Attachment B
Quality and Monitoring Activities

In compliance with STC 8(b)(iv), below is an overview of the quality monitoring activities performed during the demonstration. Reports are available upon request.

New Jersey has a consistent and coordinated framework via overarching interagency authority and oversight to deliver timely, appropriate quality health care across all populations. The programs under the Comprehensive Waiver are administered by various state agencies, however, the Department of Human Services' Division of Medical Assistance and Health Services (DMAHS) maintains authority over monitoring and oversight of the programs.

Below are quality activities performed by DMAHS, the Division of Developmental Disabilities (DDD), the Department of Children and Families, Division of Children's System of Care (CSOC), and the External Quality Review Organization (EQRO). These activities monitor the quality and performance of the Medicaid Managed Care Organizations (MCOs), Fully-integrated Dual Special Needs Plans (FIDE SNPs), Managed Long-Term Services and Supports (MLTSS) program, and Targeted Home and Community-Based Services programs.

Monitoring Quality in Managed Care

The Balanced Budget Act of 1997 established that state agencies contracting with Medicaid Managed Care Organizations (MCOs) provide for an annual external, independent review of the quality outcomes, timeliness of, and access to the services included in the contract between the state agency and the MCO. Subpart E – External Quality Review of 42 Code of Federal Regulations (CFR) sets forth the requirements for annual external quality review (EQR) of contracted MCOs. CFR 438.350 requires states to contract with an External Quality Review Organization (EQRO) to perform an annual EQR for each contracted MCO. The states must further ensure that the EQRO has sufficient information to carry out the EQR; that the information be obtained from EQR related activities; and that the information provided to the EQRO be obtained through methods consistent with the protocols established by the Centers for Medicaid and Medicare Services (CMS).

To meet these federal requirements, the New Jersey (NJ) Department of Human Services Division of Medical Assistance and Health Services (DMAHS) contracted with IPRO, an EQRO. In collaboration with the EQRO, DMAHS evaluates, assesses, monitors, and guides the Medicaid managed care program for the state. Since April 2011, New Jersey has contracted with IPRO to conduct EQRO activities.

IPRO performs the following three CMS-required activities:

- Assessment of Compliance with Medicaid Managed Care Regulations
- Validation of Performance Measures Reported by the MCO

- Validation of Performance Improvement Projects

In addition, IPRO also conducts clinical and non-clinical focused studies, audits of the care management program, and most recently, has begun to conduct surveys to assess member satisfaction. Through the development of studies and assessments, the EQRO evaluates enrollees' quality and outcomes of care, and identifies opportunities for MCO improvement. To facilitate these various activities, DMAHS ensures that the EQRO has access to enrollment data and health care and pharmacy claims and encounters. The MCOs collaborate with the EQRO to ensure that medical and care management records are available for focused clinical reviews.

The below summary includes the required and optional quality-related activities conducted by the EQRO.

Assessment of Compliance with Medicaid Managed Care Regulations

The Annual Assessment of MCO Operations determines MCO compliance with the NJ FamilyCare Managed Care Contract requirements and with State and federal regulations in accordance with the requirements of CFR 438.204(g). The EQRO conducts a comprehensive Annual Assessment of MCO Operations, including MLTSS beginning in 2015, to review for compliance with contractual, federal and State operational and quality requirements. The review cycle occurs at intervals no greater than twelve (12) months and evaluates each of the MCO's structures, processes, and outcomes of operations and monitors for adherence to, and effectiveness of, individual MCO Quality Assurance Programs. Areas included in the review during this waiver cycle include:

A. Access
B. Quality Assessment and Performance Improvement
C. Quality Management
D. Efforts to Reduce Healthcare Disparities
E. Committee Structure
F. Programs for the Elderly and Disabled
G. Provider Training and Performance
H. Satisfaction
I. Enrollee Rights and Responsibilities
J. Care Management and Continuity of Care
K. Credentialing and Recredentialing
L. Utilization Management
M. Administration and Operations
N. Management Information Systems

Comprehensive reviews of all requirements include documentation submission along with an onsite visit, documentation review, file review, MCO staff interviews, and as appropriate, the direct observation of the key program areas and systems evaluations. MCOs demonstrating contractual compliance performance at or above eighty-five percent (85%) receive a partial review every other year of only those elements that are "Not Met" or "N/A" during the comprehensive review. MCOs will receive a comprehensive assessment the first two years when newly entering the New Jersey market.

Evaluation of the MCOs Internal Quality Assurance Program (QAP)

As part of the Annual Assessment of MCO Operations, the EQRO monitors each MCO's adherence to its internal Quality Assurance Program (QAP). This evaluation ensures that the internal QAP complies with the standards for internal QAPs, which are specified in Section 4.6 of the NJ FamilyCare Managed Care Contract. The QAP is evaluated to ensure that it consists of systematic activities to monitor and evaluate the care delivered to its enrollees according to objective standards, results in improvement to access, quality and utilization of care, and affords for review by appropriate health professionals of the processes followed in delivering health services.

The Annual Assessment of MCO Operations is designed to show trends, comparisons across MCOs, best practices, deficiencies, other areas of concern, and opportunities covering all areas of the assessment.

Validation of the MCOs Performance Measures

The NJ FamilyCare Managed Care Contract article 4.6.2 (P) requires NJ FamilyCare MCOs to report annually on HEDIS® measures. The EQRO reviews the reported rates and the methodology used to calculate those measures. For measures that are not reviewed by a NCQA auditor, the EQRO performs validation of the measures. If a NCQA auditor deems a measure as not reportable or if the MCO is not fully compliant, the MCO data files are analyzed by the EQRO.

Two of the current 24 HEDIS® performance measures included in the MCO contract were not reported until 2014. These measures are: Human Papillomavirus Vaccine for Female Adolescents and Medication Management for People with Asthma. Five of the current measures began to be reported in 2013. These measures are: Controlling High Blood Pressure, Adult BMI Assessment, Annual Monitoring for Patients on Persistent Medications, Children and Adolescents' Access to Primary Care Practitioners and Ambulatory Care.

In addition, three State-specific measures are reported. These New Jersey Specific Performance Measures were first reported in 2013 and include the following:

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- Annual Preventative Dental Visits-by Dual, Disability, Other and Total categories
- Children and Adolescents' Access to Primary Care- by Dual, Disability, Other and Total categories
- Adults' Access to Preventative Care-by Dual, Disability, Other and Total categories

Quality Improvement Projects (QIPs)

Quality improvement projects and topics are defined annually by the State. They include measurable improvement goals and the specific measures and strategies for achieving each of the QIP objectives. QIPs are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and non-clinical care areas that are expected to have a favorable effect on health outcomes and enrollee satisfaction. When conducting QIPs, MCOs follow the ten-step CMS protocol. Evaluation and validation of QIPs is performed by the EQRO.

During this waiver cycle, Amerigroup, HealthFirst, Horizon and United submitted progress reports in 2013 for their sustainability year for the QIP topics concerning the EPSDT services of Dental Care, Lead Screening, and Well Child Care and Prenatal Care and Birth Outcomes. In 2014, final reports for these QIP topics were submitted by the MCOs.

In 2013, Amerigroup, HealthFirst, Horizon and United, with the guidance of the EQRO, initiated a collaborative QIP on the topic of Identification of Management of Adolescent Overweight and Obesity. Progress reports continued to be submitted in 2014 and 2015. HealthFirst submitted a progress report in June 2014 and a final report in September 2014 for the Identification of Management of Adolescent Overweight and Obesity QIP, as they exited the NJ FamilyCare Managed Care Contract in 2014. WellCare entered the NJ market and in 2014 submitted their Identification and Management of Adolescent Overweight and Obesity QIP proposal.

A new proposal for the topic of Preterm Births was submitted by Amerigroup, Horizon, United and WellCare in 2014. Progress reports were submitted during 2015.

Focused Studies

The completion of clinical and/or non-clinical focused studies is determined by the State, based upon State, federal and waiver program requirements and goals. In compliance with CMS Protocols and State guidelines, a written study design to conduct each of the studies is developed. The written protocol is based on nationally recognized practice guidelines and

standards where applicable. Through the development of the study design, MCOs can provide advance notice to providers and plan for resource allocation.

In 2013, the EQRO completed three clinical focused studies that started during 2012. These studies evaluated the quality of Early Periodic Screening, Diagnosis, and Treatment (EPSDT) services and the quality of services for Children with Special Health Care Needs (CSHCN). The EPDST studies aimed to describe primary care and dental service utilization, lead screening/follow-up, and immunizations among children enrolled in Medicaid Managed Care in New Jersey to identify the extent to which children are receiving required EPSDT services during primary care physician (PCP) visits, and to identify targets of improvement efforts.

The EQRO initiated three non-clinical focused studies in 2014 that evaluated transportation services provided through the state medical transportation broker, LogistiCare. The first was a utilization analysis designed to capture demographic, frequency, and timeliness metrics of individual trips. The second study was a rider analysis that assessed rider utilization, provider consistency, and rider penetration rates. The third study evaluated member and facility experience with LogistiCare and transportation providers using telephone interviews and written surveys.

In 2014, the EQRO also submitted a proposal for one clinical focused study relating to perinatal care. This project began in 2014 and was ongoing in 2015. The study used Medicaid encounter data, claims data, and medical record review to describe the quality of perinatal care received by a sample of Medicaid women, with the aim of identifying potentially actionable gaps in care that may affect birth outcomes. The study also included an evaluation of MCO identification of pregnant members and enrollment in prenatal support programs and in obstetric case management for all members meeting the eligibility and continuous enrollment criteria for the study.

