NJ FamilyCare Update

Meghan Davey, Director
Division of Medical Assistance and Health Services
NJ Hospital Association
March 6, 2018

January 2018 Enrollment Headlines

1,758,274 Overall Enrollment

2,138 (0.1%) Net Increase Over December 2017
10,622 (0.6%) Net Decrease Over January 2017

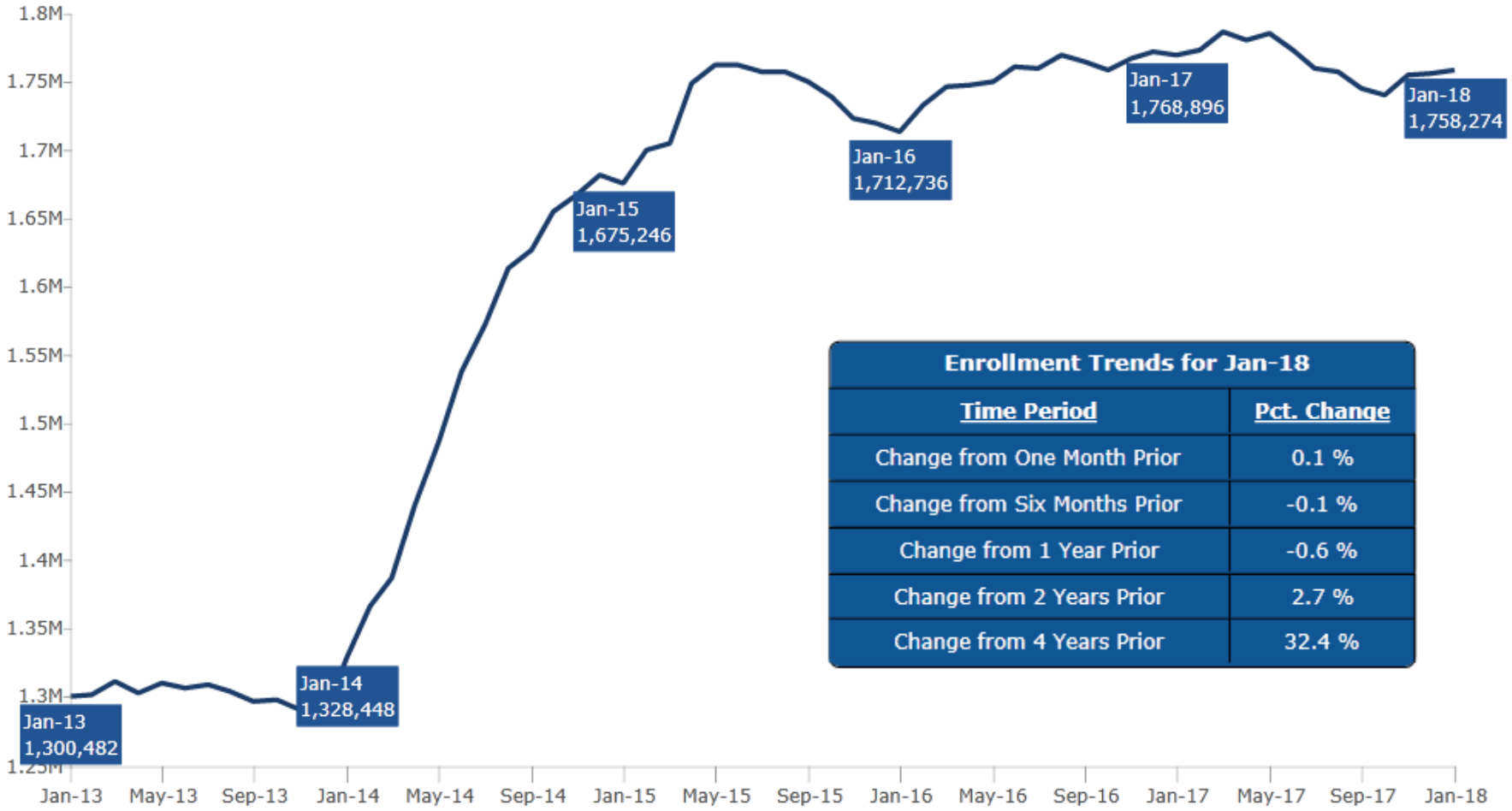
94.0% of All Recipients are Enrolled in Managed Care

Source: Monthly eligibility statistics released by NJ DMAHS Office of Research available at http://www.nj.gov/humanservices/dmahs/news/reports/index.html; Dec. eligibility recast to reflect new public statistical report categories established in January 2014

Notes: Net change since Dec. 2013; includes individuals enrolling and leaving NJFamilyCare. Does not include retroactivity.

NJFAMILYCARE Affordable health coverage. Quality care.

Overall Enrollment



Enrollment Trends for Jan-18	
Time Period	Pct. Change
Change from One Month Prior	0.1 %
Change from Six Months Prior	-0.1 %
Change from 1 Year Prior	-0.6 %
Change from 2 Years Prior	2.7 %
Change from 4 Years Prior	32.4 %

Source: SDW MMX Snapshot Universe, accessed 2/5/18.

Notes: Includes all recipients eligible for NJ DMAHS programs at any point during the month

NJ FAMILYCARE
Affordable health coverage. Quality care.

January 2018 Eligibility Summary

Total Enrollment: 1,758,274

Expansion Adults	543,986	30.9%
Other Adults	107,582	6.1%
Medicaid Children	601,205	34.2%
M-CHIP Children	90,678	5.2%
CHIP Children	114,097	6.5%
Aged/Blind/Disabled	300,726	17.1%

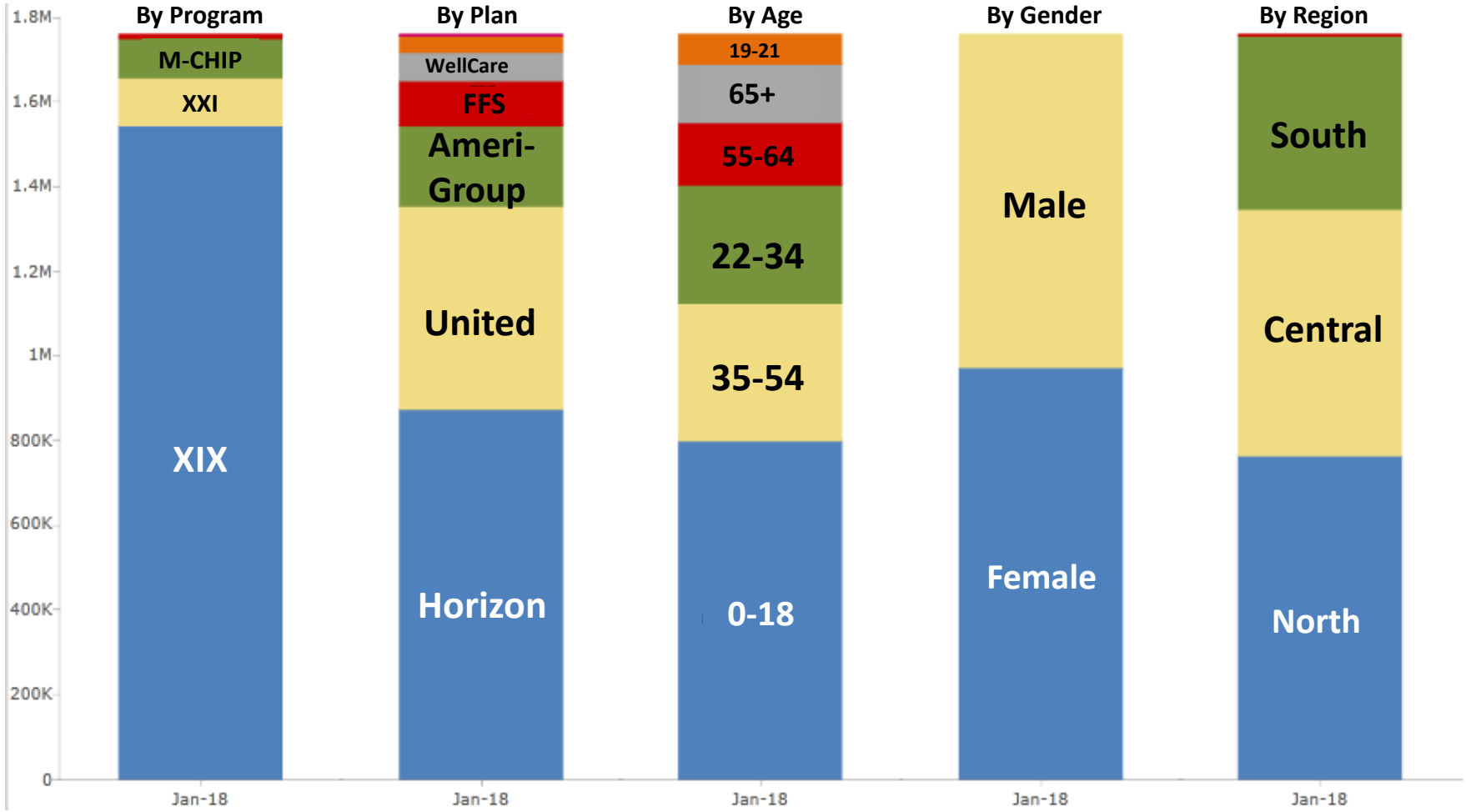
Source: Monthly eligibility statistics released by NJ DMAHS Office of Research available at http://www.nj.gov/humanservices/dmahs/news/reports/index.html;

Notes: Expansion Adults consists of 'ABP Parents' and 'ABP Other Adults'; Other Adults consists of 'Medicaid Adults'; Medicaid Children consists of 'Medicaid Children', M-CHIP' and 'Children's Services'; CHIP Children consists of all CHIP eligibility categories; ABD consists of 'Aged', 'Blind' and 'Disabled'.

