New Jersey Comprehensive Demonstration
Section 1115 Annual Report
Demonstration Year 10: July 1, 2021 – June 30, 2022

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community settings using industry best practices and guidelines;

XVII. STC 73 (p). Policies for any waiting lists where applicable;

XVIII. STC 73 (q) The state may also provide CMS with any other information it believes pertinent to the provision of the HCBS and their inclusion in the demonstration, including innovative practices, certification activity, provider enrollment and transition to managed care special populations, workforce development, access to services, the intersection between the provision of HCBS and Medicaid behavioral health services, rebalancing goals, cost-effectiveness, and short and long-term outcomes;

XIX. STC 73(r) A report of the results of the state's monitoring activities of critical incident reports; and

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I. Introduction

The New Jersey Comprehensive Demonstration (NJCD) was approved by the Centers for Medicare and Medicaid Services (CMS) on October 2, 2012, and as a result of a six-month extension followed by an additional thirty-day extension, is effective August 1, 2017 through January 30, 2022.

The first five years of the demonstration was initiated to:

- 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;
- Furnish premium assistance options to individuals with access to employer-based coverage.

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

- Maintain its MLTSS program;
- Achieve better care coordination for and the promotion of integrated behavioral and physical health for a more patient centered care experience, and to offer aligned financial incentives and value-based payments;
- Simplify and streamline the administration and oversight of services in order to better

monitor the overall health of the Medicaid population; as well as act as the first step to remove silos of care for I/DD youth transitioning from the children's system into the adultsystem;

- To provide access to services earlier in life in order to avoid unnecessary out-of-home placements, decrease interaction with the juvenile justice system, and see savings in the adult behavioral health and I/DD systems;
- To build on current processes to further streamline eligibility and enrollment for NJFC beneficiaries;
- To reduce hospitalizations and costs associated with disease and injury;
- Establish an integrated behavioral health delivery system that includes a flexible and comprehensive substance use disorder (SUD) benefit and the New Jersey continuum of care;
- To expedite financial eligibility for Medicaid in a timely manner for individuals placed under the OPG in order to receive needed Medicaid coverage;
- To provide evidence-based home visiting services to low-income families to promote enhanced health outcomes, whole person care, and community-integration.

This annual report is submitted in accordance with Special Term and Condition (STC) 73 of the NJCD.

II. STC 73 (a) Items included in the Quarterly Reports must be summarized to reflect the operation/activities throughout the DY;

The items included in the quarterly report are summarized throughout the annual report to reflect operation/activities throughout DY10.

III. STC 73 (b) Total annual expenditures for the demonstration population for each DY, with administrative costs reported separately

The administrative cost for demonstration year (DY) 10 is $1,010,856,239. This cost includes the entire Medicaid program, including salaries and benefits for all employees, not only in Medicaid, but county eligibility staff, translation services, and the cost of running the fiscal agent contract, Molina, Conduent, and all other vendors, etc.

IV. STC 73 (c) Total contributions, withdrawals, balances, and credits;

Total contributions, withdrawals, balances and credits are included in Attachment F at the end of this report.

V. STC 73 (d) Yearly enrollment reports for demonstration enrollees for each DY (enrollees include all individuals enrolled in the demonstration) that include the member months, as required to evaluate compliance with the budget neutrality agreement;

Demonstration Populations by MEG	Total Number of Demonstration participants Quarter Ending – 09/21	Total Number of Demonstration participants Quarter Ending – 12/21	Total Number of Demonstration participants Quarter Ending – 03/22	Total Number of Demonstration participants Quarter Ending – 06/22	Member Months DY 10
Title XIX	798,896	816,124	821,572	836,174	9,795,878
ABD	227,589	226,479	222,856	223,149	2,727,408
LTC					
HCBS - State plan	18,678	18,640	18,581	19,167	224,766
TBI – SP					
ACCAP – SP					
CRPD – SP					
GO – SP					
HCBS - 217-Like	18,666	18,726	18,673	19,149	225,448
TBI – 217-Like					
ACCAP – 217-Like					
CRPD – 217-Like					
GO – 217-Like					
SED - 217 Like	421	430	424	421	5,127
IDD/MI – (217 Like)	670	632	572	527	7,437
NJ Childless Adults					
Expansion Adults	699,936	716,324	723,612	736,037	8,599,232
SED at Risk	2,720	4,911	5,065	5,416	51,881
MATI at Risk					
Title XXI Exp Child					
NJFAMCAREWAIV-POP 1					
NJFAMCAREWAIV-POP 2					

VI. STC 73 (e): A Report of Service Use by Program Including Each HCBS Program (encounter data)

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

VII. STC 73 (f) A Summary of the Use of Self-directed Service Delivery Options in the State

The State of NJ maintained health and safety precautions due to the public health emergency (PHE) during the demonstration year. To assure access to personal care services (PCS), the Personal Preference Program (PPP) Team continued its collaboration with NJ's fiscal intermediary (FI) by continuing to provide the operational flexibilities that support current participants and those newly seeking self-directed PCS.

To protect the health and safety of NJ FamilyCare (NFJC) members, their families, and the FI's staff, members retained the ability to request to conduct Information and Assistance (I&A) visits via telephonic outreach or as an online interaction. These activities included new enrollment, wage updates, quarterly visit activities, expedited enrollment for prospective participants that required prompt access to the PPP, faster access to new hires, and rate changes for current workers for beneficiaries currently accessing the PPP. As restrictions eased throughout DY 10, NJFC members were offered the option to request in-person I&A while assuring all required safety protocols were followed while in the home. Due to the operational processes currently in place, PPP enrollment for NJFC participants continues to grow. The current program flexibilities allow PPP/MLTSS members to replace face-to-face meetings with telephonic/online interactions for both currently enrolled and those newly seeking self-direction when requested, unless a face-to-face meeting is preferred.
For PPP participants receiving the managed long-term services and supports (MLTSS) program, enrollment increased by 18% from DY9 to DY10. The self-directed option for NJFC members created an opportunity to better support members, current and new, with options to meet them in real-time. The updated process currently in place assures NJFC members are able to maintain their safety in the community while exercising choice when accessing their personal care services (PCS). The PPP looks to continue offering both in-person and telephonic/online options for its members as a best practice for NJFC members seeking the self-directed option.

VIII. STC 73 (g): A General Update on the Collection, Analysis and Reporting of Data by the Plansat the Aggregate Level

<u>Encounter Data</u>

The main data set that the DMAHS Office of Business Intelligence is responsible for is receiving encounter data from the MCOs. Section 3.9 of the managed care contract requires our plans to "collect, process, format, and submit electronic records for all services delivered to an enrollee." The plans are required to submit encounter records on at least a monthly basis, although there are submissions that generally occur more frequently. DMAHS has a unique set of encounter claim edits to ensure consistency and readability of encounters across the varied MCOs. The Office of Business Intelligence also sets category of service utilization benchmarks in certain areas to ensure completeness of the data submitted by the plans, and have contractual requirements related to duplicate encounter submissions and encounter MMIS denial rates. Failure to meet these requirements initially results in the withholding of capitation payments to the MCOs until the failure is resolved. If the contracted standards are not met after a specified period of withholding, the withheld amounts are liquidated and not recoverable by the plans. Plans are also required to submit encounters for payments to subcontractors and the service encounter claim information from these subcontractors.

The MCOs maintain an automated claims and encounter processing system that supports the requirements of the MCO contract, ensures the accurate and timely processing of claims and encounters and delivers records

representing all services provided to covered recipients including those services managed through a subcontracted relationship and the payments to any such subcontractor to the State. Section 3.9 of the managed care contract requires our MCOs to "collect, process, format, and submit electronic records for all services delivered to an enrollee." The MCOs are required to submit encounter records on at least a monthly basis, although there are submissions that generally occur more frequently. DMAHS employs a unique set of encounter claim edits to ensure consistency and readability of encounters across the varied MCOs. Excess encounter denial rates result in immediate financial penalties. The State also sets category of service utilization benchmarks in certain areas to ensure completeness of the data submitted by the MCOs. Failure to meet these requirements initially results in the withholding of capitation payments to the MCOs until the failure is resolved. If the contracted standards are not met after a specified period of withholding, the withheld amounts are liquidated and not recoverable by the MCOs.

Shared Data Warehouse

The Division contracts for the operation of a shared data warehouse that includes nearly all data available from the MMIS and some data from external sources (such as NJ Choice MLTSS Assessment Data, Long Term Care recipient data from the Division of Aging Services, and Electronic Birth Certificate information from the Department of Health). Access to this warehouse is available to Division staff and to certain select staff in other state departments/agencies (Department of Treasury – Office of Management and Budget, Office of State Comptroller – Medicaid Fraud Division, Department of Law and Public Safety – Division of Criminal Justice for example), with data expertise and consulting available through the Division's Office of Business Intelligence and its shared data warehouse contractor. The warehouse allows for ad-hoc and production reporting of various data metrics and is also used as the source of data for various interactive data dashboards maintained by the Office of Business Intelligence. The Research and Performance Evaluation functions within the Office of Business Intelligence are the division's "data experts" and are responsible for defining performance metrics derived from data available from the shared data warehouse and other sources and presenting this information in audience-specific formats, with products ranging from the public-facing Data Dashboards available through the NJ FamilyCare website to detailed claims-based analysis in support of future policy making and fraud detection.

PIP Project Quarterly Update

Currently, the Division of Medical Assistance and Health Services (DMAHS) is actively engaged in three performance improvement projects (PIPs) in both clinical and non-clinical areas. In January 2019, Aetna (ABHNJ), Amerigroup (AGNJ), Horizon (HNJH), United (UHC), and WellCare (WCHP) initiated a collaborative clinical PIP with a focus on Risk Behaviors and Depression in the Adolescent Population. The MCOs will submit a final report in August 2022, as the concluding sustainability data collections were completed in June 2022.

In September 2020, the five MCOs submitted individual non-clinical PIP proposals with a focus on Access to and Availability of Provider Services tied to claims. January 2022 was the start of remeasurement year 2 for AGNJ, HNJH, UHC, and WCHP. In April 2022, these four MCOs submitted project status updates, which included the results of remeasurement year 1 data. ABHNJ revised their aim statement and performance indicators, resulting in a new PIP cycle. ABHNJ submitted a PIP update in April 2022, which included results of the baseline year data and remeasurement year 1 quarter 1 data.

In September 2021, the five MCOs submitted individual clinical PIP proposals with a focus on Preventative Care in the first 30 months of life. The individual proposals were reviewed and approved by the EQRO, and the MCOs have initiated project activities in early 2022. The MCOs submitted a PIP update in April 2022, which included results of the baseline year data and remeasurement year 1 quarter 1 data.

MLTSS PIP Quarterly Update

The Decreasing Gaps in Care PIP, in which all 5 MCOs are participating, entered Sustainability, the third year in

the PIP cycle. In August 2021, all 5 MCOs submitted progress report updates which included the 2018 baseline data, all of which were reviewed and accepted by the EQRO and the State in November 2021.

In October 2018, Amerigroup was required to resubmit their PIP proposal on member falls, titled New Falls, as a result of incongruent and inconclusive data observed in the entirety of their initial Falls PIP. Amerigroup submitted their New Falls PIP proposal in October 2018. The New Falls PIP Proposal was approved and accepted by the State in collaboration with the EQRO. Amerigroup submitted their Sustainability update in August of 2021 and the final report was received and reviewed by the State in conjunction with the EQRO in August 2022.

A New PIP Topic "Improving Coordination of Care and Ambulatory Follow-up after Mental Health Hospitalization in the MLTSS Home and Community Based (HCBS) Populations" was introduced to the Plans in June of 2021. All 5 MCOs submitted in September 2021. The new PIP Proposals were accepted by the State in conjunction with the EQRO and feedback was provided to the Plans in November 2021. All 5 MCOs submitted Project Status and Baseline Updates in April 2022. Year one reporting was received and reviewed by the State in conjunction with the EQRO in August 2022.

MLTSS PIP Annual Update

All 5 MCOs submitted individual PIP proposals in December 2018 on the topic of Decreasing Gaps in Care specific to members receiving Managed Long-Term Services and Supports. The individual proposals were approved and the Health Plans initiated project activities in early 2019. All 5 MCOs submitted a progress report update in August 2020 on the topic of Decreasing Gaps in Care which included the 2018 baseline data which the EQRO reviewed. January 2021 was the start of Sustainability Year, or third year, for this PIP topic. Recommendations for performance improvement provided to the MCOs regarding this new topic were to target preventative services for MLTSS members and /or target services related to chronic disease. All 5 MCOs submitted a Sustainability progress report update in August 2021 on the topic of Decreasing Gaps in Care which included the 2018 baseline data, all of which were reviewed and accepted by the EQRO and the State in November 2021. The Decreasing Gaps in Care PIP topic entered the Sustainability year and the final report has been submitted to the EQRO and will be is currently under review by the State in conjunction with the EQRO.

All 5 MCOs provided Project status updates for the Decreasing Gaps in Care PIP project through March 2021 which were submitted in April 2021. Amerigroup was required to revise their Decreasing Gaps in Care PIP submission due to recommendations from the EQRO, as and as result lagged one year behind in the PIP project cycle. All 5 MCOs submitted their Gaps in Care PIPs timely for review. The Gaps in Care PIP is currently in the Sustainability phase and was submitted to the EQRO and reviewed in collaboration with DMAHS in August of 2022.

IX. STC 73 (h): Monitoring of the Quality and Accuracy of Screening and Assessment of Participants who Qualify for HCBS/MLTSS

MLTSS

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

During the period of July 1, 2021 through June 30, 2022, the below data identifies the number of SCS that resulted in referrals for comprehensive assessments. 60% of screens that identified at risk individuals were referred for comprehensive assessment based on consumer consent. This is mostly consistent with trends over the past several years.

SCS -I&A/Options Counseling	5,015
SCS – comprehensive assessment recommended	6,177
SCS referred for comprehensive assessment	3,737
TOTAL	11,192

The NJ Family Care Managed Care Organizations (MCO) are the entities responsible for identifying and screening members who are identified as in need of long-term services and supports. Members who screen positively or who request an assessment regardless of outcome are referred for a comprehensive assessment. The SCS has been shared with the MCOs for their programming and use and effective January 1, 2020 is a state mandated tool. Reports are pending development for inclusion of MCO screenings in future reports.

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

Effective March 1, 2020, NJ received a waiver from CMS on the completion of initial and annual level of care assessments as a result of COVID-19 state of emergency. All face-to-face assessments and visits for MLTSS members were suspended and alternate processes developed for the assessment of individuals newly seeking MLTSS enrollment. Effective November 15, 2021, face-to-face visits have been permitted to resume while flexibilities continue to be used in certain circumstances. As a result of the continued suspension of assessments from 7/1/21 to 11/15/21, there is no analysis of the change from one demonstration period to another and reporting will be limited to the number of assessments and outcomes.

During the period of July 1, 2021 through June 30, 2022, 48,257 assessments for MLTSS level of care determination were submitted. 47,012 assessments for MLTSS level of care determination (97.42%) provided a determination for existing MCO members. . A "Not Authorized determination" is issued when the level of care criteria does not appear to be met based on the MCO assessment. OCCO staff will outreach the member, conduct an in-person reassessment, and make a determination of Approved or Denied level of care. In the event of a Denial, the individual is provided fair hearing rights and the right to continue benefits during the fair hearing process. In the event of an Approval of level of care, the OCCO determination will enable continued enrollment and benefits. The final level of care determination was 5,221 Authorized with full review (11.11%), 40,812 authorized without review (86.81%) and 0 Denied (0.00%). 979 assessments (2.08%) were not provided a determination through the review process and are labeled as "Not Authorized". This rate is slightly above 2% which is the state benchmark. Denial determinations are not being issued for enrolled MLTSS members for the duration of the PHE. There were 845 assessment submissions,that were unable to be determined; these consisted of duplicate submissions, requests that MCO conduct a new assessment, outcome pending more information/screening by another entity (i.e. DDD), or other non-determination outcome. This represents 11.99% of submissions requesting a determination. DoAS distributes these reports to the MCOs annually and reviews overall trends at a care management meeting with a discussion on quality oversight best practices to reduce the percentage of non-determinations.

Effective February 1, 2017, the Department changed its internal policy of reviewing 100%of the MCO annual reassessments for existing MLTSS members to an "Authorization without Review" and auditing process. This allows the State to enter continued clinical eligibility upon receipt of the assessment without a review of the assessment. The State's role in review and determination has been to ensure that assessment and clinical eligibility determinations are completed accurately and in accordance with policy and regulatory requirements. Through ongoing training and quality assurance oversight, the review and determination process have an overall authorization rate of 97.87% and a less than 1% denial rate. The not authorized outcome percentages have stabilized in the 2% or lower range which is well within the initial established benchmark which was dropped from 7% to 5% effective July 1, 2018 based on continual improvement. Not Authorized rate is defined as the percentage of MCO assessments with a Not Authorized outcome that are subsequently determined as Approved for clinical eligibility following the OCCO reassessment.

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

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

The MCO is the responsible entity for identifying the criteria and identifying what level of review is required by the State through the assessment submission process. Various quality processes are in place to ensure authorization without review are appropriate including 1) MLTSS enrollment status is validated prior to entering the continued clinical eligibility, 2) evidence of prior clinical eligibility is validated prior to entering the continued clinical eligibility, 3) Monthly auditing of a sample of submitted records. The State may review any assessment submission at its discretion for any reason.

The State has conducted 3784 random audits – 9.27% of assessments not subject to review between July 1, 2021 and June 30, 2022. Statewide, 2.95% of audits were deemed "unsatisfactory" which is an increase from the prior year rate of 1.30%. Two MCOs have a rate of 4.45% and 4.50 % which was significantly higher than the other 3 MCOs. Unsatisfactory is defined as an assessment which does not meet one or more of the following criteria: 1) Nursing facility level of care was not able to be validated; 2) Special care nursing facility level of care was not able to be validated; 3) Assessor not registered as certified to conduct assessment in State's database; 4) assessment was not appropriate for the "authorization without review" process. In the event of an unsatisfactory audit, a full review is conducted and the Contractor is required to conduct analysis of the report to identify and implement a remediation plan. The State will continue to audit monthly and continue technical assistance and training for the MCOs on identified areas of weakness to improve accuracy and quality of the Authorization without Review process.

NJ Choice Assessment was suspended and not in use from March 2020 to November 2021. The overall quality of assessments for all MCOs was noted to be lower upon the resumption of the NJ Choice Assessment in November 2021. This was attributed to 1) length of time in which the tool was not used, 2) number of new

assessor staff, and 3) identification that both the MCO and State staff were not consistently applying established policies which may have resulted in a higher percentage of unsatisfactory outcomes than was warranted. Audit results from November 2021 through March 2022 were used by each respective agency to evaluate staff proficiency, compliance with processes, and retraining. No consequences were applied during this period. Beginning in April 2022, the audit results were evaluated for action plans. Four of the MCO rates were able to meet the compliance requirement; one MCO failed to meet the compliance requirement for the months of July and August and was issued a Corrective Action Plan in August 2022.

NJ Choice HC Recertification

Individuals who conduct assessment utilizing the state's standardized assessment tool are required to undergo recertification and demonstrate competency every three years. The recertification for all stakeholders conducting NJ Choice assessment including the MCOs was held in February/March 2021. MCO Care Management Supervisors and Master Trainers were the target audience. The MCOs then conduct training for their employees. The yearly quality monitoring component has been waived due to the requirement of in-person monitoring which has not been feasible during the PHE.

Supports Program/ Community Care Program

DDD's assessment tool, the New Jersey Comprehensive Assessment Tool (NJ CAT), is conducted through an electronic process and is completed by an individual that is knowledgeable about the service recipient. The NJCAT is the tool used to identify an individual's budget and also to determine program eligibility. This includes items like: age, Medicaid eligibility, living arrangement, if they are on another Demonstration program, etc. In addition to verifying the accuracy of screening and assessment of participants at the time of enrollment DDD conducts monthly audits to check the ongoing eligibility criteria. In addition to DDD's internal monitoring, all external DDD audits review the NJCAT for eligibility and cross-check the assessment findings with other documents for consistency (ie: person-centered planning tool, individual service plan, case notes, etc.).

I/DD-MI Program, Serious Emotional Disturbance Program:

DCF/CSOC's Contracted System Administrator (CSA) promotes improved outcomes for youth and their family/caregivers through utilization management, care coordination, quality management, and information management processes. CSOC's CSA provides a 24/7 single point of access to care for youth, families and caregivers living in New Jersey. The CSA performs a broad range of administrative service not limited to the following:

A. Providing a Customer Service Call Center with 24/7 intake and Customer Service capability;
B. Providing a web-based application that interfaces with the CSA's Management Information System (MIS);
C. Utilization management and prior authorization;
D. Coordinating access to services for youth, and;
E. Providing Quality and Outcomes Management, and System Measurement that supports CSOC's goal to promote best practices and providing assistance to the State in assuring compliance with State and federal guidelines.

CSOC collaborates with the State's Medicaid authority, the Department of Human Services, Division of Medial Assistance and Health Services to provide oversight of the Children's Support Services Program Intellectual and or Developmental Disabilities (CSSP I/DD). To ensure that youth are appropriately identified for demonstration enrollment, an eligibility algorithm was developed in collaboration with the CSA to identify youth. Youth that meet the demonstration criteria are enrolled into the Children's Support Program Intellectual Disabilities/Developmental Disabilities (CSSP I/DD) if they meet the criteria for the program. The demonstration algorithm identifies eligible youth and supports CSOC claiming Federal Financial Participation (FFP) for

demonstration services.

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

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

X. STC 73 (i): GEO Access Reports from Each Participating MCO

The Geo Access Report Summary is located under Attachment B.

XI. STC 73 (j) Waiting List(s) Information by Program Including Number of People on the List and the Amount of Time it Takes to Reach the Top of the List Where Applicable

New Jersey currently has a waiting list for the Community Care Program (CCP), however all members on the CCP waiting list are receiving services through the Supports program. There are approximately 2,100 individuals on the CCP Waiting List. During 2022, approximately 500 individuals were reached on the Waiting List.

XII. STC 73 (k): The Various Service Modalities Employed by the State, Including Updated Service Models, Opportunities for Self-direction in Additional Program, etc.

Supports Program

The implementation of the Supports Program has given the State the ability to provide home and community-based services to developmentally or intellectually disabled individuals who do not meet an institutional level of care. The Supports Program (SP) is the primary demonstration program that ID/DD young adults enter upon high school graduation, and traditionally replaces that educational entitlement with day services such as employment, career planning, day habilitation and pre-vocational services. Without these HCBS supports, members would likely deteriorate and would need institutional services.

Community Care Program

The implementation of the Community Care Program has given the State the ability to provide home and community-based services to developmentally or intellectually disabled individuals who meet an institutional level of care, and without these HCBS supports would require institutional services. The Community Care Program (CCP) is the demonstration program for adults with ID/DD that require significant HCBS service needs, and provides members with the budget authority to purchase needed supports and services while allowing them to continue residing in the least restrictive residential setting. Most individuals in the CCP choose to access similar day supports as members in the Supports Program, but members in the CCP can also

access individual supports to assist with gaining independence both in their homes and communities. There are a variety of additional HCBS supports available, such as behavioral supports, therapies, and environmental and home modifications.

SED

The CSSP SED Program provides behavioral health and HCBS benefits to beneficiaries under the age of 21 with a serious emotional disturbance (SED), who are at risk of hospitalization or require out-of-home treatment or hospital level of care. The program is administered through DCF and the Children's System of Care (CSOC) for individuals under 21 who have SED, and provides additional waiver services including social and emotional learning services, interpreter services and non-medical transportation. Additionally, this waiver provides Plan A benefits to youth that meet waiver criteria that would not otherwise meet Medicaid eligibility criteria.

I/DD-MI

The CSSP I/DD program provides HCBS benefits and supports to beneficiaries under the age of 21 that meet DCF criteria of functional eligibility for youth with intellectual or developmental disabilities. Individuals may also have co-occurring I/DD and mental health diagnoses. The program is administered through DCF and the Children's System of Care (CSOC) and provides services including individual supports, and intensive in community/in home therapeutic services and behavioral health services.

MLTSS

MLTSS provides HCBS services through a managed care delivery system to aged and disabled members who would otherwise require an institutional level of care. Services provided through MLTSS include private duty nursing, care management services, community residential services and assisted living. The implementation of MLTSS removed the silos of services that were created with the individual 1915(c) waivers.

Self-Direction

Self-directed options provide a portable budget allowing families to identify the amount and types of services needed. The Comprehensive Demonstration allowed the State to provide increased opportunities for self-direction and give different groups of individuals access to more services through MLTSS, the Community Care and Supports Programs. Within the Community Care and Supports Programs, DDD continued to see an increase in self-direction as a result of the public health emergency. Individuals and family members have stated that they have enjoyed the alternative programming options and the ability to ascertain new types of services through self-direction.

XIII. STC 73 (l): Specific Examples of How HCBS Has Been Used to Assist Participants

MLTSS

MLTSS provides comprehensive long-term services and supports through managed care, to expand home and community-based services and enhance community inclusion. The following accounts detail some of the ways in which care management has provided assistance for members.

Aetna

The member is a 61-year-old male who had an above the knee left leg amputation in 2020. The member was enrolled in MLTSS in August 2020. The member was residing at a Nursing Facility upon enrollment and expressed desire to transition home. Unfortunately, the member encountered delays due to his recovery time from the amputation, therapy associated with recovery from surgery, the use of a prosthetic, and finding appropriate housing after multiple housing applications.

The member had applied to 10 different housing programs in multiple counties but after being wait-listed at many different buildings, the member was referred to the Money Follows the Person Housing Partnership

Program (MFPHPP) which assisted the member in locating an accessible apartment in March of 2022.

The Aetna Case Manager along with the Housing Specialist, MFPHPP team members, and NF team held thorough transition IDT (Inter-Disciplinary Team) meetings with the member's brother to solidify plans for discharge planning and service initiation. It was decided that upon transition to the community, the member would receive 14 temporary hours of PCA services until a PCA assessment could be conducted in the community. In addition, the member was to receive MLTSS services such as Home Delivered Meals and PERS. The Aetna Member Advocate also arranged for furniture, clothes, and food to be delivered upon discharge. The Aetna Better Health Housing Specialist continued to follow up with the property manager to ensure that the member was approved for the apartment and to confirm the discharge date. The Housing Specialist continued communication with the property manager until a determination was finalized.

The transition team and the member were notified in April that the member was officially approved for the apartment. The transition team was able to provide all the necessary services for a safe discharge to the member's new community home. The member transitioned to his new apartment in May 2022. The member is very happy to reside in the community after years spent in a facility.

Amerigroup

The member is a 65-year-old male with a medical diagnosis of End-stage Liver Disease and Cirrhosis of the liver. The member had a past history of alcohol abuse, however, has been sober for over ten years. The member was residing in a nursing facility when first enrolled in MLTSS in August 2020. The member had intensifying confusion due to increased ammonia levels. The member had multiple hospitalizations related to liver disease and needed medical follow-up, which the member was not completing. The member was also not compliant with the medication regimen at that time.

The member's goal was to transition from the nursing facility to the community to retain as much of their independence as possible. The MLTSS care manager reached out to the member to discuss their health status, goals, needs, etc. The member discussed the need to remain in the community going forward. The care manager was able to initiate MLTSS services of PCA, Personal Emergency Response System, and Home Delivered Meals to aid in members' ADL/IADL assistance needs. The care manager was able to communicate with the member's family to aid in supporting the members' success in the community. The member was able to successfully transition into the community in May of 2021. The member now has the support of his brother and sister-in-law, who although residing a distance away, now take the member to all doctor appointments, laboratory appointments, and prepare his medication box weekly. The care manager, upon following up with the member and family, noted that a companion pet may aid the member's emotional needs. The care manager was able to assist the family with obtaining options for a pet cat which gives the member emotional support and supports the member's goal to remain as independent as possible.

The member now is compliant with all medications, follow-up medical appointments, and all prescribed regimens. Member appears less confused and remains happy residing in the community. The MLTSS CM continues to follow up with the member and PCA services remain in place. All MLTSS services remain in effect as well as the informal support of his family and the quarterly follow-up of his MLTSS CM.

Horizon

The member is a 29-year-old man who is blind and has cerebral palsy, among other diagnoses, and resides in the community with his mother. He is actively receiving PCA services, Home Delivered Meals, and MLTSS Care Management.

In March 2022, during a routine 90-day telephonic outreach, the member's mother reported that she was

pending eviction and that she wasn't able to attend the court hearing as the member could not be left alone. This news was especially concerning as the member is legally blind and has lived in his home since he was 4 years old.

