



Children and Adults Health Programs Group

April 8, 2014

Ms. Valerie Harr
Director
Division of Medical Assistance and Health Services
P.O. Box 712
Trenton, NJ 08625-0712

Dear Ms. Harr:

We are writing to share the initial results of the Centers for Medicare & Medicaid Services (CMS) review of Hospital DSRIP Plans that were approved by the state and submitted to CMS as part of the state's Delivery System Reform Incentive Payment (DSRIP) program, authorized under the New Jersey Comprehensive Waiver section 1115 demonstration. In accordance with the expectations set forth in the demonstration's Planning Protocol and Program Funding and Mechanics (PFM) Protocol, the state conducted a thorough review of the projects it received from eligible hospitals, forwarding to CMS those that met its standards for approval. Between December 13, 2013, and March 2, 2014, New Jersey submitted a total of 55 Hospital DSRIP to CMS. For its review, CMS focused on the state's execution of its own review process, while placing particular emphasis on ensuring that the health care reform efforts incentivized through DSRIP would be new projects (or significant expansion or enhancement of existing projects), and would not duplicate efforts already funded by the United States Department of Health and Human Services (DHHS). Together, our reviews helped ensure that the projects undertaken by New Jersey's hospitals will advance health care quality and system transformation, and be consistent with the goals of the DSRIP program.

At this time, CMS is approving 49 the 55 submitted plans. New Jersey may begin claiming federal financial participation for DSRIP payments to these hospitals in accordance with the demonstration's Special Terms and Conditions upon receipt of this letter. Of the 49 hospital plans:

- Ten are approved without any further condition attached.
- Twenty-four are approved on the condition that New Jersey continue to work with the hospitals to improve their plans in specific areas, and to require them to include a report on how they addressed these areas as part of their Demonstration Year 4 Annual DSRIP Application Renewal. This will allow information on how the hospitals addressed these concerns to be incorporated into the mid-point assessment of DSRIP that will take place in June 2015.

- Fifteen are approved conditional on the hospital providing the state and CMS with an attestation that its DSRIP project is not funded by any other grant obtained from the United States Department of Health and Human Services or other federal grantor. Each hospital must also submit an addendum to its project budget that identifies any expense line items for which the hospital already receives federal funding support (or a statement to the effect that no existing expense line items receive federal support). These responses must be submitted to CMS by June 30, 2014. CMS approval is contingent on the state's successful submission of the requested materials. If materials are not received for a hospital by the required date, the state will be asked to return the associated FFP. In addition, 13 of the 15 have areas for improvement that the state must work with them to address, in the same manner as for the group of 24 hospitals above.

The 6 hospitals whose plans CMS is not approving at this time will have an opportunity to revise and resubmit their plans. Hospitals in this category must address specific questions and comments from CMS in order to be reconsidered for approval. As specified in the PFM Protocol, New Jersey must submit the hospitals' revised Hospital DSRIP Plans to CMS within 30 days of the date of this letter in order for them to be considered for approval by CMS.

Enclosure 1 contains a list of all hospitals that submitted Hospital DSRIP Plans, and shows the approval status for each. Enclosure 2 lists all approved hospitals for which further state engagement is required and for which follow-up must occur as part of the mid-point assessment, along with the specific areas of concern. Enclosure 3 lists the 6 hospitals whose plans are not approved by CMS at this time, and the questions that must be addressed when they resubmit their plans.

Several of the hospitals whose applications were approved disclosed that they participate in other CMS sponsored payment reform initiatives, such as the Medicare Shared Savings Program, or Bundled Payments for Care Improvement Initiative. While participation in these programs does not constitute DHHS funding that would be duplicative of DSRIP incentive funding, the state must nevertheless consider hospitals' participation in these programs as a potential confounding factors in its evaluation of the impact of DSRIP.

Approval of these plans by CMS does not alter the responsibility of the state or the hospitals to comply with all federal program integrity and funding requirements of the Medicaid program, the demonstration's special terms and conditions (STCs), or the approved DSRIP protocols. In particular, if a hospital's baseline performance on its Stage 3 pay-for-performance metrics is found to exceed the baseline performance threshold established for those measures, the hospital will be required to delete Stage 3 measures, or select alternative Stage 3 measures, or select another DSRIP project, in accordance with Section VIII.A.iii of the Planning Protocol.

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We commend New Jersey and its hospitals for their efforts to develop Hospital DSRIP Plans that addresses their community's needs, and we look forward to continuing our collaborative work together.

Sincerely,

/s/

Diane T. Gerrits
Director
Division of State Demonstrations and Waivers

Enclosures

cc:
Michael Melendez, Associate Regional Administrator, Region II

**Enclosure 1: Roster of New Jersey Hospital DSRIP Plans and their CMS Approval Status
April 4, 2014**

Hospital ID	Hospital Name	DSRIP Focus Area	Project Title	Date Submitted to CMS	CMS Approval Status
4139402	ATLANTICARE REG'L MEDICAL CENTER	Diabetes	Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension	01/21/2014	Not approved**
4136705/ 0167011	BAYONNE HOSPITAL	Cardiac Care	Extensive Patient CHF-Focused Multi-Therapeutic Model	01/31/2014	Approved conditional on receipt of funding attestation and budget addendum, and with mid-point review follow-up*
4141105	BAYSHORE COMMUNITY HOSPITAL	Diabetes	Diabetes Group Visits for Patients and Community Education	01/30/2014	Approved, with mid-point review follow-up*
4139003	BERGEN REG'L MEDICAL CENTER	Behavioral Health	Electronic Self-Assessment Decision Support Tool	12/13/2013	Not approved**
4135709	CAPE REGIONAL MEDICAL CENTER	Diabetes	Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension	01/30/2014	Approved conditional on receipt of funding attestation and budget addendum, and with mid-point review follow-up*
3676609	CAPITAL HEALTH SYSTEM - FULD CAMPUS	Chemical Addiction/ Substance Abuse	Hospital-Wide Screening for Substance Use Disorder	12/20/2013	Not approved**
4138201	CAPITAL HEALTH SYSTEM – HOPEWELL	Obesity	After School Obesity Program	12/19/2013	Approved conditional on receipt of funding attestation and budget addendum, and with mid-point review follow-up*
4141008	CENTRASTATE MEDICAL CENTER	Diabetes	Diabetes Group Visits for Patients and Community Education	01/31/2014	Approved, with mid-point review follow-up*
4136209	CHILTON MEMORIAL HOSPITAL	Cardiac Care	The Congestive Heart Failure Transition Program (CHF-TP)	01/31/2014	Approved, with mid-point review follow-up*
3674207	CHRIST HOSPITAL	Cardiac Care	Extensive Patient CHF-Focused Multi-Therapeutic Model	12/19/2013	Approved conditional on receipt of funding attestation and budget addendum, and with mid-point review follow-up*
4135504	CLARA MAASS MEDICAL CENTER	Cardiac Care	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions	12/20/2013	Approved
3674606	COMMUNITY MEDICAL CENTER	Cardiac Care	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions	01/27/2014	Approved, with mid-point review follow-up*

**Enclosure 1: Roster of New Jersey Hospital DSRIP Plans and their CMS Approval Status
April 4, 2014**

Hospital ID	Hospital Name	DSRIP Focus Area	Project Title	Date Submitted to CMS	CMS Approval Status
4136004	COOPER UNIVERSITY MEDICAL CTR	Diabetes	Diabetes Group Visits for Patients and Community Education	12/19/2013	Approved conditional on receipt of funding attestation and budget addendum, and with mid-point review follow-up*
4140001	EAST ORANGE GENERAL HOSPITAL	Cardiac Care	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions	12/20/2013	Approved, with mid-point review follow-up*
4138309	ENGLEWOOD HOSPITAL ASSOCIATION	Cardiac Care	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions	12/19/2013	Approved conditional on receipt of funding attestation and budget addendum, and with mid-point review follow-up*
3674100	HACKENSACK UNIVERSITY MEDICAL CENTER	Cardiac Care	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions	01/27/2014	Not approved**
4137906/ 0249297	HOBOKEN HOSPITAL CENTER	Cardiac Care	Extensive Patient CHF-Focused Multi-Therapeutic Model	01/21/2014	Approved
4139801	JERSEY CITY MEDICAL CENTER	Asthma	Pediatric Asthma Case Management and Home Evaluations	12/20/2013	Not approved**
3675700	JERSEY SHORE MEDICAL CENTER	Asthma	Pediatric Asthma Case Management and Home Evaluations	12/20/2013	Approved, with mid-point review follow-up*
3676803	JFK MEDICAL CENTER {EDISON} / Anthony M. Yelencsics	Cardiac Care	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions	01/10/2014	Approved, with mid-point review follow-up*
4140206	KENNEDY MEMORIAL HOSPITALS AT STRATFORD	Diabetes	Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension	12/19/2013	Approved, with mid-point review follow-up*
3676200	KIMBALL MEDICAL CENTER	Behavioral Health	Integrated Health Home for the Seriously Mentally Ill (SMI)	01/27/2014	Approved, with mid-point review follow-up*
3675203	LOURDES MED CTR OF BURLINGTON CNTY	Cardiac Care	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions	01/30/2014	Not approved**
4141504/ 0249297	MEADOWLANDS HOSPITAL MEDICAL CENTER	Cardiac Care	The Congestive Heart Failure Transition Program (CHF-TP)	01/31/2014	Approved, with mid-point review follow-up*

**Enclosure 1: Roster of New Jersey Hospital DSRIP Plans and their CMS Approval Status
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Hospital ID	Hospital Name	DSRIP Focus Area	Project Title	Date Submitted to CMS	CMS Approval Status
3674908	MEDICAL CENTER OF OCEAN COUNTY	Diabetes	Diabetes Group Visits for Patients and Community Education	01/21/2014	Approved conditional on receipt of funding attestation and budget addendum, and with mid-point review follow-up*
4138902	MEMORIAL HOSP OF BURLINGTON CTY (Virtua)	Diabetes	Diabetes Group Visits for Patients and Community Education	01/31/2014	Approved conditional on receipt of funding attestation and budget addendum, and with mid-point review follow-up*
3675807	MONMOUTH MEDICAL CENTER	Behavioral Health	Integrated Health Home for the Seriously Mentally Ill (SMI)	01/21/2014	Approved
4136101	MORRISTOWN MEMORIAL HOSPITAL	Cardiac Care	The Congestive Heart Failure Transition Program (CHF-TP)	02/28/2014	Approved
4138708/ 0139564	MOUNTAINSIDE HOSPITAL	Diabetes	Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension	01/30/2014	Approved, with mid-point review follow-up**
4135008	NEWARK BETH ISRAEL MEDICAL CENTER	Cardiac Care	The Congestive Heart Failure Transition Program (CHF-TP)	12/20/2013	Approved
4137001	NEWTON MEMORIAL HOSPITAL	Cardiac Care	The Congestive Heart Failure Transition Program (CHF-TP)	03/03/2014	Approved conditional on receipt of funding attestation and budget addendum
4137108	OUR LADY OF LOURDES MEDICAL CENTER	Cardiac Care	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions	12/20/2013	Approved, with mid-point review follow-up*
3674801	OVERLOOK HOSPITAL	Cardiac Care	The Congestive Heart Failure Transition Program (CHF-TP)	03/03/2014	Approved conditional on receipt of funding attestation and budget addendum
4135105	PALISADES GENERAL HOSPITAL	Cardiac Care	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions	01/10/2014	Approved, with mid-point review follow-up*
4137701	R. W. JOHNSON UNIVERSITY HOSPITAL	Cardiac Care	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions	12/13/2013	Approved
4137809	RARITAN BAY MEDICAL CENTER	Cardiac Care	Care Transitions Intervention Model to Reduce 30-Day Readmissions for	12/19/2013	Approved

**Enclosure 1: Roster of New Jersey Hospital DSRIP Plans and their CMS Approval Status
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Hospital ID	Hospital Name	DSRIP Focus Area	Project Title	Date Submitted to CMS	CMS Approval Status
			Chronic Cardiac Conditions		
4137400	RIVERVIEW MEDICAL CENTER	Diabetes	Diabetes Group Visits for Patients and Community Education	01/21/2014	Approved conditional on receipt of funding attestation and budget addendum, and with mid-point review follow-up*
3676901	RWJ UNIVERSITY MEDICAL CTR AT HAMILTON	Pneumonia	Patients Receive Recommended Care for Community-Acquired Pneumonia	01/30/2014	Approved, with mid-point review follow-up*
4138406	SOMERSET MEDICAL CENTER	Diabetes	Diabetes Group Visits for Patients and Community Education	01/31/2014	Approved, with mid-point review follow-up*
3674509	SOUTH JERSEY HEALTH SYSTEM	Chemical Addiction/ Substance Abuse	Hospital-Wide Screening for Substance Use Disorder	12/20/2013	Approved
3675602	SOUTH JERSEY HEALTH SYSTEM - ELMER	Chemical Addiction/ Substance Abuse	Hospital-Wide Screening for Substance Use Disorder	01/21/2014	Approved, with mid-point review follow-up*
4141202	SOUTHERN OCEAN COUNTY HOSPITAL	Cardiac Care	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions	01/31/2014	Approved conditional on receipt of funding attestation and budget addendum, and with mid-point review follow-up*
3675904	ST. BARNABAS MEDICAL CENTER	Asthma	Hospital-Based Educators Teach Optimal Asthma Care	01/27/2014	Approved, with mid-point review follow-up*
4138601	ST. CLARE'S- RIVERSIDE MED CTR DENVILLE	Behavioral Health	Electronic Self-Assessment Decision Support Tool	01/21/2014	Approved
4136608	ST. FRANCIS MEDICAL CENTER (TRENTON)	Diabetes	Diabetes Group Visits for Patients and Community Education	12/13/2013	Approved, with mid-point review follow-up*
4136403	ST. JOSEPH'S HOSPITAL MEDICAL CENTER	Asthma	Hospital-Based Educators Teach Optimal Asthma Care	12/20/2013	Approved, with mid-point review follow-up*
4139208	ST. LUKE'S HOSPITAL (formerly Warren Hospital)	Diabetes	Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension	01/10/2014	Approved, with mid-point review follow-up*
4135300	ST. MARY'S HOSPITAL (PASSAIC)	Cardiac Care	Extensive Patient CHF-Focused Multi-Therapeutic Model	01/27/2014	Approved, with mid-point review follow-up*
4140508	ST. MICHAEL'S MEDICAL CENTER	Diabetes	Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension	01/27/2014	Approved conditional on receipt of funding attestation and budget addendum, and with mid-point review follow-up*

**Enclosure 1: Roster of New Jersey Hospital DSRIP Plans and their CMS Approval Status
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Hospital ID	Hospital Name	DSRIP Focus Area	Project Title	Date Submitted to CMS	CMS Approval Status
4139500	ST. PETER'S MEDICAL CENTER	Diabetes	Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension	12/19/2013	Approved conditional on receipt of funding attestation and budget addendum, and with mid-point review follow-up*
4136900	TRINITAS - ELIZABETH GENERAL	Chemical Addiction/ Substance Abuse	Hospital-Wide Screening for Substance Use Disorder	01/10/2014	Approved conditional on receipt of funding attestation and budget addendum, and with mid-point review follow-up*
3676102	UNDERWOOD MEMORIAL HOSPITAL	Chemical Addiction/ Substance Abuse	Hospital-Wide Screening for Substance Use Disorder	01/21/2014	Approved, with mid-point review follow-up*
3677001	UNIVERSITY HOSPITAL	Cardiac Care	The Congestive Heart Failure Transition Program (CHF-TP)	12/19/2013	Approved
4135601	UNIVERSITY MED CTR PRINCETON @ PLAINSBORO	Diabetes	Diabetes Group Visits for Patients and Community Education	01/31/2014	Approved, with mid-point review follow-up*
3674304	VIRTUA - WEST JERSEY HEALTH SYSTEM	Diabetes	Diabetes Group Visits for Patients and Community Education	01/31/2014	Approved, with mid-point review follow-up*

* Issues for mid-point review follow-up are shown in Enclosure 2.

** Questions that hospitals must address with their resubmitted plans are shown in Enclosure 3.

**Enclosure 2: New Jersey DSRIP Hospital Mid-Point Review Topics
April 4, 2014**

Project ID	Hospital Name	CMS Follow-up Issues
4136705/0167011	BAYONNE HOSPITAL	The hospital must further develop its plan for participating in the learning collaborative. The hospital must clearly state timelines that can be measured and used in reporting.
4141105	BAYSHORE COMMUNITY HOSPITAL	The hospital must further develop its plan for participating in the learning collaborative. The data collection and submission strategy – along with data sources, methodology and population denominators – is unclear and must be strengthened.
4135709	CAPE REGIONAL MEDICAL CENTER	The hospital must further develop its plan for participating in the learning collaborative. Hospital indicated potential problems completing state 3 and 4 metrics.
4138201	CAPITAL HEALTH SYSTEM – HOPEWELL	Need confirmation on smart phones and tablet usage in DY 2. Need to finalize protocol, curricula, and program components and develop method to capture measurements prior to end of DY 3.
4141008	CENTRASTATE MEDICAL CENTER	The hospital must further develop its plan for calculating and reporting baseline data for non-claims based measures. The hospital must further develop its plan for participating in the learning collaborative. The hospital must clearly state timelines that can be measured and used in reporting.
4136209	CHILTON MEMORIAL HOSPITAL	The hospital must further develop its plan for participating in the learning collaborative. The hospital must clearly state timelines that can be measured and used in reporting. The hospital needs to provide its plan for monitoring and evaluating the Home Visit Plan and associated vendor.
3674207	CHRIST HOSPITAL	The hospital must clearly state timelines that can be measured and used in reporting.
3674606	COMMUNITY MEDICAL CENTER	The hospital must further develop its plan for calculating and reporting baseline data for non-claims based measures.
4136004	COOPER UNIVERSITY MEDICAL CTR	The hospital must further develop its plan for participating in the learning collaborative. The hospital must clarify the role of provider partners in its execution of its project.
4140001	EAST ORANGE GENERAL HOSPITAL	The hospital must further develop its plan for participating in the learning collaborative. The hospital must clearly state timelines that can be measured and used in reporting. The data collection and submission strategy must be strengthened.
4138309	ENGLEWOOD HOSPITAL ASSOCIATION	The hospital must further develop its plan for calculating and reporting baseline data for non-claims based measures. The hospital must further develop its plan for participating in the learning collaborative. The hospital must clearly state timelines that can be measured and used in reporting. Roles of visiting nurses vs. FQHC need to be clarified.
3675700	JERSEY SHORE MEDICAL CENTER	The hospital must further develop its plan for participating in the learning collaborative. The hospital must clearly state timelines that can be measured and used in reporting.
3676803	JFK MEDICAL CENTER {EDISON} / Anthony M. Yelencsics	The hospital must further develop its plan for participating in the learning collaborative.

**Enclosure 2: New Jersey DSRIP Hospital Mid-Point Review Topics
April 4, 2014**

Project ID	Hospital Name	CMS Follow-up Issues
4140206	KENNEDY MEMORIAL HOSPITALS AT STRATFORD	The hospital must clearly state timelines that can be measured and used in reporting. Integration/development of PCMH elements into hospital healthcare delivery model is unclear and must be strengthened.
3676200	KIMBALL MEDICAL CENTER	The hospital must further develop its plan for participating in the learning collaborative. Potential issue of non-trained personnel transporting individuals with serious psychiatric disorders to appointments should be examined. Discharge planning, interaction with patients must incorporate evidence-based practices.
4141504/0249297	MEADOWLANDS HOSPITAL MEDICAL CENTER	The hospital must further develop its plan for calculating and reporting baseline data for non-claims based measures. The hospital must further define the areas where it expects its project to result in improvement. The hospital must further develop its plan for participating in the learning collaborative. The roles of the registered nurses, case managers, and navigator should be clarified. Training should be ongoing. Is the outpatient clinic the medical home?
3674908	MEDICAL CENTER OF OCEAN COUNTY	Project methodology lacks specificity.
4138902	MEMORIAL HOSP OF BURLINGTON CTY (Virtua)	The hospital must further develop its plan for participating in the learning collaborative.
4138708/0139564	MOUNTAINSIDE HOSPITAL	The hospital must clarify the role of provider partners in its execution of its project. More info on project population numbers. Is this entire population (including PCMH) or limited to the Adult Care Center Population.
4137108	OUR LADY OF LOURDES MEDICAL CENTER	This hospital is already a leader in cardiac care. It will be a challenge for it to raise the bar in this area.
4135105	PALISADES GENERAL HOSPITAL	The hospital must further develop its plan for calculating and reporting baseline data for non-claims based measures.
4137400	RIVERVIEW MEDICAL CENTER	The hospital must clarify the role of provider partners in its execution of its project. What is the plan for group visits beyond the three that will be done at 6 week intervals? How will physical exams be addressed for patients?
3676901	RWJ UNIVERSITY MEDICAL CTR AT HAMILTON	The hospital must further develop its plan for participating in the learning collaborative.
4138406	SOMERSET MEDICAL CENTER	The hospital must further develop its plan for calculating and reporting baseline data for non-claims based measures. The hospital must further develop its plan for participating in the learning collaborative. The hospital must clarify the role of provider partners in its execution of its project. The hospital must clearly state timelines that can be measured and used in reporting. The continued existence of the hospital's diabetes center appears to be in jeopardy, which is a situation that should be monitored.
3675602	SOUTH JERSEY HEALTH SYSTEM - ELMER	Implementation plan requires further development.

**Enclosure 2: New Jersey DSRIP Hospital Mid-Point Review Topics
April 4, 2014**

Project ID	Hospital Name	CMS Follow-up Issues
4141202	SOUTHERN OCEAN COUNTY HOSPITAL	The hospital must further develop its plan for calculating and reporting baseline data for non-claims based measures. The hospital must further develop its plan for participating in the learning collaborative.
3675904	ST. BARNABAS MEDICAL CENTER	The hospital must clarify the role of provider partners in its execution of its project.
4136608	ST. FRANCIS MEDICAL CENTER (TRENTON)	The hospital must further develop its plan for participating in the learning collaborative. No implementation strategy addressed nor time frames.
4136403	ST. JOSEPH'S HOSPITAL MEDICAL CENTER	The hospital must further develop its plan for participating in the learning collaborative. The hospital must clarify the role of provider partners in its execution of its project.
4139208	ST. LUKE'S HOSPITAL (formerly Warren Hospital)	The hospital must further develop its plan for participating in the learning collaborative. The hospital must clarify the role of provider partners in its execution of its project.
4135300	ST. MARY'S HOSPITAL (PASSAIC)	The hospital must clarify the role of provider partners in its execution of its project. Will assessments, patient/caregiver education, medication reconciliation, follow-up appointment reminders, and community resource referrals be provided to patients who do not receive a home visit?
4140508	ST. MICHAEL'S MEDICAL CENTER	The hospital must further develop its plan for participating in the learning collaborative. The hospital must clarify the role of provider partners in its execution of its project. The role of patient navigator needs to be specified.
4139500	ST. PETER'S MEDICAL CENTER	The hospital must further develop its plan for participating in the learning collaborative.
4136900	TRINITAS - ELIZABETH GENERAL	Safety issues may be of concern. How is nurse-initiation of withdrawal protocol monitored, tracked, co-signatures as needed, order renewal, medication interactions, meds/laboratory? Recommend language on how program considered patient's rights for house-wide screening, refusals and billing issues. Does substance abuse screening include ALL units? Critical supports mentioned, but not how they will be implemented.
3676102	UNDERWOOD MEMORIAL HOSPITAL	Timelines for assessments, treatment and physician intervention are unclear. Pilot numbers and data strategy are not identified.
4135601	UNIVERSITY MED CTR PRINCETON @ PLAINSBORO	The hospital must further develop its plan for calculating and reporting baseline data for non-claims based measures. The hospital must further develop its plan for participating in the learning collaborative. The hospital must clarify the role of provider partners in its execution of its project.
3674304	VIRTUA - WEST JERSEY HEALTH SYSTEM	The hospital must further develop its plan for participating in the learning collaborative.

**Enclosure 3: CMS Questions for New Jersey DSRIP Hospitals That Were Not Approved
April 4, 2014**

Project ID	Hospital Name	CMS Questions
4139402	ATLANTICARE REG'L MEDICAL CENTER	<p>Although the documents submitted provided an explanation of the Special Care Center and the unique relationship to be played with community and regional partners and payers, it was difficult to determine whether the Special Care Center program is a recipient of United States Department of Health and Human Services (DHHS) funds.</p> <ol style="list-style-type: none"> 1. Please provide a clear statement that the proposed project is not already funded by DHHS, and an addendum to your project budget that identifies any expense line items for which the hospital already receives federal funding support (or a statement to the effect that no expense line items receive federal support). 2. Please explain how the proposed DSRIP project is a new project or a significant expansion of an existing project. (Will the DSRIP program target new clients? Will the program hire additional staff members?)
4139003	BERGEN REG'L MEDICAL CENTER	<p>Please provide an attestation that Bergen Regional Medical Center will collect and report all Stage 3 measures indicated for its project in the DSRIP Planning Protocol, and will be subject to improvement targets as specified in Section VII(B)(ii) of the DSRIP Program Funding and Mechanics Protocol.</p>
3676609	CAPITAL HEALTH SYSTEM - FULD CAMPUS	<p>Capital Health System (CHS) proposes to develop a Hospital-wide Screening for Substance Use Disorder and plans to implement a new type of screening, SBIRT (Screening and brief intervention and referral to treatment), for outpatients in the Emergency Department. The program appears to be new because it targets new populations, updates a manual tracking system to an electronic system, recruits new staff members and begins the SBIRT process from the ER. However, reviewed hospital documents suggest that CHS was a recipient of 7 million dollars to implement SBIRT, an initiative of SAMHA.</p> <ol style="list-style-type: none"> 1. Please provide a clear statement that the proposed project is not already funded by the United States Department of Health and Human Services, and an addendum to your project budget that identifies any expense line items for which the hospital already receives federal funding support (or a statement to the effect that no expense line items receive federal support).
3674100	HACKENSACK UNIVERSITY MEDICAL CENTER	<ol style="list-style-type: none"> 1. Please describe your current care transitions program/process for cardiac patients (all payor designations) and distinguish this from what is being proposed under your DSRIP project. 2. Please explain how DSRIP complements but does not duplicate the interventions under your Health Care Innovation Award. Include in your response an addendum to your project budget that identifies any expense line items for which the hospital already receives federal funding support (or a statement to the effect that no expense line items receive federal support).
4139801	JERSEY CITY MEDICAL CENTER	<p>From the documents submitted, it is unclear whether the proposed DSRIP project is an enhancement to the current asthma program at Jersey City Medical Center.</p> <ol style="list-style-type: none"> 1. Please provide a clear statement that the proposed project is new and exceeds any current activities underway at Jersey City Medical Center. For example, what is the difference between the DSRIP proposal and the HRSA-funded program? Is the partnership between the two FQHC grantees in Newark considered to be the program enhancement? 2. Please provide a clear statement that the proposed project is not already funded by the United States Department of Health and Human Services, and an addendum to your project budget that identifies any expense line items for which the hospital already receives federal funding support (or a statement to the effect that no expense line items receive federal support).

**Enclosure 3: CMS Questions for New Jersey DSRIP Hospitals That Were Not Approved
April 4, 2014**

Project ID	Hospital Name	CMS Questions
3675203	LOURDES MED CTR OF BURLINGTON CNTY	<ol style="list-style-type: none"><li data-bbox="641 268 1404 352">1. Please describe your current care transitions program/process for cardiac patients (all payor designations) and distinguish this from what is being proposed under your DSRIP project.<li data-bbox="641 359 1404 462">2. Please identify the payor source designations for the (referenced) 81 patients you expect to include in your DSRIP project. (Are they expected to be Medicaid patients? Charity Care patients? Medicare patients? Other?)

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850



December 23, 2013

The Honorable Jennifer Velez
Commissioner
Department of Human Services
P.O. Box 700
Trenton, NJ 08625-0700

Dear Mr. Velez:

I am writing to inform you that the Centers for Medicare & Medicaid Services (CMS) has granted your request to amend the New Jersey's section 1115(a) demonstration (11-W- 00279/2), entitled "the New Jersey Comprehensive Waiver." Approval of this amendment is under the authority of section 1115(a) of the Social Security Act and is effective from the date of this letter.

This amendment incorporates the new Medicaid adult expansion group - 1902(a)(10)(A)(i)(VII) into the demonstration effective January 1, 2014 and modifies the Graduate Medical Education program.

CMS has also technically amended the demonstration per your request to reflect that the blind group is included in the "New Jersey Care Special Medicaid Programs ABD" in the eligibility chart. You also requested authority to restrict the number of provider agreements with managed care entities. We have determined the state's own procurement laws govern the number of provider agreements and as such, no additional authority is needed.

CMS approval of this amendment is conditioned on continued compliance with the enclosed set of Special Terms and Conditions (STCs) that define the nature, character, and extent of anticipated Federal involvement in the project. The award is subject to your written acknowledgement of the award and acceptance of the STCs within 30 days of the date of this letter.

The existing waiver and expenditure authorities for this demonstration are also enclosed and are unchanged by this amendment, and remain in force.

Your project officer for this demonstration is Ms. Lane Terwilliger. She is available to answer any questions concerning your section 1115 demonstration and this amendment. Ms. Terwilliger's contact information is

Ms. Lane Terwilliger
Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16
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Official communications regarding this demonstration should be sent simultaneously to Ms. Terwilliger and Mr. Michael Melendez, Associate Regional Administrator for the Division of Medicaid and Children's Health in our New York City Regional Office. Mr. Melendez's contact information is as follows:

Mr. Michael Melendez
Centers for Medicare & Medicaid Services
26 Federal Plaza, Room 37-100 North
New York, NY 10278
Phone: (212) 616-2430
Email: Michael.Melendez@cms.hhs.gov

If you have any questions regarding this approval, please contact Mr. Eliot Fishman, Director, Children and Adults Health Programs Group, Center for Medicaid & CHIP Services at (410) 786-5647.

Sincerely,

/s/

Cindy Mann
Director

cc: Michael Melendez, ARA Region II
Valerie Harr, New Jersey Medicaid Director

**CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY**

NUMBER: 11-W-00279/2 (Titles XIX & XXI)

TITLE: New Jersey Comprehensive Waiver Demonstration

AWARDEE: New Jersey Department of Human Services Division of Medical Assistance and Health Services

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the State for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, incurred during the period of this Demonstration, shall be regarded as expenditures under the State's title XIX plan.

The following expenditure authorities shall enable the State to operate its section 1115 Medicaid and CHIP Comprehensive Waiver Demonstration.

Title XIX – Cost Not Otherwise Matchable

1. Expenditures for health care-related costs related to services listed in Attachment E (other than those incurred through Charity Care) under the **Serious Emotional Disturbance Program** for children up to age 21 who meet the institutional or needs based level of care for serious emotional disturbance.
2. Expenditures for health care-related costs related to services listed in Attachment F (other than those incurred through Charity Care) under the **Medical Assistance Treatment Program** for adults with household income up to 150 percent of the Federal poverty level (FPL) who have been diagnosed with mental illness and have a history of opioid use.
3. Expenditures for health care-related costs (other than costs incurred through the Charity Care) under the **Work First Childless Adults** for childless non-pregnant adults ages 19 through 64 years who are not otherwise eligible under the Medicaid State plan, do not have other health insurance coverage, are residents of New Jersey, are citizens or eligible aliens, have limited assets, and either: 1) cooperate with applicable work requirements and have countable monthly household incomes up to \$140 for a childless adult and \$193 for a childless adult couple; or 2) have a medical deferral from work requirements based on a physical or mental condition, which prevents them from work requirements and have countable monthly household incomes up to \$210 for a childless adult and \$289 for a childless couple. (This authority will terminate December 31, 2013)
4. Expenditures to provide coverage under the **NJ FamilyCare Childless Adult Program** to uninsured individuals over age 18 with family income below 100% of FPL, who are childless adults and who are not otherwise eligible for Medicare, Medicaid, or have other creditable health insurance coverage who were covered by New Jersey Family Care prior to enactment of the phase out under Section 2111 of the Social Security Act. (This authority will terminate December 31, 2013)

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5. Expenditures for the 217-Like Expansion Populations.

Expenditures for the provision of Medicaid State plan services and HCBS services (as specified in Attachments C-1, C-2, and D) for individuals identified in the Special Terms and Conditions (STCs) who would otherwise be Medicaid-eligible under section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR § 435.217 in conjunction with section 1902(a)(10)(A)(ii)(V) of the Act, if the services they receive under an HCBS waiver granted to the State under section 1915(c) of the Act.

6. HCBS for SSI-Related State Plan Eligibles

Expenditures for the provision of HCBS waiver-like services (as specified in Attachments C-1 and C-2 of the STCs) that are not described in section 1905(a) of the Act, and not otherwise available under the approved State plan, but that could be provided under the authority of section 1915(c) waivers, that are furnished to HCBS/MLTSS Demonstration Participants with qualifying income and resources, and meet an institutional level of care.

7. Expenditures Related to the Transition Payments

Subject to an overall cap on the transition payments, expenditures for transition year payments to hospitals and other providers as outlined in paragraph 92 (of the STCs) for the period of the Demonstration.

8. Expenditure for HCBS/MLTSS furnished to Low Income Individuals Who Transferred Assets

Expenditures for the provision of LTC and HCBS that could be provided under the authority of 1915(c)(c) waivers, that would not otherwise be covered due to a transfer of assets penalty when the low-income individual has attested that no transfers were made during the look back period.

9. Expenditures Related to the Delivery System Reform Incentive Payment (DSRIP) Program

Subject to CMS' timely receipt and approval of all deliverables specified in STC paragraph 93, expenditures for incentive payments from pool funds for the Delivery System Reform Incentive Payment (DSRIP) Program for the period of the Demonstration.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, shall apply to the Demonstration Populations as specified in the individual not applicable beginning from the approval date of the Demonstration through June 30, 2017.

Title XIX Requirements Not Applicable to the:

1. Retroactive Eligibility

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Section 1902(a)(34)

To the extent necessary to allow the State to enroll Demonstration participants in the **Work First Childless Adults Population** no earlier than the first day of the month in which the application for the Demonstration was submitted.

2. Reasonable Promptness

Section 1902(a)(8)

To the extent necessary to enable the State to limit enrollment through waiting lists for the **Supports, Pervasive Development Disability, Persons with Intellectual Disabilities and Mental Illness, and the Persons with Intellectual Disabilities Out of State Programs, Medication Assisted Treatment Initiative, and Serious Emotional Disturbance** to receive HCBS services outlined in Attachment C, D, and E.

CHIP – Title XXI Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Act as incorporated into title XXI by section 2107(e)(2)(A), State expenditures described below (which would not otherwise be included as matchable expenditures under title XXI) shall, for the period of this project and to the extent of the State’s available allotment under section 2104 of the Act, be regarded as matchable expenditures under the State’s title XXI plan. All requirements of the title XXI statute will be applicable to such expenditures, except those specified below as not applicable to these expenditure authorities. In addition, all requirements in the enclosed STCs will apply to these expenditure authorities.

1. Expenditures to provide coverage to individuals who are uninsured custodial parents and caretaker relatives of Medicaid and CHIP children with incomes above the previous Medicaid standard up to and including 133 percent of the FPL. Coverage must meet the requirements of section 2103 of the Act, and covered services must be actuarially equivalent to the commercial HMO coverage offered in New Jersey with the most non-Medicaid enrollees. For the period October 1, 2013 to December 31, 2013, these individuals will receive title XIX funding.
2. Expenditures to provide coverage consistent with section 2103 of the Act for uninsured custodial parents and caretaker relatives of children eligible under the title XXI State plan, when the parents and caretakers have family incomes at or above 134 percent up to and including 200 percent of the FPL and are not eligible for Medicaid. For the period October 1, 2013 to December 31, 2013, these individuals will receive title XIX funding.

CHIP Requirements Not Applicable to the CHIP Expenditure Authorities

All requirements of the CHIP program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in this letter shall apply to this demonstration. To further this demonstration, we are identifying the following requirements as inapplicable to the extent indicated:

1. General Requirements, Eligibility and Outreach

Section 2102

For CHIP Parent/Caretakers up to 133 percent of the FPL:

The demonstration population does not have to reflect the state child health plan population, and eligibility standards do not have to be limited by the general principles in

section 2102(b)(1)(B). To the extent other requirements in section 2102 duplicate Medicaid or other CHIP requirements for this or other populations, they do not apply, except that the State must perform eligibility screening to ensure that the demonstration population does not include individuals otherwise eligible for Medicaid under the standards in effect on August 31, 2000.

For CHIP Parent/Caretakers with income between 134 and 200 percent of the FPL:

The demonstration population does not have to reflect the state child health plan population, and eligibility standards do not have to be limited by the general principles in section 2102(b)(1)(B). The State must perform eligibility screening to ensure that applicants for the demonstration population who are eligible for Medicaid are enrolled in that program and not in the demonstration population.

2. Restrictions on Coverage and Eligibility to Targeted Low-Income Children **Sections 2103 and 2110**

Coverage and eligibility for the demonstration populations are not restricted to targeted low-income children.

3. Federal Matching Payment and Family Coverage Limits **Section 2105**

Federal matching payment is available in excess of the 10 percent cap for expenditures related to the demonstration populations and limits on family coverage are not applicable.

Federal matching payments remain limited by the allotment determined under section 2104. Expenditures other than for coverage of the demonstration populations remain limited in accordance with section 2105(c)(2).

4. Annual Reporting Requirements **Section 2108**

Annual reporting requirements do not apply to the demonstration populations.

5. Purchase of Family Coverage Substitution Mechanism **Section 2105(c)(3)(B)**

To permit the State to apply the same waiting period for families opting for premium assistance that it applies for children that receive direct coverage under the Children's Health Insurance State plan.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITY**

NUMBER: 11-W-00279/2 (Title XIX)
TITLE: New Jersey Comprehensive Waiver Demonstration
AWARDEE: New Jersey Department of Human Services Division of Medical Assistance and Health Services

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the Demonstration from the effective date specified through June 30, 2017. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of State plan requirements contained in section 1902 of the Act are granted in order to enable New Jersey to carry out the New Jersey Comprehensive Waiver section 1115 Demonstration.

1. Statewideness **Section 1902(a)(1)**

To enable the State to conduct a phased transition of Home and Community Based Services (HCBS) for Medicaid beneficiaries from fee-for-service to a managed care delivery system based on geographic service areas.

2. Amount, Duration, & Scope **Section 1902(a)(10)(B)**

To enable the State to modify the Medicaid benefit package to provide a more limited package to beneficiaries who are eligible as parents or caretaker relatives with incomes above the 1996 AFDC income standard and at or below 133 percent of the Federal poverty level (FPL).

To the extent necessary to enable the State to vary the amount, duration, and scope of services offered to individuals, regardless of eligibility category, by providing additional services to enrollees in certain targeted programs to provide home and community-based services.

3. Freedom of Choice **Section 1902(a)(23)(A)**

To the extent necessary, to enable the State to restrict freedom of choice of provider through the use of mandatory enrollment in managed care plans for the receipt of covered services. No waiver of freedom of choice is authorized for family planning providers.

4. Direct Payment to Providers

Section 1902(a)(32)

To the extent necessary to permit the State to have individuals self-direct expenditures for HCBS long-term care and supports.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS (STCs)**

NUMBER: 11-W-00279/2 (Titles XIX and XXI)

TITLE: New Jersey Comprehensive Waiver (NJCW) Demonstration

AWARDEE: New Jersey Department Human Services
Division of Medical Assistance and Health Services

DEMONSTRATION

PERIOD: October 1, 2012 through June 30, 2017

I. PREFACE

The following are the Special Terms and Conditions (STCs) for New Jersey’s “Comprehensive Waiver” section 1115(a) Medicaid and Children’s Health Insurance Plan (CHIP) demonstration (hereinafter “demonstration”), to enable the New Jersey Department Human Services, Division of Medical Assistance and Health Services (State) to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act (Act), and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth conditions and limitations on those waivers and expenditure authorities, and describe in detail the nature, character, and extent of Federal involvement in the demonstration and the State’s obligations to CMS during the life of the demonstration. These STCs neither grant additional waivers or expenditure authorities, nor expand upon those separately granted.

The STCs related to the programs for those state plan and demonstration populations affected by the demonstration are effective from the date indicated above through June 30, 2017.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Historical Context
- III. General Program Requirements
- IV. Eligibility
- V. Benefits
- VI. Cost Sharing
- VII. Delivery System I – Managed Care Requirements
- VIII. Delivery System II – Additional Delivery System Requirements for Home and Community Based Services and Managed Long Term Services and Supports
- IX. Delivery System III - Behavioral Health
- X. Transition Requirements for Managed Long Term Services and Supports
- XI. New Home and Community Based Service Programs
- XII. Premium Assistance

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- XIII. Quality
- XIV. Funding Pools
- XV. General Reporting Requirements
- XVI. Administrative Requirements
- XVII. General Financial Requirements Under Title XIX
- XVIII. General Financial Requirements Under Title XXI
- XIX. Monitoring Budget Neutrality for the Demonstration
- XX. Evaluation Plan and Design
- XXI. Scheduled Deliverables

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A	Quarterly Report Template
Attachment B	State Plan Benefits
Attachment C.1	Non-MLTSS HCBS Benefits
Attachment C.2	HCBS Benefits
Attachment D	Serious Emotional Disturbance (SED) Program Benefits
Attachment E	Medication Assisted Treatment Initiative (MATI) Program Benefits
Attachment F	Behavioral Health Organization (BHO) and Administrative Services Organization (ASO)
Attachment G	DSRIP Planning Protocol; Attachment 1-Toolkit; Addendum 1 and Addendum 2
Attachment H	DSRIP Program Funding and Mechanics Protocol
Attachment I	Hospitals Eligible for Transition and DSRIP Payments

II. PROGRAM DESCRIPTION AND HISTORICAL CONTEXT

On September 14, 2011 the State of New Jersey submitted a Medicaid section 1115 demonstration proposal which seeks to provide comprehensive health care benefits for approximately 1.3 million individuals, including individuals eligible for benefits under New Jersey’s Medicaid Program and additional populations eligible only under the demonstration. The new demonstration consolidated the delivery of services under a number of separate State initiatives, including its Medicaid State plan, existing CHIP State plan, four previous 1915(c) waiver programs and two (2) standalone section 1115 demonstrations. The demonstration will require approximately 98 percent or 1.3 million beneficiaries to enroll in Managed Care Organizations (MCOs), with approximately 75,000 beneficiaries enrolled in Medicaid fee-for-service (FFS).

The demonstration will:

- Maintain Medicaid and CHIP State plan benefits without change;
- Continue the expanded eligibility and service delivery system under four existing 1915(c) home and community-based services (HCBS) waivers that:
 - Offer HCBS services and supports through a Traumatic Brain Injury Program

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- (TBI) to certain individuals between the ages of 21 to 64 years of age who have acquired, non-degenerative, structural brain damage and who meet the Social Security Administration's (SSA) disability standard.
 - Offer HCBS services through an AIDS Community Care Alternative program (ACCAP) to certain individuals diagnosed with AIDS that support them and their primary caregivers.
 - Offers HCBS services and supports through a Community Resources for People with Disabilities program (CRPD) to certain individuals with physical disabilities who need assistance with at least 3 activities of daily living; and,
 - Offers HCBS services and supports through a Global Options (GO) program for certain individuals 65 years of age and older and physically disabled persons between 21 years of age and 64, who are assessed as needing nursing facility level of care.
- Continue the service delivery system under two previous 1915(b) managed care waiver programs that:
 - Require Medicare and Medicaid eligible beneficiaries to mandatorily enroll in an MCO for Medicaid services only.
 - Require disabled and foster care children to enroll in an MCO for care.
- Streamline eligibility requirements with a projected spend down for individuals who meet the nursing facility level of care
- Eliminate the five year look back at time of application for applicants or beneficiaries seeking long term services and supports who have income at or below 100 percent of the Federal Poverty Level (FPL);”
- Cover additional home and community-based services to Medicaid and CHIP beneficiaries with serious emotional disturbance, opioid addiction, pervasive developmental disabilities, and intellectual disabilities/developmental disabilities;
- Cover outpatient treatment for opioid addiction or mental illness for an expanded population of adults with household incomes up to 150 percent FPL;
- Through December 31, 2013 expand eligibility to include a population of individuals between 18 and 65 who are not otherwise eligible for Medicaid, have household incomes between 25 and 100 percent of the FPL and are in satisfactory immigration status;
- Transform the State's behavioral health system for adults by delivering behavioral health through behavioral health administrative service organizations.
- Furnish premium assistance options to individuals with access to employer-based coverage.

Demonstration Goals:

Ensure continued coverage for groups of individuals currently under the Medicaid and CHIP State plans, previous waiver programs, and previously state-funded programs. In this demonstration the State seeks to achieve the following goals:

- Create “no wrong door” access and less complexity in accessing services for integrated health and Long-Term Care (LTC) care services;
- Provide community supports for LTC and mental health and addiction services;
- Provide in-home community supports for an expanded population of individuals with intellectual and developmental disabilities;

- Provide needed services and HCBS supports for an expanded population of youth with severe emotional disabilities; and
- Provide need services and HCBS supports for an expanded population of individuals with co-occurring developmental/mental health disabilities.
- Encourage structural improvements in the health care delivery system through DSRIP funding.

Demonstration Hypothesis:

The State will test the following hypotheses in its evaluation of the demonstration:

- Expanding Medicaid managed care to include long-term care services and supports will result in improved access to care and quality of care and reduced costs, and allow more individuals to live in their communities instead of institutions.
- Providing home and community-based services to Medicaid and CHIP beneficiaries and others with serious emotional disturbance, opioid addiction, pervasive developmental disabilities, or intellectual disabilities/developmental disabilities will lead to better care outcomes.
- Utilizing a projected spend-down provision and eliminating the look back period at time of application for transfer of assets for applicants or beneficiaries seeking long term services and supports whose income is at or below 100% of the FPL will simplify Medicaid eligibility and enrollment processes without compromising program integrity.
- The Delivery System Reform Incentive Payment (DSRIP) Program will result in better care for individuals (including access to care, quality of care, health outcomes), better health for the population, and lower cost through improvement.

Amendments to the Demonstration:

On August 8, 2013 CMS approved amendment request to modify Delivery System and Reform Incentive Payment (DSRIP) program so that that the Hospital relief Subsidy Fund (HRSF) transition payments could be extended through December 31, 2013 due to unforeseeable delays in completing the DSRIP Planning Protocol and DSRIP Funding & Mechanics protocol. The extension would ease the burden of the hospitals in the development of their DSRIP plans as they transition from the HRSF subsidy to the performance-based DSRIP program.

This December 2013 amendment to modifies the Graduate Medical Education payment program and to include the adult expansion eligibility group into the demonstration effective January 1, 2014.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

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- 2. Compliance with Medicaid and Child Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid program, or the Children’s Health Insurance Program (CHIP) for the separate CHIP population, expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.
- 3. Changes in Medicaid and CHIP Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.
- 4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
- a. To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this demonstration, the State must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.
 - b. If mandated changes in the Federal law require State legislation, the changes must take effect on the earlier of the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
- 5. State Plan Amendments.** The State will not be required to submit title XIX or XXI State plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP State plan is affected by a change to the demonstration, a conforming amendment to the appropriate State Plan is required, except as otherwise noted in these STCs.
- 6. Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, delivery systems, cost sharing, evaluation design, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the

demonstration that have not been approved through the amendment process set forth in paragraph 7 below.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. Amendment requests must include, but are not limited to, the following:

- a. An explanation of the public process used by the State, consistent with the requirements of STC 15 to reach a decision regarding the requested amendment;
- b. A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
- c. An up-to-date CHIP allotment worksheet, if necessary.
- d. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and
- e. If applicable, a description of how the evaluation designs will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration.**

- a. States that intend to request demonstration extensions under sections 1115(a), 1115(e) or 1115(f) must submit an extension request no later than 12 months prior to the expiration date of the demonstration. The chief executive officer of the State must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9.
- b. Compliance with Transparency Requirements 42 CFR Section 431.412:
Effective April 27, 2012, as part of the demonstration extension requests the State must provide documentation of compliance with the transparency requirements 42 CFR Section 431.412 and the public notice and tribal consultation requirements outlined in paragraph 15, as well as include the following supporting documentation:
 - i. Historical Narrative Summary of the demonstration Project: The State must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective

of the change and desired outcomes must be included.

- ii. **Special Terms and Conditions (STCs):** The State must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.
- iii. **Waiver and Expenditure Authorities:** The State must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.
- iv. **Quality:** The State must provide summaries of: External Quality Review Organization (EQRO) reports; managed care organization (MCO) and Coordinated Care Organization (CCO) reports; State quality assurance monitoring; and any other documentation that validates of the quality of care provided or corrective action taken under the demonstration.
- v. **Financial Data:** The State must provide financial data (as set forth in the current STCs) demonstrating the State's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension as well as cumulatively over the lifetime of the demonstration. CMS will work with the State to ensure that Federal expenditures under the extension of this project do not exceed the Federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension. In addition, the State must provide up to date responses to the CMS Financial Management standard questions. If title XXI funding is used in the demonstration, a CHIP Allotment Neutrality worksheet must be included.
- vi. **Evaluation Report:** The State must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.
- vii. **Documentation of Public Notice 42 CFR section 431.408:** The State must provide documentation of the State's compliance with public notice process as specified in 42 CFR section 431.408 including the post-award public input process described in 431.420(c) with a report of the issues raised by the public during the comment period and how the State considered the comments when developing the demonstration extension application.

9. Demonstration Phase-Out. The State may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

- a. **Notification of Suspension or Termination:** The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective

date and a phase-out plan. The State must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the State must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the State must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the State must provide a summary of each public comment received the State's response to the comment and how the State incorporated the received comment into a revised phase-out plan.

- b. The State must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.
- c. Phase-out Plan Requirements: The State must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the State will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.
- d. Phase-out Procedures: The State must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the State must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR §431.230. In addition, the State must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.
- e. Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.
- f. Post Award Forum: Within six months of the demonstration's implementation, and annually thereafter, the State will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the State must publish the date, time and location of the forum in a prominent location on its website. The State can use either its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The State must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly report, as specified in paragraph 102, associated with the quarter in which the forum was held. The State must also include the summary in its annual report as required in paragraph 103.