NJ FAMILYCARE
Affordable health coverage. Quality care.

NJ FamilyCare Enrollment "Breakdowns"

Total Enrollment: 1,758,274



Source: NJ DMAHS Shared Data Warehouse Snapshot Eligibility Summary Universe, run for January 2018.

Notes: By Region: North= Bergen, Essex, Hudson, Morris, Passaic, Sussex & Warren. Central= Hunterdon, Mercer, Middlesex, Monmouth, Ocean, Somerset & Union. South= Atlantic, Burlington, Camden, Cape May, Cumberland, Gloucester & Salem. Region does not add up to total enrollment due to small "unknown" category that is not displayed. *M-CHIP: Individuals eligible under Title XIX, but paid with CHIP (Title XXI) federal funds.

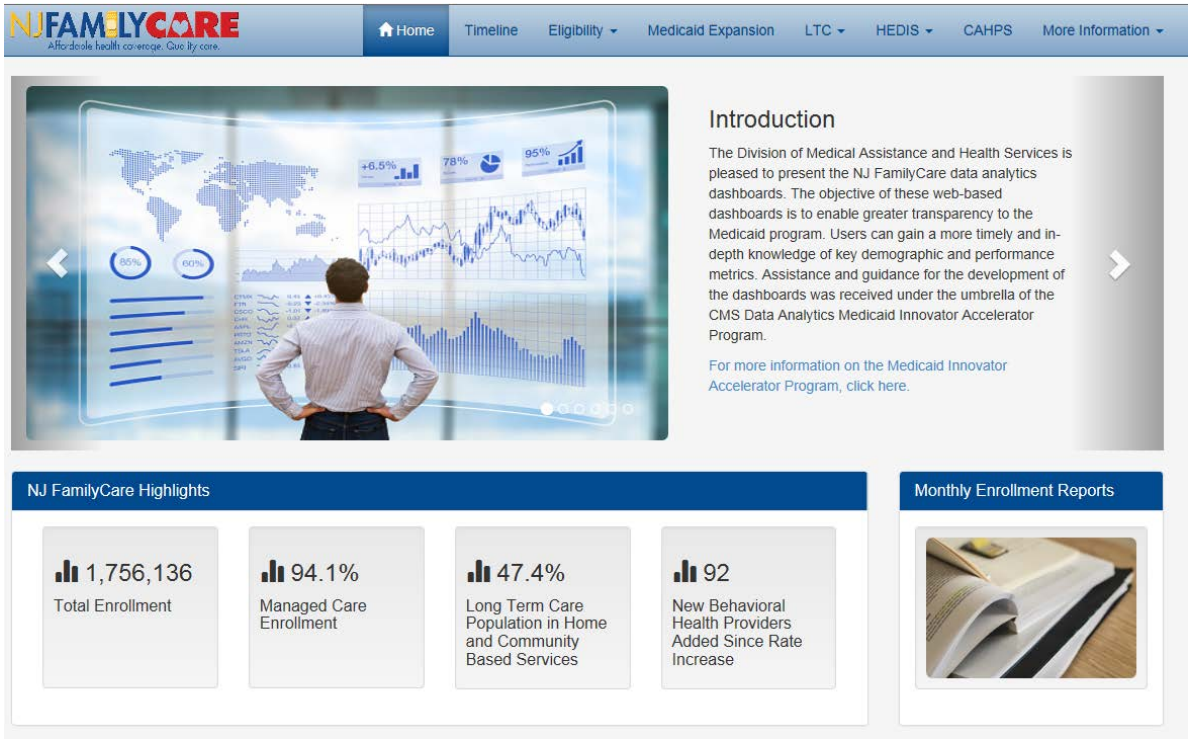
NJ FAMILYCARE Affordable health coverage. Quality care.

Aged Blind Disabled Program Online Application

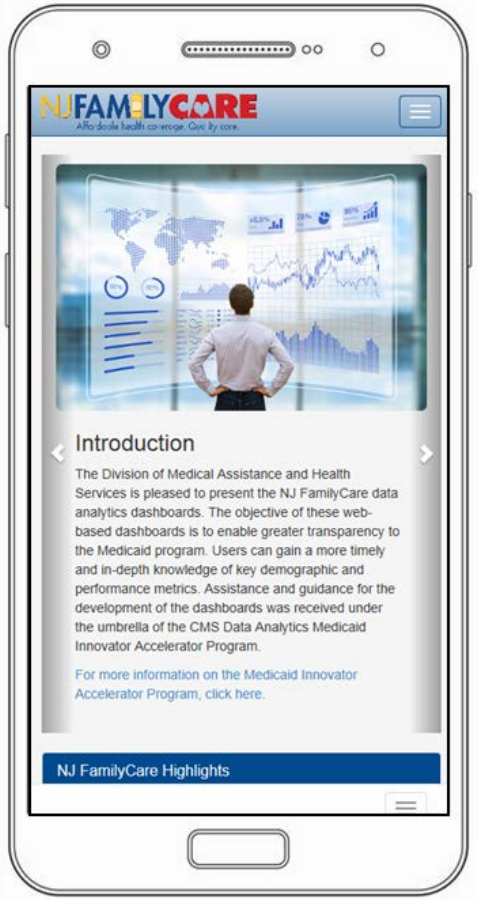
- Launched December 2017 (1,300 online applications to date)
- Applications managed online
- More online verifications (AVS and SSA Hub)
- Train and certify Assistors such as ADRC, SHIP agencies
- Worker Portal enhancements: documents attached and uploaded
- Implementing best practices with the CWAs

New! Data Analytics
NJ FamilyCare Dashboards

Public Interactive Dashboards

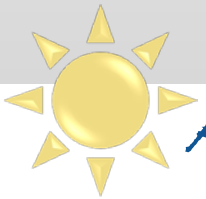


Mobile Friendly



NJ FamilyCare Public Interactive Dashboards

Eligibility
CAHPS
HEDIS
Long Term Care



Available Summer 2018

Inpatient Hospital Services

Effective 7/1/18, all inpatient hospitalizations shall be the responsibility of the Managed Care Organizations (MCOs)

- Includes recipients admitted with a psychiatric diagnosis
- MCOs shall coordinate discharges to community services

D SNP/DDD/MLTSS after 7/1/18

All 3 eligibility groups will cover ALL BH services EXCEPT targeted case management:

- **Behavioral Health Homes (BHHs)**
- **Certified Community Behavioral Health Clinics (CCBH)**
- **Integrated Case Management Services (ICMS)**
- **Program for Assistance in the Transition from Homelessness (PATH)**
- **Community Support Services (CSS)**
- **Programs of Assertive Community Treatment (PACT)**

D SNP/DDD/MLTSS after 7/1/18

All 3 eligibility groups will cover ALL SUD services:

- **Assessment**
- **Outpatient Therapy**
- **SUD Intensive Out-Patient (IOP)**
- **SUD Partial Care**
- **Ambulatory Detox**
- **SUD Residential**
- **Medication Assisted Treatment (MAT)**

NJ FamilyCare
Managed Care Update

Carol Grant

Deputy Director

Division of Medical Assistance and Health Services

NJFAMILYCARE
Affordable health coverage. Quality care.

Managed Care Contract Changes

July Managed Care Contract

- Managed Care Rule and other CMS Requirements
- Highlights of the changes on the next few slides; Managed Care Contract available online at : http://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-contract.pdf

Highlights of MCO Contract Changes

Article 3 – Managed Care Management Information Systems

Coordination of Benefits – Managed Care Rule requires MCOs to establish their own COBA with Medicare (will become operational when NJ launches new MMIS) and participate in automated claims crossover process.

Article 4 – Provision of Health Care Services

In Lieu Of Services moved from the Financial Reporting Manual to the main contract; In Lieu of Services may be provided to members outside of the Medicaid benefit. These require DMAHS and CMS approval.

- The following are included in the July 17 approved contract.
  - OTC medications
  - Smoking Cessation
  - Residential BH/SUD treatment in an IMD for 15 days or less
  - LTAC treatment
  - Residential Modifications
  - Assistance with finding or keeping housing (not rent)

Article 4 – Provision of Health Care Services, continued

- EPSDT recipients aging out of EPSDT may be assessed for MLTSS up to 6 months before their 21st birthday
- CMS required changes to what formulary information and in what format MCOs must post to their websites
- MCOs must send DMAHS on an annual basis (changed from w/in 45 days of request) a detailed description of its drug utilization review activities
- Expanded State requirements for MCO reporting of drug encounters and covered outpatient drugs so that the State can apply for drug rebates
- Contract now states specific federal law requirements for Hospice Care provided in a NF or SCNF
  - at least 95% of the of the rate that would have been paid by the State for facility services in the facility for the individual.
- MCO's MLTSS Consumer Advisory Committee must include representation by MLTSS population participants or their representatives and case managers. Must address issues related to MLTSS. Must forward results and f/u items to DMAHS quarterly.

Article 4 – Provision of Health Care Services, continued

- **Appeals process** changes resulting from new Managed Care Rule. Rule permits two levels of appeal, an Internal MCO appeal and once adjudicated, an appeal for eligible members through the Fair Hearing Process. For some services, an appeal may be tiled with the Independent Utilization Review Organization (IURO) at DOBI. A member has 60 days from the date of the initial denial to request an internal appeal. MCOS have 30 days (72 hours for expedited appeals) to reach a decision on internal appeals. The member then has 60 days to request an IURO appeal and up to 120 days from the outcome of the MCO internal appeal to request a state fair hearing. The time frame is the same with or without the IURO. As before members have the opportunity for continuity of benefits while their appeal is pending when there is an adverse determination of services the member has been receiving on a regular basis. After the initial denial, benefits will continue automatically if the member requests an appeal within 10 calendars of the Notification Letter or on or before the last day of the original authorization, whichever is later. After the internal appeal, benefits will continue if the member requests an IURO appeal, if requested within 10 calendar data of the Notification Letter following the outcome of the internal appeal in the same manner as with the Internal Appeal.

