Develop public-facing NJ FamilyCare dashboards

12-month technical assistance (April 2018)

CMS IAP Partners:

- Truven Analytics
- Health DataViz
### Overview of NJ FamilyCare (Dec 2017)

- **1.76 million**
  - NJFC Enrollment
- **20% NJ residents**
  - Enrolled in NJFC
- **94% MC Enrollment**
- **5 Partnering MCOs**
- **$15 billion**
  - Combined State and Federal Funding
<table>
<thead>
<tr>
<th>Selection Process for Visualization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survey of OPRA Requests and other Division published materials</td>
</tr>
<tr>
<td>State comparables study</td>
</tr>
<tr>
<td>IAP Partner Input</td>
</tr>
<tr>
<td>Medicaid Director</td>
</tr>
</tbody>
</table>
Survey of Requested Reports

Other Reviewed Reports:
- Monthly Enrollment Report
- Managed Care Report
- Eligibility Slide Deck
- Annual Report
- LTC Slide Deck

OPRA Requests 2016-2017

<table>
<thead>
<tr>
<th>Category</th>
<th>Requests</th>
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<tbody>
<tr>
<td>Financial</td>
<td>44</td>
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<tr>
<td>Eligibility</td>
<td>42</td>
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<tr>
<td>Claims</td>
<td>23</td>
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<tr>
<td>Utilization</td>
<td>11</td>
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<tr>
<td>Other</td>
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<td>Provider Network</td>
<td>5</td>
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<tr>
<td>Applications</td>
<td>4</td>
</tr>
</tbody>
</table>

Advisory, Consultative, Deliberative
13 Comparable States Surveyed

- Delaware
- Florida
- Louisiana
- Maine
- Maryland
- New Hampshire
- New York
- Oklahoma
- Tennessee*
- S. Carolina
- Texas
- Virginia
- Washington

*not public
## Phase 1 Selected Visualizations

### OPRA Requests and Publicly Available Reports

<table>
<thead>
<tr>
<th>Provider Accessibility</th>
<th>Financials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applications and Terminations</td>
<td>Service Utilization and/or Expenditures</td>
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</tbody>
</table>

- **CAHPS** (Consumer Assessment of Healthcare Providers)

<table>
<thead>
<tr>
<th>HEDIS and Clinical Measures</th>
<th>Eligibility</th>
</tr>
</thead>
</table>

### Other Requested Visualizations:
- Long Term Care
- Medicaid Expansion
- Managed Care Report Card
Eligibility

Data Used:

• Source Data: Snapshot data from January 2014 to prior month

• Consistent with .pdf data presented in monthly enrollment reports, managed care report, and MACC slide decks

• Filters: Dual Status, Age Band, County, HMO, Gender, Eligibility Type
HEDIS and other Performance Data

Data Used:

- HEDIS reporting set measures **CY2014** forward (MCO Contract)
- Consistent with .pdf data presented in *Annual report* (Appendix E)
Data Used:

- Source Data: CAHPS Data 2014 forward
- Populations surveyed: Children, Adults, D-SNP
- Consistent with .pdf data presented in Annual report (Appendix D)
Long Term Care

Data Used:

- **Source Data:** Eligibility and Claims Data*

- **Consistent with slide decks presented at MACC meetings and MLTSS stakeholder meetings**

- **Filters:** Dual Status, Age Band, County, HMO, Gender

*12 months claims runout
Future NJ FamilyCare dashboard

<table>
<thead>
<tr>
<th>Activity</th>
<th>Timeline</th>
<th>Completion</th>
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<tr>
<td>Comparables Research, Cataloguing of Current Requests</td>
<td>0-2 mo.</td>
<td>100%</td>
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<tr>
<td>Meeting with Director’s Office and Business Units</td>
<td>3-6 mo.</td>
<td>60%</td>
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<tr>
<td>Draft Dashboard Development</td>
<td>4-8mo.</td>
<td>60%</td>
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<td>Website and Eligibility Dashboards LIVE</td>
<td>Spring 2018</td>
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<tr>
<td>Continuing Review by Business Units</td>
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<tr>
<td>Coordination with Central Office to publish onto DMAHS website</td>
<td>Summer 2018</td>
<td>0%</td>
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</table>
Contact Us:  dmahs.referrals@dhs.state.nj.us

