8	**16**	**1.8**
m	Neglect/Mistreatment, self	1	7.7	0	0	3	0.5	0	0	0	0	**4**	**0.5**
n	Neglect/Mistreatment, other	1	7.7	0	0	0	0	0	0	1	1.8	**2**	**0.2**
o	Exploitation, financial	0	0	1	0.9	2	0.3	0	0	0	0	**3**	**0.3**
p	Exploitation, theft	0	0	0	0	3	0.5	0	0	0	0	**3**	**0.3**

N = Numerator D = Denominator % = Percentage

Deliverables due during MLTSS 1st quarter (7/1/2017 - 9/30/2017)

	MCO	MCO A		MCO B		MCO C		MCO D		MCO E		TOTAL	
18	**Critical Incident (CI) reporting types:**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
q	Exploitation, destruction of property	0	0	0	0	0	0	0	0	0	0	**0**	**0**
r	Exploitation, other	0	0	0	0	2	0.3	0	0	0	0	**2**	**0.2**
s	Theft with law enforcement involvement	0	0	0	0	6	1	0	0	0	0	**6**	**0.7**
t	Failure of member's Back-up Plan	0	0	0	0	2	0.3	0	0	0	0	**2**	**0.2**
u	Elopement/Wandering from home or facility	1	7.7	0	0	4	0.7	2	2.1	1	1.8	**8**	**0.9**
v	Inaccessible for initial/on-site meeting	0	0	8	7.3	3	0.5	13	13	0	0	**24**	**2.8**
w	Unable to Contact	0	0	2	1.8	18	3	4	4.1	1	1.8	**25**	**2.9**
x	Inappropriate or unprofessional conduct by a provider involving member	0	0	1	0.9	20	3.3	3	3.1	1	1.8	**25**	**2.9**
y	Cancellation of utilities	0	0	4	3.7	4	0.7	0	0	0	0	**8**	**0.9**
z	Eviction/loss of home	0	0	3	2.8	10	1.7	0	0	0	0	**13**	**1.5**
aa	Facility closure, with direct impact to member's health and welfare	0	0	0	0	0	0	0	0	0	0	**0**	**0**
ab	Natural disaster, with direct impact to member's health and welfare	0	0	0	0	0	0	0	0	0	0	**0**	**0**
ac	Operational Breakdown	0	0	0	0	0	0	0	0	0	0	**0**	**0**
ad	Other	0	0	8	7.3	3	0.5	6	6.2	1	1.8	**18**	**2.1**
	# OF CRITICAL INCIDENTS REPORTED FOR 4/1/2017 - 6/30/2017	13	**A**	109	**B**	598	**C**	97	**D**	55	**E**	**872**	**TOTAL**

There were a total of 872 Critical Incidents reported by the five MCOs during the April 1, 2017 to June 30, 2017 measurement period. These are reported events not unduplicated members. Overall the two most common incidents were: Medical emergency resulting in the need for medical treatment at 326 reported CIs (37% overall) and Fall resulting in the need for medical treatment at 300 reported CIs (34% overall). The next most common event, Psychiatric emergency resulting in need for medical attention, had a total of 30 reported CIs (3.4% overall).

One of the MCOs reported that they found many time when the home-based MLTSS members did not follow through with reporting Critical Incidents. As a result, the CM finds out much later, when she or he can have limited impact. As a result, this MCO is developing a refrigerator magnet that the HCBS MLTSS members will see every time they access their refrigerator. This magnet, which is awaiting final approval, will provide the CM name and contact info along with a reminder to alert their CM with any fall, ED visit, and other events meeting CI criteria.

N = Numerator D = Denominator % = Percentage N/A = Not Available O/D = Over due

Deliverables due during MLTSS 1st quarter (7/1/2017 - 9/30/2017)

Another MCO with falls accounting for 51% of their CIs has their CMs complete a falls screening tool with members in the community to report recent falls, fear of falling and potential fall risks. To date, this MCO has about 4,285 completed tools and 2767 unique members screened. The MCO is working with Living Life Solutions, an application that captures an inventory of fall risks in the member's home. The application prompts clinical staff to mitigate environmental barriers that could increase likelihood of member falls. They plan to use information gathered from screening tools to develop a pilot study with implementation targeted around SFY 2018 Q1.