- **Continuation of Benefits during a State Fair Hearing Appeal** – to have benefits continue, a member must make their request in writing within 10 calendar days of the Notification Letter following the internal appeal, on or before the last day of the original authorization whichever is later. The prior process allowed continuation of benefits to be requested within 20 calendar days, This is no longer permitted. As in the prior process, by CMS requirement, members may be required to pay for the cost of continued services if the Fair Hearing is not resolved in the member's favor.

Article 4 – Provision of Health Care Services, continued

MCO must mail notice of adverse benefit determination to Member by date of action if:

- Member has died
- Member has requested, in writing, service termination/reduction
- Member has been admitted to an institution where he/she is no longer eligible for NJFC
- Member's address is unknown – mail returned without forwarding address
- Member is accepted for Medicaid services outside of NJ
- A change in LoC is prescribed by Member's physician
- Notice involves adverse determination regarding preadmission screening (section 1919(e)(7) of the Act.
- Transfer or discharge from a facility will occur in an expedited manner

Article 4 – Provision of Health Care Services, continued

- MCO is not precluded from establishing measures to maintain quality of services and control costs, consistent with MCO's responsibilities to members
- BH providers should be listed in online directory by service descriptions (State requirement):
  - Acute Partial Hospitalization Mental Health/Psychiatric Partial Hospitalization
  - Adult Mental Health Rehabilitation (AMHR)
  - Inpatient Psychiatric Hospital Care
  - Independent Practitioner(s) (Psychiatry, Psychiatry; NP Psychiatric MH; Psychiatry; Neurology (Osteopaths Only); Psychologist)
  - Medication Monitoring
  - Opioid Treatment Services
  - Outpatient Mental health Hospital
  - Outpatient Mental Health Independent Clinic
  - Partial Care

Article 4 – Provision of Health Care Services, continued

- Managed Care Final Rule requires MCO's, when building Provider Networks, to consider:
  - How many NJ FamilyCare beneficiaries may enroll
  - The expected utilization of services, given the characteristics and health care needs of the specific populations enrolled with the Contractor
  - The numbers and types (their training, experience and specialization) of Providers required to provide the required services
  - The numbers of network Providers who are not accepting new NJ FamilyCare patients
- AWP extended through June 2018.
- AWQP section added
- Article 4.11 provides DMAHS with authority to conduct enhanced readiness reviews for significant and material MCO changes impacting members or providers. MCOs were instructed on submission criteria, processing protocol, and review timeframes. MCO's are not permitted to implement a proposed change without DMAHS approval.

Article 7 - Terms and Conditions

- Required each MCO to establish a dedicated Housing Specialist responsible for:
    - Identifying, securing and maintaining community-based housing for MLTSS Members
    - Acting as a liaison with DMAHS to receive training and capacity building assistance

Article 8 – Financial Provisions

- Medical Loss Ratio section
    - Replaced with language consistent with the Managed Care Final Rule.
    - New MLRs are 85% for non-MLTSS premium groups and 90% for all MLTSS premium groups . This measure is active and the Contract language is now consistent with MCFR.

Article 9 – Managed Long Term Services and Supports

- Expanded procedures for Member voluntary withdrawal from MLTSS and Disenrollment for non-compliance at MCO request. Defined MCO counseling responsibilities and risks to Members

- Expanded on procedures for screening potential MLTSS Members

- Expanded explanation to Member of MCO Care Management requirements and procedures

- Defined Essential Elements for person-centered plan of care:
  - Member demographics
  - Member Goals
  - Member's assessed needs
  - Service and support needs
  - Medical review
  - Caregiver's support needs
  - Member rights and responsibilities
  - Special instructions/comments

Article 9 – Managed Long Term Services and Supports, continued

- **Changes were made to the MLTSS Performance Measures**. Some were revised to provide further clarity or refine the data collected, some measures were discontinued, and others were further stratified to provide more detailed information.
  - Performance Measure #39 and #40 were further stratified to capture number of MLTSS members with substance only; mental illness only; or members with substance abuse and mental illness.
  - New Performance Measures were introduced to capture information concerning the follow-up after Emergency Department visit for mental illness or alcohol and other drug dependence (stratified for the HCBS and NF population)

- **Changes to NJ FamilyCare Health Plan Benefit Coverage** **(effective with the July 1, 2018 Contract):**
  - Behavioral Health coverage for BNJFC beneficiaries enrolled in Fully Integrated Dual Eligible Special Needs Plans (FiDE SNP) and DDD MCO members will be aligned with those for MLTSS members. The benefit plan for these groups will include all mental health benefits and will be expanded to include coverage for all NJFC covered substance use disorder (SUD) services for MLTSS, DSNP and DDD Managed Care members.
  - In addition, all admissions to a general acute care hospital including admissions to a psychiatric unit will be the responsibility of the MCO. This includes all acute care hospitals and psychiatric units contained within the Hospital. These changes are not limited to MLTSS, FIDE SNP and DDD members and are effective July 1, 2018.

Continuity of Care

Geralyn Molinari
Director, Provider Relations
Division of Medical Assistance and Health Services

NJFAMILYCARE
Affordable health coverage. Quality care.

Continuity of Care

Definition: The plan of care for an enrollee that should assure progress without unreasonable interruption

The Contractor shall ensure continuity of care and full access to primary, behavioral, specialty, MLTSS and ancillary care as required under this contract and access to full administrative programs and support services offered by the Contractor for all its lines of business and/or otherwise required under this contract.

Source: Article 2.B of the July 2017 NJ FamilyCare Managed Care Contract

Prior Authorization Guidelines for MLTSS

New Member no existing Plan of Care	Member transitions to MCO with existing Plan of Care for LTC
MCO must prior-authorize service	MCO must honor continuity of care parameter of contract
Provider must be in Network with MCO and/or have a single case agreement to serve member	MCO and Provider must set up SCA or join network. Approved services as per existing plan will be reimbursed until new plan of care established

Cost Share Overview

Calculation of Cost Share

At the time of eligibility determinations, annual renewals, and renewals based on changes in circumstance, the CWAs are required to create and send PR forms to LTSS providers and Medicaid LTSS beneficiaries or their representatives in order to notify them of their payment responsibilities.

NJ FamilyCare
Cost Share Patient Pay Liability (PPL)

County Welfare Agency (CWA)	Calculates Cost share
PR- 1	Nursing Facility
PR-2	Assisted Living
PR-3 Currently paper forms are used – cost share is paid directly to state	HCBS in private home

Calculation of Cost Share

Cost Share/PPL payments begin with the first month that an individual receives LTSS regardless of whether they are a MCO member or Medicaid FFS enrolled.

Cost Share/PPL amounts may temporarily be reduced to $0 during periods when a beneficiary is making payments for pre-eligibility medical expenses (PEME) or if the CWA determines there are allowable expenses for the month of admission or month of discharge.

The CWA will temporarily update PR forms when these situations occur.

If a provider has not received the PR information and the resident has been eligible for LTC for greater than 30 days, the provider should contact the state's County Operation Unit.

County Operation Unit: 609-588-2556

Deduction of Cost Share

FFS member

- The Cost Share/PPL is collected monthly from the beneficiary by the provider. FFS claims submitted by a LTSS provider are reduced by the member's Cost Share/PPL.
- Nursing facilities, the state deducts the amount based on the PR-1 information identified on the claim.
- Assisted Living claims, the Provider must manually deduct the Cost Share/PPL amount from the FFS claim based on the PR-2 form.

MCO enrolled MLTSS member

- MCO enrolled members -State deducts PR amount from MCO capitation and the MCO reduces claim by amount of Cost Share identified in E-mevs

MCO enrolled member – not in MLTSS

- MCO enrolled members -PR amount **is not deducted** from MCO capitation. Provider must return Cost Share amount to State as MCO will not reduce PR amount

Reconciliation of Cost Share Overpayment

A Medicaid LTSS Member's Cost Share/PPL may exceed the monthly amount billed by the facility. In situations where the cost share exceeds amount paid by Medicaid for LTC the following process should be followed by Provider to return funds to the state:

- **Fee-for-Service Members** Provider must return the Cost Share/PPL overpayment to the State of New Jersey. The provider must include a letter with a detailed explanation for the refund and a contact information regarding refund.
- **Managed Care MLTSS enrolled members:** The MCO will adjust funds paid to the Provider – if an overpayment is not addressed in MCO deductions the Provider will submit refund to the State of New Jersey:

Checks sent regular mail should be sent to:

Payee: Treasurer, State of New Jersey
Mail To: Division of Revenue
Lockbox 656
200 Woolverton Avenue, Bldg. 20
Trenton, NJ 08646

Provider Resources
Office of Managed Health Care- DMAHS

Addresses provider inquiries and/or complaints as it relates to Managed Care Organization contracting, credentialing, reimbursement, authorizations and appeals, and conducts complaint resolution tracking/reporting

- *If the provider has a specific question regarding payment for a Managed Medicaid member, they must provide detail regarding the claim.*
- *E-mail this detailed information securely to* ***mahs.provider-inquiries@dhs.state.nj.us.***
- *If multiple claims are impacted, the information should be summarized using an Excel file. (Keep in mind, all information must be sent securely, if it includes Protected Health Information (PHI)).*

DMAHS Provider Relations Inquiry Information
Provider Relations Inquiry Request form – multiple cases

DHS Website Information

Link to Individual MCO Sites:

http://www.state.nj.us/humanservices/dmahs/info/resources/hmo/

-Contact phone number for Member and Provider Relations

-Link for MCO Member Manual is posted

-Provider Manual and Quick Reference Guides (see handout)

Link to Human Services Website - MLTSS:

http://www.state.nj.us/humanservices/dmahs/home/mltss_resources.html

-Provider Frequently Asked Questions (FAQ) posted

-Provider Education PowerPoints

Managed Long Term Services and Supports

Elizabeth Brennan
Assistant Division Director
Division of Aging Services

NJFAMILYCARE
Affordable health coverage. Quality care.