Shortly after, the member's mother reached out to the Horizon CM again confirming that eviction papers were going to be served. The MLTSS CM immediately consulted with both Horizon's Member Advocate and Housing Specialist. Horizon's Member Advocate provided the CM with information regarding a potential COVID relief related grant. Unfortunately, the grant application was only available via internet submission. The family did not have internet access and did not own a computer. The CM completed a home visit and assisted the mother in completing the online application. During the visit, the CM also scanned all necessary documents and uploaded them to the grant portal. The CM also assisted the mother with calling the local county housing department to open a case for the member.

With these steps completed, the member's mother was able to request an eviction extension. The CM returned to the member's home again to scan additional documents for the grant application and also participated in a call with the county housing department to coordinate gathering other necessary information which would be needed to assist with housing. The next day, the CM was contacted by the court constable informing her that he would be going out to the family's residence to process the eviction and he wanted to know if the family had somewhere else to reside. In response, the CM again worked closely with the county housing department to ensure the member's documentation was faxed to the courthouse to show that the mother was working with agencies to attempt to pay back-rent. This allowed the mother to receive another eviction stay which provided enough time for the COVID relief grant to be approved.

The county's board received approval for back-rent and an additional 3 months of rent paid through June 2022. The member's mother is extremely appreciative of the help received by MLTSS. By working together, the MLTSS CM and the member's mother were able to salvage the member's home, the only home the member has known.

United

The UHC member is a 55-year-old woman who had lived in a Nursing Facility for 4 years and needed help to transition safely back to community with supports. The Member's apartment was set up for the member, personal care services, home delivered meals, PERS (Personal Emergency Response Services), PDN services for wound care to her left leg were set up to ensure a safe and sustainable transition to the community. Monthly visits with an infusion nurse as well as a PCP appointment and transportation were scheduled. The CM worked with the member to ensure understanding of monthly social security benefits and bills needing to be paid, now that she lives alone in the community. The CM is also in the process of setting the member up with adult daycare services.

Prior to discharge from the nursing facility the UHC CM went to the member's empty apartment to await the delivery of furniture, including a hospital bed, and a tub chair, groceries, and DME to set up the new household.

The member also lacked access to a cell phone or way of communicating post-discharge. The UHC CM completed an Assurance Wireless application online on behalf of the member. There were multiple calls made over a two-week period to Assurance Wireless and National Verification to address different issues which resulted in delays with the application being processed. Shipment of a new wireless cell phone was expedited and delivered to the facility before the member was discharged to the community.

The member reported that medications were left at the nursing facility during the discharge. The UHC CM

placed a call to nursing facility, and the medications were dropped off to the member at her new home. The CM also sent emails to the UHC Pharmacy Service Specialist regarding issues filling needed prescriptions. The member did not have her Medicare Part D card in her possession, so the UHC CM held a conference call with the member and Medicare to obtain correct Medicare Part D information. The CM then called Walgreens Pharmacy to provide Medicare Part D information. The Pharmacist was then able to process her medications. The CM placed call to the member's PCA who agreed to pick up the medication on the way to home next scheduled visit. The PCA provides daily medication reminders due to the member's forgetfulness.

Post Discharge, the member reported swelling and blistering on her left leg. The CM placed calls over several days to a home health care service to ensure a referral was received by the NF. Due to incorrect contact information, the member missed several calls from the visiting nurse to schedule visits. Once the updated contact information was provided, the visiting nurse was able to make contact and is visiting the member at home twice a week.

WellCare

The member is an 80-year-old who currently lives alone with no family support. The member's only support is his emergency contact a family friend, who stops by multiple times a week to assist with grocery shopping and taking out the garbage. The member has many medical issues including an Amputated right leg due to poor blood circulation. He is not able to see out of his right eye due to cataract. The member has a prosthetic leg and uses a wheelchair to ambulate. The member is approved for both PERS (Personal Emergency Response Services) and HDM (Home Delivered Meals).

Upon the Care Manager's meeting with the member in February, the member reported being non-compliant with medications, frequent fall risk, smoking cigarettes daily and an ill-fitted prosthetic leg. At this time the member refused PCA and additional services due to not wanting anyone in the home because of unsanitary living conditions. The member was ashamed and embarrassed of his living situation. Member reported that a provider stopped by a few weeks prior, took one look at his condition and walked out. The CM attempted to encourage acceptance of services.

Following the visit, the CM contacted the member's friend and discussed potential safety concerns and provided options for counseling. The member's friend agreed to continue to encourage the member to accept services and agreed to reach out to the CM as needs arise. A follow up visit was conducted with a CM supervisor. The WellCare MLTSS team reviewed the member's medical needs, and emphasized the importance of accepting medical care, and reminded the member that he deserves to receive services that help him live a good, happy and safe life. Elaine had also been encouraging member to accept services. The member reluctantly accepted MLTSS chore services and agreed to consider PCA services after chore services were completed.

The Chore service provider, visited the member's home and encouraged the member to accept PCA services. The Chore service provider agreed to clean members home which would take 3 days and 2 people to clean due to the conditions.

In addition, the CM reached out to the WellCare Housing Specialist to see if any resources for furniture were available. The CM was able to assist and connect the member with items he desperately needed including: a bedroom set (dresser, night stand with lamp, bed with frame headboard), linens, cleaning supplies and a mattress. The Housing Specialist and CM ensured that the member's home was clean and tidy before furniture was delivered.

When the Chore Service was complete, the service provider called the CM stating the member had denied

food as his refrigerator and stove were not in working condition. The service provider inquired whether there was a way to provide working appliances for the member. A mini fridge and microwave were purchased for the member.

The member was paranoid about deliveries and visitors, and stated he would refuse and has been back and forth about services. The CM spoke to the MLTSS Chore Services provider about handling this home improvement with care and providing the member with reassurance and empowerment. The CM spoke to the neighbor to clarify the member's concerns, and she will be present during deliveries to decrease anxiety. The HHA was there the day of furniture delivery as well.

The MLTSS Chore Services provider is a church-based organization and continues to support the member with obtaining support and services as the need arises.

I/DD-MI Program, Serious Emotional Disturbance Program:

The demonstration waiver provides additional community support and coordination of services for individuals that meet the clinical criteria for services though the Department of Children and Families (DCF), Children's System of Care (CSOC). This includes services for certain NJ FamilyCare eligible individuals that have been diagnosed with a serious emotional disturbance (SED) and individuals with intellectual/ developmental disabilities and a co-occurring mental illness (ID/DD-MI). The Children's System of Care (CSOC) is pleased to share the following success stories received from the Care Management Organizations (CMOs) that detail the impacts demonstration services have had on the quality of life for the youth and their families or caregivers.

1. The member was referred to the CMO and as a result of the services she received, saw improvement with behavioral and daily living challenges. Since working with Individual Support Service (ISS) provider, the youth has shown initiative completing Activities of Daily Living (ADLs) in the home and has learned age-appropriate coping skills in which she no longer engages in Serious Injurious Behavior (SIB) and elopement in the community when out with the caregiver. The ISS providers were able to successfully enhance the youth's ability to independently eat her food, complete tasks such as cleaning her room and other daily living skills such as dressing and hygiene. The caregiver excitedly reported that the ISS provider assisted with increasing youth's communication skills, as the youth was often shy and rarely spoke. Now the youth is often found socializing with peers and family, and engaging in conversation. The youth successfully transitioned from the Care Management Organization (CMO) on January 2022.

2. The member was enrolled in Mobile Response in April 2019. At the time of referral, the youth demonstrated physical aggression, property destruction, school refusal, and anxiety. The youth is predominantly non-verbal. Transitioning from one task to another had a triggering effect, where he would become anxious about any change in his routine and act out. The youth also had obsessive compulsive behaviors and needed assistance with proper consistent hygiene. The CMO has been able to deliver consistent care management services, and in November 2019, Intensive In-Home (IIH-C) clinical services were put in place. The youth now goes into the community with his therapist. The youth has gained significant skills in safety and his ability to be redirected. He waves to his neighbors and has gained some handwriting skills. The youth's hygiene is improving, and he does yoga and breathing exercises to help him cope. Lastly, he has not destroyed property or displayed physical aggression for months.

3. The member was enrolled with the CMO due to suicidal and homicidal ideations, violence towards animals, and maladaptive behaviors towards showering and grooming. The youth received IIH clinical services for a period of 1.5 years. Throughout this time, the youth met with a provider twice per week for 1-hour sessions. At the transition of IIH-C services, the youth reported a decrease in violent thoughts and feels comfortable

sharing when these thoughts are overwhelming. The youth has learned to advocate for herself and was able to attend her brother's graduation ceremony, as she requested to have special accommodations made for her (i.e., she had a private viewing room). The youth is showering and grooming herself appropriately. The youth is now able to walk the family dog. The family believes that IIH-C services have helped the youth learn how to manage her mental health.

4. This member was referred to CMO services because of challenges with toileting and expressive language. The youth received IIH behavioral and ISS services. Through participation, improvement with both of these needs has been demonstrated. The youth has expanded their vocabulary and with improved expressive language is better able to communicate needs with limited outbursts and behavioral disruptions. There was successful collaboration between the CMO and the youth's school, especially the speech therapist. It was also reported that toileting needs were improved (60% improvement as measured by days that a pull-up was needed to be worn throughout the day).

XIV. STC 73 (m) A description of the intersection between demonstration MLTSS and any other state programs or services aimed at assisting high-needs populations and rebalancing institutional expenditures (e.g. New Jersey's Money Follows the Person demonstration, other federal grants, optional Medicaid Health Home benefit, behavioral health programs, etc.

Money Follows the Person/Nursing Facility Transitions

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

First Quarter July 2021 Sept 2022

MCO	**# of Transitions**
Aetna	15
Amerigroup	31
Horizon	101
United Health Care	24
Wellcare	13
Quarter Total	**184**

Second Quarter Oct 2021- Dec 2021

MCO	**# of Transitions**
Aetna	21
Amerigroup	22

Horizon	99
United Health Care	10
Wellcare	10
Quarter Total	**162**

Third Quarter Jan 2022- March 2022

MCO	# of Transitions
Aetna	16
Amerigroup	15
Horizon	78
United Health Care	19
Wellcare	8
Quarter Total	**136**

Fourth Quarter April 2022- June 2022

MCO	# of Transitions
Aetna	15
Amerigroup	24
Horizon	88
United Health Care	22
Wellcare	17
Quarter Total	**166**

Grand Totals for DY

MCO	# of Transitions
Aetna	67
Amerigroup	92
Horizon	366
United Health Care	75
Wellcare	48
Grand Total	**648**

PACE

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

ten counties.

PACE in New Jersey	
NAME	**COUNTIES SERVED**
Trinity Health LIFE	Camden; parts of Burlington
Lutheran Senior LIFE	Hudson
LIFE St. Francis	Mercer; parts of Burlington
Inspira LIFE	Cumberland, Gloucester, Salem
Beacon of LIFE	Monmouth; Ocean
AtlantiCare LIFE Connection	Atlantic; Cape May

	BEACON OF LIFE	TRINITY HEALTH LIFE	LUTHERAN SENIOR LIFE	INSPIRA LIFE	LIFE ST. FRANCIS	ATLANTICARE LIFE	Total State Enrollment
Avg. Monthly Enrollment SFY17	56	224	132	229	305	N/A	946
Avg. Monthly Enrollment SFY18	88	220	130	259	321	25	1043
Avg. Monthly Enrollment SFY19	114	215	128	275	334	65	1161
Avg. Monthly Enrollment SFY20	137	215	126	274	346	93	1191

Avg. Monthly Enrollment SFY21	161	199	131	275	306	92	1164
Avg. Monthly Enrollment SFY22	191	178	124	270	278	111	1152

PACE Initiatives during DY:

- Six established PACE programs are currently serving an average of 1152 participants which is a slight decrease over the last year.
    - PACE program operations began in Ocean County in 2022, with one provider serving all county zip codes
- Union and Essex County service areas are under development.
    - Essex County is pending application submission to CMS.
    - Union County has submitted their application to CMS.
- Requests for Application have been posted for Bergen, Passaic, Middlesex, and Somerset counties

XV. STC 73 (n) A summary of the outcomes of the state's Quality Strategy for HCBS

Managed Long Term Services and Supports:

Please refer to attachment C.2 for MLTSS performance measures.

I/DD-MI Program, Serious Emotional Disturbance Program:

Please refer to attachment C.1 on CSOC performance measures.

Comprehensive Audit

The Division of Medical Assistance and Health Services' Quality Management Unit (QMU) performs a Comprehensive Audit of Autism Spectrum Disorder (ASD) Program and Children's Support Services Program (CSSP) for youth with Intellectual/Developmental Disabilities (I/DD) Children's System of Care (CSOC), a division of the Department of Children and Families (DCF), administers these programs. In addition, the QMU performs comprehensive audits of the Community Care Program (CCP) and the Supports Program, both of which are administered by the Division of Developmental Disabilities (DDD) within the NJ Department of Human Services (DHS).

The QMU monitors these programs for their quality management strategies through the evaluation of level of care determinations, responsiveness of plans of care to participants' needs, verification of provider qualifications, health and welfare assessments, and fiscal accountability.

The COVID-19 pandemic presented challenges for all branches of State government, including DMAHS, DDD and DCF. During this Public Health Emergency (PHE), DMAHS was required to adjust priorities. One of these adjustments was adherence to CMS' direction to put these and other audits on hold, and because of this, a placeholder was submitted for SFY 2021. We are now reporting on CY 2019 due to the audit pause related to the PHE. CMS has allowed us the flexibility to combine the 2020 and 2021 audits into one report, and once this has been completed, the QMU expects to return to the pre-pandemic cycle of reporting.

Children's System of Care (CSOC)

A Comprehensive Audit of the Autism Spectrum Disorder (ASD) Program and the Children's Support Services Program for youth with Intellectual/Developmental Disabilities (I/DD) for CY 2018 was completed in 2019 and was submitted to CMS in the DY8 Report in 2020. The CY 2019 audit was completed in 2021, and that report is currently being finalized.

Supports Program Audit

The Supports Program audit for CY 2019 is in progress and is expected to be completed by the end of 2022. The results of this audit will be provided during the next reporting cycle. The CY 2018 audit result findings were submitted in the DY8 Report in 2020.

Community Care Program (CCP) Audit

The CCP audit for CY 2019 is in progress and is expected to be completed by the end of 2022. The audit for CY 2018 was completed in December 2019. Because all audit-related work was paused during the PHE, the Final Report was generated in December 2021.

The QMU recognizes and understands the compliance issues for the CY 2018 audit are mainly due to the shift from the 1915c Waiver to the 1115 Demonstration and the various system changes by DDD that occurred around the same time. With proper implementation of the remediation methods by DDD, the QMU expects improvements in audit results and compliance rates for the CY 2019 audit.

XVI. STC 73 (o): Efforts and Outcomes Regarding the Establishment of Cost-effective MLTSS in Community Settings Using Industry Best Practices and Guidelines

The state developed and employs a cost effective/cost neutral placement policy in which MLTSS members will most often receive the most cost-neutral placement which will typically be in a community setting. The MCO is required to evaluate the cost neutrality of the plan of care for all MLTSSS members receiving HCBS in a community setting. Members whose cost of HCBS services exceed 85% or 100% of the state established threshold cost of institutional care are counseled on the cost effectiveness process. An Interdisciplinary Team Meeting is convened to review the plan of care, services needed, and develop a plan of care within the confines of the cost effectiveness threshold or at a higher cost based on an exception. Exceptions are recommended by the interdisciplinary team and approved by the DMAHS Medical Director based on temporary higher care needs or long term complex medical needs typically met through private duty nursing services. The IDT process ensures that members through a collaborative process are provided choice of placement, evaluated for risk, and have a back-up plan implemented as necessary. The cost effective/cost neutral policy which focuses on the individual member needs, choice and safety while maintaining overall program cost neutrality is based on industry best practice ascertained from other state's MLTSS programs

What are we (and the plans) doing and is it effective?

MCOs are required to provide service coordination and care management with a holistic perspective. All MLTSS members have an MCO assigned care manager who is responsible to coordinate acute care, long term care (MLTSS) and behavioral health services to ensure the member is as safe and independent in the community as possible. In addition, the state requires the MCO to ensure linkages to community-based services (based on need) that do not necessarily fall into a covered benefit category. This has been effective in ensuring members are connected to services and supports in their local community.

MCOs have been effective at ensuring Members receive HCBS to allow them to remain in the community, are diverted from institutional placements and avoid unnecessary use of the emergency room. MCOs also achieve

cost effectiveness by ensuring through case management, HCBS Services are provided to mitigate the need for more intensive and costly services.

XVII. STC 73 (p) Policies for Any Waiting Lists Where Applicable

The Community Care Program utilizes a waiting list to provide individuals with the opportunity to be enrolled onto the program where financial and program availability allows. When there is an opening, members move into the program on a first come, first served basis. Members may be prioritized on the waiting list in the case of crisis or emergency. While they are on the waiting list, all members receive services through the Supports program. DDD spends approximately $50 million each state fiscal year to reduce the CCP waiting list.

XVII. STC 73 (q): The State may also provide CMS with any other information it believes pertinentto the provision of the HCBS and their inclusion in the demonstration, including innovative practices, certification activity, provider enrollment and transition to managed care special populations, workforce development, access to services, the intersection between the provisionof HCBS and Medicaid behavioral health services, rebalancing goals, cost-effectiveness, and short and long-term outcomes.

Managed Long Term Services and Supports Program

MCOs continue to link with NJ's County Welfare Agencies for the purpose of assisting members with applying for programs such as utility assistance and NJ SNAP. MCOs also continue to connect with county-based Aging and Disability Resource Connections (ADRCs) to assist members with linking to community based LTSS services that are not covered by the MCO. During the current public health emergency, MCOs and the state are continuing to work collaboratively to ensure eligibility is maintained and services are delivered in alternate methodologies to ensure maximum protection of health and safety.

The state continues to work with the MCOs on the nursing facility to community transition process. As is shown above, the state remains committed to working with MCOs to ensure that members who desire to transition to more independent living in the community are afforded this opportunity in the safest and most practicable way possible during the public health emergency.

Summary of Consumer Issues from July 1, 2021 to June 30, 2022

MLTSS:

ANNUAL MLTSS Claims Processing Information by MCO

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
Total Submitted	670,463	1,524,751	3,427,819	477,731	1,293,534
Paid	538,318	1,394,802	3,137,340	420,250	1,092,277
Denied	109,200	110,051	236,019	43,155	164,395
Pending	22,945	19,898	49,460	7,854	36,862

4th Quarter MLTSS Claims Processing Information by MCO

	Aetna	Amerigroup	Horizon NJ Health	UnitedHealthcare	WellCare
Total Submitted	187,500	424,336	932,173	143,332	351,597
Paid	151,453	404,573	861,176	130,218	302,915

Denied	30,260	18,996	65,917	11,095	36,676
Pending	5,787	767	5,080	2,019	12,006

Top 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.	Duplicate Claim/service	This claim is a duplicate of a previously submitted claim for this member	Claim not submitted per EVV guidelines	Per ICD-10 the combined diagnosis codes cannot be reported together.
2	Exact Duplicate of a claim or service	Units exceed UM authorization	Incomplete/Missing Payer Claim Control Number	No Authorization on file	Prior Authorization required but not obtained
3	Time limit for filing a claim has passed	EVV submission error	Provider not eligible by contract for payment	Claim is a duplicate	Claim not submitted per EVV guidelines
4	Non-covered charges	Denied because preauthorizatio n was not obtained	Resubmit with EOB from primary carrier	Need for secondary carrier information	The time limit for filing this claim has expired
5	Invalid combination of HCPCS modifiers	Claim submitted after timely filing	Resubmit with EOB from Medicare	Claim submitted after timely filing deadline	Must submit an EOB from primary insurance carrier

MLTSS Outreach and Communications to Ensure Access Update

The State has continued to maintain its efforts to ensure that consumers, stakeholders, MCOs, providers and other community-based organizations are knowledgeable about the comprehensive demonstration and informed of changes. The State has depended on its relationships with stakeholder groups to inform consumers.

DHS provided updates to the above referenced stakeholders through the New Jersey Medical Assistance Advisory Council, a group comprised of medical care and health services professionals as well as advocacy groups who advise the State's Medicaid Director.

During the state of emergency, DHS continues outreach and technical assistance efforts with consumers and stakeholders. DHS has a webpage dedicated to COVID-19 flexibilities and interim processes to communicate to providers and facilitate access to services for consumers. Additionally, DMAHS hosts weekly calls with the five contracted MCOs to provide updates specific to the public health emergency and identify challenges and policy needs.

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

I/DD-MI Pilot Program, Serious Emotional Disturbance Program:
Provider Enrollment/Access to Services
There are (166) CSOC qualified providers that deliver demonstration services.

Total Number of Agencies Qualified by the CSOC to Deliver Demonstration Services

Demonstration	Demonstration Service	Number of Qualified Agencies
CSSP I/DD	Individual Supports	28
CSSP I/DD	Intensive In- Community Services – Habilitation (IIH) (Clinical/ Therapeutic)	33
CSSP I/DD	Intensive In- Community Services – Habilitation (IIH) (Behavioral)	29
CSSP I/DD	Respite	75
CSSP I/DD	Interpreter Services	0
CSSP I/DD	Non-Medical Transportation	1

Total Number of New Agencies Qualified by the CSOC to Deliver Demonstration Services

Demonstration	Demonstration Service	Number of Qualified Agencies
CSSP I/DD	Intensive In- Community Services – Habilitation (IIH) (Behavioral)	0
CSSP I/DD	Interpreter Services	0
CSSP I/DD r	Non-Medical Transportation	0

No new demonstration providers were added during this reporting period.

Quality Strategy Measures
The results of the Quality Strategy Measures can be found in Attachment C.1.

XIX. STC 73(r): A Report of the Results of the State's Monitoring Activities of Critical Incident Reports

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

XX. STC 73(s): Medical Loss Ratio (MLR) Reports for each participating MCO

	SFY21 MLR Summary	
	Acute	**MLTSS**
Horizon	96.7%	96.2%

UHC	95.7%	94.1%
Amerigroup	92.8%	98.7%
Aetna	89.6%	95.8%
Wellcare	96.7%	95.1%

XXI. Other Topics of Mutual Interest between CMS and the State

Managed Long Term Services and Supports Program

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

Following the transition to MLTSS on July 1, 2014, the state has maintained its efforts to ensure that consumers, stakeholders, MCOs, providers and other community-based organizations have learned and are knowledgeable about the move to managed care. The state has depended on its relationships with stakeholder groups to inform consumers about the implementation of MLTSS. In turn, stakeholders have relayed accurate information to consumers. This strategy has continued in the post-implementation phase. The Division of Aging Services (DoAS) is the primary liaison to the aging and disability networks. The DoAS has oversight of the Aging and Disability Resource Connection (ADRC) partnership as the single entry/no wrong door system for consumers to access MLTSS. The state continues to meet with groups ranging from the Human Services Directors, the 21 Area Agencies on Aging (AAAs), the County Welfare Agencies (CWAs) to the State Health Insurance Assistance Program (SHIP) counselors and Adult Protective Service (APS) providers on a regular basis.

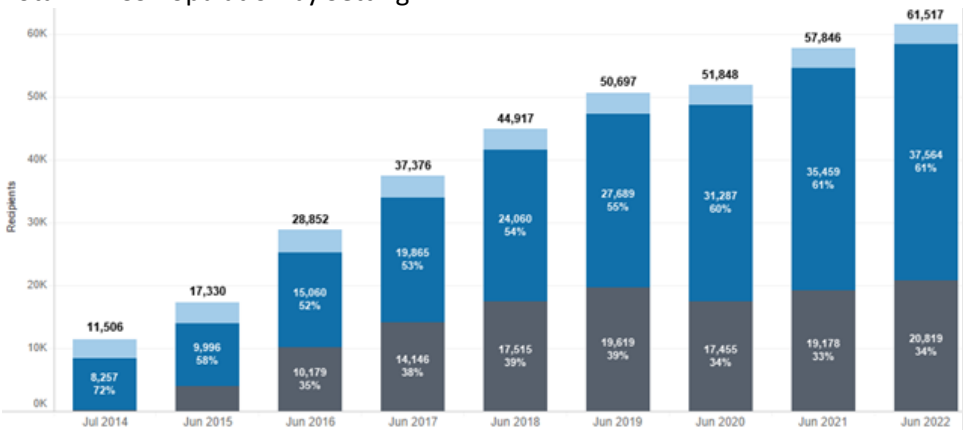
The DMAHS Office of Managed Health Care (OMHC), with its provider relations unit, has been at the forefront in spearheading communications efforts to ensure access through its provider networks in the following categories—HCBS medical; HCBS non-medical; nursing homes; assisted living providers; community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

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

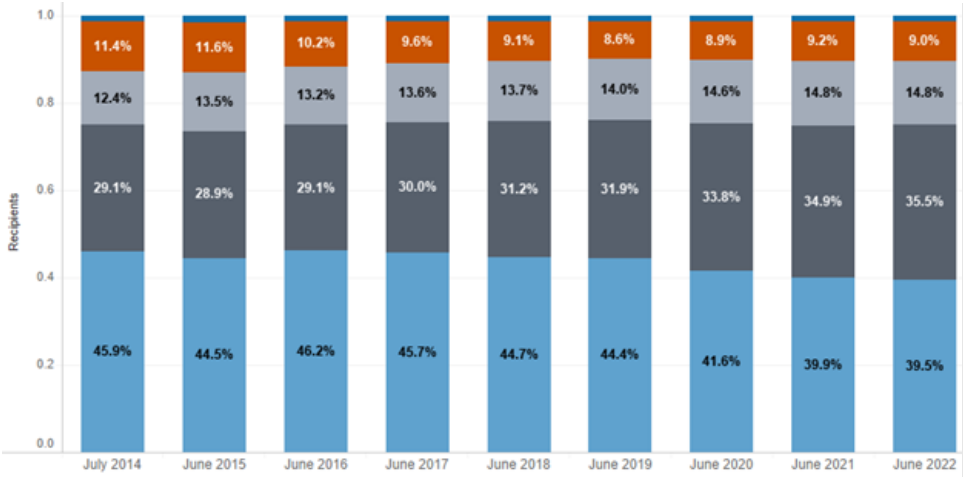
As of June 30, 2022, a total of 61,517 individuals were enrolled in MLTSS. As shown in the chart below, as the program has grown and evolved, more individuals are enrolled in Home and Community-Based (HCBS) settings than Nursing Facilities (NF). Please note that the growth of the NF population since July 1, 2014 is due to new

NF enrollees and individuals moving from fee-for-service into MLTSS. The overall NF population has decreased since July 2014 by over 6,000 people. This reduction is partially attributable to the pandemic.

Total MLTSS Population by Setting



Below is a breakdown of MLTSS participants by age group. The largest segment group of individuals enrolled in MLTSS is 80 years of age and older. Approximately 75 percent of the MLTSS population is ages 65 and older.
9MLTSS Population by Age Group



HCBS Settings Requirements

New Jersey is continuing to work toward ensuring all Medicaid beneficiaries receive services in the settings most appropriate for them. All divisions impacted by the final HCBS Settings rule (Title 42 Public Health, Chapter IV, Subchapter C Part 441.301) have identified through the CMS crosswalk, those areas needing to come into compliance. The state has finalized regulatory changes needed to ensure compliance. The state is engaging with Medicaid contracted managed care organizations to leverage this resource as a way to ensure ongoing compliance for relevant providers.

Interim Management Entity Update

As part of the Demonstration, the state identified University Behavioral Health Care (UBHC) within Rutgers University to develop and implement a 24-hour call center (ReachNJ) and an Interim Managing Entity (IME) to manage adult Substance Use Disorder (SUD) treatment services while the state moved toward an integrated managed system of care. The IME went live on July 1, 2015 and continues to serve as a point of entry for residents seeking treatment or information about SUD.

During the annual reporting period from July 1, 2021 to June 30, 2022, the IME received 36,618 calls from individuals seeking information, referral or admission to SUD treatment. There were 3,421 referrals to treatment and 3,021 individuals who received Care Coordination to facilitate treatment admission. The UM staff issued 31,640 clinical reviews for admission to the appropriate level of care, and 13,455 clinical reviews for extended treatment for Medicaid recipients and clinical reviews for treatment extensions for Medicaid beneficiaries based on clinical need. The IME received and responded to a total of 5,798 calls on the provider assistance call line to support Medicaid SUD treatment providers.

Operational/Policy Updates

Self-attestations for transfer of assets:
There were a total of 1181 self-attestations for the time period of July 1, 2021 to June 30, 2022.
MCO Choice and Auto-assignment:
10,147 individuals changed their MCO after auto-assignment.

XXII. An updated budget neutrality analysis, incorporating the most recent actual data on expenditures and member months, with updated projections of expenditures and member months through the end of the demonstration, and proposals for corrective action should the projections show that the demonstration will not be budget neutral on its scheduled end date.