10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing that the State has materially failed to comply with the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.
11. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge CMS' finding that the State materially failed to comply.
12. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.
13. **Submission of State Plan and Demonstration Amendments, and Transition Plan, Related to Implementation of the Affordable Care Act (ACA).**

Upon implementation of the Affordable Care Act (ACA) in January 2014, expenditure authority for many demonstration Expansion populations will end. To the extent that the State seeks authority for the eligibility, benefits and cost sharing for these populations under the Medicaid or CHIP State plan, the State will, by April 1, 2013, submit proposed State plan amendments for any such populations. Concurrently, the State will submit proposed amendments to the demonstration to the extent that such populations will be subject to the demonstration. In addition, the State will submit by October 1, 2013, a transition plan consistent with the provisions of the Affordable Care Act for individuals enrolled in the demonstration, including how the State plans to coordinate the transition of these individuals to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. The plan must contain the required elements and milestones described in subparagraphs outlined below. In addition, the Plan will include a schedule of implementation activities that the State will use to operationalize the Transition Plan and meet the requirements of regulations and other CMS guidance related to ACA implementation.

- a. Transition plan must assure seamless transitions: Consistent with the provisions of the Affordable Care Act, the Transition Plan will include details on how the State will obtain and review any additional information needed from each individual to determine eligibility under all eligibility groups, and coordinate the transition of individuals enrolled in the demonstration (by FPL) (or newly applying for Medicaid) to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. Specifically, the State must:

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- i. Determine eligibility under all January 1, 2014, eligibility groups for which the State is required or has opted to provide medical assistance, including the group described in §1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL.
 - ii. Identify demonstration populations not eligible for coverage under the Affordable Care Act and explain what coverage options and benefits these individuals will have effective January 1, 2014.
 - iii. Implement a process for considering, reviewing, and making preliminary determinations under all January 1, 2014 eligibility groups for new applicants for Medicaid eligibility.
 - iv. Conduct an analysis that identifies populations in the demonstration that may not be eligible for or affected by the Affordable Care Act and the authorities the State identifies that may be necessary to continue coverage for these individuals.
 - v. Develop a modified adjusted gross income (MAGI) conversion for program eligibility.
- b. Cost-sharing Transition: The Plan must include the State’s process to come into compliance with all applicable Federal cost-sharing requirements,
- c. Transition Plan Implementation:
- i. By October 1, 2013, the State must begin to implement a simplified, streamlined process for transitioning eligible enrollees in the demonstration to Medicaid, the Exchange or other coverage options in 2014. In transitioning these individuals from coverage under the waiver to coverage under the State plan, the State will not require these individuals to submit a new application.
 - ii. On or before December 31, 2013, the State must provide notice to the individual of the eligibility determination using a process that minimizes demands on the enrollees.

14. **Adequacy of Infrastructure.** The State will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

15. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The State must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009 and the tribal consultation requirements contained in the

State's approved State plan, when any program changes to the demonstration, including (but not limited to) those referenced in paragraph 7, are proposed by the State.

In States with Federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the State's approved Medicaid State plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)).

In States with Federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, and/or renewal of this demonstration (42 C.F.R. §431.408(b)(3)). The State must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

16. **Federal Financial Participation (FFP).** Federal funds are not available for expenditures for this demonstration until the effective date identified in the demonstration approval letter.

IV. ELIGIBILITY

The NJCW maintains Medicaid and CHIP eligibility for populations eligible prior to the demonstration, including eligibility under four 1915(c) waiver programs, and two 1915(b) waiver programs and the prior CHIP and childless adult demonstrations. In addition, this demonstration provides for some expanded eligibility for some additional populations, as indicated below. In addition, populations eligible under the state plan, as identified below, may be affected by the demonstration through requirements to enroll in the Medicaid managed care program under the demonstration to receive state plan benefits. Individuals eligible for both Medicare and Medicaid (duals) are covered under this demonstration for Medicaid services. The eligibility chart in STC 19 provides details including populations originally covered as Medicaid expansion populations that will be transitioned either to the adult expansion group or to the Market Place effective January 1, 2014.

17. **Eligibility Groups Affected By the Demonstration.** Benefits and service delivery options for the mandatory and optional State plan groups described in STC 19(a) and (b) below are affected by the demonstration. To the extent indicated in STC 32, these groups receive covered benefits through managed care organizations (MCOs).
18. **Expansion Groups:** Non-Medicaid eligible groups described in STC 19(c) and (d) are eligible under the demonstration, to the extent included in expenditure authorities separately granted to facilitate this demonstration. To the extent indicated in STC 32, these groups receive covered benefits through managed care organizations (MCOs).
19. **Demonstration Population Summary.** The Following Chart Describes the Populations Affected and the Demonstration Expansion Populations.

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a. Medicaid State Plan Mandatory Groups Affected by the Demonstration

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
AFDC including Pregnant women	<ul style="list-style-type: none"> ▪ Section 1931 low-income families with children- §1902(a)(10)(A)(i)(I) §1931 ▪ Individuals who lose eligibility under §1931 due to increased earned income or working hours - §1902(a)(10)(A)(i)(I) §408(a)(11)(A), §1925, 1931(c)(2), 1902(a)(52), 1902(e)(1)(B) ▪ Individuals who lose eligibility under §1931 because of income from child or spousal support - §1902(a)(10)(A)(i)(I), §1931(c)(1), §408(a)(11)(B) ▪ Qualified pregnant women - §1902(a)(10)(A)(i)(III) §1905(n)(1) ▪ Qualified children - §1902(a)(10)(A)(i)(III) §1905(n)(2) ▪ Newborns deemed eligible for one year - §1902(e)(4) ▪ Pregnant women who lose eligibility receive 60 days coverage for pregnancy-related and post-partum services - §1902(e)(5) ▪ Pregnant women losing eligibility because of a change in income remain eligible 60 days post-partum - 	<p>Through 12/31/13 AFDC standard and methodologies or more liberal (The monthly income limit for a family of four is \$507. No resource limit)</p> <p>Beginning 01/01/2014 MAGI methodology</p>	Plan A (See Attachment B)	“Title XIX”

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NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	§1902(e)(6)			
NJ FamilyCare Adult Expansion Group	<ul style="list-style-type: none"> ▪ Effective January 1, 2014, the Affordable Care Act new adult group, described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119, pursuant to the approved state plan. 	MAGI methodology	1/1/14 benefits as described in approved alternative benefit plan state plan amendment and these STCs. Plan ABP	New Adult Group
Foster Care	<ul style="list-style-type: none"> ▪ Children receiving IV-E foster care payments or with IV-E adoption assistance agreements - §1902(a)(10)(i)(I), §473(b)(3) 	Auto-eligible	Plan A (see Attachment B)	“Title XIX”
SSI recipients	<ul style="list-style-type: none"> ▪ Individuals receiving SSI cash benefits - §1902(a)(10)(A)(i)(I) ▪ Disabled children no longer eligible for SSI benefits because of a change in definition of disability - §1902(a)(10)(A)(i)(II)(aa) ▪ Individuals under age 21 eligible for Medicaid in the month they apply for SSI - §1902(a)(10)(A)(i)(II)(cc) ▪ Disabled individuals whose earnings exceed SSI substantial gainful activity level - §1619(a) ▪ Disabled widows and widowers - §1634(b) §1939(a)(2)(C) ▪ Disabled adult children - §1634(c) §1939(a)(2)(D) ▪ Early widows/widowers - §1634(d) 	<p>SSI standards and methodologies</p> <p>SSI amount and NJ includes a state supplement</p>	Plan A (see Attachment B)	<p><u>Before implementation of MLTSS</u></p> <p>(1) If enrolled in TBI, then “TBI – SP.”</p> <p>(2) If enrolled in ACCAP, then “ACCAP – SP.”</p> <p>(3) If enrolled in CRPD, then “CRPD – SP.”</p> <p>(4) If enrolled in GO, then “GO – SP.”</p> <p>(5) If not (1) through (4), then “ABD.”</p> <p><u>After implementation of MLTSS:</u></p> <p>(1) If receiving</p>

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NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	<p>§1939(a)(2)(E)</p> <ul style="list-style-type: none"> ▪ Individuals receiving mandatory State supplements - 42 CFR 435.130 ▪ Individuals eligible as essential spouses in December 1973 - 42 CFR 435.131 ▪ Institutionalized individuals who were eligible in December 1973 - 42 CFR 435.132 ▪ Blind and disabled individuals eligible in December 1973 - 42 CFR 435.133 ▪ Individuals who would be eligible except for the increase in OASDI benefits under Public Law 92-336 - 42 CFR 435.134 ▪ Individuals who become ineligible for cash assistance as a result of OASDI cost-of- living increases received after April 1977 - 42 CFR 435.135 ▪ Individuals ineligible for SSI or optional state supplement because of requirements that do not apply for Title XIX – 42 CFR 435.122 			<p>community-based MLTSS, then “HCBS – State Plan.”</p> <p>(2) If residing in a NF, ICF/MR, or other institutional setting, then “LTC.”</p> <p>3) If not (1) or (2), then “ABD.”</p>
1619 (b)	<ul style="list-style-type: none"> ▪ Disabled individuals whose earnings are too high to receive SSI cash - §1619(b) 	Earned income is less than the threshold amount as defined by Social Security	Plan A (see Attachment B)	<p><u>Before implementation of MLTSS</u></p> <p>(1) If enrolled in TBI, then “TBI – SP.”</p>

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NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
		<p>Unearned income is the SSI amount The resource amount is the SSI limit of 2,000 for an individual and 3000 for a couple.</p>		<p>(2) If enrolled in ACCAP, then “ACCAP – SP.” (3) If enrolled in CRPD, then “CRPD – SP.” (4) If enrolled in GO, then “GO – SP.” (5) If not (1) through (4), then “ABD.”</p> <p><u>After implementation of MLTSS:</u> (1) If receiving community-based MLTSS, then “HCBS – State Plan.” (2) If residing in a NF, ICF/MR, or other institutional setting, then “LTC.” 3) If not (1) or (2), then “ABD.”</p>
New Jersey Care Special Medicaid Programs	<ul style="list-style-type: none"> ▪ Poverty level pregnant women - §1902(a)(10)(A)(i)(IV) §1902(l)(1)(A) ▪ Poverty level infants - §1902(a)(10)(A)(i)(IV) §1902(l)(1)(B) 	<p>Through 12/31/2013 Pregnant Women and Infants: Income less than or equal to 133% FPL Children age 1-5:</p>	Plan A (see Attachment B)	“Title XIX”

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NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	<ul style="list-style-type: none"> ▪ Poverty level children age 1-5 §1902(a)(10)(A)(i)(VI) §1902(l)(1)(C) ▪ Poverty level children age 6-18 - §1902(a)(10)(A)(i)(VII) §1902(l)(1)(D) ▪ Poverty level infants and children receiving inpatient services who lose eligibility because of age must be covered through an inpatient stay - §1902(e)(7) 	<p>Family income less than or equal to 133% FPL Children age 6-18: Family income less than or equal to 100% FPL</p> <p>Beginning 01/01/2014 MAGI methodology</p>		

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b. Medicaid State Plan Optional Groups Affected by the Demonstration

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
AFDC including Pregnant women	<ul style="list-style-type: none"> ▪ Individuals who are eligible for but not receiving IV-A, SSI or State supplement cash assistance - §1902(a)(10)(A)(ii)(I) ▪ Individuals who would have been eligible for IV-A cash assistance, SSI, or State supplement if not in a medical institution - §1902(a)(10)(A)(ii)(IV) 	<ul style="list-style-type: none"> ▪ AFDC methodology <p>The monthly income limit for a family of four is \$507. AFDC resource limit.</p> <p>Beginning 01/01/2014 MAGI</p>	Plan A (see Attachment B)	“Title XIX”
Medicaid Special	<ul style="list-style-type: none"> ▪ All individuals under 21 who are not covered as mandatory categorically needy - §1902(a)(10)(A)(ii)(I) and (IV) §1905(a)(i) 	<ul style="list-style-type: none"> ▪ AFDC methodology ▪ The difference between the 1996 AFDC income standard and 133% FPL is disregarded from the remaining earned income. <p>Beginning 01/01/2014 MAGI</p>	Plan A (see Attachment B)	“Title XIX”
SSI recipients	<ul style="list-style-type: none"> ▪ Individuals receiving only an 	NJ state supplement	Plan A (see	<u>Before implementation</u>

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NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	<p>optional state supp. 42 CFR 435.232</p> <ul style="list-style-type: none"> ▪ Individuals who meet the SSI requirements but do not receive cash – 42 CFR 435.210 ▪ Individuals who would be eligible for cash if not in an institution – 42 CFR 435.211 	<p>only – determined annually and based on living arrangement Resources - SSI SSI methodology Income standard – SSI and SSI supplement payment Resource: SSI</p>	<p>Attachment B)</p>	<p><u>of MLTSS</u> (1) If enrolled in TBI, then “TBI – SP.” (2) If enrolled in ACCAP, then “ACCAP – SP.” (3) If enrolled in CRPD, then “CRPD – SP.” (4) If enrolled in GO, then “GO – SP.” (5) If not (1) through (4), then “ABD.”</p> <p><u>After implementation of MLTSS:</u> (1) If receiving community-based MLTSS, then “HCBS – State Plan.” (2) If residing in a NF, ICF/MR, or other institutional setting, then “LTC.” (3) If not (1) or (2), then “ABD.”</p>
<p>Institutional Medicaid</p>	<p><i>Special income level group:</i> Individuals who are in a medical institution for at least 30 consecutive days with gross income that does not exceed 300% of</p>	<p><i>Special income level group:</i> Income less 300% of SSI/Federal Benefit Rate (FBR)</p>	<p>Plan A (see Attachment B)</p>	<p><u>Before implementation of MLTSS</u> (1) If enrolled in TBI, then “TBI – 217 Like.”</p>

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NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	<p>the SSI income standard, or state-specified standard - §1902(a)(10)(A)(ii)(V)</p> <p><i>Hospice Group:</i> Individuals who are terminally ill, would be eligible if they were in a medical institution, and will receive hospice care - §1902(a)(10)(A)(ii)(VII)</p> <p><i>Special Home and Community Based Services Group:</i> Individuals who would be eligible in an institution and receiving services under the State’s current 1915(c) waivers specifically: (1) Global Options Waiver (GO) # NJ.0032; (2) Community Resources for People with Disabilities (CRPD) Waiver #NJ.4133; (3) AIDS Community Care Alternatives Program (ACCAP) NJ#06-160; (4) and Traumatic Brain Injury (TBI) Program NJ# 4174</p>	<p>per month; Resources SSI Standard; Individuals must meet institutional LOC requirements</p> <p><i>Hospice Group:</i> Individuals Income less 300% of SSI/Federal Benefit Rate (FBR) per month. Resources SSI Standard</p>		<p>(2) If enrolled in ACCAP, then “ACCAP – 217 Like.” (3) If enrolled in CRPD, then “CRPD – 217 Like.” (4) If enrolled in GO, then “GO – 217 Like.” (5) If not (1) through (4), then “ABD.”</p> <p><u>After implementation of MLTSS:</u> “LTC.” (Note: Special Home and Community Based Services Group will no longer be active after implementation of MLTSS.)</p>
New Jersey Care Special Medicaid Programs Pregnant Women and Children	<ul style="list-style-type: none"> ▪ Poverty level pregnant women not mandatorily eligible - §1902(a)(10)(A)(ii)(IX) §1902(l)(1)(A) ▪ Poverty level infants not mandatorily 	<ul style="list-style-type: none"> ▪ Pregnant women: Income less than or equal to 185% FPL 	Plan A (see Attachment B)	“Title XIX”

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NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	<p>eligible - §1902(a)(10)(A)(ii)(IX) §1902(l)(1)(B)</p> <ul style="list-style-type: none"> ▪ Optional targeted low income children age 6-18 – 1902(a)(10)(A)(ii)(XIV) 	<ul style="list-style-type: none"> ▪ Infants: Family income less than or equal to 185% FPL ▪ Children: Family income more than 100% and less than or equal to 133% FPL <p>Beginning 01/01/2014 MAGI</p>		
New Jersey Care Special Medicaid Programs ABD	<ul style="list-style-type: none"> ▪ Individuals receiving COBRA continuation benefits - §1902(a)(10)(F) 1902(u) ▪ Eligibility group only includes aged and disabled individuals - §1902(a)(10)(A)(ii)(X) ▪ Eligibility group included blind individuals – (1902)(r)(2). 	<p>Income must be less than or equal to 100% FPL. Resources up to \$4,000 for individual, \$6,000 for couple</p>	Plan A (see Attachment B)	<p><u>Before implementation of MLTSS</u></p> <p>(1) If enrolled in TBI, then “TBI – SP.”</p> <p>(2) If enrolled in ACCAP, then “ACCAP – SP.”</p> <p>(3) If enrolled in CRPD, then “CRPD – SP.”</p> <p>(4) If enrolled in GO, then “GO – SP.”</p> <p>(5) If not (1) through (4), then “ABD.”</p>

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				<u>After implementation of MLTSS:</u> (1) If receiving community-based MLTSS, then “HCBS – State Plan.” (2) If residing in a NF, ICF/MR, or other institutional setting, then “LTC.” 3) If not (1) or (2), then “ABD.”
Chafee Kids	<ul style="list-style-type: none"> ▪ Children under age 26 who were in foster care on their 18th birthday – 1902(a)(10)(A)(ii)(XVII) 	Children 18 up to 26 who were in foster care at the age of 18. On their 18 th birthday must be in DCF out of home placement supported in whole or in part by public funds No income or resource test	Plan A (see Attachment B)	“Title XIX”
Subsidized Adoption Services	<ul style="list-style-type: none"> ▪ Children under 21 who are under State adoption agreements - §1902(a)(10)(A)(ii)(VIII) 	Must be considered to have special needs	Plan A (see Attachment B)	“Title XIX”
Medically Needy Children and Pregnant Women	<ul style="list-style-type: none"> ▪ Individuals under 18 who would be mandatorily categorically eligible except for income and resources - §1902(a)(10)(C)(ii)(I) 	AFDC methodology – including spend down provision outlined in the state	Limited Plan A Services (see Attachment B)	“Title XIX”

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NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	<ul style="list-style-type: none"> ▪ Pregnant women who would be categorically eligible except for income and resources - §1902(a)(10)(C)(ii)(II) ▪ Pregnant women who lose eligibility receive 60 days coverage for pregnancy-related and post-partum services - §1902(a)(10)(C) §1905(e)(5) 	<p>plan</p> <p>Income after spend down is equal to or less than \$367 for an individual, \$434 for a couple, two person household or pregnant woman, etc. Up to \$4,000 in resources allowed for an individual, \$6,000 for a couple</p>		
Medically Needy Aged, Blind or Disabled	<ul style="list-style-type: none"> ▪ Medically Needy - §1902(a)(10)(C) ▪ Blind and disabled individuals eligible in December 1973 - 42 CFR 435.340 	<p>SSI methodology – including spend down provision outlined in the state plan</p> <p>Income after spend down is equal to or less than \$367 for an individual, \$434 for a couple, two person household or pregnant woman, etc. Up to \$4,000 in resources allowed for an individual, \$6,000 for a couple</p>	Attachment B	“ABD”
New Jersey WorkAbility	<ul style="list-style-type: none"> ▪ §1902(a)(10)(A)(ii)(XV) 	Individual must be between the ages of	Plan A (see Attachment B)	“ABD”

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		<p>16 and 65, have a permanent disability, as determined by the SSA or DMAHS and be employed</p> <p>Countable unearned income (after disregards) up to 100% FPL, countable income with earnings up to 250% FPL; resources up to \$20,000 for an individual, \$30,000 for a couple</p>		
Breast and Cervical Cancer	<ul style="list-style-type: none"> ▪ §1902(a)(10)(A)(ii)(XVIII) 	<p>Uninsured low income women under the age of 65 who have been screened at a NJ cancer education and early detection site and needs treatment</p> <p>No Medicaid income or resource limit</p>	Plan A (Attachment B)	“ABD”
Title XXI Medicaid Expansion Children		The Medicaid expansion is for children 6 to 18 years	Plan A (see Attachment B)	“Title XXI Exp Child”

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NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
		of age whose family income is above 100 percent up to and including 142 percent of the FPL.		
<p>Parents/Caretakers up to 133% FPL through 12/31/2013.</p> <p>Effective 1/01/2014, this group will move NJ FamilyCare Adult Expansion Group</p>		Uninsured custodial parents and caretaker relatives of Medicaid and CHIP children with family incomes above the previous Medicaid standard up to and including 133 percent off the FPL	<p>Plan D (see Attachment B)</p> <p>Effective 01/01/2014 moving from Plan D to plan ABP.</p>	<p><u>Through 9/30/2013</u> Title XXI under “NJFAMCAREWAIV-POP 1”</p> <p><u>9/30/2013 through 12/31/2013</u> Title XIX under “XIX CHIP Parents”</p>
<p>Through 12/31/2013 Parent Caretakers between 134 & 200% FPL</p> <p>Effective 1/01/2014 this eligibility group will not be included in this waiver</p>		<p>Uninsured custodial parents and caretaker relatives with income at or above 134 percent of the FPL, and up to and including 200 percent of the FPL.</p> <p>(Enrollment into this group was frozen March 1, 2010)</p>	Plan D (see Attachment B)	<p><u>Through 9/30/2013</u> Title XXI under “NJFAMCAREWAIV-POP 2”</p> <p><u>9/30/2013 through 12/31/2013</u> Title XIX under “XIX CHIP Parents”</p>

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c. Demonstration Expansion Eligibility Groups

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
<p>Through 12/31/2013 Work First (Childless Adults)</p> <p>Effective 1/01/2014, this group will move NJ FamilyCare Optional Adult Expansion Group</p>		<p>Through 12/31/2013 Childless non-pregnant adults ages 19 through 64 years who are not otherwise eligible under the Medicaid State plan, do not have other health insurance coverage, are residents of New Jersey, are citizens or eligible aliens, have limited assets, and either: 1) cooperate with applicable work requirements and have countable monthly household incomes up to \$140 for a childless adult and \$193 for a childless adult couple; or 2) have a medical deferral from work requirements based on a physical or mental condition, which prevents them from work requirements and have countable monthly household incomes up to</p>	<p>Plan G (see Attachment B)</p> <p>Effective 01/01/2014 moving from Plan G to Plan ABP.</p>	<p>Through 12/31/2013 “NJ Childless Adults”</p>

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NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
		\$210 for a childless adult and \$289 for a childless couple.		
Through 12/31/2013 Childless Adults Effective 1/01/2014 this eligibility group will moved and reported under the NJ FamilyCare Adult Expansion group)MEG name (New Adult Group)		Adults between 25 and 100% FPL who were enrolled in the program as of September 2001.	Plan D (see Attachment B) Effective 01/01/2014 moving from Plan D to Plan ABP.	Through 12/31/2013 "AWDC"
MATI New HCBS program	Adults 18 years and older at risk of institutionalization.	Income 150% FPL for adults who do not otherwise qualify for Medicaid	HCBS MATI services only (see Attachment E)	"MATI at Risk"

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NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
Medication Assisted Treatment Initiative (MATI)		Resources SSI Use financial institutional eligibility and post eligibility rules in the community for individuals who would not be eligible in the community because of community deeming rules in the same manner that would be used under a 1915(c) waiver program.		

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NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
New HCBS program Serious Emotional Disturbance (SED)	SED children under age 21 at risk of hospitalization who have been diagnosed as seriously emotionally disturbed. (1115)	Income 150% FPL Resources SSI. Use financial institutional eligibility and post eligibility rules for individuals who would not be eligible in the community because of community deeming rules in the same manner that would be used under a 1915(c) waiver program.	3 HCBS services plus State Plan Behavioral Health Services (Children otherwise eligible for Medicaid will receive the full Medicaid benefit package + the three HCBS services)	“SED at Risk”

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d. Demonstration Expansion 217 –Like Eligibility Groups

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
<p>217-like Existing .217 under HCBS</p>	<p>Special income level (SIL) group receiving HCBW-like or services.</p> <p>42 CFR 435.217, 435.236 and 435.726 of and section 1924 of the Social Security Act, if the State had 1915(c) waivers</p> <p>(formerly served through the Community Resources for People with Disabilities, AIDS Community Care Alternatives , Traumatic Brain Injury, and Global Options for Long Term Care 1915(c) Waivers)</p> <p>Prior to transition of TBI, ACCAP, CRPD, and GO to MLTSS, this group includes individuals participating in those programs who are eligible for Medicaid under 42 CFR 435.217,</p>	<p>Income up to 300% of SSI/FBR</p> <p>Resources SSI</p> <p>Methodology SSI</p> <p>Use institutional eligibility and post eligibility rules for individuals who would only be eligible in the institution in the same manner as specified as if the State had 1915(c) waiver programs</p>	<p>State plan services with additional waiver services (see Attachment D)</p>	<p><u>After implementation of MLTSS</u></p> <p>“HCBS – 217 Like”</p>
<p>217-like Existing .217 under HCBS</p>	<p>A subset of the aged and disabled (Aged and Disabled) poverty level group who would only be eligible in the institution and receive HCBW-like services.</p>	<p>Income up to 100% of FPL</p> <p>Resources SSI</p> <p>Methodology SSI</p> <p>Use institutional eligibility and post eligibility rules</p>	<p>State plan services with additional waiver services.</p>	<p><u>After implementation of MLTSS</u></p> <p>“HCBS – 217 Like”</p>

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NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	<p>42 CFR 435.217, 435.726, 1902(m) and section 1924 of the Social Security Act</p> <p>(formerly served through the Community Resources for People with Disabilities, AIDS Community Care Alternatives , Traumatic Brain Injury, and Global Options for Long Term Care 1915(c) Waivers)</p> <p>Prior to transition of TBI, ACCAP, CRPD, and GO to MLTSS, this group includes individuals participating in those programs who are eligible for Medicaid under 42 CFR 435.217,</p>	<p>for individuals who would only be eligible in the institution in the same manner as if the State had 1915(c) waiver programs.</p>		
New 217-like Medically Needy	<p>The medically needy with a “hypothetical” spend down receiving HCBW--like services.</p> <p>42 CFR 435.217, 435.726, 1902(a)(10)(C)(i)(III) and section 1924 of the Social Security Act</p> <p>(Medically Needy With A Spenddown under the 435.217</p>	<p>Use institutional eligibility and post eligibility rules for individuals who would only be eligible in the institution in the same manner as specified under, if the State had 1915(c) waiver programs.</p> <p>In order for medically needy individuals with a</p>	State plan services with additional waiver services	<p><u>After implementation of MLTSS</u> “HCBS – 217 Like”</p>

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NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	group. These individuals were not previously covered under the State's 1915(c) Waiver Programs)	spenddown to be covered under the 217 like HCBS group the State must develop as hypothetical spenddown to demonstrate that these individuals would be eligible if in an institution. New Jersey's hypothetical spenddown uses the annual average nursing facility costs which are the statewide average cost of institutional care. This amount will be adjusted annually in accordance with the change in the Consumer Price Index all Urban Consumers, rounded up to the nearest dollar. If the individual's hypothetical cost exceeds the individual's monthly income, individual is Medicaid eligible. However, the individual's is considered categorically needy because he/she is eligible in the 217 like		

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NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
		group and has no spenddown. Post eligibility treatment of income rules apply in accordance with 435.726 and 1924 of the Act.		
217 like New HCBS program Serious Emotional Disturbance (SED) that is optional under State Plan	SED children under age 21 meeting hospital level of care who have been diagnosed as seriously emotionally disturbed. 42 CFR 435.217, 435.726, 435.236 and 1924 of the Social Security Act	Income 300% of the SSI/FBR Resources SSI. Use institutional eligibility and post eligibility rules for individuals who would only be eligible in the institution in the same manner as specified under, if the State had 1915(c) waiver programs.	3 HCBS services plus State Plan Services	“SED – 217 Like”
Expansion group 217 like New HCBS program Intellectual Disabilities/Developmental Disabilities	IDD/MI children under age 21 meeting state mental hospital level of care 42 CFR 435.217, 435.726, 435.236 and 1924 of the Social Security Act	Income 300% SSI/FBR Resources SSI. Use institutional eligibility and post eligibility rules for individuals who would only be eligible in the institution in the same manner as specified under, if the State had 1915(c) waiver programs.	Medicaid Benefit package +HCBS services	“IDD/MI – 217 Like”

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NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
s with Co-occurring Mental Health Diagnosis (IDD/MI)				
<p>e. Excluded Populations. The following populations are excluded from the demonstration. :</p> <ul style="list-style-type: none"> a. QMBs – 1902(a)(10)(E)(i); 1905(p) b. SLMBs – 1902(a)(10)(E)(iii); 1905(p) c. QIs – 1902(a)(10)(E)(iv); 1905(p) d. QDWIs – 1902(a)(10)(E)(iii); 1905(s) e. PACE Participants 				

20. Eligibility/Post-Eligibility Treatment of Income and Resources for Institutionalized Individuals. In determining eligibility (except for short term stays) for institutionalized individuals, the State must use the rules specified in the currently approved Medicaid State plan. All individuals receiving institutional services must be subject to post-eligibility treatment of income rules set forth in section 1924 of the Act and 42 CFR Section 435.725 of the Federal regulations.

a. Individuals Receiving Home and Community Based Services or Managed Long Term Services and Supports

i. 217-Like Group of Individuals Receiving HCBS Services. Institutional eligibility and post eligibility rules apply in the same manner as specified under 42 CFR 435.217, 435.236, 435.726 and 1902(m)(1), and 1924 of the Social Security Act, if the State had 1915(c) waivers. These groups of individuals were previously included under the State’s existing 1915(c) waivers #0032, #0160, #4133 and #4174.

- The State will use the portion of the capitated payment rate that is attributable to HCBS/MLTSS as the “dollar” amount of HCBS/MLTSS services that the individual is liable for since the capitated portion of the rate that is attributable HCBS/MLTSS is the actual amount the State pays to the managed care organization/entity for these services.

ii. 217-like Medically Needy Individuals Eligible for HCBS /MLTSS Programs. Institutional eligibility and post eligibility rules apply in the same manner as specified under 42 CFR 435.217, 435.236, 435.726 and 1902(m)(1), and 1924 of the Social Security Act, if the State had 1915(c) waivers, except that a projected spend down using nursing home costs is applied to determine eligibility And, in the post-eligibility process, a maintenance amount is disregarded . This applies to individuals who could have been included under the State’s existing 1915(c) waivers #0032, #0160, #4133 and 4174 had the State elected to cover these individuals under these 1915(c) waivers and had the waiver programs not been rolled into the 1115 waiver.

- The State will use the portion of the capitated payment rate that is attributable HCBS/MLTSS as the “dollar” amount of HCBS/MLTSS services that the individual is liable for since the capitated portion of the rate that is attributable HCBS/MLTSS is the actual amount the State pays to the managed care organization/entity for these services.

iii. 217 Like Groups of Individuals Receiving HCBS Like Services Under New Medicaid Programs. Institutional eligibility and post eligibility rules apply in the same manner as specified under 42 CFR 435.217, 435.236, 435.726 and 1924 of the Social Security Act, if the State had 1915(c) waivers. The State uses the SSI resource standard.

21. **Transfer of Assets.** At the time of application for long term care and home and community based services, based on self-attestation, New Jersey will not review assets pursuant to section 1917 of the Act for applicants or beneficiaries seeking long term services and supports with income at or below 100 percent of the FPL.

V. BENEFITS

Individuals affected by, or eligible under, the demonstration will receive benefits as specified in Attachment B, as outlined in the table in paragraph 19 above. Individuals may receive additional benefits as described below to the extent that they are enrolled in the referenced programs that are set forth in sections VIII, IX, X and XI of these STCs.

22. **Alternative Benefit Plan:** The Affordable Care Act Low-Income Adult Group will receive benefits provided through the state's approved alternative benefit plan (ABP) SPA and these STCs.
23. Individuals enrolled in the Managed Long Term Services and Supports Program described in section X of these STCs receive all Medicaid and CHIP State Plan services, including behavioral health, through their Medicaid MCO listed in Attachment B. This population also receives a HCBS package of benefits listed in Attachment C.2.
24. Individuals enrolled in the Supports Program described in STC 78 receive all Medicaid and CHIP State Plan services through their Medicaid MCO listed in Attachment B. This population also receives a HCBS package of benefits listed in Attachment C.1.
25. Individuals enrolled in the Pervasive Developmental Disorders (PDD) Program described in STC 79 receive all Medicaid and CHIP State Plan services through their Medicaid MCO listed in Attachment B and behavioral health demonstration services through the children's Administrative Services Organization listed in Attachment F. This population also receives a HCBS package of benefits listed in Attachment C.1.
26. Individuals enrolled in the Pilot for Individuals with Intellectual Disabilities/ Development Disabilities with Co-Occurring Mental Health Diagnoses (ID-DD/MI) described in STC 80 receive all Medicaid State Plan services through their Medicaid MCO listed in Attachment B and behavioral health demonstration services through the children's Administrative Services Organization listed in Attachment F. This population also receives a HCBS package of benefits listed in Attachment C.1.
27. Individuals enrolled in the Intellectual Developmental Disability Program for Out of State (IDD/OOS) New Jersey Residents described in STC 81 receive all Medicaid State plan services listed in Attachment B. In addition to Medicaid State Plan services in Plan A this population receives HCBS service package of benefits designed to provide the appropriate supports to maintain the participants safely in the community listed in Attachment C.1.
28. Individuals enrolled in the Program for Children diagnosed with Serious Emotional Disturbance (SED) described in STC 82 receive all Medicaid and CHIP State Plan services through their Medicaid MCO listed in Attachment B and SED program services listed in Attachment D.
29. Individuals enrolled in the Medication Assisted Treatment Initiative (MATI) described in STC 83 receive all Medicaid and CHIP State Plan services through their Medicaid MCO listed in Attachment B and MATI services through the adult behavioral health ASO listed in

Attachment E.

30. **Short term Nursing Facility Stays.** Short term nursing facility stays are covered for individuals receiving HCBS or Managed Long Term Services and Supports. Coverage of nursing facility care for up to no more than 180 days is available to a HCBS/MLTSS demonstration participant receiving home and community-based services upon admission who requires temporary placement in a nursing facility when such participant is reasonably expected to be discharged and to resume HCBS participation within no more than 180 days including situations when a participant needs skilled or rehabilitative services for no more than 180 days due either to the temporary illness of the participant or absence of a primary caregiver.

- Such HCBS/MLTSS demonstration participants must meet the nursing facility level of care upon admission, and in such case, while receiving short-term nursing facility care may continue enrollment in the demonstration pending discharge from the nursing facility within no more than 180 days or until such time it is determined that discharge within 180 days from admission is not likely to occur, at which time the person shall be transitioned to an institution, as appropriate.
- The community maintenance needs allowance shall continue to apply during the provision of short-term nursing facility care in order to allow sufficient resources for the member to maintain his or her community residence for transition back to the community.

VI. COST SHARING

31. Costs sharing for the Medicaid and CHIP programs are reflected in Attachment B. Notwithstanding Attachment B, all cost-sharing for State plan populations must be in compliance with Medicaid and CHIP requirements that are set forth in statute, regulation and policies. In addition, aggregate cost sharing imposed on any individual adult demonstration participant on an annual basis must be limited to five percent of the individual's aggregate family income.

VIII. DELIVERY SYSTEMS I -- MANAGED CARE REQUIREMENTS

Applicability of Managed Care Requirements to Populations Affected by and Eligible Under the Demonstration. All populations affected by, or eligible under the Demonstration that receive State plan benefits (Attachment B) are enrolled in managed care organizations that comply with the managed care regulations published at 42 CFR 438 to receive such benefits, except as expressly waived or specified as not applicable to an expenditure authority. Capitation rates shall be developed and certified as actuarially sound, in accordance with 42 CFR 438.6. The certification shall identify historical utilization of State Plan and HCBS services, as appropriate, which were used in the rate development process. The following populations are excepted from mandatory enrollment in managed care:

- a. Through December 31, 2013 Work First (Childless Adults) (at which time this population

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- will be moved to the NJ FamilyCare adult expansion group);
- b. MATI At Risk;
- c. SED At Risk;
- d. American Indians and Alaska Natives; and
- e. Medicaid eligible not listed in paragraphs 19(a) or 19(b).

32. **Benefits Excepted from Managed Care Delivery System:** Benefits that are excepted from the Managed Care Delivery System are those that are designated as FFS in Attachment B.

33. **Care Coordination and Referral Under Managed Care.** As noted in plan readiness and contract requirements, the State must require that each MCO refer and/or coordinate, as appropriate, enrollees to any needed State plan services that are excluded from the managed care delivery system but available through a fee for service delivery system, and must also assure referral and coordination with services not included in the established benefit package.

34. **Managed Care Contracts.** No FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR 438 requirements prior to CMS approval of such contracts and/or contract amendments. The State shall submit any supporting documentation deemed necessary by CMS. The State must provide CMS with a minimum of 60 days to review and approve changes. CMS reserves the right, as a corrective action, to withhold FFP (either partial or full) for the demonstration, until the contract compliance requirement is met.

35. **Public Contracts.** Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).

36. **Network Requirements.** The State must ensure the delivery of all covered benefits, including high quality care. Services must be delivered in a culturally competent manner, and the MCO network must be sufficient to provide access to covered services to the low-income population. In addition, the MCO must coordinate health care services for demonstration populations. The following requirements must be included in the State's MCO contracts:

- a. **Special Health Care Needs.** Enrollees with special health care needs must have direct access to a specialist, as appropriate for the individual's health care condition, as specified in 42 C.F.R. 438.208(c)(4).
- b. **Out of Network Requirements.** Each MCO must provide demonstration populations with all demonstration program benefits described within these STCs and must allow access to non-network providers when services cannot be provided consistent with the timeliness standards required by the State.

37. **Demonstrating Network Adequacy.** Annually, each MCO must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area

and offers an adequate range of preventive, primary, pharmacy, and specialty and HCBS services for the anticipated number of enrollees in the service area.

- a. The State must verify these assurances by reviewing demographic, utilization and enrollment data for enrollees in the demonstration as well as:
 - i. The number and types of primary care, pharmacy, and specialty providers available to provide covered services to the demonstration population;
 - ii. The number of network providers accepting the new demonstration population; and
 - iii. The geographic location of providers and demonstration populations, as shown through GeoAccess or similar software.
- b. The State must submit the documentation required in subparagraphs i – iii above to CMS with initial MCO contract submission as well as with each annual report.

38. Provider Credentialing. The provider credentialing criteria described at 42 CFR 438.214 must apply to MLTSS providers. If the MCO's credentialing policies and procedures do not address non-licensed/non-certified providers, the MCO must create alternative mechanisms to ensure enrollee health and safety.

39. Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Compliance. The State must ensure that the MCOs are fulfilling the State's responsibilities for coverage, outreach, and assistance with respect to EPSDT services that are described in the requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements), and 1905(r) (definitions).

40. Advisory Committee as required in 42 CFR 438. The State must maintain for the duration of the demonstration a managed care advisory group comprised of individuals and interested parties impacted by the demonstration's use of managed care, regarding the impact and effective implementation of these changes to seniors and persons with disabilities. Membership on this group should be periodically updated to ensure adequate representation of individuals receiving MLTSS.

41. Mandatory Enrollment. The State will require that individuals served through this demonstration enroll in managed care programs to receive benefits only when the plans in the applicable geographic area have been determined by the State to meet certain readiness and network requirements and require plans to ensure sufficient access, quality of care, and care coordination for beneficiaries established by the State, as required by 42 CFR 438 and approved by CMS. The State may not mandatorily enroll individuals into any plan that does not meet network adequacy requirements as defined in 42 CFR 438.206.

42. Choice of MCO. The State must ensure that at the time of initial enrollment and on an ongoing basis, the individuals have a minimum of 2 MCOs meeting all readiness

requirements from which to choose. If at any time, the State is unable to offer 2 plans, an alternative delivery system must be available within 60 days of loss of plan choice.

43. **MCO Selection.** Demonstration participants who are enrolled in Medicaid and Medicaid Expansion populations are required to enroll in an MCO and must have no less than 10 days to make an active selection of an MCO upon notification that a selection must be made. Any demonstration participant that does not make an active selection will be assigned, by default, to a participating MCO. That assignment shall be based on 42 CFR 438.50. Once the participant is advised of the State's MCO assignment, the participant, consistent with 42 CFR section 438.56, is permitted up to 90 days to disenroll from the assigned MCO and select another. The participant then receives a second 90-day period to disenroll after enrolling in that MCO, if other MCO choices are available. Once the participant remains in an MCO beyond 90 days, disenrollment may only occur for cause (as defined by the State) or at least every 12 months during an open enrollment period.
44. **Required Notice for Change in MCO Network.** The State must provide notice to CMS as soon as it becomes aware of (or at least 90 days prior if possible) a potential change in the number of plans available for choice within an area, or any other changes impacting proposed network adequacy. The State must provide network updates through its regular meetings with CMS and submit regular documentation as requested.

VIII. DELIVERY SYSTEM --II – ADDITIONAL DELIVERY SYSTEM REQUIREMENTS FOR HOME AND COMMUNITY BASED SERVICES (HCBS) AND MANAGED LONG TERM SUPPORT SERVICES (MLTSS) PROGRAM

In addition to the requirements described in Section VII Delivery System I, the following additional delivery system requirements apply to all the HCBS programs and MLTSS programs in this demonstration.

45. **Administrative Authority.** There are multiple State agencies involved in the administration of the HCBS; therefore, the Single State Medicaid Agency (SSMA) must maintain authority over the programs. The SMA must exercise appropriate monitoring and oversight over the State agencies involved, the MCO's, and other contracted entities.
46. **Home and Community-Based Characteristics.** Residential settings located in the community will provide members with the following:
- a. Private or semi-private bedrooms including decisions associated with sharing a bedroom.
 - b. All participants must be given an option to receive home and community based services in more than one residential setting appropriate to their needs.
 - c. Private or semi-private bathrooms that include provisions for privacy.
 - d. Common living areas and shared common space for interaction between participants,

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their guests, and other residents.

- e. Enrollees must have access to a food storage or food pantry area at all times.
- f. Enrollees must be provided with an opportunity to make decisions about their day to day activities including visitors, when and what to eat, in their home and in the community.
- g. Enrollees will be treated with respect, choose to wear their own clothing, have private space for their personal items, have privacy to visit with friends, family, be able to use a telephone with privacy, choose how and when to spend their free time, and have opportunities to participate in community activities of their choosing.

47. **Health and Welfare of Enrollees.** The State, or the MCO for MLTSS enrolled individuals, through an MCO contract, shall be required on a continuous basis to identify, address, and seek to prevent instances of abuse, neglect and exploitation through the Critical Incident Management System referenced in paragraph 50.

48. **Demonstration Participant Protections.** The State will assure that children, youth, and adults in MLTSS and HCBS programs are afforded linkages to protective services (e.g., Ombudsman services, Protection and Advocacy, Division of Child Protection and Permanency) through all service entities, including the MCOs.

- a. The State will ensure that these linkages are in place before, during, and after the transition to MLTSS as applicable.
- b. The State/MCOs will develop and implement a process for community-based providers to conduct efficient, effective, and economical background checks on all prospective employees/providers with direct physical access to enrollees.

49. **Critical Incident Management System.** The State must operate a critical incident management system according to the State's established policies, procedures and regulations and as described in section XIII.

50. **Managed Care Grievance/Complaint System.** The MCO must operate a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services.

51. **Fair Hearings.** All enrollees must have access to the State fair hearing process as required by 42 CFR 431 Subpart E. In addition, the requirements governing MCO appeals and grievances in 42 CFR 438 Subpart F shall apply.

52. **Plan of Care (PoC).** A "Plan of Care" is a written plan designed to provide the demonstration enrollee with appropriate services and supports in accordance with his or her individual needs. All individuals receiving HCBS or MLTSS under the demonstration must have a PoC and will be provided services in accordance with their plan. The State must establish minimum guidelines regarding the PoC that will be reflected in contracts and/or

provider agreements. These must include at a minimum: 1) a description of qualification for individuals who will develop the PoC; 2) timing of the PoC including how and when it will be updated and including mechanisms to address changing circumstances and needs; 3) types of assessments; 4) how enrollees are informed of the services available to them; 5) the MCOs' responsibilities for implementing and monitoring the PoC.

- a. Each member's PoC must include team-based Person-Centered Planning, which is a highly individualized and ongoing process to develop care plans that focus on the person's abilities and preferences. Person-Centered Planning includes consideration of the current and unique bio-psycho-social and medical needs and history of the enrollee, as well as the person's functional level, and support systems.
- b. The State or the MCO, for those enrolled in MLTSS will emphasize services provided in home and community-based settings, maximizing health and safety, whenever possible.
- c. Meetings related to the enrollee's PoC will be held at a location, date, and time convenient to the enrollee and his/her invited participants.
- d. A back-up plan must be developed and incorporated into the plan to assure that the needed assistance will be provided in the event that the regular services and supports identified in the PoC are temporarily unavailable. The back-up plan may include other assistance or agency services.
- e. The State (not the MCOs) will be responsible for the PoC developed for each enrollee transitioning from an institutional setting to a community-based setting through the State's Money Follows the Person demonstration.
- f. The State or the MCO for those enrolled in MLTSS must ensure that services are delivered in accordance with the PoC including the type, scope, amount and frequency.
- g. The State or the MCO, for those enrolled in MLTSS must ensure that enrollees have the choice of participating providers within the plan network as well as access to non-participating providers when the appropriate provider type is not on the MCO's network.
- h. Individuals served in ID/DD programs must have the choice of institutional placements and community settings.
- i. Each enrollee's PoC must be reviewed annually at a minimum, or more frequently with individual circumstances as warranted.

53. Option for Participant Direction of certain HCBS and MLTSS. NJCW participants who elect the self-direction opportunity must have the option to self-direct the HCBS or MLTSS, Participant direction affords NJCW participants the opportunity to have choice and control over how services are provided and who provides the service. Member participation in participant direction is voluntary, and members may participate in or withdraw from participant direction at any time.

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The services, goods, and supports that a participant self-directs must be included in the calculations of the participant's budget. Participant's budget plans must reflect the plan for purchasing these needed services.

- a. Information and Assistance in Support of Participant Direction. The State/MCO shall have a support system that provides participants with information, training, counseling, and assistance, as needed or desired by each participant, to assist the participant to effectively direct and manage their self-directed services and budgets. Participants shall be informed about self-directed care, including feasible alternatives, before electing the self-direction option. Participants shall also have access to the support system throughout the time that they are self-directing their care. Support activities must include, but is not limited to Support for Participant Direction service which includes two components: Financial Management Services and Support Brokerage. Providers of Support for Participant Direction must carry out activities associated with both components. The Support for Participant Direction service provides assistance to participants who elect to self-direct their personal care services.
- b. Participant Direction by Representative. The participant who self-directs the personal care service may appoint a volunteer designated representative to assist with or perform employer responsibilities to the extent approved by the participant. Waiver services may be directed by a legal representative of the participant. Waiver services may be directed by a non-legal representative freely chosen by an adult participant. A person who serves as a representative of a participant for the purpose of directing personal care services cannot serve as a provider of personal attendant services for that participant.
- c. Independent Advocacy. Each enrollee shall have access to an independent advocate or advocacy system in the State. This function is performed by individuals or entities that do not provide direct services, perform assessments, or have monitoring, oversight or fiscal responsibilities for the demonstration. The plans will provide participants with information regarding independent advocacy such as the Ombudsman for Institutionalized Elderly and State staff who approved LOC determination and did options counseling.
- d. Participant Employer Authority. The participant (or the participant's representative) must have decision-making authority over workers who provide personal care services.
 - i. Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide personal care services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.
 - ii. Decision Making Authorities. The participant exercises the following decision making authorities: Recruit staff, select staff from worker registry,

hire staff as common law employer, verify staff qualifications, obtain criminal history and/or background investigation of staff, specify additional staff qualifications based on participant needs and preferences, evaluate staff performance, verify time worked by staff and approve time sheets, and discharge staff.

- e. **Disenrollment from Participant-Direction.** A participant may voluntarily disenroll from the self-directed option at any time and return to a traditional service delivery system. To the extent possible, the member shall provide his/her provider ten (10) days advance notice regarding his/her intent to withdraw from participant direction. A participant may also be involuntarily disenrolled from the self-directed option for cause, if continued participation in the participant-directed services option would not permit the participant's health, safety, or welfare needs to be met, or the participant demonstrates the inability to self-direct by consistently demonstrating a lack of ability to carry out the tasks needed to self-direct personal care services, or if there is fraudulent use of funds such as substantial evidence that a participant has falsified documents related to participant directed services. If a participant is terminated voluntarily or involuntarily from the self-directed service delivery option, the MCO must transition the participant to the traditional agency direction option and must have safeguards in place to ensure continuity of services.
- f. **Appeals.** The following actions shall be considered an adverse action under both 42 CFR 431 Subpart E (state fair hearing) and 42 CFR 438 Subpart F (MCO grievance process):
 - i. A reduction in services;
 - ii. A denial of a requested adjustment to the budget; or
 - iii. A reduction in amount of the budget.

Participants may use either the State fair hearing process or the MCO appeal process to request reconsideration of these adverse actions.

IX. DELIVERY SYSTEM -- III - BEHAVIORAL HEALTH

54. Behavioral Health Organization. Coverage of behavioral health services will vary depending on population and level of care as described in the Benefits section above and in Attachments B and F. In general, behavioral health for demonstration beneficiaries will be excluded from the coverage furnished through the primary managed care organization, but instead will be covered through a behavioral health organization (BHO). The State will contract with BHOs on a non-risk basis as an Administrative Services Organization (ASO). Exceptions to this service delivery system, under which behavioral health will be included in the MCO benefit package include; dual eligibles enrolled in a SNP and individuals enrolled in a MLTSS MCO furnishing long term supports and services/HCBS services.