Long Term Care (LTC) and Managed Long Term Services & Supports (MLTSS)

NJFAMILYCARE
Affordable health coverage. Quality care.

January 2018 LTC Headlines

76.7% of NJFC Long Term Care Population is Enrolled in MLTSS

48.5% of the NJ FamilyCare LTC Population is in Home and Community Based Services*

Prior Month = 48.0%; Start of Program = 28.9%

Number of Recipients Residing in Nursing Facilities is Down Over 1,000 Since the July 2014 Implementation of MLTSS**

* Methodology used to calculate completion factor for claims lag in the 'NF FFS Other' category (which primarily consists of medically needy and rehab recipients) has been recalculated as of December 2015 to account for changes in claims lag; this population was being under-estimated.

** Nursing Facility Population includes all MLTSS recipients and all FFS recipients (grandfathered, medically needy, etc.) physically residing in a nursing facility during the reporting month.

NJFAMILYCARE Affordable health coverage. Quality care.

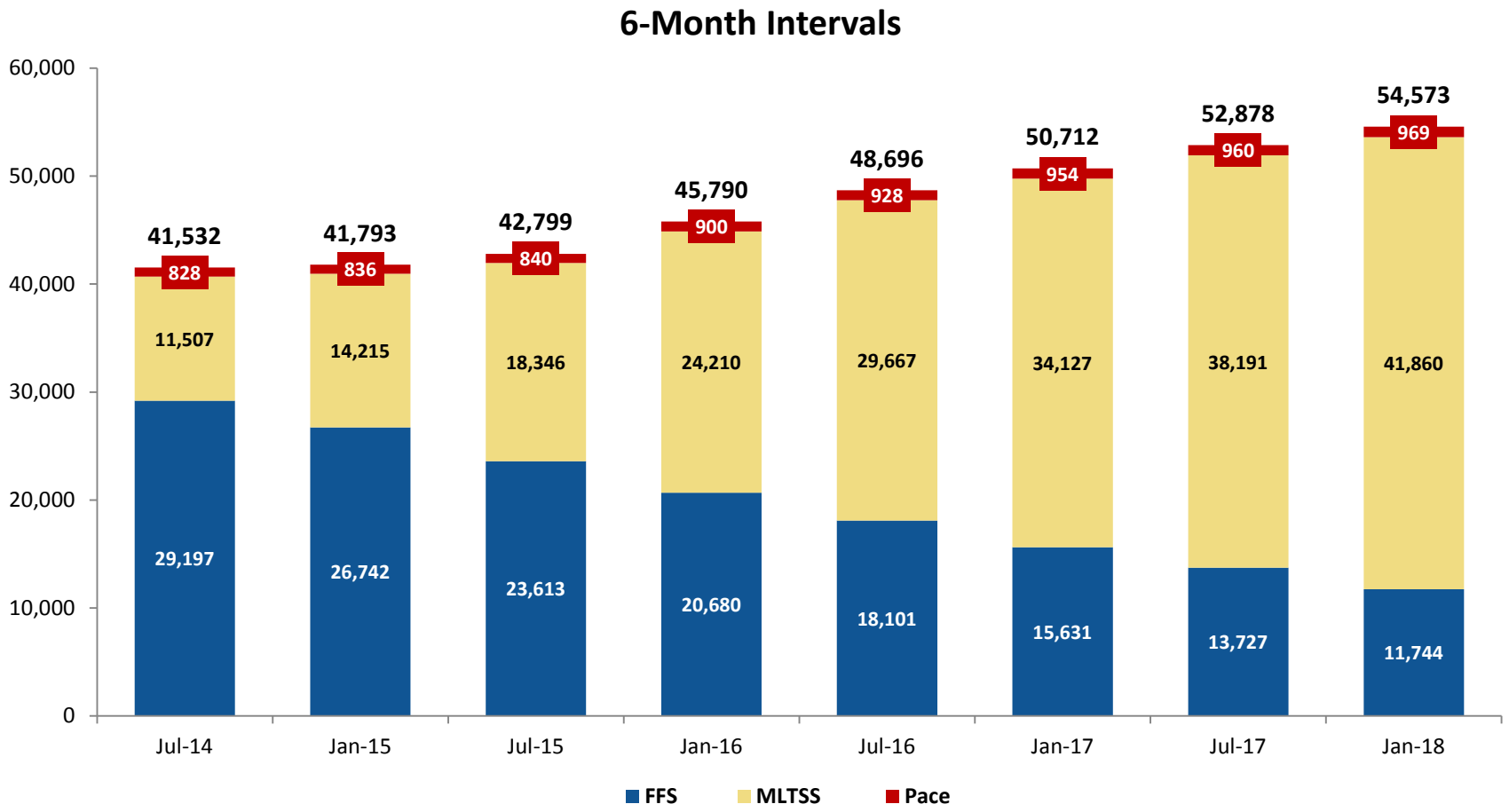
Long Term Care Recipients Summary – January 2018

Total Long Term Care Recipients*	**54,573**

Managed Long Term Support & Services (MLTSS)	**41,860**
MLTSS HCBS	22,367
MLTSS Assisted Living	3,094
MLTSS NF	16,112
MLTSS SCNF (Upper & Lower)	287
Fee For Service (FFS/Managed Care Exemption)	**11,744**
FFS Nursing Facility (NF)	8,540
FFS Skilled Nursing Facility (SCNF)	255
FFS NF – Other**	2,949
PACE	**969**

Source: NJ DMAHS Shared Data Warehouse Regular MMX Eligibility Summary Universe, accessed 2/6/2018.
Notes: Information shown includes any person who was considered LTC at any point in a given month and includes individuals with Capitation Codes 79399, 89399, 78199, 88199, 78399, 88399, 78499 & 88499, Special Program Codes 03, 05, 06, 17, 32, 60-67, Category of Service Code 07, or MC Plan Codes 220-223 (PACE).
* 'FFS NF – Other is derived based on the prior month's population with a completion factor (CF) included to estimate the impact of nursing facility claims not yet received. Historically, 63.56% of long term care nursing facility fee-for-service claims are received one month after the end of a given service month.
** Includes Medically Needy (PSC 170,180,270,280,340-370,570&580) recipients residing in nursing facilities and individuals in all other program status codes residing in nursing facilities that are not within special program codes 60-67 or capitation codes 79399, 89399, 78199, 88199, 78399, 88399, 78499 & 88499.

Long Term Care Population: FFS-MLTSS Breakdown

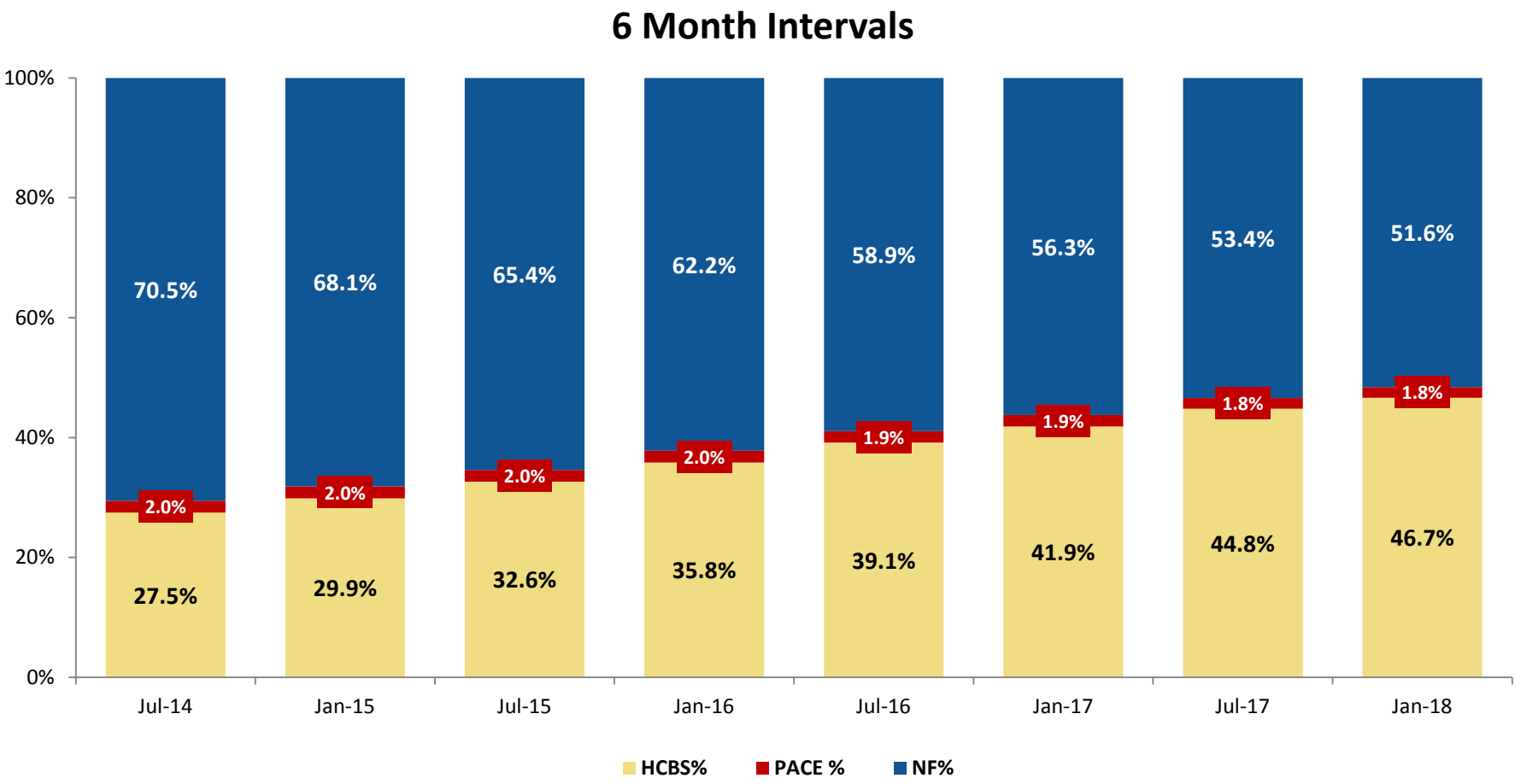


Source: Monthly Eligibility Universe (MMX) in Shared Data Warehouse (SDW), accessed on 2/6/2018.