The budget neutrality workbook is available under Attachment F under this report.

XXIII. Enclosures

A) 1115 Demonstration Service Units and Claims
- a. ASD Pilot, I/DD-MI Pilot Program, SED Program
- b. Managed Long Term Services and Supports
- c. Supports
- d. CCP

B) Geo Access Report by MCO
C.1) ASD and ID/DD-MI Performance Measurement Report
C.2) MLTSS Performance Measurement Report
D) Critical Incident Report
E) Supports/CCP Report Update
F) Budget Neutrality Analysis

XXIV. State Contacts

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XXV. Date Submitted to CMS

FEE FOR SERVICE PAYMENTS, SERVICE UNITS, AND CLAIM COUNT FOR JULY 1, 2020 THROUGH MARCH 31, 2021 FOR IDD-MI, AND SED
FEDERALLY MATCHED WAIVER SERVICES

Notes:

Service from dates for claims span July 1, 2020 through March, 31, 2021 and were paid from July 1, 2020 and August 13, 2021. Only non-voided, paid claims are reflected in the data.

IDD-MI and SED wavier services are defined by CCB295, Appendix A "New Services", for procedures marked as Matchable for SPC 37 under SED, Matchable for SPC 38 for IDD/MI, and Matchable for SPC 47, 48, 49 under Waiver. Fields to be matched include procedure code, modifiers 1 and 2, provider type, provider specialty code, special program code, and CSOCI enrolled indicator. NJMMIS Project Request Report # 14947 incorporating language interpreter services as a IDD/MI matchable waivered services is also used to identify matchable waivered claims.

Report categorizes claims as a IDD-MI or SEDS claim only if **ALL criteria** are satisfied on Appendix A OR NJMMIS Project Request Report 14947.

Row Labels	CLM PROC CDE	CLM PROC MOD CDE	CLM PROC MOD 2 CDE	PROV TYPE CDE	PROV SPECLT CDE	CLAIM PMT AMT	CLAIM SVC UNITS QTY	NET PAID CLAIM COUNT
IDD/MI						**5,241,867**	**411,199**	**28,345**
COMM BASED WRAP AROUND SERV(II HABIL	**T2021**	52	**HO**	44	**826**	**834,955**	**39,387**	**4,517**
COMM BASED WRAP AROUND SERV(II HABIL	**T2021**	HA	**HO**	44	**826**	**62,581**	**2,976**	**227**
COMM BASED WRAP AROUND(II HABILITATI	**T2021**	HA	**HN**	44	**826**	**4,613**	**246**	**49**
COMMUN BASED WRAP AROUND SERV(II HAB	**T2021**	22	**HA**	44	**826**	**812,822**	**28,865**	**4,386**
COMMUN BASED WRAP AROUND SERV(II HAB	**T2021**	HA	**22**	44	**826**	**20,538**	**727**	**81**
COMP COMM SUPP SERV(HAB IN HOME)	**H2016**	HA	**HO**	44	**826**	**2,808,987**	**250,917**	**14,785**
COMP COMM SUPP SERV(INDIV SUPPORTS)	**H2015**	HA	**HN**	44	**826**	**1,581**	**253**	**5**
COMP COMM SUPP SERV(INDIV SUPPORTS)	**H2016**	HA	**HN**	44	**826**	**139,939**	**12,614**	**629**
COMP COMMUN SUPP SERV(IND SUPPORTS)	**H2015**	HA	**HO**	44	**826**	**22,391**	**3,596**	**220**
HABILITATION RES(DDD OUT OF HOME SER	**T2016**	HA	**U1**	44	**825**	**31,008**	**203**	**203**
HABILITATION RES(DDD OUT OF HOME SER	**T2016**	HA	**U2**	44	**825**	**54,408**	**177**	**95**
MENTAL HEALTH ASSESSMENT(BCBA)	**H0031**	HA	**22**	44	**826**	**4,739**	**76**	**19**
RESPITE CARE IN HOME (PER 15 MINS)	**S9125**	HA	**52**	44	**865**	**443,306**	**71,162**	**3,129**
SED						**30,548,802**	**512,460**	**102,605**
BEHAVIORAL ASSIST SERVICES EA 15 MIN	**H2014**	TJ	**BA**	44	**903**	**3,413**	**350**	**90**
BEHAVIORAL ASSIST SERVICES EA 15 MIN	**H2014**	TJ	**U1**	44	**903**	**1,003**	**113**	**19**
BEHAVIORAL ASSIST SERVICES EA 15 MIN	**H2014**	TJ	**U2**	44	**903**	**410**	**42**	**5**
BEHAVIORAL ASSIST SERVICES EA 15 MIN	**H2014**	TJ	**TU**	44	**903**	**45**	**8**	**1**
CSOCI CARE MANAGEMENT (CMO) SERVICES	**Z5008**			44	**901**	**17,216,034**	**22,214**	**22,298**
GRP BEHAV ASSIST SERV 2 CHILDREN	**H2014**	TJ	**UN**	44	**903**	**9,756**	**1,736**	**216**
HOSPITAL LEAVE JCAHO RTC/DYFS	**Y9952**			59	**897**	**6,017**	**11**	**11**
IIC ASSESSMENT-CLIN LICENSED PRACT	**H0018**	TJ	**U1**	44	**902**	**17,628**	**156**	**52**
INDIVID BEHAVIOR ASSIST SERV 15 MIN	**H2014**	TJ		44	**903**	**673,398**	**69,272**	**10,160**
INTENS IN-COM GRP CLIN LEV 2 CHILD	**H0036**	UN	**U1**	44	**902**	**34,200**	**1,800**	**224**
INTENS IN-COM INDIV CLIN LEVEL SERV	**H0036**	TJ	**U1**	44	**902**	**7,700,756**	**273,874**	**43,736**
INTENS IN-COMM PROF IND SERV MASTERS	**H0036**	TJ	**U2**	44	**902**	**2,880,932**	**136,041**	**20,958**
MEN HLTH REHAB GROUP HOME/DYFS	**Y9935**			44	**897**	**142,331**	**1,254**	**1,048**
MEN HLTH REHAB GROUP HOME/DYFS	**Y9935**			44	**899**	**329,099**	**1,936**	**483**
MEN HLTH REHAB JCAHO RTC/DYFS	**Y9948**			59	**896**	**232,290**	**522**	**522**
MEN HLTH REHAB JCAHO RTC/DYFS	**Y9948**			59	**897**	**34,461**	**63**	**63**
MH RHAB TRANSITIONAL LIVNG HOME/DYFS	**Y9936**			44	**899**	**114,308**	**713**	**488**
MH RHB NON-RTC RESIDENTIAL CARE/DYFS	**Y9943**			44	**896**	**780,191**	**1,661**	**1,682**
MOBILE RESPONSE - INITIAL	**S9485**	TJ		44	**894**	**326,304**	**240**	**240**
MULTISYSTEMIC THERAPY FOR JUVENILES,	**H2033**			44	**903**	**10,614**	**183**	**38**
MH RHAB IN TREATMENT HOMES / DMHS	**Y9932**			44	**897**	**35,612**	**271**	**271**
Grand Total						**35,790,669**	**923,659**	**130,950**

FEE FOR SERVICE PAYMENTS, SERVICE UNITS, AND CLAIM COUNT FOR JULY 1, 2021 THROUGH MARCH 31, 2022 FOR MLTSS WAIVER RECIPIENTS

CLM_PROC_CDE	PROC_LAYMAN_NME	Net Paid Claim Indicator	Claim Payment Amount	Service Units Quantity
		238	$ 1,228,774.88	5925
S5102	MEDICAL DAY CARE	286	$ 24,624.60	286
T2031	ASSIST LIVING WAIVER/DIEM	53	$ 70,987.48	1318
Y7574	CPCH DAILY RATE	166	$ 262,277.85	4562
Y9633	ALR DAILY RATE	1277	$ 2,103,728.62	36195
		2,020	**$ 3,690,393.43**	**48,286**
Behavioral Health FFS Total		**22,045.00**	**3,683,146.51**	**71,123.00**
Grand Total MLTSS or LTC Fee for Service, including Behavioral I		**24,065**	**7,373,540**	**119,409**

Notes:
Service from dates for claims span July 1, 2021 through March, 31, 2022 and were paid from July 1, 2021 and October 14, 2022. Only non-voided, paid claims are reflected in the data. Medical Day Care, Managed Long Term Supports, Personal Care Assistant Services (not including self-directed Personal Care), and Nursing Facility claims and services are defined using the Fee for Service Category of Service and a waiver Special Program Code on the claim.

DDD Supports Waiver - July 1, 2020 through March 31, 2021

Data run through 8/13/2021

Row Labels	Claim Payments	Service Units Quantity	Net Paid Claims
ALCOHOL AND/OR DRUG SERVICES	172,199	23,958	2,365
BEHAV ASSISTANCE SERVICES IND	167,399	20,428	1,113
CAMP OVERNITE WAIVER/SESSION	121,765	1,004	329
COM WRAP-AROUND SV, 15 MIN	73,345,501	9,304,725	266,293
COMP COMM SUPP SVC, 15 MIN	521,340	123,022	12,851
DAY HABIL WAIVER PER 15 MIN	6,493,201	1,092,393	70,937
FINANCIAL MGT WAIVER/15MIN	2,950,801	39,379	39,042
HABIL PREVOC WAIVER PER HR	1,542,279	210,589	12,606
HABIL SUP EMPL WAIVER 15MIN	2,212,692	171,746	16,053
HOME MODIFICATIONS PER MONTH	478,544	60	59
NOC RETAIL ITEMS ANDSUPPLIES	7,288,546	77,611	43,305
NON-EMERG.TRANSP./MILE VOL.INT	3,350,973	1,604,008	56,183
PT OR MANIP FOR MAINT	372,415	13,508	2,248
RESPITE CARE SERVICE 15 MIN	958,232	171,470	9,615
SELF CARE MANAGEMENT TRAINING	205,747	7,772	1,761
SERV ASMNT/CARE PLAN WAIVER	23,570,188	144,719	99,116
SPECIAL MED EQUIP, NOSWAIVER	400	4	1
SPECIAL SUPPLY, NOS WAIVER	183,721	229	182
SPEECH LANGUAGE HEARING THERAP	13,003	1,751	488
VEHICLE MOD WAIVER/SERVICE	167,880	15	15
SIGN LANG/ORAL INTERPRETER	4,156	664	22
SUPPORT BROKER WAIVER/15 MIN	37,223	6,151	496
PERS INSTAL & EQUIP	1,257	15	15
FAMILY HOMECARE TRAINING 15M	10,339	90	32
Grand Total	**124,169,804**	**13,015,311**	**635,127**

Notes:

Service dates for claims span July 1, 2020 through March 31, 2021 and were paid from July 1, 2020 through August 13, 2021

Only non-voided, paid claims are reflected in the data.

Waiver services are defined as procedures directed toward dedicated appropriation codes '317' or '318' where special program code is '45' or '46'

Community Care Program Report - July 1, 2020 through March 31, 2021

Data run through 08/16/2021

Procedure	Claim Payments	Service Units Quantity	Net Paid Claims
BEHAVIORAL HLTH COUNSEL/TPY PER 15MN	$499,833.32	68,659	13,024
BEH HLTH COUN & THERAPY/15MINUTES	$1,230,325.45	64,311	10,544
COMP COM SUP SERV PER 15 MINUTES	$42,899,377.60	3,457,273	42,796
COMPR COMM SUPPORT SERV PER 15 MINS	$175,219.32	33,771	2,606
COMPREHENSIVE COM SUPP SERV PER DIEM	$65,308,945.80	125,120	106,321
COMPREHENSIVE COM SUP SERV/15 MINS	$42,241,585.72	5,728,075	106,332
COMPREHENSIVE COM SUP SERV PER DIEM	$805,917,258.88	7,156,958	1,793,839
DAY CAMP ONLY UP TO 6 HRS PER DAY	$25,347.52	210	58
DAY HABILITATION WAIVER/ 15 MINUTES	$18,791,088.18	3,288,131	244,450
DAY HABILITATION WAIVER/15 MINUTES	$12,467,005.42	1,608,755	113,103
DAY HABILITATION WAIVER PER 15 MINS	$249,095.88	97,801	7,749
DAY HABILITATION WAIVER PER/15MINS	$143,090.79	30,555	2,656
DDD FI NONMCD PROVIDER TRANSPORT	$44,418.29	7,998	710
EMERG RESPONSE SYS/MO NO INST/TEST	$5,640.40	139	139
EMERG RESPONSE SYS/MO W/INST/TESTING	$738.00	13	13
HABILITATION,PREVOC,,WAIVER PER HOUR	$26,123.48	7,074	680
HABILITATION,PREVOC,WAIVER PER HOUR	$424,444.01	56,598	5,381
HABILITATION,SUP EMPLOY,WAIVER 15MIN	$90,623.42	17,930	1,280
HABILITATION,SUP EMPLOY,WAIVER,15MIN	$4,273.47	461	41
HABILITATION,SUP,EMPLOY WAIVER 15MIN	$78,366.88	16,614	1,123
HABILITATION,SUPEMPLOY,WAIVER,15MIN	$804,750.95	57,506	5,997
HME CARE TRAINING,FAMILY;PER 15 MINS	$6,450.00	79	19
HOME MODIFICATIONS PER SERVICE	$416,876.68	51	51
MAINTENANCE PHYSICAL THERAPY	$454,648.54	16,490	3,272
MISC THER ITEM PURCHASES NOC	$2,020,254.70	32,604	13,591
NON-EMERGENCY TRANSPORT PER MILE	$331,488.44	454,758	4,888
OCCUPATIONAL THERAPY 15 MINS	$23,476.40	3,089	840
RESPITE CARE,HOME,PER DIEM	$149.11	1	1
RESPITE CARE SERVICES,UP TO 15 MINS	$458,851.70	93,231	3,238
RESPITE/DAY OOH OVNGT TIER B	$5,093.76	42	6
RESPITE/DAY OOH OVNGT TIER B AC DI	$16,260.62	67	10
RESPITE/DAY OOH OVNGT TIER C	$128,468.82	7,615	110
RESPITE/DAY OOH OVNGT TIER D	$60,019.72	206	76
RESPITE/DAY OOH OVNGT TIER D AC DIF	$38,718.84	67	14
RESPITE/DAY OOH OVNGT TIER E	$12,348.00	33	9
RESPITE/DAY OOH OVNGT TIER E AC DIF	$9,530.23	13	13
RESPITE/DAY OVNGT TIER C AC DIF	$39,982.74	98	24
RESPITE SELF DIRECTED EMPLOYEE	$102,171.81	18,522	755
SELF-CARE/HME HGT TRAINING/15 MINS	$231,089.24	8,722	2,043
SERV ASSESS/POC,DVLP,WAIVER	$22,822,160.78	135,497	95,596
SIGN LGE OR ORAL INTERP SERV/15MINS	$9,628.60	496	62
SKILLS TRNG & DEVELOPMENT/15MINUTES	$65,821.89	5,095	495
SPECIALIZED SUPPLY NOC WAIVER	$169,172.29	221	175
SPEC MED EQUIP NOC WAIVER	$700.00	7	2
SPEECH THERAPY IN HOME PER DIEM	$12,787.03	1,723	436
SPEECH THERAPY,IN HOME, PER DIEM	$519,451.49	20,039	5,869
SUPPORTS BROKE,SELF-DIR,WVR,15 MINS	$70,753.62	11,748	620
TRANSPORTATION NON-MEDICAL MFP	$1,061,678.82	483,411	13,549
VEHICLE MOD,WAIVER;PER SERVICE	$116,713.03	14	14
Grand Total	**$1,020,632,299.68**	**23,117,891**	**2,604,620**

Notes:
Service dates for claims span July 1, 2020 through March 31, 2021 and were paid from July 1, 2020 through August 16, 2020.
Only non-voided, FFS paid claims are reflected in the data.
Represents those services listed in the Appendix H: CCP Services Quick Reference Guide of the NJ Division of Developmental Disabilities' CCP Policies & Procedures Manual (Version 3.0) March 2019 for NJFC beneficiaries with a SPC = 07.

	Atlantic County 2022 2Q	Bergen County 2022 2Q	Burlington County 2022 2Q	Camden County 2022 2Q	Cape May County 2022 2Q	Cumberland County 2022 2Q	Essex County 2022 2Q	Gloucester County 2022 2Q	Hudson County 2022 2Q
Dentist (PCDs)	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 15 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**
General Dentist	95.6%	100.0%	95.4%	99.8%	100.0%	92.7%	100.0%	90.8%	100.0%
PCPs	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 15 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**
PCP	94.0%	99.9%	99.3%	99.9%	100.0%	92.6%	100.0%	95.9%	100.0%
Pediatric PCPs	94.4%	100.0%	99.1%	99.9%	100.0%	95.2%	100.0%	96.6%	100.0%
Specialist (13 Dobi)	**2 in 45 Miles**	**2 in 45 Miles**	**2 in 45 Miles**	**2 in 45 Miles**	**2 in 45 Miles**	**2 in 45 Miles**	**2 in 45 Miles**	**2 in 45 Miles**	**2 in 45 Miles**
Cardiologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Dermatologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Endocrinologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
ENT	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
General surgeon	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Neurologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Obstetrician/gynecologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Oncologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Ophthalmologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Oral surgeon	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Orthopedist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Psychiatrist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Urologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Hospitals	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**
Hospital	99.9%	99.9%	99.9%	100.0%	97.7%	97.5%	100.0%	100.0%	100.0%

	Hunterdon County 2022 2Q	Mercer County 2022 2Q	Middlesex County 2022 2Q	Monmouth County 2022 2Q	Morris County 2022 2Q	Ocean County 2022 2Q	Passaic County 2022 2Q	Salem County 2022 2Q	Somerset County 2022 2Q
Dentist (PCDs)	**2 in 15 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 15 Miles**	**2 in 6 Miles**
General Dentist	99.7%	99.3%	100.0%	97.7%	95.0%	97.6%	100.0%	100.0%	99.8%
PCPs	**2 in 15 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 6 Miles**	**2 in 15 Miles**	**2 in 6 Miles**
PCP	100.0%	100.0%	100.0%	98.5%	98.1%	98.9%	99.4%	100.0%	99.9%
Pediatric PCPs	100.0%	100.0%	100.0%	98.4%	96.3%	98.6%	99.1%	100.0%	100.0%
Specialist (13 Dobi)	**2 in 45 Miles**	**2 in 45 Miles**	**2 in 45 Miles**	**2 in 45 Miles**	**2 in 45 Miles**	**2 in 45 Miles**	**2 in 45 Miles**	**2 in 45 Miles**	**2 in 45 Miles**
Cardiologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Dermatologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Endocrinologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
ENT	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
General surgeon	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Neurologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Obstetrician/gynecologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Oncologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Ophthalmologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Oral surgeon	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Orthopedist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Psychiatrist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Urologist	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Hospitals	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**
Hospital	88.0%	100.0%	100.0%	100.0%	100.0%	99.9%	99.6%	99.7%	100.0%

	Sussex County 2022 2Q	Union County 2022 2Q	Warren County 2022 2Q
Dentist (PCDs)	**2 in 15 Miles**	**2 in 6 Miles**	**2 in 15 Miles**
General Dentist	100.0%	100.0%	100.0%
PCPs	**2 in 15 Miles**	**2 in 6 Miles**	**2 in 15 Miles**
PCP	95.6%	100.0%	100.0%
Pediatric PCPs	93.7%	100.0%	100.0%
Specialist (13 Dobi)	**2 in 45 Miles**	**2 in 45 Miles**	**2 in 45 Miles**
Cardiologist	100.0%	100.0%	100.0%
Dermatologist	100.0%	100.0%	100.0%
Endocrinologist	100.0%	100.0%	100.0%
ENT	100.0%	100.0%	100.0%
General surgeon	100.0%	100.0%	100.0%
Neurologist	100.0%	100.0%	100.0%
Obstetrician/gynecologist	100.0%	100.0%	100.0%
Oncologist	100.0%	100.0%	100.0%
Ophthalmologist	100.0%	100.0%	100.0%
Oral surgeon	100.0%	100.0%	100.0%
Orthopedist	100.0%	100.0%	100.0%
Psychiatrist	100.0%	100.0%	100.0%
Urologist	100.0%	100.0%	100.0%
Hospitals	**1 in 15 Miles**	**1 in 15 Miles**	**1 in 15 Miles**
Hospital	65.9%	100.0%	38.1%

New Jersey 1115 Comprehensive Waiver Annual Report
Demonstration Year 10 (July 1, 2021 – June 30, 2022)
Department of Children and Families
Children's System of Care

New Jersey's Department of Children and Families (DCF) is charged with serving and safeguarding the most vulnerable children and families. Since its creation in 2006, the New Jersey Department of Children and Families has designed and managed a strong, state-wide network of core services including child protection and child welfare services, children's behavioral health care, programming to support children with intellectual and developmental disabilities and their families, community-based family strengthening services, specialized educational programming, and services and programming to support women.

DCF's vision is that all New Jersey residents are safe, healthy and connected:
• **Safe**: absent harm or maltreatment.
• **Healthy**: refers to physical, mental, developmental and emotional wellbeing.
• **Connected**: bonded or tied together through biology, familiarity and/or community.

The Children's System of Care (CSOC) is a Division under DCF that serves children, youth, and young adults, herein referred to as youth, with emotional, behavioral, and substance use challenges and intellectual and developmental disabilities. The family or caregiver plays a central role in the health and well-being of youth. CSOC involves families/caregivers throughout the planning and treatment process in order to promote the advice and recommendations of the family and provide families the tools and support needed to create successful and sustainable life experiences for their youth.

The goal of DCF's CSOC is to enable the youth to remain at home, in school, and within their community. Therefore, through an organized system of care approach, CSOC is committed to providing services that are:

A. Clinically appropriate and accessible;

B. Individualized, and delivered through a continuum of services and supports, both formal and informal, based on the unique strengths and needs of each youth and his or her family/caregivers;

C. Provided in the least restrictive, most natural setting appropriate to meet the needs of the youth and his or her family or caregivers;

D. Family-guided, with families engaged as active participants at all levels of planning, organization, and service delivery;

E. Community-based, coordinated, and integrated with the focus of having services, decision-making responsibility, and management operational at a community level;

F. Culturally competent, with agencies, programs, services, and supports that are reflective of and responsive to the cultural, racial, and ethnic differences of the populations they serve;

G. Protective of the rights of youth and their family/caregivers; and

H. Collaborative across child-serving systems, including mental health, substance use, child protection, juvenile justice, and other system partners who are responsible for providing services and supports to the target populations.

Quality Strategy Measures

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

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

STC 103(d)(x) A summary of the outcomes of the State's Quality Strategy for HCBS as outlined above - CSSP I/DD Waiver

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

Percentage	DMAHS reports on this sub assurance

#2 Quality of Life Sub Assurance	All youth that meet the clinical criteria for services through the Department of Children and Families (DCF), Division of Children' s System of Care (CSOC) will be assessed utilizing the comprehensive Child and Adolescent Needs and Strengths (CANS) assessment tool
Data Source	Review of Child and Adolescent Needs and Strengths scores Contracted System Administrator (CSA) Data Data report: CSA NJ1225 Strengths & Needs Assessment – Post SPC Start
Sampling Methodology	100% New youth enrolled in the waiver
Waiver	**I/DD**
Numerator: Number of youth receiving Child and Adolescent Needs and Strengths (CANS) assessment	404
Denominator: Total number of new enrollees	408
Percentage	99%

Three youth did not receive their Strength and Needs Assessments due to loss of contact with the families. One youth did have a Strength and Needs Assessment, but it was not completed within the reporting period.

#3 Quality of Life Sub Assurance	80% of youth should show improvement in Child and Adolescent Needs and Strengths composite rating within a year
Data Source	CSA Data on CANS Initial and Subsequent Assessments Data report: CSA NJ2021CANS Waiver Outcome
Sampling Methodology	Number of youth enrolled in the waiver for at least 1 year
Waiver	**I/DD**
Numerator: Number of youth who improved within one year of admission	855
Denominator: Number of youth with Child and Adolescent Needs and Strengths assessments conducted 1 year	926

from admission or last CANS conducted	
Percentage	92%

#4 Level of Care Sub Assurance	CSOC's Contracted System's Administrator (CSA), conducts an initial Level of Care assessments (aka Intensity of Services (IOS) prior to enrollment for all youth
Data Source	CSA Data report: CSA NJ1218 New Enrollees, Quarterly Count and IOS Completed
Sampling Methodology	100% new youth enrolled in the waiver
Waiver	**I/DD**
Numerator: Number of youth receiving initial level of care determination prior to enrollment	407
Denominator: Number of new enrollees	408
Percentage	99.8%*

One youth transitioned from CMO before their waiver start date, this youth was added in error.
*This percentage should be 100% due to the one youth being added in error.

#5 Plan of Care Sub Assurance	The Plan of Care (aka Individual Service Plan (ISP)) is developed based on the needs identified in the Child and Adolescent Needs and Strengths assessment tool and according to CSOC policies
Data Source	CSA Data on Plans of Care completions, Record Review Data report: CSA NJ1219 Follow – Up Treatment Plan and Associated SNA
Sampling Methodology	100% of youth enrolled during the measurement period
Waiver	**I/DD**
Numerator: Number of Plans of Care that address youth's assessed needs	404
Denominator: Number of Plans of Care reviewed	408

Percentage	99%

Three youth did not receive their Plans of Care due to loss of contact with the families. One youth did have a Plan of Care, but it was not completed within the reporting period.

#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	**I/DD**
Numerator: Number of current Plans of Care updated at least annually	313
Denominator: Number of Plans of Care reviewed	313
Percentage	100%

#7 Plan of Care Sub Assurance	Services are authorized in accordance with the approved plan of care Data Report: CSA NJ1220 Waiver Services Provided
Data Source	CSA Data Report of Authorizations Record Review
Sampling Methodology	100% of youth enrolled during the measurement period
Waiver	**I/DD**
Numerator: Number of Plans of Care that had services authorized based on the Plan of Care	408
Denominator: Number of Plans of Care reviewed	408
Percentage	100%

#8 Plan of Care Sub Assurance	Services are delivered in accordance with the approved plan of care

Data Source	CSA Data Report of Authorizations Claims paid on authorized services through MMIS Record Review
Sampling Methodology	Random sample representing a 95% confidence level
Waiver	**I/DD**
Numerator: Number of services that were delivered	In Development
Denominator: Number of services that were authorized	In Development
Percentage	In Development

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

#9 Plan of Care Sub Assurance	Youth/families are provided a choice of providers, based on the available qualified provider network
Data Source	Record review Statewide CSA Data Report: NJ1384 Provider List - CSA Data Report
Sampling Methodology	Random sample representing a 95% confidence level
Waiver	I/DD
Numerator: Number of youth/families given a choice of providers as indicated in progress notes	1,756
Denominator: Number of records reviewed	2,302
Percentage	76%

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

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

No new waiver providers were enrolled during this reporting period.

# 11 Qualified Providers Sub Assurance	Children's System of Care verifies that providers of waiver services continually meet required qualified status, including any applicable licensure and/or certification standards
Data Source	Provider Certification
Sampling Methodology	100% Agency
Waiver	**I/DD**
Numerator: Number of providers that meet the qualifying standards applicable-licensures/certification	166
Denominator: **Total** number of providers that initially met the qualified status	166
Percentage	100%

# 12 Qualified Providers Sub Assurance	CSOC implements its policies and procedures for verifying that applicable certifications/checklists and training are provided in accordance with qualification requirements as listed in the waiver
Data Source	Record Review

Sampling Methodology	100% Community Provider Agencies
Waiver	**I/DD**
Numerator: Number of providers that have been trained and are qualified to provide waiver services	In Development
Denominator: Total number of providers that provide waiver services	In Development
Percentage	In Development

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

# 13 Health and Welfare Sub Assurance	The State demonstrates on an on-going basis, that it identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation
Data Source	Review of UIRMS database and Administrative policies & procedures
Sampling Methodology	100% of youth enrolled for the reporting period
Waiver	**I/DD**
Numerator: Total number of UIRs submitted timely according to State policies	31
Denominator: Number of UIRs submitted involving enrolled youth	45
Percentage	69%

Fourteen incidents were not submitted within the reporting period. The majority of the late submission were COVID reports for staff and/or youth. A few reports had conflicting dates of incidents. Both issues are being addressed through CSOC's UIR practice group.