Subject:  NJ FamilyCare - Data Analytics Dashboards
Mobile Friendly & Browser Independent

Introduction
The Division of Medical Assistance and Health Services is pleased to present the NJ FamilyCare data analytics dashboards. The objective of these web-based dashboards is to enable greater transparency to the Medicaid program. Users can gain a more timely and in-depth knowledge of key demographic and performance metrics. Assistance and guidance for the development of the dashboards was received under the umbrella of the CMS Data Analytics Medicaid Innovator Accelerator Program.

For more information on the Medicaid Innovator Accelerator Program, click here.

NJ FamilyCare Highlights
- **1,756,136** Total Enrollment
- **94.1%** Managed Care Enrollment
- **47.4%** Long Term Care Population in Home and Community Based Services
- **92** New Behavioral Health Providers Added Since Rate Increase

Monthly Enrollment Reports

Advisory, Consultative, Deliberative
Medicaid Substance Use Disorder (SUD) Waiver

Roxanne Kennedy and Gwen Carrick
Division of Medical Assistance and Health Services
Department of Human Services
January 2018
Why an SUD Waiver

• Steady increase each year in NJ and Country of deaths related to SUD, primarily opiates.

• The Waiver is a recommendation of the NJ Governor’s Task Force Report on Drug Abuse Control, September 2017

• President Trump’s announcement on 10/26/2017 declaring a national health emergency for SUD

• CMS is taking into consideration the modification of the IMD Exclusion within Waiver authority for Medicaid payment for SUD Treatment (approved in 5 states as of 11/17)
The Institution for Mental Diseases (IMD) Exclusion is a federal statute that prohibits the use of federal Medicaid financing for care provided to most patients in mental health and substance use disorder residential treatment facilities larger than 16 beds between the ages of 22-64.

NJ sought Waiver authority through the 1115 Comprehensive Medicaid Waiver Renewal process to include SUD treatment in an IMD as part of the SUD continuum.
Purpose of the SUD Waiver

- To expand Medicaid coverage to residential treatment in Detox, Short Term and Long Term Residential rehabilitation services.

- Increase the benefit package to include peer services and case management services for individuals with a SUD

- Provide and monitor evidenced based services for individuals with a SUD

- Closely monitor the effectiveness and efficiencies of services expanded and covered in the waiver
Effective 10/31/17, NJ FamilyCare has received Waiver authority to claim expenditures for services provided in residential facilities that meet the requirements of an Institution for Mental Disease (IMD) for individuals 18 and over.

- Non-hospital based Withdrawal Management, ASAM 3.7WM
- Short term Residential Treatment, ASAM 3.7
- Long Term Residential Treatment, ASAM 3.5

NJ FamilyCare must maintain a combined average length of stay of 30 days or less for these services.

NJ FamilyCare will provide a full continuum of SUD services that includes case management and peer recovery support services.
A Full Continuum of Benefits for SUD Treatment

Peer Support Services
Case Management
Support and Enhance existing M.A.T.
BH and Physical Health Integration

ASAM 0.5 or SBIRT
ASAM 1.0 Outpatient
ASAM 2.1 Intensive Outpatient
ASAM 2.5 Partial Care
ASAM 3.5 Long Term Residential
ASAM 3.7 Short Term Residential
ASAM 4.0WM Acute Hospital WM
ASAM 3.7WM Non-hospital based WM
ASAM 2WM Ambulatory WM

I.M.E.
Medicaid MCO

BH and Physical Health Integration
Peer Support Services
Case Management
Support and Enhance existing M.A.T.