Notes: Information shown includes any person who was considered LTC at any point in a given month based on: Capitation Codes 79399, 89399, 78199, 88199, 78399, 88399, 78499 & 88499, Special Program Codes 03, 05, 06, 17, 32, 60-67, Category of Service Code 07, or MC Plan Codes 220-223 (PACE). All recipients with PACE plan codes (220-229) are categorized as PACE regardless of SPC, Capitation Code, or COS. MLTSS includes all recipients with the cap codes listed above. FFS includes SPC 65-67 and all other COS 07, which is derived using the prior month's COS 07 population with a completion factor (CF) included to estimate the impact of nursing facility claims not yet received. Historically, 90.76% of long term care nursing facility claims and encounters are received one month after the end of a given service month.

NJFAMILYCARE Affordable health coverage. Quality care.

MLTSS Rebalancing

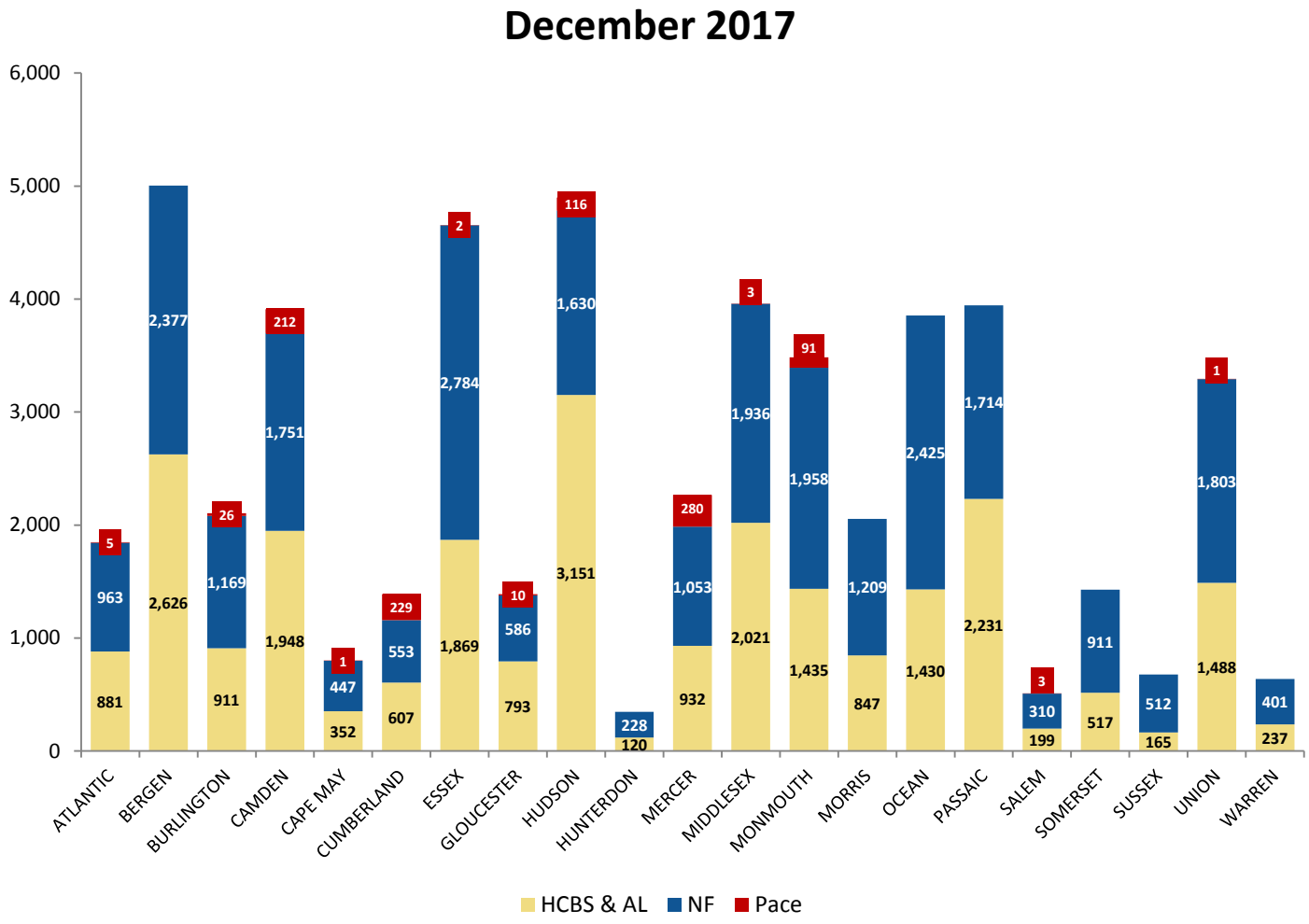


Source: Monthly Eligibility Universe (MMX) in Shared Data Warehouse (SDW), accessed on 2/6/2018.

Notes: All recipients with PACE plan codes (220-229) are categorized as PACE regardless of SPC, Capitation Code, or COS.
Home & Community Based Services (HCBS) Population is defined as recipients with a special program code (SPC) of 60 (HCBS) or 62 (HCBS – Assisted Living) OR Capitation Code 79399,89399 (MLTSS HCBS) with no fee-for-service nursing facility claims in the measured month.
Nursing Facility (NF) Population is defined as recipients with a SPC 61,63,64,65,66,67 OR CAP Code 78199,88199,78399,88399,78499,88499 OR a SPC 60,62 with a COS code 07 OR a Cap Code 79399,89399 with a COS code 07 OR a COS 07 without a SPC 60-67 (Medically Needy &/or Rehab). COS 07 count w/out a SPC 6x or one of the specified cap codes uses count for the prior month and applies a completion factor (CF) due to claims lag (majority are medically needy recipients).

NJFAMILYCARE
Affordable health coverage. Quality care.

Long Term Care Population by County



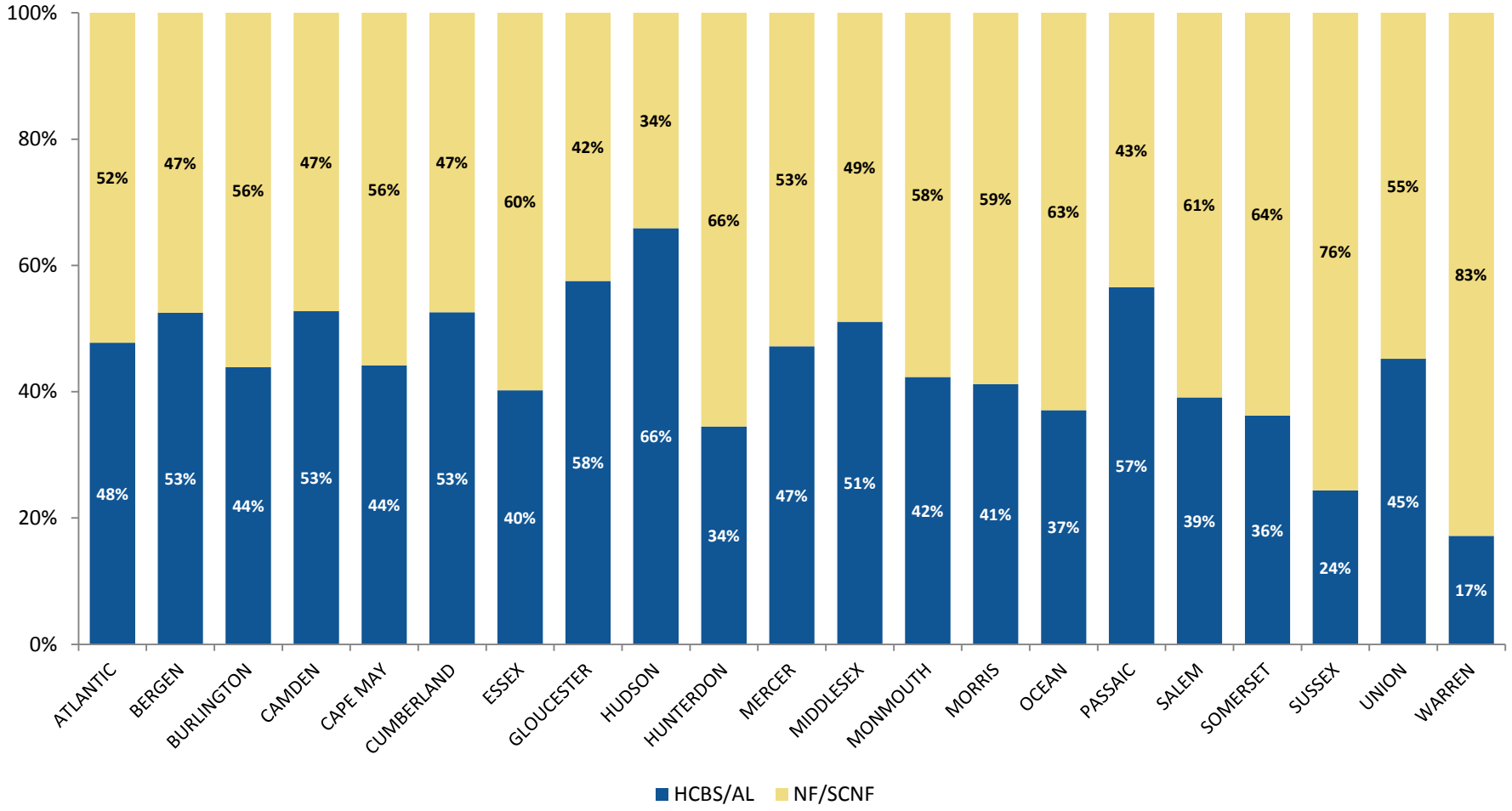
COUNTY	NJ FamilyCare	LTC
ATLANTIC	4.1%	3.5%
BERGEN	6.6%	9.5%
BURLINGTON	3.6%	4.0%
CAMDEN	8.2%	7.5%
CAPE MAY	1.1%	1.5%
CUMBERLAND	2.8%	2.6%
ESSEX	13.5%	8.9%
GLOUCESTER	2.7%	2.6%
HUDSON	10.3%	9.3%
HUNTERDON	0.6%	0.7%
MERCER	4.1%	4.3%
MIDDLESEX	7.7%	7.5%
MONMOUTH	4.7%	6.6%
MORRIS	2.5%	3.9%
OCEAN	7.5%	7.3%
PASSAIC	8.9%	7.5%
SALEM	0.9%	1.0%
SOMERSET	1.9%	2.7%
SUSSEX	0.9%	1.3%
UNION	6.6%	6.3%
WARREN	0.9%	1.2%