# 14 Health and Welfare Sub Assurance	The State incorporates an unusual incident management reporting system (UIRMS), as articulated in Administrative Order 2:05, which reviews incidents and develops polices to prevent further similar incidents (i.e., abuse, neglect, and runaways)
Data Source	Review of UIRMS database and Administrative policies & procedures

Sampling Methodology	100% of youth enrolled for the reporting period
Waiver	**I/DD**
Numerator: The number of incidents that were reported through UIRMS and had required follow up	45
Denominator: Total number of incidents reported that required follow up	45
Percentage	100%

# 15 Health and Welfare Sub Assurance	The State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed
Data Source	Review of UIRMS
Sampling Methodology	100% of all allegations of restrictive interventions reported
Waiver	**I/DD**
Numerator: Number of unusual incidents reported involving restrictive interventions that were remediated in accordance to policies and procedures	0
Denominator: Total number of unusual incidents reported involving restrictive interventions	1
Percentage	0%

There was one restraint related incident. This incident was not in accordance with policies and procedures. This incident did receive follow-up and was addressed through CSOC's UIR practice group.

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

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

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

1115 Comprehensive Waiver Quarterly Report
Demonstration Year 10
Federal Fiscal Quarter: 4 (04/01/22 – 06/30/22)
Department of Children and Families
Division of Children's System of Care

CSOC continues enrollment in both the Children's Support Services Program Intellectual/Developmental Disabilities (CSSP I/DD) and for Plan A benefits under the Children's Support Services Program Serious Emotional Disturbance (CSSP SED). During this quarter, CSOC enrolled 637 youth in the CSSP I/DD. In addition, there were an additional 464 youth in the CSSP SED that received Plan A benefits that would have not otherwise been eligible for these benefits if not for waiver participation.

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

STC 103(d)(x) A summary of the outcomes of the State's Quality Strategy for Home and Community Based Services (HCBS) - I/DD program

#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)	DMAHS reports on this sub assurance
Denominator: Total number of sub assurances audited	DMAHS reports on this sub assurance
Percentage	DMAHS reports on this sub assurance

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

Data Source	Review of Child and Adolescent Needs and Strengths scores Contracted System Administrator (CSA) Data Data report: CSA NJ1225 Strengths & Needs Assessment – Post SPC Start
Sampling Methodology	100% new youth enrolled in the waiver
Waiver	**I/DD**
Numerator: Number of youth receiving Child and Adolescent Needs and Strengths (CANS) assessment	81
Denominator: Total number of new enrollees	84
Percentage	96%

Two siblings did not receive their Strength and Needs Assessments due to loss of contact with the family. One youth did have a Strength and Needs Assessment but it was not completed within the reporting period.

#3 Quality of Life Sub Assurance	80% of youth should show improvement in Child and Adolescent Needs and Strengths composite rating within a year
Data Source	CSA Data on CANS Initial and Subsequent Assessments. Data report: CSA NJ2021CANS Waiver Outcome
Sampling Methodology	Number of youth enrolled in the waiver for at least 1 year
Waiver	**I/DD**
Numerator: Number of youth who improved within one year of admission	554
Denominator: Number of youth with Child and Adolescent Needs and Strengths Assessments conducted 1 year from admission or last CANS conducted	609
Percentage	91%

#4 Level of Care Sub Assurance	CSOC's Contracted System's Administrator (CSA), conducts an initial Level of Care assessments (aka Intensity of Services (IOS) prior to

	enrollment for all youth
Data Source	CSA Data. Data report: CSA NJ1218 New Enrollees, Quarterly Count and IOS Completed
Sampling Methodology	100% new youth enrolled in the waiver
Waiver	**I/DD**
Numerator: Number of youth receiving initial level of care determination prior to enrollment	84
Denominator: Number of new enrollees	84
Percentage	100%

#5 Plan of Care Sub Assurance	The Plan of Care (aka Individual Service Plan (ISP) is developed based on the needs identified in the Child and Adolescent Needs and Strengths assessment tool and according to CSOC policies
Data Source	CSA Data on Plans of Care completions, Record Review Data report: CSA NJ1219 Follow – Up Treatment Plan and Associated SNA
Sampling Methodology	100% of youth enrolled during the measurement period
Waiver	**I/DD**
Numerator: Number of Plans of Care that address youth's assessed needs	81
Denominator: Number of Plans of Care reviewed	84
Percentage	96%

Two siblings did not receive their Plans of Care due to loss of contact with the family. One youth did have a Plan of Care, but it was not completed within the reporting period.

#6 Plan of Care Sub Assurance	Plan of Care 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	**I/DD**
Numerator: Number of current Plans of Care updated at least annually	187
Denominator: Number of Plans of Care reviewed	187
Percentage	100%

#7 Plan of Care Sub Assurance	Services are authorized in accordance with the approved plan of care (treatment plan) Data Report: CSA NJ1220 Waiver Services Provided
Data Source	CSA Data Report of Authorizations Record Review
Sampling Methodology	100% of youth enrolled during the measurement period.
Waiver	**I/DD**
Numerator: Number of plans of care that had services authorized based on the plan of care	84
Denominator: Number of plans of care reviewed	84
Percentage	100%

#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	**I/DD**
Numerator: Number of Services that were delivered	In Development
Denominator: Number of services that were authorized	In Development
Percentage	In Development

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

#9 Plan of Care Sub Assurance	Youth/families are provided a choice of providers, based on the available qualified provider network
Data Source	Record review Statewide CSA Data Report: NJ1384 Provider List -CSA Data Report
Sampling Methodology	Random sample representing a 95% confidence level
Waiver	**I/DD**
Numerator: Number of youth/families given a choice of providers as indicated in progress notes	394
Denominator: Number of records reviewed	491
Percentage	80%

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

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

CSOC did not enroll any new waiver providers during this reporting period.

# 11 Qualified Providers Sub Assurance	Children's System of Care verifies that providers of waiver services continually meet required qualified status, including any applicable licensure and/or certification standards
Data Source	Provider HR Record Review
Sampling Methodology	100% agency
Waiver	**ID/D**
Numerator: Number of providers that meet the qualifying standards/applicable licensures/certification	166
Denominator: Total number of providers that initially met the qualified status	166
Percentage	100%

CSOC monitors certifications/qualifications of contracted providers as part of the contract renewal process. Monitoring and reporting on this measure is based on the provider population that was required to verify licensure and certification standards during this quarter.

# 12 Qualified Providers Sub Assurance	CSOC implements its policies and procedures for verifying that applicable certifications/checklists and training are provided in accordance with qualification requirements as listed in the waiver
Data Source	Record Review
Sampling Methodology	100% community provider agencies
Waiver	**I/DD**
Numerator: Number of providers that have been trained and are qualified to provide waiver services	166
Denominator: Total number of providers that provide waiver services	166
Percentage	100%

CSOC monitors certifications/qualifications of contracted providers as part of the contract renewal process. Monitoring and reporting on this measure is based on the provider population that was required to verify licensure and certification standards during this 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	**I/DD**
Numerator: Total number of UIRs submitted timely according to State policies	13
Denominator: Number of UIRs submitted involving enrolled youth	13
Percentage	100%

# 14 Health and Welfare Sub Assurance	The State incorporates an unusual incident management reporting system (UIRMS), as articulated in Administrative Order 2:05, which reviews incidents and develops 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	**I/DD**
Numerator: The number of incidents that were reported through UIRMS and had required follow up	13
Denominator: Total number of incidents reported that required follow up	13
Percentage	100%

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

Percentage	N/A

# 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	**I/DD**
Numerator: Number of youth enrolled that received a well visit	DMAHS measure
Denominator: Total number of youth enrolled	DMAHS measure
Percentage	DMAHS measure

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

Quality Strategy Measures

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

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

STC 103(d)(x) A summary of the outcomes of the State's Quality Strategy for HCBS as outlined above - CSSP I/DD Waiver

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

#2 Quality of Life Sub Assurance	All youth that meet the clinical criteria for services through the Department of Children and Families (DCF), Division of Children' s

	System of Care (CSOC) will be assessed utilizing the comprehensive Child and Adolescent Needs and Strengths (CANS) assessment tool
Data Source	Review of Child and Adolescent Needs and Strengths scores Contracted System Administrator (CSA) Data Data report: CSA NJ1225 Strengths & Needs Assessment – Post SPC Start
Sampling Methodology	100% New youth enrolled in the waiver
Waiver	**I/DD**
Numerator: Number of youth receiving Child and Adolescent Needs and Strengths (CANS) assessment	404
Denominator: Total number of new enrollees	408
Percentage	99%

Three youth did not receive their Strength and Needs Assessments due to loss of contact with the families. One youth did have a Strength and Needs Assessment, but it was not completed within the reporting period.

#3 Quality of Life Sub Assurance	80% of youth should show improvement in Child and Adolescent Needs and Strengths composite rating within a year
Data Source	CSA Data on CANS Initial and Subsequent Assessments Data report: CSA NJ2021CANS Waiver Outcome
Sampling Methodology	Number of youth enrolled in the waiver for at least 1 year
Waiver	**I/DD**
Numerator: Number of youth who improved within one year of admission	855
Denominator: Number of youth with Child and Adolescent Needs and Strengths assessments conducted 1 year	926

from admission or last CANS conducted	
Percentage	92%

#4 Level of Care Sub Assurance	CSOC's Contracted System's Administrator (CSA), conducts an initial Level of Care assessments (aka Intensity of Services (IOS) prior to enrollment for all youth
Data Source	CSA Data report: CSA NJ1218 New Enrollees, Quarterly Count and IOS Completed
Sampling Methodology	100% new youth enrolled in the waiver
Waiver	**I/DD**
Numerator: Number of youth receiving initial level of care determination prior to enrollment	407
Denominator: Number of new enrollees	408
Percentage	99.8%*

One youth transitioned from CMO before their waiver start date, this youth was added in error.
*This percentage should be 100% due to the one youth being added in error.

#5 Plan of Care Sub Assurance	The Plan of Care (aka Individual Service Plan (ISP)) is developed based on the needs identified in the Child and Adolescent Needs and Strengths assessment tool and according to CSOC policies
Data Source	CSA Data on Plans of Care completions, Record Review Data report: CSA NJ1219 Follow – Up Treatment Plan and Associated SNA
Sampling Methodology	100% of youth enrolled during the measurement period
Waiver	**I/DD**
Numerator: Number of Plans of Care that address youth's assessed needs	404

Denominator: Number of Plans of Care reviewed	408
Percentage	99%

Three youth did not receive their Plans of Care due to loss of contact with the families. One youth did have a Plan of Care, but it was not completed within the reporting period.

#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	**I/DD**
Numerator: Number of current Plans of Care updated at least annually	313
Denominator: Number of Plans of Care reviewed	313
Percentage	100%

#7 Plan of Care Sub Assurance	Services are authorized in accordance with the approved plan of care Data Report: CSA NJ1220 Waiver Services Provided
Data Source	CSA Data Report of Authorizations Record Review
Sampling Methodology	100% of youth enrolled during the measurement period
Waiver	**I/DD**
Numerator: Number of Plans of Care that had services authorized based on the Plan of Care	408
Denominator: Number of Plans of Care reviewed	408
Percentage	100%

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

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

#9 Plan of Care Sub Assurance	Youth/families are provided a choice of providers, based on the available qualified provider network
Data Source	Record review Statewide CSA Data Report: NJ1384 Provider List - CSA Data Report
Sampling Methodology	Random sample representing a 95% confidence level
Waiver	I/DD
Numerator: Number of youth/families given a choice of providers as indicated in progress notes	1,756
Denominator: Number of records reviewed	2,302
Percentage	76%

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

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

No new waiver providers were enrolled during this reporting period.

# 11 Qualified Providers Sub Assurance	Children's System of Care verifies that providers of waiver services continually meet required qualified status, including any applicable licensure and/or certification standards
Data Source	Provider Certification
Sampling Methodology	100% Agency
Waiver	**I/DD**
Numerator: Number of providers that meet the qualifying standards applicable-licensures/certification	166
Denominator: **Total** number of providers that initially met the qualified status	166
Percentage	100%

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

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

# 13 Health and Welfare Sub Assurance	The State demonstrates on an on-going basis, that it identifies, addresses and seeks to prevent instances of abuse, neglect and exploitation
Data Source	Review of UIRMS database and Administrative policies & procedures
Sampling Methodology	100% of youth enrolled for the reporting period
Waiver	**I/DD**
Numerator: Total number of UIRs submitted timely according to State policies	31
Denominator: Number of UIRs submitted involving enrolled youth	45
Percentage	69%

Fourteen incidents were not submitted within the reporting period. The majority of the late submission were COVID reports for staff and/or youth. A few reports had conflicting dates of incidents. Both issues are being addressed through CSOC's UIR practice group.

# 14 Health and Welfare Sub Assurance	The State incorporates an unusual incident management reporting system (UIRMS), as articulated in Administrative Order 2:05, which reviews incidents and develops polices to prevent further similar incidents (i.e., abuse, neglect, and runaways)
Data Source	Review of UIRMS database and Administrative policies & procedures
Sampling Methodology	100% of youth enrolled for the reporting period
Waiver	**I/DD**
Numerator: The number of incidents that were reported through UIRMS and had required follow up	45
Denominator: Total number of incidents reported that required follow up	45
Percentage	100%

# 15 Health and Welfare Sub Assurance	The State policies and procedures for the use or prohibition of restrictive interventions (including restraints and seclusion) are followed
Data Source	Review of UIRMS
Sampling Methodology	100% of all allegations of restrictive interventions reported
Waiver	**I/DD**
Numerator: Number of unusual incidents reported involving restrictive interventions that were remediated in accordance to policies and procedures	0
Denominator: Total number of unusual incidents reported involving	1

restrictive interventions	
Percentage	0%

There was one restraint related incident. This incident was not in accordance with policies and procedures. This incident did receive follow-up and was addressed through CSOC's UIR practice group.

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

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

Percentage	In Development

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

1115 Comprehensive Waiver Quarterly Report

Demonstration Year 10

Federal Fiscal Quarter: 4 (04/01/22 – 06/30/22)

Department of Children and Families

Division of Children's System of Care

CSOC continues enrollment in both the Children's Support Services Program Intellectual/Developmental Disabilities (CSSP I/DD) and for Plan A benefits under the Children's Support Services Program Serious Emotional Disturbance (CSSP SED). During this quarter, CSOC enrolled 637 youth in the CSSP I/DD. In addition, there were an additional 464 youth in the CSSP SED that received Plan A benefits that would have not otherwise been eligible for these benefits if not for waiver participation.

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

STC 103(d)(x) A summary of the outcomes of the State's Quality Strategy for Home and Community Based Services (HCBS) - I/DD program

#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)	DMAHS reports on this sub assurance
Denominator: Total number of sub assurances audited	DMAHS reports on this sub assurance
Percentage	DMAHS reports on this sub assurance

#2 Quality of Life Sub Assurance	All youth that meet the clinical criteria for services through the Department of Children and Families (DCF), Division of Children' s System of Care (CSOC) will be assessed utilizing the comprehensive Child and Adolescent Needs and Strengths (CANS) assessment tool
Data Source	Review of Child and Adolescent Needs and Strengths scores Contracted System Administrator (CSA) Data Data report: CSA NJ1225 Strengths & Needs Assessment – Post SPC Start
Sampling Methodology	100% new youth enrolled in the waiver
Waiver	**I/DD**
Numerator: Number of youth receiving Child and Adolescent Needs and Strengths (CANS) assessment	81
Denominator: Total number of new enrollees	84
Percentage	96%

Two siblings did not receive their Strength and Needs Assessments due to loss of contact with the family. One youth did have a Strength and Needs Assessment but it was not completed within the reporting period.

#3 Quality of Life Sub Assurance	80% of youth should show improvement in Child and Adolescent Needs and Strengths composite rating within a year
Data Source	CSA Data on CANS Initial and Subsequent Assessments.

	Data report: CSA NJ2021CANS Waiver Outcome
Sampling Methodology	Number of youth enrolled in the waiver for at least 1 year
Waiver	**I/DD**
Numerator: Number of youth who improved within one year of admission	554
Denominator: Number of youth with Child and Adolescent Needs and Strengths Assessments conducted 1 year from admission or last CANS conducted	609
Percentage	91%

#4 Level of Care Sub Assurance	CSOC's Contracted System's Administrator (CSA), conducts an initial Level of Care assessments (aka Intensity of Services (IOS) prior to enrollment for all youth
Data Source	CSA Data. Data report: CSA NJ1218 New Enrollees, Quarterly Count and IOS Completed
Sampling Methodology	100% new youth enrolled in the waiver
Waiver	**I/DD**
Numerator: Number of youth receiving initial level of care determination prior to enrollment	84
Denominator: Number of new enrollees	84
Percentage	100%

#5 Plan of Care Sub Assurance	The Plan of Care (aka Individual Service Plan (ISP) is developed based on the needs identified in the Child and Adolescent Needs and Strengths assessment tool and according to CSOC policies
Data Source	CSA Data on Plans of Care completions, Record Review Data report: CSA NJ1219 Follow – Up Treatment Plan and Associated SNA
Sampling Methodology	100% of youth enrolled during the measurement period
Waiver	**I/DD**
Numerator: Number of Plans of Care that address youth's assessed needs	81
Denominator: Number of Plans of Care reviewed	84
Percentage	96%

Two siblings did not receive their Plans of Care due to loss of contact with the family. One youth did have a Plan of Care, but it was not completed within the reporting period.

#6 Plan of Care Sub Assurance	Plan of Care 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	**I/DD**
Numerator: Number of current Plans of Care updated at least annually	187
Denominator: Number of Plans of Care reviewed	187
Percentage	100%

#7 Plan of Care Sub Assurance	Services are authorized in accordance with the approved plan of care (treatment plan)

	Data Report: CSA NJ1220 Waiver Services Provided
Data Source	CSA Data Report of Authorizations Record Review
Sampling Methodology	100% of youth enrolled during the measurement period.
Waiver	**I/DD**
Numerator: Number of plans of care that had services authorized based on the plan of care	84
Denominator: Number of plans of care reviewed	84
Percentage	100%

#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	**I/DD**
Numerator: Number of Services that were delivered	In Development
Denominator: Number of services that were authorized	In Development
Percentage	In Development

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

#9 Plan of Care Sub Assurance	Youth/families are provided a choice of providers, based on the available qualified provider network
Data Source	Record review Statewide CSA Data Report: NJ1384

	Provider List -CSA Data Report
Sampling Methodology	Random sample representing a 95% confidence level
Waiver	**I/DD**
Numerator: Number of youth/families given a choice of providers as indicated in progress notes	394
Denominator: Number of records reviewed	491
Percentage	80%

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

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

CSOC did not enroll any new waiver providers during this reporting period.

# 11 Qualified Providers Sub Assurance	Children's System of Care verifies that providers of waiver services continually meet required qualified status, including any applicable licensure and/or certification standards
Data Source	Provider HR Record Review
Sampling Methodology	100% agency
Waiver	**ID/D**
Numerator: Number of providers that meet the qualifying standards/applicable licensures/certification	166
Denominator: Total number of providers that initially met the qualified status	166
Percentage	100%

CSOC monitors certifications/qualifications of contracted providers as part of the contract renewal process. Monitoring and reporting on this measure is based on the provider population that was required to verify licensure and certification standards during this quarter.

# 12 Qualified Providers Sub Assurance	CSOC implements its policies and procedures for verifying that applicable certifications/checklists and training are provided in accordance with qualification requirements as listed in the waiver
Data Source	Record Review
Sampling Methodology	100% community provider agencies
Waiver	**I/DD**
Numerator: Number of providers that have been trained and are qualified to provide waiver services	166
Denominator: Total number of providers that provide waiver services	166

Percentage	100%

CSOC monitors certifications/qualifications of contracted providers as part of the contract renewal process. Monitoring and reporting on this measure is based on the provider population that was required to verify licensure and certification standards during this 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	**I/DD**
Numerator: Total number of UIRs submitted timely according to State policies	13
Denominator: Number of UIRs submitted involving enrolled youth	13
Percentage	100%

# 14 Health and Welfare Sub Assurance	The State incorporates an unusual incident management reporting system (UIRMS), as articulated in Administrative Order 2:05, which reviews incidents and develops 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	**I/DD**
Numerator: The number of incidents that were reported through UIRMS and had required follow up	13
Denominator: Total number of incidents reported	13

that required follow up	
Percentage	100%

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

# 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	**I/DD**
Numerator: Number of youth enrolled that received a well visit	DMAHS measure
Denominator: Total number of youth enrolled	DMAHS measure

Percentage	DMAHS measure

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

Deliverables due during MLTSS 4th quarter (4/1/2022 – 6/30/2022)

The Division of Medical Assistance and Health Services' (DMAHS) Office of Managed Long-Term Services and Supports Quality Monitoring (MLTSS QM) receives and analyzes the Performance Measure (PM) data submitted by the respective data source. This quarterly report reflects the Performance Measures (PMs) that were reported by the Managed Care Organizations (MCOs) and the Division of Aging Services (DoAS) to the Office of MLTSS QM during the eighth year, fourth quarter (4/1/2022 – 6/30/2022) of the MLTSS program. Depending on the data source for the numerator/denominator, some PMs require longer lag times to allow for collection and analysis of the information. Because of the different lag times, each Performance Measure in this report identifies the measurement period reported.

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

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

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

In March 2020, challenges related to the COVID-19 pandemic mandated changes to the MLTSS program, including the suspension of face-to-face assessments and in-person Care Manager (CM) visits. Policy guidance was issued to the MCOs in August 2021 regarding the phase in of the resumption of face-to-face CM visits. High-risk MLTSS members were prioritized for visits from 8/15/2021 to 11/15/2021 for wellness checks and Plan of Care (POC) reviews.

Beginning 11/16/2021, the face-to-face visits were expanded to all MLTSS members and MCO CMs resumed conducting the NJ Choice level of care assessment. The changes that took place during this reporting period may affect some of the PMs in this report and subsequent reports. The impact will be noted in the narrative for the respective PM in this and subsequent reports.

Deliverables due during MLTSS 4th quarter (4/1/2022 – 6/30/2022)

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

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

The DoAS does a monthly 100% audit on all MCO Not Authorized cases to monitor and ensure a 95% satisfactory rate. The DoAS has provided training for the MCOs regarding streamlined assessment review; Nursing Facility Level of Care Review and requirements for a Corrective Action Plan if the MCO is out of compliance.

As of November 2019, the revised report reflects the DoAS 100% Not Authorized Monthly Auditing data. This report is an accurate reporting for PM #03 defined as: nursing facility level of care assessments conducted by the MCO determined to be "Not Authorized" with a State determination of “Approved”. There is a four-month lag to allow the State reassessment to be completed and recorded.

The pending report is for January through March, due to the lag time in which it takes OCCO to reassess all Not Authorized Reassessment and the State of Emergency Order with the subsequent suspension of all face-to-face assessments (initial and annual) effective March 18, 2020. Performance Measure 03 has no data to report at this time. Once the assessment restrictions are lifted, the State will resume their 100% Audit of all Not Authorized Assessments. Reporting will resume on a quarterly basis.

Deliverables due during MLTSS 4th quarter (4/1/2022 – 6/30/2022)

PM 04	Timeliness of nursing facility level of care assessment by MCO
Numerator:	Cases in the denominator who received an assessment within 30 days of referral to the MCO or from the date of discharge from rehabilitation.
Denominator:	Unique count of MCO enrolled members with a referral for MLTSS during the measurement period
Data Source:	MCO
Frequency:	Monthly – Due 45 days after measurement period

February 2022	A	B	C	D	E	TOTAL
Numerator	0	0	13	0	0	**13**
Denominator	21	60	188	233	225	**706**
%	0	0	6.9	0	0	**1.8**

March 2022	A	B	C	D	E	TOTAL
Numerator	0	0	10	0	0	**10**
Denominator	64	47	168	280	232	**727**
%	0	0	6	0	0	**1.4**

April 2022	A	B	C	D	E	TOTAL
Numerator	0	0	27	0	0	**27**
Denominator	30	42	223	340	163	**798**
%	0	0	12.1	0	0	**3.4**

MCO A worked with the EQRO to investigate the denominator of zero previously reported for this deliverable for WYE 2022. After resolving the issue, they resubmitted data for PM 04 (see table below). MCO B reports although they have returned to the field for completion of the NJCA for existing MTLSS members, due to State guidance related to Covid-19, their rates will continue to be 0 until the return to field State guidance includes completion of the NJ Choice assessments (NJCA) for enrollment of members who have been referred for MLTSS. MCO C reports members being referred to MLTSS and having a NJ Choice assessment completed and submitted. MCO C has reported receiving referrals, and being approved by OCCO and now enrolled, during the reporting period, the numbers have increased in April 2022. MCO D reports due to the COVID 19 face-to-face suspension, no NF level of care assessments were completed. MCO E reports there were no NJHC assessments completed for the members enrolled due to COVID-19 NJ State mandate.

PM 04 - MCO A Resubmissions for WYE 2022									
Measurement Period:	**07/2021**	**08/2021**	**09/2021**	**10/2021**	**11/2021**	**12/2021**	**01/2022**	**02/2022**	**03/2022**
Numerator:	0	0	0	0	0	0	0	0	0
Denominator:	19	26	24	34	22	21	34	21	64
%	0	0	0	0	0	0	0	0	0

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

PM 04a	Timeliness of nursing facility level of care assessment
Numerator:	The number of assessments in the denominator where the OCCO/ADRC assessment/determination date is less than 30 days from the referral date
Denominator:	Number of new MLTSS enrollees within the reporting month with an assessment completed by OCCO/ADRC
Data Source:	DoAS
Frequency:	Monthly – Due 45 days after measurement period

Measurement period	03/2022	04/2022	05/2022
Numerator	554	415	328
Denominator	620	457	367
%	89.4	90.8	89.4

DoAS Staff returned to the field in November 2021. Due to Covid-19, many of the nursing facilities were closed to visitors, which prohibited the OCCO Assessors from completing NJ Choice assessments. For the measurement period (March 2022 – May 2022), DoAS had at least an 89.4% rate of completing level of care assessments within 30 days of referral.

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

Due to the COVID-19 State of Emergency Order and the subsequent suspension of all face-to-face assessments, initial and annual, effective March 2020, the 12- and 13-month reports are being sent to the MCOs, however, no action plan is required. Therefore, there is no data to report for the quarterly report due June 2022. Level of care assessments and re-assessments using the NJ Choice assessment resumed on 11/16/2021. The State anticipates there will be data reported in an upcoming report.

Deliverables due during MLTSS 4th quarter (4/1/2022 – 6/30/2022)

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

Measurement Period	12/2021	1/2022	2/2022	3/2022	4/2022
Numerator	1103	1200	1015	964	606
Denominator	1131	1212	1045	1007	626
%	97.5	99	97.1	95.7	96.8

The data reported in the report indicates that there is continual progress since the MCO and OCCO staff returned to field in November 2021. Although the MCO/OCCO staff returned to field in November 2021, there were many nursing facilities closed to visitors, prohibiting staff from completing the NJ Choice Assessment. The rate of compliance for this measure has remained above 95% since December 2021.

PM 08	Initial Plans of Care established within 45 days of enrollment into MLTSS
Numerator:	Number of records in the denominator that have a Plan of Care developed within 45 days of MLTSS enrollment
Denominator:	Total number of records selected for review for members newly enrolled in MLTSS in the measurement year
Data Source:	Annual MLTSS NF/SCNF Care Management Audit conducted by the EQRO
Frequency:	Annually

Waiver Year 2021	A	B	C	D	E	TOTAL
Numerator	8	1	2	0	2	**13**
Denominator	9	6	2	2	2	**21**
%	88.9	16.7	100	0	100	**61.9**

Beginning in 2021, the NF audit included evaluating the NF Population on the MLTSS Performance Measures. Compliance with Performance Measure 08 was calculated using 45 calendar days to establish an initial plan of care. The data reported for PM 08 did not yield significance, as the numbers were too low to comment on performance.

PM 09	MLTSS NF/SCNF Member's Plan of Care is reviewed annually within 30 days of the member's anniversary and as necessary
Numerator:	Number of records in the denominator that have a Plan of Care developed 30 days or less from re-determination date
Denominator:	Total number of MLTSS NF/SCNF records selected for review for members receiving an annual level of care re-determination for the measurement year
Data Source:	Annual MLTSS NF/SCNF Care Management Audit conducted by the EQRO
Frequency:	Annually

Waiver Year 2021	A	B	C	D	E	TOTAL
Numerator	75	81	98	58	54	**366**
Denominator	100	100	100	100	100	**500**
%	75	81	98	58	54	**73.2**

Beginning in 2021, the NF audit included evaluating the NF Population on the MLTSS Performance Measures. The annual NF CM audit review period is from July 1, 2019 through June 30, 2020. However, due to the COVID-19 pandemic, the MCOs were mandated to suspend Face-to-Face Care Management activities. Therefore, IPRO and DMAHS agreed that for the current review cycle, the MCOs would be evaluated only for the period through which they could conduct normal business activities. The 2020 NF CM review period changed from a full year review to a partial year review beginning July 1, 2019 and ending February 29, 2020. For cases with no evidence of annual review, members are excluded from this measure if there was less than 13 months between the initial POC and the end of the study period. MCO C scored above 86% (CAP threshold) for this measure. All other MCOs scored below 86% and recommendations to complete a CAP (corrective action plan) were provided in their final reports.