ASAM 0.5 or SBIRT
ASAM 1.0 Outpatient
ASAM 2.1 Intensive Outpatient
ASAM 2.5 Partial Care
ASAM 3.5 Long Term Residential
ASAM 3.7 Short Term Residential
ASAM 4.0WM Acute Hospital WM
ASAM 3.7WM Non-hospital based WM
ASAM 2WM Ambulatory WM

I.M.E.
Medicaid MCO

BH and Physical Health Integration
Peer Support Services
Case Management
Support and Enhance existing M.A.T.

ASAM 0.5 or SBIRT
ASAM 1.0 Outpatient
ASAM 2.1 Intensive Outpatient
ASAM 2.5 Partial Care
ASAM 3.5 Long Term Residential
ASAM 3.7 Short Term Residential
ASAM 4.0WM Acute Hospital WM
ASAM 3.7WM Non-hospital based WM
ASAM 2WM Ambulatory WM

I.M.E.
Medicaid MCO

BH and Physical Health Integration
Peer Support Services
Case Management
Support and Enhance existing M.A.T.
Withdrawal Management (Detox) Beds

- Color = number of beds
- Numbers = admissions by County of Residence for CY 2016, FPL<=133%

IMD Restriction

No IMD Restriction
Short Term Residential Beds

- Color = number of beds.
- Numbers = admissions by County of Residence for CY 2016, FPL<=133%

IMD Restriction

No IMD Restriction
Long Term Residential Beds

IMD Restriction

- Color = Number of beds.
- Number = admissions by County of Residence for CY 2016, FPL<=133%

No IMD Restriction

- Color = Number of beds.
- Number = admissions by County of Residence for CY 2016, FPL<=133%
Special Terms and Conditions

Milestone 1
- Access to Critical Levels of Care
  - ASAM 3.7 WM
  - ASAM 3.7 STR
  - ASAM 3.5 LTR

Milestone 2
- Evidence Based Placement Criteria ASAM
  - LOCI-3 for UM Review

Milestone 3
- State process to review providers for ASAM compliance
- Ensure residential services offer use of MAT on site or via affiliation

Milestone 4
- Ensure Provider Capacity

Milestone 5
- Develop opioid prescribing guidelines
  - Expand coverage of and access to Naloxone
  - Increase utilization and improve function of PDMS

Milestone 6
- Ensure residential and inpatient facilities link beneficiaries with community based services and supports
Special Terms and Conditions

Additional CMS Deliverables

- SUD Program Implementation Plan
- SUD Program Health IT Plan
- SUD Program Evaluation Design
- SUD Program Monitoring Protocol
- Budget Neutrality
Service Implementation Timeline

- **July 2018**
  - IMD services Medicaid covered STR and WM

- **October 2018**
  - IMD service Medicaid covered LTR

- **July 2019**
  - Medicaid covered Case Management for SUD

- **July 2019**
  - Medicaid covered Peer services benefit coverage

*Dates are projections and are contingent upon CMS approval.*
Impact on SUD Providers

• Providers of **Short Term, Long Term and Detox residential services** will bill Medicaid for all Medicaid beneficiaries.

• Providers that receive state only FFS funds are required to be Medicaid providers.

• Providers licensed through DHS (DOH) for these services will be able to apply to be in the Medicaid SUD provider network regardless of their participation in the state only FFS network.