Source: DMAHS Shared Data Warehouse Monthly Eligibility Universe, accessed 2/6/18.

Notes: Information shown includes any person who was considered LTC at any point in a given month, based on CAP Codes 79399, 89399, 78199, 88199, 78399, 88399, 78499 & 88499, Special Program Codes 60-67, Category of Service Code 07, or MC Plan Codes 220-223 (PACE). * Uses count for the prior month due to claims lag in identifying medically needy (PSC 170,180,270,280,340-370,570&580) and other non-exempt fee-for-service nursing facility recipients.

NJFAMILYCARE Affordable health coverage. Quality care.

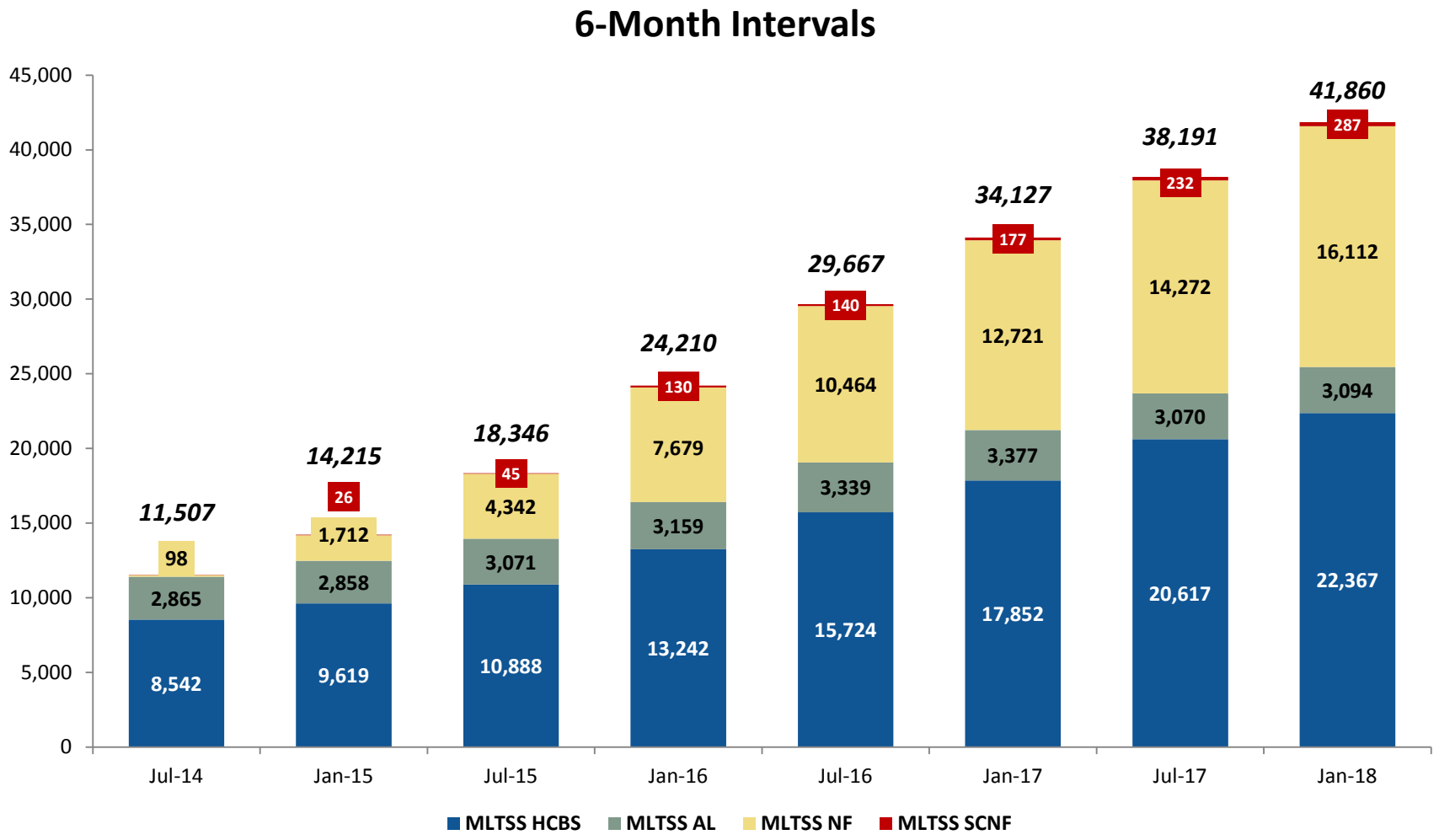
Rebalancing Long Term Care, by County



Source: NJ DMAHS Shared Data Warehouse Regular MMX Eligibility Summary Universe, accessed 2/6/2018.
Notes: Information shown includes any person who was considered LTC at any point in a given month and includes individuals with Capitation Codes 79399, 89399, 78199, 88199, 78399, 88399, 78499 & 88499, Special Program Codes 03, 05, 06, 17, 32 (prior to 7/1/14) or SPC 60-67 (post 7/1/14), Category of Service Code 07, or MC Plan Codes 220-223 (PACE). County distinction is based on recipient's county of residence in the given month.

NJ FAMILYCARE Affordable health coverage. Quality care.

MLTSS Population by Setting

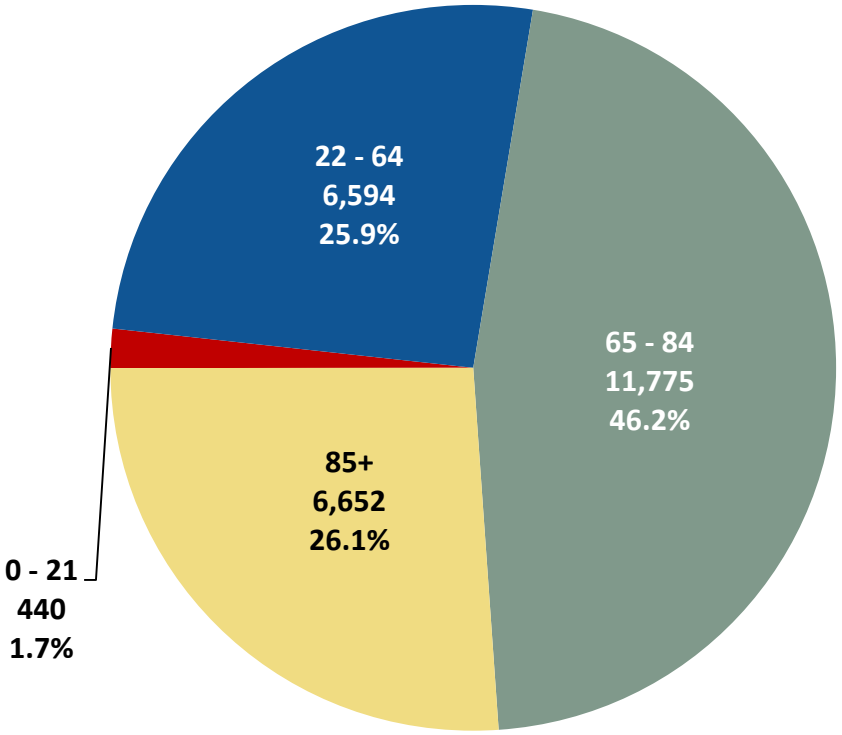


Source: DMAHS Shared Data Warehouse Monthly Eligibility Universe, accessed 2/6/2018.