The EQRO is currently working with DMAHS on the design of focused studies related to access and availability of network providers and age-appropriate developmental surveillance.

Care/Case Management Audits

The EQRO evaluates the effectiveness of each MCO's contractually-required care management program. This annual on-site audit includes a statistically valid sample of enrollees. Specific populations audited are members who receive services from the Division of Developmental Disabilities and the Division of Child Protection and Permanency, along with members in the general population. Audit activities include an evaluation of the following metrics: identification, outreach, preventive services, continuity of care, and coordination of services.

Quality Technical Reports

The EQRO aggregates the information on all CMS required activities and EQR related voluntary activities and prepares a report that summarizes timeliness, quality and access to care. This is a retrospective report of the activities that occurred in the prior year.

Consumer and Health Care Provider Satisfaction Surveys (CAHPS)

The CAHPS survey is an annual survey conducted by the state and each Managed Care Organization. The state survey was completed by the health benefits coordinator up until 2014, and moved to the EQRO in 2015. These surveys are submitted to the Agency for Healthcare Research and Quality (AHRQ) and are also used to inform the NJ FamilyCare Annual report.

Annual Report

The State through the DMAHS Office of Business Intelligence compiles an annual report showing the progress of the overall NJ FamilyCare program. This report is comprehensive and includes descriptions of all NJ FamilyCare initiatives, achievements for the past year, a status check on various aspects of the program, and intended initiatives for the upcoming year. The historical performance and progress of the MLTSS program (and other waiver initiatives) are discussed in this report.

Monitoring Quality and Access to Care: Managed Long-Term Services and Supports (MLTSS)

In addition to the existing NJ FamilyCare Managed Care Contract requirements, a MLTSS set of reporting requirements were developed and included in the Contract. As a result, the EQRO conducts one, unified set of mandatory external quality review activities outlined in 42 CFR 438.358, including the Annual Assessment of Operations, Performance Measures and QIPs, that review the quality of the NJ FamilyCare plan and the requirements of the MLTSS program.

The State worked with its EQRO, IPRO, to develop a comprehensive set of MLTSS elements that were added to the 2015 Annual Assessment and initiate a MLTSS QIP. The EQRO is working with the State to validate and refine the current MLTSS Performance Measures, calculate Performance Measures, and develop future Performance Measures. The EQRO conducts focused studies to calculate some of the MLTSS Performance Measures and audits of the MLTSS care management program. Through the development of studies and assessments, the EQRO evaluates the quality and outcomes of MLTSS service delivery and identify opportunities for MCO improvement. The MCOs collaborate with the EQRO to ensure that the MLTSS member records, claims, and authorizations are available for focused reviews.

Beginning in 2016, the EQRO began participating in the State's monthly MLTSS MCO Quality Workgroup meetings via teleconference.

Required and Optional MLTSS Quality-Related Activities Conducted by the EQRO.

A. Assessment of Compliance with Medicaid Managed Care Regulations (including MLTSS contract requirements)

The EQRO conducts a comprehensive Annual Assessment of MCO Operations to review for compliance with contractual, federal, and State operational and quality requirements. Beginning in 2015, MLTSS was included in this review. The review cycle occurs at intervals no greater than twelve (12) months and includes MLTSS in the sample records for review. MCOs demonstrating contractual compliance performance at or above eighty-five percent (85%) receive a partial review every other year of only those elements that are "Not Met" or "N/A" during the comprehensive review. However, if the elements are related to specific performance measures or required by the Special Terms and Conditions of the Comprehensive Waiver they will be reviewed according to the respective required periodicity.

B. Validation of the MCOs Performance Measures

The NJ FamilyCare Managed Care Contract article 9.11.E requires NJ FamilyCare MCOs to report on Performance Measures (PM) for the MLTSS program. The EQRO will assess the MCOs process for calculating performance measures and whether the process adhered to each measure's specifications, and the accuracy of the PM rates as calculated and reported by the MCOs. The EQRO will perform this validation for eighteen (18) measures as some measures are combined measures. Utilizing the performance measures outlines provided by the State, the EQRO is developing PM specifications for the MCOs. The annual validation report will include the results of the EQRO review of the MCO documentation, the EQRO's prepared rate tables and analysis of PM results.

C. Quality Improvement Projects (QIPs)

The EQRO reviews the QIPs for methodological soundness of design, conduct and reporting to ensure real improvement in care and confidence in the reported improvements. In cooperation with the State, the EQRO assisted in the identification of the initial QIP topic for MLTSS. The 2015 MLTSS QIP topic was 'Falls Prevention'. When conducting QIPs, the MCOs follow the ten-step CMS protocol. The MLTSS QIP topic was introduced to the MCOs during the August 2015 QIP training provided by the

EQRO. The five MLTSS MCOs submitted their respective MLTSS QIP Proposal related to prevention of falls to the EQRO for review and acceptance. The MCOs are required to submit their initial progress reports to the EQRO in June 2016 with a progress report update in September 2016.

D. MLTSS Care Management Audits

The EQRO evaluates the effectiveness of each MCO's contractually-required MLTSS care management program. For year one of the MLTSS program this audit was conducted in two parts. During March/April 2015, the EQRO reviewed a sampling of MLTSS members' records from the four MLTSS MCOs who were enrolled in MLTSS between the period of July 1, 2014 and December 31, 2014 and still enrolled with the MCO at the time of the record selection. Audit activities include an evaluation of the following metrics: identification, outreach, face-to-face visits, initial plan of care, ongoing care management, and gaps in care. The tool used for the audit included State-specific contract requirements/standards, reviewer guidelines (noting specific elements that must be reviewed by the EQRO reviewers), and selected MCO staff members to clarify and confirm findings. To complete the review for the first year, additional records were selected from the original four MLTSS MCOs so that there was a minimum of one-hundred records reviewed in total for the January 2016 review. This sampling included MLTSS members enrolled in MLTSS between the period of January 1, 2015 through June 30, 2015 and were still enrolled in the MCO at the time of the record selection. Based on the findings of the initial six-month review, the MCOs were required to submit a work plan to the State addressing the EQRO's recommendations as well as any Performance Measure that scored less than eighty-five percent (85%). The State in conjunction with the EQRO reviewed and requested modifications and updates on the work plans. The work plan will be validated during the next annual MLTSS care management audit scheduled for August/September 2016.

E. Calculation of Performance Measures

The EQRO uses the data from the annual assessment, focus studies, and MLTSS care management (CM) audit to calculate certain MLTSS Performance Measures. The results of the MLTSS Performance Measures calculated by the EQRO are included in the State's respective quarterly/annual report to CMS for the respective deliverable period. The following, is a listing of PM the EQRO is responsible for calculating along with the respective data source:

- (8) Plans of Care (POC) established within 30-days of enrollment into MLTSS/HCBS (CM Audit)

- (9) POC reassessments for MLTSS/HCBS members conducted within 30-days of annual level of care redetermination (CM audit, deferred for 1st year)
- (9a) POC amended based on change of member condition (CM audit, deferred for 1st year)
- (10) Plans of Care are aligned with members needs based on the results of the NJ Choice Assessment (CM Audit)
- (11) POC developed using "person-centered principles" (CM Audit)
- (12) MLTSS/HCBS POC that contain a back-up plan (CM audit)
- (13) MLTSS/HCBS services are delivered in accordance with the POC, including the type, scope, amount, frequency, and duration. (Focus Study – lag report based on claims/authorizations)
- (15, 15a) MCO MLTSS providers are credentialed/re-credentialed in a timely manner (incorporated in the Annual Assessment report)
- (16) MCO member training on identifying/reporting critical incidents (CM Audit, deferred for 1st year)

MLTSS MCO Quality Workgroup

In November 2014, the DMAHS' Office of MLTSS Quality Monitoring formed a workgroup, "MLTSS MCO Quality Workgroup", with representation from each of the MCOs, DoAS, and DMAHS. This workgroup meets on a monthly basis and primarily focuses on the MLTSS PM and other MLTSS contract required reports. The workgroup's initial focus was to review each of the PM, define the numerator and denominator, identify acceptable data sources, measurement period, and due dates. These meetings facilitate the discussion of reporting elements that may present challenges to the MCOs in reporting and developing a consensus on how to address so that the data received from each MCO can be aggregated and representative of the overall MLTSS program. Each month, the Office of MLTSS/QM reviews the information received from the MCO to date, identifies any issues raised by the MCOs, and facilitates resolution. It is understood that the data received for the first year of MLTSS is an opportunity for the MCOs to begin evaluating their data analytics, make necessary changes, and to serve as a baseline moving forward. In addition to the PM deliverables, this workgroup discusses other MCO contract required, MLTSS reporting requirements. Reporting templates are developed and agreed upon along with the reporting timeline. Any areas of concern are discussed at a following meeting along with recommendations and resolution. The PM data self-reported by the MCOs is shared during these meetings with the MCOs to illustrate the outcome and for the participants to examine the results. This affords the work group the opportunity to view how their respective MCO is reportedly performing in comparison to another MCO. In addition to sharing the PM data with the MCOs, it is also presented to the Medical Assistance Advisory Council (MAAC) and the MLTSS Steering Committee during their quarterly meetings.

MAAC meeting minutes/presentations can be found at: http://www.nj.gov/humanservices/dmahs/boards/maac/.

InterDivisional MLTSS Quality Committee

The InterDivisional MLTSS Quality Committee is an operational committee comprised of leadership representation from the DMAHS and DoAS that meets on a monthly basis. The committee is focused on aligning Divisional quality activities and business processes with MLTSS quality management goals; overseeing and providing strategic direction for MLTSS quality oversight; and providing decisions to or recommendations for resolution of issues or determination the need to escalate to agency and/or department administration. The goals of the committee are to continue development of a monitoring program to review, aggregate and integrate various data elements to assess MCO and MLTSS program performance; identify and facilitate timely resolution and remove barriers to issues that may impede the effective implementation of the MLTSS Quality Strategy, and to promote quality principles throughout the MLTSS Quality Enterprise.