• Once a benefit and rate is designed for **Case Management** and **Recovery Supports Services**, the providers of these services will be able to bill for Medicaid beneficiaries.
Stakeholder Meetings

- Nov. 27, 2017: SUD Workgroup (multi-department and division workgroup)
- Nov. 28, 2017: Division of Mental Health and Addictions Services Senior Staff Meeting
- Dec. 4, 2017: County Drug and Alcohol Directors Meeting
- Dec. 7, 2017: DMHAS Stakeholder Leadership Constituency Meeting
- Dec. 8, 2017: Professional Advisory Committee (PAC)
- Dec. 14, 2017: Quarterly Provider Meeting
- Dec. 15, 2017: Opioid Taskforce Meeting
- Jan. 24, 2018: Medical Assistance Advisory Council (MAAC) Meeting
- Feb. 14, 2018: Mental Health Planning Council Meeting
• State Medicaid Director’s Letter *Strategies to Address the Opioid Epidemic:*

• NJ Standard Terms and Conditions of the 1115 Waiver Renewal (Section 40 re: SUD):
Questions
NJ FamilyCare Managed Care Contract Changes

Carol Grant
Deputy Director
Division of Medical Assistance and Health Services
Managed Care Contract Changes

- 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
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
  o OTC medications
  o Smoking Cessation
  o Residential BH/SUD treatment in an IMD for 15 days or less
  o LTAC treatment
  o Residential Modifications
  o Assistance with finding or keeping housing (not rent)
• 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
• The Administration lowered the threshold for Blood Lead Testing threshold from 10 to 5 micrograms/deciliter obtained through a capillary sample now required to be confirmed by a venous sample.
  o If the test shows a lead level greater than 5 micrograms/deciliter, the MCO should recommend that the other children and pregnant women living in the household be tested.
  o Children between 24 – 72 months who have not had a screening blood lead test must be tested immediately regardless of level of risk. If the blood level is found to be 5 – 9 mcg/dl, MCO must ensure PCPs cooperate with local health department to facilitate a preliminary environmental evaluation.
  o MCO must provide DMAHS an annual action plan for interventions used in outreaching parents/caregivers of children with positive lead screening tests. Lead Case Management Program applies to children with blood lead levels >5mcg/dl.
Article 4 – Provision of Health Care Services, cont.

- Contract now states specific federal law requirements for Hospice Care provided in a NF or SCNF
  - at least 95% of the rate that would have been paid by the State for facility services in the facility for the individual.
- Performance Measures:
  - Added: Electronic submission requirement – Complete HEDIS Workbook incl. all measures required by the NJFC MC Contract and measures submitted to NCQA for accreditation.
  - Expanded: MCO must submit a workplan for measures as defined by the State by 8/15 of each year. DMAHS may require a Corrective Action Plan for performance below minimum acceptable service levels. Progress updates may be requested by the State.
  - Added HEDIS reporting measure: Use of Multiple Concurrent Antipsychotics in Children and Adolescents
- 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.
- Appeals process changes resulting from new Managed Care Rule (as discussed at the July MAAC):
  - 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 fashion
- Managed Care Rule required changes to Provider Networks requirements:
  - The Contractor is not required to contract with more Providers than necessary to meet the needs of its Members.
  - MCO may use different reimbursement amounts for different specialties or different practitioners in the same specialty
Article 4 - Provision of Health Care Services, cont.

- 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

- 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 already active.
  - 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, cont.

- 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).
Nursing Facility Quality Improvement Initiative

Elizabeth Brennan
Assistant Division Director
Division of Aging Services
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
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 6/30/17.

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.
The three primary goals of the AWQP program are:

• 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
Implementation Activities

• AWQP Initiative has launched
  – 302 Medicaid certified NFs are included
  – SCNFs, Private Pay, and small volume facilities are excluded
• Webinars for NF providers have begun
  – DHS (DMAHS and DoAS) is presenting a comprehensive overview
  – Hosted by the NJ Hospital Association; open to all NFs
    – January 23rd, February 1st, February 7th
• Quality Performance Standards data will be released to providers in February
• Resident/Family experience (Core Q) and Hospital Utilization Tracking pre-survey will be administered by Dr. Nick Castle of University of Pittsburg
## Timeline (Abbreviated)