55. Behavioral Health for Children. Upon the effective date of this demonstration, children

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who are not in a HCBS/MLTSS/SNP population will have their behavioral health care coordinated by a behavioral health ASO.

a. The ASO shall perform the following functions on behalf of the State:

1. 24/7 Call Center
2. Member services
3. Medical Management
4. Provide and manage MIS/EMR for Children's System of Care
5. Dispatch Mobile Response/Crisis Response
6. Clinical Phone Triage (performed by licensed clinicians)
7. Facilitate Needs Assessments
8. Clinical Reviews of Needs Assessments
9. Care Coordination
10. Intensity of Service Determinations
11. Treatment Plan Reviews
12. Prior Authorizations
13. Quality Monitoring in Coordination with DCF
14. Utilization Management
15. Data Sharing and Reporting
16. Grievance and Intensity of Service Dispute Resolution
17. Behavioral Health and Primary Health Coordination

b. Excluded Children's ASO functions.

1. Provider Network Management
2. Claims payment
3. Rate Setting

c. Should the State decide to implement an at-risk arrangement for the BHO the State will submit an amendment to CMS in accordance with paragraph 7.

56. Behavioral Health for Adults. Behavioral health services will not be included in the benefit package provided by the primary managed care organization. Effective July 1, 2013 or a date thereafter, adults will have their behavioral health care coordinated by a behavioral health ASO. Prior to that date, behavioral health services will be covered on a fee for service basis.

a. Functions of the Adult ASO. The ASO shall perform the following functions:

1. 24/7 Call Center
2. Member services
3. Screening and assessment
4. Prior authorization
5. Network management
6. Utilization management, including level of care determination and continuing care review
7. Care management

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8. Medical management
9. Care coordination
10. Quality management
11. Information technology
12. Data submission and reporting requirements
13. Financial management, including claims processing and payment
14. Development of care models and service arrays for consumers with intellectual and developmental disabilities; non-SNP dual eligibles (Medicare and Medicaid), and Medicaid expansion populations
15. Coordination with the MCOs regarding high-utilizing consumers and consumers screened with behavioral health/medical conditions

b. Excluded Adult ASO function.

1. Adult populations currently enrolled in the 1915(c) programs who are moving to MLTSS program will be excluded from the ASO since their behavioral health care will be managed by the MCO.
2. Should the State decide to implement an at-risk arrangement for the BHO the State will submit an amendment to CMS in accordance with paragraph 7.

57. **Behavioral Health Home.** The State is seeking to implement a behavioral health home through the State Plan Amendment process. Upon implementation of the health home the ASO(s) will coordinate with the provider for comprehensive behavioral health care.

58. **Services Provided by the BHO/ASO.** The services provided by the BHO/ASO are listed in Attachment F.

59. **Duplication of Payment.** To avoid duplication of payment for services for demonstration participants who require behavioral health, the Behavioral Health Service and Payer table in Attachment F will determine who the payer for behavioral health care is.

X. MANAGED LONG TERM SERVICES AND SUPPORTS (MLTSS) PROGRAM

60. **Transition of Existing section 1915(c) Programs.** Prior to the implementation of MLTSS, the State provided HCBS through section 1915(c) waivers using a fee-for-service delivery system for long-term care services and supports. The following 1915(c) waivers that will be transitioned into the demonstration and into a mandated managed care delivery systems upon CMS review and approval of a transition plan, the State completion of managed care readiness reviews, and providing notice of transition to program participants are:

- Traumatic Brain Injury (TBI) Program, NJ4174;
- Community Resources for People with Disabilities (CRPD) Program, NJ 4133;
- Global Options for Long Term Care (GO) Program, NJ 0032; and
- AIDS Community Care Alternatives Program (ACCAP) Program, NJ0160.

61. **Notice of Transition to Program Participants.** The State will provide notice to participants

of current 1915 (c) waiver authority to the demonstration, that no action is required on behalf of the participant, and that there is no disruption of services. Such notice must be provided to said beneficiaries 30 days prior to the transfer of waiver authorities from section 1915(c) to the section 1115 demonstration. (42 CFR 431.210) requires States to notify 1915(c) waiver participants 30 days prior to waiver termination.

62. Transition Plan from FFS Programs to Managed Care Delivery System. To ensure a seamless transition of HCBS waiver participants and those currently in a nursing facility from fee for service delivery systems and section 1915(c) waivers to MLTSS, the State must:

- a. Prepare a MLTSS Transition Plan to be reviewed by CMS.
- b. Meet regularly with the MCOs during transition process and thereafter. Complete an outreach and communication strategy to HCBS demonstration participants impacted by MLTSS to include multiple contacts and notice with HCBS/MLTSS participants in a staggered manner to commence 90 days prior to the implementation of MLTSS.
- c. Provide materials for enrollees in languages, formats, and reading levels to meet enrollee needs.
- d. Make available to the MCOs sufficient data to assist them in developing appropriate care plans for each enrollee.
 - i. The data will include past claims data, providers, including HCBS and the individual's past and current Plan of Care (PoC).
 - ii. The State will ensure participants will receive the same type and level of services they received in section 1915(c) programs until the MCO has completed an assessment.
 - iii. Enrollees transitioning from one plan to another will continue to receive the same services until the new MCO is able to perform its own Assessment, and develop an updated Plan of Care (PoC).
- e. To facilitate the establishment of a smooth transition process, the State will develop a readiness certification tool to be used to assess the readiness of the MCOs to assume the provision of the MLTSS. The State will submit its MCO readiness certification tool for the provision of the MLTSS to CMS prior to its use.
- f. The State will submit to CMS for review all informing notices that will be sent to participants outlining their new services, changes in the service delivery system, and due process rights. Informing notices will be sent to beneficiaries no less than 45 days prior to the transition to MLTSS.
- g. To facilitate collaboration with case management functions, the State agencies will

- require each MCO to have a MLTSS Consumer Advisory Committee including representation of MLTSS stakeholders, including participants, case managers, and others, and will address issues related to MLTSS.
- h. Upon receipt of a plan acceptable by the State Medicaid Agency, it will perform a desk-level review of the MCO's policies and procedures, an on-site review to validate readiness.
 - i. The State will develop a readiness certification /review tool to assure uniformity in the determinations made about each MCO's compliance and its ability to perform under the MLTSS contract provisions.

63. Readiness Review Requirements. The State shall begin a readiness review of each MCO at least 90 days prior to program implementation.

- a. Readiness reviews shall address each MCO's capacity to serve the enrollees, including, but not limited to, adequate network capacity, and operational readiness to provide the intensive level of support and care management to this population as well as the ability to implement a self-direction program.
- b. At least 30 days prior to the State's planned implementation date for the expansion, the State must submit the following to CMS review, according to the timelines specified below:
 - i. A list of deliverables and submissions the State will request from health plans to establish their readiness, with a description of the State's approach to analysis and verification;
 - ii. Plans for ongoing monitoring and oversight of MCO contract compliance;
 - iii. A contingency plan for addressing insufficient network issues;
 - iv. A plan for the transition from the section 1915(c) waiver program to the demonstration HCBS programs as described in STC 63;
 - v. Proposed managed care contracts or contract amendments, as needed, to implement the Expansion.
- c. CMS reserves the right to request additional documentation and impose additional milestones on the Expansion in light of findings from the readiness review activities.
- d. The transition plan terminating 1915(c) waiver services for these populations must be submitted to notify CMS as part of the Readiness Review specified in STC 63 and with the "intent to terminate 1915(c) waivers" letter that must be sent to the CMS Regional Office writing at least 30 days prior to waiver termination, per 42 CFR 441.307.

64. **Steering Committee.** For a period of time, DMAHS will authorize a MLTSS Steering Committee that will include adequate representation of stakeholders. Additionally, it's Medical Care Advisory Committee per 42 CFR 431.12 will include MLTSS representation.
65. **Transition of Care Period from FFS to Managed Care.** Each enrollee who is receiving HCBS and who continues to meet the appropriate level of care criteria in place at the time of MLTSS implementation must continue to receive services under the enrollee's pre-existing service plan until a care assessment has been completed by the MCO. During this assessment, should the MCO determine that the enrollee's circumstances have changed sufficiently to warrant a complete re-evaluation, such a re-evaluation shall be initiated. Any reduction, suspension, denial or termination of previously authorized services shall trigger the required notice under 42 CFR 438.404.
66. **Money Follows the Person (MFP).** The State will continue to operate its MFP demonstration program outside of the section 1115 demonstration. Under New Jersey's MFP program, the State will continue its responsibilities for developing transitional plans of services for enrollees. With the implementation of MLTSS on January 1, 2013 or at a date thereafter, the State must update the MFP demonstration's Operational Protocols. A draft of the revised Operational Protocol will be due to CMS by 30 days prior to implementation of MLTSS.
- a. The MLTSS plans' responsibilities include:
1. Identifying enrollees who may be appropriate to transition from nursing homes;
 2. Referring enrollees to State staff in the MFP office;
 3. Providing ongoing care, case management and coordination when the enrollee returns to the community;
 4. The delivery of MLTSS, and
 5. Reassessing the MFP participant prior to the 365th day in the MFP program and designating which HCBS services are the most appropriate.
67. **Nursing Facility Diversion.** Each MCO, with assistance from the State, will develop and implement a "NF Diversion Plan" to include processes for enrollees receiving HCBS and enrollees at risk for NF placement, including short-term stays. The diversion plan will comply with requirements established by the State and be prior approved by the State, and CMS. The Plan will include a requirement for the MCOs to monitor hospitalizations and short-stay NF admission for at-risk enrollees, and identify issues and strategies to improve diversion outcomes.
68. **Nursing Facility Transition to Community Plan.** Each MCO, with assistance from the State, will develop and implement a "NF to Community Transition Plan" for each enrollee placed in a NF when the enrollee can be safely transitioned to the community, and has requested transition to the community. The Plan will include a requirement for the MCOs to work with State entities overseeing services to older adults and other special populations utilizing NF services. Each MCO will have a process to identify NF residents with the ability and desire to transition to a community setting. MCOs will also be required to monitor

hospitalizations, re-hospitalizations, and NF admissions to identify issues and implement strategies to improve enrollee outcomes.

69. Level of Care Assessment for MLTSS Enrollees. The following procedures and policies shall be applied to enrollees receiving MLTSS:

- a. An evaluation for LOC must be given to all applicants for whom there is reasonable indication that services may be needed by either the State or the MCO.
 - i. The plans and the State will use the “NJ Choice” tool as the standardized functional assessment for determining a LOC.
 - ii. In addition to the NJ Choice tool, the State and the MCOs may also utilize the "Home and Community-Based Long Term Care Assessment" Form (CP-CM-1).
- b. The State must perform the assessment function for individuals not presently enrolled in managed care. The MCO must complete the LOC assessment as part of its comprehensive needs assessment for its members and will forward to the State for final approval for those individuals determined to meet NF LOC.
- c. The MCOs must not fundamentally alter the nature of the NJ Choice tool when accommodating it to their electronic/database needs.
- d. The MCOs and, or the State must perform functional assessments within 30 days of the time a referral is received.
- e. All enrollees must be reevaluated at least annually or as otherwise specified by the State, as a contractual requirement by the MCO.

70. Demonstration Participant Protections under MLTSS. The State will assure that children, youth, and adults in MLTSS and HCBS programs are afforded linkages to protective services through all service entities, including the MCOs.

- a. The State will ensure that these linkages are in place before, during, and after the transition to MLTSS.
- b. The State/MCO’s will develop and implement a process for community-based providers to conduct efficient, effective, and economical background checks on all prospective employees/providers with direct physical access to enrollees.

71. Institutional and Community-Based MLTSS. The provisions related to institutional and community-based MLTSS are as follows:

- a. Enrollees receiving MLTSS will most often receive a cost-effective placement, which will usually be in a community environment.

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- b. Enrollees receiving MLTSS will typically have costs limited/aligned to the annual expenditure associated with their LOC assessment (e.g. Hospital, Nursing Facility).
- c. Exceptions are permitted to the above provisions in situations where a) an enrollee is transitioning from institutional care to community-based placement; b) the enrollee experiences a change in health condition expected to last no more than six months that involve additional significant costs; c) special circumstances where the State determines an exception must be made to accommodate an enrollee's unique needs. The State will establish a review procedure to describe the criteria for exceptional service determinations between the State and the MCOs which shall be approved by CMS.
- d. MCOs may require community-based placements, provided the enrollee's PoC provides for adequate and appropriate protections to assure the enrollee's health and safety.
- e. If the estimated cost of providing the necessary community-based MLTSS to the enrollee exceeds the estimated cost of providing care in an institutional setting, the MCO may refuse to offer the community-based MLTSS. However, as described in (c) above, exceptions may be made in individual special circumstances where the State determines the enrollee's community costs shall be permitted to exceed the institutional costs.
- f. If an enrollee whose community-based costs exceed the costs of institutional care refuses to live in an institutional setting and chooses to remain in a community-based setting, the enrollee and the MCO will complete a special risk assessment detailing the risks of the enrollee in remaining in a community-based setting, and outlining the safeguards that have been put in place. The risk assessment will include a detailed back-up plan to assure the health and safety of the enrollee under the cost cap that has been imposed by the State.
- g. Nothing in these STCs relieves the State of its responsibility to comply with the Supreme Court *Olmstead* decision, and the Americans with Disabilities Act.

72. Care Coordination for MLTSS. Care Coordination is services to assist enrollees in gaining access to needed demonstration and other services, regardless of the funding source. Care Coordinators are responsible for ongoing monitoring of the provision of services included in the PoC and assuring enrollee health and safety. Care Coordinators initiate the process to evaluate or re-evaluate the enrollee's PoC, his or her level of care determination (where appropriate), and other service needs.

- a. Integrated care coordination for physical health and MLTSS will be provided by the MCOs in a manner that is "conflict-free."
- b. The State will establish a process for conflict free care coordination, to be approved by CMS that will include safeguards, such as separation of services and other structural requirements, State/enrollee oversight, and administrative review.

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- c. Each MCO shall also assign a Behavioral Health Administrator to develop processes to coordinate behavioral health care with physical health care and MLTSS, in collaboration with the care coordinators.
- d. The State will assure that there are standard, established timelines for initial contact, assessment, development of the PoC, the individual service agreement, and authorization and implementation of services between the state and the MCOs.
- e. Care coordinators must monitor the adequacy and appropriateness of services provided through self-direction, and the adequacy of payment rates for self-directed services.

XI. SPECIAL TARGETED HCBS PROGRAMS

73. New HCBS Programs. HCBS is provided outside of the Managed Long Term Services and Supports (MLTSS) MCO in the following programs: The Supports Program; Persons with Pervasive Developmental Disorders (PDD); Persons with intellectual disabilities and mental illness (IDD/MI); Persons with intellectual developmental disabilities who live out of state (IDD OOS) but in an HCBS setting; Serious emotional disturbance (SED) and Medication Assisted Treatment Initiative (MATI).

74. Network Adequacy and Access Requirements. The State must ensure that the fee-for-service network complies with network adequacy and access requirements, including that services are delivered in a culturally competent manner that is sufficient to provide access to covered services to the low-income population. Providers must meet standards for timely access to care and services, considering the urgency of the service needed.

- a. Accessibility to primary health care services will be provided at a location in accordance at least equal to those offered to the Medicaid fee-for-service participants.
- b. Primary care and Urgent Care appointments will be provided at least equal to those offered to the Medicaid fee-for-service participants.
- c. Specialty care access will be provided at least equal to those offered to the Medicaid fee-for-service participants.
- d. FFS providers must offer office hours at least equal to those offered to the Medicaid fee-for-service participants.
- e. The State must establish mechanisms to ensure and monitor provider compliance and must take corrective action when noncompliance occurs.
- f. The State must establish alternative primary and specialty access standards for rural areas in accordance with the Medicaid State Plan.

75. **Provider Credentialing.** The provider credentialing criteria are included for each separate service as outlined in Attachment C. To assure the health and welfare of the demonstration participants, the State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to furnishing services. The State also monitors non-licensed/non-certified providers to assure adherence to other standards prior to their furnishing waiver services.

76. **Non-duplication of Services.** HCBS will not duplicate services included in an enrollee's Individualized Education Program under the Individuals with Disabilities Education Act, or services provided under the Rehabilitation Act of 1973.

77. **Supports Program**

- a. Program Overview: The Supports Program is to provide a basic level of support services to individuals who live with family members or who live in their own homes that are not licensed by the State.
- b. Operations: The administration of the program is through the Division of Developmental Disabilities (DDD).
- c. Eligibility:
 - i. Are Medicaid eligible;
 - ii. Are at least 21 years of age and have completed their educational entitlement;
 - iii. Live in an unlicensed setting, such as on their own or with their family; and
 - iv. Meet all criteria for functional eligibility for DDD services including the following definition of "developmental disability": Developmental disability is defined as: "a severe, chronic disability of an individual which:
 1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
 2. Is manifest before age 22;
 3. Is likely to continue indefinitely;
 4. Results in substantial functional limitations in three of more of the following areas of major life activity, that is: self-care, receptive and expressive language, learning, mobility, self-direction capacity for independent living and economic self-sufficiency;
 5. Reflects the need for a combination and sequences of special interdisciplinary or generic care, treatment or other services which are

of lifelong or extended duration and are individually planned and coordinated; and

6. Includes but is not limited to severe disabilities attributable to intellectual disability, autism, cerebral palsy, epilepsy, spina bifida and other neurological impairments where the above criteria are met.”
- d. POC Referral. When it has been confirmed that a candidate has met all of the requirements for enrollment, DDD will refer the case to the appropriate support coordination provider for development of the Participant's plan of care (PoC) and initiation of services.
 - e. Exclusions: Individuals may not enroll in the Supports Program if:
 - i. They are enrolled in another HCBS/MLTSS program, the Out-of-State IDD programs, or the Community Care Waiver.
 - ii. They require institutional care and cannot be maintained safely in the community.
 - f. Expenditure Cap. Participants in the program will have an individual expenditure cap per person per year that is based on functional assessment. This expenditure cap is reevaluated annually during development of the annual plan of care.
 - g. Case Management. Every Participant will have access to Support Coordination (case management) which is outside of the expenditure cap. Every Participant will have access (if they choose) to Financial Management Services (fiscal intermediary) if he/she chooses to self-direct services. This will also be outside of the expenditure cap.
 - h. Bump –Up. This program also contains a unique feature whereby Participants who experience a major change in life circumstances which results in a need for additional temporary services may be eligible to receive a short-term “bump up” in their expenditure cap. This “bump up” is capped at \$5,000 per Participant. The bump up will be effective for up to one year. Participants may only seek bump up services once every three years. The services that may be purchased with bump up dollars are any services described in Attachment C-1 under Supports Program, with the exception of the Day Program Related Services described above.
 - i. Enrollment: All referrals for the Supports Program are screened by DDD to determine if the individual meets the target population criteria, is Medicaid eligible, meets LOC clinical criteria, is in need of support services, and participant’s needs can be safely met in the community. Individuals who currently receive state-funded day services and/or state-funded support services as of the effective date of the demonstration will be assessed for Medicaid eligibility and LOC clinical criteria and enrolled into the program in phases. When potential new participants are referred, they will be assessed for eligibility and enrolled based on availability of annual state budget allocations.

- j. Level of Care (LOC) Assessment: The participant has a developmental disability and substantial functional limitations in three or more major life activities.
- k. Assessment tool: DDD is in the process of streamlining their current multiple assessment instruments that will be used to assess clinical LOC and functional level for budget determination(s). A statement will be included certifying that an individual meets the functional criteria for DDD and is eligible for the Supports Program.
- l. LOC Reassessment: Reassessment will occur when there is a noted change in a participant's functional level that warrants less supports.. The initial LOC assessment is based on an individual being diagnosed with a developmental disability and substantial functional limitation in three or more major life activities. This is unlikely to change from year to year.
- m. Transition: If health and safety cannot be maintained for a participant on this program because s/he requires a higher level of services than are available, the IDT will make the recommendation and the participant will voluntarily disenroll from the program. The IDT will commence transition planning to identify service needs and necessary resources. Referrals will be made to all services, as applicable including the Community Care Waiver.
- n. Disenrollment: Participants will disenroll from the program if they lose Medicaid eligibility, choose to decline participation in the program, enroll on the CCW, no longer need support services, or no longer reside in New Jersey.
- o. Benefits/Services, Limitations, and Provider Specifications: In addition to Plan A services in Attachment B, Supports program participants receive the benefits outlined in Attachment C.
- p. Cost Sharing: See Attachment B.
- o. Delivery System: Medicaid State Plan services for this population will be delivered and coordinated through their Medicaid MCO. HCBS services available to this population will be delivered either through providers that are enrolled as Medicaid providers and are approved by DDD or through non-traditional service providers that are approved by DDD and bill for services through a fiscal intermediary. Services can be either provider-managed, self-directed, or a combination thereof, as approved in the participant's Plan of Care.

78. Pervasive Developmental Disorders (PDD) Pilot Program

- a. Program Overview: This program is intended to provide NJ FamilyCare/Medicaid eligible children with needed therapies that they are unable to access via the State plan that are available to other children via private health insurance. The State will provide children up to their 13th birthday who have a diagnosis of Pervasive Developmental

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Disability (PDD), with habilitation services. Through the assessment process, PDD participants will be screened by DCF to determine eligibility, LOC, and to determine their level of need. Those with the highest need will receive up to \$27,000 in services; those with moderate needs will receive up to \$18,000 in services and the lowest needs participants will receive \$9,000 in PDD services. If the participant's needs change at any time, she/he can be reassessed to determine the current acuity level and the service package would be adjusted accordingly. Services will be coordinated and managed through the participant's Plan of Care, as developed by the Care Managers with the Medicaid MCOs.

- b. Eligibility: Children up to their 13th birthday who are eligible for either the New Jersey Medicaid or CHIP programs and have a PDD diagnosis covered under the *DSM IV* (soon to be *DSM V*) as determined by a medical doctor, doctor of osteopathy, or Ph.D. psychologist using an approved assessment tool referenced below:
 - i. Approved Assessment Tools include:
 - 1. ABAS – Adaptive Behavior Assessment System II
 - 2. CARS – Childhood Autism Rating Scale
 - 3. DDRT – Developmental Disabilities Resource Tool
 - 4. GARS – Gilliam Autism Rating Scale
 - 5. ADOS – Autism Diagnostic Observation Scale
 - 6. ADI – Autism Diagnostic Interview-Revised
 - 7. ASDS – Asperger's Syndrome Diagnostic Scale
 - ii. Meet the ICF/MR level of care criteria
- c. Exclusions:
 - i. Individuals over the age of 13
 - ii. Individuals without a PDD diagnosis
 - iii. Children with private insurance that offers these types of benefits, whether or not they have exhausted the benefits.
- d. Enrollment: Potential PDD program participants are referred to DCF for screening and assessment. Once a child has been determined to have a PDD and assessed for LOC clinical eligibility and acuity level by DCF, she/he will be referred to DMAHS for enrollment onto the demonstration.
- e. Enrollment Cap: In cases where the State determines, based on advance budget projections that it cannot continue to enroll PDD Program participants without exceeding the funding available for the program the State can establish an enrollment cap for the PDD Program.
 - i. *Notice* - before affirmatively implementing the caps authorized in subparagraph (e), the State must notify CMS at least 60 days in advance. This

- notice must also include the impact on budget neutrality.
- ii. *Implementing the Limit* - if the State imposes an enrollment cap, it will implement a waiting list whereby applicants will be added to the demonstration based on date of application starting with the oldest date. Should there be several applicants with the same application date, the State will enroll based on date of birth starting with the oldest applicant
 - iii. *Outreach for those on the Wait Lists* - the State will conduct outreach for those individuals who are on the PDD Program wait list for at least 6 months, to afford those individuals the opportunity to sign up for other programs if they are continuing to seek coverage. Outreach materials will remind individuals they can apply for Medicaid.
 - iv. *Removing the Limit* – the State must notify CMS in writing at least 30 days in advance when removing the limit.
- f. LOC Criteria: The participant has substantial functional limitations in three or more major life activities, one of which is self care, which require care and/or treatment in an ICF/MR or alternatively, in a community setting. The substantial functional limitations shall be evaluated according to the expectations based upon the child’s chronological age. When evaluating very young children, a showing of substantial functional limitations in two or more major life activities can be enough to qualify the child, due to the lack of relevance of some of the major life activities to young children (e.g., economic sufficiency).
- i. *LOC Assessment*: Administration, by a licensed clinical professional approved and/or employed by the State, of the assessment tool to be developed by the State prior to implementation will be used to determine ICF/MR LOC will be performed prior to enrollment into the program and a minimum of annually thereafter.
 - ii. *LOC Reassessment*: A reassessment will be conducted a minimum of annually and will use the same tool.
- g. Transition: The services offered under this program are targeted for young children. When a child in the demonstration reaches 12 years of age, transition planning will be initiated by the Interdisciplinary Team and the Medicaid MCO to identify service needs & available resources, support the participant, and maintain health and safety. Referrals will be made to all services as applicable. Should an individual require continued HCBS services, enrollment will be facilitated to other programs.
- h. Disenrollment: A participant will be disenrolled from the demonstration for the following reasons:
- i. Age out at age 13

- ii. Participant is deemed no longer in need of services, as per the reassessment process.
- iii. Loss of NJ FamilyCare/Medicaid eligibility
- iv. Participant no longer resides in New Jersey
- i. Benefits/Services, Limitations, and Provider Qualifications: In addition to Medicaid and CHIP State Plan services listed in Attachment B, this demonstration population receives a PDD service package of benefits. The full list of services may be found in Attachment C. Services rendered in a school setting are not included in this program.
- j. Cost sharing: See Attachment B.
- k. Delivery System: All State plan and PDD services for this population will be delivered and coordinated through their Medicaid MCO. Behavioral health services will be delivered and coordinated through the children's ASO. The Plan of Care will be developed and overseen by the Medicaid MCOs care management staff.

79. Intellectual Disabilities/ Development Disabilities with Co-Occurring Mental Health Diagnoses (ID-DD/MI) Pilot

- a. Program Overview: The primary goal of the program is to provide a safe, stable, and therapeutically supportive environment for children with developmental disabilities and co-occurring mental health diagnoses, ages five (5) up to twenty-one (21), with significantly challenging behaviors. This program provides intensive in-home and out-of-home services.
- b. Delivery System and Benefits: All Medicaid State Plan services through their Medicaid MCO; behavioral health and demonstration services through the children's ASO.
- c. Eligibility: Medicaid-eligible children with developmental disabilities and co-occurring mental health diagnoses, age five (5) up to twenty-one (21), who are still in their educational entitlement, have significantly challenging behaviors, and meet the LOC clinical criteria. Developmental disability is defined as: "a severe, chronic disability of an individual which:
 - i. is attributable to a mental or physical impairment or combination of mental and physical impairments;
 - ii. is manifest before age 21;
 - iii. is likely to continue indefinitely;
 - iv. results in substantial functional limitations in three or more of the following areas of major life activity, that is: self-care, receptive and expressive

language, learning, mobility, self-direction capacity for independent living and economic self-sufficiency;

- v. reflects the need for a combination and sequences of special interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and are individually planned and coordinated;
 - vi. includes but is not limited to severe disabilities attributable to intellectual disability, autism, cerebral palsy, epilepsy, spina bifida and other neurological impairments where the above criteria are met;”
 - vii. the substantial functional limitations shall be evaluated according to the expectations based upon the child’s chronological age; and
 - viii. Mental health diagnosis is defined as: “ a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within DSM-IV-TR with the exception of other V codes, substance use, and developmental disorders, unless these disorders co-occur with another diagnosable disturbance.”
- d. Exclusions:
- i. Individuals who are not residents of New Jersey
 - ii. Services eligible to be provided through their educational entitlement are not covered under this demonstration
 - iii. For in-home services, these cannot be provided if the family/caregiver is unwilling or unable to comply with all program requirements. In these instances, individuals will be provided with out-of-home services if necessary.
- e. LOC Assessment: Co-occurring developmental disability and mental health diagnosis that meets the state mental hospital level of care. The participant will be assessed at least annually, using the New Jersey System of Care Strengths and Needs Assessment tool.
- f. Enrollment: All referrals for the program are screened to determine if the individual meets the target population criteria, is Medicaid eligible, meets LOC clinical criteria, is in need of program services, and participant’s needs can be safely met in the community.
- g. Enrollment Cap: In cases where the State determines, based on advance budget projections that it cannot continue to enroll ID-DD/MI participants without exceeding the funding available for the program the State can establish an enrollment cap for the ID-DD/MI program.
- i. *Notice:* Before affirmatively implementing the caps authorized in subparagraph (g), the State must notify CMS at least 60 days in advance. This

notice must also include the impact on budget neutrality.

- ii. *Implementing the Limit* - if the State imposes an enrollment cap, it will implement a waiting list whereby applicants will be added to the demonstration based on date of application starting with the oldest date. Should there be several applicants with the same application date, the State will enroll based on date of birth starting with the oldest applicant
 - iii. *Outreach for those on the Wait Lists* - the State will conduct outreach for those individuals who are on the IDD Out-of-State wait list for at least 6 months, to afford those individuals the opportunity to sign up for other programs if they are continuing to seek coverage. Outreach materials will remind individuals they can apply for Medicaid.
 - iv. *Removing the Limit* – the State must notify CMS in writing at least 30 days in advance when removing the limit.
- h. **Disenrollment:** An individual will be disenrolled from the program for the following reasons:
- i. The family/caregiver declines participation or requests to be disenrolled from the program; or
 - ii. The family/caregiver is unable or unwilling to implement the treatment plan or fails to comply with the terms as outlined in the plan. Prior to disenrollment, the team will collaborate and make substantial efforts to ensure the individual’s success in the program, including working to remedy any barriers or issues that have arisen. An individual will only be disenrolled after significant efforts have been made to achieve success. If they will be disenrolled, the team will make recommendations and identify alternative local community and other resources for the individual prior to disenrollment; or
 - iii. The individual’s documented treatment plan goals and objectives have been met.
- i. **Transition:** At least one year in advance of an individual aging out of this program, the Interdisciplinary Team and Medicaid MCO will commence transition planning to identify service needs and necessary resources. Referrals will be made to all services, as applicable. Should an individual require continued HCBS services, enrollment will be facilitated to the other program.
- j. **Benefits/Services, Limitations, and Provider Qualifications:** In addition to Medicaid State Plan services, this population receives HCBS service package of benefits designed to provide the appropriate supports to maintain the participants safely in the community. The full list of program services may be found in Attachment C.

- k. Cost Sharing: For out of home services: The family of the individuals receiving ID/DD-MI out of home services will be assessed for their ability to contribute towards the cost of care and maintenance. The amount paid by the family is based both on earned (wages over minimum wage) and unearned income.

80. Intellectual Developmental Disability Program for Out of State (IDD/OOS)New Jersey Residents

- a. Program Overview: This program consists of individuals who receive out-of-state HCBS coordinated by DDD. Services claimed through this program will not duplicate services provided through a participant’s educational entitlement or via the Rehabilitation Act. Other than the individuals currently living in an eligible out of state setting who will be enrolled onto the IDD/OOS program. The only additional demonstration participants who will be added to this program are those who DDD has been court-ordered to provide the services in an out-of-state setting.
- b. Eligibility: An individual must be Medicaid eligible and meet all criteria for DDD eligibility for services. Specifically, an individual must be determined functionally eligible, based on a determination that they have a developmental disability and must apply for all other benefits for which he or she may be entitled. Developmental disability is defined as: “a severe, chronic disability of an individual which: (1) is attributable to a mental or physical impairment or combination of mental and physical impairments; (2) is manifest before age 22; (3) is likely to continue indefinitely; (4) results in substantial functional limitations in three or more of the following areas of major life activity, that is: self-care, receptive and expressive language, learning, mobility, self-direction capacity for independent living and economic self-sufficiency (e.g.5) reflects the need for a combination and sequences of special interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and are individually planned and coordinated; and (6) includes but is not limited to severe disabilities attributable to intellectual disability, autism, cerebral palsy, epilepsy, spina bifida and other neurological impairments where the above criteria are met.”
- c. Exclusionary Criteria:
 - i. Individuals who live in New Jersey;
 - ii. Individuals who are enrolled in another HCBS program;
 - iii. Individuals who have declared residency in another state;
 - iv. Individuals who require institutional care and cannot be maintained safely in the community; and
 - v. Individuals who do not meet ICF/MR-DD level of care
- d. Enrollment: New enrollments in the IDD Out-of-State program will only include those

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demonstration participants who are currently residing in an eligible out of state setting or those individuals who are court ordered after the effective date of this program to receive services outside of New Jersey.

- e. LOC Assessment: The LOC criteria: The participant has substantial functional limitations in three or more major life activities, one of which is self care, which require care and/or treatment in an ICF/MR-DD or alternatively, in a community setting. The LOC tool will be developed prior to the program being implemented.
- f. LOC Reassessment: The reassessment is made as part of the annual Service Plan for each participant. Functional assessment tools are utilized to confirm LOC assessment and to determine service needs. Goals and training in the Service Plan are based on the needs identified at the time of the reassessment.
- g. Transition: New individuals will not transition into this program, except per court order. Individuals will transition out of this program as outlined in Program Overview and Disenrollment. The majority of individuals transitioning out of this program will transition into community-based settings in New Jersey and will then be enrolled on the Community Care Waiver or the Supports Program.
- h. Disenrollment: An individual will be disenrolled from the program for the following reasons:
 - i. Acceptable alternative services are identified in state and the individual is returned to New Jersey;
 - ii. Residency in the state in which they are currently receiving services can be established and/or the individual transfers to services funded by that state;
 - iii. An individual declines participation/requests to be disenrolled;
 - iv. The agency serving the individual notifies the individual and DDD (30 days advance notice is required) that they can no longer serve the individual for one of the following reasons:
 - 1) The individual's medical needs have increased and the provider is no longer able to manage their care;
 - 2) The individual's behaviors have escalated and the provider is no longer able to manage their care.
- i. Benefits: In addition to Medicaid State Plan services Plan A in Attachment B, this population receives HCBS service package of benefits designed to provide the appropriate supports to maintain the participants safely in the community.
- j. Delivery System: Medicaid State Plan and HCBS services are delivered through fee-for-service, coordinated by New Jersey's DDD. The State assures CMS that 100 percent of the payment to providers is maintained by the provider. The State shall only claim its federal match rate for any out of State services rendered, based upon the federal match rate of NJ.

81. Program for Children diagnosed with Serious Emotional Disturbance (SED)

- a. Program Overview: The SED Program provides behavioral health services for demonstration enrollees who have been diagnosed as seriously emotionally disturbed which places them at risk for hospitalization and out-of-home placement.
- b. Eligibility: Enrollees in the SED Program must meet the following criteria:
 - i. All children served under this population who are eligible for Medicaid or CHIP State plan populations, or,
 - ii. NJ will use the Institutional Medicaid financial eligibility standards of:
 - 1) Children from age of a SED diagnosis up to age 21 years will be eligible for the services;
 - 2) The child must meet a hospital level of care up to 300% of FBR or at risk of hospitalization up to 150% FPL;
 - 3) Must be a US Citizen or lawfully residing alien;
 - 4) Must be a resident in the State of New Jersey; and
 - 5) For the purposes of this program, "family" is defined as the persons who live with or provide care to a person served in the SED Program, and may include a parent, step parent, legal guardian, siblings, relatives, grandparents, or foster parents.
- c. Functional Eligibility: To be functionally eligible for the SED program, the enrollee must meet one of the two programmatic criteria for participation:
 - i. Acute Stabilization Program– the enrollee must meet the following criteria necessary for participation in this LOC.
 - 1) The enrollee must be between the ages of 5 and up to 21 years. Special consideration will be given to children under age five which include:
 - a. The child meets the clinical criteria for the services for which are being sought.
 - b. The child cannot obtain the needed services through the NJ Early Intervention Program through the Department of Health
 - c. The Medical Director at the ASO reviews determines the service is appropriate, and authorizes the service.
 - 2) The DCBHS Assessment and other relevant information must indicate that the enrollee has a need that can be served by the Care

Management Organization or the Mobile Response Stabilization Services LOC.

- 3) The enrollee exhibits at-risk behaviors.
 - 4) The enrollee exhibits behavioral/emotional symptoms based on the NJ System of Care Needs Assessment Tool.
 - 5) The enrollee is at risk of being placed out of his/her home or present living arrangement.
 - 6) The enrollee requires immediate intervention in order to be maintained in his/her home or present living arrangement.
- d. Enrollment: SED Program enrollees are initially referred to the children’s ASO by providers, parents, or schools. The ASO performs a clinical triage performed by an appropriately licensed clinician and screens for insurance including Medicaid and CHIP programs. Any youth that is determined in the initial screening to potentially be SED must receive a complete “in-community” bio-psycho-social assessment that includes the completion of the Child and Adolescent Needs and Strengths (CANS) Assessment. This assessment, reviewed by the ASO, will be used to determine enrollment.
- e. Reassessment: The Care Management Organization must submit an updated Individualized Service Plan (ISP) at least every 90 days and the ASO must make a determination for continued eligibility with each submitted ISP.
- f. Exclusion criteria. Include at least one of the following:
- i. The person(s) with authority to consent to treatment for the youth refuses to participate
 - ii. Current assessment or other relevant information indicates that the enrollee/young adult can be safely maintained and effectively supported at a less intensive LOC.
 - iii. The behavioral symptoms are the result of a medical condition that warrants a medical setting for treatment as determined and documented by the child’s primary care physician and or the ASO Medical Director.
 - iv. The enrollee has a sole diagnosis of Substance Abuse and there is no identified, co-occurring emotional or behavioral disturbances consistent with a DSM IV-TR Axis I Disorder.
 - v. The enrollee’s sole diagnosis is a Developmental Disability that may include one of the following:

- 1) The enrollee has a sole diagnosis of Autism and there are no co-occurring DSM IV-TR Axis I Diagnoses or symptoms/behaviors consistent with a DSM IV-TR Axis I Diagnosis.
- 2) The enrollee has a sole diagnosis of Intellectual Disability/Cognitive Impairment and there are no co-occurring DSM IV-TR Axis I Diagnoses or symptoms/behaviors consistent with a DSM IV-TR Axis I Diagnosis.

82. Medication Assisted Treatment Initiative (MATI)

- a. Program Overview. Effective July 1, 2013, or a date thereafter, the treatment program delivers a comprehensive array of medication-assisted treatment and other clinical services through MATI provider mobile and office-based sites. The program goals include:
 - i. The reduction in the spread of blood borne diseases through sharing of syringes;
 - ii. The reduction of opioid and other drug dependence among eligible participants;
 - iii. The stabilization of chronic mental health and physical health conditions; and,
 - iv. Improved housing and employment outcomes among program participants.
- b. Eligibility: Demonstration enrollees applying for services must be screened by the mobile or fixed site service provider using a standardized clinical and functional assessment tool that will be independently reviewed by appropriate qualified clinicians to determine if the applicant meets the following program eligibility criteria:
 - i. Be a resident of New Jersey and at least 18 years old;
 - ii. Have household income at or below 150% of FPL;
 - iii. Have a history of injectable drug use;
 - iv. Test positive for opiates or have a documented one-year history of opiate dependence; this requirement may be waived for individuals who have recently been incarcerated and subsequently released or in residential treatment.
 - v. Provide proof of identification (to prevent dual enrollment in medication assisted treatment)
 - vi. Not currently enrolled as a client in an Opioid Treatment Program (OTP) or a client under the care of a Center for Substance Abuse Treatment (CSAT) waived physician providing Office-Based Opioid Treatment Services (OBTS)
- c. Programmatic Eligibility - Applicants must also meet at least two of the following criteria:
 - i. Diagnosed with a mental illness or a substance use disorder at least once in

their lifetime by a licensed professional in the state of New Jersey qualified to render such a diagnosis within their scope of practice.

- 1) A mental illness diagnosis may be rendered by: an MD or DO Board Certified or Board eligible in psychiatry; a Certified Nurse Practitioner-Psychiatry and Mental Health (CNP-PMH); an Advanced Practice Nurse-Psychiatry and Mental Health (APN-PMH); a Physician's Assistant (PA) w/Psychiatric and Mental Health certification; a Licensed Clinical Social Worker (LCSW); Licensed Professional Counselor (LPC); Licensed Psychologist; or Licensed Marriage and Family Therapist (LMFT).
 - 2) A substance use disorder diagnosis may be rendered by one of the qualified licensed professionals listed above or a Licensed Clinical Alcohol and Drug Counselor (LCADC).
- ii. Diagnosed with one or more chronic medical conditions (e.g., Chronic Obstructive Pulmonary Disease (COPD), Diabetes, HIV/AIDS, Hepatitis C, Asthma, etc.).
 - iii. Homeless or lacking stable housing for one year or longer.
 - iv. Unemployed or lacking stable employment for two years or longer.
- d. Enrollment: Enrollees in the MATI program who are not eligible for other demonstration populations and only gain demonstration eligibility for MATI services by enrollment into the MATI program. The MATI population is able to enroll in the program directly at the MATI provider agency mobile medication unit or office-based site. The MATI provider, in collaboration with the ASO, will facilitate Medicaid enrollment.
- e. Level of Care Assessment: The provider must conduct an initial assessment of the program applicant, including documentation of eligibility criteria, on the mobile unit or at the office-based site using an American Society of Addiction Medicine (ASAM)-based standardized clinical assessment tool to determine appropriateness for medication-assisted treatment and level of care placement. If the applicant is deemed clinically appropriate for medication assisted treatment he/she will meet with a qualified physician within 48 hours to determine the specific medication protocol.
- i. Documentation of program eligibility and clinical assessment results will be electronically submitted to the ASO for independent review.
 - ii. Within one business day, a determination of eligibility will be rendered from the ASO to both the provider and applicant.
 - iii. Upon enrollment in the MATI the ASO will provide for continued care management.

- f. LOC Reassessment: A reassessment of eligibility requirements will be conducted quarterly for each enrollee by the provider and sent to the ASO for review and approval of continuation in the program. Reassessment for eligibility will include review of the following criteria:
 - i. The enrollee continues to demonstrate need for medication assisted treatment (MAT) services to support recovery; and
 - ii. The enrollee continues to be at or below 150% of FLP; or
 - iii. The enrollee is above 150% FLP with no identified alternative payer.
- g. Disenrollment: A consumer will be considered no longer enrolled in the MATI program if they meet one of the following criteria:
 - i. The enrollee is no longer appropriate for MATI services to support recovery; as determined by consultation among the clinician, the physician and the consumer; or
 - ii. The enrollee continues to be appropriate for MATI services and has another identified payer.
- h. Benefits: Please refer to attachment F for a comprehensive list of MATI services and benefits.
- i. Delivery System: MATI services are reimbursed at fee-for-service through the ASO.

XII. PREMIUM ASSISTANCE PROGRAMS

83. New Jersey Family Care/Premium Support Program (PSP) – Title XXI Funded

- a. Program Overview: The PSP is designed to cover individuals eligible for NJ FamilyCare (and under certain conditions, non-eligible family members) who have access to cost effective employer-sponsored health plans. Some uninsured families have access to health insurance coverage through an employer, but have not purchased the coverage because they cannot afford the premiums. Assistance is provided in the form of a direct reimbursement to the beneficiary for the entire premium deduction, or a portion thereof, required for participation in the employer-sponsored health insurance plan. Beneficiaries are reimbursed on a regular schedule, to coincide with their employer's payroll deduction, so as to minimize any adverse financial impact on the beneficiary. Note that this program operates under title 2105(c)(3) of the Social Security Act, but has waived certain title XXI provisions for children and families by virtue of this Section 1115 demonstration.
- b. Eligibility Requirements: Parents and/or their children must be determined eligible for NJ FamilyCare in order to participate in the PSP. If the PSP unit determines that the parents

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have a cost-effective employer-sponsored plan available to them, the parents must enroll in the plan as a condition of participation in the NJ FamilyCare program. The PSP will reimburse the premiums for the non-eligible family members only if it is cost-effective in the aggregate. Children and parents must **not** have had coverage under a group health plan for three months prior to enrollment in the PSP. If proven cost effective, family members are required to enroll in ESI as their primary healthcare plan rather than direct state plan coverage.

- c. **Benefit Package:** NJ's Plan D mirrors the benchmark health plan offered through an HMO with the largest commercial, non-Medicaid enrollment in the state. If the employer's health plan is not equal to Plan D, then the state provides wraparound services for children and adults through its managed care organizations. "Wraparound service" means any service that is not covered by the enrollee's employer plan that is an eligible service covered by NJ FamilyCare for the enrollee's category of eligibility. This process is no different than how NJ currently handles all other beneficiaries who have TPL. Assurances to that effect will also be inserted in the Managed Care contract.
- i. **Process for Benefit Analysis:** If an uninsured parent has access to employer-sponsored insurance, the PSP Unit evaluates the application and assesses the employer's plan and a description of the benefits covered by the employer's plan. The PSP reviews the employer's response and compares the services to NJ FamilyCare services, taking into account any limitations on coverage.
- d. **Cost Sharing:** Premiums and co-payments vary under employer-sponsored plans regardless of FPL, but cost sharing is capped at 5 percent of the individual or family's gross income. This protection applies equally to parents enrolled in NJ FamilyCare and to parents enrolled in an employer-sponsored plan through the PSP.
- i. The PSP will reimburse the beneficiary for the difference between the NJFC/PSP co-payment amount and that of the employer-sponsored plan co-payment amount. For example, if the NJFC/PSP co-payment amount for a physician's office visit is \$5.00 and the employer-sponsored plan co-pay charge is \$15.00 for the same service, the PSP will reimburse the beneficiary the difference in excess of the NJFC/PSP co-payment amount (\$10.00).
 - ii. When the 5 percent limit is reached for the year, the parent's NJ FamilyCare identification card is revised to indicate that no cost-sharing can be imposed for the rest of the calendar year.
 - iii. If the PSP participant makes an out-of-pocket payment after the 5 percent limit is reached, any additional charges submitted to the PSP for the remainder of the calendar year are reimbursed at 100 percent as long as the parent submits proof of additional expenses.
 - iv. Parents may also request that the PSP notify medical service providers that a voucher can be submitted to the PSP for any cost sharing charges for the remainder of the year.

e. **Employer Contribution:** Each plan must provide an employer contribution amount as required under 2105(c)(3). The amount will not be specified by the State and can vary by plan. The contribution amount may range from 5% to 100%.

f. Cost Effectiveness Test –

i. Cost-effectiveness shall be determined in the aggregate by comparing the cost of all eligible family members' participation in the NJ FamilyCare program against the total cost to the State, including administrative costs, (e.g. Office of Premium Support and Office of Information Technology staff, as well as phone, postage, computers, and printers), of reimbursing eligible members for their employer-sponsored insurance. The amounts used for the calculations shall be derived from actuarial tables used by the NJ FamilyCare program and actual costs reported by the employee/employer during the processing of the Premium Support Program (PSP) application.

ii. The cost of the employer-sponsored plans shall be determined by totaling the amount of the employee's premiums plus the actuarial value of all "wraparound" services, if applicable, minus any NJFC premium contributions owed the state under the CHIP state plan.

iii. As a condition of PSP approval, the result of the cost-effectiveness test in the aggregate shall indicate a cost savings difference of, at a minimum, five percent between what the State would pay for the beneficiaries' participation in the employer-sponsored health plan vs. what the State would pay for their participation in the NJ FamilyCare program alone.

iv. If the employer-sponsored plans are determined by the Division to be cost-effective in the aggregate in accordance with (i) above, the applicants shall participate in the Premium Support Program. If the employer-sponsored plan is determined not cost-effective, in accordance with (i) above, the beneficiary will continue to participate solely in the NJ FamilyCare program.

XIII. QUALITY

84. Administrative Authority. When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency shall maintain authority, accountability, and oversight of the program. The State Medicaid Agency shall exercise oversight of all delegated functions to operating agencies, MCOs and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

85. Quality for Managed Care/MLTSS. The State must develop a comprehensive Quality Strategy with measures related to behavioral health and Managed Care measures to reflect all CHIP, Medicaid, Behavioral Health Programs, (including SED, PDD, and MATI Programs) acute and primary health care, and MLTSS operating under the programs proposed through this demonstration and submit to CMS for approval 90 days prior to implementation. The State must obtain the input of recipients and other stakeholders in the development of its comprehensive Quality Strategy and make the Strategy available for public comment.

86. Quality for Fee for Service HCBS Programs. The State must develop Quality Strategies to reflect all Programs operated under this demonstration through the Division of Developmental Disabilities and the Division of Children and Families. The State must obtain the input of recipients and other stakeholders in the development of its comprehensive Quality Strategy and make the Strategy available for public comment.

- a. FFS HCBS Programs under the Division of Developmental Disabilities (Supports, and IDD-OOS) will submit a quality plan to CMS for approval 60 days prior to the implementation of any programs.
- b. FFS or ASO HCBS Programs - (ID-DD/MI) under the Division of Children and Families will submit a quality plan for CMS approval 60 days prior to the implementation of any programs.

87. Content of Quality Strategy(ies). All Managed Care, MLTSS (Comprehensive) and HCBS Quality Strategies for all services must include the application of a continuous quality improvement process, representative sampling methodology, frequency of data collections and analysis, and performance measure in the following areas:

- a. Outcomes related to qualities of life; and,
- b. Health and welfare of participants receiving services including:
 - i. Development and monitoring of each participant's person-centered service plan to ensure that the State and MCOs are appropriately creating and implementing service plans based on enrollee's identified needs.
 - ii. Specific eligibility criteria for each identified HCBS program that addresses level of care determinations – to ensure that approved instruments are being used and applied appropriately and as necessary, and to ensure that individuals being served with HCBS or MLTSS have been assessed to meet the required level of care for those services.
 - iii. Adherence to provider qualifications and/or licensure for HCBS programs and MCO credentialing and/or verification policies for managed care and MLTSS are provided by qualified providers. Also need to indicate specifications when the participant self directs. While these providers frequently are not credentialed or licensed, some have alternative provisions for assuring qualifications are in place.
 - iv. Assurance of health and safety and participant safeguards for demonstration participants to ensure that the State or the MCO operates a critical incident management system according to the State's established policies, procedures and regulations. Specifically, on an ongoing basis the State ensures that all entities, including the MCO identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation, and ensures participant

safeguards concerning seclusion, restraint, risk mitigation, and medication management.

- v. The State shall incorporate by reference its policies, procedures and regulations for health, safety and participant safeguards into MCO contracts with adherence expectations defined. Any changes to the policies, procedures and regulations must be submitted to CMS for review prior to implementation.
- vi. Administrative oversight by the State Medicaid Agency of State Operating Agencies, the Managed Care Plans, and any other entities performing delegated administrative functions.