A work group within this committee is currently examining the existing PMs identified for MLTSS and researching outcome measures for consideration in the waiver renewal that cross the span of the State's long-term services and supports programs (PACE, MLTSS/HCBS, MLTSS/NF, and FIDE SNP that are more quality driven versus process or compliance driven. Once quality measures are identified for consideration, the State will consult with its EQRO in the development of the measurements with intended implementation in July 2017.

Medicaid IAP Incentivizing Quality and Outcomes (IQO) Technical Assistance

New Jersey applied and was accepted into the Medicaid IAP Incentivizing Quality and Outcomes (IQO) Technical Assistance opportunity for MLTSS community, Implementing IQO Strategies beginning in September 2016. As the State is planning to transition our performance measures from a focus on compliance with organizational process to focus more on responsiveness to personal outcomes and quality, we applied for this opportunity to explore tying our measures to a purchasing strategy and further innovation. We are seeking program support in the following areas: identification of quality measurement strategy, effective stakeholder engagement during incentive design, operational aspects of implementing incentives, data sets and analytics to support community-based long-term services and supports, and purchasing strategy design.

National Core Indicators – Aging and Disabilities

Attachment B
Quality and Monitoring Activities

The NCI-AD is an initiative designed to support states' interest in assessing the performance of their programs and delivery systems and improving services for older adults, individuals with physical disabilities, and caregivers. NCI-AD is a collaborative effort between the National Association of States United for Aging and Disabilities (NASUAD), Human Services Research Institute (HSRI), and the National Association of State Directors of Developmental Disabilities Services (NASDDDS). The NCI-AD's primary aim is to collect and maintain valid and reliable data that give states a broad view of how publicly-funded services impact the quality of life and outcomes of service recipients. New Jersey is participating in this initiative to examine their funded long-term services and supports (LTSS) programs regardless of funding source (NJ FamilyCare/Medicaid; PACE; or Older Americans Act). The NCI-AD is an in-person survey that focuses on the performance of NJ's LTSS systems instead of specific services and provides an opportunity for cross agency comparison. New Jersey is anticipating the use of the NCI-AD project as one of the tools used to assess the performance of NJ's funded LTSS programs and how they impact the quality of life and outcomes of service recipients; as well as a tool to ensure choice, person-centered planning and other components of the HCBS settings rule. New Jersey is one of six States participating in the expedited survey schedule and thirteen overall States participating in year one of the survey. New Jersey conducted their survey between July 2015 and October 2015 of individuals participating in the LTSS programs from July 2014 through December 2014 and still in the program at time of sample selection in May 2015. The results of the first year results will be available in NASUAD's mid-year report released in May 2016.

MLTSS Performance Measure Data Report

The Office of MLTSS/QM reviews the data, analysis, and action taken for the MLTSS Performance Measures that were developed in response to the Special Terms and Conditions of the 1115 Comprehensive Medicaid Waiver, reported by the respective specified data source (DoAS, MCOs, EQRO, and DDS). The results are reported to CMS in New Jersey's 1115 Comprehensive Medicaid Waiver's Quarterly and Annual Report. As the MCOs and DoAS further refine their system requirements for PM reporting, they submit corrected reports to the Office of MLTSS/QM. Corrections submitted by the MCOs as a part of the refinement of their reporting systems are included at the end of this attachment.

Care Management Monitoring

The transitioning of care management responsibilities from one-hundred community-based agencies to four MCOs began February 1, 2014, and concluded July 1, 2014 when MLTSS was implemented. In collaboration with DMAHS, DoAS launched a comprehensive strategy that ensured:

1. A smooth transition of individuals served through DoAS and the Division of Disability Services' (DDS) four 1915(c) Home and Community-Based Waiver programs to MLTSS under the 1115 Demonstration Waiver.
2. The infrastructure for the fee-for-service system was maintained during the transition phase, while simultaneously building capacity within the managed care service delivery system; and
3. The 1915(c) care management system was strengthened to meet the new MLTSS care management requirements, thus enabling the MCOs to build upon and advance their care management services for the MLTSS program.

This approach enabled the MCOs to build their care management capacity, administrative infrastructure and streamline the transition process to MLTSS over a five month period. It also:

1. Provided a systematic approach to transitioning from a fee-for-service to MLTSS model;
2. Ensured the health and safety and continuity of care for the 1915 c waiver participants;
3. Ensured that the MCOs maintained the same care management responsibilities, credentialing, and oversight as the former HCBS waiver care management agencies had;
4. Enabled MCOs to develop their service delivery system and complete comprehensive training, while gaining experience before assuming the transfer of 11,000 waiver participants; and
5. Ensured quality management through an interdivisional collaboration that served as the foundation for the new MLTSS Quality Management Unit.

The State enrolled the MCOs as 1915(c) waiver care management agencies to assume responsibility for individuals served through the Global Options for Long Term Care, (GO), Traumatic Brain Injury (TBI), Aids Community Care Alternative Program (ACCAP), and Community Resources for Persons with Disabilities (CRPD) waivers. This allowed the MCOs to build their care management capacity. Additionally, the State established specific assurances and a checklist that MCOs had to satisfy before they were approved for FFS waiver care management.

The DoAS Office of Community Choice Options (OCCO) conducted in-service training sessions for State clinical assessors and the 21 Area Agencies on Aging (AAA)/Aging and Disability Resource Connection (ADRC) Information and Referral Specialists and Outreach Workers on how to counsel consumers on selecting a MCO that met their healthcare needs. Once trained the State and ADRC specialists provided one-on-one counseling to consumers, which helped to further mitigate any potential conflict in selecting a MCO for HCBS waiver services and MLTSS.

<u>MLTSS Mandatory Training Sessions for MCOs</u>

Attachment B
Quality and Monitoring Activities

MCO training for Long-Term Services and Supports included:

- Care management standards, clinical and financial eligibility process, service coordination, service limitation and special considerations in service planning, Plan of Care, approved provider types, individual service agreements, service verification, special requests, documentation and monitoring recordkeeping, re-evaluation of level of care, and the intricacies of assisted living settings and services in those setting.
- Special needs and service planning for children and adults with medically complex disabilities;
- Traumatic Brain Injury (TBI) overview, care management, and plan of care development; and;
- AIDS waiver and community services.
- Adult Protective Services and the Office of Public Guardian
- Aging and Disability delivery service systems available through the county area agencies on aging, county offices of disability services, county welfare agencies and community based organizations.

All of the essential trainings were recorded and posted to the Department's website.

Effective January 2014, MCOs were required to utilize the NJ Choice to determine Medical Day Care (MDC) eligibility. The eligibility is determined at the MCO level and not reviewed/determined by the State. In preparation for this change, the Department conducted training on the NJ Choice and Medical Day Care Eligibility. Following the training, a pilot program was initiated.

The purpose of the pilot was to oversee the implementation of the NJ Choice, identify areas of weakness, provide feedback on areas of strength and weakness, and to monitor action plans. This pilot also served to aid the MCOs in gaining experience and proficiency in the assessment tool and process that would be used for MLTSS eligibility. The trainings and pilot began in September 2013.

Benchmarks were established for proficiency standards. The pilot allowed a significant number of master trainers and assessors to be fully trained and proficient in the assessment processes. The pilot ended in March 2014 with all MCOs being recognized as proficient in assessment processes.

The attached training outline documents the trainings held for the MCOs in preparation for MLTSS implementation. The trainings were held in various formats including in-person or via webinar. Many of the essential trainings were recorded and posted to the Department's website.

The MCOs were required to ensure that all staff completed the trainings by December 2014. Several essential training sessions were mandatory before assuming MLTSS job responsibilities including NJ Choice and Options Counseling.

Effective April 28, 2014, the transfer of care management responsibilities to the MCOs began for select members, partly in response to the instability of the former care management agencies that were losing CM to the MCOs. Technical assistance was offered to the MCO Care Managers by the State. Recognizing that the transfer of client records/files would be critical to ensure a smooth transition process, DoAS created a Participant Record Transfer Protocol that established how the cases were transferred in an organized and efficient manner.

A Care Management Hotline for was established specifically for former care management agencies to use during the MLTSS implementation. This was in anticipation that the prior care management agency as the longstanding point of contact would continue to receive requests and calls from their former participants. Each call to the hotline was logged and forwarded to the appropriate unit. This logging allowed the Department to track the types of issues.

Post-implementation

Clinical Assessments

The MCO is required to submit all assessments completed with the NJ Choice to the Department. This includes assessments for MDC and MLTSS. The MDC assessments are collected for rate setting and quality assurance purposes. There is currently no quality assurance plan for the MDC assessments.

In the first several months of MLTSS implementation, the Department identified issues with the quality of the comprehensive assessments conducted by the MCOs for MLTSS. This was most apparent through the high rate of Not Authorized review outcomes. Not Authorized is identified as an assessment that is conducted by the MCO and reviewed by the Department. The Department review is unable to make a determination for level of care eligibility because the clinical criteria are not indicated. The Department is responsible for conducting a face to face reassessment for the Not Authorized outcomes. Due to the high percentage (ranged 18-33%) identified, the Department implemented an aggressive training strategy. The attached training outline documents the trainings held specifically for the MCOs specific to MLTSS processes and assessment.