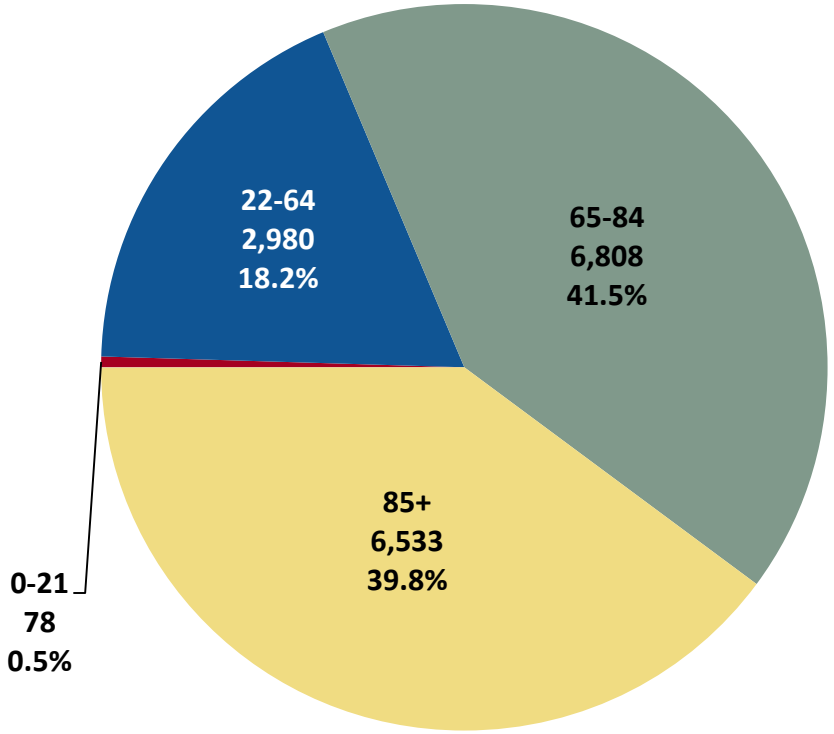
Notes: Includes all recipients in Capitation Codes 79399, 89399, 78199, 88199, 78399, 88399, 78499, 88499 at any point in the given month and categorizes them considering both their cap code and their SPC.

MLTSS Population, by Age Group
January 2018

MLTSS HCBS/AL



MLTSS NF/SCNF

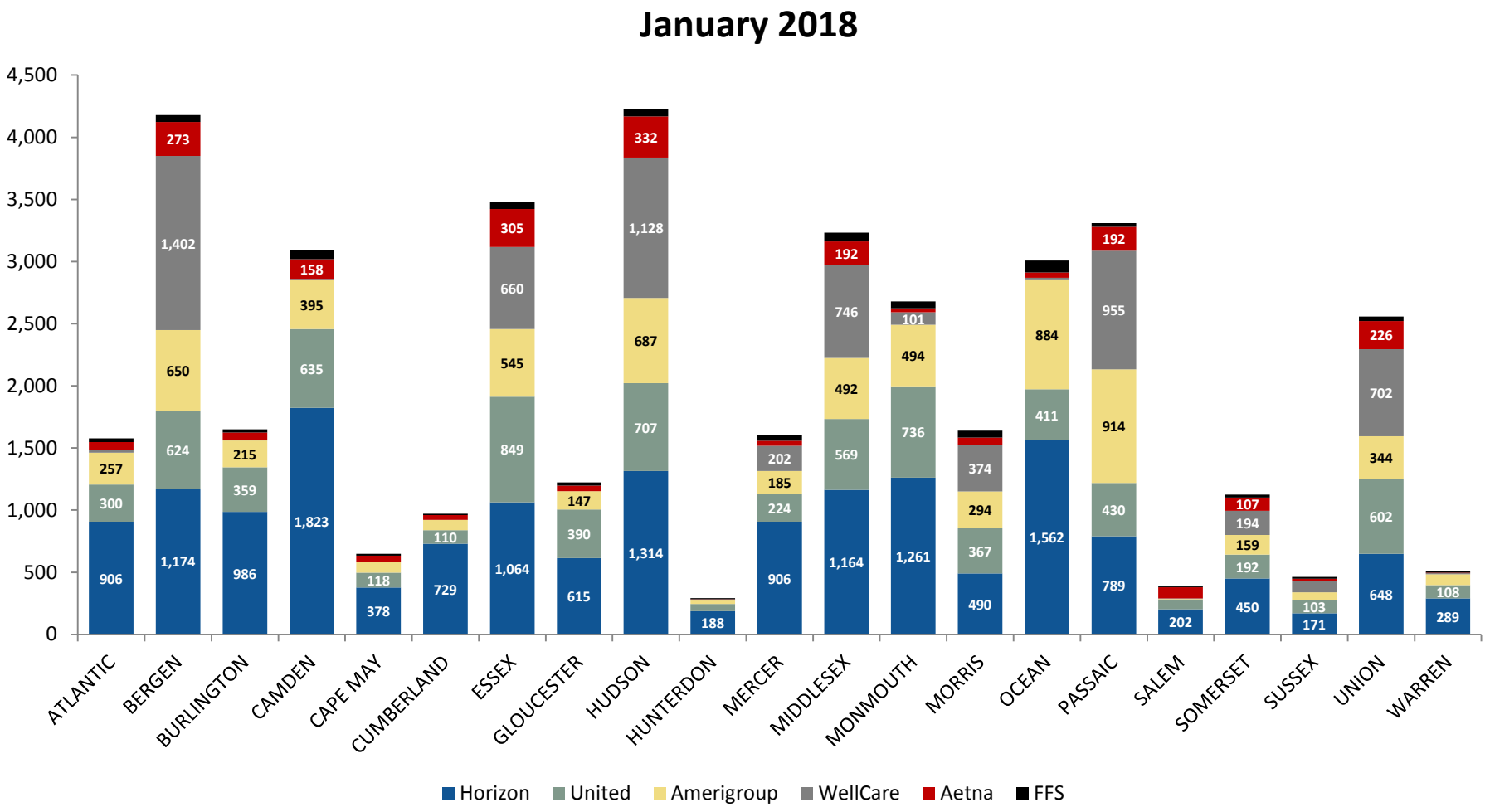


Source: DMAHS Shared Data Warehouse Monthly Eligibility Universe, accessed 2/6/2018.

Notes: Includes all recipients in Capitation Codes 79399, 89399, 78199, 88199, 78399, 88399, 78499, 88499 at any point in the given month and categorizes them by age.

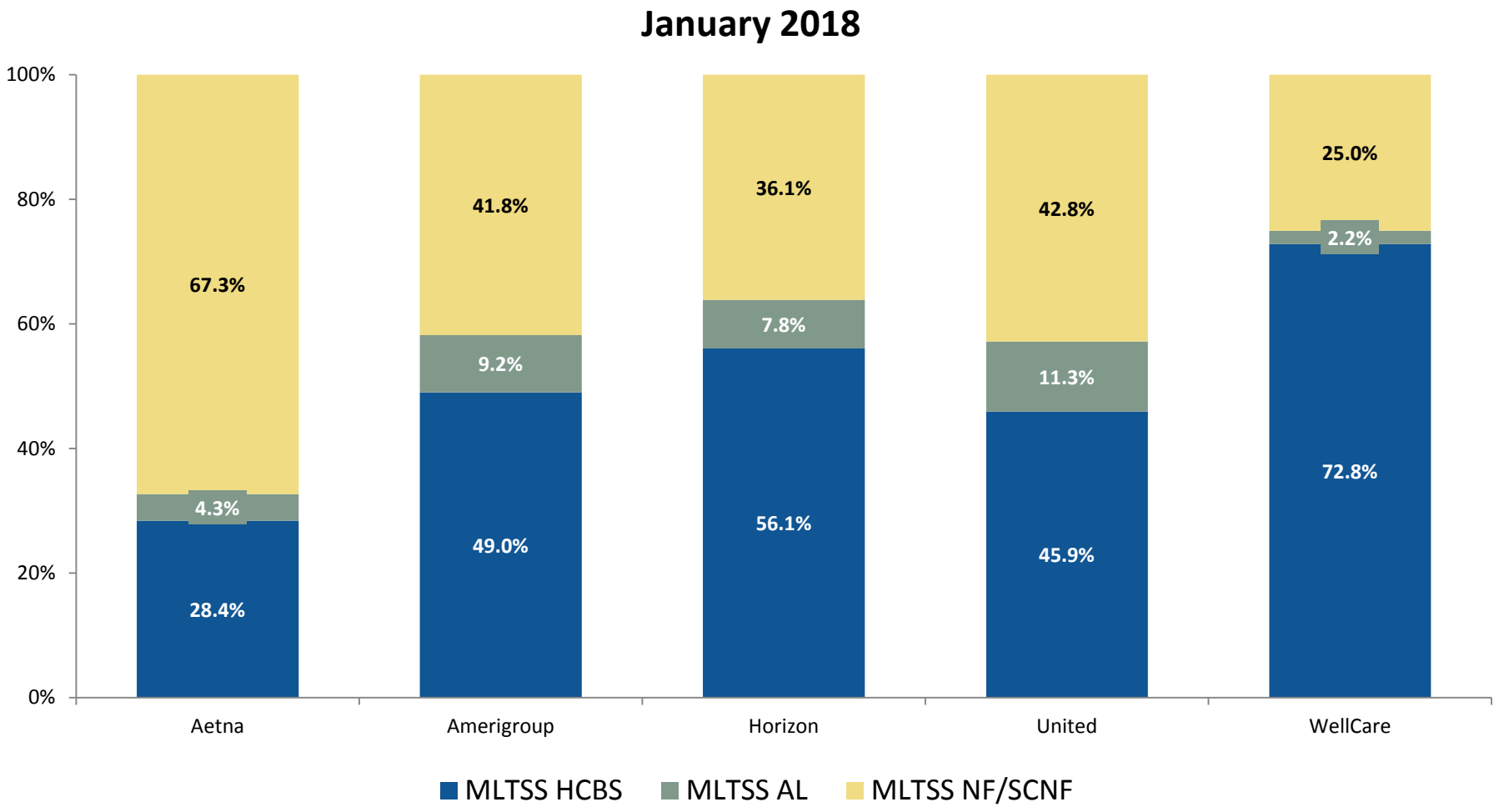
NJFAMILYCARE Affordable health coverage. Quality care.

MLTSS Recipients per County, by Plan



Source: NJ DMAHS Shared Data Warehouse Regular MMX Eligibility Summary Universe, accessed 2/1/2018.
Notes: Information shown includes any person who was considered MLTSS at any point in a given month and includes individuals with Capitation Codes 79399, 89399, 78199, 88199, 78399, 88399, 78499 & 88499 AND Special Program Codes 60-64. County distinction is based on recipient's county of residence in the given month.