88. Oversight process: Required Monitoring Activities related to the areas above shall be conducted by State and/or External Quality Review Organization (EQRO). As defined and delegated by the State Medicaid Agency, the State's EQRO process shall meet all the requirements of 42 CFR 438 Subpart E. The State, or its EQRO, shall monitor and annually evaluate the MCOs' performance on specific requirements under MLTSS. The State shall also include minimum oversight expectations of the Managed Care Organizations' oversight of providers in the contracts. These include the areas in the Quality Strategy(ies) as applicable.

89. Revision of the State Quality Strategy(ies) and Reporting. The Single State Medicaid Agency shall update its Quality Strategy(ies) whenever significant changes are made, including changes through this demonstration, and submit to CMS for approval. The State must obtain the input of recipients and other stakeholders in the development of revised Quality Strategy(ies) and make the Strategy(ies) available for public comment. In addition, the State must provide CMS with annual reports on the implementation and effectiveness of the updated Quality Strategy(ies) as it impacts the beneficiaries in the demonstration. Specifically, the annual reports shall include summaries of analyzed and aggregated data on measures and quality improvements.

XIII. FUNDING POOLS

The terms and conditions in Section IX apply to the State's exercise of the following Expenditure Authorities: (7) Expenditures Related to Transition Payments, and Expenditures Related to the Delivery System Reform Incentive Payment (DSRIP) Pool.

90. Terms and Conditions Applying to Pools Generally.

- a. The non-Federal share of pool payments to providers may be funded by state general revenue funds and transfers from units of local government that are compliant with section 1903(w) of the Act. Any payments funded by intergovernmental transfers from governmental providers must remain with the provider, and may not be transferred back to any unit of government. CMS reserves the right to withhold or reclaim FFP based on a finding that the provisions of this subparagraph have not been followed.

- b. The State must inform CMS of the funding of all payments from the pools to hospitals through a quarterly payment report, in coordination with the quarterly operational report required by paragraph 102, to be submitted to CMS within 60 days after the end of each quarter. This report must identify and fully disclose all the underlying primary and secondary funding sources of the non-Federal share (including health care related taxes, certified public expenditures, intergovernmental transfers, general revenue appropriations, and any other mechanism) for each type of payment received by each provider.
- c. On or before December 31, 2012, the State must submit Medicaid State plan amendments to CMS to remove all supplemental payments for inpatient and outpatient hospital services from its State plan, with an effective date the same as the approval date for this demonstration. Except as discussed in paragraph 92(h), the State may not subsequently amend its Medicaid State plan to authorize supplemental payments for hospitals, so long as the expenditure authorities for pool payments under this demonstration remain in force.
- d. The State will ensure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of services available under the State plan or this demonstration. The preceding sentence is not intended to preclude the State from modifying the Medicaid benefit through the State Plan amendment process.
- e. Each quarter the State makes DSRIP Payments or Transition payments (as described below) and claims FFP, appropriate supporting documentation will be made available for CMS to determine the allowability of the payments. Supporting documentation may include, but is not limited to, summary electronic records containing all relevant data fields such as Payee, Program Name, Program ID, Amount, Payment Date, Liability Date, Warrant/Check Number, and Fund Source. Documentation regarding the Funds revenue source for payments will also identify all other funds transferred to such fund making the payment.

91. Transition Payments. During the Transition Period (which is the period between the approval date for this demonstration and December 31, 2013), the State will make Transition Payments to hospitals that received supplemental payments under the Medicaid State plan for SFY 2012 (July 1, 2011 through June 30, 2012). The Transition Period ensures that providers are eligible to secure historical Medicaid funding as the State develops the Delivery System Reform Incentive Payment Pool. Transition Payments may be made only during the Transition Period, and are subject to the following requirements.

- a. The hospitals eligible to receive Transition Payments are listed in Attachment K. These hospitals meet the following criteria:
 - i. Is enrolled as a New Jersey Medicaid provider, and
 - ii. Received a supplemental payment under the Medicaid State plan during SFY 12.

- b. Qualifying hospitals may receive two distinct types of Transition Payments, as described in (i) and (ii) below.
- i. 2013 HRSF Transition Payments may be paid to hospitals in proportion to the supplemental payments that each hospital received from the Hospital Relief Subsidy Fund in SFY 2012. The total amount of 2013 HRSF Transition Payments for all hospitals combined may not exceed the following amount: \$166,600,000, less any payments that hospitals received in Hospital Relief Subsidy Fund payments under the State plan in SFY 2013. 2014 HRSF Transition Payments shall be paid to hospitals in proportion to the supplemental payments that each hospital received from the Hospital Relief Subsidy Fund (HRSF) in SFY 2012. The total amount of 2014 HRSF Transition Payments for all hospitals combined shall not exceed \$83,300,000.
 - ii. 2013 GME Transition Payments may be paid to hospitals in proportion to the supplemental payments that each hospital received for GME in SFY 2012. The total amount of 2013 GME Transition Payments for all hospitals combined may not exceed the following amount: \$90,000,000 less any payments that hospitals received in Graduate Medical Education payments under the State plan in SFY 2013.
- c. Participating providers are eligible to receive one-ninth of their total 2013 Transition Payment amount each month in the Transition Period, beginning October 1, 2012, through the quarter ending June 30, 2013. Participating providers are eligible to receive one-sixth of their total 2014 Transition Payment amount each month in the Transition Period, beginning July 1, 2013 and ending December 31, 2013.
- d. As part of the first Quarterly Progress Report submitted under this demonstration, the State must provide a table showing the amounts of 2012 State plan supplemental payments received by each hospital listed in Attachment K (by type of payment), the amounts of 2013 State plan supplemental payments received by each hospital, and the total of each type of Transition Payments each hospital can expect to receive in DY 1 and DY 2. The State must identify the source of funding for each Transition Payment as a part of this list. Should the State determine that any of the hospitals listed in Attachment K will not receive Transition Payments; the State must provide an explanation for this in its report.
- e. In the first Annual Report submitted by the State after the end of the Transition Period, the State must provide a list of hospitals that received Transition Payments DY 1 and DY 2, and the amounts actually paid to each hospital, along with an explanation for how the payment amounts were determined.
- f. The State may alter the list of hospitals eligible to receive Transition Payments, or change the formula for determining the amounts to be paid, by submitting a request to amend the demonstration, following the process described in paragraph 7.

- g. Transition Payments received by a hospital provider count as title XIX revenue, and must be included as offsetting revenue in the State's annual DSH audit reports.
- h. During the Transition Period, CMS shall work with the State to get a State Plan Amendment approved by July 1, 2013 that allows the State to pay Graduate Medical Education (GME) payments directly to hospitals per 42 CFR 438.60, starting in DY 2. These payments will not be subject to federal fee-for-service upper payment limit restriction, but will be subject to the budget neutrality test for this demonstration.

92. **Delivery System Reform Incentive Payment (DSRIP) Pool.** The DSRIP Pool is available in DY 2 (following the end of the Transition Period) through the end of DY 5 for the development of a program of activity that supports hospitals' efforts to enhance access to health care, the quality of care, and the health of the patients and families they serve. The program of activity funded by the DSRIP will be those activities that are directly responsive to the needs and characteristics of the populations and communities served by each hospital. Each participating hospital will develop a Hospital DSRIP Plan, consistent with the DSRIP Planning Protocol, that is rooted in the intensive learning and sharing that will accelerate meaningful improvement. The Individual Hospital DSRIP Plan will be consistent with the hospital's mission and quality goals, as well as CMS's overarching approach for improving health care through the simultaneous pursuit of three aims: better care for individuals (including access to care, quality of care, and health outcomes), better health for the population, and lower cost through improvement (without any harm whatsoever to individuals, families or communities). In its Hospital DSRIP Plan, each hospital will describe how it will carry out a *project* that is designed to improve the quality of care provided, the efficiency with which care is provided, or population health. Each project will consist of a series of *activities* drawn from a predetermined menu of activities grouped according to four *Project Stages*. Hospitals may qualify to receive incentive payments (*DSRIP Payments*) for fully meeting performance *metrics* (as specified in the Hospital DSRIP Plan), which represent measurable, incremental steps toward the completion of project activities, or demonstration of their impact on health system performance or quality of care.

- a. **Eligibility.** The program of activity funded by the DSRIP shall take place in the general acute care hospitals listed and shown in Attachment K.
- b. **Project Focus Areas:** Each eligible hospital will select a project from the menu of focus areas listed below. Projects may include those based on regional planning needs as part of its DSRIP plan. Each focus area has an explicit connection to the achievement of the Three Part Aim:
 - Behavioral Health,
 - HIV/AIDS,
 - Chemical Addiction/Substance Abuse,
 - Cardiac Care,

- Asthma,
- Diabetes,
- Obesity,
- Pneumonia, or
- Another medical condition that is unique to a specific hospital, if approved by CMS. (The DSRIP Program Funding and Mechanics Protocol must specify a process for the State to obtain CMS approval for hospital-specific Focus Areas.)

c. **Project Stages.** Hospital projects will consist of activities that can be grouped into four stages.

- i. *Stage 1: Infrastructure Development* – Activities in this stage lay the foundation for delivery system transformation through investments in technology, tools, and human resources that will strengthen the ability of providers to serve populations and continuously improve services.
- ii. *Stage 2: Chronic Medical Condition Redesign and Management.* Activities in this stage include the piloting, testing, and replicating of chronic patient care models.
- iii. *Stage 3: Quality Improvements* – This stage involves the broad dissemination of interventions from a list of activities identified by the State, in which major improvements in care can be achieved within four years. To the extent possible the interventions will rely on the work of the New Jersey Hospital Engagement Network currently under development. These are hospital-specific initiatives and will be jointly developed by hospitals, the State, and CMS and are unlikely to be uniform across all of the hospitals.
- iv. *Stage 4: Population Focused Improvements* – Activities in this stage include reporting measures across several domains selected by the State based on community readmission rates and hospital acquired infections, which will allow the impact of activities performed under Stages 1 through 3 to be measured, and may include:
 - (A) Patient experience,
 - (B) Care outcomes, and
 - (C) Population health.

d. **DSRIP Performance Indicators.** The State will choose performance indicators that are connected to the achievement of providing better care, better access to care, and enhanced prevention of chronic medical conditions and population improvement. The DSRIP Performance Indicators will comprise the list of reporting measures that hospitals will be required to report under Stage 4: Population Focused Improvements.

e. **DSRIP Planning Protocol.** The State must develop and submit to CMS for approval a

DSRIP Planning Protocol, following the timeline specified in paragraph 95(a). Once approved by CMS, this document will be incorporated as Attachment H of these STCs, and once incorporated may be altered only by amending the demonstration through the process described in paragraph 7. The Protocol must:

- i. Outline the global context, goals and outcomes that the State seeks to achieve through the combined implementation of individual projects by hospitals;
 - ii. Specify the Project Stages, as shown in subparagraph (c) above, and for each Stage specify a menu of activities, along with their associated population-focused objectives and evaluation metrics, from which each eligible hospital will select to create its own projects;
 - iii. Detail the requirements of the Hospital DSRIP Plans, consistent with subparagraph (g); and
 - iv. Specify a set of Stage 4 measures that must be collected and reported by all hospitals, regardless of the specific projects that they choose to undertake.
- f. **DSRIP Program Funding and Mechanics Protocol.** The State must develop a DSRIP Program Funding and Mechanics Protocol to be submitted to CMS for approval, following the timeline specified in paragraph 95(a). Once approved by CMS, this document will be incorporated as Attachment I of these STCs, and once incorporated may be altered only by amending the demonstration through the process described in paragraph 7. DSRIP payments for each participating hospital are contingent on the hospital fully meeting project metrics defined in the approved hospital-specific Hospital DSRIP Plan. In order to receive incentive funding relating to any metric, the hospital must submit all required reporting, as outlined in the DSRIP Program Funding and Mechanics Protocol. In addition, the DSRIP Program Funding and Mechanics Protocol must:
- i. Include guidelines requiring hospitals to develop individual Hospital DSRIP Plans, which shall include timelines and deadlines for the meeting of metrics associated with the projects and activities undertaken to ensure timely performance;
 - ii. Provide minimum standards for the process by which hospitals seek public input in the development of their Hospital DSRIP Plans, and provide that hospitals must include documentation of public input in their Hospital DSRIP Plans;
 - iii. Specify a State review process and criteria to evaluate each hospital's individual DSRIP plan and develop its recommendation for approval or disapproval prior to submission to CMS for final approval;
 - iv. Specify a process for obtaining CMS approval for hospital-specific Focus

Areas that do not appear on the list in paragraph 93(b);

- v. Allow sufficient time for CMS to conduct its review of the Hospital DSRIP Plans;
- vi. Describe, and specify the role and function, of a standardized, hospital-specific application to be submitted to the State on an annual basis for the utilization of DSRIP funds that outlines the hospital's specific DSRIP plan, as well as any data books or reports that hospitals may be required to submit to report baseline information or substantiate progress;
- vii. Specify that hospitals must submit semi-annual reports to the State using a standardized reporting form to document their progress (as measured by the specific metrics applicable to the projects that the hospitals have chosen), and qualify to receive DSRIP Payments if the specified performance levels were achieved;
- viii. Specify a review process and timeline to evaluate hospital progress on its DSRIP plan metrics in which first the State and then CMS must certify that a hospital has met its approved metrics as a condition for the release of associated DSRIP funds to the hospital;
- ix. Specify an incentive payment formula to determine the total annual amount of DSRIP incentive payments each participating hospital may be eligible to receive during the implementation of the DSRIP project, consistent with subparagraphs (i) and (j) below, and a formula for determining the incentive payment amounts associated with the specific activities and metrics selected by each hospital, such that the amount of incentive payment is commensurate with the value and level of effort required;
- x. Specify that hospital's failure to fully meet a performance metric under its Hospital DSRIP Plan within the time frame specified will result in forfeiture of the associated incentive payment (i.e., no payment for partial fulfillment);
- xi. Describe a process by which a hospital that fails to meet a performance metric in a timely fashion (and thereby forfeits the associated DSRIP Payment) can reclaim the payment at a later point in time (not to exceed one year after the original performance deadline) by fully achieving the original metric in combination with timely performance on a subsequent related metric, or by which a payment missed by one hospital can be redistributed to other hospitals, including rules governing when missed payments can be reclaimed or must be redistributed;
- xii. Include a process that allows for potential hospital plan modification (including possible reclamation, or redistribution, pending State and CMS approval) and an identification of circumstances under which a plan

modification may be considered, which shall stipulate that CMS may require that a plan be modified if it becomes evident that the previous targeting/estimation is no longer appropriate or that targets were greatly exceeded or underachieved; and

- xiii. Include a State process of developing an evaluation of DSRIP as a component of the draft evaluation design as required by paragraph 134. When developing the DSRIP Planning Protocol, the State should consider ways to structure the different projects that will facilitate the collection, dissemination, and comparison of valid quantitative data to support the Evaluation Design required in section XVI of the STCs. The State must select a preferred evaluation plan for the applicable evaluation question, and provide a rationale for its selection. To the extent possible, participating hospitals should use similar metrics for similar projects to enhance evaluation and learning experience between hospitals. To facilitate evaluation, the DSRIP Planning Protocol must identify a core set of Category 4 metrics that all participating hospitals must be required to report even if the participating hospital chooses not to undertake that project. The intent of this data set is to enable cross hospital comparison even if the hospital did not elect the intervention.

g. **Hospital DSRIP Plans.** The hospitals will develop hospital specific Hospital DSRIP Plans in good faith, to leverage hospital and other community resources to best achieve delivery system transformation goals of the State consistent with the demonstration's requirements.

- i. Each hospital's DSRIP plan must identify the project, population-focused objectives, and specific activities and metrics, which must be chosen from the approved DSRIP Planning Protocol, and meet all the requirements pursuant to this waiver.
- ii. Each project must feature activities from all four Stages, and require the hospital to report at least two metrics in each reporting cycle and report metrics for all four Stages in each DY 3 through 5.
- iii. For each stated goal or objective of a project, there must be an associated outcome (Stage 4) metric that must be reported in all years. The initially submitted Hospital DSRIP Plan must include baseline data on all Stage 4 measures.
- iv. Hospital DSRIP Plans shall include estimated funding available by year to support DSRIP payments, and specific allocation of funding to DSRIP activities proposed within the Hospital DSRIP Plan, with greater weight of payment on Stage 1 and 2 metrics in the early years, and on Stage 3 and 4 metrics in the later years.

- v. Payment of funds allocated in a Hospital DSRIP Plan to Stage 4 may be contingent on the hospital reporting DSRIP Performance Indicators to the State and CMS, on the hospital meeting a target level of improvement in the DSRIP Performance Indicator relative to baseline, or both. At least some of the funds so allocated in DY 3 and DY 4, and all such funds allocated in DY 5, must be contingent on meeting a target level of improvement.
 - vi. Hospitals shall provide opportunities for public input to the development of Hospital DSRIP Plans, and shall provide opportunities for discussion and review of proposed Hospital DSRIP Plans prior to plan submission to the State.
 - vii. Participating hospitals must implement new, or significantly enhance existing health care initiatives; to this end, hospitals must identify the CMS and HHS funded initiatives in which they participate, and explain how their proposed DSRIP activities are not duplicative of activities that are already funded.
 - viii. Each individual Hospital DSRIP Plan must report on progress to receive DSRIP funding. Eligibility for DSRIP Payments will be based on successfully meeting metrics associated with approved activities as outlined in the Hospital DSRIP Plans. Hospitals may not receive credit for metrics achieved prior to CMS approval of their Hospital DSRIP Plans.
- h. **Status of DSRIP Payments.** DSRIP payments are not direct reimbursement for expenditures or payments for services. Payments from the DSRIP pool are intended to support and reward hospital systems and other providers for improvements in their delivery systems that support the simultaneous pursuit of improving the experience of care, improving the health of populations, and reducing per capita costs of health care. Payments from the DSRIP Pool are not considered patient care revenue, and shall not be offset against disproportionate share hospital expenditures or other Medicaid expenditures that are related to the cost of patient care (including stepped down costs of administration of such care) as defined under these Special Terms and Conditions, and/or under the State Plan.
- i. **Demonstration Year 2 DSRIP Payments.** Each hospital's DSRIP payments for DY 2 shall equal two-thirds of the following sum: the total amount of the 2013 HRSF Transition Payments it received in DY 1 plus HRSF payments paid to the hospital under the state plan during SFY 2013. In addition, adjustments may be made to each hospital's DSRIP payment to ensure that a floor amount is available to each hospital or to make additional payments available from a supplemental pool, as defined in the Program Funding and Mechanics Protocol. Payments are further contingent on the hospital's submission of a Hospital DSRIP Plan, and its acceptance by the State and CMS. Total DY 2 DSRIP payments to all hospitals combined shall not exceed \$83,300,000.
- i. Upon receiving each Hospital DSRIP Plan, the State will conduct a review to

determine whether the plan meets the requirements outlined in the DSRIP Planning Protocol, DSRIP Program Funding and Mechanics Protocol, and these STCs.

- ii. If a hospital's Hospital DSRIP Plan is not accepted by the State and not approved by CMS by January 31, 2014, the State may not claim FFP for DSRIP Payments made to that hospital for DY 2 or any subsequent DY, except under the circumstances described in subparagraph (iv).
- iii. A hospital may receive no more than one-half of its maximum of DY 2 DSRIP Payments (not including payments made during the transition period) upon CMS approval of its Hospital DSRIP Plan, and may receive the remainder based on its performance on metrics included in its approved Hospital DSRIP Plan.
- iv. If either (A) or (B) applies, the State may submit a Hospital DSRIP Plan to CMS no later than September 30, 2014 for a hospital that did not receive approval of a plan under subparagraph (ii), which would allow the hospital to qualify for DSRIP Payments in DY 3 through 5 if approved by CMS. The State must notify CMS at least 30 days in advance of its intention to submit a Hospital DSRIP Plan under this provision.

(A) If a hospital failed to submit a DSRIP plan by September 20, 2013, because of a significant adverse unforeseen circumstance and the hospital's prior year HRSF payment was not less than 0.5% of the hospital's annual Net Patient Service Revenues as shown on the most recent year audited Financial Statements, the Hospital may submit a DSRIP plan. A significant adverse unforeseen circumstance is one not commonly experienced by hospitals.

(B) If a Hospital did not receive approval of its Hospital DSRIP Plan or failed to submit a plan and the hospital received certificate of need approval of a merger, acquisition, or other business combination of a hospital within the State of New Jersey, the hospital may submit a Hospital DSRIP Plan in the year the merger, acquisition, or business combination is completed, provided the successor hospital is a participating provider contracted with all Managed Care Insurers licensed and operating in the State of New Jersey.

- j. **Demonstration Years 3 through 5 Payments.** Each hospital with a State and CMS approved Hospital DSRIP Plan may receive DSRIP Payments in DY 3, DY 4, and DY 5. The total amount of DSRIP Payments available to each hospital in DY 3, 4, and 5 will be determined based on the parameters listed below. The determination of weighting factors to be used will be based on discussions with hospital industry as to what will best accelerate meaningful improvement.

- i. Percentage of Medicaid, NJ FamilyCare and Charity Care admissions, patient days, and revenues;
- ii. Trends in absolute percentage changes in the Medicaid, NJ FamilyCare and Charity Care admissions, patient days, and revenues;
- iii. Trends in absolute percentage changes in the Medicaid, NJ FamilyCare and Charity Care admissions, patient days, and revenues from the base period of budget neutrality measurement; and
- iv. Geographic location: urban vs. suburban.

93. Federal Financial Participation (FFP) For DSRIP. The following terms govern the State's eligibility to claim FFP for DSRIP.

- b. The State may not claim FFP for DSRIP until after CMS has approved the DSRIP Planning Protocol and DSRIP Funding and Mechanics Protocol.
- c. The State may claim FFP for payments to hospitals during the Transition Period in accordance with the provisions of paragraph 92, above. The State may claim FFP for payments to hospitals for submission of their Hospital DSRIP Plans in DY 2 upon approval of those plans by CMS. The State may claim FFP for the remaining DY 2 incentive payments to hospitals on the same conditions applicable to DY 3 through 5 DSRIP Payments as presented in subparagraph (c) below.
- d. The State may not claim FFP for DSRIP Payments in DY 3 through 5 until both the State and CMS have concluded that the hospitals have met the performance indicated for each payment. Hospitals' reports must contain sufficient data and documentation to allow the State and CMS to determine if the hospital has fully met the specified metric, and hospitals must have available for review by the State or CMS, upon request, all supporting data and back-up documentation. FFP will be available only for payments related to activities listed in an approved Hospital DSRIP Plan.
- e. In addition to the documentation discussed in paragraph 91(e), the State must use the documentation discussed in paragraph 93(f)(vii) to support claims made for FFP for DSRIP Payments that are made on the CMS-64.9 Waiver forms.

94. Life Cycle of Five-Year Demonstration. This is a synopsis of anticipated funding pool activities planned for this demonstration.

a. Demonstration Year 1 – Planning and Design

- i. Payment Type: Transition Payments, in the amounts discussed in paragraph 92(b)

- ii The State will work with the hospital industry to establish priorities for the DSRIP program.
 - iii The program application, status reports and data books will be developed. These will be submitted to the State annually as part of the hospitals' formal DSRIP application process.
 - iv Starting no later than January 1, 2013, the State must submit to CMS its initial drafts of the DSRIP Planning Protocol and DSRIP Funding and Mechanics Protocol, and CMS, the State, and hospitals will begin a collaborative process to develop and finalize these documents. The State and CMS agree to a target date of February 28, 2013 for CMS to issue its final approval of these protocols.
 - v Hospitals will begin drafting their Hospital DSRIP Plans after the DSRIP Planning Protocol and DSRIP Funding and Mechanics Protocol are approved by CMS.
- b. *Demonstration Year 2 – Transition through December 31, 2013, the Infrastructure Development*
- i Payment Type: Transition Payments through December 31, 2013 and DSRIP Payments thereafter, totaling \$166.6 million. If a hospital does not submit a Hospital DSRIP Plan and application approved by the state and CMS, all of its DY 2 DSRIP payment (not transition payment) must be withheld, consistent with paragraph 93(i).
 - ii On or before September 20, 2013, 2013, Hospitals will submit their initial DSRIP applications, data books and DSRIP plans that will include:
 - a. Infrastructure investments that will be made;
 - b. How it specifically sees these investments leading to efficient and more effective care in accordance with the State's DSRIP vision;
 - c. Baseline performance metrics.
 - iii By December 13, 2013, the State must submit all accepted Hospital DSRIP Plans to CMS, as well as a list of eligible hospitals that will be excluded from DSRIP for failure to submit an acceptable Hospital DSRIP Plan.
 - iv CMS and the State will work diligently to review the Hospital DSRIP Plans, with a goal of making final decisions by January 31, 2014.
 - v Note that hospitals can begin to make infrastructure improvements in this

year.

c. *Demonstration Year 3 – Chronic Medical Condition Redesign and Management Begins*

- i Payment Type: DSRIP totaling \$166.6 million.
- ii Hospitals are fully engaged in infrastructure investments as specified in their DSRIP plans.
- iii Hospitals will begin utilizing them to improve upon the baseline performance data submitted with the DSRIP plan.
- iv Hospitals will submit to the State the semi-annual status of their DSRIP progress and infrastructure developments. A hospital's progress, or lack of progress, will be the determining factor for their receipt of DSRIP Payments over the course of the year.
- v By the end of this year, hospitals will submit a status report on the infrastructure developments and its plan to begin utilizing them. As part of the status report, the hospital will submit updates to performance metrics identified in the DSRIP plan.

d. *Demonstration Year 4 – Quality Improvement and Measurements*

- i. Payment Type: DSRIP totaling \$166.6 million.
- ii. Hospitals' infrastructure improvements are complete or nearly complete.
- iii. Hospitals will update the State on a quarterly basis to demonstrate progress towards the desired outcome measures. A hospital's progress, or lack of progress, will be the determining factor for their receipt of DSRIP Payments over the course of the year.
- iv. Hospitals will submit a status report outlining progress as part of its application for the next demonstration year.

e. *Demonstration Year 5 – Quality Improvement and Measurements*

- i. Payment Type: DSRIP totaling \$166.6 million
- ii. The State reviews the progress hospitals have made on their desired outcomes.
- iii. Initial DSRIP payments for this year will be based on hospitals' overall performances in DY 4 along with any other projects they may want to undertake.

- iv. Hospitals will update the State on a semi-annual basis to demonstrate progress towards the desired outcome measures. A hospital's progress, or lack of progress, will be the determining factor for their receipt of DSRIP payment over the course of the year
- v. Hospitals will submit a status report on the project five-year DSRIP plan outcome.

95. Limits on Pool Payments. The State can claim FFP for Transition Payments and DSRIP Payments in each DY up to the limits on total computable payments shown in the table below. The \$256.6 million that the State had budgeted to provide to hospitals in the forms of Hospital Relief Subsidy Fund and Graduate Medical Education supplemental payments in SFY 2012 (less amounts paid to hospitals in State plan supplemental payments in SFY 2013) establish the limit on the Transition Payments in DY 1. The \$166.6 million that the State provided to hospitals in SFY 2012 in the form of Hospital Relief Subsidy Fund supplemental payments equals the limit on transition payments plus the DSRIP pool payments in DY 2, then DSRIP payments through DY 5. GME payments made in DY 2 or later under a State plan amendment are not subject to the limits shown below. If the state wishes to change any provision of the DSRIP program, it must submit a waiver amendment to CMS. The waiver amendment must be approved by CMS before any changes are made to the program. Except as permitted under paragraph 93(f)(xii) above, the State may not carry over DSRIP funds from one Demonstration Year to the next.

Pool Allocations According to Demonstration Year (All figures are total computable dollars.)

Type of Pool	DY 1 Approval to 6/30/13	DY 2 7/1/13 to 6/30/14	DY 3 7/1/14 to 6/30/15	DY 4 7/1/15 to 6/30/16	DY 5 7/1/16 to 6/30/17	Totals
DSRIP	n/a	\$83.3 Million	\$166.6 Million	\$166.6 Million	\$166.6 Million	\$583.1 Million
Transition Payments	\$256.6 Million minus State plan supplemental payments in SFY 2013	\$83.3 Million	n/a	n/a	n/a	\$339.9 Million minus State plan supplemental payments in SFY 2013
Total/DY	\$256.6 Million minus State plan supplemental payments in SFY 2013	\$166.6 Million	\$166.6 Million	\$166.6 Million	\$166.6 Million	\$923 Million less SFY 2013 state supplemental payments

96. **Transition Plan for Funding Pools** No later than June 30, 2016, the State shall submit a transition plan to CMS based on the experience with the DSRIP pool, actual uncompensated care trends in the State, and investment in value based purchasing or other payment reform options.

XIV. GENERAL REPORTING REQUIREMENTS

97. **General Financial Requirements.** The State must comply with all general financial requirements, including reporting requirements related to monitoring budget neutrality, set forth in section 0 of these STCs. The State must submit any corrected budget and/or allotment neutrality data upon request.

98. **MLTSS Data Plan for Quality.** The State will collect and submit MLTSS data as follows:

a. Reporting on:

- i. Numbers of beneficiaries receiving HCBS and NF services just prior to implementation;
- ii. Numbers of enrollees receiving HCBS and NF services during each twelve month period;
- iii. HCBS and NF expenditures for MLTSS during a twelve month period as percentages of total long-term services and supports expenditures;
- iv. Average HCBS and NF expenditures per enrollee during a twelve month period;
- v. Average length of stay in HCBS and NFs during a twelve month period
- vi. Percent of new MLTSS enrollees admitted to NFs during a twelve month period
- vii. Number of transitioning individuals from NFs to the community, and the community to NFs, during a twelve month period;
- viii. Other data relevant to system rebalancing;
- ix. The State will assure that appropriate electronic collection of MLTSS data systems will be in place to record identified data elements prior to the implementation of MLTSS.
- x. Baseline data will be submitted to CMS within 18 months of the last day of the twelve month period prior to MLTSS implementation. Thereafter, an electronic copy of the MLTSS data for each demonstration year will be submitted to CMS within a year of the last day of each demonstration year.

- xi. The State will require the MCOs to revise all existing applicable policies and plans for quality to account for MLTSS requirements. Quality measures that need revising and submission at least 45 days prior to implementation of MLTSS by each MCO.
- xii. The State will also require the MCOs to establish processes and provide assurances to the State regarding access standards described in 42 CFR.438, Subpart D including availability of services, adequate capacity and services, coordination and continuity of care, and coverage and authorization of services.
- xiii. The State Medicaid Agency will make a preliminary selection of HEDIS, OASIS, Medicaid Adult and Child Quality Measures and other performance measures as appropriate, and may adjust the underlying methodology to account for the unique features of the MLTSS. These may include: reductions in NF placements, timely initiation of MLTSS, reduction in hospital readmissions, and percent of Medicaid funding spent on HCBS including MLTSS. The measures will take into consideration particular programs, groups, geographic areas, and characteristics of the MCO.

99. Monthly Enrollment Report. Within 20 days following the first day of each month, the State must report via e-mail the demonstration enrollment figures for the month just completed to the CMS Project Officer, the Regional Office contact, and the CMS CAHPG Enrollment mailbox, using the table below.

The data requested under this subparagraph is similar to the data requested for the Quarterly Report in Attachment A, except that they are compiled on a monthly basis.

Demonstration Populations (as hard coded in the CMS 64)	Point In Time Enrollment (last day of month)	Newly Enrolled Last Month	Disenrolled Last Month
MEG			
MEG			
Totals			

100. Monthly Monitoring Calls. CMS will convene monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to: transition and implementation activities, health care delivery, enrollment, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, legislative developments, and any

demonstration amendments the State is considering submitting. CMS will provide updates on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the demonstration. The State and CMS will jointly develop the agenda for the calls.

101. **Quarterly Progress Reports.** The State must submit quarterly progress reports in accordance with the guidelines in Attachment A no later than 60 days following the end of each quarter. The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports must include the following, but are not limited to:

- a. An updated budget neutrality monitoring spreadsheet;
- b. A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including, but not limited to: benefits, enrollment and disenrollment, provider enrollment and transition from FFS to managed care complaints and grievances, quality of care, and access that is relevant to the demonstration, pertinent legislative or litigation activity, and other operational issues;
- c. HCBS/MLTSS activities including reporting for each program operating under the demonstration including the PDD pilot program;
- d. Adverse incidents including abuse, neglect, exploitation, morality reviews and critical incidents that result in death;
- e. Action plans for addressing any policy, administrative, or budget issues identified;
- f. Medical Loss Ratio (MLR) reports for each participating MCO;
- g. A description of any actions or sanctions taken by the State against any MCO, SNP, PACE organization, or ASO;
- h. Quarterly enrollment reports for demonstration participants, that include the member months and end of quarter, point-in-time enrollment for each demonstration population, and other statistical reports listed in Attachment A;
- i. Number of participants who chose an MCO and the number of participants who change plans after being auto-assigned;
- j. Hotline Reporting (from MCOs) – Complaints, Grievances and Appeals by type including access to urgent, routine, specialty and MLTSS; and,

102. **Annual Report.**

- a. The State must submit a draft annual report documenting accomplishments, project

Approved October 1, 2012 through June 30, 2017

Amended December 23, 2013

status, quantitative and case study findings, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the demonstration.

- b. The State must submit the draft annual report no later than 120 days after the close of the demonstration year (DY).
- c. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.
- d. Elements of the Annual report should include:
 - i. A report of service use by program including each HCBS program (encounter data);
 - ii. a summary of the use of self-directed service delivery options in the State;
 - iii. a general update on the collection, analysis and reporting of data by the plans at the aggregate level;
 - iv. monitoring of the quality and accuracy of screening and assessment of participants who qualify for HCBS/MLTSS;
 - v. GEO access reports from each participating MCO;
 - vi. waiting list(s) information by program including number of people on the list and the amount of time it takes to reach the top of the list where applicable;
 - vii. the various service modalities employed by the State, including updated service models, opportunities for self-direction in additional program, etc.;
 - viii. specific examples of how HCBS have been used to assist participants;
 - ix. a description of the intersection between demonstration MLTSS and any other State programs or services aimed at assisting high-needs populations and rebalancing institutional expenditures (e.g. New Jersey's Money Follows the Person demonstration, other Federal grants, optional Medicaid Health Home benefit, behavioral health programs, etc.);
 - x. A summary of the outcomes of the State's Quality Strategy for HCBS as outlined above;
 - xi. Efforts and outcomes regarding the establishment of cost-effective MLTSS in community settings using industry best practices and guidelines;
 - xii. policies for any waiting lists where applicable;

- xiii. Other topics of mutual interest between CMS and the State related to the HCBS included in the demonstration;
- xiv. The State may also provide CMS with any other information it believes pertinent to the provision of the HCBS and their inclusion in the demonstration, including innovative practices, certification activity, provider enrollment and transition to managed care special populations, workforce development, access to services, the intersection between the provision of HCBS and Medicaid behavioral health services, rebalancing goals, cost-effectiveness, and short and long-term outcomes.
- xv. A report of the results of the State's monitoring activities of critical incident reports
- xvi. An updated budget neutrality analysis, incorporating the most recent actual data on expenditures and member months, with updated projections of expenditures and member months through the end of the demonstration, and proposals for corrective action should the projections show that the demonstration will not be budget neutral on its scheduled end date.

XVI. ADMINISTRATIVE REQUIREMENTS

103. General Requirements

- a. **Medicaid Administrative Requirements.** Unless otherwise specified in these STCs, all processes (e.g., eligibility, enrollment, redeterminations, terminations, appeals) must comply with Federal law and regulations governing Medicaid program.

Facilitating Medicaid Enrollment. The State must screen new applicants for Medicaid eligibility, and if determined eligible, enroll the individual in Medicaid, and must screen current the General Assistance participants at least annually upon recertification / renewal of enrollment.

XVII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

- 104. **Reporting Expenditures under the Demonstration.** The State will provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. The CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs. FFP will be provided for expenditures net of collections in the form of pharmacy rebates, cost sharing, or third party liability.

- a. **Use of Waiver Forms.** In order to track expenditures under this demonstration, the State must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All demonstration expenditures claimed under authority of title XIX and section 1115 and subject to the budget neutrality expenditure limit (as defined in Section XVIII below) must be reported on separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration Project Number assigned by CMS.

- b. **Reporting by Demonstration Year (DY) by Date of Service.** In each quarter, demonstration expenditures (including prior period adjustments) must be reported separately by DY (as defined in subparagraph (h) below). Separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted for each DY for which expenditures are reported. The DY is identified using the Project Number Extension, which is a 2-digit number appended to the Demonstration Project Number. Capitation and premium payments must be reported in the DY that includes the month for which the payment was principally made. Pool payments are subject to annual limits by DY, and must be reported in DY corresponding to the limit under which the payment was made. All other expenditures must be assigned to DYs according to date of service,

- c. **Use of Waiver Names.** In each quarter, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted for the following categories of expenditures, identified using the Waiver Names shown in “quotes.” Waiver Names (i) through (xiii) are to be used to report all expenditures for individuals identified with those names in the MEG columns in the tables in paragraph 22, except as noted. For the other Waiver Names, a description of the expenditures to be reported is included in each subparagraph.
 - i. “Title XIX”
 - ii. Beginning 01/01/2014 “Adult Expansion Group”
 - iii. “ABD”
 - iv. “LTC” (This waiver name will be used following the transition to MLTSS.)
 - v. “HCBS – State Plan” (This waiver name will be used following the transition to MLTSS.)
 - vi. “HCBS – 217 Like” (This waiver name will be used following the transition to MLTSS.)
 - vii. “SED – 217 Like”
 - viii. “IDD/MI – 217 Like”

- ix. “Childless Adults” (Used through 12/31/2013.)
- x. “XIX CHIP Parents” (Used 10/1/2013 through 12/31/2013.)
- xi. “AWDC” (Used through 12/31/2013.)
- xii. “SED at Risk”
- xiii. “MATI at Risk”
- xiv. “TBI – SP”: This waiver name will be used prior to transition to MLTSS.
- xv. “ACCAP – SP”: This waiver name will be used prior to transition to MLTSS.
- xvi. “CRPD – SP”: This waiver name will be used prior to transition to MLTSS.
- xvii. “GO – SP”: This waiver name will be used prior to transition to MLTSS.
- xviii. “TBI – 217 Like”: This waiver name will be used prior to transition to MLTSS.
- xix. “ACCAP – 217 Like”: This waiver name will be used prior to transition to MLTSS.
- xx. “CRPD – 217 Like”: This waiver name will be used prior to transition to MLTSS.
- xxi. “GO – 217 Like”: This waiver name will be used prior to transition to MLTSS.
- xxii. “HRSF &GME”: 2013 (DY 1) HRSF Transition Payments and GME are to be reported here.
- xxiii. “GME State Plan”: GME payments made under a State plan amendment described in paragraph 92(h) are to be reported here.
- xxiv. “DSRIP”: All DSRIP Payments are to be reported here.
- xxv. “HSRF Transition Payments”: 2014 (DY 2) HRSF Transition Payments are to be reported here.

d. For monitoring purposes, cost settlements related to demonstration expenditures must be recorded on Line 10.b, in lieu of Lines 9 or 10.c. For any other cost settlements (i.e.,

those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10.c, as instructed in the State Medicaid Manual.

- e. **Pharmacy Rebates.** By November 30, 2012, the State must propose a methodology to CMS for assigning a portion of pharmacy rebates to the demonstration, in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which reasonably identifies pharmacy rebate amounts with DYs and with MEGs. Pharmacy rebates cannot be reported on Waiver forms for budget neutrality purposes until an assignment methodology is approved by the CMS Regional Office. Changes to the methodology must also be approved in advance by the Regional Office. The portion of pharmacy rebates assigned to the demonstration using the approved methodology will be reported on the appropriate Forms CMS-64.9 Waiver for the demonstration and not on any other CMS 64.9 form to avoid double-counting.

- f. **Premium and Cost Sharing Adjustments.** Premiums and other applicable cost-sharing contributions that are collected by the State from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet Line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and Federal share) should also be reported separately by demonstration Year on the Form CMS-64 Narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to demonstration populations will be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration’s actual expenditures on a quarterly basis.

- g. **Mandated Increase in Physician Payment Rates in 2013 and 2014.** Section 1202 of the Health Care and Education Reconciliation Act of 2010 (Pub. Law 110-152) requires State Medicaid programs to reimburse physicians for primary care services at rates that are no less than what Medicare pays, for services furnished in 2013 and 2014, with the Federal Government paying 100 percent of the increase. The entire amount of this increase will be excluded from the budget neutrality test for this demonstration. The specifics of separate reporting of these expenditures will be described in guidance to be issued by CMS at a later date,

- h. **Demonstration Years.** The first Demonstration Year (DY1) will be the year effective date of the approval letter through June 30, 2017, and subsequent DYs will be defined as follows:

Demonstration Year 1 (DY1)	October 1, 2012 to June 30, 2013	9 months
Demonstration Year 2 (DY2)	July 1, 2013 to June 30, 2014	12 months
Demonstration Year 3 (DY3)	July 1, 2014 to June 30,	12 months

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	2015	
Demonstration Year 4 (DY4)	July 1, 2015 to June 30, 2016	12 months
Demonstration Year 5 (DY5)	July 1, 2016 to June 30, 2017	2 months

105. **Expenditures Subject to the Budget Agreement.** For the purpose of this section, the term “expenditures subject to the budget neutrality limit” will include the following:
- a. All medical assistance expenditures (including those authorized in the Medicaid State plan, through section 1915(c) waivers, and through section 1115 waivers and expenditure authorities, but excluding the increased expenditures resulting from the mandated increase in payments to physicians) made on behalf of all demonstration participants listed in the table in paragraph 22, with dates of service within the demonstration’s approval period;
 - b. GME payments made under a State plan amendment described in paragraph 92(h) and
 - c. All Transition Payments and DSRIP Payments.
106. **Administrative Costs.** Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the demonstration, using separate CMS-64.10 waiver and 64.10 waiver forms, with waiver name “ADM”.
107. **Claiming Period.** All claims for expenditures subject to the budget neutrality limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the Form CMS-64 in order to properly account for these expenditures in determining budget neutrality.
108. **Reporting Member Months.** For the purpose of calculating the budget neutrality expenditure limit and other purposes, the State must provide to CMS on a quarterly basis the actual number of eligible member/months for demonstration participants. Enrollment information should be provided to CMS in conjunction with the quarterly and monthly enrollment reports referred to in section XV of these STCs. If a quarter overlaps the end of one DY and the beginning of another DY, member/months pertaining to the first DY must be distinguished from those pertaining to the second.

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- a. The term “eligible member/months” refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member/months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member/months.
- b. The demonstration populations will be reported for the purpose of calculating the without waiver baseline (budget neutrality expenditure limit) using the following Waiver Names, following the cross-walk shown in paragraph 22.

- i. Title XIX,

- ii. Beginning 01/01/2014 Adult Expansion Group

- iii. ABD,

- iv. LTC (Reporting for this waiver name will begin following the transition to MLTSS),

- v. HCBS – 217 Like (Before transition to MLTSS, the state must instead report separate member month totals for ACCAP – SP, CRPD – SP, GO – SP, and TBI - SP.),

- vi. AWDC (July-March only)

- vii. AWDC (April-June only)

- viii. HCBS – 217 Like (Before transition to MLTSS, the state must instead report separate member month totals for ACCAP – 217 Like, CRPD – 217 Like, GO – 217 Like, and TBI – 217 Like.),

- ix. SED – 217 Like,

- x. IDD/MI – 217 Like, and

- xi. XIX CHIP Parents (October-December 2013 only).

109. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used during the demonstration. The State must estimate matchable Medicaid expenditures on the quarterly Form CMS-37. As a supplement to the Form CMS-37, the State will provide updated estimates of expenditures subject to the budget neutrality limit. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64

quarterly with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

110. **Extent of FFP for the Demonstration.** The CMS will provide FFP at the applicable Federal matching rate for the following, subject to the limits described in paragraph 132:Section XVIII:
- a. Administrative costs, including those associated with the administration of the demonstration.
 - b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State plan.
 - c. Medical Assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.
111. **Sources of Non-Federal Share.** The State certifies that the matching non-Federal share of funds for the demonstration is State/local monies. The State further certifies that such funds shall not be used as the match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.
- a. CMS may review the sources of the non-Federal share of funding for the demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
 - b. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.
112. **State Certification of Funding Conditions.** Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the State as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the State government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes—including health care provider-related taxes—fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

XVIII GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI

113. The State shall provide quarterly expenditure reports using the Form CMS-21 to report
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total expenditures for services provided under the approved CHIP plan and those provided through the New Jersey demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS will provide Federal financial participation (FFP) only for allowable New Jersey demonstration expenditures that do not exceed the State's available title XXI funding.

114. In order to track expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-21 reporting instructions outlined in section 2115 of the State Medicaid Manual. Title XXI demonstration expenditures will be reported on separate Form CMS-64-21U Waiver and/or CMS-21P Waiver, identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services rendered or for which capitation payments were made). All expenditures under this demonstration must be reported on separate Forms CMS-21 Waiver and/or CMS-21P Waiver for each of the demonstration populations using the information in the drop-down listing as follows:
- a. CHIP Expansion Children up to 133 percent of the FPL (Waiver Name: "Title XXI Exp Child")
 - b. CHIP Parents/Caretakers above AFDC limit up to and including 133 percent of the FPL (Waiver Name: "NJFAMCAREWAIV-POP 1")
 - c. CHIP Parents/Caretakers 134 up to and including 200 percent of the FPL (Waiver Name: "NJFAMCAREWAIV-POP 2")
115. All claims for expenditures related to the demonstration (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the Form CMS-21.
116. The standard CHIP funding process will be used during the demonstration. New Jersey must estimate matchable CHIP expenditures on the quarterly Form CMS-21B. As a footnote to the CMS 21B, the State shall provide updated estimates of expenditures for the demonstration populations. CMS will determine the availability of Federal funds based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-21 quarterly CHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-21 with Federal funding previously made available to the State, and including the reconciling adjustment in the finalization of the grant award to the State, if appropriate.
117. The State will certify State/local monies used as matching funds for the demonstration and will further certify that such funds will not be used as matching funds for any other

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Federal grant or contract, except as permitted by Federal law.

118. New Jersey will be subject to a limit on the amount of Federal title XXI funding that the State may receive on demonstration expenditures during the demonstration period. Federal title XXI funding available for demonstration expenditures is limited to the State's available allotment, including currently available reallocated funds. Should the State expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of the approved title XXI child health program or demonstration until the next allotment becomes available.
119. Total Federal title XXI funds for the State's CHIP program (i.e., the approved title XXI State plan and this demonstration) are restricted to the State's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with the State plan population. Demonstration expenditures are limited to remaining funds.
120. Total expenditures for outreach and other reasonable costs to administer the title XXI State plan and the demonstration that are applied against the State's title XXI allotment may not exceed 10 percent of total title XXI expenditures.
121. If the State exhausts the available title XXI Federal funds for the claiming period, the State will continue to provide coverage to the approved title XXI State plan separate child health program population and to the Uninsured custodial parents and caretaker relatives of Medicaid and CHIP children with incomes above the previous Medicaid standard up to and including 133 percent of the FPL and the uninsured custodial parents and caretaker relatives with income at or above 134 percent of the FPL, and up to and including 200 percent of the FPL. Title XIX Federal matching funds will be provided for these populations when title XXI allotment is no longer available after September 30, 2013, pursuant to the State's budget neutrality monitoring agreement, appended as Attachment C of this document.
122. The State shall provide CMS with 60 days notification before it begins to draw down title XIX matching funds for Medicaid expansion if appropriate, in accordance with the terms of the demonstration.
123. All Federal rules shall continue to apply during the period of the demonstration that title XXI Federal funds are not available. The State may close enrollment or institute a waiting list with respect to Uninsured custodial parents and caretaker relatives of Medicaid and CHIP children with incomes above the previous Medicaid standard up to and including 133 percent of the FPL and the uninsured custodial parents and caretaker relatives with income at or above 134 percent of the FPL, and up to and including 200 percent of the FPL upon 60 days' notice to CMS.

XIX. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

124. **Limit on Title XIX Funding.** The State will be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures

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during the period of approval of the demonstration. The limit is determined by using the per capita cost method described in paragraph 0, and budget neutrality expenditure limits are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the State to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the State's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

125. **Risk.** The State will be at risk for the per capita cost (as determined by the method described below) for state plan and hypothetical populations, but not at risk for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration populations, CMS will not place the State at risk for changing economic conditions. However, by placing the State at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.
126. **Calculation of the Budget Neutrality Limit and How It Is Applied.** For the purpose of calculating the overall budget neutrality limit for the demonstration, separate annual budget limits will be calculated for each DY on a total computable basis, by multiplying the predetermined PMPM cost for each EG (shown on the table in paragraph 127) by the corresponding actual member months total, and summing the results of those calculations. The annual limits will then be added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality limit by Composite Federal Share 1, which is defined in paragraph 132 below. The demonstration expenditures subject to the budget neutrality limit are those reported under the following Waiver Names (Title XIX, ABD, LTC, HCBS – State Plan, NJ Familycare Adult group, SED at Risk, MATI at Risk, TBI – SP, ACCAP – SP, CRPD – SP, GO – SP, HRSF & GME, GME State Plan, HRSF Transition Payments, DSRIP), plus any excess spending from the Supplemental Tests described in paragraph 130.
127. **Impermissible DSH, Taxes, or Donations.** CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of laws and policy statements, including regulations and letters regarding impermissible provider payments, health care related taxes, or other payments (if necessary adjustments must be made). CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.
128. The trend rates and per capita cost estimates for each EG for each year of the demonstration are listed in the table below. The PMPM cost estimates are based on actual Medicaid PMPM costs in SFY 2012, trended forward using trends based on the lower of state historical trends from SFY 2006 to 2008 and the FFY 2012 President's Budget trends. Year-

to-year changes in the ABD MEG differ from the stated percentage in the early years of the demonstration due to the effect of adjustments made to the PMPMs after trending.