PM # 18	**Quarterly and Annual Critical Incident reporting for abuse, neglect and exploitation**
Numerator:	# of critical incidents per category
Denominator:	Total # of critical incidents reported for measurement period (quarter or annual)
Data Source:	MCO
Measurement Period:	July 2016 – June 2017

	MCO	**MCO A**		**MCO B**		**MCO C**		**MCO D**		**MCO E**		**TOTAL**	
18	**Critical Incident (CI) reporting types:**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
a	Unexpected death of a member	0	0	4	1	15	0.6	11	2.8	3	1.8	**33**	**1**
b	Media involvement or the potential for media involvement	0	0	11	2.7	6	0.3	8	2	3	1.8	**28**	**0.8**
c	Physical abuse (including seclusion and restraints both physical and chemical)	3	10.3	10	2.4	33	1.4	10	2.6	1	0.6	**57**	**1.7**
d	Psychological / Verbal abuse	0	0	0	0	6	0.3	1	0.3	1	0.6	**8**	**0.2**
e	Sexual abuse and/or suspected sexual abuse	0	0	2	0.5	3	0.1	2	0.5	0	0	**7**	**0.2**
f	Fall resulting in the need for medical treatment	13	44.8	193	47	690	29	145	37	96	57	**1137**	**34**
g	Medical emergency resulting in need for medical treatment	5	17.2	10	2.4	1118	47	47	12	37	22	**1217**	**36**
h	Medication error resulting in serious consequences	0	0	0	0	5	0.2	2	0.5	0	0	**7**	**0.2**
i	Psychiatric emergency resulting in need for medical treatment	0	0	18	4.4	76	3.2	3	0.8	7	4.1	**104**	**3.1**
j	Severe injury resulting in the need for medical treatment	0	0	12	2.9	48	2	13	3.3	5	3	**78**	**2.3**
k	Suicide attempt resulting in the need for medical attention	0	0	4	1	8	0.3	1	0.3	0	0	**13**	**0.4**
l	Neglect/Mistreatment, caregiver (paid or unpaid)	1	3.4	21	5.1	23	1	15	3.8	3	1.8	**63**	**1.9**
m	Neglect/Mistreatment, self	1	3.4	0	0	16	0.7	2	0.5	0	0	**19**	**0.6**

N = Numerator D = Denominator % = Percentage N/A = Not Available O/D = Over due

Deliverables due during MLTSS 1st quarter (7/1/2017 - 9/30/2017)

	MCO	MCO A		MCO B		MCO C		MCO D		MCO E		TOTAL	
18	**Critical Incident (CI) reporting types:**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
n	Neglect/Mistreatment, other	1	3.4	0	0	9	0.4	3	0.8	1	0.6	**14**	**0.4**
o	Exploitation, financial	2	6.9	5	1.2	11	0.5	0	0	0	0	**18**	**0.5**
p	Exploitation, theft	0	0	2	0.5	14	0.6	0	0	0	0	**16**	**0.5**
q	Exploitation, destruction of property	0	0	0	0	0	0	0	0	0	0	**0**	**0**
r	Exploitation, other	0	0	0	0	5	0.2	0	0	0	0	**5**	**0.1**
s	Theft with law enforcement involvement	0	0	5	1.2	18	0.8	2	0.5	1	0.6	**26**	**0.8**
t	Failure of member's Back-up Plan	1	3.4	0	0	9	0.4	0	0	1	0.6	**11**	**0.3**
u	Elopement/Wandering from home or facility	1	3.4	8	2	20	0.8	4	1	2	1.2	**35**	**1**
v	Inaccessible for initial/on-site meeting	0	0	29	7.1	8	0.3	60	15	0	0	**97**	**2.9**
w	Unable to Contact	0	0	15	3.7	79	3.3	28	7.1	2	1.2	**124**	**3.7**
x	Inappropriate or unprofessional conduct by a provider involving member	0	0	6	1.5	94	4	4	1	3	1.8	**107**	**3.2**
y	Cancellation of utilities	0	0	5	1.2	7	0.3	0	0	1	0.6	**13**	**0.4**
z	Eviction/loss of home	1	3.4	5	1.2	35	1.5	3	0.8	0	0	**44**	**1.3**
aa	Facility closure, with direct impact to member's health and welfare	0	0	2	0.5	0	0	0	0	0	0	**2**	**0.1**
ab	Natural disaster, with direct impact to member's health and welfare	0	0	0	0	0	0	1	0.3	0	0	**1**	**0**
ac	Operational Breakdown	0	0	0	0	1	0	3	0.8	0	0	**4**	**0.1**
ad	Other	0	0	43	11	9	0.4	24	6.1	2	1.2	**78**	**2.3**
	# OF CRITICAL INCIDENTS REPORTED FOR 7/1/2016 - 6/30/2017	29	**A**	410	**B**	2366	**C**	392	**D**	169	**E**	**3366**	**TOTAL**