<table>
<thead>
<tr>
<th>Timeline</th>
<th>Key DMAHS and DoAS Activities</th>
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</thead>
<tbody>
<tr>
<td>January 2018</td>
<td>Prepare baseline data for distribution</td>
</tr>
<tr>
<td></td>
<td>Conduct webinars</td>
</tr>
<tr>
<td>February 2018</td>
<td>Baseline data is released</td>
</tr>
<tr>
<td>March 2018</td>
<td>Receive NF Quality Performance Plans (QPP)</td>
</tr>
<tr>
<td></td>
<td>Receive and review any NF appeals related to data</td>
</tr>
<tr>
<td>July 2018</td>
<td>Prepare data for distribution</td>
</tr>
<tr>
<td>August 2018</td>
<td>Baseline interim data is released</td>
</tr>
<tr>
<td>September 2018</td>
<td>Receive and review NF Quality Performance Plans (QPP)</td>
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<td>January 2019</td>
<td>Prepare 1\textsuperscript{st} annual data for distribution</td>
</tr>
<tr>
<td>February 2019</td>
<td>1\textsuperscript{st} annual data is released</td>
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<tr>
<td>March 2019</td>
<td>Receive NF Quality Performance Plans (QPP)</td>
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<td>Receive and review any NF appeals</td>
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<tr>
<td>April 2019</td>
<td><strong>AWQP annual designation is provided</strong>\textit{ for the first time}</td>
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✓ 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
Long Term Care (LTC) and Managed Long Term Services & Supports (MLTSS)
## Long Term Care Recipients Summary – December 2017

**Total Long Term Care Recipients**  
*53,516*

### Managed Long Term Support & Services (MLTSS)  

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<td>MLTSS HCBS</td>
<td>21,604</td>
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<tr>
<td>MLTSS Assisted Living</td>
<td>3,094</td>
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<tr>
<td>MLTSS NF</td>
<td>15,522</td>
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<tr>
<td>MLTSS SCNF (Upper &amp; Lower)</td>
<td>280</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>40,500</strong></td>
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### Fee For Service (FFS/Managed Care Exemption)  

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<tr>
<th>Service Type</th>
<th>Recipients</th>
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<tbody>
<tr>
<td>FFS Nursing Facility (includes SCNF)</td>
<td>9,010</td>
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<tr>
<td>FFS NF – Other**</td>
<td>3,027</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>12,037</strong></td>
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### PACE  

<table>
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<tr>
<td>PACE</td>
<td>972</td>
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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, 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

6-Month Intervals


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.
Long Term Care Population by Setting


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). 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).
MLTSS Rebalancing

6 Month Intervals


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).
## Long Term Care Population by County

### November 2017

<table>
<thead>
<tr>
<th>COUNTY</th>
<th>NJ FamilyCare</th>
<th>LTC</th>
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<td>MONMOUTH</td>
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<td>MORRIS</td>
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<tr>
<td>OCEAN</td>
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<td>PASSAIC</td>
<td>8.9%</td>
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<tr>
<td>SALEM</td>
<td>0.9%</td>
<td>1.0%</td>
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<tr>
<td>SOMERSET</td>
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<td>2.8%</td>
</tr>
<tr>
<td>SUSSEX</td>
<td>0.9%</td>
<td>1.3%</td>
</tr>
<tr>
<td>UNION</td>
<td>6.6%</td>
<td>6.3%</td>
</tr>
<tr>
<td>WARREN</td>
<td>0.9%</td>
<td>1.9%</td>
</tr>
</tbody>
</table>

**Source:** DMAHS Shared Data Warehouse Monthly Eligibility Universe, accessed 1/11/18.

**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.
Advisory, Consultative, Deliberative

Long Term Care Recipients per County, MC vs FFS

County Long Term Care Population, by MC vs. FFS
November 2017

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.
Long Term Care Recipients per County, by Age Grouping


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.
Rebalancing Long Term Care, by County