MEG	TREND	DY 1 - PMPM	DY 2 – PMPM	DY3 – PMPM	DY4 – PMPM	–DY5 – PMPM
Title XIX	5.8%	\$327.03	\$346.00	\$366.07	\$387.30	\$409.76
ABD	3.6%	\$1,045.04	\$1,123.36	\$1,163.80	\$1,205.69	\$1,249.10
LTC*	3.9%	\$8,636.81	\$8,973.64	\$9,323.62	\$9,687.24	\$10,065.04
HCBS – State Plan**	3.7%	\$2,256.69	\$2,340.19	\$2,426.78	\$2,516.57	\$2,609.68

* Prior to implementation of MLTSS, the member month total used for LTC is the sum of the subsets from other MEGs, as described in paragraph 109(b), and the member month totals for the other MEGs must be adjusted to remove LTC member months.

** Prior to implementation of MLTSS, the member month total used for HCBS – State Plan is the combined total from the following categories: ACCAP – SP, CRPD – SP, GO – SP, and TBI – SP.

129. Supplemental Tests.

- a. **Supplemental Budget Neutrality Test 1: Hypothetical Eligibility Groups and the Hypotheticals Test.** Budget neutrality agreements may include optional Medicaid populations that could be added under the State plan but have not been and are not included in current expenditures. However, the agreement will not permit accumulate or access to budget neutrality “savings.” A prospective per capita cap on Federal financial risk is established for these groups based on the costs that the population is expected to incur under the demonstration.

- i. The MEGs listed in the table below are the hypothetical groups included in the calculation of the Hypotheticals Cap.

MEG	TREND	DY 1 – PMPM	DY 2 – PMPM	DY3 – PMPM	DY4 – PMPM	–DY5 – PMPM
HCBS 217-Like*	3.7%	\$2,256.69	\$2,340.19	\$2,426.78	\$2,516.57	\$2,609.68
SED – 217 Like	6.0%	\$2,246.37	\$2,381.15	\$2,524.02	\$2,675.46	\$2,835.99
IDD/MI – 217 Like	6.0%	\$9,839.39	\$10,429.75	\$11,055.53	\$11,718.87	\$12,422.00
AWDC	3.7%	\$277.00 (October 2012- March 2013)	\$288.00 (July- December 2013)			
AWDC	3.7%	\$288.00 (April- June 2013)				
XIX CHIP			\$307.24			

Parents			(October-December 2013)			
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* Prior to implementation of MLTSS, the member month total used for HCBS – 217 Like is the combined total from the following categories: ACCAP – 217 Like, CRPD – 217 Like, GO – 217 Like, and TBI – 217 Like.

- ii. The Hypotheticals Cap is calculated by taking the PMPM cost projection for each group and in each DY times the number of eligible member months for that group in that DY, and adding the products together across groups and DYs. The Federal share of the Hypotheticals Cap is obtained by multiplying the Hypotheticals Cap by Composite Federal Share 2.
 - iii. If total FFP for hypothetical groups should exceed the Federal share of the Hypotheticals Cap, the difference must be reported as a cost against the budget neutrality limit described in paragraphs 127 and 129 of these STCs.
- b. **Supplemental Budget Neutrality Test 2: New Adult Group.** Effective January 1, 2014, adults eligible for Medicaid as the group defined in section 1902(a)(10)(A)(i)(VIII) of the Act are included in this demonstration, and in budget neutrality. However, the state will not be allowed to obtain budget neutrality “savings” from this population. Therefore, a separate expenditure cap is established for medical expenditures for this group, to be known as Supplemental Budget Neutrality Test 2.
- i. The MEG listed in the table below is included in Supplemental Budget Neutrality Test 2.

MEG	TREND	DY 2 – PMPM	DY3 – PMPM	DY4 – PMPM	–DY5 – PMPM
New Adult Group	5.0%	\$492.15	\$516.75	542.59	569.72

- ii. If the state’s experience of the take up rate for the new adult group and other factors that affect the costs of this population indicates that the PMPM limit described above in subparagraph (a) may underestimate the actual costs of medical assistance for the new adult group, the state may submit an adjustment to subparagraph (a) for CMS review without submitting an amendment pursuant to STC 7. Adjustments to the PMPM limit for a demonstration year must be submitted to CMS by no later than October 1 of the demonstration year for which the adjustment would take effect.
- iii. Supplemental Cap 2 is calculated by taking the PMPM cost projection for New Adult Group in each DY, times the number of eligible member months for New Adult Group and DY, and adding the products together across DYs. The Federal share of Supplemental Cap 2 is obtained by multiplying Supplemental Cap 2 by Composite Federal Share 3.

- iv. Supplemental Budget Neutrality Test 2 is a comparison between the federal share of Supplemental Cap 2 and total FFP reported by the state for New Adult Group.

130. **Composite Federal Share Ratios.** The Composite Federal Share is the ratio calculated by dividing the sum total of Federal financial participation (FFP) received by the State on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. There are three Composite Federal Share Ratios for this demonstration: Composite Federal Share 1, based on the expenditures reported under the Waiver Names listed in paragraph 127, Composite Federal Share 2, based on the Waiver Names listed in paragraph 130(a)(iii), and Composite Federal Share 3, based on the Waiver Name listed in paragraph 130(b)(iii). For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.

131. **Exceeding Budget Neutrality.** The budget neutrality limits calculated in paragraphs 127 and 130 will apply to actual expenditures for demonstration services as reported by the State under section XV of these STCs. If at the end of the demonstration period the budget neutrality limit has been exceeded, the excess Federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the demonstration period, the budget neutrality test will be based on the time period through the termination date.

132. **Enforcement of Budget Neutrality.** If the State exceeds the calculated cumulative target limit by the percentage identified below for any of the DYs, the State shall submit a corrective action plan to CMS for approval. .

Year	Cumulative target definition	Percentage
DY 1	Cumulative budget neutrality cap plus:	0.25 percent
DY 2	Cumulative budget neutrality cap plus:	0.25 percent
DY 3, 4, & 5	Cumulative budget neutrality cap plus:	0 percent

XX. EVALUATION OF THE DEMONSTRATION

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133. **Submission of a Draft Evaluation Design.** The State shall submit to CMS for approval a draft Evaluation Design for an overall evaluation of the demonstration no later than 120 days after CMS approval of the demonstration. The draft Evaluation Design must include a discussion of the goals, objectives, and specific hypotheses that are being tested, and identify outcome measures that shall be used to evaluate the demonstration's impact. It shall discuss the data sources, including the use of Medicaid encounter data, and sampling methodology for assessing these outcomes. The draft Evaluation Design must describe how the effects of the demonstration will be isolated from other initiatives occurring in the State. The draft Evaluation Design shall identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

- a. Domains of Focus. The Evaluation Design must, at a minimum, address the research questions listed below. For questions that cover broad subject areas, the State may propose a more narrow focus for the evaluation.
 - i What is the impact of the managed care expansion on access to care, the quality, efficiency, and coordination of care, and the cost of care?
 - ii What is the impact of including long-term care services in the capitated managed care benefit on access to care, quality of care, and mix of care settings employed?
 - iii What is the impact of the hypothetical spend-down provision on the Medicaid eligibility and enrollment process? What economies or efficiencies were achieved, and if so, what were they? Was there a change in the number of individuals or on the mix of individuals qualifying for Medicaid due to this provision?
 - iv What is the impact of using self-attestation on the Transfer of assets look-back period of long term care and home and community based services for individuals who are at or below 100 percent of the FPL. Was there a change in the number of individuals or on the mix of individuals qualifying for Medicaid due to this provision?
 - v What is the impact of providing additional home and community-based services to Medicaid and CHIP beneficiaries with serious emotional disturbance, opioid addiction, pervasive developmental disabilities, or intellectual disabilities/developmental disabilities?
 - vi What is the impact of the program to provide a safe, stable, and therapeutically supportive environment for children from age 5 up to age 21 with serious emotional disturbance who have, or who would otherwise be at risk for, institutionalization?
 - vii What is the impact of providing adults who do not qualify for Medicaid or the Work First Childless Adults population with outpatient treatment for their opioid addiction or mental illness?

- viii Was the DSRIP program effective in achieving the goals of better care for individuals (including access to care, quality of care, health outcomes), better health for the population, or lower cost through improvement? To what degree can improvements be attributed to the activities undertaken under DSRIP?
- ix What is the impact of the transition from supplemental payments to DSRIP on hospitals' finances and the distribution of payments across hospitals?
- iv. What do key stakeholders (covered individuals and families, advocacy groups, providers, health plans) perceive to be the strengths and weaknesses, successes and challenges of the expanded managed care program, and of the DSRIP pool? What changes would these stakeholders recommend to improve program operations and outcomes?
- b. Evaluation Design Process: Addressing the research questions listed above will require a mix of quantitative and qualitative research methodologies. When developing the DSRIP Planning Protocol, the State should consider ways to structure the different projects that will facilitate the collection, dissemination, and comparison of valid quantitative data to support the Evaluation Design. From these, the State must select a preferred research plan for the applicable research question, and provide a rationale for its selection.

To the extent applicable, the following items must be specified for each design option that is proposed:

- i. Quantitative or qualitative outcome measures;
- ii. Baseline and/or control comparisons;
- iii. Process and improvement outcome measures and specifications;
- iv. Data sources and collection frequency;
- v. Robust sampling designs (e.g., controlled before-and-after studies, interrupted time series design, and comparison group analyses);
- vi. Cost estimates;
- vii. Timelines for deliverables.
- c. Levels of Analysis: The evaluation designs proposed for each question may include analysis at the beneficiary, provider, and aggregate program level, as appropriate, and include population stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups. In its review of the draft evaluation plan, CMS reserves the right to request additional levels of analysis.

134. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft Evaluation Design within 60 days of receipt, and the State shall submit a final Evaluation Design within 60 days after receipt of CMS comments. The State shall implement the Evaluation Design and submit its progress in each of the quarterly and annual reports.

135. **Evaluation Reports.**

- a. **Interim Evaluation Report.** The State must submit a Draft Interim Evaluation Report by July 1, 2016, or in conjunction with the State’s application for renewal of the demonstration, whichever is earlier. The purpose of the Interim Evaluation Report is to present preliminary evaluation findings, and plans for completing the evaluation design and submitting a Final Evaluation Report according to the schedule outlined in (b). The State shall submit the final Interim Evaluation Report within 60 days after receipt of CMS comments.
- b. **Final Evaluation Report.** The State shall submit to CMS a draft of the Final Evaluation Report by July 1, 2017. The State shall submit the final evaluation report within 60 days after receipt of CMS comments.

136. **Cooperation with Federal Evaluators.** Should CMS undertake an independent evaluation of any component of the demonstration, the State shall cooperate fully with CMS or the independent evaluator selected by CMS. The State shall submit the required data to CMS or the contractor.

XXI. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Date	Deliverable	Paragraph
Administrative		
30 days after approval date	State acceptance of demonstration Waivers, STCs, and Expenditure Authorities	Approval letter
30 days prior to implementation	Termination of authority notice regarding the 1915(c) waivers	Paragraph 62
30 days after approval date	Termination of authority notice regarding the 1915(b) waivers	
30 days after approval date	Termination of authority notice regarding the existing section 1115 demonstrations	
120 days after approval date	Submit Draft Design for Evaluation Report	Paragraph 134
See quality section STC	A revised Quality Strategy	Paragraph 85

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60 days prior to (August 1, 2013)	Letter notifying CMS of transition from title XXI funds to title XIX funds	Paragraph 123
July 1, 2013	ACA Transition Plan	Paragraph
July 1, 2016, or with renewal application	Submit Draft Interim Evaluation Report	Paragraph 136(a)
60 days after receipt of CMS comments	Submit Final Interim Evaluation Report	Paragraph 136(a)
July 1, 2017	Submit Draft Final Evaluation Report	Paragraph 136(b)
60 days after receipt of CMS comments	Submit Final Evaluation Report	Paragraph 136(b)
DSRIP Pool		
	Medicaid State plan amendment to remove supplemental payments from the State Plan	Paragraph 91
	DSRIP Planning Protocol	Paragraph 93
	Submit a Transition Plan for DSRIP Pool	Paragraph 93
	DSRIP Plan	Paragraph 93
HCBS/MLTSS		
90days prior to implementation	MLTSS Transition Plan	Paragraph 63
30 days prior the implementation of MLTSS	Readiness Review Plan for the MLTSS	Paragraph 64
Monthly Deliverables	Monitoring Call	Paragraph 100
	Monthly Enrollment Report	Paragraph 100
Quarterly Deliverables Due 60 days after end of each quarter, except 4 th quarter	Quarterly Progress Reports	Paragraph 101 and Attachment A
	Quarterly Expenditure Reports	Paragraph 104
Annual Deliverables - Due 120 days after end of each 4 th quarter	Annual Reports	Paragraph 102 and Attachment A

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ATTACHMENT A

Pursuant to paragraph 101 (*Quarterly Progress Report*) of these STCs, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook must be provided.

NARRATIVE REPORT FORMAT:

Title Line One –New Jersey Comprehensive Waiver Demonstration

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example: Demonstration Year: 1 (4/1/2011 – 3/31/2012)

Federal Fiscal Quarter: 3/2011 (4/11 - 7/11)

Footer: Date on the approval letter through June 30, 2017

I. Introduction

Present information describing the goal of the demonstration, what it does, and the status of key dates of approval/operation.

II. Enrollment and Benefits Information

Discuss the following:

- Trends and any issues related to eligibility, enrollment, disenrollment, access, and delivery network.
- Any changes or anticipated changes in populations served and benefits. Progress on implementing any demonstration amendments related to eligibility or benefits.

Please complete the following table that outlines all enrollment activity under the demonstration. The State should indicate “N/A” where appropriate. If there was no activity under a particular enrollment category, the State should indicate that by “0”.

III. Enrollment Counts for Quarter

Note: Enrollment counts should be unique enrollee counts, not member months

Demonstration Populations by MEG	Total Number of Demonstration participants Quarter Ending – MM/YY	Total Number of Demonstration participants Quarter Ending – MM/YY	Total Number of Demonstration participants Quarter Ending – MM/YY	Total Number of Demonstration participants Quarter Ending – MM/YY
Title XIX				
ABD				
LTC				
HCBS (State plan)				
HCBS (217-like)				
SED (217-like)				
IDD/MI (217-like)				
NJ childless adults				
AwDC				
XIX CHIP Parents				
SED At Risk				
MATI At Risk				
Title XXI Exp Child				
XIX CHIP Parents				
XIX CHIP Parents				

IV. Outreach/Innovative Activities to Assure Access

Summarize marketing, outreach, or advocacy activities to potential eligibles and/or promising practices for the current quarter to assure access for demonstration participants or potential eligibles.

V. Collection and Verification of Encounter Data and Enrollment Data

Summarize any issues, activities, or findings related to the collection and verification of encounter data and enrollment data.

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

A status update that identifies all other significant program developments/issues/problems that have occurred in the current quarter or are anticipated to occur in the near future that affect health care delivery, including but not limited to program development, quality of care, approval

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and contracting with new plans, health plan contract compliance and financial performance relevant to the demonstration, fiscal issues, systems issues, and pertinent legislative or litigation activity.

VII. Action Plans for Addressing Any Issues Identified

Summarize the development, implementation, and administration of any action plans for addressing issues related to the demonstration. Include a discussion of the status of action plans implemented in previous periods until resolved.

VIII. Financial/Budget Neutrality Development/Issues

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 and budget neutrality reporting for the current quarter. Identify the State’s actions to address these issues.

IX. Member Month Reporting

Enter the member months for each of the EGs for the quarter.

A. For Use in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Title XIX				
ABD				
LTC (following transition to MLTSS)				
HCBS (State plan)				
HCBS (217-like)				
SED (217-like)				
IDD/MI (217-like)				
NJ childless adults				
AwDC				
SED At Risk				
MATI At Risk				
Title XXI Exp Child				
XIX CHIP Parents				
XIX CHIP Parents				

X. Consumer Issues

A summary of the types of complaints or problems consumers identified about the program or grievances in the current quarter. Include any trends discovered, the resolution of complaints or grievances, and any actions taken or to be taken to prevent other occurrences.

XI. Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity or any other quality of care findings and issues in current quarter.

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XII. Demonstration Evaluation

Discuss progress of evaluation plan and planning, evaluation activities, and interim findings.

XIII. Enclosures/Attachments

Identify by title the budget neutrality monitoring tables and any other attachments along with a brief description of what information the document contains.

XIV. State Contact(s)

Identify the individual(s) by name, title, phone, fax, and address that CMS may contact should any questions arise.

XV. Date Submitted to CMS.

Attachment B – Demonstration Benefits

New Jersey Comprehensive Waiver Benefit Table

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
Abortions	Federal law covers only if mother's life is endangered if pregnancy goes to term, or in cases of rape or incest	Yes – FFS for therapeutic/induced abortions; MCO for spontaneous abortions/ miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes – FFS for therapeutic/induced abortions; MCO for spontaneous abortions/ miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes – FFS for therapeutic/induced abortions; MCO for spontaneous abortions/ miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes – FFS for therapeutic/induced abortions; MCO for spontaneous abortions/ miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes
Abortions – Induced/therapeutic	Mandatory - Federal law covers only if mother's life is endangered if pregnancy goes to term, or in cases of rape or incest	Yes – FFS for therapeutic/induced abortions; (dx: 623, 634.0-634.99, 635.9, 637.0-637.99)	Yes – FFS for therapeutic/induced abortions; (dx: 623, 634.0-634.99, 635.9, 637.0-637.99)	Yes – FFS for therapeutic/induced abortions; (dx: 623, 634.0-634.99, 635.9, 637.0-637.99)	Yes – FFS for therapeutic/induced abortions; (dx: 623, 634.0-634.99, 635.9, 637.0-637.99)	Yes
Abortions - Spontaneous	Mandatory - Federal law covers only if mother's life is endangered if pregnancy goes to term, or in cases of rape or incest	Yes – MCO for spontaneous abortions/ miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes – MCO for spontaneous abortions/ miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes – MCO for spontaneous abortions/ miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes – MCO for spontaneous abortions/ miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes
Biofeedback	Optional	No	No	No	No	No

Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C ^{1, 2}	NJ FamilyCare Plan D ^{1, 2, 3}	Plan G GA
Blood and Blood Plasma	Mandatory when needed for inpatient hospital and other mandatory services (e.g., home health, NF and outpatient hospital)	Yes	Yes	Yes	No	Yes
Blood Processing Administrative Cost	Mandatory when needed for inpatient hospital and other mandatory services (e.g., home health, NF and outpatient hospital); otherwise optional	Yes	Yes	Yes	Yes	Yes
Case Management (Targeted) - Chronically III	Optional	Yes	Yes	Yes	No	No
Case Management - Chronic mental illness	Optional	No	No	No	No	Yes

Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C ^{1, 2}	NJ FamilyCare Plan D ^{1, 2, 3}	Plan G GA
Certified Nurse Practitioner/Clinical Nurse Specialist	Mandatory when covered by State under physician, EPSDT, home health or certified nurse midwife; otherwise optional (e.g., if covered under Other Licensed Practitioner)	Yes	Yes	Yes - \$5 copayment except for preventive care services	Yes - \$5 copayment except for preventive services. \$10 copayment for non-office hours and home visits if indicated on the ID card	Yes
Chiropractor	Optional	Yes – spinal manipulation only	Yes – spinal manipulation only	Yes – spinal manipulation only – \$5 copayment	No	Yes
Clinic Services (free standing) - Ambulatory	Optional, other than Federally Qualified Health Centers (FQHC), RHCs and outpatient hospital which are mandatory	Yes	Yes	Yes – \$5 copayment except for preventive services	Yes – \$5 copayment except for preventive services	Yes
Clinic Services (free standing) - End Stage Renal Disease	Optional, other than FQHCs, RHCs and outpatient hospital which are mandatory	Yes	Yes	Yes	Yes	Yes

Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C ^{1, 2}	NJ FamilyCare Plan D ^{1, 2, 3}	Plan G GA
Clinic Services (free standing) - Family Planning	Mandatory	Yes - Family planning services and supplies from either the MCO's family planning provider network or from any other qualified Medicaid family planning provider for plans A, B and C - not available outside the MCO's provider network for Plan D (except for PSC 380)	Yes - Family planning services and supplies from either the MCO's family planning provider network or from any other qualified Medicaid family planning provider for plans A, B and C - not available outside the MCO's provider network for Plan D (except for PSC 380)	Yes - \$5 copayment except for PAP smear - family planning services and supplies from either the MCO's family planning provider network or from any other qualified Medicaid family planning provider for plans A, B and C - not available outside the MCO's provider network for Plan D (except for PSC 380)	Yes - \$5 copayment except for PAP smear - family planning services and supplies from either the MCO's family planning provider network or from any other qualified Medicaid family planning provider for plans A, B and C - not available outside the MCO's provider network for Plan D (except for PSC 380)	Yes
Clinic Services (free standing) - Mental Health	Optional, other than FQHCs, RHCs and outpatient hospital which are mandatory	Yes - MCO for DDD clients until MBHO is operational	Yes - FFS	Yes - FFS - \$5 copayment	Yes - FFS - \$5 copayment - 35 days inpatient and 20 visits outpatient per year; \$25 copayment for outpatient hospital mental health; \$5 copayment for psychologist services	Yes

Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C ^{1, 2}	NJ FamilyCare Plan D ^{1, 2, 3}	Plan G GA
Cosmetic Services	Optional	No – except cosmetic surgery when medically necessary and approved	No – except cosmetic surgery when medically necessary and approved	No – except cosmetic surgery when medically necessary and approved	No – except cosmetic surgery when medically necessary and approved	No – except cosmetic surgery when medically necessary and approved
Dental - Medical/Surgical Services of Dentist	Mandatory	Yes	Yes	Yes	Yes	Yes
Dental Services	Optional	Yes – MCO; FFS for specified codes when initiated by a Medicaid non-managed care provider prior to first time managed care enrollment (exemption only if initially received services during 60-120 day period immediately prior to initial managed care enrollment)	Yes – MCO; FFS for specified codes when initiated by a Medicaid non-managed care provider prior to first time managed care enrollment (exemption only if initially received services during 60-120 day period immediately prior to initial managed care enrollment)	Yes – \$5 copayment unless preventive care – MCO; FFS for specified codes when initiated by a Medicaid non-managed care provider prior to first time managed care enrollment (exemption only if initially received services during 60-120 day period immediately prior to initial managed care enrollment)	Yes – same level of dental services as provided to Plan A-C for children under the age of 19	NA

Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C ^{1, 2}	NJ FamilyCare Plan D ^{1, 2, 3}	Plan G GA
Dental Services - Orthodontia	Optional	Yes – limited to children with medical necessity to improve the craniofacial dysfunction and/or dentofacial deformity or orthodontia services initiated prior to July 1, 2010	Yes – limited to children with medical necessity to improve the craniofacial dysfunction and/or dentofacial deformity or orthodontia services initiated prior to July 1, 2010	Yes – limited to children with medical necessity to improve the craniofacial dysfunction and/or dentofacial deformity or orthodontia services initiated prior to July 1, 2010	Yes – limited to children with medical necessity to improve the craniofacial dysfunction and/or dentofacial deformity or orthodontia services initiated prior to July 1, 2010 (for children whose orthodontia services were initiated while enrolled in NJ FamilyCare)	NA
Diabetic Supplies and Equipment	Optional	Yes	Yes	Yes	Yes	Yes
Durable Medical Equipment (DME) for Vision Impairment	Optional	Yes	Yes	Yes	No	Yes
DME	Optional	Yes	Yes	Yes	Yes – limited to certain DME services that could prevent costly future inpatient admissions	Yes
Early Intervention	Optional	Yes - FFS	Yes - FFS	Yes - FFS	Yes - FFS	NA

Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C ^{1, 2}	NJ FamilyCare Plan D ^{1, 2, 3}	Plan G GA
Emergency Services	Mandatory	Yes	Yes	Yes – \$10 copayment	Yes – \$35 copayment per visit; no copayment if results in an admission or if referred to ER by primary care provider (PCP)	Charity Care
EPSDT	Mandatory	Yes	Yes – EPSDT exams, dental, vision and hearing services are covered.	Yes – EPSDT exams, dental, vision and hearing services are covered.	Yes - Well child care only	Yes – under 21
Experimental Services	Optional	No	No	No	No	No
Family Planning Services	Mandatory	Yes – FFS when furnished by a non-participating provider and MCO when furnished by a participating provider	Yes – FFS when furnished by a non-participating provider and MCO when furnished by a participating provider	Yes – FFS when furnished by a non-participating provider and MCO when furnished by a participating provider	Yes – MCO provider only except for PSC 380	Yes
Family Planning Services - Infertility Services	Optional	No	No	No	No	No
FQHC	Mandatory	Yes	Yes	Yes – \$5 copayment for non-preventive care visits	Yes – \$5 copayment for non-preventive care visits	Yes
HealthStart	Mandatory	Yes	Yes	Yes	Yes	NA

Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C ^{1, 2}	NJ FamilyCare Plan D ^{1, 2, 3}	Plan G GA
Hearing Aid Services	Optional	Yes	Yes	Yes	Yes – only covered for children age 15 or younger in NJ FamilyCare D	Yes
Home Health	Mandatory	Yes	Yes	Yes	Yes	Yes
Home Health - Rehabilitation Services	Optional	Yes	Yes – 60 consecutive business days per incident/injury per year	Yes – 60 consecutive business days per incident/injury per year	Yes – \$5 copayment – 60 consecutive business days per incident/injury per year	Yes
Hospice Services	Optional	Yes	Yes	Yes	Yes	Yes
Hospital – Inpatient	Mandatory	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Charity Care
Hospital - Inpatient - Religious Non-Medical Services - Mt. Carmel Guild Hospital and Christian Science Sanitaria Care	Optional	Yes - FFS	No	No	No	No

Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C ^{1, 2}	NJ FamilyCare Plan D ^{1, 2, 3}	Plan G GA
Hospital – Outpatient	Mandatory	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – \$5 copayment except for preventive services; institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – \$5 copayment except for preventive services; institutions owned or operated by federal government, such as VA hospitals, are excluded	Charity Care
Hospital – Rehabilitation	Mandatory	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Charity Care
Intermediate Care Facility for Persons with Mental Retardation (ICF/MR)	Optional	Yes – FFS	No	No	No	No
Laboratory	Mandatory	Yes	Yes	Yes	Yes – \$5 copayment	Yes
Maternity	Mandatory	Yes	Yes	Yes – \$5 copayment for first prenatal care visit only	Yes – \$5 copayment for first prenatal care visit only	No
Maternity - Midwifery Services (non- maternity)	Mandatory	Yes	Yes	Yes - \$5 copayment except for preventive care services	Yes - \$5 copayment except for preventive care services	Yes

Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C ^{1, 2}	NJ FamilyCare Plan D ^{1, 2, 3}	Plan G GA
Maternity - Midwifery Services (maternity)	Mandatory	Yes	Yes	Yes - \$5 copayment except for prenatal care visit	Yes - \$5 copayment except for prenatal care visit; \$10 copayment for non-office hours and home visits	No
Medical Day Care - Adult	Optional	Yes	No	No	No	No
Medical Day Care - pediatric	Optional	Yes	No	No	No	No
Medical Supplies	Optional	Yes	Yes	Yes	Yes – limited	Yes
Mental Health - Adult Rehabilitation	Optional	Yes – FFS; MCO for DDD clients	No	No	No	No
Mental Health – Inpatient	Optional	Yes – FFS; MCO for DDD clients	Yes – FFS	Yes – FFS	Yes – FFS; limited to 35 days per year.	Charity Care
Mental Health - Outpatient	Optional	Yes – FFS; MCO for DDD clients	Yes – FFS	Yes – FFS	Yes – FFS - \$25 copayment per visit	Charity Care
Methadone Maintenance	Optional	Yes - FFS	No	No	No	Yes
NF	Mandatory for over age 21	Yes – MCO first 30 days and FFS after 30 days (moves to Managed Care July 1, 2012)	No	No	No	No
Ophthalmology Services	Mandatory	Yes	Yes	Yes	Yes	Yes

Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C ^{1, 2}	NJ FamilyCare Plan D ^{1, 2, 3}	Plan G GA
Optical Appliances	Optional	Yes	Yes	Yes	Yes – limited to one pair of glasses or contact lenses per 24 month period or as medically necessary	Yes
Optometrist	Optional	Yes	Yes	Yes – \$5 copayment per visit	Yes – \$5 copayment per visit; one routine eye exam per year	Yes
Organ Transplants	Optional	Yes – experimental organ transplants not covered	Yes – experimental organ transplants not covered			
Orthotics	Optional	Yes	Yes	Yes	No	Yes
Other Therapies	Optional	Yes	Yes	Yes - \$5 copayment	Yes	Yes
Partial Care	Optional	Yes – FFS	Yes – FFS	Yes – FFS	Yes – FFS – limitations apply – 20 outpatient visits per year	Yes
Partial Hospital	Optional	Yes – FFS	Yes – FFS	Yes – FFS	Yes – FFS – limitations apply – 35 inpatient visits per year	Yes – charity care
Personal Care Assistant	Optional	Yes	No	No	No	Yes
Personal Care Assistant - Mental Health	Optional	Yes – FFS, No PA, 25 hour per week limit	No	No	No	Yes

Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C ^{1, 2}	NJ FamilyCare Plan D ^{1, 2, 3}	Plan G GA
Pharmacy – (ADDP) Covered Anti-Retroviral Drugs	Optional - Pharmaceuticals on the Master Rebate List are mandatory	Yes	Yes	Yes	Yes	Yes
Pharmacy – Erectile Dysfunction Drugs	Optional	No	No	No	No	No
Pharmacy - Mental Health/Substance Abuse	Optional, other than FQHCs, RHCs and outpatient hospitals which are mandatory	Yes	Yes	Yes	Yes	Yes
Pharmacy - Atypical anti-psych	Optional	Yes	Yes	Yes	Yes	Yes
Pharmacy - High Cost Drugs	Optional - Pharmaceuticals on the Master Rebate List are mandatory	Yes	Yes	Yes	Yes	Yes
Pharmacy - Infertility	Optional - Pharmaceuticals on the Master Rebate List are mandatory	No	No	No	No	No
Pharmacy - Suboxone	Optional - Pharmaceuticals on the Master Rebate List are mandatory	Yes	Yes	Yes	Yes	Yes

Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C ^{1, 2}	NJ FamilyCare Plan D ^{1, 2, 3}	Plan G GA
Pharmacy – Over the Counter (OTC) Drugs and All Other OTC Products	Optional	Yes	Yes	Yes	No	Yes
Pharmacy – Over the Counter Drugs – Cough, Cold and Cosmetic Products	Optional	Yes - for children (EPSDT service)	Yes - for children (EPSDT service)	Yes - for children (EPSDT service)	No	Yes – under 21 (EPSDT services)
Pharmacy - Physician Administered Drugs	Optional	Yes	Yes	Yes	Yes	Yes
Pharmacy – Prescription Drugs Not Reimbursable	Optional	Yes	Yes	Yes – \$1 copayment for generic/\$5 brand – includes insulin, needles and syringes	Yes – \$5 copayment/\$10 copayment>34 day supply	Yes
Pharmacy – Prescription Drugs Reimbursable	Optional	Yes	Yes	Yes – \$1 copayment for generic/\$5 brand – includes insulin, needles and syringes	Yes – \$5 copayment/\$10 copayment>34 day supply	Yes
Pharmacy - Reimbursable Blood Factor	Optional - Pharmaceuticals on the Master Rebate List are mandatory	Yes	Yes	Yes	No	No

Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C ^{1, 2}	NJ FamilyCare Plan D ^{1, 2, 3}	Plan G GA
Physician/PCP Practitioner	Mandatory	Yes	Yes	Yes – \$5 copayment for non- preventive visits	Yes – \$5 copayment for non-preventive visits; \$10 copayment for after hours and home visits	Yes
Podiatrist	Optional	Yes – no routine care	Yes – no routine care	Yes – no routine care; \$5 copayment	Yes – no routine care; \$5 copayment	Yes - no routine care
Private Duty Nursing	Optional	Yes – when authorized; up to 21 years of age	Yes – when authorized	Yes – when authorized	Yes – when authorized	No
Prosthetics	Optional	Yes	Yes	Yes	Yes – limited to the initial provision of a prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease, injury or congenital defect	Yes
Psychiatric Hospital – Inpatient	Optional if covered by the SPA	Yes – FFS for under 21 and over 65 years of age	Yes – FFS for under 21 and over 65 years of age	Yes – FFS for under 21 and over 65 years of age	Yes – FFS for under 21 and over 65 years of age; limited to 35 days per year	Charity Care
Radial Keratotomy	Optional	No	No	No	No	No

Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C ^{1, 2}	NJ FamilyCare Plan D ^{1, 2, 3}	Plan G GA
Radiology	Mandatory	Yes	Yes	Yes	Yes – \$5 copayment	Yes
Recreational Therapy	Optional	No	No	No	No	No
Rehabilitation – Outpatient Physical, Occupational, Speech	Optional	Yes	Yes – 60 consecutive business days per incident/injury per year	Yes – 60 consecutive business days per incident/injury per year	Yes – \$5 copayment – 60 consecutive business days per incident/injury per year	Yes
RTC Services	Optional	Yes – FFS	Yes – FFS	Yes – FFS	No	No
Respite Care	Optional	No – (will be covered by Managed LTC July 1, 2012)	No	No	No	No
School Based Services	Optional	Yes - FFS	No	No	No	No
Sex Abuse Exams	Mandatory	Yes – FFS	Yes – FFS	Yes – FFS	Yes – FFS	Yes
Skilled Nursing Facility	Mandatory	Yes – MCO first 30 days and FFS after 30 days (moves to Managed LTC July 1, 2012)	Yes	Yes	No	No
Substance Abuse – Inpatient (SAI)*	Optional	Yes – FFS; MCO for DDD clients	Yes – FFS	Yes – FFS	Yes – FFS (detox only)	Only through the SAI
Substance Abuse – Outpatient*	Optional	Yes – FFS; MCO for DDD clients	Yes – FFS	Yes – FFS	Yes – FFS - \$5 copayment per visit (detox only)	Only through the SAI
Temporomandibular or Joint Disorder Treatment	Optional	Yes	Yes	Yes	No	Yes

Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C ^{1, 2}	NJ FamilyCare Plan D ^{1, 2, 3}	Plan G GA
Thermograms and Thermography	Optional	Yes	Yes	Yes	No	Yes
Transportation – Emergent (Ambulance, Mobile Intensive Care Unit)	Mandatory	Yes	Yes	Yes	Yes	Yes
Transportation – Non-Emergent (Ambulance Non-Emergency, Medical Assistance Vehicles (MAV), Livery, Clinic)	Optional	Yes	Yes, no livery	Yes, no livery	No	Yes
Vaccines	Mandatory for EPSDT	Yes – While the vaccine administration costs remain the responsibility of the MCOs, the vaccination cost for Title XIX children (NJ FamilyCare A) are not the responsibility of the MCOs. These vaccine costs are covered under the Vaccines for Children (VFC) program.	Yes	Yes	Yes	NA

Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C ^{1, 2}	NJ FamilyCare Plan D ^{1, 2, 3}	Plan G GA
Vaccines - Administration	Mandatory for EPSDT	Yes – While the vaccine administration costs remain the responsibility of the MCOs, the vaccination cost for children (NJ FamilyCare A) are not the responsibility of the MCOs. These vaccine costs are covered under the VFC program.	Yes	Yes	Yes	
Vaccines - Vaccination	Mandatory for EPSDT	Yes – While the vaccine administration costs remain the responsibility of the MCOs, the vaccination cost for children (NJ FamilyCare A) are not the responsibility of the MCOs. These vaccine costs are covered under the VFC program.	Yes	Yes	Yes	

1 - Both Eskimos and Native American Indian children under the age of 19, identified by Race Code 3, are not required to pay copayments.

2 - The total family (regardless of family size) limit on all cost-sharing may not exceed 5% of the annual family income.

3 - Plan D copayments limited only to adult enrollees with incomes greater than 150% FPL. All Plan D children have copayments.

Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C ^{1, 2}	NJ FamilyCare Plan D ^{1, 2, 3}	NJ FamilyCare Plan G GA
4 - Sources Covered Services - Article 4.1 of Volume I of Medicaid/NJ FamilyCare Managed Care Contract; and Section B.4.1 of Appendices (Volume II) of Medicaid/NJ FamilyCare Managed Care Contract.						
Copayments - Section B.5.2 of Appendices (Volume II) of Medicaid/NJ FamilyCare Managed Care Contract.						
Federal Medicaid Law - 42 CFR Part 440						

Attachment C.1
New Jersey’s Comprehensive Waiver Demonstration
Home and Community Based Services – Fee for Service Program
Service Definitions

The Supports Program:

Program Overview: The Supports Program is to provide a basic level of support services to Demonstration participants who live with family members or who live in their own homes that are not licensed by the State. Each individual served will receive a smaller package of program services than what is available to individuals served in New Jersey’s Community Care Waiver (CCW), primarily because individuals have access to nonpaid supports available to them. In effect, federal financial participation is available for New Jersey’s current Family Support Program plus adds some new services centered on independent living including employment and day services.

The goal of this program is to support each Demonstration participant in the least restrictive setting in the community and ensure the Demonstration participant’s health and safety while respecting the rights of the individual. Language from the New Jersey Family Support Act of 1993 expresses well the primary goal of this program: “[Supports] ...must be easily accessible, flexible, culturally sensitive and individualized. They must be designed to promote interdependence, independence, productivity and integration of people with disabilities into the community. Supports must also be built on existing social networks and naturally occurring supports including extended families, neighbors and community associations. ...Failure to provide needed supports can result in premature placement of the [Demonstration participant] in a setting outside the home.”

The following services are available through the Supports Program:

1. **Service Name:** Support Coordination

- a. **Description:** Services that assist Demonstration participants in gaining access to needed program and State plan services, as well as needed medical, social, educational and other services. Support Coordination is managed by one individual (the Support Coordinator) for each Demonstration participant. The Support Coordinator is responsible for developing and maintaining the Individualized Service Plan with the Demonstration participant, their family, and other team members designated by the Demonstration participant. The Support Coordinator is responsible for the ongoing monitoring of the provision of services included in the Individualized Service Plan.
- b. **Service Limits:** All Supports Program Demonstration participants receive monthly contact with their Support Coordinator.
- c. **Provider Specification(s):**
 - i. Approved Medicaid provider;
 - ii. Has met the qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
- d. Participant Direction Option
- e. Provider Directed Participant Directed

2. **Service Name:** Community Inclusion Services

- a. **Description:** Services provided outside of a Demonstration participant's home that support and assist Demonstration participants in educational, enrichment or recreational activities as outlined in his/her Service Plan that are intended to enhance inclusion in the community. Community Inclusion Services are delivered in a group setting not to exceed six (6) individuals.
- b. **Service Limits:** Community Inclusion Services are limited to 30 hours per week. . Transportation to or from a Community Inclusion Service site is not included in the service.
- c. **Provider Specification(s):**
 - i. Approved Medicaid provider
 - ii. Has met the qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

3. **Service Name:** Community Based Supports

- a. **Description:** Services that provide direct support and assistance for Demonstration participants, with or without the caregiver present , in or out of the Demonstration participant's residence, to achieve and/or maintain the outcomes of increased independence, productivity, enhanced family functioning, and inclusion in the community, as outlined in his/her Service Plan. Community-Based Supports are delivered one-on-one with a Demonstration participant and may include but are not limited to: assistance with community-based activities and assistance to, as well as training and supervision of, individuals as they learn and perform the various tasks that are included in basic self-care, social skills, and activities of daily living. .
- b. **Service Limits:** Providers of Community-Based Support Services may be members of the Demonstration participant's family except for spouse or parent of a minor child, provided that the family member has met the same standards as providers who are unrelated to the individual.
- c. **Provider Specification(s):**
 - i. Approved Medicaid provider
 - ii. Has met the qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
 - iii. Individual Supports Assistant (for Demonstration participants that self-direct) who has met all eligibility requirements established by the DHS/DDD to be hired by a Demonstration participant who serves as the Employer of Record.
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

4. **Service Name:** Day Habilitation

- a. **Description:** Services that provide education and training to acquire the skills and experience needed to participate in the community, consistent with the Demonstration participant's Service Plan. This may include activities to support Demonstration participants with building problem-solving skills, self-help, social skills, adaptive skills, daily living skills, and leisure skills. Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal

competence, greater independence and personal choice. Services are provided during daytime hours and do not include employment-related training. Day Habilitation may be offered in a center-based or community-based setting.

- b. **Service Limits:** Day Habilitation does not include services, activities or training which the Demonstration participant may be entitled to under federal or state programs of public elementary or secondary education, State Plan services, or federally funded vocational rehabilitation. Day Habilitation is limited to 30 hours per week. Transportation to or from a Day Habilitation site is not included in the service.
- c. **Provider Specification(s):**
 - i. Approved Medicaid provider
 - ii. Has met the qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

5. **Service Name:** Prevocational Training

- a. **Description:** Services that provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services may include training in effective communication with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; and general workplace safety and mobility training. Prevocational Training is intended to be a service that Demonstration participants receive over a defined period of time and with specific outcomes to be achieved in preparation for securing competitive, integrated employment in the community for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Prevocational Training services cannot be delivered within a sheltered workshop. Supports are delivered in a face-to-face setting, either one-on-one with the Demonstration participant or in a group of two to eight Demonstration participants.
- b. **Service Limits:** This service is available to Demonstration participants in accordance with the DHS/DDD Employment Services and Supports Policy Manual, and as authorized in their Service Plan. Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.) or P.L. 94-142. Prevocational Training is limited to 30 hours per week. Transportation to or from a Prevocational Training site is not included in the service.
- c. **Provider Specification(s):**
 - i. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
 - ii. Provider approved by DHS/DDD
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

6. **Service Name:** Supported Employment– Individual Employment Support

- a. **Description:** Activities needed to help a Demonstration participant obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The service may be delivered for an intensive period upon the Demonstration participant’s initial employment to support the Demonstration participant who, because of their disability, would not be able to sustain employment without supports. Supports in the intensive period are delivered in a face-to-face setting, one-on-one. The service may also be delivered to a Demonstration participant on a less intensive, ongoing basis (“follow along”) where supports are delivered either face-to-face or by phone with the Demonstration participant and/or his or her employer. Services are individualized and may include but are not limited to: training and systematic instruction, job coaching, benefit support, travel training, and other workplace support services including services not specifically related to job-skill training that enable the Demonstration participant to be successful in integrating into the job setting.
- b. **Service Limits:** This service is available to Demonstration participants in accordance with the DHS/DDD Employment Services and Supports Policy Manual, and as authorized in their Service Plan. Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.) or P.L. 94-142. Supported Employment – Individual Employment Support is limited to 30 hours per week. Transportation to or from a Supported Employment site is not included in the service. When Supported Employment is provided at a work site in which people without disabilities are employed, payment will be made only for the adaptations, supervision and training required for Demonstration participants as a result of their disabilities and will not include payment for the supervisory activities rendered as a normal part of the business setting or for incentive payments, subsidies or unrelated training expenses.
- c. **Provider Specification(s):**
 - i. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD);
 - ii. Provider approved by DHS/DDD;
 - iii. Division of Vocational Rehabilitation Services (DVRS) approved supported employment vendor;
 - iv. Employment specialist/job coach that has met all qualifications as specified by DHS/DDD
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

7. **Service Name:** Supported Employment – Small Group Employment Support

- a. **Description:** Services and training activities provided to Demonstration participants in regular business, industry and community settings for groups of two to eight workers with disabilities. Services may include mobile crews and other business-

- based workgroups employing small groups of workers with disabilities in employment in the community. Services must be provided in a manner that promotes integration into the workplace and interaction between Demonstration participants and people without disabilities. Services may include but are not limited to: job placement, job development, negotiation with prospective employers, job analysis, training and systematic instruction, job coaching, benefit support, travel training and planning.
- b. **Service Limits:** This service is available to Demonstration participants in accordance with the DHS/DDD Employment Services and Supports Policy Manual, and as authorized in their Service Plan. Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.) or P.L. 94-142. Supported Employment – Small Group Employment Support is limited to 30 hours per week. Transportation to or from a Supported Employment site is not included in the service. When Supported Employment is provided at a work site in which people without disabilities are employed, payment will be made only for the adaptations, supervision and training required for Demonstration participants as a result of their disabilities and will not include payment for the supervisory activities rendered as a normal part of the business setting or for incentive payments, subsidies or unrelated training expenses.
 - c. **Provider Specification(s):**
 - i. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD);
 - ii. Provider approved by DHS/DDD;
 - iii. Division of Vocational Rehabilitation Services (DVRS) approved supported employment vendor;
 - d. Participant Direction Option
 - i. Provider Directed Participant Directed

8. **Service Name:** Career Planning

- a. **Description:** Career planning is a person-centered, comprehensive employment planning and support service that provides assistance for program Demonstration participants to obtain, maintain or advance in competitive employment or self-employment. It is a focused, time-limited service engaging a Demonstration participant in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the state’s minimum wage. The outcome of this service is documentation of the Demonstration participant’s stated career objective and a career plan used to guide individual employment support. If a Demonstration participant is employed and receiving supported employment services, career planning maybe used to find other competitive employment more consistent with the person’s skills and interests or to explore advancement opportunities in his or her chosen career.
- b. **Service Limits:** This service is available to Demonstration participants in accordance with the DHS/DDD Employment Services and Supports Policy Manual, and as authorized in their Service Plan. This service is available to Demonstration participants at a maximum of 80 hours per Service Plan year. If the Demonstration

participant is eligible for services from the State's Division of Vocational Rehabilitation Services, these services must be exhausted before Career Planning can be offered to the Demonstration participant.

c. **Provider Specification(s):**

- i. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD);
- ii. Provider approved by DHS/DDD;
- iii. Division of Vocational Rehabilitation Services (DVRS) approved time-limited job coaching or supported employment vendor;
- iv. Employment specialist/job developer that has met all qualifications as specified by DHS/DDD
- v.

d. Participant Direction Option

- i. Provider Directed Participant Directed

9. **Service Name:** Respite

a. **Description:** Services provided to Demonstration participants unable to care for them that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the Demonstration participant. Respite may be delivered in multiple periods of duration such as partial hour, hourly, daily without overnight, or daily with overnight. Respite may be provided in the Demonstration participant's home, a DHS licensed group home, , or another community-based setting approved by DHS. Some settings, such as a hotel, may be approved by the State for use when options using other settings have been exhausted.

b. **Service Limits:** Room and board costs will not be paid when services are provided in the Demonstration participant's home. Hotel Respite shall not exceed two consecutive weeks and 30 days per year. **Provider Specification(s):**

- i. Provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
- ii. Provider approved by DHS/DDD
- iii. A homemaker agency approved as a Medicaid provider
- iv. A licensed, certified home health agency approved as a Medicaid provider
- v. Individual Supports Assistant (for Demonstration participants that self-direct) who has met all eligibility requirements established by the DHS/DDD to be hired by a Demonstration participant and paid through the fiscal intermediary.

c. Participant Direction Option

- i. Provider Directed Participant Directed

10. **Service Name:** Transportation

a. **Description:** Service offered in order to enable Demonstration participants to gain access to services, activities and resources, as specified by the Service Plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State Plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Whenever possible, family,

- neighbors, friends, or community agencies which can provide this service without charge are utilized.
- b. **Service Limits:** Reimbursement for transportation is limited to distances not to exceed 150 miles one way and only within the States of New Jersey, New York, Pennsylvania and Delaware.
 - c. **Provider Specification(s):**
 - i. Approved Medicaid provider that has met the qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD);
 - ii. Provider approved by DHS/DDD;
 - iii. Valid driver's license;
 - iv. Valid vehicle registration;
 - v. Valid insurance
 - vi. A homemaker agency approved as a Medicaid provider.
 - vii. A licensed, certified home health agency approved as a Medicaid provider.
 - viii. Individual Supports Assistant (for Demonstration participants that self-direct) who has met all eligibility requirements established by the DHS/DDD to be hired by a Demonstration participant who serves as the Employer of Record.
 - d. Participant Direction Option
 - i. Provider Directed Participant Directed

11. Service Name: Natural Supports Training

- a. **Description:** Training and counseling services for individuals who provide unpaid support, training, companionship or supervision to Demonstration participants. For purposes of this service, individual is defined as: “any person, family member, neighbor, friend, companion, or co-worker who provides uncompensated care, training, guidance, companionship or support to a Demonstration participant.” Training includes instruction about treatment regimens and other services included in the Service Plan, use of equipment specified in the Service Plan, and includes updates as necessary to safely maintain the Demonstration participant at home. Counseling must be aimed at assisting the unpaid caregiver in meeting the needs of the Demonstration participant. All training for individuals who provide unpaid support to the Demonstration participant must be included in the Demonstration participant's Service Plan. Natural Supports Training may be delivered to one individual or may be shared with one other individual.
- b. **Service Limits:** This service may not be provided in order to train paid caregivers. When delivered by a Direct Service Professional (DSP), the DSP must have a minimum of two years' experience working with individuals with developmental disabilities. When delivered by professional staff, the professional must have a license in psychiatry, physical therapy, occupational therapy, speech language pathology, social work, or must be a registered nurse or a degreed psychologist.
- c. **Provider Specification(s):**
 - i. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD) Office of Quality Improvement
 - ii. A homemaker agency approved as a Medicaid provider

- iii. A social work agency approved as a Medicaid provider
- iv. A licensed, certified home health agency approved as a Medicaid provider
- v. A board-certified and board-eligible psychiatrist approved as a Medicaid provider
- vi. A clinical psychologist approved as a Medicaid provider
- vii. A licensed registered nurse approved as a Medicaid provider
- viii. A licensed social worker approved as a Medicaid provider
- ix. A licensed physical therapist approved as a Medicaid provider
- x. A licensed occupational therapist approved as a Medicaid provider
- xi. A licensed speech language pathologist approved as a Medicaid provider
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

12. **Service Name:** Behavioral Management

- a. **Description:** Individual and/or group counseling, behavioral interventions, diagnostic evaluations or consultations related to the individual's developmental disability and necessary for the individual to acquire or maintain appropriate interactions with others. Intervention modalities must relate to an identified challenging behavioral need of the individual. Specific criteria for remediation of the behavior shall be established. The provider(s) shall be identified in the Service Plan and shall have the minimum qualification level necessary to achieve the specific criteria for remediation. Behavioral management includes a complete assessment of the challenging behavior(s), development of a structured behavioral modification plan, implementation of the plan, ongoing training and supervision of caregivers and behavioral aides, and periodic reassessment of the plan.
- b. **Service Limits:** Behavioral management services are offered in addition to and do not replace treatment services for behavioral health conditions that can be accessed through the State Plan/MBHO and mental health service system. Individuals with co-occurring diagnoses of developmental disabilities and mental health conditions shall have identified needs met by each of the appropriate systems without duplication but with coordination to obtain the best outcome for the individual. .
- c. **Provider Specification(s):**
 - i. Provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
 - ii. Provider approved by DHS/DDD
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

13. **Service Name:** Cognitive Rehabilitative Therapy (CRT)

- a. **Description:** As defined by Harley, et al, a systematic, functionally-oriented service of therapeutic cognitive activities, based on an assessment and understanding of the person's brain behavior deficits. Services are directed to achieve functional changes: by (1) reinforcing, strengthening or re-establishing previously learned patterns of behavior, or (2) establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems. Therapeutic interventions include but are not limited to direct retraining, use of compensatory strategies, use of cognitive

- orthotics and prostheses. Activity type and frequency are determined by assessment of the Demonstration participant, the development of a treatment plan based on recognized deficits, and periodic reassessments. Cognitive therapy can be provided in the individual's home or community settings
- b. **Service Limits:** Daily limits as delineated by the Demonstration participant's Service Plan. Frequency and duration of service must be supported by assessment and included in the Demonstration participant's Service Plan. CRT may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five Demonstration participants. Both group and individual sessions may not exceed 60 minutes in length. The therapist must record the time the therapy session started and when it ended in the Demonstration participant's clinical record. This service must be coordinated and overseen by a CRT provider holding at least a master's degree. All individuals who provide or supervise the CRT service must complete six hours of relevant ongoing training in CRT and or brain injury rehabilitation. Training may include, but is not limited to, participation in seminars, workshops, conferences, and in-services.
 - c. **Provider Specification(s):**
 - i. A board-certified and board-eligible psychiatrist approved as a Medicaid provider
 - ii. A clinical psychologist approved as a Medicaid provider
 - iii. Mental Health Agency
 - iv. Post-acute non-residential rehabilitative services provider agency
 - v. An outpatient program of a rehabilitation hospital
 - vi. Certified Occupational Therapy Assistants (COTAs) and Physical Therapy Assistants (PTAs) may provide CRT but only under the guidelines described in the New Jersey practice acts for occupational and physical therapists.
 - vii. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
 - viii. Staff members working for any of the agencies above who meet the above-mentioned degree requirements, but are not licensed or certified, may practice under the supervision of a rehabilitation practitioner who is licensed and/or meets the criteria for certification by the Society for Cognitive Rehabilitation (actual certification is not necessary so long as criteria is met).
 - d. Participant Direction Option
 - i. Provider Directed X Participant Directed

14. Service Name: Interpreter Services

- a. **Description:** Service delivered to a Demonstration participant face-to-face to support them in integrating more fully with community-based activities or employment. Interpreter services may be delivered in a Demonstration participant's home or in a community setting. For language interpretation, the interpreter service must be delivered by an individual proficient in reading and speaking in the language that the Demonstration participant speaks in.
- b. **Service Limits:** Interpreter services may be used when the State Plan service for language line interpretation is not available or not feasible or when natural interpretive supports are not available.