Webinars

Nine webinars were provided between August 2014 and February 2015. Key webinars related to assessment included:

- Key Areas of NJ Choice – focus on the areas of the assessment tool that are specific to the clinical eligibility criteria as well as those areas that have a direct correlation
- Narratives – focus on the NJ Choice narrative which provides an overall summary of the assessment findings. Correlation between the narrative and the assessment coding is essential to a level of care determination
- Special Care Nursing Facility (SCNF) Level of Care (LOC) Need – individuals who require a higher level of care need and require medically complex services are identified in the assessment process. These individuals receive a higher cost threshold for community services
- Trends in Requests For Information; NF LOC overview – focus on reasons why a level of care determination cannot be made; the required information for assessment; the criteria for nursing facility level of care

Care Management Collaboration

Several Care Management meetings were convened to discuss care management and assessment issues and collaboration on solutions. The following solutions had a direct impact on improving assessment quality.

- Ability of MCO to obtain and utilize assessments conducted by the State that qualified individuals for MLTSS within four months of enrollment.
- Evaluation by MCOs of the outstanding Not Authorized outcomes and strategy to have those that appeared to have errors in the initial assessment were reassessed by the MCO.
- Individual meetings with each MCO to review assessments in which outstanding information was still pending; provide guidance obtaining and submitting the information

NJ Choice Annual Recertification

Individuals who conduct assessment utilizing the state's standardized assessment tool are required to undergo annual recertification and demonstrate competency. The annual recertification for the MCOs was held in February 2015 for Care Management Supervisors and Master Trainers. These individuals were responsible for implementing the training internally for their assessment staff between the period of February through August 2015. The annual recertification for State and ADRC assessors was held in April 2015. The State added a Role Play Module and a Mentoring Module to the training to enhance the skills of the assessors. The Role Play Module focuses on typical scenarios and challenges, skill building for interview skills, and identification of deficits that impact level of care need. The Mentoring Module gives the

assessor the opportunity to strengthen and enhance their skills in real life situations with support, guidance, and feedback.

Mentoring

The Mentoring Module as part of the annual recertification process is the responsibility of the entity that is conducting assessment. In order to prepare these entities for the mentoring module, the State implemented an extensive Mentoring Program for the 5 NJ FamilyCare MCOs and 3 ADRC counties. This mentoring program paired entity assessors, identified as Lead Mentors based on the strong assessment and interview skills, with State assessors, identified as Master Mentors based on strong assessment, interview, and mentoring skills. The Master Mentor was responsible for modeling assessment skills, observing the Lead Mentor skills, and providing feedback and guidance on areas of weakness.

Outcomes

The collaborative meetings, webinars, enhanced recertification process, and mentoring were all implemented to improve the quality of the screening and assessment of individuals for MLTSS. In the immediate months following the conclusion of the recertification and mentoring process, the MCO Not Authorized rate dropped from an overall average of 25 percent to 12 percent (range 8 to 12 percent) which was a significant improvement.

The Not Authorized rate for the month of November 2015 has an overall average of 6 percent (range 1 to11 percent) before factoring in the final State determination. The State has proposed a new quality measure for the Not Authorized rate for the July 2015 contract (pending CMS approval). The measure requires that the Not Authorized rate is to be at or below 7 percent. This rate is calculated after the State's final determination of nursing facility level of care. Three of the five MCOs are meeting this standard prior to the State's final determination which indicates that their final rate will be within the quality measure parameters. The remaining two MCOs pre-determination rate is 8 percent and 11 percent. The State expects both these MCOs will drop within the parameters this quarter.

Ongoing Quality Assurance Development

The Department has implemented a workgroup to focus on training needs and quality assurance measures related to training and assessment quality. The workgroup consists of representatives from the MCOs and the Divisions of Medical Assistance and Health Services and Aging Services. The goal of the workgroup is to identify training needs, processes, and quality assurance measures. The MCOs are required to submit monthly training calendars to the Department for the purpose of quality assurance purposes.

Attachment B
Quality and Monitoring Activities

The Department has begun to implement a formal clinical assessment audit tool to record and track audits of the clinical assessment. This auditing occurs on each case that is reviewed by the Department, but the tools will allow the Department to capture data, identify trends, and develop reports.

DoAS continues to monitor and report on two performance measures for MLTSS, 17 and 17A. 17 is the timeliness of Critical Incident (CI) written reports received within the required two business days. 17A is reporting on the timeliness of Critical Incident (CI) reporting (verbally within 1 business day) for media and unexpected death incidents.

MLTSS Quality Monitoring Activities Conducted within the Office of Business Intelligence

MLTSS Slides

The DMAHS Office of Business Intelligence prepares and presents a monthly slide deck showing enrollment in MLTSS and the services consumed by MLTSS members. There are three main sections in these slides:

- **Enrollment and Service Consumption –** These slides allow senior staff and other MLTSS decision makers and operational staff to track the intended rebalancing of the NJ FamilyCare long term care system away from institutional settings towards home and community based services, provides some migration statistics that allow decision makers to see if there are changes or tweaks that are needed in the MLTSS assessment and enrollment process, and allows for review of services being consumed by the overall MLTSS population. These slides are updated monthly and presented on the third Thursday of each month to the New Jersey MLTSS Operations Team.

- **Quality -** These slides allow senior staff and other MLTSS decision makers and operational staff to track how each managed care plan is performing on some of the 40+ quality measures included in the MLTSS Quality Strategy. These slides are updated as additional data is received; some measures are monthly, some quarterly, some are reported twice and year, and others are annual.

- **Fiscal –** These slides show the financial health and projected cost of the MLTSS initiatives. These slides are updated on an ad-hoc basis as needed or requested.

Encounter Data Monitoring

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

Quality Monitoring Components of the NJ Dual-Eligible Special Needs Plan Program

The New Jersey Dual Eligible Special Needs Plan (DSNP) program began January 1, 2012. Only participating NJ FamilyCare Medicaid Managed Care Organizations (NJFC MCOs) are eligible to contract with the state for the DSNP/FIDE product. Each participating NJFC MCO signs a MIPPA (Medicare Improvements for Patients and Providers Act of 2008) wraparound contract in addition to amendments to the NJFC MCO Contract.

Beneficiary enrollment in the DSNP/FIDE product is *voluntary*, but upon electing to enroll in a DSNP, simultaneous enrollment in the Medicare Advantage DSNP company's NJ FamilyCare product is *mandatory*. This allows the state to monitor performance holistically across each DSNP enrollee's experience with Medicare and Medicaid. By DMAHS' design, contract performance review is an integrated evaluation of how well the contractors perform every aspect of the Medicaid wraparound function from enrollment to initial benefit determination, to honoring enrollee rights and proper marketing material review and beyond.

NJ maintains a unique contract for its DSNP program and a distinct quality monitoring cycle for its DSNP program separate and apart from quality monitoring for the NJFC program. It combines formal annual assessment by the EQRO of contract compliance and performance, contractual reporting to the DMAHS, HEDIS, CAHPS, ad hoc reporting and notices of deficiency when corrective action is required.

Attachment B
Quality and Monitoring Activities

Participation by Medicaid managed care contractors in the NJ DSNP program is voluntary. During the first four years of operation, three DSNPs exited the market and two entered. The result is an inconsistent set of contractors represented in annual quality reporting. Owing to the rapid rate of change and growth within the scope of the DSNP program during the "startup" years (2012 - 2015), a full annual assessment was performed for each participating plan for each year.

Recently, New Jersey added significant expansions to the DSNP benefit package--Managed Long-Term Services and Supports in 2016, following the addition of nursing facility services in 2015. With each major evolution of the DSNP program, the EQRO's annual audit tool receives corresponding updates to the scope and depth of operational evaluation. All participating DSNP plans will receive a full review of 2015 and 2016 operations to examine performance with MLTSS services in contract.

A summary of specific DSNP quality monitoring and reporting follows:

External Quality Review Organization (EQRO)

NJ evaluates the mandatory EQRO activities for the DSNP MIPPA Contract, including validation of performance measures, QIPs, and annual assessments. Operational domains evaluated during the annual assessment include:

- Access
- Quality Assessment and Performance Improvement (QAPI)
- Programs for the Elderly and Disabled
- Enrollee Rights and Responsibilities
- Care Management and Continuity of Care
- Credentialing and Recredentialing
- Utilization Management
- Administration and Operations
- Management Information Systems

On-site file review includes:

- Provider Grievances
- Member Grievances
- Member Appeals
- Utilization Management
- Care Management
- Credentialing

- Recredentialing

Where the EQRO finds that contract quality and compliance achieved a "not met" score, the Contractor must supply a corrective action plan for monitoring by the EQRO.

Quality Improvement Projects (QIPs)

Additionally, NJ DSNP Contractors participate in individual QIPs. These QIPs are distinct projects from those submitted for NJFC or for Medicare Advantage purposes. The DSNP QIP domain is chosen by the DMAHS in consultation with the EQRO; each contractor then determines the project topic within the domain established by the DMAHS. For the 2012-2015 QIP cycle, the DSNP topic was Medication Therapy Management. The topic for 2016-2019 is Preventing Avoidable Complications. The first such report was issued in 2013, but initial QIP project proposals were submitted in September 2012.

Quality Technical Reports (QTRs)

The EQRO produces an annual quality technical report for the DSNP covering all mandatory EQRO activities for the DSNP MIPPA Contract (Annual Assessment, Performance Measure Validation, and QIPs).

Consumer and Health Care Provider Satisfaction Surveys (CAHPS)

CAHPS reporting provides essential insight into member experience during the early years of the DSNP product. There are CAHPS reports for each year of operation from 2013 onward, but a varying mix of contractors were evaluated based on participating MCOs at the time of the annual survey.