PM 09a	MLTSS NF/SCNF Member's Plan of Care is amended based on change of Member condition
Numerator:	Number of records in the denominator that had a revised Plan of Care
Denominator:	Total number of MLTSS NF/SCNF Member records selected for review where there was a significant change in the member's condition in the measurement year
Data Source:	Annual MLTSS NF/SCNF Care Management Audit conducted by the EQRO
Frequency:	Annually

Waiver Year 2021	A	B	C	D	E	TOTAL
Numerator	1	0	12	2	3	**18**
Denominator	1	0	12	2	3	**18**
%	100	CNC*	100	100	100	**100**

*CNC- could not calculate

Members who did not have a documented change in condition during the study period are excluded from this measure. All MCOs scored above the 86% CAP threshold for this measure. MCO B did not have any members that met this criterion, which resulted in a CNC-could not calculate result.

PM 11	MLTSS NF/SCNF Member's Plan of Care is developed using "Person-Centered Principles"
Numerator:	Number of records in the denominator that were developed using Person-Centered Principles
Denominator:	Total number of MLTSS NF/SCNF records selected for review for the measurement year
Data Source:	Annual MLTSS NF/SCNF Care Management Audit conducted by the EQRO
Frequency:	Annually

Waiver Year 2021	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	91	88	98	58	51	**386**
Denominator	100	100	100	100	100	**500**
%	91	88	98	58	51	**77.2**

MCOs A, B, and C all met the 86% CAP threshold for this measure. MCOs D and E were required to complete a Corrective Action Plan (CAP) due to not meeting the threshold rate. In the current review period, documentation should have demonstrated that the Member and/or authorized representative were involved in goal setting and in agreement with the established goals. The Member's expressed needs and preferences, informal and formal supports, and options should have been addressed in the Plan of Care.

PM 16	MLTSS NF/SCNF Member training on identifying/reporting critical incidents
Numerator:	Number of records in the denominator where the MLTSS NF/SCNF member (or family member/authorized representative) received information/education on identifying and reporting abuse, neglect, and/or exploitation at least annually
Denominator:	Total number of MLTSS NF/SCNF records selected for review for the measurement year
Data Source:	Annual MLTSS NF/SCNF Care Management Audit conducted by the EQRO
Frequency:	Annually

Waiver Year 2021	**A**	**B**	**C**	**D**	**E**	**TOTAL**
Numerator	89	90	96	58	62	**395**
Denominator	100	100	100	100	100	**500**
%	89	90	96	58	62	**79**

MCOs A, B and C all reported rates above 86%, which made them compliant. MCOs D and E did not meet the CAP threshold guideline, and were required to develop a corrective action plan.

Deliverables due during MLTSS 4th quarter (4/1/2022 – 6/30/2022)

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

Measurement period	**3/2022**	**4/2022**	**5/2022**
Numerator	1016	921	1019
Denominator	1067	964	1042
%	95.2	95.5	97.8

Analysis of this measure reflects an increase in the total number of critical incidents reported from February to March. A decrease was noted from March to April and a similar noted increase from April to May. There has been an increasing percentage trend of the critical incidents being reported timely over the duration of the quarter. During this measurement period, all five MCOs were required to submit CAPs on how to improve timeliness of reporting critical incidents. Four out of the five MCOs submitted their CAP.

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

Measurement period	**3/2022**	**4/2022**	**5/2022**
Numerator	17	8	8
Denominator	17	8	9
%	100	100	88.9

Of the 17 critical incidents reported in March 2022, 16 events were unexpected deaths due to COVID-19 and non-COVID-19 related and one Media event reported timely during this same period. In April 2022, all eight critical incidents reported were unexpected deaths due to COVID-19 and non-COVID-19 related, and all were reported timely. In May, of the nine critical incidents reported, seven were unexpected deaths and two were for Potential for Media event. One of the unexpected deaths reported in May was not reported timely. A corrective action plan from MCO E has been obtained for this delay in reporting.

Deliverables due during MLTSS 4th quarter (4/1/2022 – 6/30/2022)

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

Table 3A UM Appeals

01/1/2022 – 03/31/2022	A	B	C	D	E	TOTAL
Numerator	33	11	84	51	28	**207**
Denominator	33	12	85	51	29	**210**
%	100	91.7	98.8	100	96.6	**98.6**

Table 3B Non-UM Grievances

01/1/2022 – 03/31/2022	A	B	C	D	E	TOTAL
Numerator	25	53	82	33	25	**218**
Denominator	25	55	84	33	25	**222**
%	100	96.4	97.6	100	100	**98.2**

During the 1/1/2022 – 3/30/2022 measurement period, two MCOs reported that 100% of UM Appeals in Table 3A were resolved within 30 days. MCO B reported that one appeal took more than 30 days to resolve, MCO C reported that one appeal took more than 30 days to resolve and MCO E reported that one appeal took more than 30 days to resolve. For this measurement period, the top five UM appeal categories for all MCOs combined were Denial of dental services (68/210 = 32.3%); Denial of inpatient hospital days (29/210 = 13.8%); Denial of skilled nursing facility inpatient rehabilitation services (20/210 = 9.5%); Denial of PCA services (19/210 = 9.0%); and Denial of medical equipment (DME) and/or supplies (19/210 = 9.0%).

During the 1/1/2022 – 3/30/2022 measurement period, three MCOs reported that 100% of non-UM Grievances in Table 3B were resolved within 30 days. MCO B reported that two grievances took more than 30 days to resolve, and MCO C reported that two grievances took more than 30 days to resolve.

The top three non-UM grievance categories for this measurement period were Reimbursement problems/ unpaid claims (41/222 = 18.4%); Dissatisfaction with quality of medical care, other type of provider (22/222 = 9.9%); and Dissatisfaction with transportation services (14/222 = 6.3%).

The tables below detail the number and type of MLTSS enrollee appeals (Table 3A) and grievances (Table 3B) filed during the measurement period of 1/1/2022 – 3/30/2022.

Deliverables due during MLTSS 4th quarter (4/1/2022 – 6/30/2022)

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

PM 19 - Table 3A Utilization Management (UM) enrollee appeal categories	January - March 2022					
	MCO A	MCO B	MCO C	MCO D	MCO E	TOTAL
Denial of acute inpatient rehabilitation services						0
Denial of assisted living services						0
Denial of dental services	3	5	29	23	8	68
Denial of hearing aid services						0
Denial of home delivered meal services						0
Denial of hospice care		1				1
Denial of in-home periodic skilled services (nursing, social services, nutrition, etc.)		1				1
Denial of in-home rehabilitation therapy (PT, OT, speech, etc.)						0
Denial of inpatient hospital days	20		7		2	29
Denial of Medical Day Care (adult & pediatric)	2					2
Denial of medical equipment (DME) and/or supplies	1	1	10	6	1	19
Denial of Mental Health services			1			1
Denial of non-medical transportation						0
Denial of optical appliances						0
Denial of optometric services						0
Denial of other TBI services (CRS, Structured Day, Supported Day, etc.)						0
Denial of outpatient medical treatment/diagnostic testing	**1**	**1**	**4**	**1**	**9**	16
Denial of outpatient rehabilitation therapy (PT, OT, Cardiac, Speech, Cognitive, etc.)			1		2	3
Denial of outpatient TBI habilitation therapy (PT, OT, speech, cognitive etc.)						0
Denial of PCA services		2	7	10		19
Denial of Personal Emergency Response Systems (PERS)						0
Denial of Private Duty Nursing			1	1		2
Denial of referral to out-of-network specialist			**1**	**4**		5
Denial of residential modification			3			3
Denial of respite services	1					1
Denial of skilled nursing facility (custodial)	2					2
Denial of skilled nursing facility inpatient rehabilitation services			19	1		20
Denial of Special Care Nursing Facility (custodial) SCNF						0
Denial of sub-acute inpatient rehabilitation services			2			2
Denial of SUD services						0
Denial of surgical procedure						0
Denial of vehicle modification						0
Other (MLTSS)						0
Other (non-MLTSS)	1					1
Pharmacy	2	1		5	7	15
Reduction of acuity level (inpatient)						0
Service considered cosmetic, not medically necessary						0
Service considered experimental/investigational						0
Table 3A/UM Appeal TOTALS	**33**	**12**	**85**	**51**	**29**	**210**

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

Deliverables due during MLTSS 4th quarter (4/1/2022 – 6/30/2022)

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

PM 19 - Table 3B non-utilization management (non-UM) enrollee grievance categories	January - March 2022					
	MCO A	MCO B	MCO C	MCO D	MCO E	TOTAL
Appointment availability, other type of provider						0
Appointment availability, PCP		1				1
Appointment availability, specialist						0
Difficulty obtaining access to a healthcare professional after hours (via phone)						0
Difficulty obtaining access to DME and/or medical supplies	1	2	1	2		6
Difficulty obtaining access to mental health providers				2		2
Difficulty obtaining access to MLTSS providers		1	2			3
Difficulty obtaining access to non-MLTSS providers				1		1
Difficulty obtaining access to other in-home health services (skilled and non-skilled)	1	1	7			9
Difficulty obtaining access to PCA services		1		2		3
Difficulty obtaining access to PDN services						0
Difficulty obtaining access to self-directed PCA services (PPP)		1		1		2
Difficulty obtaining access to SUD providers						0
Difficulty obtaining access to transportation services					1	1
Difficulty obtaining referral to network specialist of member's choice						0
Difficulty obtaining referrals for covered mental health services						0
Difficulty obtaining referrals for covered MLTSS services		5		4		9
Difficulty obtaining referrals for covered services, dental services		1	1	1	1	4
Difficulty obtaining referrals for covered SUD services						0
Difficulty related to obtaining emergency services						0
Dissatisfaction with dental services		1	3	2	2	8
Dissatisfaction with DME and/or medical supplies	1	2	4		1	8
Dissatisfaction with marketing, member handbook, etc.	3	3	2	2	2	12
Dissatisfaction with member services	4		6	3		13
Dissatisfaction with NJ FamilyCare Benefits				1		1
Dissatisfaction with other in-home health services (skilled and non-skilled)	2	1	3	1	2	9
Dissatisfaction with PCA services	1		3			4
Dissatisfaction with PDN services			1			1
Dissatisfaction with policies regarding specialty referrals (i.e. out of network specialist)						0
Dissatisfaction with provider network	1	1	1		2	5
Dissatisfaction with provider office administration		1	8	2	1	12
Dissatisfaction with quality of medical care, hospital	1		5	2		8
Dissatisfaction with quality of medical care, other type of provider	1	14	4	1	2	22
Dissatisfaction with quality of medical care, PCP		4	2	2	2	10
Dissatisfaction with quality of medical care, specialist			4			4
Dissatisfaction with transportation services	1	7		2	4	14
Dissatisfaction with utilization management appeal process						0
Dissatisfaction with vision services			1			1
Enrollment issues			2	1		3
Laboratory issues						0
Pharmacy/formulary issues	1	1	1			3
Reimbursement problems/unpaid claims	7	5	23	1	5	41
Waiting time too long at office, PCP		2				2
Waiting time too long at office, specialist						0
Table 3B/non-UM Grievance TOTALS	**25**	**55**	**84**	**33**	**25**	**222**

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

07/1/2021 – 09/30/2021	A	B	C	D	E	TOTAL
Numerator	3879	N/A	17658	N/A	7899	N/A
Denominator	5353	N/A	22367	N/A	12835	N/A
%	72.5	N/A	78.9	N/A	61.5	N/A

In the 7/1/2021 - 09/30/2021 quarter, MCO A reports slight decrease (72.5%) during the measurement period from the previous quarter (74.1%). MCO A states NF and Assisted Living residents constitute 78.8% of all those with service authorizations (3057/3879 = 78.8%). MCO C reports that 78.9% of their MLTSS membership is receiving at least one MLTSS service, which is consistent with the previous quarters. MCO E reports that there was a slight increase in the rates of members receiving MLTSS services during this period as compared to the previous quarter from 60.9% to 61.5%.

PM 20b	MLTSS HCBS members receiving MLTSS services
Numerator:	The unique count of members in the denominator with at least one claim for MLTSS services during the measurement period. Services for CM, PCA, Medical Day, NF, and Behavioral Health Services are not counted.
Denominator:	The unique count of MLTSS HCBS Members meeting eligibility criteria at any time during the measurement period.
Data Source:	MCO
Frequency:	Quarterly/Annually - Due 210 days after measurement period

1/1/2021 to 3/31/2021	A	B	C	D	E	TOTAL
Numerator	1333	N/A	9652	N/A	5062	**N/A**
Denominator	2664	N/A	14219	N/A	9611	**N/A**
%	50.0	N/A	67.9	N/A	52.7	**N/A**

4/1/2021 to 6/30/2021	A	B	C	D	E	TOTAL
Numerator	1404	N/A	9716	N/A	5292	**N/A**
Denominator	2801	N/A	14329	N/A	9954	**N/A**
%	50.1	N/A	67.8	N/A	53.2	**N/A**

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

7/1/2020 to 6/30/2021	A	B	C	D	E	TOTAL
Numerator	1836	N/A	11968	N/A	N/A	**N/A**
Denominator	3486	N/A	17133	N/A	N/A	**N/A**
%	52.7	N/A	69.9	N/A	N/A	**N/A**

7/1/2021 to 9/30/2021	A	B	C	D	E	TOTAL
Numerator	1427	N/A	9723	N/A	5464	N/A
Denominator	2772	N/A	14375	N/A	10124	N/A
%	51.5	N/A	67.6	N/A	54.0	N/A

MCO A reports a 51.5% rate of MLTSS HCBS members having claims for at least one MLTSS-specific service for the measurement period 7/1/2021 – 9/30/2021. The highest number of claims received continues to be for Personal Emergency Response System (PERS). For the 7/1/2021 – 9/30/2021 measurement period, MCO C reports that out of 14,375 unique MLTSS HCBS members, 67.6% (9,723) of the members had a paid MLTSS service claim during the measurement period. This rate is consistent with the previous quarter's rate (67.8%). For the 7/1/2021 – 9/30/2021 measurement period, MCO E reported 54% rate of members with MLTSS services. MCOs B and D are continuing to work through the validation process with the EQRO for this measure. Therefore, data has not been submitted and will be reported upon receipt.

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

7/1/2021 - 9/30/2021	A	B	C	D	E	TOTAL
Numerator	4	3	53	N/A	10	**N/A**
Denominator	2250	2717	7710	N/A	2351	**N/A**
%	0.2	0.1	0.7	N/A	0.4	**N/A**

10/1/2021 - 12/31/2021	A	B	C	D	E	TOTAL
Numerator	5	4	78	N/A	7	N/A
Denominator	2295	2748	7901	N/A	2409	N/A
%	0.2	.15	1.0	N/A	0.3	N/A

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

Deliverables due during MLTSS 4th quarter (4/1/2022 – 6/30/2022)

01/1/2022 - 03/31/2022	A	B	C	D	E	TOTAL
Numerator	3	N/A	74	N/A	7	N/A
Denominator	2293	N/A	7879	N/A	2411	N/A
%	0.1	N/A	0.9	N/A	0.3	N/A

MCO A reported transitioning three members (0.1%) from a NF to an HCBS setting during the 1/1/2022 – 3/30/2022 measurement period. Although the denominator remains very similar to last quarter, there has been a decrease for members transitioning. MCO A also reports discovering that some members have transitioned without notifying them, which may not be reflected in this report. MCO C transitioned 74 (0.9%) members into a HCBS during the measurement period. The rate of transition has decreased slightly for MCO C since the previous quarter. MCO E reports seven members transitioned from a nursing facility setting to a HCBS setting during the measurement period of 1/1/2022 – 3/30/2022, corresponding to a 0.3% transition rate.

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

7/1/2021 - 9/30/2021	A	B	C	D	E	TOTAL
Numerator	1	N/A	10	N/A	N/A	**N/A**
Denominator	6	N/A	68	N/A	N/A	**N/A**
%	16.7	N/A	14.7	N/A	N/A	**N/A**

10/1/2021 - 12/31/2021	A	B	C	D	E	TOTAL
Numerator	1	N/A	7	N/A	N/A	N/A
Denominator	3	N/A	79	N/A	N/A	N/A
%	33.3	N/A	8.9	N/A	N/A	N/A

For the 10/1/2021-12/31/2021 measurement period, MCO A reported reports 3 unique members meeting eligibility criteria, who transitioned to HCBS during the measurement period. Of these transitions, one of the members returned to the NF setting within 90 days of the transition. This calculates to 33.3% of the NF transitions returning to NF setting within 90 days of transition to the community. MCO C reported for measurement period 10/1/2021 - 12/31/2021, of the 79 members that transitioned from a Nursing Facility to a Community setting during this measurement period, 7 (8.9%) returned to the Nursing Facility within 90 days of the transition.

Deliverables due during MLTSS 4th quarter (4/1/2022 – 6/30/2022)

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

7/1/2020 - 9/30/2020	A	B	C	D	E	TOTAL
Numerator	187	340	N/A	429	N/A	**N/A**
Denominator	5812	14892	N/A	14246	N/A	**N/A**
%	3.2	2.3	N/A	3.0	N/A	**N/A**

10/1/2020 – 12/31/2020	A	B	C	D	E	TOTAL
Numerator	230	422	N/A	450	N/A	**N/A**
Denominator	6951	17436	N/A	14383	N/A	**N/A**
%	3.3	2.4	N/A	3.1	N/A	**N/A**

1/1/2021 – 3/31/2021	A	B	C	D	E	TOTAL
Numerator	183	497	N/A	561	N/A	**N/A**
Denominator	6748	17805	N/A	15583	N/A	**N/A**
%	2.7	2.8	N/A	3.6	N/A	**N/A**

4/1/2021 - 6/30/2021	A	B	C	D	E	TOTAL
Numerator	210	564	N/A	560	N/A	**N/A**
Denominator	7158	16860	N/A	16280	N/A	**N/A**
%	2.9	3.34	N/A	3.4	N/A	**N/A**

7/1/2020 - 6/30/2021	A	B	C	D	E	TOTAL
Numerator	774	2005	N/A	1947	N/A	**N/A**
Denominator	26120	64097	N/A	59873	N/A	**N/A**
%	3.0	3.1	N/A	3.3	N/A	**N/A**

7/1/2021 - 9/30/2021	A	B	C	D	E	TOTAL
Numerator	N/A	N/A	N/A	N/A	N/A	**N/A**
Denominator	N/A	N/A	N/A	N/A	N/A	**N/A**
%	N/A	N/A	N/A	N/A	N/A	**N/A**

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

Deliverables due during MLTSS 4th quarter (4/1/2022 – 6/30/2022)

MCOs C and E continue to work through the validation process for WYE 2021 with the State's EQRO. For the 7/1/2021- 9/30/2021 measurement period, all MCOs are working with the State's EQRO on their coding for this performance measure and have an extension to submit this report upon validation. This data along with any reconciled rates for other measurement periods will be included in the next quarterly report.

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

7/1/2020 - 9/30/2020	A	B	C	D	E	TOTAL
Numerator	191	154	N/A	182	N/A	**N/A**
Denominator	5929	8164	N/A	8724	N/A	**N/A**
%	3.2	1.9	N/A	2.1	N/A	**N/A**

10/1/2020 – 12/31/2020	A	B	C	D	E	TOTAL
Numerator	188	141	N/A	159	N/A	**N/A**
Denominator	6394	8772	N/A	8249	N/A	**N/A**
%	2.9	1.6	N/A	1.9	N/A	**N/A**

1/1/2021 – 3/31/2021	A	B	C	D	E	TOTAL
Numerator	179	160	N/A	155	N/A	**N/A**
Denominator	6383	8690	N/A	8272	N/A	**N/A**
%	2.8	1.8	N/A	1.9	N/A	**N/A**

4/1/2021 - 6/30/2021	A	B	C	D	E	TOTAL
Numerator	211	215	N/A	180	N/A	**N/A**
Denominator	6546	8595	N/A	8557	N/A	**N/A**
%	3.2	2.5	N/A	2.1	N/A	**N/A**

7/1/2020 - 6/30/2021	A	B	C	D	E	TOTAL
Numerator	750	804	N/A	647	N/A	**N/A**
Denominator	23899	32121	N/A	32427	N/A	**N/A**
%	3.1	2.5	N/A	2.0	N/A	**N/A**

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

7/1/2021 - 9/30/2021	A	B	C	D	E	TOTAL
Numerator	N/A	N/A	N/A	N/A	N/A	**N/A**
Denominator	N/A	N/A	N/A	N/A	N/A	**N/A**
%	N/A	N/A	N/A	N/A	N/A	**N/A**

MCOs C and E continue to work through the validation process for WYE 2021 with the State's EQRO. For the 7/1/2021- 9/30/2021 measurement period, all MCOs are working with the State's EQRO on their coding for this performance measure and have an extension to submit this report upon validation. This data along with any reconciled rates for other measurement periods will be included in the next quarterly report.

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

7/1/2020 - 9/30/2020	A	B	C	D	E	TOTAL
Numerator	3	50	N/A	34	N/A	**N/A**
Denominator	10	254	N/A	233	N/A	**N/A**
%	30.0	19.6	N/A	14.6	N/A	**N/A**

10/1/2020 – 12/31/2020	A	B	C	D	E	TOTAL
Numerator	9	47	N/A	55	N/A	**N/A**
Denominator	25	288	N/A	280	N/A	**N/A**
%	36.0	16.3	N/A	19.6	N/A	**N/A**

1/1/2021 – 3/31/2021	A	B	C	D	E	TOTAL
Numerator	4	63	N/A	74	N/A	**N/A**
Denominator	14	335	N/A	332	N/A	**N/A**
%	28.6	18.8	N/A	22.3	N/A	**N/A**

4/1/2021 - 6/30/2021	A	B	C	D	E	TOTAL
Numerator	4	84	N/A	75	N/A	**N/A**
Denominator	26	367	N/A	332	N/A	**N/A**
%	15.4	22.9	N/A	22.6	N/A	**N/A**

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

Deliverables due during MLTSS 4th quarter (4/1/2022 – 6/30/2022)

7/1/2020 - 6/30/2021	A	B	C	D	E	TOTAL
Numerator	4	117	N/A	108	N/A	**N/A**
Denominator	50	804	N/A	799	N/A	**N/A**
%	8.0	14.6	N/A	13.5	N/A	**N/A**

7/1/2021 - 9/30/2021	A	B	C	D	E	TOTAL
Numerator	N/A	N/A	N/A	N/A	N/A	**N/A**
Denominator	N/A	N/A	N/A	N/A	N/A	**N/A**
%	N/A	N/A	N/A	N/A	N/A	**N/A**

MCOs C and E continue to work through the validation process for WYE 2021 with the State's EQRO. For the 7/1/2021- 9/30/2021 measurement period, all MCOs are working with the State's EQRO on their coding for this performance measure and have an extension to submit this report upon validation. This data along with any reconciled rates for other measurement periods will be included in the next quarterly report.

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

7/1/2020 - 9/30/2020	A	B	C	D	E	TOTAL
Numerator	2	15	N/A	8	N/A	**N/A**
Denominator	12	57	N/A	64	N/A	**N/A**
%	16.7	26.3	N/A	12.5	N/A	**N/A**

10/1/2020 – 12/31/2020	A	B	C	D	E	TOTAL
Numerator	1	10	N/A	13	N/A	**N/A**
Denominator	14	75	N/A	65	N/A	**N/A**
%	7.1	13.3	N/A	20.0	N/A	**N/A**

1/1/2021 – 3/31/2021	A	B	C	D	E	TOTAL
Numerator	6	18	N/A	13	N/A	**N/A**
Denominator	16	68	N/A	76	N/A	**N/A**
%	37.5	26.5	N/A	17.1	N/A	**N/A**

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

Deliverables due during MLTSS 4th quarter (4/1/2022 – 6/30/2022)

4/1/2021 - 6/30/2021	A	B	C	D	E	TOTAL
Numerator	10	16	N/A	17	N/A	**N/A**
Denominator	31	55	N/A	83	N/A	**N/A**
%	32.3	29.1	N/A	20.5	N/A	**N/A**

7/1/2020 - 6/30/2021	A	B	C	D	E	TOTAL
Numerator	11	22	N/A	17	N/A	**N/A**
Denominator	58	120	N/A	181	N/A	**N/A**
%	19.0	18.3	N/A	9.4	N/A	**N/A**

7/1/2021 - 9/30/2021	A	B	C	D	E	TOTAL
Numerator	N/A	N/A	N/A	N/A	N/A	**N/A**
Denominator	N/A	N/A	N/A	N/A	N/A	**N/A**
%	N/A	N/A	N/A	N/A	N/A	**N/A**

MCOs C and E continue to work through the validation process for WYE 2021 with the State's EQRO. For the 7/1/2021- 9/30/2021 measurement period, all MCOs are working with the State's EQRO on their coding for this performance measure and have an extension to submit this report upon validation. This data along with any reconciled rates for other measurement periods will be included in the next quarterly report.

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

7/1/2020 - 9/30/2020	A	B	C	D	E	TOTAL
Numerator	256	655	N/A	752	N/A	**N/A**
Denominator	5812	14892	N/A	14246	N/A	**N/A**
%	4.4	4.4	N/A	5.3	N/A	**N/A**

10/1/2020 – 12/31/2020	A	B	C	D	E	TOTAL
Numerator	235	733	N/A	758	N/A	**N/A**
Denominator	6951	17436	N/A	14383	N/A	**N/A**
%	3.4	4.2	N/A	5.3	N/A	**N/A**

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

Deliverables due during MLTSS 4th quarter (4/1/2022 – 6/30/2022)

1/1/2021 – 3/31/2021	A	B	C	D	E	TOTAL
Numerator	236	783	N/A	842	N/A	**N/A**
Denominator	6748	17805	N/A	15583	N/A	**N/A**
%	3.5	4.4	N/A	5.4	N/A	**N/A**

4/1/2021 - 6/30/2021	A	B	C	D	E	TOTAL
Numerator	324	1051	N/A	1100	N/A	**N/A**
Denominator	7163	16860	N/A	16280	N/A	**N/A**
%	4.5	6.2	N/A	6.8	N/A	**N/A**

7/1/2020 - 6/30/2021	A	B	C	D	E	TOTAL
Numerator	1017	3555	N/A	3420	N/A	**N/A**
Denominator	26120	64097	N/A	59873	N/A	**N/A**
%	3.9	5.5	N/A	5.7	N/A	**N/A**

7/1/2021 - 9/30/2021	A	B	C	D	E	TOTAL
Numerator	N/A	N/A	N/A	N/A	N/A	**N/A**
Denominator	N/A	N/A	N/A	N/A	N/A	**N/A**
%	N/A	N/A	N/A	N/A	N/A	**N/A**

MCOs C and E continue to work through the validation process for WYE 2021 with the State's EQRO. For the 7/1/2021- 9/30/2021 measurement period, all MCOs are working with the State's EQRO on their coding for this performance measure and have an extension to submit this report upon validation. This data along with any reconciled rates for other measurement periods will be included in the next quarterly report.

PM 31	Emergency Department utilization by MLTSS NF members: HEDIS AMB
Numerator:	Reporting is at the Total level for ED events. Report rate per 100 in the State template and rate per 1000 in Data Analysis.
Denominator:	Follow HEDIS specifications for Ambulatory Care (AMB) for ED Visits for MLTSS NF members. Sum of MLTSS NF member months in the measurement period.
Data Source:	MCO
Frequency:	Quarterly/Annually - Due 210 days after measurement period

7/1/2020 - 9/30/2020	A	B	C	D	E	TOTAL
Numerator	13	48	N/A	44	N/A	**N/A**
Denominator	5929	8164	N/A	8724	N/A	**N/A**
%	0.2	0.6	N/A	0.5	N/A	**N/A**

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

Deliverables due during MLTSS 4th quarter (4/1/2022 – 6/30/2022)

10/1/2020 – 12/31/2020	A	B	C	D	E	TOTAL
Numerator	21	36	N/A	68	N/A	**N/A**
Denominator	6394	8772	N/A	8249	N/A	**N/A**
%	0.3	0.4	N/A	0.8	N/A	**N/A**

1/1/2021 – 3/31/2021	A	B	C	D	E	TOTAL
Numerator	18	51	N/A	54	N/A	**N/A**
Denominator	6383	8690	N/A	8272	N/A	**N/A**
%	0.3	0.6	N/A	0.7	N/A	**N/A**

4/1/2021 - 6/30/2021	A	B	C	D	E	TOTAL
Numerator	41	84	N/A	53	N/A	**N/A**
Denominator	6547	8578	N/A	8557	N/A	**N/A**
%	0.6	1.0	N/A	0.6	N/A	**N/A**

7/1/2020 - 6/30/2021	A	B	C	D	E	TOTAL
Numerator	87	225	N/A	207	N/A	**N/A**
Denominator	23899	32121	N/A	32427	N/A	**N/A**
%	0.4	0.7	N/A	0.6	N/A	**N/A**

7/1/2021 - 9/30/2021	A	B	C	D	E	TOTAL
Numerator	N/A	N/A	N/A	N/A	N/A	**N/A**
Denominator	N/A	N/A	N/A	N/A	N/A	**N/A**
%	N/A	N/A	N/A	N/A	N/A	**N/A**

MCOs C and E continue to work through the validation process for WYE 2021 with the State's EQRO. For the 7/1/2021- 9/30/2021 measurement period, all MCOs are working with the State's EQRO on their coding for this performance measure and have an extension to submit this report upon validation. This data along with any reconciled rates for other measurement periods will be included in the next quarterly report.