There were a total of 3,366 Critical Incidents reported by the five MCOs during the July 1, 2016 to June 30, 2017 measurement period. The two most common incidents were: Medical emergency resulting in the need for medical treatment at 1,217 reported CIs (36% overall) and Fall resulting in the need for medical treatment at 1,137 reported CIs (34% overall).

When comparing the four reported quarters for WYE 2017 to the annual report, it was discovered that one of the MCOs had re-categorized some of their CIs for the annual report. The overall total of the quarters and the total for the year matched, but the MCO stated that, after further review, some CIs were re-categorized to better reflect the type of critical incident. Moving forward, the MCO reports that they will work to identify any re-categorizations of incidents in the performance measure report itself.

N = Numerator D = Denominator % = Percentage N/A = Not Available O/D = Over due

Deliverables due during MLTSS 1st quarter (7/1/2017 - 9/30/2017)

Another MCO reports that their MLTSS Department runs weekly, monthly, and quarterly reports on all CIs reported to help identify members that may require more frequent contact, visits and/or safety precautions. If it is identified by the MCO's MLTSS Department that a member is experiencing multiple Critical Incidents, the CM is outreached by the CI Team to ensure more frequent monitoring is completed, and that the Plan of Care is meeting the member's needs.

During the measurement period July 1, 2016 to June 30, 2017, another MCO received notification of 169 CIs. They found the number of CIs reported during this WYE 2017 increased significantly over WYE 2016, which had a total of 82 CIs. They state that this increase can be attributed to several factors:

1. MLTSS membership increased over last year from 3788 to 5183.
2. An increase in provider education and understanding in reporting CIs.
3. An increase in staff understanding of what constitutes a CI and their role in reporting through ongoing education.

The Office of MLTSS Quality Monitoring and DoAS are working with the MCOs and the EQRO to revise how CIs are reported and how related data, such as the average time it takes for the MCO to be notified of a CI, is documented and reported to the State.

1115 Comprehensive Waiver Quarterly Report
Demonstration Year 5
Federal Fiscal Quarter: 4/2017 (7/01/17- 9/30/17)
Department of Children and Families/Division of Children's System of Care (DCF/CSOC)

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

- **IDD –MI and ASD Pilots**

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

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

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

- **IDD –MI and ASD Pilots**
- **Measurement period 07/01/2017 - 09/30/2017**

#2 Quality of Life Sub Assurance	All youth that meet the clinical criteria for services through the Department of Children and Families(DCF), Division of Children' s System of Care (CSOC) will be assessed utilizing the comprehensive Child and Adolescent Needs and Strengths (CANS) assessment tool

Data Source	Review of Child and Adolescent Needs and Strengths scores Contracted System Administrator (CSA) Data. Data report: CSA NJ1225 Strengths & Needs Assessment – Post SPC Start	
Sampling Methodology	100% New youth enrolled in the waiver	
Waiver	**ID/DD –MI**	**ASD**
Numerator: Number of youth receiving Child and Adolescent Needs and Strengths (CANS) assessment	178	15
Denominator : Total number of new enrollees	179	15
Percentage	99%	100%

Review of CSOC's Electronic Health Record (EHR) for the single youth missing a Strengths and Needs Assessment (SNA) indicated they were enrolled in the wavier the middle of September and the SNA assessment was scheduled for the beginning of the next month. Further review of the progress notes indicated the family wasn't able to complete the SNA because they moved out of New Jersey the following month and the provider closed . Without the youth our sub assurance compliance is 100% and CSOC will continue to conduct ongoing monitoring for this sub assurance.