Contractual Quality Monitoring and Reporting

Contractor representatives attend two monthly meetings--DSNP IT Issues and DSNP Policy, Operations and Contract Issues. During these meetings quality and performance feedback is provided by the state and, where improvement is needed across contractors, solutions are discussed and monitored. The DMAHS Dual Integration Unit, which oversees the operation of the DSNPs (now FIDE SNPs), issues when necessary, ad hoc requests for information on structure and process and quality outcomes. The unit maintains a compliance reporting inbox for state monitoring.

In the 2015 MIPPA contract year, which runs January 1 thru December 31, the DMAHS added to the DSNP MIPPA contract the Integrated Denial Notice report, which follows the natural

history of each case of denied benefit through final resolution with Medicare and/or Medicaid appeal, grievance and fair hearing options.

Additionally, there are ongoing efforts by the DMAHS to continually refine monitoring, reporting and alignment of contractual reporting with the DMAHS' DSNP/FIDE SNP operational oversight needs.

Monitoring Quality for the Targeted Home and Community-Based Services Programs

State Medicaid Agency Oversight

Division of Medical Assistance and Health Services' (DMAHS) Quality Management Unit has been assigned to oversee and monitor the Quality Management Strategies of Division of Developmental Disabilities (DDD) and Department of Children and Families' (DCF) Children System of Care (CSOC) in the implementation of their Home and Community Based Services (HCBS) programs. DDD is responsible for the daily program operations of Supports Program and Intellectual Developmental Disability Program for Out of State (IDD/OOS). CSOC is responsible for the daily administration of Autism Spectrum Disorder Program (ASD), Serious Emotional Disturbance Program (SED), and Intellectual Disabilities Developmental Disabilities with Co-occurring Mental Health Diagnosis Program (ID/DD-MI).

The Quality Management Unit has a system in place that measures performance, identifies opportunities of improvement and monitors quality outcomes. QMU's Quality Monitoring Oversight of the programs consists of three components:

- Oversight Management
- Quality Assurance and Quality Improvement Monitoring, and
- Coordination of Interdepartmental Resources

Oversight Management

The QMU staff is responsible for implementing the DMAHS HCBS Program Oversight and Monitoring Work Plan to ensure that the functions related to the operations and performance of Supports Program, IDD-OOS, ASD, SED, and IDD/MI programs are performed according to CMS requirements and the activities of the program itself. QMU administrative staff works with DDD and CSOC to ensure that their quality assurance programs have been implemented and that the functions and activities stated in their Quality Management Strategy (QMS) for program participants are performed in accordance with CMS' requirements for quality assurance.

Attachment B
Quality and Monitoring Activities

DMAHS is the Administrative Authority over DDD's CCW under 1915(c) HCBS Waiver. DMAHS has established the QMU in its Office of Preventive Services in 2008 to perform the quality oversight of the CCW. The QMU maintains the same quality monitoring oversight for DDD's Support Program and IDD/OOS. Quality measures are discussed in the Quality Assurance Advisory Committee meetings to remedy identified problem areas in order to improve upon program operations. The QMU Clinical Lead Liaison participates in DDD's quality assurance meetings in order to review its data collection findings, discuss trends, and assist in developing remediation strategies. QMU's first meeting with DDD to discuss the Quality Plan for Supports Program and IDD/OOS occurred in May 2015. Succeeding communication between the two offices, QMU and DDD to target quality assurance of both programs went smoothly. Latest meeting was conducted on February 19, 2016 and covered an overview of the Supports Program. QMU is currently coordinating with DDD the iRecord Training to be attended by the entire QMU staff. The Comprehensive Audit of the Supports Program is scheduled in August 2016. The audit is a review of significant sample of participant records to ensure that DDD adheres to its Quality Management Strategy. QMU will utilize its Quality Oversight Monitoring Work Plan upon implementation of IDD/OOS Program.

DMAHS' QMU meetings with CSOC to discuss quality measures identified in the Quality Plan for each program started in March of 2015. The QMU staff works collaboratively with CSOC Administrative Staff for information sharing to achieve successful outcomes. An open dialogue is maintained between QMU and CSOC to facilitate effective communication. The QMU staff has participated in the CSOC Strength and Needs Assessment Training conducted in July 2015, NJ CSOC Wraparound Training in December 2015, CSOC Cyber Training in March 2016, and several other meetings and trainings conducted with DMAHS' Office of Business Intelligence directed for the successful implementation of the CSOC programs. QMU is scheduled to do the Comprehensive Audit of CSOC's ASD, SED and IDD/MI programs in May 2016.

Quality Assurance and Quality Improvement Monitoring

The QMU staff conducts an annual retrospective review of participant records and use the data obtained to measure the performance of DDD and CSOC to ensure they comply with their Quality Management Strategy. The QMU audit process provides the framework for the collection and analysis of aggregate data to identify areas for quality improvement at the system level. Participants of each program are randomly selected for an audit sampling using a CMS referred "Sample Size Calculator". A statistically significant sample is generated that represent a 95 percent confidence level, 5 percent confidence interval, and 50 percent response distribution. The QMU staff reviews the records utilizing the QMU Measures to include desired outcomes, indicators, measurements, evaluation criteria, data sources, and supporting documents. The audit captures the following:

- Quality of life
- Level of care need determinations and re-evaluations
- Responsiveness of Plans of Care to participants needs
- Assurance that individuals receive services from qualified providers
- Health and welfare of participants
- Fiscal accountability is assured for the services rendered

The QMU audit assesses compliance to assurances by determining the compliance rate for each sub-assurance:

Numerator: Number of deficient participant records for each sub-assurance Denominator: Number of participant records reviewed for each sub-assurance

The Comprehensive Audit also assesses gaps in services, barriers to care, access to services, care coordination, tracking mechanisms, as well as networking capabilities. The State Operating Agency is responsible to begin the remediation process upon discovery of a provider not meeting with waiver standards for participation. The QMU informs DDD and CSOC Administrative Staff of the stratified findings at the completion of audit. A report of system-wide strengths, weaknesses and recommendations is created and sent to both operating agencies. DDD and CSOC are required to submit a Plan of Correction (POC) if documentation of assurance is lacking in more than 14% of the records reviewed. Identified areas of non-compliance that have the potential for adversely affecting the health and well-being of participant or functioning of staff is followed-up on an urgent basis by QMU Healthcare Administrator who confers with the DMAHS Medical director for follow-up measures.

The QMU is scheduled to perform the Comprehensive Audit on CSOC's ASD, SED and ID/DD-MI Programs in May of 2016. DMAHS' Office of Business Intelligence is currently working on the significant sample from the universe of each program. The Comprehensive Audit of Supports Program immediately follows the completion of QMU's audit on CSOC's programs and is to be conducted in August 2016.

Coordination of Interdepartmental Resources

Regulatory and State policy compliance issues identified in the QMU audit findings will be addressed with the Office of Legal and Regulatory Affairs (OLRA) and Eligibility Policy which are also DMAHS' CMS liaison and responsible for ensuring that DDD and CSOC operate their respective programs in accordance with federal regulations and the provisions of each program by reviewing, approving, and submitting to CMS all new, renewals and extensions of

applications and amendments. All required follow-up will be conducted by the QMU with collaboration of DDD and CSOC. In instances that may have the potential for adversely affecting health and well-being of participants, functioning of staff or potentially impacting upon fiscal responsibility, the QMU Clinical Lead Liaison notifies the QMU Healthcare Administrator who confers with the DMAHS Division Director for follow up measures. DDD or CSOC is copied on all required follow-up.

Other collaborative resources available to the QMU in the performance of its quality monitoring include the State fiscal agent, Office of Program Integrity and Accountability, Medicaid Fraud, Division of the State Comptroller and Office of Business Intelligence.

Department of Children and Families, Children's System of Care Quality Activities

New Jersey's Department of Children and Families (DCF), Children's System of Care (CSOC) provides a single point of access for support and services to youth and their families/caregivers that present with serious emotional and/or behavioral challenges, substance use challenges, and/or intellectual/developmental disabilities. CSOC's objectives are to deliver services that enable the youth to remain at home, in school and in the community.

The NJ Children's System of Care is founded on the following Core Values and Principles:

I. Core Values:

- Child/Youth Centered & Family Driven – Families are engaged as active participants at all levels of planning, organization, and service delivery
- Culturally and Linguistically Competent – learning and incorporating the youth and family's culture, values, preferences, and interests into the planning process, including the identified language of the family
- Community Based – identifying and utilizing supports that are least restrictive, accessible, and sustainable to maintain and strengthen the family's existing community relationships

II. Principles:

- Accessible
- Accountable
- Collaborative
- Comprehensive
- Cost Effective
- Family Involvement
- Flexible

- Home, School, and Community Based
- Individualized
- Needs Driven
- Normalized
- Outcome Based
- Promoting Independence
- Strengths Based
- Team Based
- Unconditional Care

Services authorized for CSOC involved youth are:

- Clinically appropriate
- Individualized
- Provided in the least restrictive environment
- Family-driven, with families engaged as active participants

CSOC works to assure that its system of care is culturally competent and responsive to differences in culture, race and ethnicity, and identity. CSOC and it system partners collaborate across child-serving systems (child welfare, juvenile justice).

CSOC's Continuous Quality Improvement Plan:

The CSOC has recently drafted a revised system-wide Continuous Quality Improvement (CQI) plan. The CQI outlines CSOC's system-wide vision of the quality improvement process. As part of the plan, the requirements of the 1115 Demonstration Waiver quality strategy reporting have been incorporated for quality oversight of the three DCF/CSOC components under the Waiver; the Intellectually/ Developmentally Disabled and Mental Illness (ID/DD-MI); Autism Spectrum Disorder (ASD); and Serious Emotionally Disturbed (SED).