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

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

7/1/2021 - 9/30/2021	A	B	C	D	E	TOTAL
Numerator	178	N/A	N/A	N/A	629	**N/A**
Denominator	2,771	N/A	N/A	N/A	10,276	**N/A**
%	6.4	N/A	N/A	N/A	6.1	**N/A**

MCO A reported during the 7/1/2021 - 9/30/2021 measurement period, of the members enrolled in MLTSS HCBS, 178 had claims for PCA services ONLY during the measurement period. This calculates to 6.4% of the HCBS population. MCO E reported 629 unique HCBS members identified in the numerator as having had only PCA services, corresponding to 6.1%. MCOs B, C and D are continuing to work with the EQRO for validation of this measure. Reconciled data will be reported upon receipt.

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

7/1/2021 - 9/30/2021	A	B	C	D	E	TOTAL
Numerator	403	N/A	N/A	N/A	1,854	**N/A**
Denominator	2,771	N/A	N/A	N/A	10,276	**N/A**
%	14.5	N/A	N/A	N/A	18	**N/A**

MCO A reported during the 7/1/2021 - 9/30/2021 measurement period, that of the 2771 HCBS members for this measurement period, 403 are identified for at least one claim for Medical Day services. That indicates that 14.5% of the HCBS members have claims for MDC services only. MCO E reported during the 7/1/2021 - 9/30/2021 measurement period that of the 10276 members identified in the denominator, 1854 or 18% members were reported in the numerator as having Medical Day Services only. MCOs B, C and D are continuing to work with the EQRO for validation of this measure. Reconciled data will be reported upon receipt.

Deliverables due during MLTSS 4th quarter (4/1/2022 – 6/30/2022)

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

7/1/2020 - 9/30/2020	A	B	C	D	E	TOTAL
Numerator	2	6	9	1	N/A	**N/A**
Denominator	4	13	14	3	N/A	**N/A**
%	50	46.2	64.3	33.3	N/A	**N/A**

10/1/2020 – 12/31/2020	A	B	C	D	E	TOTAL
Numerator	2	3	5	3	N/A	**N/A**
Denominator	4	14	13	7	N/A	**N/A**
%	50.0	21.4	38.5	42.9	N/A	**N/A**

1/1/2021 – 3/31/2021	A	B	C	D	E	TOTAL
Numerator	2	4	N/A	2	N/A	**N/A**
Denominator	4	7	N/A	3	N/A	**N/A**
%	50.0	57.1	N/A	66.7	N/A	**N/A**

4/1/2021 - 6/30/2021	A	B	C	D	E	TOTAL
Numerator	3	3	N/A	4	N/A	**N/A**
Denominator	9	6	N/A	5	N/A	**N/A**
%	33.3	50.0	N/A	80.0	N/A	**N/A**

7/1/2020 - 6/30/2021	A	B	C	D	E	TOTAL
Numerator	9	16	N/A	14	N/A	**N/A**
Denominator	23	23	N/A	26	N/A	**N/A**
%	39.1	69.6	N/A	53.9	N/A	**N/A**

7/1/2021 - 9/30/2021	A	B	C	D	E	TOTAL
Numerator	N/A	N/A	N/A	N/A	N/A	**N/A**
Denominator	N/A	N/A	N/A	N/A	N/A	**N/A**
%	N/A	N/A	N/A	N/A	N/A	**N/A**

MCOs C and E continue to work through the validation process for WYE 2021 with the State's EQRO. For the 7/1/2021- 9/30/2021 measurement period, all MCOs are working with the State's EQRO on

their coding for this performance measure and have an extension to submit this report upon validation. This data along with any reconciled rates for other measurement periods will be included in the next quarterly report.

PM 38	Follow-up after mental health hospitalization for MLTSS NF members: HEDIS FUH
Numerator:	Sum of qualifying follow-up visits with a mental health practitioner within 30 days after discharge. Only the 30-day follow-up rate is reported.
Denominator:	Follow HEDIS specifications for Follow-Up after Hospitalization for Mental Illness (FUH) for MLTSS NF members. The denominator for this measure is based on discharges, not on members.
Data Source:	MCO
Frequency:	Quarterly/Annually - Due 240 days after measurement period

7/1/2020 - 9/30/2020	A	B	C	D	E	TOTAL
Numerator	0	0	0	0	N/A	**N/A**
Denominator	2	1	0	2	N/A	**N/A**
%	0	0	0	0	N/A	**N/A**

10/1/2020 – 12/31/2020	A	B	C	D	E	TOTAL
Numerator	0	0	0	0	N/A	**N/A**
Denominator	2	1	1	0	N/A	**N/A**
%	0	0	0	0	N/A	**N/A**

1/1/2021 – 3/31/2021	A	B	C	D	E	TOTAL
Numerator	0	0	N/A	0	N/A	**N/A**
Denominator	0	0	N/A	0	N/A	**N/A**
%	0	0	N/A	0	N/A	**N/A**

4/1/2021 - 6/30/2021	A	B	C	D	E	TOTAL
Numerator	0	0	N/A	0	N/A	**N/A**
Denominator	0	0	N/A	0	N/A	**N/A**
%	0	0	N/A	0	N/A	**N/A**

7/1/2020 - 6/30/2021	A	B	C	D	E	TOTAL
Numerator	0	0	N/A	0	N/A	**N/A**
Denominator	3	3	N/A	3	N/A	**N/A**
%	0	0	N/A	0	N/A	**N/A**

Deliverables due during MLTSS 4th quarter (4/1/2022 – 6/30/2022)

7/1/2021 -9/30/2021	A	B	C	D	E	TOTAL
Numerator	N/A	N/A	N/A	N/A	N/A	**N/A**
Denominator	N/A	N/A	N/A	N/A	N/A	**N/A**
%	N/A	N/A	N/A	N/A	N/A	**N/A**

MCOs C and E continue to work through the validation process for WYE 2021 with the State's EQRO. For the 7/1/2021- 9/30/2021 measurement period, all MCOs are working with the State's EQRO on their coding for this performance measure and have an extension to submit this report upon validation. This data along with any reconciled rates for other measurement periods will be included in the next quarterly report.

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

7/1/2021 -9/30/2021	A	B	C	D	E	TOTAL
Numerator	285	N/A	N/A	N/A	1,362	**N/A**
Denominator	2,771	N/A	N/A	N/A	10,276	**N/A**
%	10.3	N/A	N/A	N/A	13.3	**N/A**

For the 7/1/2021 - 9/30/2021 measurement period, MCO A reported 2771 HCBS members that meet the criteria as defined in approved specifications, enrolled at any time during the measurement period. Of the 2771 HCBS members for this measurement period, 285 members had claims for MDC and PCA services provided during the period. This result calculates to 10.3% of HCBS members receiving MDC and PCA and not any MLTSS-specific services. MCO E reported 10, 276 members in the denominator and 1362 members were identified as having PCA and Medical Day Care Services only or 13.3%, during the 7/1/2021 – 9/30/2021 measurement period. For the 7/1/2021-9/30/2021 measurement period, MCOs B, C, and D are working with the State's EQRO on their coding for this PM and have an extension to submit this report upon validation. This data along with any reconciled rates for other measurement periods will be included in the next quarterly report.

Deliverables due during MLTSS 4th quarter (4/1/2022 – 6/30/2022)

PM 42	Follow-up after Emergency Department visit for Alcohol or Other Drug Dependence (AOD) for MLTSS HCBS members: HEDIS FUA
Numerator:	Sum of qualifying follow-up visits with any practitioner, with a principal diagnosis of AOD within 30 days after the ED visit (31 total days). Only the 30-day follow-up rate is reported.
Denominator:	Follow HEDIS specifications for Follow-Up after Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA) for MLTSS HCBS members. The denominator for this measure is based on ED visits, not on members.
Data Source:	MCO
Frequency:	Quarterly/Annually - Due 240 days after measurement period

7/1/2020 - 9/30/2020	A	B	C	D	E	TOTAL
Numerator	0	2	5	2	N/A	**N/A**
Denominator	4	9	21	12	N/A	**N/A**
%	0	22.2	23.8	16.7	N/A	**N/A**

10/1/2020 – 12/31/2020	A	B	C	D	E	TOTAL
Numerator	1	1	5	0	N/A	**N/A**
Denominator	5	13	27	5	N/A	**N/A**
%	20.0	7.7	18.5	0	N/A	**N/A**

1/1/2021 – 3/31/2021	A	B	C	D	E	TOTAL
Numerator	0	3	N/A	2	N/A	**N/A**
Denominator	3	8	N/A	10	N/A	**N/A**
%	0	37.5	N/A	20.0	N/A	**N/A**

4/1/2021 - 6/30/2021	A	B	C	D	E	TOTAL
Numerator	1	2	N/A	3	N/A	**N/A**
Denominator	9	11	N/A	18	N/A	**N/A**
%	11.1	18.2	N/A	16.7	N/A	**N/A**

7/1/2020 - 6/30/2021	A	B	C	D	E	TOTAL
Numerator	1	12	N/A	9	N/A	**N/A**
Denominator	15	127	N/A	45	N/A	**N/A**
%	6.7	9.4	N/A	20.0	N/A	**N/A**

7/1/2021 - 9/30/2021	A	B	C	D	E	TOTAL
Numerator	N/A	N/A	N/A	N/A	N/A	**N/A**
Denominator	N/A	N/A	N/A	N/A	N/A	**N/A**
%	N/A	N/A	N/A	N/A	N/A	**N/A**

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

Deliverables due during MLTSS 4th quarter (4/1/2022 – 6/30/2022)

MCOs C and E continue to work through the validation process for WYE 2021 with the State's EQRO. For the 7/1/2021- 9/30/2021 measurement period, all MCOs are working with the State's EQRO on their coding for this performance measure and have an extension to submit this report upon validation. This data along with any reconciled rates for other measurement periods will be included in the next quarterly report.

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

7/1/2020 - 9/30/2020	A	B	C	D	E	TOTAL
Numerator	0	0	0	0	N/A	**N/A**
Denominator	0	1	4	0	N/A	**N/A**
%	0	0	0	0	N/A	**N/A**

10/1/2020 – 12/31/2020	A	B	C	D	E	TOTAL
Numerator	0	0	1	0	N/A	**N/A**
Denominator	2	0	3	0	N/A	**N/A**
%	0	0	33.3	0	N/A	**N/A**

1/1/2021 – 3/31/2021	A	B	C	D	E	TOTAL
Numerator	0	0	N/A	0	N/A	**N/A**
Denominator	0	0	N/A	0	N/A	**N/A**
%	0	0	N/A	0	N/A	**N/A**

4/1/2021 - 6/30/2021	A	B	C	D	E	TOTAL
Numerator	0	1	N/A	0	N/A	**N/A**
Denominator	2	2	N/A	2	N/A	**N/A**
%	0	50.0	N/A	0	N/A	**N/A**

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

Deliverables due during MLTSS 4th quarter (4/1/2022 – 6/30/2022)

7/1/2020 - 6/30/2021	A	B	C	D	E	TOTAL
Numerator	0	3	N/A	0	N/A	**N/A**
Denominator	3	8	N/A	0	N/A	**N/A**
%	0	37.5	N/A	0	N/A	**N/A**

7/1/2021 - 9/30/2021	A	B	C	D	E	TOTAL
Numerator	N/A	N/A	N/A	N/A	N/A	**N/A**
Denominator	N/A	N/A	N/A	N/A	N/A	**N/A**
%	N/A	N/A	N/A	N/A	N/A	**N/A**

MCOs C and E continue to work through the validation process for WYE 2021 with the State's EQRO. For the 7/1/2021- 9/30/2021 measurement period, all MCOs are working with the State's EQRO on their coding for this performance measure and have an extension to submit this report upon validation. This data along with any reconciled rates for other measurement periods will be included in the next quarterly report.

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

7/1/2020 - 9/30/2020	A	B	C	D	E	TOTAL
Numerator	2	7	10	5	N/A	**N/A**
Denominator	2	9	18	6	N/A	**N/A**
%	100	77.8	55.6	83.3	N/A	**N/A**

10/1/2020 – 12/31/2020	A	B	C	D	E	TOTAL
Numerator	0	3	9	3	N/A	**N/A**
Denominator	1	3	13	5	N/A	**N/A**
%	0	100	69.2	60.0	N/A	**N/A**

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

Deliverables due during MLTSS 4th quarter (4/1/2022 – 6/30/2022)

1/1/2021 – 3/31/2021	A	B	C	D	E	TOTAL
Numerator	2	8	N/A	4	N/A	**N/A**
Denominator	3	15	N/A	12	N/A	**N/A**
%	66.7	53.3	N/A	33.3	N/A	**N/A**

4/1/2021 - 6/30/2021	A	B	C	D	E	TOTAL
Numerator	8	6	N/A	7	N/A	**N/A**
Denominator	8	10	N/A	12	N/A	**N/A**
%	100	60.0	N/A	58.3	N/A	**N/A**

7/1/2020 - 6/30/2021	A	B	C	D	E	TOTAL
Numerator	10	73	N/A	18	N/A	**N/A**
Denominator	12	112	N/A	33	N/A	**N/A**
%	83.3	65.2	N/A	54.5	N/A	**N/A**

7/1/2021 - 9/30/2021	A	B	C	D	E	TOTAL
Numerator	N/A	N/A	N/A	N/A	N/A	**N/A**
Denominator	N/A	N/A	N/A	N/A	N/A	**N/A**
%	N/A	N/A	N/A	N/A	N/A	**N/A**

MCOs C and E continue to work through the validation process for WYE 2021 with the State's EQRO. For the 7/1/2021- 9/30/2021 measurement period, all MCOs are working with the State's EQRO on their coding for this performance measure and have an extension to submit this report upon validation. This data along with any reconciled rates for other measurement periods will be included in the next quarterly report.

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

Deliverables due during MLTSS 4th quarter (4/1/2022 – 6/30/2022)

7/1/2020 - 9/30/2020	A	B	C	D	E	TOTAL
Numerator	0	0	0	0	N/A	**N/A**
Denominator	0	2	0	0	N/A	**N/A**
%	0	0	0	0	N/A	**N/A**

10/1/2020 – 12/31/2020	A	B	C	D	E	TOTAL
Numerator	1	1	0	0	N/A	**N/A**
Denominator	1	1	1	0	N/A	**N/A**
%	100	100	0	0	N/A	**N/A**

1/1/2021 – 3/31/2021	A	B	C	D	E	TOTAL
Numerator	0	0	N/A	0	N/A	**N/A**
Denominator	0	1	N/A	1	N/A	**N/A**
%	0	0	N/A	0	N/A	**N/A**

4/1/2021 - 6/30/2021	A	B	C	D	E	TOTAL
Numerator	0	0	N/A	1	N/A	**N/A**
Denominator	0	0	N/A	1	N/A	**N/A**
%	0	0	N/A	100	N/A	**N/A**

7/1/2020 - 6/30/2021	A	B	C	D	E	TOTAL
Numerator	1	6	N/A	0	N/A	**N/A**
Denominator	1	12	N/A	1	N/A	**N/A**
%	100	50.0	N/A	0	N/A	**N/A**

7/1/2021 - 9/30/2021	A	B	C	D	E	TOTAL
Numerator	N/A	N/A	N/A	N/A	N/A	**N/A**
Denominator	N/A	N/A	N/A	N/A	N/A	**N/A**
%	N/A	N/A	N/A	N/A	N/A	**N/A**

MCOs C and E continue to work through the validation process for WYE 2021 with the State's EQRO. For the 7/1/2021- 9/30/2021 measurement period, all MCOs are working with the State's EQRO on their coding for this performance measure and have an extension to submit this report upon validation. This data along with any reconciled rates for other measurement periods will be included in the next quarterly report.

Deliverables due during MLTSS 4th quarter (04/01/2022 – 06/30/2022)

PM # 18A	% of CIs the MCO became aware of during the measurement period that were reported to the State
Numerator:	# of CIs in the denominator reported to the State as of the 7th day of the month following the end of the measurement period
Denominator:	# of CIs the MCO became aware of during the measurement period
Data source:	MCO
Measurement period:	07/01/2021 – 09/30/2021

Critical Incident (CI) reporting types: Jul - Sep 2021	MCO A			MCO B			MCO C			MCO D			MCO E			TOTAL		
	D	N	%	D	N	%	D	N	%	D	N	%	D	N	%	D	N	%
Unexpected death of a member	5	5	100.0	7	7	100.0	13	13	100.0	n/a	n/a	n/a	2	2	100.0	n/a	n/a	n/a
Media involvement or the potential for media involvement	1	1	100.0	2	2	100.0				n/a	n/a	n/a				n/a	n/a	n/a
Physical abuse (incl. seclusion and restraints both physical and chemical)	1	1	100.0	5	5	100.0	13	13	100.0	n/a	n/a	n/a	6	6	100.0	n/a	n/a	n/a
Psychological/Verbal abuse	1	1	100.0	1	1	100.0	3	3	100.0	n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Sexual abuse and/or suspected sexual abuse										n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Fall resulting in the need of medical treatment	75	75	100.0	114	114	100.0	132	132	100.0	n/a	n/a	n/a	45	45	100.0	n/a	n/a	n/a
Medical emergency resulting in need for medical treatment	509	507	99.6	1265	1263	99.8	355	355	100.0	n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Medication error resulting in serious consequences				3	3	100.0				n/a	n/a	n/a				n/a	n/a	n/a
Psychiatric emergency resulting in need for medical treatment	35	35	100.0	37	37	100.0	14	14	100.0	n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Severe injury resulting in the need of medical treatment				9	9	100.0	10	10	100.0	n/a	n/a	n/a	7	7	100.0	n/a	n/a	n/a
Suicide attempt resulting in the need for medical attention	1	1	100.0				1	1	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Neglect/Mistreatment, caregiver (paid or unpaid)				3	3	100.0	2	2	100.0	n/a	n/a	n/a	2	2	100.0	n/a	n/a	n/a
Neglect/Mistreatment, self	1	1	100.0	6	6	100.0	7	7	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Neglect/Mistreatment, other				2	2	100.0				n/a	n/a	n/a				n/a	n/a	n/a
Exploitation, financial							2	2	100.0	n/a	n/a	n/a	2	2	100.0	n/a	n/a	n/a
Exploitation, theft				1	1	100.0				n/a	n/a	n/a				n/a	n/a	n/a
Exploitation, destruction of property										n/a	n/a	n/a	2	2	100.0	n/a	n/a	n/a
Exploitation, other							1	1	100.0	n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Theft with law enforcement involvement							4	4	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Failure of member's Back-up Plan	9	9	100.0	9	9	100.0				n/a	n/a	n/a				n/a	n/a	n/a
Elopement/Wandering from home or facility	1	1	100.0							n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Inaccessible for initial/on-site meeting				19	19	100.0	1	1	100.0	n/a	n/a	n/a	10	10	100.0	n/a	n/a	n/a
Unable to Contact				16	16	100.0	14	14	100.0	n/a	n/a	n/a	9	9	100.0	n/a	n/a	n/a
Inappropriate/unprofessional conduct by provider involving member				1	1	100.0	152	152	100.0	n/a	n/a	n/a	2	2	100.0	n/a	n/a	n/a
Cancellation of utilities										n/a	n/a	n/a				n/a	n/a	n/a
Eviction/loss of home				4	4	100.0	6	6	100.0	n/a	n/a	n/a	3	3	100.0	n/a	n/a	n/a
Facility closure with direct impact to member's health/welfare										n/a	n/a	n/a				n/a	n/a	n/a
Natural disaster with direct impact to member's health/welfare	4	4	100.0	6	6	100.0	1	1	100.0	n/a	n/a	n/a	20	20	100.0	n/a	n/a	n/a
Operational Breakdown										n/a	n/a	n/a				n/a	n/a	n/a
Other	5	5	100.0	22	22	100.0	2	2	100.0	n/a	n/a	n/a	4	4	100.0	n/a	n/a	n/a
PM #18 A Totals	**648**	**646**	**99.7**	**1532**	**1530**	**99.9**	**733**	**733**	**100.0**	**n/a**	**n/a**	**n/a**	**120**	**120**	**100.0**	**n/a**	**n/a**	**n/a**

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

Deliverables due during MLTSS 4th quarter (04/01/2022 – 06/30/2022)

PM # 18A	% of CIs the MCO became aware of during the measurement period that were reported to the State
Numerator:	# of CIs in the denominator reported to the State as of the 7th day of the month following the end of the measurement period
Denominator:	# of CIs the MCO became aware of during the measurement period
Data source:	MCO
Measurement period:	10/01/2021 – 12/31/2021

Critical Incident (CI) reporting types: Oct 2021 - Dec 2021	MCO A			MCO B			MCO C			MCO D			MCO E			TOTAL		
	D	N	%	D	N	%	D	N	%	D	N	%	D	N	%	D	N	%
Unexpected death of a member	1	1	100.0	8	8	100.0	12	12	100.0	n/a	n/a	n/a	7	7	100.0	n/a	n/a	n/a
Media involvement or the potential for media involvement							2	2	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Physical abuse (incl. seclusion and restraints both physical and chemical)	2	2	100.0	2	2	100.0	6	6	100.0	n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Psychological/Verbal abuse				3	3	100.0				n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Sexual abuse and/or suspected sexual abuse				1	1	100.0	1	1	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Fall resulting in the need of medical treatment	65	65	100.0	113	113	100.0	108	108	100.0	n/a	n/a	n/a	33	33	100.0	n/a	n/a	n/a
Medical emergency resulting in need for medical treatment	473	469	99.2	1046	1045	99.9	297	297	100.0	n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Medication error resulting in serious consequences				2	2	100.0				n/a	n/a	n/a				n/a	n/a	n/a
Psychiatric emergency resulting in need for medical treatment	18	18	100.0	28	28	100.0	8	8	100.0	n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Severe injury resulting in the need of medical treatment				7	6	85.7	7	7	100.0	n/a	n/a	n/a	5	5	100.0	n/a	n/a	n/a
Suicide attempt resulting in the need for medical attention	1	1	100.0	1	1	100.0	1	1	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Neglect/Mistreatment, caregiver (paid or unpaid)	1	1	100.0	1	1	100.0	7	7	100.0	n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Neglect/Mistreatment, self							1	1	100.0	n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Neglect/Mistreatment, other										n/a	n/a	n/a				n/a	n/a	n/a
Exploitation, financial							1	1	100.0	n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Exploitation, theft	1	1	100.0				2	2	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Exploitation, destruction of property										n/a	n/a	n/a				n/a	n/a	n/a
Exploitation, other										n/a	n/a	n/a				n/a	n/a	n/a
Theft with law enforcement involvement							2	2	100.0	n/a	n/a	n/a	2	2	100.0	n/a	n/a	n/a
Failure of member's Back-up Plan	3	3	100.0	4	4	100.0				n/a	n/a	n/a				n/a	n/a	n/a
Elopement/Wandering from home or facility				1	1	100.0				n/a	n/a	n/a	3	3	100.0	n/a	n/a	n/a
Inaccessible for initial/on-site meeting	1	1	100.0	16	16	100.0	3	3	100.0	n/a	n/a	n/a	3	3	100.0	n/a	n/a	n/a
Unable to Contact	1	1	100.0	39	39	100.0	15	15	100.0	n/a	n/a	n/a	5	5	100.0	n/a	n/a	n/a
Inappropriate/unprofessional conduct by provider involving member				3	3	100.0	94	94	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Cancellation of utilities										n/a	n/a	n/a				n/a	n/a	n/a
Eviction/loss of home				2	2	100.0	1	1	100.0	n/a	n/a	n/a	3	3	100.0	n/a	n/a	n/a
Facility closure with direct impact to member's health/welfare										n/a	n/a	n/a				n/a	n/a	n/a
Natural disaster with direct impact to member's health/welfare										n/a	n/a	n/a				n/a	n/a	n/a
Operational Breakdown				3	3	100.0	19	19	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Other				29	29	100.0	2	2	100.0	n/a	n/a	n/a				n/a	n/a	n/a
PM #18 A Totals	**567**	**563**	**99.3**	**1309**	**1307**	**99.8**	**589**	**589**	**100.0**	**n/a**	**n/a**	**n/a**	**68**	**68**	**100.0**	**n/a**	**n/a**	**n/a**

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

A = Aetna B = Amerigroup C = Horizon NJ Health D = United HealthCare E = WellCare

Deliverables due during MLTSS 4th quarter (04/01/2022 – 06/30/2022)

PM # 18A	% of CIs the MCO became aware of during the measurement period that were reported to the State
Numerator:	# of CIs in the denominator reported to the State as of the 7th day of the month following the end of the measurement period
Denominator:	# of CIs the MCO became aware of during the measurement period
Data source:	MCO
Measurement period:	01/01/2022 – 03/30/2022

Critical Incident (CI) reporting types: Jan - Mar 2022	MCO A			MCO B			MCO C			MCO D			MCO E			TOTAL		
	D	N	%	D	N	%	D	N	%	D	N	%	D	N	%	D	N	%
Unexpected death of a member	1	1	100.0	28	28	100.0	22	22	100.0	n/a	n/a	n/a	11	11	100.0	n/a	n/a	n/a
Media involvement or the potential for media involvement							1	1	100.0	n/a	n/a	n/a	2	2	100.0	n/a	n/a	n/a
Physical abuse (incl. seclusion and restraints both physical and chemical)	2	2	100.0				4	4	100.0	n/a	n/a	n/a	3	3	100.0	n/a	n/a	n/a
Psychological/Verbal abuse				1	1	100.0	3	3	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Sexual abuse and/or suspected sexual abuse				1	1	100.0	1	1	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Fall resulting in the need of medical treatment	73	73	100.0	124	124	100.0	113	113	100.0	n/a	n/a	n/a	43	43	100.0	n/a	n/a	n/a
Medical emergency resulting in need for medical treatment	486	484	99.6	1072	1072	100.0	277	277	100.0	n/a	n/a	n/a	3	3	100.0	n/a	n/a	n/a
Medication error resulting in serious consequences				1	1	100.0				n/a	n/a	n/a				n/a	n/a	n/a
Psychiatric emergency resulting in need for medical treatment	26	26	100.0	45	45	100.0	13	13	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Severe injury resulting in the need of medical treatment	1	1	100.0	7	7	100.0	9	9	100.0	n/a	n/a	n/a	7	7	100.0	n/a	n/a	n/a
Suicide attempt resulting in the need for medical attention	3	3	100.0				1	1	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Neglect/Mistreatment, caregiver (paid or unpaid)	1	1	100.0	2	2	100.0	7	7	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Neglect/Mistreatment, self							1	1	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Neglect/Mistreatment, other	2	2	100.0							n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Exploitation, financial							1	1	100.0	n/a	n/a	n/a	2	2	100.0	n/a	n/a	n/a
Exploitation, theft				2	2	100.0	2	2	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Exploitation, destruction of property										n/a	n/a	n/a				n/a	n/a	n/a
Exploitation, other							2	2	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Theft with law enforcement involvement							2	2	100.0	n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Failure of member's Back-up Plan				4	4	100.0	1	1	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Elopement/Wandering from home or facility							1	1	100.0	n/a	n/a	n/a	2	2	100.0	n/a	n/a	n/a
Inaccessible for initial/on-site meeting				34	34	100.0	1	1	100.0	n/a	n/a	n/a	13	13	100.0	n/a	n/a	n/a
Unable to Contact				33	33	100.0	15	15	100.0	n/a	n/a	n/a	13	13	100.0	n/a	n/a	n/a
Inappropriate/unprofessional conduct by provider involving member							62	62	100.0	n/a	n/a	n/a	4	4	100.0	n/a	n/a	n/a
Cancellation of utilities										n/a	n/a	n/a				n/a	n/a	n/a
Eviction/loss of home				5	5	100.0	3	3	100.0	n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Facility closure with direct impact to member's health/welfare										n/a	n/a	n/a				n/a	n/a	n/a
Natural disaster with direct impact to member's health/welfare										n/a	n/a	n/a				n/a	n/a	n/a
Operational Breakdown				6	6	100.0	1	1	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Other	2	2	100.0	128	128	100.0	2	2	100.0	n/a	n/a	n/a				n/a	n/a	n/a
PM #18 A Totals	**597**	**595**	**99.7**	**1493**	**1493**	**100.0**	**545**	**545**	**100.0**	**n/a**	**n/a**	**n/a**	**106**	**106**	**100.0**	**n/a**	**n/a**	**n/a**