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, 78499 & 88499, Special Program Codes 03, 05, 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.
MLTSS Population Trend, by Age Group

6-Month Intervals


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.
A Look at the June 30, 2014 Waiver Population Today


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 Population’s LTC Services Cost**

**SFY17**

- **NF/SCNF Services**: $716,937,264
- **PCA/Home-Based Support Care**: $219,266,601
- **Assisted Living**: $59,744,072
- **Medical Day Services**: $53,400,766
- **Private Duty Nursing**: $31,674,076
- **Community Residential Services**: $13,064,391
- **TBI Habilitative Therapies**: $9,745,257
- **Home-Delivered Meals**: $8,270,103
- **Structured Day Program**: $3,831,196
- **PERS Set-up & Monitoring**: $2,581,311
- **Respite**: $1,783,167
- **Other**: $1,634,358
- **Social Adult Day Care**: $512,865
- **Supported Day Services**: $9,712

**Monthly Average Number of Recipients: SFY17**

- **HCBS/AL**: 20,438
- **NF/SCNF**: 12,137
- **Grand Total**: 32,575

**Source**: NJ DMAHS Share Data Warehouse MLTSS Services Dictionary, accessed on 9/18/17.

**Notes**: Dollars represent encounters paid through the date that the SDW was accessed. Subcapitations are not included in this data. Other Includes: Adult Family Care, Caregiver Training, Chore Services, Community Transition Services, Medication Dispensing Device (Monitoring), Medication Dispensing Device (Setup), Residential Modifications, TBI Behavioral Management, Non-Medical Transportation, and Vehicle Modifications.
MLTSS DDD Recipients

Source: NJ DMAHS Share Data Warehouse MLTSS Table and Claims Universe, accessed 9/18/17.

Notes: Includes all MLTSS recipients, as defined by capitation codes 79399;89399;78199;88199;78399;88399;78499;88499 with a DDD paycode designation on the RHMF. Includes the following paycodes: 4, 6, B, C, D, S (respectively: High Cost Drugs & DDD; Cystic Fibrosis & DDD; AIDS & DDD; HIV+ & DDD; DDD; DYFS and ABD and DDD). Note that the same recipient may appear in multiple month’s counts. Recipients are grouped according to their age on the last day of each state fiscal year.

MLTSS Recipients (by Age Group) with a DDD Claim

<table>
<thead>
<tr>
<th>Age Group</th>
<th>SFY15</th>
<th>SFY16</th>
<th>SFY17</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-21</td>
<td>496</td>
<td>713</td>
<td>868</td>
</tr>
<tr>
<td>22-64</td>
<td>68</td>
<td>106</td>
<td>147</td>
</tr>
<tr>
<td>65-84</td>
<td>322</td>
<td>443</td>
<td>534</td>
</tr>
<tr>
<td>85+</td>
<td>106</td>
<td>159</td>
<td>181</td>
</tr>
</tbody>
</table>

Source: NJ DMAHS Share Data Warehouse MLTSS Table and Claims Universe, accessed 9/18/17.

Notes: Includes all MLTSS recipients, as defined by capitation codes 79399;89399;78199;88199;78399;88399;78499;88499 with a DDD paycode designation on the RHMF. Includes the following paycodes: 4, 6, B, C, D, S (respectively: High Cost Drugs & DDD; Cystic Fibrosis & DDD; AIDS & DDD; HIV+ & DDD; DDD; DYFS and ABD and DDD). Note that the same recipient may appear in multiple month’s counts. Recipients are grouped according to their age on the last day of each state fiscal year.
MLTSS Recipients Receiving Behavioral Health Services
Monthly Counts, By Dual Status