The CQI plan is designed to assess CSOC's performance across services throughout the state of New Jersey. The plan outlines the formal process by which CSOC sets objective indicators for the monitoring and evaluation of the quality of services provided to the youth and families. It assists CSOC in the identification of areas of strength and needs as well as areas of improvement and promotes a performance driven system of care that strives on achieving goals and the satisfaction of the youth and family served.

Through the implementation of the CQI Plan, CSOC is able to:

- Collect and analyze data to make improvements as needed

- Identify inconsistencies in service delivery
- Identify needs for changes and enhancements in services
- Identify new service needed
- Ensure effectiveness

The CQI plan is essential to managing data and is an essential part of improving deliverables. This involves collecting, tracking, analyzing, interpreting and action on the data that is collected. The CQI Plan measures specific performance areas such as:

- Eligibility process
- Timeliness of service delivery
- Appropriate level of care determinations
- Utilization management of services
- Populations served
- Provider adequacy
- Youth and family satisfaction
- Clinical and functional outcomes of system care providers
- Assessments of needs of youth referred to CSOC
- Customer service

Quality Improvement (QI) Team

CSOC's CQI plan includes the Quality Improvement Operations Team (QI), Quality Improvement Committee, CSOC's Contracted System Administrator (CSA), system partners and community stakeholders. The QI Operations Team is led by the Quality Coordinator. In collaboration with the CSOC staff and the CSA, the coordinator ensures consistency and compliance throughout the System of Care and is tasked to routinely analyze data and operations throughout the system to ensure the utmost compliance to the goals of CSOC and recommend changes at both program level and system level.

Quality Improvement Committee and Subcommittees

The CQI Plan, in part, is carried out through the Quality Improvement Committee and the Utilization Management Subcommittee.

The QI Committee utilizes a continuous quality improvement philosophy by monitoring and evaluating:

- The appropriateness of care
- Identifying opportunities for improving quality and access

- Establishing initiatives to accomplish agreed upon improvements
- Monitoring resolution of barriers

The QI Committee is responsible for assuring that the needs of CSOC population are addressed. This is accomplished through the development of treatment and performance goals, and monitoring of all entities involved in a youth's care to assess achievement with these established goals. A primary goal of QI Committee is to continuously improve care and services to children and families through monitoring, evaluation data collections, measurement and analysis.
Responsibilities of the QI Committee include:

- Directing and coordinating work for the Quality Improvement sub-committees
- Review reports and data collected at the requested of CSOC
- Recommend changes to policies and procedures
- Review and approve studies and recommendations of the sub-committees
- Assure that corrective action plans are implemented and that performance improves
- Assess the performance relative to goals and objectives of the annual plan as well as performance indicators
- Evaluate appropriateness and outcomes of care
- Review annual evaluations
- Initiate studies, recommend policy changes or take additional steps in response to issues or concerns raised

The Utilization Management Subcommittee is charged with monitoring and evaluating treatment services and the application of clinical criteria for determination for level of care, delivery of services, family participation, and the transitioning of youth from various intensities of service. This subcommittee works to improve the quality of assessments, implementing standard practices, creating models and tools for furthering family education.

The Outcomes Management Subcommittee is responsible for creating a system-wide outcomes program that encompasses outcomes for the individual youth, program and statewide. This committee is charged with delineating actual outcomes, developing protocols for collecting data, oversees outcomes reporting, and to assess the value and benefit of services to youth and families.

Together, these committees' responsibilities include:

- Delineating performance measures, benchmarks, and targets
- Reviewing and analyzing data
- Identifying, implementing measuring and standardizing improvement initiatives
- Creating reports for selected indicators of performance

- Design, implement, measure and evaluate initiatives
- Conduct an annual evaluation of the committees activities and achievements
- Assess existing measures and determine where to refine, standardize and expand
- Determine methodology for administration of instruments as needed

Waiver Specific Reports

In addition to record review, CSOC and its CSA have defined the parameters to collect data in order to assess, monitor and report outcomes required for the 1115 Waiver Quality Strategy reporting.

The following reports are specific to the 1115 Demonstration Waiver/ Quality Strategy Reporting:

- **NJ1218 – Initial Level of Care Assessment**
  - Quarterly report that identifies if the youth has met the initial level of care (Level of Care Assurance)
- **NJ1219 - Plan of Care Follow-Up & Strengths and Needs Assessment (SNA) Attachment**
  - Quarterly report that identifies if the youth had required plan of care updated at least annually (Plan of Care Assurance)
- **NJ1220 – Authorization Activity**
  - Quarterly report that identifies if services are authorized in accordance with the approved plan of care (Plan of Care Assurance)
- **NJ1225 – Child and Adolescent Needs and Strengths (CANS) Assessment Follow-Up Activity**
  - Quarterly report that identifies if the youth received the required CANS (Quality of Life Assurance)

Qualified Providers and Monitoring

CSOC's has developed a network of providers that have been qualified to deliver services as defined by CSOC and the waiver. Each of these providers are required to meet qualifications specified by DCF, and may have either responded to a Request for Proposal or Qualification (RFP/Q). Additionally, any provider that is contracted with CSOC agrees to uphold identified deliverables, including staff trained in the standards set by DCF and CSOC. If the provider is not keeping up to the standards, the QI team can provide training and assistance to the provider to make improvements, or direct the provider to resources. Programs and service providers are monitored by CSOC to assure that each provider is holding to the standards set forth.

If CSOC requires providers to make adjustments within a program, a corrective action plan may be created. Areas that may be addressed include but are not limited to:

- Regulation requirement
- Program deliverables
- Treatment of youth
- Ineffective treatment

The QI team monitors the corrective action plan to ensure provider compliance. In cases of continuous non-compliance, CSOC may terminate relationship with the provider. If this action occurs, CSOC will ensure that a transition plan is implemented for continuation of care.

Unusual Incident Reporting

New Jersey Administrative Order 2:05 (AO 2:05) first established policy for the reporting of unusual incidents affecting the health, safety and welfare of DCF's service recipients. Standard expectations and procedures for the reporting of unusual incidents were further defined by the Administrative Order 2:05 Addendum, in order to promote and improve confidence, reliability, and program integrity throughout the Department's various service entities and programs.

These policies are designed to:

- Standardize the identification of reportable incidents
- Ensure the immediate and appropriate response to reported incidents
- Provide accurate and timely alert to Executive Management Staff
- Ensure timely and appropriate investigative activities
- Facilitate the analysis of trends and the identification of factors associated with the occurrence of unusual incidents
- Enable the integration of intradepartmental service delivery
- Promote the collaboration of effective and efficient management of services

DCF manages incident reports through the Unusual Incident Reporting & Management System (UIRMS), an electronic way of collecting, reporting and analyzing information about incidents that occur in programs. Within UIRMS, incidents are categorized in order to determine the severity of a situation, which parties the incident should be communicated to, and the timeframe in which DCF should be notified of the incident. If the UIR is in reference to a youth receiving services through CSOC, the department notifies the CSOC UIR Coordinator. The UIR Coordinator reviews the report and distributes it to the QI Director and the identified CSOC staff for monitoring as needed.

Division of Developmental Disabilities Quality Activities

The first person was enrolled in the Supports Program in July 2015. As of April 2016 there are 194 individuals receiving services through the Supports Program. This is the first program operated by DDD where every participant directs their services through an individualized budget and agencies delivering waiver services were required to become Medicaid providers who bill Molina directly. Historically, agencies received funding via contracts with DDD. Enrollment in the Supports Program was designed to be staggered to ensure that any issues could be addressed in a timely manner. Quality activities that occurred prior to standing up the Supports program include training for Support Coordination agencies, forums and leadership meetings for provider agencies on how to become a Medicaid provider, and Supports Program informational webinars for individuals, families, providers and advocates on the Supports Program. Transparency and education were of the utmost importance. Ongoing quality activities include mandated Support Coordinator deliverables regarding the completion of the Service Plan and the monthly Monitoring Tools. Both are tracked and monitored by Division staff.

Upcoming quality activities include an audit by the Quality Management Unit (QMU), under the Department of Human Services Division of Medical Assistance and Health Services Office of Preventative Health Services, to ensure compliance with the outcomes and performance measures as indicated in the Comprehensive Medicaid Waiver's Supports Program's Quality Plan. The first audit is scheduled to occur late summer through early fall of 2016. The audit period is Calendar Year (CY) 2015. Because DDD operates both the Supports Program (1115 Demonstration) and the Community Care Waiver (1915 (c) HCBS Waiver) and the quality plans are very similar the QMU will conduct one annual audit that includes a representative sample of persons in both Waivers. In March of 2016, DDD provided training to QMU on how the Supports Program's ensures compliance in the following performance measure areas: service plans, level of care, qualified providers, health and welfare, and financial accountability. QMU provides DDD with a report of their audit findings. All findings with a compliance rate below 86% require a corrective action plan. DDD also intends to implement additional oversight activities by Waiver Monitors in the Fall of 2016. Currently DDD is working on enhancing the monitoring tools so that data can be aggregated and analyzed. Data related to the performance measures will be reviewed by a Waiver Compliance Committee (WCC) quarterly with a formal meeting occurring at least annually. Measures for collecting data and determining compliance are also included or being built into the electronic health record (known as iRecord) utilized by Support Coordinators and DDD.