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

A = Aetna B = Amerigroup C = Horizon NJ Health D = United HealthCare E = WellCare

Deliverables due during MLTSS 4th quarter (04/01/2022 – 06/30/2022)

PM # 18B	% of CIs in the denominator the MCO reported to the State within 2 business days
Numerator:	# of CIs in the denominator that were reported to the State within two business days
Denominator:	# of CIs the MCO became aware of during the measurement period
Data source:	MCO
Measurement period:	07/01/2021 – 09/30/2021

Critical Incident (CI) reporting types: Jul - Sep 2021	MCO A			MCO B			MCO C			MCO D			MCO E			TOTAL		
	D	N	%	D	N	%	D	N	%	D	N	%	D	N	%	D	N	%
Unexpected death of a member	5	5	100.0	7	6	85.7	13	13	100.0	n/a	n/a	n/a	2	2	100.0	n/a	n/a	n/a
Media involvement or the potential for media involvement	1	1	100.0	2	2	100.0				n/a	n/a	n/a				n/a	n/a	n/a
Physical abuse (incl. seclusion and restraints both physical and chemical)	1	1	100.0	5	5	100.0	13	11	84.6	n/a	n/a	n/a	6	6	100.0	n/a	n/a	n/a
Psychological/Verbal abuse	1	1	100.0	1	1	100.0	3	2	66.7	n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Sexual abuse and/or suspected sexual abuse										n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Fall resulting in the need of medical treatment	75	74	98.7	114	102	89.5	132	129	97.7	n/a	n/a	n/a	45	44	97.8	n/a	n/a	n/a
Medical emergency resulting in need for medical treatment	509	493	96.9	1265	1088	86.0	355	349	98.3	n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Medication error resulting in serious consequences				3	1	33.3				n/a	n/a	n/a				n/a	n/a	n/a
Psychiatric emergency resulting in need for medical treatment	35	34	97.1	37	36	97.3	14	14	100.0	n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Severe injury resulting in the need of medical treatment				9	7	77.8	10	10	100.0	n/a	n/a	n/a	7	7	100.0	n/a	n/a	n/a
Suicide attempt resulting in the need for medical attention	1	1	100.0				1	1	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Neglect/Mistreatment, caregiver (paid or unpaid)				3	2	66.7	2	2	100.0	n/a	n/a	n/a	2	2	100.0	n/a	n/a	n/a
Neglect/Mistreatment, self	1	1	100.0	6	6	100.0	7	6	85.7	n/a	n/a	n/a				n/a	n/a	n/a
Neglect/Mistreatment, other				2	2	100.0				n/a	n/a	n/a				n/a	n/a	n/a
Exploitation, financial							2	2	100.0	n/a	n/a	n/a	2	2	100.0	n/a	n/a	n/a
Exploitation, theft				1	1	100.0				n/a	n/a	n/a				n/a	n/a	n/a
Exploitation, destruction of property										n/a	n/a	n/a	2	2	100.0	n/a	n/a	n/a
Exploitation, other							1	1	100.0	n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Theft with law enforcement involvement							4	3	75.0	n/a	n/a	n/a				n/a	n/a	n/a
Failure of member's Back-up Plan	9	9	100.0	9	9	100.0				n/a	n/a	n/a				n/a	n/a	n/a
Elopement/Wandering from home or facility	1	1	100.0							n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Inaccessible for initial/on-site meeting				19	18	94.7	1	1	100.0	n/a	n/a	n/a	10	10	100.0	n/a	n/a	n/a
Unable to Contact				16	16	100.0	14	12	85.7	n/a	n/a	n/a	9	9	100.0	n/a	n/a	n/a
Inappropriate/unprofessional conduct by provider involving member				1	1	100.0	152	142	93.4	n/a	n/a	n/a	2	2	100.0	n/a	n/a	n/a
Cancellation of utilities										n/a	n/a	n/a				n/a	n/a	n/a
Eviction/loss of home				4	1	25.0	6	5	83.3	n/a	n/a	n/a	3	3	100.0	n/a	n/a	n/a
Facility closure with direct impact to member's health/welfare										n/a	n/a	n/a				n/a	n/a	n/a
Natural disaster with direct impact to member's health/welfare	4	3	75.0	6	5	83.3	1	1	100.0	n/a	n/a	n/a	20	16	80.0	n/a	n/a	n/a
Operational Breakdown										n/a	n/a	n/a				n/a	n/a	n/a
Other	5	5	100.0	22	20	90.9	2	2	100.0	n/a	n/a	n/a	4	4	100.0	n/a	n/a	n/a
PM #18 B Totals	**648**	**629**	**97.1**	**1532**	**1329**	**86.7**	**733**	**706**	**96.3**	**n/a**	**n/a**	**n/a**	**120**	**115**	**95.8**	**n/a**	**n/a**	**n/a**

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Deliverables due during MLTSS 4th quarter (04/01/2022 – 06/30/2022)

PM # 18B	% of CIs in the denominator the MCO reported to the State within 2 business days
Numerator:	# of CIs in the denominator that were reported to the State within two business days
Denominator:	# of CIs the MCO became aware of during the measurement period
Data source:	MCO
Measurement period:	10/01/2021 – 12/31/2021

Critical Incident (CI) reporting types: Oct - Dec 2021	MCO A			MCO B			MCO C			MCO D			MCO E			TOTAL		
	D	N	%	D	N	%	D	N	%	D	N	%	D	N	%	D	N	%
Unexpected death of a member	1	1	100.0	8	8	100.0	12	12	100.0	n/a	n/a	n/a	7	7	100.0	n/a	n/a	n/a
Media involvement or the potential for media involvement							2	2	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Physical abuse (incl. seclusion and restraints both physical and chemical)	2	1	50.0	2	2	100.0	6	6	100.0	n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Psychological/Verbal abuse				3	3	100.0				n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Sexual abuse and/or suspected sexual abuse				1	1	100.0	1	1	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Fall resulting in the need of medical treatment	65	62	95.4	113	106	93.8	108	101	93.5	n/a	n/a	n/a	33	31	93.9	n/a	n/a	n/a
Medical emergency resulting in need for medical treatment	473	453	95.8	1046	993	94.9	297	294	99.0	n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Medication error resulting in serious consequences				2	2	100.0				n/a	n/a	n/a				n/a	n/a	n/a
Psychiatric emergency resulting in need for medical treatment	18	17	94.4	28	27	96.4	8	8	100.0	n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Severe injury resulting in the need of medical treatment				7	6	85.7	7	7	100.0	n/a	n/a	n/a	5	5	100.0	n/a	n/a	n/a
Suicide attempt resulting in the need for medical attention	1	1	100.0	1	1	100.0	1	1	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Neglect/Mistreatment, caregiver (paid or unpaid)	1	1	100.0	1	1	100.0	7	5	71.4	n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Neglect/Mistreatment, self							1	1	100.0	n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Neglect/Mistreatment, other										n/a	n/a	n/a				n/a	n/a	n/a
Exploitation, financial							1	1	100.0	n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Exploitation, theft	1	1	100.0				2	2	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Exploitation, destruction of property										n/a	n/a	n/a				n/a	n/a	n/a
Exploitation, other										n/a	n/a	n/a				n/a	n/a	n/a
Theft with law enforcement involvement							2	2	100.0	n/a	n/a	n/a	2	2	100.0	n/a	n/a	n/a
Failure of member's Back-up Plan	3	3	100.0	4	4	100.0				n/a	n/a	n/a				n/a	n/a	n/a
Elopement/Wandering from home or facility				1	1	100.0				n/a	n/a	n/a	3	3	100.0	n/a	n/a	n/a
Inaccessible for initial/on-site meeting	1	1	100.0	16	16	100.0	3	1	33.3	n/a	n/a	n/a	3	3	100.0	n/a	n/a	n/a
Unable to Contact	1	1	100.0	39	38	97.4	15	11	73.3	n/a	n/a	n/a	5	5	100.0	n/a	n/a	n/a
Inappropriate/unprofessional conduct by provider involving member				3	3	100.0	94	90	95.7	n/a	n/a	n/a				n/a	n/a	n/a
Cancellation of utilities										n/a	n/a	n/a				n/a	n/a	n/a
Eviction/loss of home				2	2	100.0	1	1	100.0	n/a	n/a	n/a	3	3	100.0	n/a	n/a	n/a
Facility closure with direct impact to member's health/welfare										n/a	n/a	n/a				n/a	n/a	n/a
Natural disaster with direct impact to member's health/welfare										n/a	n/a	n/a				n/a	n/a	n/a
Operational Breakdown				3	3	100.0	19	19	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Other				29	29	100.0	2	2	100.0	n/a	n/a	n/a				n/a	n/a	n/a
PM #18 B Totals	**567**	**542**	**95.6**	**1309**	**1246**	**95.2**	**589**	**567**	**96.3**	**n/a**	**n/a**	**n/a**	**68**	**66**	**97.1**	**n/a**	**n/a**	**n/a**

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

A = Aetna B = Amerigroup C = Horizon NJ Health D = United HealthCare E = WellCare

Deliverables due during MLTSS 4th quarter (04/01/2022 – 06/30/2022)

PM # 18B	% of CIs in the denominator the MCO reported to the State within 2 business days
Numerator:	# of CIs in the denominator that were reported to the State within two business days
Denominator:	# of CIs the MCO became aware of during the measurement period
Data source:	MCO
Measurement period:	01/01/2022 – 03/31/2022

Critical Incident (CI) reporting types: Jan - Mar 2022	MCO A			MCO B			MCO C			MCO D			MCO E			TOTAL		
	D	N	%	D	N	%	D	N	%	D	N	%	D	N	%	D	N	%
Unexpected death of a member	1	1	100.0	28	28	100.0	22	19	86.4	n/a	n/a	n/a	11	11	100.0	n/a	n/a	n/a
Media involvement or the potential for media involvement							1	1	100.0	n/a	n/a	n/a	2	2	100.0	n/a	n/a	n/a
Physical abuse (incl. seclusion and restraints both physical and chemical)	2	2	100.0				4	4	100.0	n/a	n/a	n/a	3	3	100.0	n/a	n/a	n/a
Psychological/Verbal abuse				1	1	100.0	3	3	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Sexual abuse and/or suspected sexual abuse				1	1	100.0	1	1	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Fall resulting in the need of medical treatment	73	69	94.5	124	116	93.5	113	105	92.9	n/a	n/a	n/a	43	40	93.0	n/a	n/a	n/a
Medical emergency resulting in need for medical treatment	486	457	94.0	1072	1013	94.5	277	273	98.6	n/a	n/a	n/a	3	3	100.0	n/a	n/a	n/a
Medication error resulting in serious consequences				1	1	100.0				n/a	n/a	n/a				n/a	n/a	n/a
Psychiatric emergency resulting in need for medical treatment	26	23	88.5	45	45	100.0	13	13	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Severe injury resulting in the need of medical treatment	1	1	100.0	7	6	85.7	9	9	100.0	n/a	n/a	n/a	7	7	100.0	n/a	n/a	n/a
Suicide attempt resulting in the need for medical attention	3	3	100.0				1	1	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Neglect/Mistreatment, caregiver (paid or unpaid)	1	1	100.0	2	2	100.0	7	7	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Neglect/Mistreatment, self							1	1	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Neglect/Mistreatment, other	2	1	50.0							n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Exploitation, financial							1	1	100.0	n/a	n/a	n/a	2	2	100.0	n/a	n/a	n/a
Exploitation, theft				2	2	100.0	2	2	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Exploitation, destruction of property										n/a	n/a	n/a				n/a	n/a	n/a
Exploitation, other							2	2	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Theft with law enforcement involvement							2	2	100.0	n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Failure of member's Back-up Plan				4	4	100.0	1	1	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Elopement/Wandering from home or facility							1	1	100.0	n/a	n/a	n/a	2	2	100.0	n/a	n/a	n/a
Inaccessible for initial/on-site meeting				34	32	94.1	1	1	100.0	n/a	n/a	n/a	13	13	100.0	n/a	n/a	n/a
Unable to Contact				33	31	93.9	15	10	66.7	n/a	n/a	n/a	13	13	100.0	n/a	n/a	n/a
Inappropriate/unprofessional conduct by provider involving member							62	59	95.2	n/a	n/a	n/a	4	4	100.0	n/a	n/a	n/a
Cancellation of utilities										n/a	n/a	n/a				n/a	n/a	n/a
Eviction/loss of home				5	4	80.0	3	3	100.0	n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Facility closure with direct impact to member's health/welfare										n/a	n/a	n/a				n/a	n/a	n/a
Natural disaster with direct impact to member's health/welfare										n/a	n/a	n/a				n/a	n/a	n/a
Operational Breakdown				6	5	83.3	1	0	0.0	n/a	n/a	n/a				n/a	n/a	n/a
Other	2	2	100.0	128	122	95.3	2	2	100.0	n/a	n/a	n/a				n/a	n/a	n/a
PM #18 B Totals	**597**	**560**	**93.8**	**1493**	**1413**	**94.6**	**545**	**521**	**95.6**	**n/a**	**n/a**	**n/a**	**106**	**103**	**97.2**	**n/a**	**n/a**	**n/a**

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Deliverables due during MLTSS 4th quarter (04/01/2022 – 06/30/2022)

PM # 18C	% of CIs that the MCO became aware of during the measurement period for which a date of occurrence was available
Numerator:	# of CIs in the denominator for which a date of occurrence is known
Denominator:	# of CIs the MCO became aware of during the measurement period
Data source:	MCO
Measurement period:	07/01/2021 – 09/30/2021

Critical Incident (CI) reporting types: Jul - Sep 2021	MCO A			MCO B			MCO C			MCO D			MCO E			TOTAL		
	D	N	%	D	N	%	D	N	%	D	N	%	D	N	%	D	N	%
Unexpected death of a member	5	5	100.0	7	7	100.0	13	13	100.0	n/a	n/a	n/a	2	2	100.0	n/a	n/a	n/a
Media involvement or the potential for media involvement	1	1	100.0	2	2	100.0				n/a	n/a	n/a				n/a	n/a	n/a
Physical abuse (incl. seclusion and restraints both physical and chemical)	1	0	0.0	5	5	100.0	13	12	92.3	n/a	n/a	n/a	6	6	100.0	n/a	n/a	n/a
Psychological/Verbal abuse	1	1	100.0	1	1	100.0	3	3	100.0	n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Sexual abuse and/or suspected sexual abuse										n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Fall resulting in the need of medical treatment	75	73	97.3	114	112	98.2	132	131	99.2	n/a	n/a	n/a	45	45	100.0	n/a	n/a	n/a
Medical emergency resulting in need for medical treatment	509	498	97.8	1265	1259	99.5	355	352	99.2	n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Medication error resulting in serious consequences				3	3	100.0				n/a	n/a	n/a				n/a	n/a	n/a
Psychiatric emergency resulting in need for medical treatment	35	35	100.0	37	37	100.0	14	14	100.0	n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Severe injury resulting in the need of medical treatment				9	9	100.0	10	10	100.0	n/a	n/a	n/a	7	7	100.0	n/a	n/a	n/a
Suicide attempt resulting in the need for medical attention	1	1	100.0				1	1	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Neglect/Mistreatment, caregiver (paid or unpaid)				3	3	100.0	2	2	100.0	n/a	n/a	n/a	2	2	100.0	n/a	n/a	n/a
Neglect/Mistreatment, self	1	1	100.0	6	6	100.0	7	7	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Neglect/Mistreatment, other				2	2	100.0				n/a	n/a	n/a				n/a	n/a	n/a
Exploitation, financial							2	1	50.0	n/a	n/a	n/a	2	2	100.0	n/a	n/a	n/a
Exploitation, theft				1	1	100.0				n/a	n/a	n/a				n/a	n/a	n/a
Exploitation, destruction of property										n/a	n/a	n/a	2	2	100.0	n/a	n/a	n/a
Exploitation, other							1	1	100.0	n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Theft with law enforcement involvement							4	4	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Failure of member's Back-up Plan	9	8	88.9	9	9	100.0				n/a	n/a	n/a				n/a	n/a	n/a
Elopement/Wandering from home or facility	1	1	100.0							n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Inaccessible for initial/on-site meeting				19	19	100.0	1	1	100.0	n/a	n/a	n/a	10	10	100.0	n/a	n/a	n/a
Unable to Contact				16	16	100.0	14	14	100.0	n/a	n/a	n/a	9	9	100.0	n/a	n/a	n/a
Inappropriate/unprofessional conduct by provider involving member				1	1	100.0	152	150	98.7	n/a	n/a	n/a	2	2	100.0	n/a	n/a	n/a
Cancellation of utilities										n/a	n/a	n/a				n/a	n/a	n/a
Eviction/loss of home				4	4	100.0	6	6	100.0	n/a	n/a	n/a	3	3	100.0	n/a	n/a	n/a
Facility closure with direct impact to member's health/welfare										n/a	n/a	n/a				n/a	n/a	n/a
Natural disaster with direct impact to member's health/welfare	4	4	100.0	6	6	100.0	1	1	100.0	n/a	n/a	n/a	20	20	100.0	n/a	n/a	n/a
Operational Breakdown										n/a	n/a	n/a				n/a	n/a	n/a
Other	5	4	80.0	22	21	95.5	2	2	100.0	n/a	n/a	n/a	4	4	100.0	n/a	n/a	n/a
PM #18 C Totals	**648**	**632**	**97.5**	**1532**	**1523**	**99.4**	**733**	**725**	**98.9**	**n/a**	**n/a**	**n/a**	**120**	**120**	**100.0**	**n/a**	**n/a**	**n/a**

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

A = Aetna B = Amerigroup C = Horizon NJ Health D = United HealthCare E = WellCare

Deliverables due during MLTSS 4th quarter (04/01/2022 – 06/30/2022)

PM # 18C	% of CIs that the MCO became aware of during the measurement period for which a date of occurrence was available
Numerator:	# of CIs in the denominator for which a date of occurrence is known
Denominator:	# of CIs the MCO became aware of during the measurement period
Data source:	MCO
Measurement period:	10/01/2021 – 12/31/2021

Critical Incident (CI) reporting types: Oct - Dec 2021	MCO A			MCO B			MCO C			MCO D			MCO E			TOTAL		
	D	N	%	D	N	%	D	N	%	D	N	%	D	N	%	D	N	%
Unexpected death of a member	1	1	100.0	8	8	100.0	12	12	100.0	n/a	n/a	n/a	7	7	100.0	n/a	n/a	n/a
Media involvement or the potential for media involvement							2	2	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Physical abuse (incl. seclusion and restraints both physical and chemical)	2	1	50.0	2	2	100.0	6	6	100.0	n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Psychological/Verbal abuse				3	3	100.0				n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Sexual abuse and/or suspected sexual abuse				1	1	100.0	1	1	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Fall resulting in the need of medical treatment	65	62	95.4	113	111	98.2	108	107	99.1	n/a	n/a	n/a	33	33	100.0	n/a	n/a	n/a
Medical emergency resulting in need for medical treatment	473	461	97.5	1046	1043	99.7	297	297	100.0	n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Medication error resulting in serious consequences				2	2	100.0				n/a	n/a	n/a				n/a	n/a	n/a
Psychiatric emergency resulting in need for medical treatment	18	16	88.9	28	28	100.0	8	8	100.0	n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Severe injury resulting in the need of medical treatment				7	7	100.0	7	6	85.7	n/a	n/a	n/a	5	5	100.0	n/a	n/a	n/a
Suicide attempt resulting in the need for medical attention	1	1	100.0	1	1	100.0	1	1	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Neglect/Mistreatment, caregiver (paid or unpaid)	1	1	100.0	1	1	100.0	7	7	100.0	n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Neglect/Mistreatment, self							1	1	100.0	n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Neglect/Mistreatment, other										n/a	n/a	n/a				n/a	n/a	n/a
Exploitation, financial							1	1	100.0	n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Exploitation, theft	1	1	100.0				2	2	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Exploitation, destruction of property										n/a	n/a	n/a				n/a	n/a	n/a
Exploitation, other										n/a	n/a	n/a				n/a	n/a	n/a
Theft with law enforcement involvement							2	1	50.0	n/a	n/a	n/a	2	2	100.0	n/a	n/a	n/a
Failure of member's Back-up Plan	3	3	100.0	4	4	100.0				n/a	n/a	n/a				n/a	n/a	n/a
Elopement/Wandering from home or facility				1	1	100.0				n/a	n/a	n/a	3	3	100.0	n/a	n/a	n/a
Inaccessible for initial/on-site meeting	1	1	100.0	16	16	100.0	3	3	100.0	n/a	n/a	n/a	3	3	100.0	n/a	n/a	n/a
Unable to Contact	1	0	0.0	39	39	100.0	15	15	100.0	n/a	n/a	n/a	5	5	100.0	n/a	n/a	n/a
Inappropriate/unprofessional conduct by provider involving member				3	3	100.0	94	93	98.9	n/a	n/a	n/a				n/a	n/a	n/a
Cancellation of utilities										n/a	n/a	n/a				n/a	n/a	n/a
Eviction/loss of home				2	2	100.0	1	1	100.0	n/a	n/a	n/a	3	3	100.0	n/a	n/a	n/a
Facility closure with direct impact to member's health/welfare										n/a	n/a	n/a				n/a	n/a	n/a
Natural disaster with direct impact to member's health/welfare										n/a	n/a	n/a				n/a	n/a	n/a
Operational Breakdown				3	3	100.0	19	19	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Other				29	28	96.6	2	2	100.0	n/a	n/a	n/a				n/a	n/a	n/a
PM #18 C Totals	**567**	**548**	**96.6**	**1309**	**1303**	**99.5**	**589**	**585**	**99.3**	**n/a**	**n/a**	**n/a**	**68**	**68**	**100.0**	**n/a**	**n/a**	**n/a**

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Deliverables due during MLTSS 4th quarter (04/01/2022 – 06/30/2022)

PM # 18C	% of CIs that the MCO became aware of during the measurement period for which a date of occurrence was available
Numerator:	# of CIs in the denominator for which a date of occurrence is known
Denominator:	# of CIs the MCO became aware of during the measurement period
Data source:	MCO
Measurement period:	01/01/2022 – 03/31/2022

Critical Incident (CI) reporting types: Jan - Mar 2022	MCO A			MCO B			MCO C			MCO D			MCO E			TOTAL		
	D	N	%	D	N	%	D	N	%	D	N	%	D	N	%	D	N	%
Unexpected death of a member	1	1	100.0	28	28	100.0	22	22	100.0	n/a	n/a	n/a	11	11	100.0	n/a	n/a	n/a
Media involvement or the potential for media involvement							1	0	0.0	n/a	n/a	n/a	2	2	100.0	n/a	n/a	n/a
Physical abuse (incl. seclusion and restraints both physical and chemical)	2	2	100.0				4	4	100.0	n/a	n/a	n/a	3	3	100.0	n/a	n/a	n/a
Psychological/Verbal abuse				1	1	100.0	3	2	66.7	n/a	n/a	n/a				n/a	n/a	n/a
Sexual abuse and/or suspected sexual abuse				1	1	100.0	1	0	0.0	n/a	n/a	n/a				n/a	n/a	n/a
Fall resulting in the need of medical treatment	73	70	95.9	124	123	99.2	113	106	93.8	n/a	n/a	n/a	43	43	100.0	n/a	n/a	n/a
Medical emergency resulting in need for medical treatment	486	472	97.1	1072	1068	99.6	277	274	98.9	n/a	n/a	n/a	3	3	100.0	n/a	n/a	n/a
Medication error resulting in serious consequences				1	1	100.0				n/a	n/a	n/a				n/a	n/a	n/a
Psychiatric emergency resulting in need for medical treatment	26	26	100.0	45	43	95.6	13	13	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Severe injury resulting in the need of medical treatment	1	1	100.0	7	7	100.0	9	9	100.0	n/a	n/a	n/a	7	7	100.0	n/a	n/a	n/a
Suicide attempt resulting in the need for medical attention	3	2	66.7				1	1	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Neglect/Mistreatment, caregiver (paid or unpaid)	1	0	0.0	2	2	100.0	7	7	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Neglect/Mistreatment, self							1	1	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Neglect/Mistreatment, other	2	1	50.0							n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Exploitation, financial							1	1	100.0	n/a	n/a	n/a	2	2	100.0	n/a	n/a	n/a
Exploitation, theft				2	1	50.0	2	2	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Exploitation, destruction of property										n/a	n/a	n/a				n/a	n/a	n/a
Exploitation, other							2	2	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Theft with law enforcement involvement							2	2	100.0	n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Failure of member's Back-up Plan				4	4	100.0	1	1	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Elopement/Wandering from home or facility							1	1	100.0	n/a	n/a	n/a	2	2	100.0	n/a	n/a	n/a
Inaccessible for initial/on-site meeting				34	34	100.0	1	1	100.0	n/a	n/a	n/a	13	13	100.0	n/a	n/a	n/a
Unable to Contact				33	33	100.0	15	15	100.0	n/a	n/a	n/a	13	13	100.0	n/a	n/a	n/a
Inappropriate/unprofessional conduct by provider involving member							62	62	100.0	n/a	n/a	n/a	4	4	100.0	n/a	n/a	n/a
Cancellation of utilities										n/a	n/a	n/a				n/a	n/a	n/a
Eviction/loss of home				5	5	100.0	3	3	100.0	n/a	n/a	n/a	1	1	100.0	n/a	n/a	n/a
Facility closure with direct impact to member's health/welfare										n/a	n/a	n/a				n/a	n/a	n/a
Natural disaster with direct impact to member's health/welfare										n/a	n/a	n/a				n/a	n/a	n/a
Operational Breakdown				6	6	100.0	1	1	100.0	n/a	n/a	n/a				n/a	n/a	n/a
Other	2	2	100.0	128	122	95.3	2	2	100.0	n/a	n/a	n/a				n/a	n/a	n/a
PM #18 C Totals	**597**	**577**	**96.6**	**1493**	**1479**	**99.1**	**545**	**532**	**97.6**	**n/a**	**n/a**	**n/a**	**106**	**106**	**100.0**	**n/a**	**n/a**	**n/a**

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Deliverables due during MLTSS 4th quarter (04/01/2022 – 06/30/2022)

PM # 18D	Of those CIs with a known date of occurrence, average # of days from date of occurrence to date MCO became aware
Numerator:	Sum of days from date of occurrence to date MCO became aware of the CI
Denominator:	# of CIs the MCO became aware of during the measurement period for which a date of occurrence is known
Data source:	MCO
Measurement period:	07/01/2021 – 09/30/2021