- c. **Provider Specification(s):**
 - i. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
 - ii. Individual Supports Assistant (for Demonstration participants that self-direct) who has met all eligibility requirements established by the DHS/DDD to be hired by a Demonstration participant who serves as the Employer of Record
 - iii. For language interpreter: 18 yrs of age, cleared criminal background check, proficient in reading & speaking both languages
- d. Participant Direction Option
 - i. Provider Directed X Participant Directed X

15. **Service Name:** Physical Therapy

- a. **Description:** The scope and nature of these services do not otherwise differ from the Physical Therapy services described in the State Plan. They may be either rehabilitative or habilitative in nature. Services that are rehabilitative in nature are only provided when the limits of physical therapy services under the approved State Plan are exhausted. The provider qualifications specified in the State plan apply. Physical Therapy may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five Demonstration participants.
- b. **Service Limits:** These services are only available as specified in Demonstration participant's Service Plan and when prescribed by an appropriate health care professional. These services can be delivered on an individual basis or in groups. A group session is limited to 1 therapist with 5 participants and may not exceed 60 minutes in length. The therapist must record the time the therapy session started and when it ended in the Demonstration participant's clinical record.
- c. **Provider Specification(s):**
 - i. A licensed physical therapist or physical therapy assistant approved as a Medicaid provider
 - ii. Licensed, certified home health agency
 - iii. Post-acute non-residential rehabilitative services provider agency
 - iv. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD)
 - v. Staff members working for any of the agencies above shall meet the New Jersey licensure standards and requirements for practice (N.J.A.C. 13:39A).
- d. Participant Direction Option
 - i. Provider Directed X Participant Directed

16. **Service Name:** Occupational Therapy

- a. **Description:** The scope and nature of these services do not otherwise differ from the Occupational Therapy services described in the State Plan. They may be either rehabilitative or habilitative in nature. Services that are rehabilitative in nature are only provided when the limits of occupational therapy services under the approved State Plan are exhausted. The provider qualifications specified in the State plan apply. Occupational Therapy may be provided on an individual basis or in groups. A

- group session is limited to one therapist with maximum of five Demonstration participants.
- b. **Service Limits:** These services are only available as specified in Demonstration participant's Service Plan and when prescribed by an appropriate health care professional. These services can be delivered on an individual basis or in groups. A group session is limited to one therapist with a maximum of five participants and may not exceed 60 minutes in length. The therapist must record the time the therapy session started and when it ended in the Demonstration participant's clinical record.
 - c. **Provider Specification(s):**
 - i. A licensed occupational therapist or occupational therapy assistant approved as a Medicaid provider
 - ii. Licensed, certified home health agency
 - iii. Post-acute non-residential rehabilitative services provider agency
 - iv. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD) Office of Quality Improvement
 - v. Staff members working for any of the agencies above shall be registered as an occupational therapist (OTR) with the American Occupational Therapy Association (AOTA). A certified occupational therapy assistant (COTA) shall be registered with the AOTA and work under the direction of the OTR.
 - d. Participant Direction Option
 - i. Provider Directed Participant Directed

17. Service Name: Speech, Language, and Hearing Therapy (ST)

- a. **Description:** The scope and nature of these services do not otherwise differ from the Speech Therapy services described in the State Plan. They may be either rehabilitative or habilitative in nature. Services that are rehabilitative in nature are only provided when the limits of speech therapy services under the approved State Plan are exhausted. The provider qualifications specified in the State plan apply. Speech, Language or Hearing Therapy may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five Demonstration participants.
- b. **Service Limits:** These services are only available as specified in Demonstration participant's Service Plan and when prescribed by an appropriate health care professional. These services can be delivered on an individual basis or in groups. Group sessions are limited to one therapist with five participants and may not exceed 60 minutes in length. The therapist must record the time the therapy session started and when it ended in the Demonstration participant's clinical record.
- c. **Provider Specification(s):**
 - i. A licensed speech therapist approved as a Medicaid provider
 - ii. Licensed, certified home health agency
 - iii. Post-acute non-residential rehabilitative services provider agency
 - iv. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD) Office of Quality Improvement

- v. Staff members working for any of the agencies above shall meet the New Jersey licensure standards and requirements for practice (N.J.A.C. 13:44C).
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

18. **Service Name:** Demonstration participant-Directed Goods and Services

- a. **Description:** Demonstration participant-Directed Goods and Services are services, equipment or supplies, not otherwise provided through generic resources, this program, or through the State Plan, which address an identified need (including improving and maintaining the Demonstration participant’s opportunities for full membership in the community) and meet the following requirements: the item or service would decrease the need for other Medicaid services; AND/OR promote inclusion in the community; AND/OR increase the Demonstration participant’s safety in the home environment; AND, the Demonstration participant does not have the funds to purchase the item or service or the item or service is not available through another source. Demonstration participant-Directed Goods and Services are purchased from the Demonstration participant-directed budget and paid and documented by the fiscal intermediary.
- b. **Service Limits:** Experimental or prohibited treatments are excluded. Demonstration participant-Directed Goods and Services must be based on assessed need and specifically documented in the Service Plan.
- c. **Provider Specification(s):**
 - i. Fiscal intermediary provider that has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
 - ii. Individual Supports Assistant (for Demonstration participants that self-direct) who has met all eligibility requirements established by the DHS/DDD to be hired by a Demonstration participant who serves as the Employer of Record
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

19. **Service Name:** Supports Brokerage

- a. **Description:** Service/function that assists the Demonstration participant (or the Demonstration participant’s family or representative, as appropriate) in arranging for, directing and managing services. Serving as the agent of the Demonstration participant or family, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services. Practical skills training is offered to enable families and Demonstration participants to independently direct and manage program services. Examples of skills training include providing information on recruiting and hiring personal care workers, managing workers and providing information on effective communication and problem-solving. The service/function includes providing information to ensure that Demonstration participants understand the responsibilities involved with directing their services.
- b. **Service Limits:** This service is available only to Demonstration participants who self-direct some or all of the services in their Service Plan and is intended to supplement, but not duplicate, the Support Coordination service. The extent of the

assistance furnished to the Demonstration participant or family is specified in the Service Plan. The Supports Brokerage services cannot be paid to New Jersey DDD provider agencies or employees of these agencies, legal guardians of the Demonstration participant, or other individuals who reside with the Demonstration participant. Legal guardians or other natural supports can provide the service at no cost to the State.

- c. **Provider Specification(s):**
 - i. Provider that has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
 - ii. Individual Supports Assistant (for Demonstration participants that self-direct) who has met all eligibility requirements established by the DHS/DDD to be hired by a Demonstration participant who serves as the Employer of Record
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

20. **Service Name:** Financial Management Services

- a. **Description:** Service/function that assists the Demonstration participant (or the Demonstration participant's family or representative, as appropriate) to: (a) manage and direct the disbursement of funds contained in the Demonstration participant-directed budget; (b) facilitate the employment of staff by the family or Demonstration participant, by performing (as the Demonstration participant's agent) such employer responsibilities as processing payroll, withholding Federal, state, and local tax and making tax payments to appropriate tax authorities; and, (c) performing fiscal accounting and making expenditure reports to the Demonstration participant or family and state authorities.
- b. **Service Limits:** This service is available only to Demonstration participants who self-direct some or all of the services in their Service Plan.
- c. **Provider Specification(s):**
 - i. Fiscal intermediary provider that has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD) Office of Quality Improvement.
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

21. **Service Name:** Environmental Modifications

- a. **Description:** Those physical adaptations to the private residence of the Demonstration participant or the Demonstration participant's family, based on assessment and as required by the Demonstration participant's Service Plan, that are necessary to ensure the health, welfare and safety of the Demonstration participant or that enable the Demonstration participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the Demonstration participant.

- b. **Service Limits:** All services shall be provided in accordance with applicable State or local building codes and are subject to prior approval on an individual basis by DDD. Excluded items are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the Demonstration participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).
- c. **Provider Specification(s):**
 - i. Provider approved by the DHS/DDD.
 - ii. New Jersey licensed contractor and proof of liability insurance.
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

22. **Service Name:** Vehicle Modifications

- a. **Description:** Assessments, Adaptations, or alterations to an automobile or van that is the Demonstration participant's primary means of transportation in order to accommodate the special needs of the Demonstration participant. Vehicle adaptations are specified by the Service Plan, are necessary to enable the Demonstration participant to integrate more fully into the community and to ensure the health, welfare and safety of the Demonstration participant.
- b. **Service Limits:** All Vehicle Modifications are subject to prior approval on an individual basis by DDD. The following are specifically excluded: (1) Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual; (2) Purchase or lease of a vehicle; and (3) Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.
- c. **Provider Specification(s):**
 - i. Provider approved by the DHS/DDD.
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

23. **Service Name:** Assistive Technology

- a. **Description:** Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of Demonstration participants. Assistive technology service means a service that directly assists a Demonstration participant in the selection, acquisition, or use of an assistive technology device. Assistive technology includes: (A) the evaluation of the assistive technology needs of a Demonstration participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the Demonstration participant in the customary environment of the Demonstration participant; (B) services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for Demonstration participants; (C) services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; (D) ongoing maintenance fees to utilize the assistive technology

- (e.g., remote monitoring devices); (E) coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the Service Plan; (F) training or technical assistance for the Demonstration participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the Demonstration participant; and (G) training or technical assistance for professionals or other individuals who provide services.
- b. **Service Limits:** All Assistive Technology services and devices shall meet applicable standards of manufacture, design and installation and are subject to prior approval on an individual basis by DDD. Prior approval will be based on the functional evaluation as described above. Items covered by the Medicaid State Plan cannot be purchased through this service.
 - c. **Provider Specification(s):**
 - i. Provider approved by the DHS/DDD.
 - d. Participant Direction Option
 - i. Provider Directed Participant Directed

24. Service Name: Personal Emergency Response System (PERS)

- a. **Description:** PERS is an electronic device that enables program Demonstration participants to secure help in an emergency. The Demonstration participant may also wear a portable "help" button to allow for mobility. The system is connected to the Demonstration participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified herein. The service may include the purchase, the installation, a monthly service fee, or all of the above.
- b. **Service Limits:** All PERS shall meet applicable standards of manufacture, design and installation and are subject to prior approval on an individual basis by DDD.
- c. **Provider Specification(s):**
 - i. Provider approved by the DHS/DDD.
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

Children with Pervasive Developmental Disabilities Program

Program Overview: Habilitation services will be provided to children with a diagnosis of Pervasive Developmental Disability (PDD) according to the American Psychological Association's most recent version of the Diagnostic and Statistical Manual of Mental Disorders, up to their 13th birthday. Evidence-based habilitation services will support the child's functional development, and enhance his/her inclusion in the community with improved adaptive behavior, language, and cognitive outcomes. Highest need children will receive up to \$27,000 in services; those with moderate needs will receive up to \$18,000 in services and the lowest needs participants will receive \$9,000 in services. If the participant's needs change at any time, s/he can be reassessed to determine the current acuity level and the service package would be adjusted accordingly. Services will be coordinated and managed through the participant's Service Plan, as developed by the MCO care coordinators. PDD Habilitation services are available to the extent that they are not available under a program funded by the Individuals with Disabilities Education Act and the Rehabilitation Services Act of 1973.

1. Service Name: Behavior Consultative Supports (BCS)

- a. Service Description - Assessing a child, designing a Behavior Plan that is part of the larger Plan of Care developed by the Case Manager / with interventions for the child, and providing on-going consultation to the family. Consultative Supports are intended to address the behavioral symptoms often related to the diagnosis of PDD through the teaching of adaptive skills provided by the Consultative Supports staff. BCS are also intended to assist the family and paid support staff or other professionals with carrying out the Behavioral Plan (BP) that supports the child's functional development and inclusion in the community.

Behavior Consultative Supports consist of:

- i. Completion of a comprehensive assessment
- ii. Identification, with family's input, of which therapies and/or interventions will be utilized. Therapies and interventions will be based on reliable evidence, and may be: drawn from the principles of applied behavior analysis (ABA), social skills interventions, play or interaction focused interventions, play/interaction focused interventions, and cognitive behavioral therapy.
- iii. Development of the Behavior Plan based on the identified needs of the child with the family's input and guidance.
- iv. Basic training and technical assistance to the family and paid support staff regarding the particular child's needs, in order to carry out the BP.
- v. Development of the teaching protocol by which the Behavior Supports Individual Support person implements the evidence-based treatment.
- vi. Monitor the child's progress within the program.
- vii. Utilizes data-based decision making to monitor progress, track gains, and make program modifications.
- viii. Assists families to participate in the development, training, and implementation of the evidence-based therapy being utilized.

b. Service Limits:

- No more than one Consultative Supports person may be paid for services at any given time.
- Travel time is not reimbursable.

c. Provider Specifications:

- Medicaid MCO Network provider
- Master's degree, preferably in human services-related fields or education and documentation of 2,000 hours of experience working with a child with PDD OR Board Certified Behavior Analysts (BCBA) OR Board Certified Assistant Behavior Analyst (BCBA)
- Training in the intervention/therapy identified in the BP
- Must successfully pass criminal background checks

d. Participant Direction Option

- Provider Directed Participant Directed

2. Service Name: Individual Behavior Supports

- a. Service Description- services, as identified in the BP, provided to a child with PDD to assist in acquiring, retaining, improving, and generalizing the self-help, socialization, and adaptive skills necessary to reside and function successfully in home and community settings. Therapies and interventions will be based on reliable evidence, and may be: drawn from the principles of applied behavior analysis (ABA), social skills interventions, play or interaction focused interventions, play/interaction focused interventions, and cognitive behavioral therapy. Services are provided through evidence-based and data-driven methodologies.
- b. Supports are provided by the Individual Supports person who is trained on the particular needs of the child, and works under the direction of the Consultative Supports person and provides one-one services with the child, and documents services provided.

Individual Supports include assisting with the development of skills such as:

- i. (including imitation, social initiations and response to adults and peers, parallel and interactive play with peers and siblings)
 - ii. Expressive verbal language, receptive language, and nonverbal communications skills which may be enhanced through the use of a functional symbolic communication system.
 - iii. Increased engagement and flexibility in developmentally appropriate tasks and play, including the ability to attend to the environment and respond to an appropriate motivational system, based on positive behavioral supports.
 - iv. Fine and gross motor skills used for age-appropriate functional activities, as needed
 - v. Cognitive skills, including symbolic play and basic concepts, as well as academic skills
 - vi. Positive behavioral skills, in place of negative behavior patterns
 - vii. Independent organizational skills and other socially appropriate behaviors that facilitate successful community integration (such as completing a task independently, following instruction in a group, or asking for help)
- b. Service Limits: The majority of these contacts must occur in community locations where the child lives, has child care, and/or socializes, etc.
 - c. Provider Specifications:
 - i. Medicaid MCO Network provider
 - ii. Training in the intervention/therapy identified in the BP/POC.
 - iii. Bachelor's degree, preferably in education or human services-related fields OR 60 college credit hours
 - iv. Documentation of 1,000 hours of experience working with a child with a PDD Disorder OR Board Certified Assistant Behavior Analyst (BCBA)
 - v. Must work under the direction of the Consultative Supports person
 - vi. Must successfully pass criminal background checks
 - d. Participant Direction Option
 - i. Provider Directed Participant Directed

3. Service Name: Occupational Therapy

- a. **Description:** Services that are provided when the limits of occupational therapy services under the approved State plan are exhausted. The scope and nature of these services do not otherwise differ from the physical therapy service furnished under the State plan. The provider qualifications specified in the State plan apply. Physical Therapy may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five participants.
- b. **Service Limits:** These services are only available when prescribed by an appropriate health care professional. These services are available to the extent that they are not available under a program funded by the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).
- c. **Provider Specification(s):**
 - i. A licensed occupational therapist or occupational therapy assistant approved as a Medicaid provider
 - ii. Licensed, certified home health agency
 - iii. Post-acute non-residential rehabilitative services provider agency
 - iv. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Children & Families
 - v. Staff members working for any of the agencies above shall be registered as an occupational therapist (OTR) with the American Occupational Therapy Association (AOTA). A certified occupational therapy assistant (COTA) shall be registered with the AOTA and work under the direction of the OTR.
- d.
 - a. Participant Direction Option
 - i. Provider Directed Participant Directed

4. Service Name: Physical Therapy

- a. **Service Description:** Services that are provided when the limits of physical therapy services under the approved State Plan are exhausted. The scope and nature of these services do not otherwise differ from the physical therapy service furnished under the State plan. The provider qualifications specified in the State Plan apply. Physical Therapy may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five participants.
- b. **Service Limits:** These services are only available when prescribed by an appropriate health care professional. These services are available to the extent that they are not available under a program funded by the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).
- c. **Provider Specification(s):**
 - b.A licensed physical therapist or physical therapy assistant approved as a Medicaid provider
 - c.Licensed, certified home health agency
 - d.Post-acute non-residential rehabilitative services provider agency
 - e.Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Children & Families

- f. Staff members working for any of the agencies above shall meet the New Jersey licensure standards and requirements for practice (N.J.A.C. 13:39A).
- a.
- b. Participant Direction Option
 - a. Provider Directed Participant Directed

5. Service Name: Speech and Language Therapy (ST)

- a. **Service Description:** Services that are provided when the limits of speech and language therapy services under the approved State Plan are exhausted. The scope and nature of these services do not otherwise differ from the speech and language therapy service furnished under the State plan. The provider qualifications specified in the State Plan apply. Speech and Language Therapy may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five participants.
- b. **Service Limits:** These services are only available when prescribed by an appropriate health care professional. These services are available to the extent that they are not available under a program funded by the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).
- c. **Provider Specification(s):**
 - i. A licensed speech therapist approved as a Medicaid provider
 - ii. Licensed, certified home health agency
 - iii. Post-acute non-residential rehabilitative services provider agency
 - iv. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Children & Families
 - v. Staff members working for any of the agencies above shall meet the New Jersey licensure standards and requirements for practice (N.J.A.C. 13:44C).
- d.
- e. Participant Direction Option
 - i. Provider Directed Participant Directed

ID/DD-MI Dually Diagnosed Children Service Program

Program Overview: The primary goal of the program is to provide a safe, stable, and therapeutically supportive environment for children with developmental disabilities and co-occurring mental health diagnoses, ages five (5) up to twenty-one (21), with significantly challenging behaviors (Demonstration participants). This program provides both in-home intensive and out-of-home services.

It is the purpose of this program to serve and stabilize the child with ID-DD/MI in the least restrictive environment. The optimum goal is for the child to remain, or return, home with their natural supports. It may not always be possible for a child to remain or return to their natural home. In these cases, the program will provide out of home services for the child. The in-home services provided to a child remaining in their own home are intended to develop a safe, structured home environment while increasing the ability of the family/caregiver to provide the needed supports. This program is intended to assist families/caregivers by working with qualified agencies and consultants skilled in positive behavior supports to develop appropriate and safe ways to redirect the child to a more productive, safe and involved lifestyle. As the

family/caregiver gains knowledge and becomes more skilled in working with their child, the level of supports will be decreased to match the level of intensive behavioral need. The ultimate goal is to return the family home to an environment requiring minimal, if any, outside intervention.

The following services are available through this Program.

1. **Service Name:** Case/Care Management

a. Service Description: Services which will assist individuals who receive program services, in gaining access to needed program and specific State Plan services, as well as needed medical, social, behavioral, educational and other services. The Case/Care Manager is responsible for convening team meetings, developing and implementing the treatment plan, community resource development, information management, quality assessment and improvement, coordination of care with all providers and agencies with whom the family is involved, and routine coordination (including regular contact, sharing of treatment plan documents, and regular team meetings) with the MCO to assist the individual in accessing physical health care.

b. Service Limits: None

c. Provider Specifications:

- 1. Agency that has met the qualifications as specified by the Department of Human Services (DHS) or the Department of Children & Families (DCF);
- 2. Must pass criminal background check.
- 3. Must have a Bachelor's degree.

e. Participant Direction Option

- i. Provider Directed Participant Directed

2. **Service Name:** Individual Supports

a. Service Description: Individual Support services assist the child with acquiring, retaining, improving and generalizing the behavioral, self-help, socialization and adaptive skills necessary to function successfully in the home and community. Individual Support workers will provide services directly to the child through evidence-based and data driven methodologies. Individual support services are behavioral, self-care and habilitative related tasks performed and/or supervised by service provider staff in a Demonstration participant's family home, the home of a relative or in other community-based settings, in accordance with approved treatment plans.

These supports include behavioral supports & training, adaptive skill development, assistance with activities of daily living and community inclusion that assist the Demonstration participant to reside in the most integrated setting appropriate to his/her needs. Services may be furnished in the following living arrangements: Demonstration participant's own home, the home of a relative or other community based living arrangement.

- b. **Service Limits:** Supports in own home cannot exceed 16 hours per day; payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. Services are prior authorized, by the State or its designee, based on needs assessment and as delineated in the treatment plan.
- c. **Provider Specifications:** Staff must meet the minimum levels of education, experience and training as described in the DHS/DCF Contract Reimbursement Manual or as required for Medicaid participation.
 - Agency that has met the qualifications as specified by the Department of Human Services (DHS) or the Department of Children & Families (DCF);
 - DDD Contracted Agency; NJAC 10:44 A and/or NJAC 10:44B and/or NJAC 10:44C; or DCF Contracted Agency;
 - Medicaid enrolled provider.
- o Participant Direction Option
 - Provider Directed Participant Directed

3. **Service Name:** Natural Supports Training

- a. **Service Description:** Training and counseling services for individuals who provide unpaid support, training, companionship, or supervision to Demonstration participants. For purposes of this service, individual is defined as any person, family member, neighbor, friend, companion, or co-worker who provides uncompensated care, training, guidance, companionship or support to a Demonstration participant. Training includes instruction about treatment regimens and other services included in the treatment plan, use of equipment specified in the treatment plan, as well as updates as necessary to safely maintain the Demonstration participant at home. Counseling must be aimed at assisting the unpaid caregiver in meeting the needs of the Demonstration participant. All training for individuals who provide unpaid support to the Demonstration participant must be included in the Demonstration participant's treatment plan.
- b. **Service Limits:** Prior authorization required by the State or its designee, based on needs assessment and as delineated in the treatment plan. This service may not be provided in order to train paid caregivers.
- c. **Provider Specifications:** Provider must meet the minimum levels of education, experience and training as determined by DCF and as required for Medicaid participation. Provider must be an approved provider and meet all applicable licensing and credentialing standards in psychiatry, physical therapy, occupational therapy, speech language pathology, social work, or must be registered nurse or a degreed psychologist or hold a degree in other related areas.
 - Agency that has met the qualifications as specified by the Department of Human Services (DHS) or the Department of Children & Families (DCF);
 - DDD Contracted Agency; NJAC 10:44 A and/or NJAC 10:44B and/or NJAC 10:44C; or DCF Contracted Agency

- Medicaid enrolled provider
- Participant Direction Option
 - Provider Directed Participant Directed

4. **Service Name:** Intensive In-Community Services - Habilitation

a. Service Description: Clinical and therapeutic services that are not covered by the State Plan and assist unpaid caregivers and/or paid support staff in carrying out individual treatment/support plans, and are necessary to improve the individual’s independence and inclusion in their community. These services are flexible, multi-purpose, in-home/community clinical support for Demonstration participants and their parents/caregivers/guardians. These services are flexible both as to where and when they are provided based on the family’s needs. This Demonstration participant-driven treatment is based on targeted needs as identified in the treatment plan. The treatment plan includes specific intervention(s) with target dates for accomplishment of goals that focus on the restorative functioning of the Demonstration participant with the intention of:

- Stabilizing the Demonstration participant’s behavior(s) that led to the crisis,
- Preventing/reducing the need for inpatient hospitalization,
- Preventing the movement of the Demonstration participant’s residence,
- Preventing the need for out-of-home living arrangements.

The services provided will also facilitate a Demonstration participant’s transition from an intensive treatment setting back to his/her home. Interventions will be delivered with the goal of diminishing the intensity of treatment over time.

These services encompass a broad array of interventions ranging from clinical therapy to behavioral assistance. Behavioral assistance (BA) services are medically necessary, objective, behavior changing through measurable goals intervention. These services are provided to a “moderate” or “high needs” youth and his/her family. BA services occur in the youth’s natural environment (school, home, neighborhood), are not office-based, and work to improve youth’s functioning in his/her natural environment. BA services are provided to make change through the diminution of maladaptive behaviors and/or the development of adaptive behaviors. Behaviors of focus for BA services are fully described in terms of intensity, frequency, antecedents, and desired outcome. Consequently, BA services are the most easily evaluated for effectiveness and change. Services include a comprehensive integrated program of clinical rehabilitation services to support improved behavioral, social, educational and vocational functioning. In general, this program will provide children/youth and their families with services such as psychoeducation, negotiation and conflict resolution skill training, effective coping skills, healthy limit-setting, stress management, self-care, budgeting, symptom/medication management, and developing or building on skills that would enhance self-fulfillment, education and potential employability.

b. Service Limits: Use of this service requires the preparation of a formal comprehensive assessment and submission of any behavioral support program, Level III, to the provider agency’s internal Behavior Management Committee & Human Rights Committee or the State’s Behavior Management Committee & Human Rights Committee for assurance of compliance to Division Circulars 19 & 34 for approval prior to implementation. Contacts

cannot be office-based and must occur in community locations where the child lives, has child care, and/or socializes, etc. Treatment modalities must be based in best practices.

- c. **Provider Specification:** Staff qualifications: Psychologists, Masters Level or Board Certified Behavior Specialist, Bachelor Level Behaviorist with oversight by a Masters Level or Board Certified Behavior Analyst; Licensed Clinical Social Workers, Professional Counselor;
- Agency that has met the qualifications as specified by the Department of Human Services (DHS) or the Department of Children & Families (DCF);
 - DDD Contracted Agency; NJAC 10:44 A and/or NJAC 10:44B and/or NJAC 10:44C; or DCF Contracted Agency
 - Medicaid enrolled provider
- o Participant Direction Option
- Provider Directed Participant Directed

5. **Service Name:** Respite

a. **Service Description:** Services provided to Demonstration participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the Demonstration participant. Respite may be provided in the Demonstration participant's home, a program group home, a licensed respite care facility, or a State-approved camp. Respite will not be provided in hospital settings.

b. **Service Limits:** Must comply with all requirements of DCF respite policy. The State does not pay for room and board except for licensed, non-private residence facilities that are approved by the State. Camp may not be delivered simultaneously with Day Habilitation, Community-Based Supports or during the extended school year. Transportation to or from camp services is not included in the service.

c. **Provider Specifications:**

- Agency that has met the qualifications as specified by the Department of Human Services (DHS) or the Department of Children & Families (DCF);
 - DDD Contracted Agency; NJAC 10:44 A and/or NJAC 10:44B and/or NJAC 10:44C or DCF Contracted Agency;
 - Authorized Camps: N.J.A.C. 8:25; or
 - Authorized Medicaid provider
- o Participant Direction Option
- Provider Directed Participant Directed

6. **Service Name:** Non-Medical Transportation

- a. **Service Description:** Service offered in order to enable Demonstration participant to gain access to program and other community services, activities and resources, as specified by the Service Plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State Plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Transportation services are offered in accordance with the Demonstration participant’s Service Plan. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized.
- b. **Service Limits:** Outside of medical transportation, transportation provided through the educational entitlement, transportation available through the Medicaid State Plan, or transportation available at no charge or as part of an administrative expenditure. Reimbursement for transportation is limited to distances not to exceed 150 miles one way and only within the States of New Jersey, New York, Pennsylvania and Delaware. Reimbursement for mileage will not exceed the rate established by the State.
- c. **Provider Specifications:** Valid Driver’s license, registration and insurance.
 - Agency that has met the qualifications as specified by the Department of Human Services (DHS) or the Department of Children & Families (DCF); or
 - DDD Contracted Agency; NJAC 10:44 A and/or NJAC 10:44B and/or NJAC 10:44C or DCF Contracted Agency; or
 - Authorized Medicaid provider.
- o Participant Direction Option
 - Provider Directed Participant Directed

7. **Service Name:** Interpreter Services

- a. **Service Description:** Service delivered to a Demonstration participant or uncompensated caregiver face-to-face to support them in carrying out Demonstration participants’ treatment/support plans, and that are not covered by the Medicaid State Plan. For language interpretation, the interpreter service must be delivered by an individual proficient in reading and speaking in the language in which the Demonstration participant speaks.
- b. **Service Limits:** Prior authorization required by the State or its designee. Interpreter services may be used when the State Plan service for language line interpretation is not available or not feasible or when natural interpretive supports – i.e. an adult family member who can provide the interpretation - are not available.
- c. **Provider Specification:**
 - Agency that has met the qualifications as specified by the Department of Human Services (DHS) or the Department of Children & Families (DCF);

- Sign language interpreter: Screened by the NJ Division of the Deaf and Hard of Hearing and/or possess certification offered by the National Registry of Interpreters for the Deaf.

Language interpreter:

- 18 yrs of age;
- Cleared Criminal background check; and
- Proficient in reading & speaking both languages.

f. Participant Direction Option

- i. Provider Directed Participant Directed

IDD/OOS Service Definitions

Program Overview: This program consists of individuals who receive out-of-state services funded by DDD. At this time, individuals are only being added to this program in extremely limited cases (only when DDD has been court-ordered to provide the services in an out-of-state setting), so this program is not expected to grow. Historically, individuals in this program were referred out of state for a variety of reasons. Some were placed in an out-of-state program by their local school district as part of their educational entitlement. In those cases, DDD may have been partially funding the placement prior to the individual aging out of their educational entitlement, as part of a shared agreement with the school or by court order. In other cases, DDD may not have had any involvement with - or knowledge of - the out of state placement until the educational entitlement was ending, at which time the individual/family requested that DDD pick up the funding to allow the individual to remain in their out of state placement. Additionally, some adults were referred for out of state services by DDD staff historically, when an acceptable alternative could not be accessed in the state. The available services vary from setting to setting.

Notably, DDD is making great efforts to minimize the use of out-of-state services for people with intellectual and developmental disabilities. To that end, DDD is no longer approving out-of-state services for new individuals, except where court ordered to do so. DDD is also working to return the out-of-state individuals to New Jersey to receive services, or alternatively, to assist them in becoming residents of, and receiving services from, the state in which they are currently located. Also, as individuals who were placed out-of-state as part of their educational entitlement approach the end of that entitlement, DDD is identifying them, notifying them that DDD will not fund the out-of-state services once they age out of school, and beginning the process of locating appropriate in-state services.

The following services will be available through this Program.

1. **Service Name:** Case Management

- a. **Description:** Services which will assist Demonstration participants in planning and gaining access to needed services. DDD Case managers are responsible for participating in Team meetings to develop the Demonstration participant's Plan of care and reviewing and authorizing Service Plans. Provider Case Managers are responsible for coordinating and leading the Plan of

care meetings and development process, and assisting the Demonstration participants in locating and coordinating access to medical and other needed services. Provider Case Managers are responsible for the ongoing monitoring of the service plan.

b. **Service Limits:** None.

c. **Provider Specifications:**

i. For DDD Case Managers:

1. Must meet the qualifications for a QMRP.
2. Must have a Bachelor's degree.
3. Must pass criminal background check.
4. Must qualify for and pass a NJ Civil Service Test.
5. Must be employed in position.

ii. For Provider Case Managers:

1. Must have a Bachelor's degree in a Human Services field
2. Must have 2 years of previous experience
3. Must pass criminal background check.

d. Participant Direction Option

i. Provider Directed Participant Directed

2. **Service Name:** Individual Supports

a. **Description:** Services provided to assist, train, and supervise a Demonstration participant as they learn and perform various tasks that are included in basic self-care, social skills and activities of daily living. This also includes but is not limited to: personal care, companion services, chore services, day and night supervision, transportation and travel training.

b. **Service Limits:** These services are only available as specified in the Demonstration participant's Service Plan.

c. **Provider Specifications:**

- i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
- ii. Must pass criminal background check.

d. Participant Direction Option

i. Provider Directed Participant Directed

3. **Service Name:** Habilitation

a. **Description:** Services which are designed to develop, maintain and/or maximize the individual's independent functioning in self-care, physical and emotional growth, socialization, communication and prevocational training.

b. **Service Limits:** These services are only available as specified in Demonstration participant's Service Plan.

c. **Provider Specifications:**

- i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
- ii. Must pass criminal background check.

d. Participant Direction Option

i. Provider Directed Participant Directed

4. **Service Name:** Supported Employment

- a. **Description:** Supported employment includes job development, pre-job placement and job coaching activities that can assist an individual to secure a job that will result in paid employment and/or to maintain that employment.
- b. **Service Limits:** These services are only available as specified in Demonstration participant's Service Plan.
- c. Documentation is maintained in the file of each Demonstration participant that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) as applicable.
- d. **Provider Specifications:**
 - i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
 - ii. Must pass criminal background check.
- e. Participant Direction Option
 - i. Provider Directed Participant Directed

5. **Service Name:** Occupational Therapy

- a. **Description:** Services that are provided to the Demonstration participant when they are unable to access needed occupational therapy from the State Plan because of the geographic location of their out of state placement. The scope and nature of these services do not otherwise differ from the Occupational Therapy services described in the State Plan. They may be either rehabilitative or habilitative in nature. Services that are rehabilitative in nature are only provided when the limits of occupational therapy services under the approved State Plan are exhausted. .
- b. **Service Limits:**
 - i. These services are only available as specified in Demonstration participant's Plan of care and when prescribed by an appropriate health care professional. These services can be delivered on an individual basis or in groups.
 - ii. Services available through the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.), as applicable, must be utilized before program services are made available.
- c. **Provider Specifications:**
 - i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
 - ii. Must pass criminal background check.
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

6. **Service Name:** Physical Therapy

- a. **Description:** Services that are provided to the Demonstration participant when they are unable to access needed physical therapy from the State Plan because of the geographic location of their out of state placement. The scope and nature of these services do not otherwise differ from the Physical Therapy services described in the State Plan. They may be either rehabilitative or habilitative in nature. Services that are rehabilitative in nature are only provided when the limits of physical therapy services under the approved State Plan are exhausted.
- b. **Service Limits:**
 - i. These services are only available as specified in Demonstration participant's Plan of care and when prescribed by an appropriate health care professional. These services can be delivered on an individual basis or in groups.

- ii. Services available through the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.), as applicable, must be utilized before program services are made available.
- c. **Provider Specifications:**
 - i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
 - ii. Must pass criminal background check.
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

7. **Service Name:** Speech and Language Therapy

- a. **Description:** Services that are provided to the Demonstration participant when they are unable to access needed speech therapy from the State Plan because of the geographic location of their out of state placement. The scope and nature of these services do not otherwise differ from the Speech Therapy services described in the State Plan. They may be either rehabilitative or habilitative in nature. Services that are rehabilitative in nature are only provided when the limits of speech therapy services under the approved State Plan are exhausted.
- b. **Service Limits:**
 - i. These services are only available as specified in Demonstration participant’s Plan of care and when prescribed by an appropriate health care professional. These services can be delivered on an individual basis or in groups.
 - ii. Services available through the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.), as applicable, must be utilized before program services are made available.
- c. **Provider Specifications:**
 - i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
 - ii. Must pass criminal background check.
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

8. **Service Name:** Transportation

- a. **Description:** Services which allow the individual to access services, activities, and resources, as specified by the Service Plan, and to participate in their communities.
- b. **Service Limits:** This service may include provider-run transportation services, drivers, taxi fares, train and bus tickets, or other public transportation services or private contractors. The selected service chosen must be the most cost effective means of transportation that the individual is reasonably able to access. Reimbursement for mileage will not exceed the established rate.
- c. **Provider Specifications:**
 - i. Valid driver’s license
 - ii. Valid vehicle registration
 - iii. Valid insurance
 - iv. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

9. **Service Name:** Counseling & Psychological Supports

Description: Services designed to provide counseling and psychological supports and services to Demonstration participants when they are unable to access those services from the State plan because of the geographic location of their out-of-state residential placement.

- a. **Service Limits:** Services available through the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.), as applicable, must be utilized before program services are made available.
- b. **Provider Specifications:**
 - i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
 - ii. Must pass criminal background check.
- c. **Participant Direction Option**
 - i. Provider Directed Participant Directed

10. **Service Name:** Behavioral Assessment & Management

- a. **Description:** Services designed to assist an individual with functional behavioral issues. These services may include a functional behavioral assessment, development of a behavioral support plan, implementation of behavioral interventions as specified in the plan, and ongoing monitoring of the behavioral support plan. Behavioral interventions are geared toward developing positive behaviors needed for the individual to remain safe and healthy and function in community environments.
- b. **Service Limits:** These services are only available as specified in Demonstration participant's Service Plan.
- c. Services available through the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.), as applicable, must be utilized before program services are made available.
- d. **Provider Specifications:**
 - i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
 - ii. Must pass a criminal background check.
- e. **Participant Direction Option**
 - i. Provider Directed Participant Directed

11. **Service Name:** Community Integration

- a. **Description:** Services provided outside of a residential setting that support and assist Demonstration participants in educational or enrichment activities, as outlined in the Service Plan, that are intended to enhance inclusion in the community.
- b. **Service Limits:** These services can be delivered in an individual or group setting. These services may not be delivered simultaneously with Habilitation, Therapeutic Recreation, or Supported Employment.
- c. **Provider Specifications:**
 - i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
 - ii. Must pass criminal background check.
- d. **Participant Direction Option**
 - i. Provider Directed Participant Directed

12. **Service Name:** Routine Health Care & Medication

- a. **Description:** Routine health care services that are provided to the Demonstration participant when they are unable to access those services from the State plan because of the geographic location of their out-of-state residential placement. These services include primary health care, nursing, medication, medication management, and other routine medical assistance.
- b. **Service Limits:** None.
- c. **Provider Specifications:**
 - i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

Attachment C.2

New Jersey's Comprehensive Waiver Demonstration

Home and Community Based Services – Current 1915(c) Programs that Will be Transitioned to Managed Care Service Definitions

Global Options Waiver (Formerly NJ.0032)

1. Service Name: Care Management

a. Description: Care Management is a service that will assist individuals who receive Waiver services in gaining access to needed Waiver and other State Plan services (as identified in the Waiver), as well as medical, social, educational and other services, regardless of the funding source. Care Managers are responsible for ongoing monitoring of the provision of services included in the individual's Plan of Care.

Care Managers initiate and oversee the process of re-evaluation of the individual's level of care and the review of plans of care every 12 months at a minimum.

b. Service Limits: Care Managers are required to contact each participant at specific intervals, on an as needed basis, and visit each participant quarterly. Examples of circumstances that would be considered an "as needed basis" contact by the Care Manager could include: if the participant requested a change in service provider or frequency of services, if the participant prompted a contact to the Care Manager, if the participant had a recent hospitalization, or if the participant needed assistance of some sort and a change in the Plan of Care were necessary.

c. Provider Specification(s):

i. Adult Family Care Sponsor Agency

ii. Accredited Registered Homemaker Agency

iii. Licensed Medicare Certified Home Health Agency

iv. Proprietary or Not-for-Profit Care Management Entity

v. Area Agency on Aging

vi. County Welfare Agency

2. Service Name: Respite

a. Description: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of an unpaid, informal caregiver (those persons who normally provide unpaid care) for the participant. Federal financial participation is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite Care may be provided in the following location(s): 1) the Individual's home or place of residence; 2) a Medicaid certified Nursing Facility that has a separate Medicaid provider number to bill for Respite; 3) An other community care residence approved by the State that is not a private residence including only: an Assisted Living Residence (AL), a Comprehensive Personal Care Home (CPCH), or an Adult Family Care (AFC) Home

b. Service Limits: Respite is limited to 30 days per participant per Waiver year. Room and Board charges are included in Institutional Respite rate. The Medicaid Waiver Year starts October 1st. If 30 days of nursing facility Respite is reached, but the participant needs to remain in the facility longer, the individual must be referred to the Regional Office of Community Choice Options for a short-term Pre Admission Screen (PAS).

Respite will not be reimbursed for individuals who reside permanently in an Assisted Living Residence or Comprehensive Personal Care Home or for GO participants that are admitted to the Nursing Facility.

Respite care shall not be reimbursed as a separate service during the hours the participant is participating in either Adult Day Health Services or Social Adult Day Care. Services excluded from additional billing while simultaneously receiving Respite care include: Chore, Home-Based Supportive Care, Home-delivered meals, and Personal Care Assistant.

Sitter, live-in, or companion services are not considered Respite Services and cannot be authorized as such.

Respite services are not provided for formal, paid caregivers (i.e. Home Health or Certified Nurse Aides). Respite services are not to be authorized due to the absence of those persons who would normally provide paid care for the participant.

Respite care in a nursing facility requires a negative Pre Admission Screening Resident Review (PASRR) Level I screen prior to service authorization.

- c. Provider Specification(s)
- i. Adult Family Care Sponsor Agencies
 - ii. Licensed Employment Agency and Temporary Help Agency (In-home respite)
 - iii. Licensed Health Care Service Firm (In-home respite)
 - iv. Licensed, Certified Home Health Agency (In-home respite)
 - v. Licensed Assisted Living Residence (ALR) or Comprehensive Personal Care Home (CPCH)
 - vi. Accredited, Registered Home Care Agency (In-home respite)
 - vii. Licensed Adult Family Care (AFC) Caregiver (Individual)
 - viii. Licensed Nursing Facility

3. Service Name: Adult Family Care

a. Description: Adult Family Care (AFC) enables up to three unrelated individuals to live in the community in the primary residence of a trained caregiver who provides support and health services for the resident. Adult Family Care may provide personal care, meal preparation, transportation, laundry, errands, housekeeping, socialization and recreational activities, monitoring of participant's funds when requested by the participant, up to 24 hours a day of supervision, and medication administration.

The individual remains responsible for the cost of Room and Board and cost share, if applicable.

b. Service Limits: Individuals that opt for Adult Family Care do not receive Personal Care Assistant, Chore Service, Home-Delivered Meals, Home-Based Supportive Care, Caregiver/Participant Training, Assisted Living, or Assisted Living Program. Those services would duplicate services integral to and inherent in the provision of Adult Family Care services.

c. Provider Specification(s)

i. Licensed Adult Family Care (AFC) Caregiver (Individual)

ii. Licensed Adult Family Care (AFC) Sponsor Agency (Agency)

4. Service Name: Assisted Living (ALR or CPCH)

a. Description: Assisted Living means a coordinated array of supportive personal and health services, chore, medication administration, intermittent skilled nursing services, available 24 hours per day, to residents who have been assessed to need these services including persons who require nursing home level of care. A planned, diversified program of resident activities shall be offered daily for residents, including individual and/or group activities, on-site or off-site, to meet the individual needs of residents. Assisted Living facilities also either arrange or provide for transportation that is specified in the Plan of Care and periodic nursing evaluations. Assisted Living promotes resident self-direction and participation in decisions that emphasize independence, individuality, privacy, dignity, and homelike surroundings.

ALR "Assisted Living Residence" means a facility which is licensed by the Department of Health to provide apartment-style housing and congregate dining and to assure that assisted living services are available when needed, for four or more adult persons unrelated to the proprietor. Apartment units offer, at a minimum, one unfurnished room, a private bathroom, a kitchenette, and a lockable door on the unit entrance. CPCH "Comprehensive Personal Care Home" means a facility which is licensed by the Department of Health to provide room and board and to assure that assisted living services are available when needed, to four or more adults unrelated to the proprietor. Residential units in comprehensive personal care homes house no more than two residents and have a lockable door on the unit entrance.

Individuals in Assisted Living are responsible to pay their Room and Board costs at a rate established by the Department and any applicable cost share.

Residents in Assisted Living Facilities have access to both their own living unit's kitchen 24/7 and to a facility pantry with food and beverages 24/7.

Residents in Comprehensive Personal Care Homes have access to their own living unit's kitchen 24/7. In some situations, these kitchens may be modified to eliminate the cooking appliance. However their refrigerator and dry food storage is available.

b. Service Limits: Individuals that opt for Assisted Living do not receive Personal Care Assistant, Adult Family Care, Assisted Living Program, Environmental Accessibility Adaptations, Chore Services, Personal Emergency Response Services, Home-Delivered Meals, Caregiver/Participant Training, Adult Day Health Services, Social Adult Day Care, Attendant Care, Home-Based Supportive Care, or Respite as they would duplicate services integral to and inherent in the provision of Assisted Living services.

c. Provider Specification(s)

i. Comprehensive Personal Care Home (CPCH)

ii. Assisted Living Residence (ALR)

5. Service Name: Assisted Living Program (ALP) in Subsidized Housing

a. Description: Assisted Living Program means the provision of or arrangement for meals and assisted living services to the tenants/residents of publicly subsidized housing. Assisted Living Services include personal care, homemaker, chore, and medication oversight and administration throughout the day.

Individuals reside in their own independent apartments. The individual is responsible for his or her own rent and utility payments as defined in a lease with the landlord. Individuals are also responsible for the cost of meals and other household expenses.

Again, Assisted Living Program means the provision of or arrangement for meals and assisted living services to the tenants/residents of publicly subsidized housing. Assisted Living Program services are provided to individuals who reside in their own independent apartments. The ALP individual is responsible for his or her own rent and utility payments as defined in a lease with the landlord.

Having an ALP provider offers the subsidized housing tenants the opportunity to remain in their own apartments with the support of others, while maintaining their independence dignity.

Participation in the services of an Assisted Living Program (ALP) are voluntary on the part of any tenant of any ALP contracted publicly subsidized housing building.

The ALP is to make available dining services and/or meal preparation assistance to meet the daily nutritional needs of residents.

ALP providers work with participants to ensure a strong sense of connectedness in each apartment community as well as with the larger communities in which they are located. Individuals may participate in tenant/resident meetings, attend community-based civic

association meetings and plan recreational activities. Sometimes, ALP providers host community health screening events to encourage wellness for the tenant population at large.

By state regulation, ALP providers are required to have procedures for arranging resident transportation to and from health care services provided outside of the program site, and shall provide reasonable plans for security and accountability for the resident and his or her personal possessions.

Additionally, a planned, diversified program of activities is to be posted and offered daily for residents, including individual and/or group activities, on-site or off-site to meet the service needs of residents.

Because ALPs are located in independent subsidized housing, tenants are free to be as actively involved in their communities as they desire to be. ALP buildings often have relationships with community partners and local strategic alliances that create conditions to promote increased access, inclusiveness, and tenant engagement in local happenings as well as, better health and wellness services and opportunities for tenants.

b. **Service Limits:** Individuals that opt for Assisted Living Program do not receive Personal Care Assistant, Adult Day Health Services, Chore Service, Attendant Care, Home-Based Supportive Care, Caregiver/Participant Training, Assisted Living, or Adult Family Care as they would duplicate services integral to and inherent in the provision of Assisted Living Program services. The subsidized housing provider is responsible for Environmental Accessibility Adaptations.

c. **Provider Specification(s)**

i. **Assisted Living Program in Subsidized Housing**

6. **Service Name: Attendant Care**

a. **Description:** Hands-on care (needs physical assistance to accomplish task), of both a supportive and health-related nature, specific to the needs of a medically stable physically disabled individual, who is capable of self directing his or her own health care. Supportive services are those that substitute for the absence, loss, diminution, or impairment of a physical function.