Quality Monitoring Reports

EQRO Reports: October 2012 – December 2012

Assessment of MCO Operations

- Partial Assessment*:* MCOs achieving a compliance rate at or above 85% in the previous year received a partial review of the 171 elements that scored as "Not Met" or "Not Applicable".
- Amerigroup, Healthfirst, Horizon and United all received a partial assessment.

Performance Measure Validation

- Submitted in June 2012.

Quality Improvement Projects

- Submitted in June and September 2012.

Focused Studies

- In Progress: EPSDT Services for New Jersey Medicaid Managed Care Enrollees
- In Progress: EPSDT and Care Management Services for CSHCN Enrolled in New Jersey Medicaid Managed Care

Care/Case Management Audits

- Onsite reviews done in June and July 2012.

EQRO Technical Reports

- The Quality Technical Report (QTR) for the activities performed by IPRO in contract year 1 included:
  - Summary of Key Findings for CMS Mandatory and Voluntary Activities
  - State Initiatives
  - MCO Strategies to Reduce Disparities in Healthcare Outcomes
  - Follow-up to QTR Recommendations from the Previous Year
  - Conclusions and Recommendations

EQRO Reports: January 2013 – December 2013

Assessment of MCO Operations

- Amerigroup, Healthfirst, Horizon and United all received a full assessment.
- A total of 172 elements were subject to review.
- The Care Management section had significant changes with 3 elements now scored based on the Care Management Audit findings.

Attachment B
Quality and Monitoring Activities

Performance Measure Validation • Amerigroup, Healthfirst, Horizon and United, as required by the NJ FamilyCare Managed Care Contract, submitted 22 HEDIS measures and three (3) NJ Specific Performance Measures. • The 3 NJ Specific Performance Measures included the AAP and CAP HEDIS measures stratified by dual, disabled and other low income; and a Preventive Dental measure.
Quality Improvement Projects • Amerigroup, Healthfirst, Horizon and United submitted progress reports in June and September 2013, for their sustainability year, for the following QIP topics: o Dental Care o Lead Screening o Well Child Care o Prenatal Care and Birth Outcomes • Amerigroup, Healthfirst, Horizon and United, with the guidance of the EQRO, initiated a collaborative QIP on the topic of Identification and Management of Adolescent Overweight and Obesity. Each plan was required to submit a proposal by the end of the year (2013).
Focused Studies • Completed: EPSDT Services for New Jersey Medicaid Managed Care Enrollees • Completed: EPSDT and Care Management Services for CSHCN Enrolled in New Jersey Medicaid Managed Care
Care/Case Management Audits • Amerigroup, Healthfirst, Horizon and United had Care Management audits in June and July. • The audits focused on the following populations: o Enrollees in the Division of Developmental Disabilities (DDD) o Enrollees in the Division of Child Protection and Permanency (DCP&P) o Enrollees in the general population • The following five metrics were evaluated: o Identification o Outreach o Preventive Services o Continuity of Care o Coordination of Services
EQRO Technical Reports • The Quality Technical Report (QTR) for the activities performed by IPRO in

contract year 2 included:
- Summary of Key Findings for CMS Mandatory and Voluntary Activities
- State Initiatives
- MCO Strategies to Reduce Disparities in Healthcare Outcomes
- Follow-up to QTR Recommendations from the Previous Year
- Conclusions and Recommendations

EQRO Reports: January 2014 – December 2014

Assessment of MCO Operations

- Partial Assessment*:* MCOs achieving a compliance rate at or above 85% in the previous year received a partial review of the 175 elements that scored as "Not Met" or "Not Applicable".
- Amerigroup, Horizon, United all received a partial assessment
- Wellcare newly entered the NJ FamilyCare Managed Care Contract and received a full assessment.
- Three (3) new elements were added to the annual assessment to be evaluated and scored to assess healthcare disparities.
- The Quality Management (QM11) element is now scored based on the QIP reviews performed by the EQRO.

Performance Measure Validation

- Amerigroup, Healthfirst, Horizon, United, as required by the NJ FamilyCare Managed Care Contract, submitted 24 HEDIS measures and 3 NJ Specific Performance Measures.
- The 3 NJ Specific Performance Measures included the AAP and CAP HEDIS measures stratified by dual, disabled and other low income; and a Preventive Dental measure.

Quality Improvement Projects

- Amerigroup, Healthfirst, Horizon and United submitted their final reports (with the exception of United for their Prenatal and Birth Outcomes), for the following QIP topics:
  - Dental Care
  - Lead Screening
  - Well Child Care
  - Prenatal Care and Birth Outcomes
- Amerigroup, Horizon and United submitted their progress reports in June and September for the Identification and Management of Adolescent Overweight and Obesity QIP.

- Healthfirst submitted a progress report in June and a final report in September for the Identification and Management of Adolescent Overweight and Obesity QIP, as they exited the NJ FamilyCare Managed Care Contract in 2014.
- WellCare submitted their Identification and Management of Adolescent Overweight and Obesity QIP proposal.
- Amerigroup, Horizon, United and WellCare submitted their proposals for the topic of Preterm Births.

Focused Studies

- Transportation Study: Utilization Analysis of Individual Trips
- Transportation Study: Rider Analysis
- Transportation Study: Member and Facility Perspective

Care/Case Management Audits

- Amerigroup, Horizon and United had Care Management audits in July and August.
- The audits focused on the following populations:
  - Enrollees in the Division of Developmental Disabilities (DDD)
  - Enrollees in the Division of Child Protection and Permanency (DCP&P)
  - Enrollees in the general population
- The following five metrics were evaluated:
  - Identification
  - Outreach
  - Preventive Services
  - Continuity of Care
  - Coordination of Services

EQRO Technical Reports

- The Quality Technical Report (QTR) for the activities performed by IPRO in contract year 3 included:
  - Summary of Key Findings for CMS Mandatory and Voluntary Activities
  - State Initiatives
  - Follow-up to QTR Recommendations from the Previous Year
  - Conclusions and Recommendations

EQRO Reports: January 2015 – December 2015

Assessment of MCO Operations

- Aetna, Amerigroup, Horizon, United and Wellcare all received a full assessment
- A total of 197 elements were subject to review
- Effective July 2014, DMAHS implemented the Managed Long Term Services and

Supports Program (MLTSS). Additional elements were added to evaluate those services specific to MLTSS.

Performance Measure Validation

- Amerigroup, Horizon, United and Wellcare as required by the NJ FamilyCare Managed Care Contract, submitted 24 HEDIS measures and 3 NJ Specific Performance Measures
- The 3 NJ Specific Performance Measures included the AAP and CAP HEDIS measures stratified by dual, disabled and other low income; and a Preventive Dental measure.

Quality Improvement Projects

- United submitted their final report on the Prenatal and Birth Outcomes QIP.
- Amerigroup, Horizon United and Wellcare submitted progress reports in June and September on their Identification and Management of Adolescent Overweight and Obesity and their Preterm Births QIPs.

Focused Studies

- Prenatal and Postpartum Care

Care/Case Management Audits

- Amerigroup, Horizon, United and WellCare had Care Management audits in July.
- The audits focused on the following populations:
  - Enrollees in the Division of Developmental Disabilities (DDD)
  - Enrollees in the Division of Child Protection and Permanency (DCP&P)
  - Enrollees in the general population
- The following five metrics were evaluated:
  - Identification
  - Outreach
  - Preventive Services
  - Continuity of Care
  - Coordination of Services

EQRO Technical Reports

- The Quality Technical Report (QTR) for the activities performed by IPRO in contract year 4 included:
  - Summary of Key Findings for CMS Mandatory and Voluntary Activities
  - State Initiatives
  - Follow-up to QTR Recommendations from the Previous Year
  - Conclusions and Recommendations

Attachment B
Quality and Monitoring Activities

EQRO Reports: January 2016 – December 2016
Assessment of MCO Operations • Scheduled for fall of 2016
Performance Measure Validation • Scheduled for June 2016
Quality Improvement Projects • Progress Reports scheduled for June and September 2016.
Focused Studies • Scheduled for spring/summer 2016.
Care/Case Management Audits • Scheduled for spring 2016.
EQRO Technical Reports • To be completed within 30 days post the completion of the last activity performed by IPRO for the first extension year.
EQRO MLTSS Reports: January 2015 – December 2015
Assessment of MCO Operations conducted, final reports due in 2016 • Aetna, Amerigroup, Horizon, United and WellCare all received a full assessment • A total of 197 elements were subject to review • Effective July 2014, DMAHS implemented the Managed Long Term Services and Supports Program (MLTSS). Additional elements were added to the 2015 assessment to evaluate those services specific to MLTSS. • The Annual Assessment for 2015 is available upon request.
Performance Measure Validation • This activity was added as an amendment to the State's existing EQRO contract. The EQRO was provided with the current performance measure outlines used by the MCOs for self-reporting. In 2016, the EQRO will develop PM specifications based on the State's outline for the MCOs to adhere to an initiate their validation of MCO data.
Quality Improvement Projects • MCOs submitted their project proposal submission on 'Falls Prevention' in September 2015
MLTSS Care Management Focused Studies • EQRO conducted the MLTSS Care Management Audits for year one of MLTSS as focus studies.

EQRO MLTSS Reports: January 2016 – December 2016
Assessment of MCO Operations • Scheduled for fall of 2016
MLTSS Performance Measure Validation • Complete the PM specifications for current measures and work with State to develop new PM specifications for MLTSS beginning 7/1/17. • Initiate validation process for the current measures reported by MCOs.
Quality Improvement Projects • Project Baseline – scheduled for June 2016 • Progress Reports (Year 1) – scheduled for September 2016.
Focused Studies • Obtain data through focus studies and calculate performance measures: o PM #13 – spring 2016
Care/Case Management Audits • Scheduled for late summer 2016.
Performance Measure Calculation • To be completed within 30 days post the completion of the MLTSS Care Management Audit for PM #8, #9, #9a, #10, #11, #12, #16 – early fall 2016

MLTSS Performance Measure Data Report Update

As the MCOs and DoAS have refined their system requirements for PM reporting, they submit corrected reports to the Office of MLTSS/QM. Corrections received as of April 1, 2016 are contained in the following tables in red, bold font.