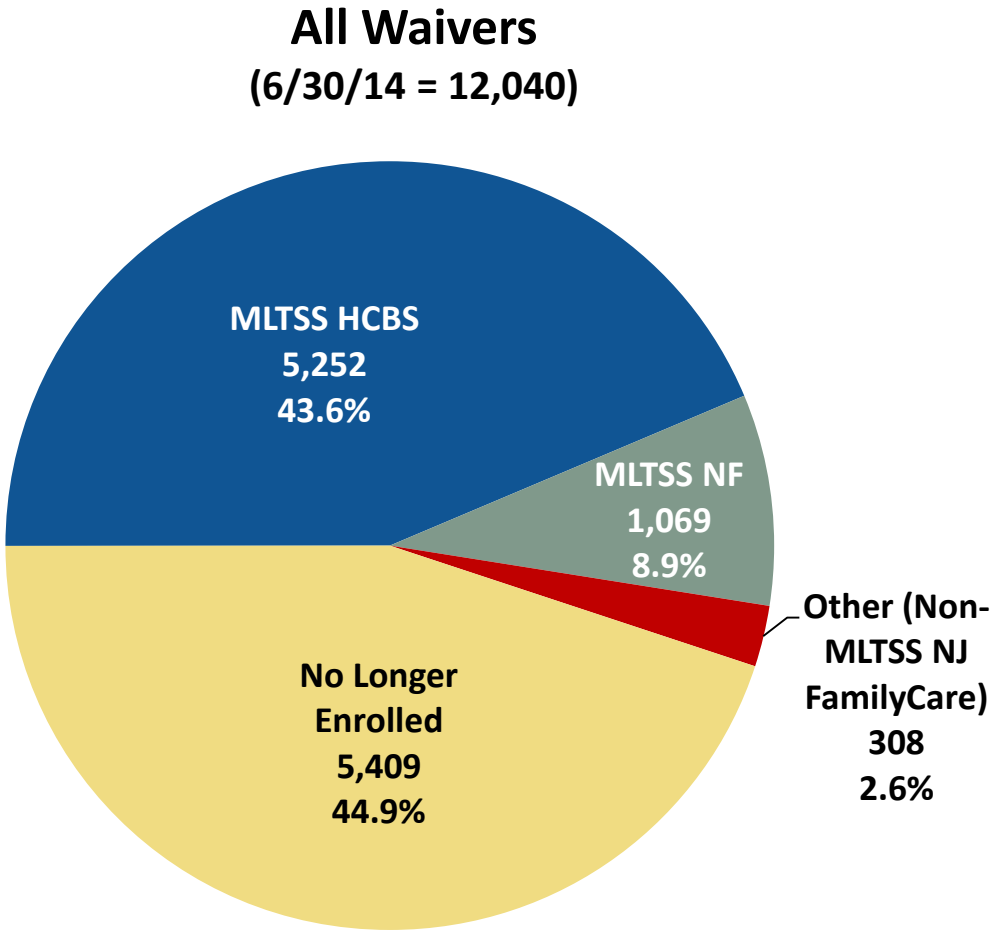
MLTSS Setting by Plan



Source: DMAHS Shared Data Warehouse Monthly Eligibility Universe, accessed 2/6/2018.

Notes: Includes all recipients in Capitation Codes 79399, 89399, 78199, 88199, 78399, 88399, 78499, 88499 at any point in the given month and categorizes them by plan.

A Look at the June 30, 2014 Waiver Population Today



Source: DMAHS Shared Data Warehouse Monthly Eligibility Universe, accessed 2/6/2018.

Notes: Includes all recipients who were in a waiver SPC (03, 05, 06, 17 or 32) on 6/30/14. Where they are now is based on capitation code or PSC. Those without a current capitation code or PSC are determined to be "No Longer Enrolled". Of the total number no longer enrolled, 93.8% (3,102) have a date of death in the system (current through 7-11-16).

MLTSS Services Cost

MLTSS Population's LTC Services Utilization, SFY17

Long Term Care Service Type	Utilization Dollars
NF/SCNF Services	$1,710,764,634
PCA/Home-Based Support Care	$222,260,602
Assisted Living	$63,650,092
Medical Day Services	$53,696,264
Private Duty Nursing	$32,490,894
Community Residential Services	$13,228,420
TBI Habilitative Therapies	$9,936,089
Home-Delivered Meals	$8,285,563
Structured Day Program	$3,895,072
PERS Set-up & Monitoring	$2,586,195
Respite	$2,089,713
Residential Modifications	$1,108,144
Other	$626,108
Social Adult Day Care	$521,124
Supported Day Services	$10,292
Grand Total	**$2,125,149,206**

Source: NJ DMAHS Share Data Warehouse MLTSS Services Dictionary, accessed on 1/22/2018.
Notes: Claims represent encounters paid through the date that the SDW was accessed. Subcapitations are not included in this data. Data not shown for services whose claims represent 5% or less of total claims. LTC Services not shown include: Adult Family Care, Assisted Living Program, Caregiver Training, Chore Services, Cognitive Therapy (Group/Indiv.), Community Transition Services, Home-Delivered Meals, Medication Dispensing Device (Monitoring), Medication Dispensing Device (Setup), Occupational Therapy (Group/Indiv.), PERS Monitoring, PERS Setup, Physical Therapy (Group/Indiv.), Residential Modifications, Respite (Daily/Hourly), Social Adult Day Care, Speech/Language/Hearing Therapy (Group/Indiv.), Structured Day Program, Supported Day Services, TBI Behavioral Management, and Vehicle Modifications.

Nursing Facility Quality Improvement Initiative

Guiding Principles

1. Improved Resident Experience and Quality of Life
2. Transparency & Collaboration with the Stakeholder Community
3. Consistent approach to Quality Measurement
4. Quality Monitoring & Promoting Continuous Quality Improvement
5. Oversight and Protections

Any Willing Provider (AWP) Policy

New Jersey's goal has been to safeguard the NF industry's financial health and minimize disruption to NF residents as the state moves from FFS to managed care under MLTSS.

The AWP provision currently requires the MCOs to contract with the NFs at least at the approved state Medicaid rates.

The AWP contracting policy for NFs was extended beyond its original two year period until 6/30/18.

Before eliminating AWP, NJ is developing NF provider network requirements and quality indicators that will be used in the contracting process between providers and the MCOs.

Any Willing Qualified Provider (AWQP)

Three primary goals of the AWQP program:

- Setting the stage for value based purchasing – the AWQP program needs to be aligned with value based purchasing because its focus is also on quality and outcomes of care
- Improving NF quality for long-stay residents ("raise all ships") - by providing regular feedback on performance to NFs, they can design and implement quality improvement plans to improve outcomes for all residents
- Provide MCOs with a pathway towards stronger network management - in addition to rewarding quality through higher reimbursement to quality providers, MCOs will be able to share provider performance with members so they have the knowledge base to select high value service providers

Quality Performance Standards (QPS)

QPS	Measures	Data Source
QPS 1	Is the percent of long-stay residents who are immunized against influenza annually at or above the statewide average? (calculated annually during influenza season)	MDS
QPS 2*	Is the facility at or below the statewide average for antipsychotic medication use in the long-stay residents on a quarterly basis?	
QPS 3*	Is the percent of long-stay, high risk residents with a pressure ulcer at or below the statewide average on a quarterly basis?	
QPS 4*	Is the percent of long-stay residents who are physically restrained at or below the statewide average on a quarterly basis?	
QPS 5*	Is the percent of long-stay residents experiencing one or more falls with major injury at or below the statewide average on a quarterly basis?	
QPS 6	Resident/family experience in the NF.	CoreQ Composite Score
QPS 7	Is the facility using INTERACT™, Advancing Excellence tools, TrendTracker™, or another validated tool to measure 30-day hospitalizations and hospital utilization so that it can share data with the MCOs?	Self-reported

*To meet any of these four individual standards, NFs must be at or below the DHS established benchmark for at least four out of six quarters for the most recently publicly available data.

Implementation Activities

- AWQP Initiative has launched
  - 304 Medicaid certified NFs are included
  - SCNFs, Private Pay, and small volume facilities are excluded
- Webinars for NF providers have occurred
  - DHS (DMAHS and DoAS) presented a comprehensive overview
  - Over 400 participants in total over three sessions
  - Materials, audio recording, and Q&A will be posted through NJHA

Implementation Activities

- Resident/Family experience (Core Q) and Hospital Utilization Tracking pre-survey has been emailed
  - Survey Monkey link emailed to 304 NFs by Dr. Nick Castle of University of Pittsburgh
- Core Q Webinars will be held on 3/14 and 3/27
  - Registration information through NJHA
- Quality Performance Standards MDS data was released to providers in February
- Appeals and QPP Reports are to be submitted to DHS in March
- DHS Website updated to post all relevant materials

Timeline (Abbreviated)

Timeline	Key DMAHS and DoAS Activities
January 2018	Prepare baseline data for distribution Conduct webinars
February 2018	Baseline data is released
March 2018	Receive NF Quality Performance Plans (QPP) Receive and review any NF appeals related to data
July 2018	Prepare data for distribution
August 2018	Baseline interim data is released
September 2018	Receive and review NF Quality Performance Plans (QPP)
January 2019	Prepare 1st annual data for distribution
February 2019	1st annual data is released
March 2019	Receive NF Quality Performance Plans (QPP) Receive and review any NF appeals
April 2019	**AWQP annual designation is provided <u>for the first time</u>**

Additional Information

- ✓ Website

  http://www.state.nj.us/humanservices/dmahs/home/mltss_nhq.html

- ✓ Email

  dhs.awqpinitiative@dhs.state.nj.us

- ✓ Leah Rogers, DoAS QA Coordinator

  609-588-6510

Questions ?