This service is intended to assist individuals in accessing care of a more health related nature, beyond basic Activities of Daily Living/Instrumental Activities of Daily Living (ADL/IADL). This service may include skilled or nursing care to the extent permitted by State law. Supervision must be furnished directly by the participant when the person has been trained to perform this function and when the safety and efficacy of participant-provided supervision has been certified in writing by a Registered Nurse or otherwise as provided in State law. This certification must be based on direct observation of the participant and the specific attendant care provider by the Registered Nurse evaluator, during the actual provision of care.

Housekeeping activities that are incidental to the performance of care may also be furnished as part of this activity.

Attendant Care may ONLY be provided by a Participant-Employed Provider. Attendant Care is not available in Assisted Living, Adult Family Care or Assisted Living Program as it would duplicate services furnished through the Assisted Living, Adult Family Care and Assisted Living Program service packages.

b. Service Limits: Attendant Care is limited to a total of 40 hours per week.

c. Provider Specification(s)

i. Participant Employed Provider (PEP)

7. Service Name: Caregiver Participant Training

a. Description: Instruction provided to a client or caregiver in either a one-to-one or group situation to teach a variety of skills necessary for independent living, including: use of specialized or adaptive equipment, completion of medically related procedures required to maintain the participant in a home or community setting; activities of daily living; adjustment to mobility impairment; management of personal care needs; skills to deal with care providers and attendants. Training needs must be identified through the comprehensive evaluation, re-evaluation, or in a professional evaluation and must be identified in the approved Plan of Care as a required service.

Caregiver/Participant Training is not available to participants that have chosen Assisted Living, Adult Family Care, or the Assisted Living Program as it would duplicate services furnished through Assisted Living, Adult Family Care or Assisted Living Program.

b. Service Limits: Caregiver Participant Training is not considered a service that can be received monthly by GO participants.

c. Provider Specification(s)

i. Individual with appropriate expertise (i.e. RN, OT) to train the recipient/caregiver as required by the Plan of Care (Individual Provider)

ii. Homemaker Agency with Health Care Service Firm

iii. Centers for Independent Living (CIL)

iv. Health Care Service Firm

v. Licensed Medicare Certified Home Health Agency

vi. Adult Family Care Sponsor Agency

vii. Proprietary or Not-for-Profit Business entity

8. Service Name: Chore Services

a. Description: Services needed to maintain the home in a clean, sanitary and safe environment. The chores are non-continuous, non-routine heavy household maintenance tasks intended to increase the safety of the individual. Chore services include cleaning appliances, cleaning and securing rugs and carpets, washing walls, windows, and scrubbing floors, cleaning attics and basements to remove fire and health hazards, clearing walkways of ice, snow, leaves, trimming overhanging tree branches, replacing fuses, light bulbs, electric plugs, frayed cords, replacing door locks, window catches, replacing faucet washers, installing safety equipment, seasonal changes of screens and storm windows, weather stripping around doors, and caulking windows.

Chore Services do not include normal everyday housekeeping tasks such as dusting, vacuuming, changing bed linens, washing dishes, cleaning the bathroom, etc.

Chore is not a service that would be received monthly by a GO participant.

b. Service Limits: Chore service is not available to those who opt for Assisted Living, Adult Family Care, or Assisted Living Program as it is included in the Assisted Living, Adult Family Care and Assisted Living Program service packages.

Chore services are appropriate only when neither the participant, nor anyone else in the household, is capable of performing the chore; there is no one else in the household capable of financially paying for the chore service; and there is no relative, caregiver, landlord, community agency, volunteer, or 3rd party payer capable or responsible to complete this chore.

c. Provider Specification(s)

i. Participant-Employed Provider (PEP) (Individual provider)

ii. Congregate Housing Services Program

iii. Private Contractor (Individual Provider)

iv. Subsidized Independent Housing for Seniors

9. Service Name: Community Transition Services

a. Description: Community Transitions Services (CTS) are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to an Assisted Living Facility, Adult Family Care home or a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; (e) moving expenses; (f) necessary accessibility adaptations; and (g) activities to assess need, arrange for and procure need resources. Community Transition Services are furnished only to the extent that

they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan, and the person is unable to meet such expense or when the services cannot be obtained from other sources.

Community Transition Services may be furnished as a Waiver service to individuals to facilitate the transition from an institution to a more independent/less restrictive living arrangement.

Community Transition Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

b. **Service Limits:** Community Transition Services are non-recurring and available one time only per person. If a participant returns to the Nursing Home, remains there for any period of time, and wishes to return again to the community, he or she may do so and participate in the Waiver, but Community Transition Services will not be a Waiver service the person may utilize again.

Community Transition Services may not be used to pay for furnishing living arrangements that are owned or leased by a waiver provider where the provision of these items and services are inherent to the service they are already providing.

All Community Transition Services are prior authorized by the Division of Aging and Community Services' Central Office and not considered in the monthly spending cap.

c. **Provider Specification(s)**

i. **Private Contractor/Business (Individual provider)**

10. **Service Name: Environmental Accessibility Adaptations (EAA)**

a. **Description:** Those physical adaptations to the private residence of the participant or the participant's family, required by the participant's Plan of Care which are necessary to ensure the health, safety and welfare of the participant and enable the participant to function with greater independence in the home, without which the participant would require institutionalization.

Adaptations may include the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electrical and plumbing systems necessary to accommodate the medical equipment and supplies essential for the participant's welfare. Excluded are those adaptations or improvements to the home which are of general utility and are not of direct medical or remedial benefit to the participant, including but not limited to items such as carpeting, roof repairs and central air conditioning. Adaptation to vehicles (vehicle modifications) are excluded and not a covered service. Adaptations which add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g. in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a participant's wheelchair. All services shall be provided in accordance with applicable State, Local and Americans with Disability Act (ADA) and/or ADA Accessibility Guidelines (ADAAG) and Specifications.

Per Olmstead Letter #3, assessments for the accessibility and need for modifications to a participant's home may be included as an expense in the EAA Waiver Service as a relevant service by another provider such as a home health agency or occupational therapist.

Evidence of permits, approvals or authorizations must be made available if required.

Participants living in licensed residences (ALR, CPCH, ALP, and Class B Boarding Homes) are not eligible to receive EAAs. Modifications to public apartment buildings and/or rental properties are the responsibility of the owner/landlord and excluded from this benefit.

Environmental accessibility adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services, except for approved Adult Family Care (AFC) Caregivers' homes as assessed to be needed by GO program participants.

EAAs are not comparable or equivalent to Vehicle Modifications. Vehicle modifications are not a covered waiver service for GO participants.

EAAs are not considered a waiver service that a participant can receive on a monthly basis.

A minimum of two estimates are required by approved Waiver providers reflecting the EAA's total cost. Total cost includes all materials, labor, and equipment, shipping fees, permits or any other expenditure to be incurred from the initiation phase to the completion phase of the EAA modification. Authorized EAA costs do not include potential removal fees of the modification.

All home modifications are limited based on the participant's assessed need for an EAA. The adaptation will represent the most cost effective means to meet the needs of the participant. The adaptation will be specific to, but not in excess of, the participant's needs. If another service, such as a State Plan Service or other Waiver service (i.e. Specialized Medical Equipment and Supplies) will meet the same need for which an EAA is being proposed, the SME will be the authorized service.

b. Service Limits: Environmental Accessibility Adaptations that cost \$500 or more must be prior authorized by the Division of Aging and Community Services. The cost of the Environmental Accessibility Adaptation is outside the participant's individual spending cap.

If the EAA cost is over \$500, a minimum of two independent cost estimates must be submitted to the Division of Aging and Community Services (DACs). If the estimates are far apart in cost, a revision or third estimate may be necessary. Estimates must include the approved provider's contact information. A description of work to be done to include pictures/schematics if appropriate and will also detail materials and labor costs. The estimate is to include a Physicians Order if appropriate indicating the service needed and the medical rationale for the service. Also, a letter from the owner of the property approving the modification to the property and acknowledging that the State is not responsible for the removal of the modification from the property is required.

Environmental Accessibility Adaptations are limited to \$5,000 per participant per Waiver year. Additional modification costs exceeding those limits may be requested if a participant's health and safety require special consideration, however, the service of EAA is subject to a \$10,000 lifetime cost cap for each participant assessed to require such adaptation(s).

For those individuals who are in need of Environmental Accessibility Adaptations to transition from a nursing facility to the community, the State may initiate the adaptations up to 180 days prior to actual discharge but authorization of the EAA and reimbursement of the service will not be reimbursed until program enrollment has occurred.

- c. Provider Specification(s)
- i. Private Contractor/Business (Individual Provider)

11. Service Name: Home-Based Supportive Care

a. Description: Services designed to reduce or prevent inappropriate institutionalization by maintaining, strengthening, or restoring an individual's functioning. Needs must be identified through the validated InterRAI comprehensive level of care evaluation tool or re-evaluation, and must be itemized in the approved Plan of Care as a required service. All services include the provision of non-medical transportation necessary for the implementation of the Plan of Care.

Home-Based Supportive Care is not a duplication of the State Plan of Personal Care Assistant. According to N.J.A.C. 10:60-1.2, Personal care assistant services means "health related tasks performed by a qualified individual in a beneficiary's home, under the supervision of a Registered Nurse, as certified by a physician in accordance with a beneficiary's written plan of care." PCA services are prior authorized by the Division of Disability Services in the Department of Human Services. In Home-Based Supportive Care, the services listed in the next paragraph are authorized by the Care Manager based on the needs identified in the initial Level of Care Evaluation and include services beyond "health-related."

Home-Based Supportive Care includes providing assistance with Activities of Daily Living: bathing, dressing, toileting, transferring, eating, bed mobility, and locomotion, either hands-on (needs physical assistance to accomplish the task) or through supervision and cueing. Home-Based Supportive Care also includes assistance with Instrumental Activities of Daily Living (IADL): preparing meals, shopping, managing money, housework, laundry, medication administration, transportation, and mobility outside the home.

Home-Based Supportive Care may be provided by an approved Agency or a Participant-Employed Provider (PEP) selected and hired by the participant.

Individuals will receive Options Counseling from the Office of Community Choice Options Community Choice Counselors and/or County Assessors to assure that the individual has the choice between Home-Based Supportive Care and the State Plan Personal Care Assistant Service.

Home-Based Supportive Care is not available in an Assisted Living Facility, Adult Family Care Home, or Assisted Living Program as it would duplicate services required in Assisted Living, Adult Family Care, or Assisted Living Program.

b. Service Limits: Home-Based Supportive Care is limited to 40 hours a week. If a participant selects Home-Based Supportive Care, he or she is then excluded from receiving Personal Care Assistant.

Home-Based Supportive Care is not reimbursed when the participant is hospitalized or institutionalized.

c. Provider Specification(s)

i. Subsidized Independent Housing for Seniors

ii. Licensed Medicare Certified Home Health Agency

iii. Homemaker Agency that has Health Care Service Firm license

iv. Licensed Health Care Service Firm

v. Participant Employed Provider (PEP) (Individual Provider)

vi. Licensed Employment Agency or Temporary Help Agency

vii. Congregate Housing Services Program

12. Service Name: Home-Delivered Meals

a. Description: Nutritionally balanced meals delivered to the participant's home when this meal provision is more cost effective than having a personal care provider prepare the meal. These meals do not constitute a full nutritional regimen, but each meal shall provide at least 1/3 of the current Recommended Dietary Allowance established by the Food & Nutrition Board of the National Academy of Sciences, and National Research Council.

When the participant's needs cannot be met by a Title III (Area Plan Contract) provider due to: geographic inaccessibility, special dietary needs, the time of day or week the meal is needed, or existing Title III provider waiting lists precluding service delivery, a meal may be provided by restaurants, cafeterias, or caterers who comply with the New Jersey State Department of Health and local Board of Health regulations for food service establishments. The need for this service must be specified in the participant's Plan of Care, and the unavailability of other resources to satisfy this need must be documented in the case record.

Home-Delivered Meals are not provided in an Assisted Living Facility or Adult Family Care as meal provision is included in the Assisted Living Facility or Adult Family Care service package. A Home-Delivered Meal is not to be used to replace the regular form of "board" associated with routine living in an Assisted Living Facility or Adult Family Care Home. Waiver participants eligible for non-Waiver nutritional services would access those services first.

b. Service Limits: A unit of service equals one meal.

Home-delivered meals are provided to an individual at home, and included in the Plan of Care only when the participant is unable to leave the home independently, unable to prepare the meal, and there is no other person, paid or unpaid, to prepare the meal.

No more than one meal per day will be reimbursed under the GO Waiver.

c. Provider Specification(s)

i. Title III Approved Provider of Meal Service

ii. Restaurant or Food Service Vendor (Individual Provider)

13. Service Name: Personal Emergency Response System (PERS)

a. Description: Personal Emergency Response System is an electronic device, which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable “help” button to allow for mobility. The system is connected to the person’s phone and programmed to signal a response center once a “help” button is activated. Personal Emergency Response System. Trained professionals staff the response center.

A Personal Emergency Response System unit may also include an electronic medication-dispensing device that allows for a set amount of medications to be dispensed as per the dosage instructions. If the medication is not removed from the unit in a timely manner the unit will “lock” that dosage, not allowing the participant access to the missed medication. Before locking, the unit will use a series of verbal and/or auditory reminders that the participant is to take his or her medication. If there is no response, a telephone call will be made to the participant, participant’s contact person, and care management site in that order until a “live” person is reached.

Installation, upkeep and maintenance of device/systems is provided.

Personal Emergency Response System is not available to individuals residing in Assisted Living Facilities (ALF) as it would duplicate services intrinsic to Assisted Living Facilities.

b. Service Limits: Personal Emergency Response System services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

c. Provider Specification(s)

i. Electronic communication equipment vendor & monitoring staff (Individual Provider)

14. Service Name: Social Adult Day Care

a. Description: Social Adult Day Care (SADC) is a community-based group program designed to meet the needs of adults with functional impairments through an individualized Plan of Care. Social Adult Day Care is a structured comprehensive program that provides a variety of health, social and related support services in a protective setting during any part of a day but less than 24-hour care.

Individuals who participate in Social Adult Day Care attend on a planned basis during specified hours. Social Adult Day Care assists its participants to remain in the community, enabling families and other caregivers to continue caring at home for a family member with impairment.

Social Adult Day Care services shall be provided for at least five consecutive hours daily, exclusive of any transportation time, up to five days a week.

b. Service Limits: Social Adult Day Care services shall be provided for at least five consecutive hours daily, exclusive of any transportation time, up to five days a week.

Social Adult Day Care is not available to those residing in an Assisted Living Facility as it would duplicate services required by the Assisted Living Licensing Regulations.

Social Adult Day Care cannot be combined with Adult Day Health Services.

The individual has no specific medical diagnosis requiring the oversight of an RN while in attendance at the Social Adult Day Care.

Assisted Living Program (ALP) participants, not ALR or CPCH participants may attend Social Adult Day Care 2 (two) days a week, and (3) three days with prior authorization by the Division of Aging and Community Services' County Liaison/Quality Assurance Specialist.

Adult Family Care (AFC) participants may attend Social Adult Day Care 2 (two) days a week, and (3) three days with prior authorization by the Division of Aging and Community Services' County Liaison/Quality Assurance Specialist.

c. Provider Specification(s)

i. Social Adult Day Care

15. Service Name: Specialized Medical Equipment and Supplies

a. Description: Specialized medical equipment and supplies is also a State Plan Service, but the scope of the Waiver coverage is materially different from the State plan service and the providers of the Waiver service may be different from the providers of the State plan service.

Specialized medical equipment (SME) and supplies as a Waiver service include (a) devices, controls, or appliances, specified in the Plan of Care, which enable individuals to increase their abilities to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the State plan that is necessary to address participant functional limitations; and, (e) necessary medical supplies not available under the State plan. Items reimbursed with Waiver funds are in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items, which are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.

SME items reimbursed with Waiver funds are in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items, which are not of direct medical or remedial benefit to the participant.

For verification of SME items covered in the State Plan, the Care Manager must contact the Medical Assistance Customer Center (MACC) in the applicable county.

b. Service Limits: Specialized medical equipment and supplies that cost \$250 or more (such as a lift chair) require prior authorization by the Division of Aging and Community Services' Central Office Staff and are not included in the spending cap.

SME, as a GO Waiver service, do not include supplies that are already included in the per diem reimbursement for the Assisted Living Program in Subsidized Housing, the Assisted Living (ALR/CPCH) service package, or the Adult Family Care option

c. Provider Specification(s)

i. Licensed Medicare Certified Home Health Agency

ii. Medical Supplier (Individual Provider)

iii. Various Approved Vendors (Individual Provider)

16. Service Name: Transitional Care Management

a. Description: Services which will assist individuals who are in a nursing facility or sub-acute unit of a hospital or nursing facility to gain access to Waiver services. Transitional Care Management services foster the transition from an institution to a community-based living arrangement.

Transitional Care Management involves the planning, arranging, and authorization of services necessary for the individual to transfer back to the community. Community Transition Services is the actual implementation of a set-up service identified as a need by the Transitional Care Manager and applicant during the planning stage of the relocation.

b. Service Limits: Transitional Care Management may be provided up to six months before the individual leaves the institutional setting. However, Medicaid cannot pay for transitional care management services until after the applicant moves into the community and enrolls in the GO waiver.

Transitional care management (TCM) services are not considered services that a GO participant will receive on a monthly basis. TCM may only be provided in certain circumstances with the purpose of facilitating the transition of a consumer from an institutional setting to the community.

Approved care management agencies may bill for one unit of the waiver service Transitional Care Management, at the designated price, i.e. \$200 for the initial transition/first month of GO enrollment when the Care Manager has participated in the Interdisciplinary Team meeting. When a GO participant has been admitted to a nursing facility and returns back to the community, the care management agency may bill up to \$285 (3 months x \$95 a month) for up to three months if

the Care Manager helped facilitate the transition back to the community, contacted the participant, and worked with the nursing facility staff for interdisciplinary team planning.

The initial fee for Transitional Care Management is billable only if the individual is discharged from the nursing facility/sub-acute unit and enrolled in GO as a new participant.

The Care Manager bills for Transitional Care Management in place of Initial Care Management for the first month of GO enrollment when the Care Manager participated in an IDT.

It is not permissible to bill for both Transitional Care Management and Initial Care Management for the same person.

The fee for Transitional Care Management for the GO participant who is readmitted to the NF is billable for up to three months only if the Care Manager makes the required contacts each month and the person is discharged back to the community.

- c. Provider Specification(s)
 - i. Accredited Registered Homemaker Agency
 - ii. Proprietary or Not-for-profit Care Management entity
 - iii. Adult Family Care Sponsor Agency
 - iv. Area Agency on Aging
 - v. County Welfare Agency
 - vi. Licensed Medicare Certified Home Health Agency

17. Service Name: Transportation

a. Description: Service offered in order to enable individuals served on the Waiver to gain access to Waiver and other community services, activities and resources specified in the Plan of Care. This service is offered in addition to medical transportation required under 42 Code of Federal Regulations 431.53 and transportation services under the State plan, defined at 42 Code of Federal Regulations 440.170(a) (if applicable), and shall not replace them. Transportation services under the Waiver shall be offered in accordance with the individual's Plan of Care. Whenever possible, family, neighbors, friends, or community agencies, which can provide this service without charge, will be utilized. Transportation as a Waiver service is one that enhances the individual's quality of life. An approved provider may transport the participant to shopping, to the beauty salon, the bank, or to the religious services of his or her choice.

b. Service Limits: Services are limited to those that are required for implementation of the Plan of Care.

Transportation incidental to the provision of another service is not reimbursable.

Reimbursement for private vehicles will be set at the State rate of mileage reimbursement.

When available, appropriate to the participant's need and capabilities, and cost-effective, transportation shall also mean the use of public transit, tickets, etc.

- c. Provider Specification(s)
 - i. Adult Family Care Caregiver or substitute caregiver
 - ii. Participant Employed Provider (PEP) (Individual Provider)
 - iii. Transportation Provider Registered as a Business in NJ

Community Resources for People with Disabilities (CRPD) (Formerly HCBS Waiver Base #NJ4133)

1. Service Name: Case Management

a. Description: Case Management services are those which assist waiver participants in gaining access to needed waiver and specific State Plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Case managers shall be responsible for the assessment and re-assessment, at specified intervals, of the need for waiver services; development and review of the service plan; ongoing monitoring of the provision of services included in the participants plan of care; coordinating among multiple providers and/or multiple waiver services; and monitoring the service plan and participant's health and welfare. The case manager shall initiate process of re-evaluation of the participant's level of care at the specified intervals and address any problems in service provision.

b. Service Limits: N/A

c. Provider Specification(s):

- i. New Jersey Department of Health, Special Child Health Services, Case Management Services
- ii. County Welfare Agency
- iii. Licensed Certified Home Health Agency
- iv. A Proprietary or Not-for-Profit Case Management Agency that has met requirements pursuant to NJSA 45:11-26 and NJSA 45:15BB and is a Medicaid approved provider.
- v. Non-Profit Freestanding Community Health Center
- vi. Non-Profit, Registered, Accredited Homemaker Agency

2. Service Name: Community Transitional Services

a. Description: CTS are those services provided to a participant that may aid in the transitioning from institutional settings to his/her own home in the community through coverage of one-time transitional expenses. Examples of those expenses include the cost of furnishing an apartment (basic living items such as bed, table, chairs, window blinds, eating utensils, and food preparation items); moving expenses required to occupy and use a community domicile; the expense of security deposits; utility connection fees (e.g. telephone, electricity, gas, etc.); health and safety assurances such as pest eradication, allergen control, or one-time cleaning prior to occupancy. These services may not constitute payment for housing or for rent. The concept of essential furnishings does not include diversional or recreational items (TV, VCR, cable access, etc.). Reasonable costs are necessary expenses in the judgment of the State for an individual to establish his or her basic living arrangement. The addition of the fiscal intermediary is the modification to the provider specifications. Previously the provider of the specific service was required to execute a purchase agreement with the case manager; now that agreement is between the fiscal intermediary and the service provider.

b. Service Limits: As noted, these are one-time expenses and delivered on an as-needed basis.

c. Provider Specification(s)

i. Fiscal Intermediary

3. Service Name: Environmental/Residential Modification

a. Description: Those physical modifications/adaptations to a participant's home required by his/her plan of care which are necessary to ensure the health, welfare and safety of the individual, or which enable him/her to function with greater independence in the home or community and without which the individual would require institutionalization. Such adaptations may include the installation of ramps and grab bars, widening of doorways, modifications of bathrooms, or installation of specialized electrical or plumbing systems that are necessary to accommodate the medical equipment and supplies which are needed for the welfare of the individual. The addition of the fiscal intermediary is the modification to the provider specifications. Previously the provider of the specific service was required to execute a purchase agreement with the case management agency; now that agreement is between the fiscal intermediary and the service provider.

b. Service Limits: Excluded from this service are those modifications to the home that are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which increase the square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State/local building codes. This is not a stand-alone service. The participant must need other home and community-based services supporting the return to the community (de-institutionalization) or to remain in the community (at risk of nursing facility placement).

c. Provider Specification(s)

i. Fiscal Intermediary

4. Service Name: Personal Emergency Response Service (PERS)

a. Description: PERS is an electronic device which enables participants at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and is programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. The service consists of two components both of which are managed by the PERS contractor; first is the initial installation of the equipment and the second is the monitoring of the service by staff at the response center. The addition of the fiscal intermediary is the modification to the provider specifications. Previously the provider of the specific service was required to execute a purchase agreement with the case management agency; now that agreement is between the fiscal intermediary and the service provider.

b. Service Limits: PERS services are limited to those individuals who live alone or who are alone for significant portions of the day and who have no regular caregiver for extended portions of time and who would otherwise require extensive routine supervision. PERS is not available to individuals who live in congregate settings.

c. Provider Specification(s)

i. Fiscal Intermediary

5. Service Name: Private Duty Nursing

a. Description: Individual and continuous care (in contrast to part-time or intermittent care) provided by licensed nurses within the scope of the State law. These services are provided to an individual at home.

b. Service Limits: To receive private duty nursing, a participant must be assessed by the DDS to require individual and continuous care provided by a licensed nurse. Private duty nursing will be provided only when there is a live-in primary caregiver (adult relative or significant other adult) who accepts 24-hour responsibility for the health and welfare of the participant. Private duty nursing shall be limited per person to a maximum of 16 hours in a 24-hour period.

c. Provider Specification(s)

i. Licensed Certified Home Health Agency

ii. Registered, Accredited Private Duty Nursing Agency

6. Service Name: Vehicular Modification

a. Description: The service includes needed vehicle modification (such as electronic monitoring systems to enhance beneficiary safety, mechanical lifts to make access possible) to a

participant or family vehicle as defined in an approved plan of care. Modifications must be needed to ensure the health, welfare and safety of a participant or which enable the individual to function more independently in the home or community. All services shall be provided in accordance with applicable State motor vehicle codes. The addition of the fiscal intermediary is the modification to the provider specifications. Previously the provider of the specific service was required to execute a purchase agreement with the case management agency; now that agreement is between the fiscal intermediary and the service provider.

b. Service Limits: Excluded are those adaptations/modifications to the vehicle which are of general utility, and are not of direct medical or remedial benefit to the participant. Maintenance of the normal vehicle systems is not permitted as a part of this service; neither is the purchase/leasing of a vehicle. This is not a stand-alone service and the participant requesting this service must also require ongoing waiver services supporting the return to the community (de-institutionalization) or to remain in the community (at risk of placement).

c. Provider Specification(s)

i. Fiscal Intermediary

AIDS Community Care Alternatives Program (ACCAP)

1. Service Name: Case Management

a. Description: Case Management services are those which assist waiver participants in gaining access to needed waiver and specific State Plan services as well as needed medical, social, educational and other services regardless of the funding source for the service to which access is gained. Case Managers shall be responsible for the assessment and re-assessment of the need for waiver services, development and review of the service plan; ongoing monitoring of the provision of services included in the participant's plan of care; coordinating among multiple providers and/or multiple services; and monitoring the service plan and participant's health and welfare. The case manager shall initiate the process of re-evaluation of the participant's level of care at the specific intervals and address any problems in service provision.

b. Service Limits: N/A

c. Provider Specification(s):

i. Licensed, Certified Home Health Agency

ii. Non-Profit, Freestanding Community Health Centers

iii. Hospital

iv. Private, Incorporated Case Management Firm

v. Non-Profit, Accredited, Registered Homemaker Agency

vi. New Jersey Department of Health, Special Child Health Services, Case Management Services

vii. A Proprietary or Not-for-Profit Case Management Agency that has met requirements pursuant to NJSA 45:11-26 and NJSA 45:15BB, and is a Medicaid approved provider.

2. Service Name: Personal Care Assistant

a. Description: Personal Care Assistant Services (PCA) are those services rendered by a certified homemaker-home health aide to assist a waiver participant with his/her activities of daily living (ADL). ADL are the functions or tasks for self-care which are performed either independently or with supervision or assistance. Activities of daily living include at least mobility, transferring, walking, grooming, bathing, dressing and undressing, eating, and toileting. Services can be provided up to 24 hours a day, based on medical need and available CAP dollars. The State Plan PCA service is a maximum of 40-hours per week.

b. Service Limits: N/A

c. Provider Specification(s)

i. Licensed, Certified Home Health Agency

ii. Registered, Accredited Homemaker Agency

3. Service Name: Private Duty Nursing

a. Description: Individual and continuous care (in contrast to part-time or intermittent care) provided by licensed nurses within the scope of the State law. These services are provided to an individual at home.

b. Service Limits: To receive private duty nursing, a participant must be assessed by the DDS to require individual and continuous care provided by a licensed nurse. Private duty nursing will be provided only when there is a live-in primary caregiver (adult relative or significant other adult) who accepts 24-hour responsibility for the health and welfare of the participant and provides a minimum of 8-hours of care.

Private duty nursing shall be limited per person to a maximum of 16 hours in a 24-hour period.

c. Provider Specification(s)

i. Licensed Certified Home Health Agency

ii. Registered, Accredited Homemaker Agency

Traumatic Brain Injury (TBI) Program

1. **Service Name:** Case Management
 - a. **Description:** Services which will assist individuals who receive waiver services in gaining access to needed waiver and specific State Plan services, as well as needed medical, social, education, and other services regardless of the funding source for the services to which access is gained. Case Managers are responsible for planning, locating, coordinating, authorizing, and monitoring a group of services designed to meet the needs of the participant. As well as developing the plan of care with the waiver participant and for monitoring the cost of the service package.
 - b. **Service Limits:** All TBI program participants receive monthly (face-to-face visits) services from their case manager.
 - c. **Provider Specification(s):**
 - i. Agency provider that is a privately incorporated case management firm.
 - ii. Agency provider that is a proprietary or non-for-profit Case Management Agency that has met requirements pursuant to NJSA 45:11-26 and NJSA 45:15BB, and is a approved Medicaid provider.
 - iii. A private incorporated case management consulting firm.
 - iv. A licensed certified home health agency.
2. **Service Name:** Respite
 - a. **Description:** Services provided to participants unable to care for themselves, furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. Respite services are provided in the participant's home (place of residence) or a Community Residential Services (CRS) provider.
 - b. **Service Limits:** This service is only available to participants who are NOT receiving services in a Community Residential Services (CRS) setting and living at home.
 - c. **Provider Specification(s):**
 - i. A non-profit accredited, registered homemaker agency
 - ii. Community Residential Services (CRS) provider
 - iii. Licensed, certified home health agency
3. **Service Name:** Occupational Therapy
 - a. **Description:** This therapy service is extended beyond the parameters of the State Plan service definition. The expansion of therapy services allows TBI participants who are primarily ambulatory young adults with cognitive, behavioral, and physical defects to continue to receive this service even though they may no longer require intensive rehabilitation and have exhausted all Medicare or State Plan benefits for this service. Therapy shall continue to be offered alone or in combination with other TBI waiver services to enhance or maintain participant functioning as required by the plan of care. An occupational therapy provider shall be registered as an occupational therapist (OTR) with the American Occupational Therapy Association

(AOTA). A certified occupational therapy assistant (COTA) shall be registered with the AOTA and work under the direction of an OTR.

- i. An OTR and COTA shall be under contract to, or on the staff of, a licensed community residential services provider, rehabilitation hospital or agency, or home health agency which shall be reimbursed for the OT services.
- ii. OT may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five participants. The addition of OT group session is a modification of the service definition.
- iii. All therapy services are a part of the approved waiver care plan prepared by the TBI waiver case manager with input from the participant, involved parties, and providers. Case managers are required to send a confirmation of services letter to providers of services delineating exactly what services and from what payment source they are to be provided. Therapy services under the waiver are fee-for-service with billing codes exclusive to services provided to TBI participants. Should a participant still qualify for therapy services under Medicare or State Plan, those payment sources and the duration of that source are identified on the participant care plan. DDS monitors care plans at the case management sites on an ongoing basis and compares services on the approved care plan to paid claims reports which are provided monthly to DDS by Medicaid information systems.

b. **Service Limits:** Both group and individual session are 30 minutes in length. The therapist must record the time the therapy session started and when it ended in the participant's clinical record.

c. **Provider Specification(s):**

- i. A rehabilitation hospital
- ii. Community Residential Services (CRS) provider
- iii. Licensed, certified home health agency
- iv. Post-acute non-residential rehabilitative services provider agency

4. **Service Name:** Physical Therapy

- a. **Description:** This therapy service is extended beyond the parameters of the State Plan service definition. The expansion of therapy services allows TBI participants who are primarily ambulatory young adults with cognitive, behavioral, and physical defects to continue to receive this service even though they may no longer require intensive rehabilitation and have exhausted all Medicare or State Plan benefits for this service. Therapy shall continue to be offered alone or in combination with other TBI waiver services to enhance or maintain participant functioning as required by the plan of care. Physical therapists (PT) and physical therapy assistants (PTA) shall meet the New Jersey licensure standards and requirements for practice (see

N.J.A.C. 13:39A). PT and PTA shall be under contract to, or on the staff of, a licensed community residential services provider, rehabilitation hospital or agency, or home health agency which shall be reimbursed for the PT services.

- i. PT may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five participants. The addition of PT group session is a modification of the service definition.
 - ii. All therapy services are a part of the approved waiver care plan prepared by the TBI waiver case manager with input from the participant, involved parties, and providers. Case managers are required to send a confirmation of services letter to providers of services delineating exactly what services and from what payment source they are to be provided. Therapy services under the waiver are fee-for-service with billing codes exclusive to services provided to TBI participants. Should a participant still qualify for therapy services under Medicare or State Plan, those payment sources and the duration of that source are identified on the participant care plan. DDS monitors care plans at the case management sites on an ongoing basis and compares services on the approved care plan to paid claims reports which are provided monthly to DDS by Medicaid information systems.
 - b. **Service Limits:** Both group and individual session are 30 minutes in length. The therapist must record the time the therapy session started and when it ended in the participant's clinical record.
 - c. **Provider Specification(s):**
 - i. A rehabilitation hospital
 - ii. Community Residential Services (CRS) provider
 - iii. Licensed, certified home health agency
 - iv. Post-acute non-residential rehabilitative services provider agency
5. **Service Name:** Speech, Language, and Hearing Therapy (ST)
 - a. **Description:** This therapy service is extended beyond the parameters of the State Plan service definition. The expansion of therapy services allows TBI participants who are primarily ambulatory young adults with cognitive, behavioral, and physical defects to continue to receive this service even though they may no longer require intensive rehabilitation and have exhausted all Medicare or State Plan benefits for this service. Therapy shall continue to be offered alone or in combination with other TBI waiver services to enhance or maintain participant functioning as required by the plan of care. A speech-language pathologist provider shall be licensed by the State of New Jersey (see N.J.A.C. 13:44C). A speech-language pathologist shall be under contract to a community residential services provider,

rehabilitation hospital or agency, or home health agency, which shall be reimbursed for the speech-language therapy services.

- i. ST may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five participants. The addition of ST group session is a modification of the service definition.
 - ii. All therapy services are a part of the approved waiver care plan prepared by the TBI waiver case manager with input from the participant, involved parties, and providers. Case managers are required to send a confirmation of services letter to providers of services delineating exactly what services and from what payment source they are to be provided. Therapy services under the waiver are fee-for-service with billing codes exclusive to services provided to TBI participants. Should a participant still qualify for therapy services under Medicare or State Plan, those payment sources and the duration of that source are identified on the participant care plan. DDS monitors care plans at the case management sites on an ongoing basis and compares services on the approved care plan to paid claims reports which are provided monthly to DDS by Medicaid information systems.
- b. **Service Limits:** Both group and individual session are 30 minutes in length. The therapist must record the time the therapy session started and when it ended in the participant's clinical record.
- c. **Provider Specification(s):**
- i. A rehabilitation hospital
 - ii. Community Residential Services (CRS) provider
 - iii. Licensed, certified home health agency
 - iv. Post-acute non-residential rehabilitative services provider agency

6. **Service Name:** Behavioral Management

- a. **Description:** A daily program provided by, and under the supervision of, a licensed psychologist or board-certified/board-eligible psychiatrist and by trained behavioral aides designed to service recipients who display severe maladaptive or aggressive behavior which is potentially destructive to self or others. The program, provided in the home or out of the home, is time-limited and designed to treat the individual and caregivers, if appropriate, on a short-term basis. Behavioral programming includes a complete assessment of the maladaptive behavior(s); development of a structured behavioral modification plan, implementation of the plan, ongoing training and supervision of caregivers and behavioral aides, and periodic reassessment of the plan. The goal of the program is to return the individual to the prior level of functioning which is safe for him/her and others. The average timeframe needed to provide this service is usually four to six months.

- i. Program enrollment requires prior evaluation and recommendation of a board-certified and eligible psychiatrist, a licensed neuropsychologist or neuro-psychiatrist with subsequent consultation by same on an as-needed basis. The case manager shall also prior authorize the service.
 - b. **Service Limits:** Both group and individual session are 30 minutes in length. The therapist must record the time the therapy session started and when it ended in the participant's clinical record.
 - c. **Provider Specification(s):**
 - i. A board-certified and board-eligible psychiatrist
 - ii. Clinical psychologist
 - iii. Mental Health Agency
 - iv. A rehabilitation hospital
 - v. Community Residential Services (CRS) provider
 - vi. Post-acute non-residential rehabilitative services provider agency
- 7. **Service Name:** Cognitive Rehabilitative Therapy
 - a. **Description:** "systematic, functionally-oriented service of therapeutic cognitive activities, based on an assessment and understanding of the person's brain-behavior deficits." "Services are directed to achieve functional changes by (1) reinforcing, strengthening, or reestablishing previously learned patterns of behavior, or (2) establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems " (Harley, et al., 1992, p.63).
 - i. As defined by the Brain Injury Interdisciplinary Special Interest Group (BI-ISIG) of the American Congress of Rehabilitation Medicine, and is quoted by the Society for Cognitive Rehabilitation. Therapeutic interventions include but are not limited to direct retraining, use of compensatory strategies, use of cognitive orthotics and prostheses, etc. Activity type and frequency are determined by assessment of the participant, the development of a treatment plan based on recognized deficits, and periodic reassessments.
 - ii. Cognitive rehabilitation therapy can be provided in various settings, including but not limited to the individual's own home and community, outpatient rehabilitation facilities, or residential programs. This service may be provided by rehabilitation professionals with the following credentials, training, experience, and supervision:
 - iii. Training
 - 1. Minimum of a master's or degree in an allied health field from an accredited institution or holds licensure and or certification or
 - 2. Minimum of bachelor's degree from an accredited institution in allied health fields where the degree is sufficient for licensure, certification or registration or in

fields where licensure, certification or registration are not available (i.e. special education) or

3. Applicable degree programs including but not limited to communication disorders (speech), counseling, education, psychology, physical therapy, occupational therapy, recreation therapy, social work, and special education.
4. Certified Occupational Therapy Assistants (COTA'S) and Physical Therapy Assistants (PTA'S) may provide CRT only under the guidelines described in the New Jersey practice acts for occupational and physical therapists.
5. Staff members who meet the above-mentioned degree requirements, but are not licensed or certified, may practice under the supervision of a rehabilitation practitioner who is licensed and/or meets the criteria for certification by the Society for Cognitive Rehabilitation (actual certification is not necessary so long as criteria is met).

iv. Supervision

1. This service must be coordinated and overseen by a CRT provider holding at least a master's degree. Provided by a rehabilitation professional that is licensed or certified. The master's level CRT provider must ensure that bachelor's level CRT providers receive the appropriate level of supervision, as delineated below.
 2. Supervision for CRT providers who are not licensed or certified is based on number of years of experience
 - a. 1) For staff with less than 1 year of experience: 4 hours of individual supervision per month.
 - b. 2) 1 to 5 years experience: 2 hours individual supervision per month
 - c. 3) More than 5 years experience: 1 hour per month
 - v. All individuals who provide or supervise the CRT service must complete 6 hours of relevant ongoing training in CRT and or brain injury rehabilitation. Training may include, but is not limited to, participation in seminars, workshops, conferences, and in-services.
- b. **Service Limits:** Daily limits as delineated by the participants plan of care. Frequency and duration of service must be supported by assessment and included in participant care plan.
- i. CRT may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five participants. The addition of CRT group session and the

provider qualifications and service is a modification of the service.

- ii. Both group and individual session are 30 minutes in length. The therapist must record the time the therapy session started and when it ended in the participant's clinical record.

c. **Provider Specification(s):**

- i. A rehabilitation hospital
- ii. Community Residential Services (CRS) provider
- iii. Post-acute non-residential rehabilitative services provider agency

8. **Service Name:** Community Residential Services (CRS)

- a. **Description:** A package of services provided to a participant living in the community, residence-owned, rented, or supervised by a CRS provider. The services include personal care, companion services, chore services, transportation, night supervision, and recreational activities. The service does not include room and board and personal needs which will be paid by the participant. A CRS is a participant's "home." The bundling of these services distinguishes supervision/residential services from the unique day program services provided under the waiver at the CRS as well.

- i. The CRS provider is responsible for coordinating the service to ensure the participant's safety and access to services as determined by the participant and TBI waiver case manager. Waiver participants are assigned one of three levels of supervision. These levels are determined by the dependency of the participant. The case manager, in conjunction with CRS staff, evaluate participant, using the "TBI WAIVER LEVEL OF CARE GUIDELINES FOR CRS" form. This form, on file at DDS and available to CMS upon request, lists categories of dependency. Level I is indicative of a high level of independence; Level II is indicative of a moderate level of dependence; and Level III representing the highest level of dependency or the need for the 2-person lift.

- ii. The State will make retainer payments for providers of Community Residential Services (CRS) when the waiver participant is hospitalized or absent from his/her home for a period of no more than 30 consecutive days. For hospital absences and related absences (e.g., rehabilitation time in a rehabilitation unit) the service plan does not need to reflect the absence. For all other absences, the service plan shall reflect the need for absence from the home.

- b. **Service Limits:** The level of assessment is assessed minimally on an annual basis, more frequently if there is a change in participants care. Service is not rendered in conjunction with service provider retainer. Only one level of service can be billed per 24-hour period (12:00 a.m. to 11:59 p.m.)

- c. **Provider Specification(s):**
 - i. Community Residential Services (CRS) provider
9. **Service Name:** Counseling
- a. **Description:** Counseling of an intensive or long-term nature to resolve interpsychic or interpersonal conflicts resulting from the head injury may be provided to participant and family, if necessary. Counseling as an adjunct to a behavioral program may be provided in severe cases. Counseling for a substance abuse problem should be provided by a Certified Alcohol and Drug Counselor familiar with head injury or a local alcohol/drug treatment program. Due to the high correlation between TBI and substance abuse, detailed drug/alcohol abuse history should be obtained by the case manager for each participant to monitor a potential for substance abuse. Waiver services should be utilized only if state plan counseling services for mental health or drug treatment are either unavailable or inappropriate to meet participant needs.
 - i. Under the TBI waiver, the service of counseling can be billed by mental health agencies, family service agencies, or clinical psychologists. Registered nurses (45:11-26) or licensed clinical social workers (45:1-15) may provide this service as an employee of one of the agencies listed in the provider categories under Appendix C:3-1. Additionally, a licensed clinical social worker may provide this service under the supervision of a clinical psychologist as listed in Appendix C:3-1 under the “Individual” provider specification.
 - b. **Service Limits:** n/a
 - c. **Provider Specification(s):**
 - i. Clinical psychologist
 - ii. Family Services Agency
 - iii. Mental Health Agency
10. **Service Name:** Environmental/Vehicular Modifications
- a. **Description:**
 - i. Those physical modifications/adaptations to a participant's home required by his/her plan of care which are necessary to ensure the health, welfare and safety of the individual, or which enable him/her to function with greater independence in the home or community and without which the individual would require institutionalization. Such adaptations may include the installation of ramps and grab bars, widening of doorways, modifications of bathrooms, or installation of specialized electrical or plumbing systems that are necessary to accommodate the medical equipment and supplies which are needed for the welfare of the participant.
 - ii. Vehicle modification; such as, electronic monitoring systems to enhance beneficiary safety, mechanical lifts to make access possible to a participant's or family's vehicle as defined in an

approved plan of care are acceptable services. Modification must be needed to ensure the health, welfare and safety of a participant or which enable the individual to function more independently in the home or community. All services shall be provided in accordance with applicable State motor vehicle codes.

- b. **Service Limits:** Excluded from this service are those modifications to the home that are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which increase the square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State/local building codes. This is not a stand-alone service. The participant must need other home and community-based services supporting the return to the community (de-institutionalizations) or to remain in the community (at risk of nursing facility placement).
 - i. Excluded are those adaptations/modifications to the vehicle which are of general utility, and are not of direct medical or remedial benefit to the participant. Maintenance of the normal vehicle systems is not permitted as a part of this service; neither is the purchase/leasing of a vehicle. This is not a stand-alone service and the participant requesting this service must also require ongoing waiver services supporting the return to the community (de-institutionalization) or to remain in the community (at risk of placement).
 - ii. This service is not available to participants living in Community Residential Services (CRS) settings. Residence modifications are the responsibility of the CRS provider.
 - iii. The case manager must project what impact the cost of the environmental/vehicular modification will have on the participant's monthly service caps.
- c. **Provider Specification(s):**
 - i. Fiscal intermediary

11. Service Name: Structured Day Program

- a. **Description:** A program of productive supervised activities, directed at the development and maintenance of independent and community living skills.
 - i. Services will be provided in a setting separate from the home in which the participant lives. Services may include group or individualized life skills training that will prepare the participant for community reintegration, including but not limited to attention skills, task completion, problem solving, money management, and safety. This service will include nutritional supervision, health monitoring, and recreation as appropriate to the individualized care plan. The service is provided in half day (3 hours) or full day (6 hours or more,

including lunch) segments. The program will not cover services paid for by other agencies. The program excludes medical day care, which may be provided as a State Plan Service.

- b. **Service Limits:** If the participant is in a full structured day program, the combined total number of additional therapy (OT, PT, ST, CRT) sessions (30 minute intervals) cannot exceed six.
- c. **Provider Specification(s):**
 - i. Post-acute, non-residential rehabilitation services provider agency
 - ii. Comprehensive Outpatient Rehabilitation Facility; Post-acute Day Program
 - iii. Community Residential Services (CRS) provider
 - iv. Rehabilitation Hospital (outpatient)

12. Service Name: Supported Day Services

- a. **Description:** A program of individual activities directed at the development of productive activity patterns, requiring initial and periodic oversight, at least monthly, from a professional holding at least a Master's degree in a rehabilitation related discipline (including but not limited to; Psychology, Social Work, PT, OT, SLP, Nursing, CRC, etc.) to sustain the program. This service may be provided by rehabilitation staff at the paraprofessional level (minimum of 48 college credits) or higher, and the program and service providers will receive ongoing supervision from a licensed or certified professional at a minimum, in addition to the clinical oversight provided by the aforementioned Master's level rehabilitation professional.
 - i. This service is provided in the home or community, not within a Structured Day Program or CRS setting. Activities that support this service include but are not limited to therapeutic recreation, volunteer activities, household management, shopping for food, household goods, clothing, etc., negotiating various components of activities in the community, building social supports in the community etc.
 - ii. The professional support will be reimbursed on an hourly basis, depending on the amount of support required. Supported Day Services are provided as an alternative to Structure Day Program when the participant does not require continual supervision.
 - iii. Registered nurses (NJSА 45:11-26) and licensed clinical social workers (NJSА 45:1-15) may provide this service when employed by an approved provider agency such as a mental health agency or family service agency. Licensed, clinical social worker may provide this service if under the supervision of a psychologist who is listed as an individual provider under specifications for this waiver service.

- b. **Service Limits:** Services are not to be provided in a setting where the setting itself is already paid to supervise the participant. Limits in service should be delineated by assessment of the person receiving the service, as directed by the Master's level Rehabilitation professional as noted above.
 - i. The amount, frequency, and duration of this service are determined by the recommendation made by the qualified professional identified above to the TBI waiver case manager. The case manager develops the plan of care, taking the professional's recommendations into account when developing the total service package necessary to maintain the participant in the home/community environment within the confines of the monthly service cap.
- c. **Provider Specification(s):**
 - i. Psychologist
 - ii. Family Services Agency
 - iii. Post-acute, non-residential rehabilitation services provider agency
 - iv. Community Residential Services (CRS) provider
 - v. Mental Health Agency

Attachment D
SED Program
Service Definitions

SED Program Overview

The SED Program provides behavioral health services for children up to age 21 who have been diagnosed as seriously emotionally disturbed which places them at risk for hospitalization and out-of-home placement. The program serves two primary purposes. First, it allows for Medicaid eligibility based on SED determination irrespective of parental income to extend SED services to more youth. Secondly, three new services that have been found to be critical for the success of youth we are serving are being created. The goals of the program are to:

- i. improve participants emotional stability;
- ii. maintain children in the community and increase community integration;
- iii. support youth with SED that are transitioning into adulthood;
- iv. improve participants success in a wide range of life domains;
- v. reduce residential lengths of stay by providing a less restrictive but medically appropriate treatment option;
- vi. reduce acute hospitalization lengths of stay and recidivism; and,
- vii. improve social and educational functioning and reduce incidents of criminal activity for those children eligible for the program.

1. Service Name: Transitioning Youth Life Skill Building

- a. Service Description: Services that will assist youth ages 16 to 21 that have an SED and are transitioning out of child behavioral health services into adult life and possibly adult mental health services. The service is aimed at building the core communication and self-organizational skills needed for a Demonstration participant to manage his or her own life's affairs as they transition into adulthood. The self-empowerment enhancing service will provide education and guidance in the areas of continuing education, professional skill building/training, finances, personal health, relationships, parenthood, transportation, community connections and resources, and many other areas that will focus on the basic skills needed to successfully integrate into a community and avoid incarceration, homelessness, and hospitalization. The provider of these services is responsible for developing a structured curriculum that utilizes individual and/or small group sessions. DCF will develop a policy explaining the core components of an acceptable curriculum and all curriculums will be required to adhere to this policy. The curriculum must be approved by the NJ Department of Children and Families and will be consistent with services provided to youth who are aging out of the child welfare system.
- b. Service Limits: This service must be a part of a comprehensive individualized service plan developed by a Care Management Organization (CMO) and prior authorized by the ASO. The youth must be currently authorized and receiving care management services from a CMO. Frequency and duration of service must be supported by the NJ System of Care Strength and Needs Assessment Tool and included in the Demonstration participant's individualized service plan. This service must be provided in a community setting and is not to be used in a residential or hospital setting.
- c. Provider Specification:

- i. A licensed community mental health provider
- ii. A state-certified Intensive In-Community and Behavioral Assistance provider

2. Service Name: Youth Support and Training

- a. **Service Description:** Services that will assist youth ages 5 to 16 to provide guidance, training, and support, to include positive role modeling, to help the youth be successful with basic activities of life such as peer and family relationships, social interactions, responding to authority, personal health, school functioning, internet/social media safety, spirituality, and many other areas that will focus on the basic skills needed to successfully function at home, in school and in their community.

Service Limits: This service must be a part of a comprehensive individualized service plan developed by a Care Management Organization (CMO) and prior authorized by the ASO.

These services are to be provided on an individual basis, not a group setting. The youth must be currently authorized and receiving care management services from a CMO. Frequency and duration of service must be supported by the NJ System of Care Strength and Needs

Assessment Tool and included in the Demonstration participant's individualized service plan.