Notes: All recipients counted above are defined as MLTSS based on capitation code (79399;89399;78199;88199;78399;88399;78499;88499) and defined as BH based on receipt of services classified as BH based on procedure code or revenue code as defined in the MLTSS BH Services Dictionary. Does not include services meeting the definition of MLTSS Waiver, Medical Day Care or PCA as defined in the MLTSS Services Dictionary. Individual recipients may be counted more than once in a state fiscal year if they transitioned between settings (HCBS,AL,NF).
MLTSS Recipients Receiving Behavioral Health Services
Annual Counts, By Setting


Notes: All recipients counted above are defined as MLTSS based on capitation code (79399;89399;78199;88199;78399;88399;78499;88499) and defined as BH based on receipt of services classified as BH based on procedure code or revenue code as defined in the MLTSS BH Services Dictionary. Does not include services meeting the definition of MLTSS Waiver, Medical Day Care or PCA as defined in the MLTSS Services Dictionary. Individual recipients may be counted more than once in a state fiscal year if they transitioned between settings (HCBS,AL,NF).
MLTSS Behavioral Health Services Utilization, by Setting

MLTSS Recipients' BH Service Utilization (ENC)

Unique BH Recipients

<table>
<thead>
<tr>
<th></th>
<th>SFY15</th>
<th>SFY16</th>
<th>SFY17</th>
</tr>
</thead>
<tbody>
<tr>
<td>SFY15</td>
<td>410</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SFY16</td>
<td>1,175</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SFY17</td>
<td>1,975</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes: Amounts shown by service dates. Services are classified as BH based on procedure code or revenue code as defined in the MLTSS BH Services Dictionary. Does not include services meeting the definition of MLTSS Waiver, Medical Day Care or PCA as defined in the MLTSS Services Dictionary. Amounts shown are dollars paid by NJ FamilyCare MCOs to providers for services supplied to NJ FamilyCare members – capitation payments made by NJ FamilyCare to its managed care organizations are not included. Amounts shown include all claims paid through 2/8/17 for services provided in the time period shown. Additional service claims may have been received after this date. Subcapitations are not included in this data.
Advisory, Consultative, Deliberative

MLTSS Behavioral Health Services Utilization, by Service


Notes: Amounts shown by service dates. Services are classified as BH based on procedure code or revenue code as defined in the MLTSS BH Services Dictionary. Does not include services meeting the definition of MLTSS Waiver, Medical Day Care or PCA as defined in the MLTSS Services Dictionary. Amounts shown are dollars paid by NJ FamilyCare MCOs to providers for services supplied to NJ FamilyCare members – capitation payments made by NJ FamilyCare to its managed care organizations are not included. Amounts shown include all claims paid through 2/8/17 for services provided in the time period shown. Additional service claims may have been received after this date. Subcapitations are not included in this data. *Psychiatric Partial Care includes both inpatient & outpatient partial care.
The New Jersey Department of Human Services
Division of Developmental Disabilities

SUPPORTS PROGRAM UPDATE

Jennifer Joyce
Supports Program & Employment Services,
Provider Performance & Monitoring, and Support Coordination Units
Supports Program Information

- Launched July 2015
- 5,700 individuals currently enrolled
- Enrollment is ongoing
  - New presenters to DDD
  - Individuals currently receiving DDD services
    - As service plans come up for renewal
    - As identified for enrollment
  - 2018 graduates – approximately 700
  - Shift to Supports Program expected to be complete by end of FY18
- 105 Medicaid/DDD Approved Support Coordination Agencies
Ongoing/Upcoming

- Release of revised Supports Program Policies & Procedures Manual – expected within the next few weeks
- Ongoing outreach to leadership groups and stakeholders to further identify and address areas in need of improvement
- Continued webinars
  - Q&A Sessions
  - Overviews of Services
Additional Information

- Supports Program Policies & Procedures Manual

- Supports Program page of the DDD website

- Archived Webinars
NJ FamilyCare Update

Meghan Davey, Director
Division of Medical Assistance and Health Services

Medical Assistance Advisory Council Meeting
January 24, 2018
## December 2017 Enrollment Headlines