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

- **IDD –MI and ASD Pilots**
- **Measurement period 07/01/2017 - 09/30/2017**

#3 Quality of Life Sub Assurance	80% of youth should show improvement in Child and Adolescent Needs and Strengths composite rating within a year	
Data Source	CSA Data on CANS Initial and Subsequent Assessments. Data report: CSA NJ2021CANS Waiver Outcome	
Sampling Methodology	Number of youth enrolled in the waiver for at least 1 year	
Waiver	**ID/DD –MI**	**ASD**
Numerator: Number of youth who improved within one year of admission	791	177

Denominator: Number of youth with Child and Adolescent Needs and Strengths assessments conducted 1 year from admission or last CANS conducted	864	186
Percentage	92%	95%

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

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

- **IDD –MI and ASD Pilots**
- **Measurement period 07/01/2017 - 09/30/2017**

#4 Level of Care Sub Assurance	CSOC's Contracted System's Administrator (CSA), conducts an initial Level of Care assessments (aka Intensity of Services (IOS) prior to enrollment for all youth	
Data Source	CSA Data. Data report: CSA NJ1218 New Enrollees, Quarterly Count and IOS Completed	
Sampling Methodology	100% new youth enrolled in the waiver	
Waiver	**ID/DD –MI**	**ASD**
Numerator: Number of youth receiving initial level of care determination prior to enrollment	179	15
Denominator: Number of new enrollees	179	15
Percentage	100%	100%

CSOC reviewed all new enrollees for the ID/DD – MI and ASD waivers. During the reporting period all the youth met the sub assurance.

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

- **IDD –MI and ASD Pilots**
- **Measurement period 07/01/2017 - 09/30/2017**

#5 Plan of Care Sub Assurance	The Plan of Care (aka Individual Service Plan (ISP)) is developed based on the needs identified in the Child and Adolescent Needs and Strengths assessment tool and according to CSOC policies	
Data Source	CSA Data on Plans of Care completions, Record Review. Data report: CSA NJ1219 Follow – Up Treatment Plan and Associated SNA	
Sampling Methodology	100% of youth enrolled during the measurement period	
Waiver	**ID/DD –MI**	**ASD**
Numerator: Number of Plans of Care that address youth's assessed needs	178	15
Denominator: Number of Plans of Care reviewed	179	15
Percentage	99%	100%

As stated above on youth would not be included since they were enrolled in the waiver late September and have been since been closed to the provider before the ISP would have been due and should not be included. CSOC reviewed all new enrollees for the ID/DD – MI and ASD waivers. Without the youth our sub assurance compliance is 100% and CSOC will continue to conduct ongoing monitoring for this sub assurance.

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

- **IDD –MI and ASD Pilots**
- **Measurement period 07/01/2017 - 09/30/2017**

#6 Plan of Care Sub Assurance	Plan of Care (ISP) is updated at least annually or as the needs of the youth changes

Data Source	CSA Data Report : CSA NJ1289 Waiver ISP Aggregate Report All Youth	
Sampling Methodology	100% of youth enrolled during the measurement period	
Waiver	**ID/DD –MI**	**ASD**
Numerator: Number of current Plans of Care updated at least annually	36	39
Denominator: Number of Plans of Care reviewed	36	39
Percentage	100%	100%

CSOC conducted a review of the data for all youth during the reporting period served under the ID/DD – MI and ASD waivers that have been in the waiver for at least a year. During the reporting all youth on the waiver had at least an annual ISP update. CSOC will continue to monitor this indicator to make sure that ISPs are updated at least annually.