Critical Incident (CI) reporting types: Jul-Sep 2021	MCO A			MCO B			MCO C			MCO D			MCO E			TOTAL		
	D	N	Avg	D	N	Avg	D	N	Avg	D	N	Avg	D	N	Avg	D	N	Avg
Unexpected death of a member	5	54	10.8	7	24	3.4	13	41	3.2	n/a	n/a	n/a	2	32	16.0	n/a	n/a	n/a
Media involvement or the potential for media involvement	1	0	0.0	2	0	0.0				n/a	n/a	n/a				n/a	n/a	n/a
Physical abuse (incl. seclusion and restraints both physical and chemical)				5	17	3.4	12	108	9.0	n/a	n/a	n/a	6	63	10.5	n/a	n/a	n/a
Psychological/Verbal abuse	1	4	4.0	1	1	1.0	3	0	0.0	n/a	n/a	n/a	1	0	0.0	n/a	n/a	n/a
Sexual abuse and/or suspected sexual abuse										n/a	n/a	n/a	1	1	1.0	n/a	n/a	n/a
Fall resulting in the need of medical treatment	73	2062	28.2	112	2049	18.3	131	2280	17.4	n/a	n/a	n/a	45	879	19.5	n/a	n/a	n/a
Medical emergency resulting in need for medical treatment	498	12247	24.6	1259	13200	10.5	352	3580	10.2	n/a	n/a	n/a	1	14	14.0	n/a	n/a	n/a
Medication error resulting in serious consequences				3	46	15.3				n/a	n/a	n/a				n/a	n/a	n/a
Psychiatric emergency resulting in need for medical treatment	35	363	10.4	37	199	5.4	14	30	2.1	n/a	n/a	n/a	1	6	6.0	n/a	n/a	n/a
Severe injury resulting in the need of medical treatment				9	92	10.2	10	84	8.4	n/a	n/a	n/a	7	55	7.9	n/a	n/a	n/a
Suicide attempt resulting in the need for medical attention	1	3	3.0				1	1	1.0	n/a	n/a	n/a				n/a	n/a	n/a
Neglect/Mistreatment, caregiver (paid or unpaid)				3	18	6.0	2	2	1.0	n/a	n/a	n/a	2	0	0.0	n/a	n/a	n/a
Neglect/Mistreatment, self	1	0	0.0	6	7	1.2	7	4	0.6	n/a	n/a	n/a				n/a	n/a	n/a
Neglect/Mistreatment, other				2	15	7.5				n/a	n/a	n/a				n/a	n/a	n/a
Exploitation, financial							1	0	0.0	n/a	n/a	n/a	2	13	6.5	n/a	n/a	n/a
Exploitation, theft				1	7	7.0				n/a	n/a	n/a				n/a	n/a	n/a
Exploitation, destruction of property										n/a	n/a	n/a	2	95	47.5	n/a	n/a	n/a
Exploitation, other							1	0	0.0	n/a	n/a	n/a	1	0	0.0	n/a	n/a	n/a
Theft with law enforcement involvement							4	23	5.8	n/a	n/a	n/a				n/a	n/a	n/a
Failure of member's Back-up Plan	8	13	1.6	9	101	11.2				n/a	n/a	n/a				n/a	n/a	n/a
Elopement/Wandering from home or facility	1	9	9.0							n/a	n/a	n/a	1	31	31.0	n/a	n/a	n/a
Inaccessible for initial/on-site meeting				19	122	6.4	1	8	8.0	n/a	n/a	n/a	10	0	0.0	n/a	n/a	n/a
Unable to Contact				16	108	6.8	14	0	0.0	n/a	n/a	n/a	9	0	0.0	n/a	n/a	n/a
Inappropriate/unprofessional conduct by provider involving member				1	2	2.0	150	2070	13.8	n/a	n/a	n/a	2	2	1.0	n/a	n/a	n/a
Cancellation of utilities										n/a	n/a	n/a				n/a	n/a	n/a
Eviction/loss of home				4	4	1.0	6	12	2.0	n/a	n/a	n/a	3	11	3.7	n/a	n/a	n/a
Facility closure with direct impact to member's health/welfare										n/a	n/a	n/a				n/a	n/a	n/a
Natural disaster with direct impact to member's health/welfare	4	13	3.3	6	39	6.5	1	0	0.0	n/a	n/a	n/a	20	174	8.7	n/a	n/a	n/a
Operational Breakdown										n/a	n/a	n/a				n/a	n/a	n/a
Other	4	16	4.0	21	256	12.2	2	0	0.0	n/a	n/a	n/a	4	30	7.5	n/a	n/a	n/a
PM #18 D Totals	**632**	**14784**	**23.4**	**1523**	**16307**	**10.7**	**725**	**8243**	**11.4**	**n/a**	**n/a**	**n/a**	**120**	**1406**	**11.7**	**n/a**	**n/a**	**n/a**

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Deliverables due during MLTSS 4th quarter (04/01/2022 – 06/30/2022)

PM # 18D	Of those CIs with a known date of occurrence, average # of days from date of occurrence to date MCO became aware
Numerator:	Sum of days from date of occurrence to date MCO became aware of the CI
Denominator:	# of CIs the MCO became aware of during the measurement period for which a date of occurrence is known
Data source:	MCO
Measurement period:	10/01/2021 – 12/31/2021

Critical Incident (CI) reporting types: Oct - Dec 2021	MCO A			MCO B			MCO C			MCO D			MCO E			TOTAL		
	D	N	Avg	D	N	Avg	D	N	Avg	D	N	Avg	D	N	Avg	D	N	Avg
Unexpected death of a member	1	8	8.0	8	68	8.5	12	65	5.4	n/a	n/a	n/a	7	59	8.4	n/a	n/a	n/a
Media involvement or the potential for media involvement							2	6	3.0	n/a	n/a	n/a				n/a	n/a	n/a
Physical abuse (incl. seclusion and restraints both physical and chemical)	1	57	57.0	2	19	9.5	6	110	18.3	n/a	n/a	n/a	1	0	0.0	n/a	n/a	n/a
Psychological/Verbal abuse				3	25	8.3				n/a	n/a	n/a	1	13	13.0	n/a	n/a	n/a
Sexual abuse and/or suspected sexual abuse				1	8	8.0	1	63	63.0	n/a	n/a	n/a				n/a	n/a	n/a
Fall resulting in the need of medical treatment	62	1091	17.6	111	1496	13.5	107	1853	17.3	n/a	n/a	n/a	33	592	17.9	n/a	n/a	n/a
Medical emergency resulting in need for medical treatment	461	9948	21.6	1043	10658	10.2	297	3359	11.3	n/a	n/a	n/a	1	2	2.0	n/a	n/a	n/a
Medication error resulting in serious consequences				2	73	36.5				n/a	n/a	n/a				n/a	n/a	n/a
Psychiatric emergency resulting in need for medical treatment	16	415	25.9	28	112	4.0	8	78	9.8	n/a	n/a	n/a	1	0	0.0	n/a	n/a	n/a
Severe injury resulting in the need of medical treatment				7	69	9.9	6	118	19.7	n/a	n/a	n/a	5	51	10.2	n/a	n/a	n/a
Suicide attempt resulting in the need for medical attention	1	105	105.0	1	6	6.0	1	3	3.0	n/a	n/a	n/a				n/a	n/a	n/a
Neglect/Mistreatment, caregiver (paid or unpaid)	1	0	0.0	1	4	4.0	7	30	4.3	n/a	n/a	n/a	1	8	8.0	n/a	n/a	n/a
Neglect/Mistreatment, self							1	2	2.0	n/a	n/a	n/a	1	0	0.0	n/a	n/a	n/a
Neglect/Mistreatment, other										n/a	n/a	n/a				n/a	n/a	n/a
Exploitation, financial							1	0	0.0	n/a	n/a	n/a	1	0	0.0	n/a	n/a	n/a
Exploitation, theft	1	0	0.0				2	19	9.5	n/a	n/a	n/a				n/a	n/a	n/a
Exploitation, destruction of property										n/a	n/a	n/a				n/a	n/a	n/a
Exploitation, other										n/a	n/a	n/a				n/a	n/a	n/a
Theft with law enforcement involvement							1	38	38.0	n/a	n/a	n/a	2	154	77.0	n/a	n/a	n/a
Failure of member's Back-up Plan	3	2	0.7	4	1	0.3				n/a	n/a	n/a				n/a	n/a	n/a
Elopement/Wandering from home or facility				1	2	2.0				n/a	n/a	n/a	3	19	6.3	n/a	n/a	n/a
Inaccessible for initial/on-site meeting	1	0	0.0	16	0	0.0	3	0	0.0	n/a	n/a	n/a	3	0	0.0	n/a	n/a	n/a
Unable to Contact				39	224	5.7	15	132	8.8	n/a	n/a	n/a	5	0	0.0	n/a	n/a	n/a
Inappropriate/unprofessional conduct by provider involving member				3	2	0.7	93	677	7.3	n/a	n/a	n/a				n/a	n/a	n/a
Cancellation of utilities										n/a	n/a	n/a				n/a	n/a	n/a
Eviction/loss of home				2	0	0.0	1	3	3.0	n/a	n/a	n/a	3	123	41.0	n/a	n/a	n/a
Facility closure with direct impact to member's health/welfare										n/a	n/a	n/a				n/a	n/a	n/a
Natural disaster with direct impact to member's health/welfare										n/a	n/a	n/a				n/a	n/a	n/a
Operational Breakdown				3	0	0.0	19	76	4.0	n/a	n/a	n/a				n/a	n/a	n/a
Other				28	245	8.8	2	36	18.0	n/a	n/a	n/a				n/a	n/a	n/a
PM #18 D Totals	**548**	**11626**	**21.2**	**1303**	**13012**	**10.0**	**585**	**6668**	**11.4**	**n/a**	**n/a**	**n/a**	**68**	**1021**	**15.0**	**n/a**	**n/a**	**n/a**

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

A = Aetna B = Amerigroup C = Horizon NJ Health D = United HealthCare E = WellCare

Deliverables due during MLTSS 4th quarter (04/01/2022 – 06/30/2022)

PM # 18D	Of those CIs with a known date of occurrence, average # of days from date of occurrence to date MCO became aware
Numerator:	Sum of days from date of occurrence to date MCO became aware of the CI
Denominator:	# of CIs the MCO became aware of during the measurement period for which a date of occurrence is known
Data source:	MCO
Measurement period:	01/01/2022 – 03/30/2022

Critical Incident (CI) reporting types: Jan - Mar 2022	MCO A			MCO B			MCO C			MCO D			MCO E			TOTAL		
	D	N	Avg	D	N	Avg	D	N	Avg	D	N	Avg	D	N	Avg	D	N	Avg
Unexpected death of a member	1	20	20.0	28	178	6.4	22	128	5.8	n/a	n/a	n/a	11	135	12.3	n/a	n/a	n/a
Media involvement or the potential for media involvement										n/a	n/a	n/a	2	0	0.0	n/a	n/a	n/a
Physical abuse (incl. seclusion and restraints both physical and chemical)	2	39	19.5				4	25	6.3	n/a	n/a	n/a	3	24	8.0	n/a	n/a	n/a
Psychological/Verbal abuse				1	0	0.0	2	2	1.0	n/a	n/a	n/a				n/a	n/a	n/a
Sexual abuse and/or suspected sexual abuse				1	1	1.0				n/a	n/a	n/a				n/a	n/a	n/a
Fall resulting in the need of medical treatment	70	1964	28.1	123	2670	21.7	106	2059	19.4	n/a	n/a	n/a	43	1217	28.3	n/a	n/a	n/a
Medical emergency resulting in need for medical treatment	472	9515	20.2	1068	11132	10.4	274	3534	12.9	n/a	n/a	n/a	3	90	30.0	n/a	n/a	n/a
Medication error resulting in serious consequences				1	2	2.0				n/a	n/a	n/a				n/a	n/a	n/a
Psychiatric emergency resulting in need for medical treatment	26	312	12.0	43	343	8.0	13	102	7.8	n/a	n/a	n/a				n/a	n/a	n/a
Severe injury resulting in the need of medical treatment	1	47	47.0	7	365	52.1	9	294	32.7	n/a	n/a	n/a	7	286	40.9	n/a	n/a	n/a
Suicide attempt resulting in the need for medical attention	2	7	3.5				1	8	8.0	n/a	n/a	n/a				n/a	n/a	n/a
Neglect/Mistreatment, caregiver (paid or unpaid)				2	8	4.0	7	28	4.0	n/a	n/a	n/a				n/a	n/a	n/a
Neglect/Mistreatment, self							1	0	0.0	n/a	n/a	n/a				n/a	n/a	n/a
Neglect/Mistreatment, other	1	0	0.0							n/a	n/a	n/a	1	74	74.0	n/a	n/a	n/a
Exploitation, financial							1	7	7.0	n/a	n/a	n/a	2	0	0.0	n/a	n/a	n/a
Exploitation, theft				1	24	24.0	2	11	5.5	n/a	n/a	n/a				n/a	n/a	n/a
Exploitation, destruction of property										n/a	n/a	n/a				n/a	n/a	n/a
Exploitation, other							2	64	32.0	n/a	n/a	n/a				n/a	n/a	n/a
Theft with law enforcement involvement							2	16	8.0	n/a	n/a	n/a	1	3	3.0	n/a	n/a	n/a
Failure of member's Back-up Plan				4	3	0.8	1	0	0.0	n/a	n/a	n/a				n/a	n/a	n/a
Elopement/Wandering from home or facility							1	0	0.0	n/a	n/a	n/a	2	5	2.5	n/a	n/a	n/a
Inaccessible for initial/on-site meeting				34	0	0.0	1	0	0.0	n/a	n/a	n/a	13	0	0.0	n/a	n/a	n/a
Unable to Contact				33	3	0.1	15	23	1.5	n/a	n/a	n/a	13	0	0.0	n/a	n/a	n/a
Inappropriate/unprofessional conduct by provider involving member							62	268	4.3	n/a	n/a	n/a	4	13	3.3	n/a	n/a	n/a
Cancellation of utilities										n/a	n/a	n/a				n/a	n/a	n/a
Eviction/loss of home				5	6	1.2	3	2	0.7	n/a	n/a	n/a	1	64	64.0	n/a	n/a	n/a
Facility closure with direct impact to member's health/welfare										n/a	n/a	n/a				n/a	n/a	n/a
Natural disaster with direct impact to member's health/welfare										n/a	n/a	n/a				n/a	n/a	n/a
Operational Breakdown				6	13	2.2	1	2	2.0	n/a	n/a	n/a				n/a	n/a	n/a
Other	2	6	3.0	122	2243	18.4	2	49	24.5	n/a	n/a	n/a				n/a	n/a	n/a
PM #18 D Totals	**577**	**11910**	**20.6**	**1479**	**16991**	**11.5**	**532**	**6622**	**12.4**	**n/a**	**n/a**	**n/a**	**106**	**1911**	**18.0**	**n/a**	**n/a**	**n/a**

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Deliverables due during MLTSS 4th quarter (04/01/2022 – 06/30/2022)

Reported Critical Incidents (CIs) for Measurement Period 1/1/2022 – 3/30/2022

During the measurement period of 1/1/2022 – 3/30/2022, four out of five MCOs became aware of 2741 CIs and of those, 2739 (99.9%) were reported to the State for PM #18A. The top three CIs reported for PM #18A were: Medical emergency resulting in need for medical treatment (1838/2741 = 67%); Fall resulting in the need of medical treatment (353/2741=13%); and Other (132/2741=5%).

PM #18B reflects that 2597 of the 2741 (94.7%) CIs for this measurement period were reported to the State within two days, which is a 94.7% success rate of timely entry of critical incidents.

The data reported by the four MCOs for PM #18C during this quarter, show that 2694 of the 2741 CIs had known dates of occurences, which calculates to 98.3% of critical incidents with a known date.

PM #18D shows an all MCO average of 13.9 days from date of occurrence to the date the MCOs became aware of the incident with individual MCOs ranging from 11.5 days (MCO B) to 20.6 days (MCO A). This reflects an increase of a day from the previous quarter of 12.9 days for the four MCOS that reported this quarter.

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

DY10 FFQ4 (April 01, 2022 to June 30, 2022) CI Report from DoAS:

Performance Measure **#17**

Performance Measure 17 is the timeliness of all Critical Incidents (CI) being reported to the state and entered to the CI reporting system within two business days from April 1, 2022 to June 30, 2022.

This measurement is determined by the number of CIs reported in writing to the Division of Aging Services (DoAS) within two business days of the MCO being made aware of the incident divided by the total number of critical incidents reported to DoAS for the measurement period.

Based on the first and second year of reporting, the DoAS established that the minimum percentage accepted is 100%. Anything less requires a response from the MCO stating what actions will be taken to improve timeliness. For this measurement period, a total of 3129 CIs were reported within the measurement period. Out of the total CIs, 2990 were reported timely yielding to 95.56 percentage. The total number of CIs are noted to be slightly higher compared to previous quarter reported. The CMS Covid-19 Emergency Declaration Blanket Waiver issued on March 30, 2020, has been lifted as of August 31, 2021. Therefore, corrective action plans were obtained and filed from all the MCOs that did not meet the timeliness.

Performance Measure **#17a**

Performance Measure #17a is the measurement of Critical Incidents (CI) reported verbally to the state and entered in the CI reporting system within one business day for Potential Media Events and Unexpected Death incidents from April 1, 2022 to June 30, 2022.

This measurement is determined by the number of Critical Incidents (CI) reported to DoAS verbally within one business day of the MCO being made aware of Potential Media Event and Unexpected Death incidents divided by the total number of CI reported verbally to DoAS for the measurement period.

Based on the first and second year of reporting, the DoAS has established that the minimum percentage accepted is 100%. Anything less will require a response from the MCO stating what actions they will take to improve timeliness. For this measurement period, a total of 24 CI was reported in which 1 of the unexpected death incident were not reported timely yielded to 95.83 percentage. Out of the total CIs, 2 Potential Media Event and 22 unexpected deaths CI were reported during this measurement period. The Unexpected Death numbers includes both COVID-19 related and non-COVID-19 events which has significantly decreased comparing to previous quarter. The COVID-19 related unexpected deaths were a total of 3; none for April, one for May, and 2 for June. For the month of May, a corrective action plan was obtained from WellCare for not reporting the unexpected death CI in a timely manner. For April and June, no corrective actions were required from any MCOs as they met the reporting requirements.

Outreach/Innovative Activities to Ensure Success:

Division of Developmental Disabilities (DDD) is responsible for the daily operations of both the Supports Program (SP) and the Community Care Program (CCP). DDD addresses outreach and access to both their programs concurrently as the Supports and Community Care program offer similar services and (the/many of the)providers and advocacy organizations are affiliated with both programs. The primary difference between the two DDD programs is the required level of care.? Therefore, the below represents data elements that is representative of both DDD programs.

4th Quarter Supports Program (SP) and Community Care Program (CCP)

The Waiver Unit's DDD Medicaid Eligibility Helpdesk (MEH) assists families, providers, advocates, etc. with questions related to Medicaid and DDD 1115 programming operations. During the fourth quarter, there were 990 questions submitted and answered, or referred to the correct helpdesk. Three areas have consistently composed approximately 70-75% of the emails received, Medicaid troubleshooting, voucher payments, and Supports Program + Private Duty Nursing. (Upon/After) conducting an analysis, the team decided to remove the "other" category, as a majority of the items in this category related to Medicaid Troubleshooting, Policy/Process or other helpdesk issues. As a result, two new categories were created: Policy/Process and Referred elsewhere. The three categories that encompassed 75% of inquiries were: Medicaid Troubleshooting (32%), SP+PDN (28%), and Referred Elsewhere (15%). The remainder of the questions focused on citizenship issues, program enrollment questions, follow-up emails that resulted in immediate resolution, and voucher payments. In addition, the helpdesk is involved in assisting children who are losing their EPSDT PDN services on their 21st birthday enroll into the Supports Program + PDN without a gap in service delivery as well as assisting individuals who want to move to another 1115 program.

Annual

The MEH (what is MEH?) was developed out of a need to offer guidance to individuals, guardians, payees, and providers maintaining and re-establish? Medicaid coverage. The helpdesk received 3,955 questions this DY or an average of 989 questions per month. The Division has received many compliments regarding the Helpdesk's customer service, timely responses, and helpful information. The majority of the questions received focus on trouble shooting Medicaid questions. Inquiries are often related to changes in income or (type) of coverage, such as losing SSI or a parent retiring. The helpdesk also receives a large amount of questions related to enrollment or transition between 1115 programs. During this DY there was a significant decrease in MEH questions (~30%). This decrease may be attributed to the increase in education (about) MEH or because under the Maintenance of Effort individuals retained coverage An analysis will be conducted after the end of the PHE (into this)

In addition to the helpdesk, Medicaid related webinars and guidance documents are being developed and are on the DDD website for families and individuals, Support Coordinators, and Providers. The HCBS staff, inclusive of the MEH staff, meets with Medicaid staff from the Eligibility Unit regularly, to ensure

that the information is current and accurate. The meetings primarily focused on the public health emergency and Appendix K flexibilities, as well as developing an action plan once the PHE ends. The collaboration between the two units has improved the consistency in messaging to families, providers, and advocates.

Operational/Policy/Systems/Fiscal Developments/Issues

As previously indicated most operational, policy, systems and fiscal developments for both the SP and CCP are concurrently discussed at meetings and through communications. Therefore the below is representative of both DDD programs.

4th Quarter Supports Program (SP) and Community Care Program (CCP)

During this quarter, the Division of Developmental Disabilities (DDD) continued to enroll individuals into the Supports Program and Community Care Program. At of the end of the 4th reporting quarter, DDD had approximately 12,100 individuals enrolled in the CCP and 12, 700 individuals enrolled in the SP.

DDD routinely meets with the trade organizations, individual providers, family members, and advocacy organizations including Disability Rights of NJ to provide systems updates. DDD continues to answer provider questions and provide guidance on the application process for provider enrollment. During this quarter, the Division of Developmental Disabilities leadership facilitated and attended the following using a telehealth system such as zoom or Teams: Support Coordination Supervisors meeting, the Medical Assistance Advisory Committee meeting (MAAC), the Family Advisory Council meeting, Provider Leadership meetings. Additionally, the Assistant Commissioner for DDD holds a bi-weekly Webinar for all constituents to discuss COVID-19 actions and DDD initiatives. Additionally, during this quarter the Division continued to work collaboratively withDivisions on the implementation of CMS' Electronic Visit Verification (EVV) and Home and Community Based Services Final Rule's Statewide Transition Plan (STP) federal mandates. DDD developed various communications, guidance documents, and webinars related to these initiatives.

Annual

During this DY the Supports Program enrollment increased by approximately 900 individuals. The CCP enrollment increased by approximately 200 individuals. These numbers are similar to the preceding DY (CCP 200, SP 800). The Supports Program enrollment is higher annually due to children transitioning into the adult I/DD service system following graduation. This is the first DY that the individuals on the SP have exceeded the number of individuals on the CCP. This is a milestone as 100% of individuals in the SP are residing in their own homes/apartments or living in a family member's home. Individuals in the CCP may reside in Provider managed group homes, supervised apartments, etc. or their own homes.

DDD routinely meets with the trade organizations, individual providers, family members, and advocacy organizations including Disability Rights of NJ to provide system updates. Traditionally, these meetings occur in person, but due to the public health emergency (PHE) all of these meetings occurred via online conferencing platforms such as Zoom and Teams. In addition to the standard monthly and quarterly meetings, the Division of Developmental Disabilities leadership facilitated or attended the following: Support Coordination Supervisors meeting, the Medical Assistance Advisory Committee meeting (MAAC), the Family Advisory Council meeting, Provider Leadership meeting. Additionally, the Assistant Commissioner for DDD held bi-weekly webinars for all constituents to discuss COVID-19 actions and DDD initiatives. During the early months these webinars had an attendance rate of a couple hundred which increased to over 1,000 by the end of the DY. Additionally, during this DY the Division worked collaboratively with their sister Divisions on the implementation of CMS' Electronic Visit Verification (EVV) Phase 1 and Phase 2 and the Home and Community Based Services Final Rule's Statewide Transition Plan (STP) federal mandates. DDD developed numerous communications, guidance documents, and webinars related to these initiatives. These materials are available to the public on DDD's website. Activities for these federal mandates shifted from development to quality control. Tools were developed to ensure compliance and/or track success rates.

Quality Assurance/Monitoring Activity

4th Quarter and Annual Report

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

DDD requires reporting on approximately 80 Incident Reporting (IR) codes. The IR codes are the same for both DDD programs. During the fourth quarter there were 598 incidents reported for the Supports Program. For the CCP, there were 2,964 incidents reported in the fourth quarter. Of the approximate 3,500 incidents this quarter, 1,251 were a result of a positive COVID outcome. This is an increase from the preceding quarter. However, the preceding quarter saw a steep rise in the weekly cases in January followed by leveling off in February and very low numbers in March. This quarter appears to have no extreme high weeks or extreme low weeks. (last quarter fluctuated this quarter did not have extremes)

Some IR codes, such as abuse, neglect, or exploitation require an investigation by the Office of Investigations. Less than 1% of the Incident Reports filed required an investigation by the Office of Investigations. If there were minor or no injuries then the provider agency is responsible for conducting an investigation and submiting their findings and action plan for review to 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 conducts an investigation. A Risk Council meets quarterly to look at IR from a system perspective. and develops action items based on the data. The Risk Management Unit also conducts systemic and individual remediation activities as a result of IR analysis.

Annual

During this DY there were approximately 13,300 incident reports generated averaging approximately 1,100 incidents per month. For the CCP there were approximately 11,350 incident reports generated and approximately 1,930 for the Supports program. It is worth noting that consistent with the previous DY, the Division saw a large amount of incidents due to COVID-19. The DDD Office of Risk Management worked closely with The Office of Program Integrity to track COVID incidents and to ensure proper guidance was available and updated, as reporting criteria changed as a result of increased During the early stages of COVID, all areas of risk/ were captured (e.g.: possible exposure, undergoing testing, testing outcomes,, death).However, due to the volume of incidents, over time the criteria changed (e.g.: exposure, positive outcome, death). Additionally, additional preventative protocols were put in place such as mandatory testing of provider managed settings, vaccine mandates that impacted provider managed participants, and vaccine mandates for residential and congregate day program employees and Support Coordinators and Division staff who have contact with individuals. This DY also saw the reopening of congregate day settings as well as the larger community.

The Risk Management Council continues to meet quarterly to review risk indicators in providers. The Risk Management Council offers technical assistance and enhanced oversight regarding agencies that trip a certain percentage of risk indicators. Council meetings continued this DY using zoom.

Waiver Unit staff continues to meet with the Provider Performance & Monitoring Unit (PPMU)to discuss monitoring activities. This unit utilizes tools to monitor Medicaid/DDD approved providers for both DDD programs and provides further guidance and technical assistance based on the results/findings.

Audits were modified again this DY as a result of COVID. Many audits were changed to desk audits, however in-person audits occur on an as needed basis. Protocols were put in place to ensure privacy compliance for desk audits. The external auditing firm completed their audit and DDD is working on a corrective action plan.

The Division worked diligently with its sister Division's on NJs Statewide Transition Plan, in partnership with CMS. Great progress was made including provider surveys, in-person reviews and interviews with service recipients and provider staff, webinars on the STP requirements and Toolbox webinars/documents on how to enhance community integration, and linking the STP HCBS expectations into monitoring tools.

The Division continued to work closely with its sister Division's on the implementation of EVV this DY. DDD developed tools and implemented a Pilot audit of agencies who identified that they were exempt from EVV because they were only providing community based services. The Pilot audit was a success and showed that 100% of the Pilot agencies were in fact only providing community based services. No services were provided inside the service recipient's home. The audit has since been expanded to all providers who stated they were exempt from EVV.

DDD participates in the National Core Indicators. This DY DDD was successful in conducting over 400 face-to-face interviews with adults receiving services via telehealth modalities. This had once again posed some challenges for families who did not have supporting technology. However, itremains an exciting time because the NCI survey added a considerable amount of questions related to services as a result of COVID. These questions were included in this DYs annual NCI report. NJ DDD once again participated in the NCI Staff Stability Survey this DY and is proud to state that once again, despite challenging times, had good representation of participation from our providers. Again, the State is looking forward to seeing the impact of COVID as related to staff issues. The DRAFT NCI findings were released and DDD Waiver and Quality Unit is analyzing the data and developing a PowerPoint related to NJs NCI outcomes. The review includes a careful analysis of how the NCI data is linked to the STP domains.

DDD has received compliments related to our transparency, webinars, and helpdesks related to these initiatives. Webinars and tool kits are being developed for providers to ensure that community integration and quality improvement are at the forefront of every service plan.

Monitoring of the Quality and Accuracy of Screening and Assessment of Participants who Qualify for HCBS/MLTSS

DDD's assessment tool, the New Jersey Comprehensive Assessment Tool (NJ CAT), is conducted through an electronic process and is completed by an individual that is knowledgeable about the service recipient. The NJCAT is the tool used to identify an individual's budget and also to determine program eligibility. This includes items like: age, Medicaid eligibility, living arrangement, if they are on another Demonstration program, etc. In addition to verifying the accuracy of screening and assessment of participants at the time of enrollment DDD conducts monthly audits to check the ongoing eligibility criteria. In addition to DDD's internal monitoring, all external DDD audits review the NJCAT for eligibility and cross-check the assessment findings with other documents for consistency (ie: person-centered planning tool, individual service plan, case notes, etc.).

Specific Examples of How HCBS Has Been Used to Assist Participants

The addition of a second waiver program, Supports Program including the Supports Program + PDN, as well as the movement of the Community Care Waiver into the 1115 has resulted in countless stories of how much better service recipients lives are. Examples include how the addition of services such as therapies and behavioral supports have changed the quality of life for individuals. Families have stated that these services, especially the behavioral supports, are instrumental in allowing individuals to remain in their own homes rather than having to be placed in a provider's residential setting. Families have also stated that therapies have always been available only through the state plan. The issue families of this population faced was that the state plan only allowed for rehabilitative therapy and it was time limited. The addition of habilitative therapies into the waiver allowed them to receive on-going maintenance therapy which aids in maintaining range of motion, etc. Many individuals have been able to benefit from adaptive equipment and habilitative physical and occupational therapy.

Additional positive feedback has been received from individuals and families around assigning a budget based on need and one that is portable. Individuals need to operate within their assigned budget, but they can purchase the waiver services that best meet their needs as well as the amount of service needed. Individuals also choose if they want to receive services from a traditional provider or if they want to hire their own employees and self-direct their services. Individuals may also choose to self-direct some services and receive some services in a more traditional provider managed setting.