<table>
<thead>
<tr>
<th>Enrollment Headline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1,756,136 Overall Enrollment</strong></td>
</tr>
<tr>
<td><strong>2nd Monthly Increase After 6 Month Decline</strong></td>
</tr>
<tr>
<td><strong>2,366 (0.1%) Net Increase Over November 2017</strong></td>
</tr>
<tr>
<td><strong>15,536 (0.9%) Net Decrease Over December 2016</strong></td>
</tr>
<tr>
<td><strong>94.1% of All Recipients are Enrolled in Managed Care</strong></td>
</tr>
</tbody>
</table>


**Notes:** Net change since Dec. 2013; includes individuals enrolling and leaving NJFamilyCare. Does not include retroactivity.
NJ Total Population: 9,005,644

1,756,136 Total NJ FamilyCare Enrollees
(December 2017)

19.5% % of New Jersey Population Enrolled
(December 2017)

798,685 Children (Age 0-18) Enrolled
(about 1/3 of all NJ children)

## December 2017 Eligibility Summary

Total Enrollment: 1,756,136

<table>
<thead>
<tr>
<th>Category</th>
<th>Enrolled</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expansion Adults</td>
<td>543,817</td>
<td>31.0%</td>
</tr>
<tr>
<td>Other Adults</td>
<td>108,033</td>
<td>6.2%</td>
</tr>
<tr>
<td>Medicaid Children</td>
<td>600,371</td>
<td>34.2%</td>
</tr>
<tr>
<td>M-CHIP Children</td>
<td>90,330</td>
<td>5.1%</td>
</tr>
<tr>
<td>CHIP Children</td>
<td>113,111</td>
<td>6.4%</td>
</tr>
<tr>
<td>Aged/Blind/Disabled</td>
<td>300,474</td>
<td>17.1%</td>
</tr>
</tbody>
</table>


**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 ‘Childrens Services'; CHIP Children consists of all CHIP eligibility categories; ABD consists of ‘Aged’, ‘Blind’ and ‘Disabled’.
### Total Enrollment: 1,756,136

#### By Program
- M-CHIP
- XXI

#### By Plan
- Aetna
- WellCare
- FFS
- AmeriGroup
- United

#### By Age
- 0-18
- 19-21
- 22-34
- 35-54
- 55-64
- 65+

#### By Gender
- Male
- Female

#### By Region
- North
- Central
- South

---

**Source:** NJ DMAHS Shared Data Warehouse Snapshot Eligibility Summary Universe, run for December 2017.

**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.*
Child Health Insurance Program (CHIP) - Update
CHIP Update

• CHIP funding expired as of September 30, 2017.

• Renewed on January 22, 2018 for six years.

• Funding remains at ACA levels (88%) for two years, then will decrease over two years to pre-ACA level.
More Updates...

- Aged-Blind-Disabled Online Application
- Credentialing Universal Provider Credentialing System
Diabetes Legislation Update
Diabetes Legislation

Requires Medicaid to cover diabetes self-management education, training, services and equipment for patients with diabetes, gestational diabetes and pre-diabetes. Passed 7/21/2017

Public Law A2993
Diabetes State Plan Amendment (SPA)

**Diabetes Services to Include:**

**Diabetes Self-management Education (DMSE):** Items and services meeting the American Diabetes Association DSME standards to be made available to beneficiaries.

**Diabetes Prevention Program:** Designed for beneficiaries diagnosed with prediabetes as defined by the American Diabetes Association and meet the standards of CDC-recognized programs.

**Medical Nutrition Therapy** Services to be provided to beneficiaries by certain credentialed nutrition professionals.
Diabetes State Plan Amendment (SPA)

Diabetic equipment and supplies already covered by NJ FamilyCare.

New fee-for-service provider types will be created so that they may be reimbursed by NJ FamilyCare: nutritionists, dieticians, and/or certified diabetes educators.