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

- **IDD –MI and ASD Pilots**
- **Measurement period 07/01/2017 - 09/30/2017**

#7 Plan of Care Sub Assurance	Services are authorized in accordance with the approved plan of care (ISP) Data Report: CSA NJ1220 Waiver Services Provided	
Data Source	CSA Data Report of Authorizations Record Review	
Sampling Methodology	100% of youth enrolled during the measurement period	
Waiver	**ID/DD –MI**	**ASD**
Numerator: Number of plans of care that had	179	15

services authorized based on the plan of care		
Denominator: Number of plans of care reviewed	179	15
Percentage	100%	100%

CSOC conducted a review of the data for the youth enrolled during the reporting period under the ID/DD – MI and ASD waivers. The one youth mentioned above also had respite services so a waiver service was provided and was counted. The youth was referred to a Care Management Organization and transitioned prior to a service plan completed by the CMO. CSOC is working to address our reporting process. All the youth who were enrolled in the waiver during this period had an authorization for provided services.

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

- **IDD –MI and ASD Pilots**
- **Measurement period 07/01/2017 - 09/30/2017**

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

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

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

- **IDD –MI and ASD Pilots**
- **Measurement period 07/01/2017 - 09/30/2017**

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

*CSOC does not have data available for this reporting range; we plan to report on this sub assurance next quarter.

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

- **IDD –MI and ASD Pilots**
- **Measurement period 07/01/2017 - 09/30/2017**

#10 Qualified Providers Sub Assurance	Children's System of Care verifies that providers of waiver services initially meet required qualified status, including any applicable licensure and/or certification standards prior to their furnishing waiver services	
Data Source	Record review	
Sampling Methodology	100% Agency	
Waiver	**ID/DD –MI**	**ASD**
Numerator:	N/A*	N/A*

Number of new providers that met the qualifying standards prior to furnishing waiver services		
Denominator: Total number of new providers	N/A*	N/A*
Percentage	N/A*	N/A*

*No new waiver providers were qualified in this quarter.

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

- **IDD –MI and ASD Pilots**
- **Measurement period 07/01/2017 - 09/30/2017**

# 11 Qualified Providers Sub Assurance	Children's System of Care verifies that providers of waiver services continually meet required qualified status, including any applicable licensure and/or certification standards	
Data Source	Provider HR Record Review	
Sampling Methodology	100% Agency	
Waiver	**ID/DD –MI**	**ASD**
Numerator: Number of providers that meet the qualifying standards –applicable Licensures/certification	In Development	In Development
Denominator: Total number of providers that initially met the qualified status	In Development	In Development
Percentage	In Development	In Development

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

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

- **IDD –MI and ASD Pilots**
- **Measurement period 07/01/2017 - 09/30/2017**

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

*CSOC does not have data available for this reporting range; we plan to report on this sub assurance next quarter.

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

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

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

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

# 15 Health and Welfare Sub Assurance	The State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed	
Data Source	Review of UIRMS	
Sampling Methodology	100% of all allegations of restrictive interventions reported	
Waiver	**ID/DD –MI**	**ASD**
Numerator: Number of unusual incidents reported involving restrictive interventions that were remediated in accordance to	In Development	In Development

policies and procedures		
Denominator: Total number of unusual incidents reported involving restrictive interventions	In Development	In Development
Percentage	In Development	In Development

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

# 16 Health and Welfare Sub Assurance	The State establishes overall healthcare standards and monitors those standards based on the NJ established EPSDT periodicity schedule for well visits	
Data Source	MMIS Claims/Encounter Data	
Sampling Methodology	100% of youth enrolled for the reporting period	
Waiver	**ID/DD –MI**	**ASD**
Numerator: Number of youth enrolled that received a well visit	In Development	In Development
Denominator: Total number of youth enrolled	In Development	In Development
Percentage	In Development	In Development

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

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

centered plan authorization		
Denominator: Total number of claims submitted	In Development	In Development
Percentage	In Development	In Development

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