PM # 7	Members offered a choice between institutional and HCBS settings
Data Source:	DoAS

Measurement Period	**July 2014**	**August 2014**	**Sept 2014**	**Oct. 2014**	**Nov. 2014**	**Dec. 2014**	**Jan. 2015**	**Feb. 2015**	**March 2015**	**April 2015**
Numerator	1372	1916	1923	1518	2266	**975**	**771**	**661**	**738**	**705**
Denominator	1739	2578	2653	1964	2833	1188	973	819	1094	1053
%	79	74	72	77	80	**82**	**79**	**81**	**67**	**67**

Attachment B
Quality and Monitoring Activities

Measurement Period	May 2015	June 2015	July 2015	August 2015	Sept 2015	Oct 2015	Nov 2015
Numerator	937	962	2566	1276	1195	1193	1246
Denominator	1257	1756	2708	2316	2286	2311	2314
%	75	55	95	55	52	52	54

PM # 19	Timelines for investigation of complaints, appeals, grievances (complete within 30 days)
Data Source:	MCO Table 3A and 3B Reports; DMAHS

1/1/15 – 3/31/15	A	B	C	D	E	TOTAL	4/1/15 – 6/30/15	A	B	C	D	E	TOTAL
Numerator	0	1	46	68	5	120	Numerator	0	3	22	36	5	66
Denominator	0	1	46	68	5	120	Denominator	0	3	23	36	5	67
%	0	100	100	100	100	100	*%*	0	100	96	100	100	99

Complaints (Table 3B)

1/1/15 – 3/31/15	A	B	C	D	E	TOTAL	4/1/15 – 6/30/15	A	B	C	D	E	TOTAL
Numerator	0	0	43	10	4	57	Numerator	0	1	97	7	3	108
Denominator	0	0	43	10	4	57	Denominator	0	1	98	7	3	109
%	0	0	100	100	100	100	*%*	0	100	99	100	100	99

PM # 20	Total # of MLTSS members receiving MLTSS services
Data Source:	MCO

7/1/14-9/30/14	A	B	C	D	E	TOTAL	10/1/14 – 12/31/14	A	B	C	D	E	TOTAL
Numerator	0	1466	4946	2817	687	9916	Numerator	0	1575	5160	3066	721	10522
Denominator	0	1813	5364	3073	694	10944	Denominator	0	2227	8451	3314	731	14723
%	0	80.9	92.2	91.7	98.9	90.6	*%*	0	70.7	61	92.5	98.6	71.5

PM # 21	MLTSS members transitioned from NF to Community
Data Source:	MCO – living arrangement file and client tracking system

Attachment B
Quality and Monitoring Activities

7/1/14-9/30/14	A	B	C	D	E	TOTAL	10/1/14 – 12/31/14	A	B	C	D	E	TOTAL
Numerator	0	**6**	0	0	0	**6**	Numerator	0	**17**	**21**	9	0	**47**
Denominator	0	**76**	31	16	2	**125**	Denominator	0	**142**	293	201	11	**647**
%	0	**7.9**	0	0	0	**4.8**	%	0	**12**	**7.2**	4.5	0	**7.3**

1/1/15 – 3/31/15	A	B	C	D	E	TOTAL	4/1/15 – 6/30/15	A	B	C	D	E	TOTAL
Numerator	0	**7**	**37**	**55**	2	**101**	Numerator	0	**7**	**45**	**16**	11	**79**
Denominator	0	**222**	1017	**586**	76	**1901**	Denominator	51	**260**	1512	**938**	179	**2940**
%	0	**3.2**	**3.6**	**9.4**	2.6	**5.3**	%	0	**2.7**	**3.0**	**1.7**	6.14	**2.7**

7/1/14 – 6/30/15	A	B	C	D	E	TOTAL
Numerator	0	**36**	**103**	**83**	13	**235**
Denominator	81	**603**	523	**1162**	179	**2548**
%	0	**6.0**	**19.7**	**7.1**	7.3	**9.2**

PM # 22	New NF admissions for MLTSS members (excluding previous fee for service residents defined SPC 60 with living arrangement of Nursing Home)
Data Source:	MCO – living arrangement file, prior auth. and/or client tracking system.

7/1/14 -6/30/15	A	B	C	D	E	TOTAL
Numerator	**1**	506	1739	537	262	**3045**
Denominator	113	3165	10297	4329	1419	19323
%	**0.9**	16	17	12.4	18.4	15.8

PM # 23	MLTSS members transitioned from NF to the community at any point during the preceding quarter who returned to the NF within 90 days
Data Source:	MCO – Living arrangement file, CM tracking and prior auth. System (r/o respite/rehab). MCO to identify how the dates were calculated.

7/1/14-9/30/14	A	B	C	D	E	TOTAL	10/1/14 – 12/31/14	A	B	C	D	E	TOTAL
Numerator	0	0	0	0	0	0	Numerator	0	**2**	6	0	0	**8**
Denominator	0	0	0	0	0	0	Denominator	0	**33**	**21**	9	0	**63**
%	0	0	0	0	0	0	%	0	**6.1**	**29**	0	0	**12.7**

1/1/15 – 3/31/15	A	B	C	D	E	TOTAL	7/1/2014-6/30/2015 (Year)	A	B	C	D	E	TOTAL
Numerator	0	1	1	2	0	4	Numerator	0.0	3.0	9.0	3.0	0.0	15.0
Denominator	0	7	37	55	2	101	Denominator	0.0	36.0	103.0	83.0	15.0	237.0
%	0	14.3	2.7	3.6	0	4	**%**	0.0	8.33	9.0	3.6	0.0	6.3

PM # 26	# of hospitalizations per MLTSS HCBS members
Data Source:	MCO paid and denied (excluding duplicate claims) claims according to logic for the MCO encounter Categories of Services (separate file)

7/1/14-9/30/14	A	B	C	D	E	TOTAL	10/1/14 – 12/31/14	A	B	C	D	E	TOTAL
Numerator	10	379	341	155	110	985	Numerator	0	212	442	147	147	948
Denominator	0	5000	17078	9234	1893	33205	Denominator	0	5703	18535	9417	1974	35629
%	0	7.6	2	1.7	5.8	3	%	0	3.7	2.4	1.6	7.4	2.7

PM # 27	# of hospitalizations of NF members (not unique members)
Data Source:	MCO paid claims and denied claims (excluding duplicate claims) according to logic for the MCO encounter Categories of Services (separate file)

7/1/14-9/30/14	A	B	C	D	E	TOTAL	10/1/14 – 12/31/14	A	B	C	D	E	TOTAL
Numerator	0	4	0	0	1	5	Numerator	0	14	24	17	3	58
Denominator	0	18	12	19	2	51	Denominator	0	172	664	342	17	1195
%	0	22.2	0	0	50	9.8	%	0	8.1	3.6	5.0	17.6	4.9

PM # 28	# of readmissions of MLTSS HCBS members (not unique members) to the hospital within 30 days
Data Source:	MCO paid and denied claims (exclude denials for duplicate submissions) for numerator and 834 file for denominator.

7/1/14-9/30/14	A	B	C	D	E	TOTAL	10/1/14 – 12/31/14	A	B	C	D	E	TOTAL
Numerator	0	5	15	64	29	113	Numerator	0	9	31	93	26	159
Denominator	0	160	341	155	108	764	Denominator	0	212	442	147	147	948
%	0	3.1	4.4	41	26.8	14.8	%	0	4.3	7	63.2	17.7	16.8

PM # 29	# of readmissions of MLTSS NF members (not unique members) to the hospital within 30 days

Numerator:	# of readmissions of MLTSS NF members (not unique members) to the hospital within 30 days from date of discharge (service through date and new service start date) during the measurement period
Denominator:	# of hospitalizations (unique combination of member-provider-service date) of MLTSS NF members (not unique members) during the measurement period
Data Source:	MCO paid claims and denied claims (exclude denials for duplicate submissions) for numerator and 834 file for denominator.
Measurement Period:	Monthly data reported Quarterly/Annually Lag Report Due: 240 days after quarter and year.

7/1/14-9/30/14	A	B	C	D	E	TOTAL	10/1/14 – 12/31/14	A	B	C	D	E	TOTAL
Numerator	0	0	**0**	0	1	**1**	Numerator	0	2	5	7	0	14
Denominator	0	0	**0**	0	1	**1**	Denominator	0	14	25	17	**3**	**59**
%	0	0	**0**	0	100	**100**	%	0	14.3	20	41.2	0	**23.7**

PM # 30	# of ER utilization by MLTSS HCBS members (not unique members)
Data Source:	MCO paid claims and denied claims (exclude denials for duplicate submissions) for numerator and 834 file for denominator.

7/1/14-9/30/14	A	B	C	D	E	TOTAL	10/1/14 – 12/31/14	A	B	C	D	E	TOTAL
Numerator	0	302	655	388	116	1461	Numerator	0	**366**	751	306	162	**1585**
Denominator	0	5000	17078	9234	1893	33205	Denominator	0	**5703**	**18535**	9417	1974	**35629**
%	0	6	3.8	4.2	6.1	4.4	%	0	**6.4**	4.1	3.2	8.2	**4.4**