This service must be provide in a community setting and is not to be used in a residential or hospital setting. This service is limited to no more than 5 hours per week and a total of 120 hours in any 12 month period.

- b. **Provider Specification:**
 - i. These services are provided by individuals that are employed by an approved agency, successfully complete a criminal background check, and are trained in the basics of child safety and development. The providers of these services are not expected to be licensed mental health professionals. Providers may include:
 - 1. A licensed community mental health provider
 - 2. A state-certified Intensive In-Community and Behavioral Assistance provider

3. Non-medical transportation

- a. **Service Description:** This transportation service will be provided to children from ages 5 to 21 and/or their primary caregiver that are determined by the Care Management Organization to be in need of short-term transportation to and/or from a non-medical activity that is an integral part of the youth's individualized service plan where there are no other feasible transportation options. These non-medical services could include, but are not limited to, recreational activities, youth training sessions, transitioning youth services, after-school programs not associated with a youth's Individual Education Plan (IEP), and parent support services.

- b. **Service Limits:** This service must be a part of a comprehensive individualized service plan developed by a Care Management Organization (CMO) and prior authorized by the ASO. The youth must be currently authorized and receiving care management services from a CMO. Frequency and duration of service must be supported by the NJ System of Care Strength and Needs Assessment Tool and included in the Demonstration participant's individualized service plan. This service must be provided in a community setting and is not to be used in a residential or hospital setting. This service is limited to 3 roundtrip transports a week and a total of 36 roundtrip transports per year.

- c. **Provider Specification:**

- i. Agency that has met the qualifications as specified by the Department of Human Services (DHS) or the Department of Children and Families (DCF): or
- ii. Authorized Medicaid provider.

MATI - Medically Assisted Treatment Initiative

MATI Methadone, Suboxone, and Substance Abuse (SA) Clinical Services

Effective July 1, 2013, or a date thereafter, the treatment program delivers a comprehensive array of medication-assisted treatment and other clinical services through MATI provider mobile and office-based sites. The program goals include:

- the reduction in the spread of blood borne diseases through sharing of syringes;
- the reduction of opioid and other drug dependence among eligible participants;
- the stabilization of chronic mental health and physical health conditions; and,
- improved housing and employment outcomes among program participants.

Eligibility: Demonstration enrollees receiving these services must be screened by the mobile or fixed site service provider using a standardized clinical and functional assessment tool that will be independently reviewed by appropriate qualified clinicians to determine if the applicants meets the following criteria:

- be a resident of New Jersey and at least 18 years old;
- have household income at or below 150% of the FPL;
- have a history of injectable drug use;
- test positive for opiates or have a documented one-year history of opiate dependence.

Service Name	Description	Comment	Unit Value
Methodone medication and dispensing in a licensed opioid treatment facility*	The MATI program will follow the Medicaid state plan with no variance.	N/A	4.25 dose
Suboxone medication and dispensing in a licensed opioid treatment facility*	The MATI program will exceed the State plan limit for this service; however, all other components to the Medicaid state plan will apply.	The Medicaid state plan includes suboxone in the Rx formulary but does not include dispensing in an opioid treatment facility.	7.25-11.38 depending on dose
Medication Monitoring - MAT*	The MATI program will exceed the State plan limit for this service; however, all other components to the Medicaid state plan will apply.	MATI participants will receive up to 2 units of medication monitoring a day and no more than 2 units a month.	42
Comprehensive Assessment in a SA treatment facility	The state plan does not include this MATI service.	MATI participants will receive up to 4 units of comprehensive assessment annually.	26.00 thirty minutes
Outpatient substance abuse counseling individual*	The MATI program will follow the Medicaid state plan with no variance.	N/A	24.50 thirty minutes
Outpatient substance abuse counseling group*	The MATI program will follow the Medicaid state plan with no variance.	N/A	23.00 hour
Cognitive Behavioral Motivational Therapy - Group	The state plan does not include this MATI service.	MATI participants will receive up to 16 units of CBT group a month and no more than 1 in a single day.	25.00 hour

MATI - Medically Assisted Treatment Initiative

Intensive Outpatient Treatment in a SA treatment facility	The state plan does not include this MATI service.	MATI participants will receive up to 18 units of IOP a month and no more than 1 in a single day.	71.00 day
Outpatient - Family Counseling/ Education in a SA treatment facility	The state plan does not include this MATI service.	MATI participants will receive up to 2 units of family counseling/education a month.	49.00 hour
Case Management -Recovery Support	The state plan does not include this MATI service.	MATI participants will receive up to 8 units of CBT group a month.	12.00 fifteen minutes
Urine Drug Screen - Collection **	The state plan does not include this MATI service.	MATI participants are eligible for collection of up to 8 specimens a month and no more than 1 in a single day.	8.00 per collection
Oral Swab Drug Screen - Collection**	The state plan does not include this MATI service.	MATI participants are eligible for collection of up to 8 specimens a month and no more than 1 in a single day.	8.00 per collection
TB test*	The MATI program will follow the Medicaid state plan with no variance.	N/A	10.00 per test
Continuing Care Review - LOCI	The state plan does not include this MATI service.	MATI participants will receive up to 1 continuing care review a month.	25.00 twenty minutes

MATI - Medically Assisted Treatment Initiative

MATI Co-Occurring Mental Health and Substance Use Disorder Services ¹			
Service Name	Description	Comment	
Case Management - co-occurring disorder in a SA treatment facility	The state plan does not include this MATI service.	MATI participants will receive up to 8 units of case management a month.	12.00 fifteen minutes
Comprehensive Evaluation - co-occurring disorder in a SA treatment facility	The state plan does not include this MATI service.	MATI participants are eligible for up to 6 units of comprehensive intake evaluation in a month.	26.00 thirty minutes
Crisis Intervention - co-occurring disorder in a SA treatment facility	The state plan does not include this MATI service.	MATI participants will receive up to 8 units of crisis intervention a month and no more than 8 units in a single day.	13.00 fifteen minutes
Family Therapy (with patient)*	The MATI program will follow the Medicaid state plan with no variance.	N/A	24.50 thirty minutes
Family Therapy (without patient)	The state plan does not include this MATI service.	MATI participants are eligible for up to 10 units of family therapy a month and no more than 2 units in a single day.	24.50 thirty minutes
Individual Therapy *	The MATI program will follow the Medicaid state plan with no variance.	N/A	24.50 thirty minutes
Clinical Consultation - co-occurring disorder in a SA treatment facility	The state plan does not include this MATI service.	MATI participants will receive up to 6 units of clinical consultation a month and no more than 4 units in a single day.	25.00 thirty minutes
Medication Monitoring -Co-Occuring*	The MATI program will follow the Medicaid state plan with no variance.	N/A	42.00 fifteen minutes
Psychiatric Evaluation*	The MATI program will follow the Medicaid state plan with no variance.	N/A	32.00 fifteen minutes

MATI - Medically Assisted Treatment Initiative

MATI Residential Community-Based SA Treatemnt Services ²			
Service Name	Description	Comment	
Short Term Residential	N/A	N/A	147.00 day
Long Term Residential	N/A	N/A	68.00 day
Halfway House	N/A	N/A	57.00 day
Detoxification Level III.7	N/A	N/A	204.00 day
Medically Enhanced Detoxification Level III.7 D Enhanced	N/A	N/A	416.00 day

* MATI rates for these services are higher than State Plan service rates.

** Does not include single or multiuse device lab testing.

¹Co-Occurring services were not included in original budget projection; however, anticipated costs for these services will not exceed projected costs for the program. The independent assessment component in the original budget is no longer required.

²These services are subject to IMD exclusion and not proposed for state plan inclusion; however, MATI participants will be able to access these services through state funds based on clinical need.

ATTACHMENT F – BHO/ASO BENEFIT AND PAYMENT TABLE

Services	Payment Methodology/ Responsibility
Ambulatory care	
Assessment and treatment of a BH condition when provided by a BHO authorized provider	FFS/ASO/BHO
Assessment and treatment of a BH condition when provided by a MCO authorized provider (i.e., PCP office visit for depression)	MCO
Services utilizing methadone treatment for maintenance, Cyclazocine, or their equivalents	FFS/ASO/BHO
24-hour care	
Admission to an acute care hospital, psychiatric facility or other specialty facility when ordered by a BHO authorized provider for the treatment of a BH condition, excluding detoxification	FFS/ASO/BHO
Admission by a BHO authorized provider for subacute medically managed detoxification or subacute enhanced detoxification	FFS/ASO/BHO
Detoxification in a medical bed for acute withdrawal, seizures, Delirium Tremens or medical instability when ordered by a MCO authorized provider	MCO
Stabilization in a medical bed or in ICU for treatment of eating disorders or following attempted suicide or self-induced trauma poisoning	MCO
Emergency department (ED)	
Facility and professional fees for primary BH diagnoses (codes 291 to 319 except as noted under “Miscellaneous” at the end of this table)	FFS/ASO/BHO

Services	Payment Methodology/ Responsibility
Facility charges and professional fees for primary PH diagnosis, including medical stabilization for attempted suicide or self-induced trauma poisoning	MCO
Consults	
BH consult on medical surgical unit, nursing home or assisted living facility, with the exception of individuals in MLTSS who will have their BH services provided by the MCO.	Determinant is treating provider type
Medical/surgical consult on a BH unit	MCO
Prescription Drugs	
Prescription drugs – outpatient cost of drug including atypical antipsychotic drugs and medications for addictions treatment (ie, buprenorphine) except methadone for addiction treatment	MCO
In office administration (i.e., medication assisted therapies, injectable drugs)	Determinant is treating provider type
Methadone maintenance programs	FFS/ASO/BHO
Ambulance	
Transport to the hospital when primary diagnosis is medical, including medical stabilization for suicide attempt, and transfers from psychiatric or substance use disorder treatment bed to a medical bed	MCO
Outpatient diagnostic procedures	
When ordered by a BHO network provider (i.e., x-rays, EKG, laboratory work such as therapeutic drug levels, complete drug count (CBC), urinalysis, etc.)	Determinant is treating provider type

Services	Payment Methodology/ Responsibility
When ordered by a MCO network provider (i.e., tests ordered prior to having a patient medically cleared or for the evaluation of medical problems such as CT scans, thyroid studies, EKG, etc.)	MCO
Psychological testing	
Psychological or neuropsychological testing when approved by the BHO	FFS/ASO/BHO
Neuropsychological testing when ordered by a MCO authorized provider as part of a comprehensive neurological evaluation or treatment program	MCO
Miscellaneous	
Any BH service delivered through an FQHC	Determinant is treating provider type
Electroconvulsive therapy, including anesthesiology services	FFS/ASO/BHO
Assessment and treatment of chronic pain	Determinant is treating provider type
TBI – out patient psycho-therapy, psychiatric consultation	Determinant is treating provider type
TBI – medical or medical rehabilitation programs	MCO
Treatment for caffeine related disorders	MCO
Treatment for nicotine related disorders (including smoking cessation programs)	Determinant is treating provider type

Services	Payment Methodology/ Responsibility
Treatment for disorders which are primarily neurologically or organically based, including delirium, dementia, amnesia and other cognitive disorders	MCO
Treatment for Korsakoff's disease/Wernicke's	MCO
Treatment for fetal alcohol syndrome or other symptoms exhibited by newborns whose mothers abused drugs	MCO
Treatment for primary sleep disorders	Excluded

NJ DSRIP Planning Protocol Addendum 1 - Stage 3 Measures Catalogue

Measure Count	Measure Name	NQF	Measure Steward	NJ Data Source	Eligible for Pay for Performance (P4P)?	Reporting Period (Placeholder)	NJ Improvement Target Goal (Placeholder)	National Benchmark (Placeholder)
Project 1 - Hospital-Based Educators Teach Optimal Asthma Care								
1.1	CAC-1: Relievers for Inpatient Asthma	0143	The Joint Commission	MMIS	No			
1.2	CAC-2 systemic corticosteroids for Inpatient Asthma	0144	The Joint Commission	MMIS	No			
1.3	Use of Appropriate Medications for People with Asthma	0036	NCQA	MMIS	No			
1.4	Medication Management for People with Asthma - 75%	1799	NCQA	MMIS	P4P			
1.5	Percent of patients who have had a visit to an Emergency Department (ED)/ Urgent Care office for asthma in the past six months.	Not Found	HRSA	MMIS	P4P			
1.6	CMS Core Adult Measure PQI-15 (Asthma Admission Rate)	0283	AHRQ	MMIS	P4P			
1.7	Asthma admission rate (area-level): rate per 100,000 population	Not Found	AHRQ	MMIS	P4P			
Project 2 - Pediatric Asthma Case Management and Home Evaluations								
2.1	CAC-1: Relievers for Inpatient Asthma	0143	The Joint Commission	MMIS	No			
2.2	CAC-2 systemic corticosteroids for Inpatient Asthma	0144	The Joint Commission	MMIS	No			
2.3	Use of Appropriate Medications for People with Asthma	0036	NCQA	MMIS	No			
2.4	Medication Management for People with Asthma - 75%	1799	NCQA	MMIS	P4P			
2.5	Percent of patients who have had a visit to an Emergency Department (ED)/Urgent Care office for asthma in the past six months.	Not Found	HRSA	MMIS	P4P			

NJ DSRIP Planning Protocol Addendum 1 - Stage 3 Measures Catalogue

Measure Count	Measure Name	NQF	Measure Steward	NJ Data Source	Eligible for Pay for Performance (P4P)?	Reporting Period (Placeholder)	NJ Improvement Target Goal (Placeholder)	National Benchmark (Placeholder)
2.6	Percent of patients evaluated for environmental triggers other than environmental tobacco smoke (dust mites, cats, dogs, molds/fungi, cockroaches) either by history of exposure and/or by allergy testing.	Not Found	HRSA	Chart/ EHR	P4P			
2.7	Asthma admission rate (area-level): rate per 100,000 population	Not Found	AHRQ	MMIS	P4P			
Project 3 – Integrated Health Home for the Seriously Mentally Ill (SMI)								
3.1	Follow-up After Hospitalization for Mental Illness – <i>30 days post discharge</i>	0576	NCQA	MMIS	No			
3.2	Antidepressant Medication Management – <i>Effective Continuation Phase Treatment</i>	0105	NCQA	MMIS	No			
3.3	Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications (SSD)	1932	NCQA	MMIS	No			
3.4	Major Depressive Disorder (MDD): Suicide Risk Assessment	0104	AMA-PCPI	Chart/EHR	No			
3.5	Mental Health Utilization	Not Found	NCQA	MMIS	No			
3.6	Follow-up After Hospitalization for Mental Illness – <i>7 days post discharge</i>	0576	NCQA	MMIS	P4P			
3.7	Antidepressant Medication Management – <i>Effective Acute Phase Treatment</i>	0105	NCQA	MMIS	P4P			
3.8	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	0110	CQAIMH	Chart/EHR	P4P			
3.9	Depression Remission at 12 Months	0710	Minnesota Community Measurement	Chart/ EHR	P4P			

NJ DSRIP Planning Protocol Addendum 1 - Stage 3 Measures Catalogue

Measure Count	Measure Name	NQF	Measure Steward	NJ Data Source	Eligible for Pay for Performance (P4P)?	Reporting Period (Placeholder)	NJ Improvement Target Goal (Placeholder)	National Benchmark (Placeholder)
Project 4 – Day Program and School Support Expansion								
4.1	Follow-up After Hospitalization for Mental Illness – <i>30 days post discharge</i>	0576	NCQA	MMIS	No			
4.2	Mental Health Utilization	Not Found	NCQA	MMIS	No			
4.3	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	1365	AMA-PCPI	MMIS	No			
4.4	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	0024	NCQA	MMIS	No			
4.5	Follow-up After Hospitalization for Mental Illness – <i>7 days post discharge</i>	0576	NCQA	MMIS	P4P			
4.6	Screening for Clinical Depression and Follow-up Plan	0418	CMS	Chart/ EHR	P4P			
4.7	Follow-up Care for Children Prescribed ADHD Medication (ADD)	0108	NCQA	MMIS	P4P			
4.8	Adolescent Well-Care visits	Not Found	NCQA	MMIS	P4P			
Project 5 – Electronic Self-Assessment Decision Support Tool								
5.1	Follow-up After Hospitalization for Mental Illness – <i>30 days post discharge</i>	0576	NCQA	MMIS	No			
5.2	Bipolar Disorder and Major Depression: Appraisal for alcohol or chemical substance use	0110	CQAIMH	Chart/ EHR	No			
5.3	Screening for Clinical Depression and Follow-up Plan	0418	CMS	Chart/ EHR	No			
5.4	Mental Health Utilization	Not Found	NCQA	MMIS	No			
5.5	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	0024	NCQA	MMIS	No			
5.6	Adult BMI Assessment	Not Found	NCQA	MMIS	No			

NJ DSRIP Planning Protocol Addendum 1 - Stage 3 Measures Catalogue

Measure Count	Measure Name	NQF	Measure Steward	NJ Data Source	Eligible for Pay for Performance (P4P)?	Reporting Period (Placeholder)	NJ Improvement Target Goal (Placeholder)	National Benchmark (Placeholder)
5.7	Adolescent Well-Care Visit	Not Found	NCQA	MMIS	No			
5.8	Follow-up After Hospitalization for Mental Illness – 7 days post discharge	0576	NCQA	MMIS	P4P			
5.9	Depression Remission at 12 Months	0710	Minnesota Community Measurement	Chart/ EHR	P4P			
5.10	Follow-up Care for Children Prescribed ADHD Medication (ADD)	0108	NCQA	MMIIS	P4P			
5.11	Antidepressant Medication Management – Effective Acute Phase Treatment	0105	NCQA	MMIS	P4P			
Project 6 – Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions								
6.1	Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction	0081	AMA-PCPI	Chart/ EHR	No			
6.2	Controlling High Blood Pressure	0018	NCQA	Chart/ EHR	No			
6.3	Post-Discharge Appointment for Heart Failure Patients	Not Found	AMA-PCPI	Chart/ EHR	No			
6.4	Medication Reconciliation	0097	NCQA	Chart/ EHR	No			
6.5	Care Transition Measure (CTM-3)	0228	University of Colorado	Chart/ EHR	P4P			
6.6	30-Day All-Cause Readmission Following Heart Failure (HF) Hospitalization	0330	The Joint Commission	MMIS	P4P			
6.7	30-Day All-Cause Readmission Following Acute Myocardial Infarction (AMI) Hospitalization	0505	The Joint Commission	MMIS	P4P			
6.8	Heart Failure Admission Rate	0277	AHRQ	MMIS	P4P			
6.9	Timely Transmission of Transition Record	0648	AMA-PCPI	Chart/ EHR	P4P			

NJ DSRIP Planning Protocol Addendum 1 - Stage 3 Measures Catalogue

Measure Count	Measure Name	NQF	Measure Steward	NJ Data Source	Eligible for Pay for Performance (P4P)?	Reporting Period (Placeholder)	NJ Improvement Target Goal (Placeholder)	National Benchmark (Placeholder)
Project 7 – Extensive Patient CHF-Focused Multi-Therapeutic Model								
7.1	Left Ventricular Ejection Fraction (LVEF) Assessment	0079	AMA-PCPI	MMIS	No			
7.2	Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction	0081	AMA-PCPI	Chart/ EHR	No			
7.3	Controlling High Blood Pressure	0018	NCQA	Chart/ EHR	No			
7.4	Post-Discharge Appointment for Heart Failure Patients	Not Found	AMA-PCPI	Chart/ EHR	No			
7.5	Medication Reconciliation	0097	NCQA	Chart/ EHR	No			
7.6	Care Transition Measure (CTM-3)	0228	University of Colorado	Chart/ EHR	P4P			
7.7	30-Day All-Cause Readmission Following Heart Failure (HF) Hospitalization	0330	The Joint Commission	MMIS	P4P			
7.8	30-Day All-Cause Readmission Following Acute Myocardial Infarction (AMI) Hospitalization	0505	The Joint Commission	MMIS	P4P			
7.9	Heart Failure Admission Rate	0277	AHRQ	MMIS	P4P			
Project 8 – The Congestive Heart Failure Transition Program (CHF-TP)								
8.1	Left Ventricular Ejection Fraction (LVEF) Assessment	0079	AMA-PCPI	MMIS	No			
8.2	Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction	0081	AMA-PCPI	Chart/ EHR	No			
8.3	Controlling High Blood Pressure	0018	NCQA	Chart/ EHR	No			
8.4	Post-Discharge Appointment for Heart Failure Patients	Not Found	AMA-PCPI	Chart/ EHR	No			
8.5	Medication Reconciliation	0097	NCQA	Chart/ EHR	No			
8.6	Care Transition Measure (CTM-3)	0228	University of Colorado	Chart/ EHR	P4P			

NJ DSRIP Planning Protocol Addendum 1 - Stage 3 Measures Catalogue

Measure Count	Measure Name	NQF	Measure Steward	NJ Data Source	Eligible for Pay for Performance (P4P)?	Reporting Period (Placeholder)	NJ Improvement Target Goal (Placeholder)	National Benchmark (Placeholder)
8.7	30-Day All-Cause Readmission Following Heart Failure (HF) Hospitalization	0330	The Joint Commission	MMIS	P4P			
8.8	30-Day All-Cause Readmission Following Acute Myocardial Infarction (AMI) Hospitalization	0505	The Joint Commission	MMIS	P4P			
8.9	Heart Failure Admission Rate	0277	AHRQ	MMIS	P4P			
Project 9 – Hospital-Wide Screening for Substance Use Disorder								
9.1	Percent of hospitalized patients who are screened during the hospital stay using a validated screening questionnaire for unhealthy alcohol use	Not Found	The Joint Commission	Chart/ EHR	No			
9.2	Percent of patients aged 18 years and older with a diagnosis of current substance abuse or dependence who were screened for depression within the 12 month reporting period	Not Found	AMA-PCPI	MMIS	No			
9.3	Initiation of alcohol and other drug treatment	0004	NCQA	MMIS	P4P			
9.4	Engagement of alcohol and other drug treatment	0004	NCQA	MMIS	P4P			
Project 10 – Hospital Partners with Residential Treatment Facility to Offer Alternative Setting to Intoxicated Patients								
10.1	Percentage of patients aged 18 years and older with a diagnosis of current alcohol dependence who were counseled regarding psychosocial and pharmacologic treatment options for alcohol dependence within the 12 month reporting period	Not Found	AMA-PCPI	Chart/ EHR	No			
10.2	Screening for Clinical Depression and Follow-up Plan	0418	CMS	Chart/ EHR	No			

NJ DSRIP Planning Protocol Addendum 1 - Stage 3 Measures Catalogue

Measure Count	Measure Name	NQF	Measure Steward	NJ Data Source	Eligible for Pay for Performance (P4P)?	Reporting Period (Placeholder)	NJ Improvement Target Goal (Placeholder)	National Benchmark (Placeholder)
10.3	Initiation of alcohol and other drug treatment	0004	NCQA	MMIS	P4P			
10.4	Engagement of alcohol and other drug treatment	0004	NCQA	MMIS	P4P			
Project 11 – Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension								
11.1	Lipid Management	Not Found	AMA-PCPI	MMIS	No			
11.2	Foot Examination	Not Found	AMA-PCPI	MMIS	No			
11.3	Eye Examination	Not Found	AMA-PCPI	MMIS	No			
11.4	Comprehensive Diabetes Care (CDC): Hemoglobin A1C (HbA1C) testing	0057	NCQA	MMIS	No			
11.5	Uncontrolled Diabetes Admission Rate (PQI 14)	0638	AHRQ	MMIS	P4P			
11.6	Diabetes Short-Term Complications Admission Rate (PQI 1)	0272	AHRQ	MMIS	P4P			
11.7	Hypertension Admission Rate	Not Found	AHRQ	MMIS	P4P			
11.8	Controlling High Blood Pressure	0061	NCQA	Chart/ EHR	P4P			
11.9	Diabetes Long-Term Complications Admission Rate (PQI 3)	0274	AHRQ	MMIS	P4P			
Project 12 – Diabetes Group Visits for Patients and Community Education								
12.1	Lipid Management	Not Found	AMA-PCPI	MMIS	No			
12.2	Foot Examination	Not Found	AMA-PCPI	MMIS	No			
12.3	Eye Examination	Not Found	AMA-PCPI	MMIS	No			
12.4	Comprehensive Diabetes Care (CDC) : Hemoglobin A1C (HbA1C) testing	0057	NCQA	MMIS	No			
12.5	Hemoglobin A1C Testing for Pediatric Patients	0060	NCQA	MMIS	No			

NJ DSRIP Planning Protocol Addendum 1 - Stage 3 Measures Catalogue

Measure Count	Measure Name	NQF	Measure Steward	NJ Data Source	Eligible for Pay for Performance (P4P)?	Reporting Period (Placeholder)	NJ Improvement Target Goal (Placeholder)	National Benchmark (Placeholder)
12.6	Controlling High Blood Pressure	0061	NCQA	Chart/ EHR	P4P			
12.7	Diabetes Short-Term Complications Admission Rate (PQI 1)	0272	AHRQ	MMIS	P4P			
12.8	Uncontrolled Diabetes Admission Rate (PQI 14)	0638	AHRQ	MMIS	P4P			
12.9	Diabetes Long-Term Complications Admission Rate (PQI 3)	0274	AHRQ	MMIS	P4P			
Project 13 – Develop Intensive Case Management for Medically Complex High Cost Patients								
13.1	Lipid Management	Not Found	AMA-PCPI	MMIS	No			
13.2	Foot Examination	Not Found	AMA-PCPI	MMIS	No			
13.3	Eye Examination	Not Found	AMA-PCPI	MMIS	No			
13.4	Comprehensive Diabetes Care (CDC) : Hemoglobin A1C (HbA1C) testing	0057	NCQA	MMIS	No			
13.5	Hemoglobin A1C Testing for Pediatric Patients	0060	NCQA	MMIS	No			
13.6	Controlling High Blood Pressure	0061	NCQA	Chart/ EHR	P4P			
13.7	Diabetes Short-Term Complications Admission Rate (PQI 1)	0272	AHRQ	MMIS	P4P			
13.8	Uncontrolled Diabetes Admission Rate (PQI 14)	0638	AHRQ	MMIS	P4P			
13.9	Diabetes Long-Term Complications Admission Rate (PQI 3)	0274	AHRQ	MMIS	P4P			
Project 14 – Patient Centered Medical Home for Patients with HIV/ AIDS								
14.1	CD4 T-Cell Count	Not Found	HRSA-HAB	MMIS	No			
14.2	HAART	Not Found	HRSA-HAB	Chart/ EHR	No			
14.3	Hepatitis C Screening	Not Found	AMA-PCPI	Chart/ EHR	No			
14.4	Gap in HIV Visits	2080	HRSA-HAB	MMIS	P4P			

NJ DSRIP Planning Protocol Addendum 1 - Stage 3 Measures Catalogue

Measure Count	Measure Name	NQF	Measure Steward	NJ Data Source	Eligible for Pay for Performance (P4P)?	Reporting Period (Placeholder)	NJ Improvement Target Goal (Placeholder)	National Benchmark (Placeholder)
14.5	Medical Case Management	Not Found	HRSA-HAB	Chart/ EHR	P4P			
14.6	HIV viral load suppression	2082	HRSA-HAB	Chart/ EHR	P4P			
14.7	PCP Prophylaxis	405	NCQA	Chart/ EHR	P4P			
Project 15 – After-School Obesity Program								
15.1	Percentage of mature adolescent and adult patients with an elevated body mass index (BMI greater than or equal to 25) who have set an individualized goal along with target date for reduction in BMI.	0421	ICSI	Chart/ EHR	No			
15.2	Children and Adolescents’ Access to Primary Care Practitioners	Not Found	NCQA	Chart/ EHR	No			
15.3	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	0024	NCQA	MMIS	P4P			
15.4	Children Age 6-17 Years who Engage in Weekly Physical Activity	1348	HRSA-MCHB	Chart/ EHR	P4P			
Project 16 – Wellness Program for Parents and Preschoolers								
16.1	Percentage of mature adolescent and adult patients with an elevated body mass index (BMI greater than or equal to 25) who have set an individualized goal along with target date for reduction in BMI.	0421	ICSI	Chart/ EHR	No			
16.2	Children and Adolescents’ Access to Primary Care Practitioners	Not Found	NCQA	Chart/ EHR	No			

NJ DSRIP Planning Protocol Addendum 1 - Stage 3 Measures Catalogue

Measure Count	Measure Name	NQF	Measure Steward	NJ Data Source	Eligible for Pay for Performance (P4P)?	Reporting Period (Placeholder)	NJ Improvement Target Goal (Placeholder)	National Benchmark (Placeholder)
16.3	Percentage of mature adolescent and adult patients with an elevated body mass index (BMI greater than or equal to 25) who receive education and counseling for weight loss strategies that include nutrition, physical activity, life style changes, medication therapy and/or surgery.	Not Found	ICSI	Chart/ EHR	P4P			
16.4	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents	0024	NCQA	Chart/ EHR	P4P			
Project 17 – Patients Receive Recommended Care for Community-Acquired Pneumonia								
17.1	Percentage of patients aged greater than or equal to 18 years diagnosed with community-acquired bacterial pneumonia who had a chest x-ray performed	Not Found	AMA	MMIS	No			
17.2	Percentage of patients aged greater than or equal to 18 years diagnosed with community-acquired bacterial pneumonia for whom mental status is assessed	Not Found	AMA	MMIS	No			
17.3	Initial antibiotic selection for community-acquired pneumonia (CAP) in immunocompetent patients – Non-Intensive Care Unit	Not Found	The Joint Commission	Chart/ EHR	No			
17.4	Initial antibiotic selection for community-acquired pneumonia (CAP) in immunocompetent patients – Intensive Care Unit (ICU)	Not Found	The Joint Commission	Chart/ EHR	No			
17.5	Initial antibiotic selection for community-acquired pneumonia (CAP) in immunocompetent patients	0147	CMS	Chart/ EHR	P4P			

NJ DSRIP Planning Protocol Addendum 1 - Stage 3 Measures Catalogue

Measure Count	Measure Name	NQF	Measure Steward	NJ Data Source	Eligible for Pay for Performance (P4P)?	Reporting Period (Placeholder)	NJ Improvement Target Goal (Placeholder)	National Benchmark (Placeholder)
17.6	30-Day All-Cause Readmission Following Pneumonia (PN) Hospitalization	0506	The Joint Commission	MMIS	P4P			

Acronym Key:

- AHRQ – Agency for Healthcare Research and Quality
- AMA – American Medical Association
- AMA- PCPI – American Medical Association – Physician Consortium for Performance Improvement
- CDC – Centers for Disease Control and Prevention
- CMS – Centers for Medicare & Medicaid Services
- CQAIHM – Center for Quality Assessment and Improvement in Mental Health
- EHR – Electronic Health Record
- HAB – HIV/AIDS Bureau
- HRSA – Health Resources and Services Administration
- ICSI – Institute for Clinical Systems Improvement
- MCHB – Maternal and Child Health Bureau
- MMIS – Medicaid Management Information System
- NCQA – National Committee for Quality Assurance
- P4P – Pay for Performance

NJ DSRIP Planning Protocol Addendum 2 - Stage 4 Measures Catalogue

Measure Count	Measure Name	NQF	Measure Steward	NJ Data Source	Reporting Period (Placeholder)	Eligible for Universal Performance Pool?	Eligible for Substitution for UPP?
1	Inpatient Utilization – General Hospital/ Acute Care	Not Found	NCQA	MMIS		No	No
2	Mental Health Utilization	Not Found	NCQA	MMIS		No	No
3	Pneumococcal Immunization (PPV 23)	1653	CMS	MMIS		No	No
4	Prophylactic Antibiotic Selection for Surgical Patients – Overall Rate	0528	CDC & Joint Commission	Chart/ EHR		No	No
5	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time – Overall Rate	0529	CDC & Joint Commission	Chart/ EHR		No	No
6	Urinary catheter removed on Postoperative Day 1 (POD 1) or Postoperative Day 2 (POD 2) with day of surgery being day zero	0453	CDC & Joint Commission	Chart/ EHR		No	No
7	Venous Thromboembolism Prophylaxis	0371	Joint Commission	Chart/ EHR		No	No
8	Intensive Care Unit Venous Thromboembolism Prophylaxis	0372	Joint Commission	Chart/ EHR		No	No
9	Venous Thromboembolism Patients Receiving Unfractionated Heparin with Dosages/ Platelet Count Monitoring by Protocol or Nomogram	Not Found	Joint Commission	Chart/ EHR		No	No
10	Venous Thromboembolism Warfarin Therapy Discharge Instructions	Not Found	Joint Commission	Chart/ EHR		No	No
11	Follow-up After Hospitalization for Mental Illness – 7 Days	0576	NCQA	MMIS		No	No
12	Engagement of alcohol and other drug treatment	0004	NCQA	MMIS		No	No
13	Percent of patients who have had a visit to an Emergency Department (ED)/ Urgent Care office for asthma in the past six months	Not Found	HRSA	MMIS		No	No
14	Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic*	0068	NCQA	Chart/ EHR		No	No
15	Preventive Care and Screening: High Blood Pressure*	Not Found	CMS	Chart/ EHR		No	No
16	Controlling High Blood Pressure*	0018	NCQA	Chart/ EHR		No	No
17	Comprehensive Diabetes Care: LDL-C Control <100mg/dL*	0064	NCQA	Chart/ EHR		No	No

NJ DSRIP Planning Protocol Addendum 2 - Stage 4 Measures Catalogue

Measure Count	Measure Description	NQF	Measure Steward	NJ Data	Reporting Period (Placeholder)	Eligible for Universal Performance Pool?	Eligible for Substitution for UPP?
18	Ischemic Vascular Disease (IVD): Complete Lipid Profile and LDL-C Control <100mg/dL*	0075	NCQA	Chart/ EHR		No	No
19	Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention*	0028	AMA-PCPI	Chart/ EHR		No	No
20	Annual Pediatric Hemoglobin A1C Testing	0060	NCQA	Chart/ EHR		No	No
21	CD4 T-Cell Count	Not Found	HRSA	MMIS		No	No
22	Gap in HIV Visits	2080	HRSA-HAB	MMIS		No	No
23	Breast Cancer Screening	0031	NCQA	MMIS		No	No
24	Cervical Cancer Screening	0032	NCQA	MMIS		No	No
25	Chlamydia Screening in Women Age 21 – 24	0033	NCQA	MMIS		No	No
26	Childhood Immunization Status	0038	NCQA	MMIS		No	No
27	Well-Child Visits in the First 15 Months of Life	1392	NCQA	MMIS		No	No
28	Child and Adolescent Access to Primary Care Practitioners	Not Found	NCQA	MMIS		No	No
29	Antenatal Steroids	0476	Joint Commission	Chart/ EHR		No	No
30	Hospital Acquired Potentially-Preventable Venous Thromboembolism	Not Found	Joint Commission	Chart/ EHR		UPP	No
31	Asthma in Younger Adults Admission	0283	AHRQ	MMIS		UPP	No
32	Diabetes Short-Term Complications Admission Rate	0272	AHRQ (Patient Quality Indicators)	MMIS		UPP	No
33	Ambulatory Care – Emergency Department Visits	Not Found	NCQA	MMIS		UPP	No
34	COPD Admission Rate	0275	AHRQ	MMIS		UPP	No
35	CHF Admission Rate	0277	AHRQ	MMIS		UPP	No
36	Central Line-Associated Bloodstream Infection (CLABSI) Event	0139	CDC	Chart/ EHR		UPP	No
37	Postoperative Sepsis	Not Found	AHRQ (Patient Safety Indicator)	Chart/ EHR		UPP	No

NJ DSRIP Planning Protocol Addendum 2 - Stage 4 Measures Catalogue

Measure Count	Measure Name	NQF	Measure Steward	NJ Data Source	Reporting Period (Placeholder)	Eligible for Universal Performance Pool?	Eligible for Substitution for UPP?
38	Pediatric Central-Line Associated Bloodstream Infections (CLABSI) – Neonatal Intensive Care Unit and Pediatric Intensive Care Unit**	0139	CDC	Chart/ EHR		UPP	No
39	Percentage of Live Births Weighing Less Than 2,500 grams**	Not Found	CDC	MMIS		UPP	No
40	Cesarean Rate for Nulliparous Singleton Visits**	Not Found	California Maternal Quality Care Collaborative	MMIS		UPP	No
41	Elective Delivery**	0469	Joint Commission	MMIS		UPP	No
42	30-Day All-Cause Readmission Following Heart Failure (HF) Hospitalization	0330	Joint Commission	MMIS		No	Yes
43	30-Day All-Cause Readmission Following Acute Myocardial Infarction (AMI) Hospitalization	0505	Joint Commission	MMIS		No	Yes
44	30-Day All-Cause Readmission Following Pneumonia (PN) Hospitalization	0506	Joint Commission	MMIS		No	Yes
45	30-Day All-Cause Readmission Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	1893	Joint Commission	MMIS		No	Yes

*This measure is included in the Million Hearts measure list. It may be used as a substitution for a cardiac measure when substitution is required.

**This measure may be replaced by a measure from the substitution list, but only if your hospital does not perform such services.

Acronym Key:

AHRQ – Agency for Healthcare Research and Quality
 AMA- PCPI – American Medical Association – Physician Consortium for Performance Improvement
 CDC – Centers for Disease Control and Prevention
 CMS – Centers for Medicare & Medicaid Services
 EHR – Electronic Health Record
 HRSA – Health Resources and Services Administration
 MMIS – Medicaid Management Information System
 NCQA – National Committee for Quality Assurance
 UPP – Universal Performance Pool

ATTACHMENT 1

New Jersey Delivery System Reform Incentive Payment (DSRIP)

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I. General Overview

A. Overview of DSRIP and Toolkit

The New Jersey Delivery System Reform Incentive Payment (DSRIP) program provides an opportunity to improve patient care for New Jersey's low income population by incentivizing delivery system reforms that improve access, enhance quality of care, and promote the health of patients and families they serve. These investments contribute directly to CMS' over-arching Triple Aim and position safety net providers for the emerging healthcare market where data, quality, and pay for performance foster competition among facilities and bend the health care cost curve.

In conjunction with the DSRIP Planning Protocol and the DSRIP Funding and Mechanics Protocol, this toolkit is to provide guidance surrounding both the requirements of the DSRIP Program and the completion of the hospital's DSRIP Plan.

B. Description of DSRIP Planning Protocol

The Department developed and submitted to CMS a DSRIP Planning Protocol approved by CMS on **XXX XX**, 2013. The DSRIP Planning Protocol is included as Attachment H of the Special Terms and Conditions (STCs) (as Amended) of the New Jersey Comprehensive Waiver ("Waiver"). The Planning Protocol, along with this toolkit:

- Outlines the global context, goals and outcomes that the State seeks to achieve through the combined implementation of individual projects by hospitals;
- Specifies the Project Stages and for each Stage specifies a menu of activities, along with their associated actions and milestones, metrics, and minimum submission requirements
- Details the requirements of the Hospital DSRIP Plans
- Includes a Department process of developing an evaluation of DSRIP as a component of the draft evaluation design as required by the STCs.

C. Description of DSRIP Funding and Mechanics Protocol

The Department developed and submitted to CMS a DSRIP Funding and Mechanics Protocol approved by CMS on **XXXX XX**, 2013. The DSRIP Funding and Mechanics Protocol is included as Attachment I of the STCs of the Waiver. DSRIP payments for each participating hospital are contingent on the hospital fully meeting project metrics defined in the approved hospital-specific Hospital DSRIP Plan. In order to receive funding relating to any metric, the hospital must submit all required reporting, as outlined in the DSRIP Funding and Mechanics Protocol and this toolkit, using the format and process agreed upon by the Department and CMS. The Funding and Mechanics Protocol, along with this toolkit:

- Includes guidelines requiring hospitals to develop individual Hospital DSRIP Plans, which shall include timelines and deadlines for the meeting of metrics associated with the projects and activities undertaken to ensure timely performance;
- Provides minimum standards for the process by which hospitals seek public input in the development of their Hospital DSRIP Plans, and provides that hospitals must include documentation of public input in their Hospital DSRIP Plans;



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- Specifies a Department review process and criteria to evaluate each hospital's individual Hospital DSRIP plan and develop its recommendation for approval or disapproval prior to submission to CMS for final approval;
- Specifies a process for obtaining CMS approval for a unique Focus Area that does not appear on the list included in this toolkit in Section III. Quality Projects or a unique project that falls under one of the prescribed focus areas but is not one of the 17 projects included in the project array;
- Allows sufficient time for CMS to conduct its review of the Hospital DSRIP Plans;
- Describes, and specifies the role and function, of a standardized, hospital-specific application to be submitted to the Department, and renewed on an annual basis for the utilization of DSRIP funds that outlines the hospital's DSRIP plan, as well as any databooks or reports that hospitals may be required to submit to report baseline information or substantiate progress;
- Specifies that hospitals must submit periodic reports to the Department using a standardized reporting form to document their progress (as measured by the specific metrics applicable to the projects that the hospitals have chosen), and qualify to receive DSRIP Payments if the specified performance levels were achieved;
- Specifies a review process and timeline to evaluate hospital progress on its DSRIP plan metrics in which first the Department and then CMS must certify that a hospital has met its approved metrics as a condition for the release of associated DSRIP funds to the hospital;
- Specifies an incentive payment formula to determine the total annual amount of DSRIP incentive payments each participating hospital may be eligible to receive in DY 2 through 5 and a formula for determining the incentive payment amounts associated with the specific activities and metrics selected by each hospital, such that the amount of incentive payment is commensurate with the value and level of effort required;
- Specifies that hospital's failure to fully meet a performance metric under its Hospital DSRIP Plan within the time frame specified will result in forfeiture of the associated incentive payment (i.e., no payment for partial fulfillment);
- Includes a yearly application process that allows for potential hospital plan modification and an identification of circumstances under which a plan modification may be considered;



II. Calendar - Timelines

A. Timeline of DSRIP Events

The following events represent hospital, Department, and CMS timelines for the DSRIP Program. Unless otherwise specified, denoted dates throughout the document refer to calendar days and any specified date that falls on a weekend or holiday is due the prior business day.

DSRIP Activity	Timeline
Hospital DSRIP Plan review and approval steps	
Target approval date by CMS of the NJ DSRIP Planning Protocol submitted to CMS	TBD
Target approval date by CMS of the NJ DSRIP Funding and Mechanics Protocol submitted to CMS	TBD
Hospital DSRIP Plan must be submitted to New Jersey Department of Health (NJDOH) if project is a unique focus area or “off-menu” from pre-defined list	September 9, 2013
Hospital DSRIP Plan submitted to NJDOH	September 20, 2013
Department completes initial review of Hospital DSRIP Plan; submits questions in writing to hospital	Within 45 days
Hospital responds in writing to Department questions	By timeframe indicated, but no later than 15 days from Department notification
Department finalizes review and submits approved hospital DSRIP Plans to CMS	December 13, 2013
Target approval/denial date by CMS of the Department approved Hospital DSRIP Plans; CMS may conditionally approve a plan with a requirement to modify deficiencies	January 31, 2014
Hospital’s DSRIP Plan re-submitted to NJDOH upon conditional approval by CMS	By timeframe indicated, but no later than 15 days from Department notification
Department completes review and submits revised Hospital DSRIP Plan to CMS	Within 30 days from CMS notification
Target approval/denial date by CMS of conditionally approved Hospital DSRIP Plans	March 17, 2014
Hospital DSRIP Plan due ONLY if that hospital meets the criteria for an Exceptional Circumstance	May 15, 2014
Department finalizes review and submits approved hospital DSRIP Plans that meet criteria for an Exceptional Circumstance to CMS	June 13, 2014
Target approval/denial date by CMS of the Department approved Hospital DSRIP Plans that meet criteria for an Exceptional Circumstance	August 29, 2014
Standardized reporting form and databook	
Toolkit is updated with the standardized reporting form and databook	November 15, 2013
Claims-based (i.e. MMIS) metric baseline results calculated and provided to hospitals	December 13, 2013
Hospital submits attestation of verification for claims-based measure results used in calculating the New Jersey Low Income baseline dataset	January 7, 2014
New Jersey Low Income Improvement Target Goals and Baseline Performance Thresholds established	January 31, 2014

B. Reporting Periods and Frequency



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The following reporting periods shall be followed by the hospitals participating in the DSRIP Program.

Reporting Activity	Description	Completion Month/Year	Minimum Submission Requirements
Quarterly Progress Report	Report Progress of Stage I, II, III, and IV Metrics by submitting all minimum submission requirements for each completed Stage I, II, III, and IV metric/milestone for the Demonstration Year in which the activity was completed.	April 30, 2014 (DY2) July 31, 2014 (DY3) October 31, 2014 (DY3) January 31, 2015 (DY3) April 30, 2015 (DY3) July 31, 2015 (DY4) October 31, 2015 (DY4) January 31, 2016 (DY4) April 30, 2016 (DY4) July 31, 2016 (DY5) October 31, 2016 (DY5) January 31, 2017 (DY5) April 30, 2017 (DY5)	<ul style="list-style-type: none"> • Progress Report submitted includes: <ul style="list-style-type: none"> ○ The progress of each process metric ○ Verification of Department calculated claims-based Stage 3 and Stage 4 metrics, including a description of how the hospital verified the reported metrics and an attestation of the verification (October and April progress reports). ○ The progress of current activities, including whether the stage activity has been completed, is in progress, or has not been started ○ Documentation supporting the completion of milestones during the report period ○ The infrastructure developments made and outcomes of those developments ○ The project developments and outcomes as they relate to the pilot populations ○ How rapid-cycle evaluation was used for improvement ○ Summary of the hospital's stakeholder engagement and activities ○ Work accomplished with external partners ○ How the project tools and processes were modified based on the pilot testing results ○ A timeline of future activities ○ Budget and return on investment analysis
Application Renewal for Demonstration Year 3	Hospital's annual application renewal to continue participation in the DSRIP Program.	April 30, 2014 (for DY3)	<ul style="list-style-type: none"> • Annual application renewal should be submitted to New Jersey Department of Health (DOH) and include: <ul style="list-style-type: none"> ○ Hospital's notification of intent to continue in the DSRIP Program in the following demonstration year ○ Annual Renewal Form, which will indicate any changes or modifications to the DSRIP Plan that the hospital may propose (subject to Department and CMS approval) in order to continue participation ○ For DY3 application, a description of the infrastructure expansions and the hospital's plan to begin utilizing them



Reporting Activity	Description	Completion Month/Year	Minimum Submission Requirements
			<ul style="list-style-type: none"> in Demonstration Year 3 o A timeline of future activities o Annual budget analysis that provides project budget estimation including line item expenditure information
Application Renewal for Demonstration Year 4	Hospital's annual application renewal to continue participation in the DSIRP Program.	April 30, 2015 (for DY4)	<ul style="list-style-type: none"> • Annual application renewal should be submitted to New Jersey Department of Health (DOH) and include: <ul style="list-style-type: none"> o Hospital's notification of intent to continue in the DSRIP Program in the following demonstration year o Annual Renewal Form, which will indicate any changes or modifications to the DSRIP Plan that the hospital may propose (subject to Department and CMS approval) in order to continue participation o For DY 4, a description of the project developments and outcomes as they relate to the pilot populations o For DY 4, a description of how the project tools and processes were modified based on the pilot testing results o A timeline of future activities • Annual budget analysis that provides project budget estimation including line item expenditure information
Application Renewal for Demonstration Year 5	Hospital's annual application renewal to continue participation in the DSIRP Program.	April 30, 2016 (for DY5)	<ul style="list-style-type: none"> • Annual application renewal should be submitted to New Jersey DOH and include: <ul style="list-style-type: none"> o Hospital's notification of intent to continue in the DSRIP Program in the following demonstration year o Annual Renewal Form, which will indicate any changes or modifications to the DSRIP Plan that the hospital may propose (subject to Department and CMS approval) in order to continue participation o Any changes/modifications to the project's infrastructure is documented along with the rationale for making such changes o A timeline of future activities o Annual budget analysis that provides project budget estimation including line item expenditure information

III. Quality Projects



A. Overview

In this section there are 17 pre-defined projects identified by the New Jersey Department of Health as the projects from which a participating DSRIP hospital can base their DSRIP Plan. These projects fall into one of the following project focus areas determined by the Department as being significant to the health and welfare of the State of New Jersey.

- Asthma
- Behavioral Health
- Cardiac Care
- Chemical Addictions/Substance Abuse
- Diabetes
- HIV/AIDS
- Obesity
- Pneumonia

Should a hospital deem another medical condition that does not fall under any of the above 8 focus areas unique to their hospital, or chooses to select a project within the eight conditions but is not one of the pre-defined projects (i.e. off-menu), the hospital may submit a DSRIP Plan under the application Focus Area labeled “Other.” A hospital choosing to submit a DSRIP Plan under the Focus Area “Other” is advised that by doing so, the plan will be subject to higher scrutiny since the project has not been approved by both the Department and CMS. Required application elements for “Other” Focus Area or off-menu projects are discussed in more detail under section **C. Project Elements** below.

B. Pre-defined Project Selection Process

The pre-defined projects were developed based on project ideas submitted by the hospital industry, the U.S. Agency for Healthcare Research and Quality (AHRQ) Health Care Innovations Exchange¹ project profiles, or a combination thereof.

AHRQ profiles describe successful evidence-based innovation activities. If a DSRIP project was developed based on an AHRQ profile, the profile link is footnoted on the project detail sheet along with its applicable Evidence Rating. As defined by AHRQ, the Evidence Rating is an assessment of the quality and strength of the evidence that the results described in the profile are due to the innovation and not to other factors. This information can be used to assist the hospital in selection and development of a project.

C. Project Elements

Each project detail sheet presents the project’s title, defined objective, high level methodology, anticipated outcomes and clinical performance measures. This information must be included within the hospital’s application submission. This will be *pre-populated* in the application based on the pre-defined project selected. The hospital is responsible for describing in further detail the manner and means by which the hospital will fulfill the project.

¹Agency for Healthcare Research and Quality (AHRQ) Health Care Innovations Exchange;
<http://www.innovations.ahrq.gov/index.aspx>



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Hospitals may select an “off-menu” project related to the focus area selected, however, this project will need to be completely developed by the hospital and will be subject to higher levels of scrutiny and review through the approval process. CMS approval will be required for all hospital unique focus areas and “off menu” projects. If the hospital chooses to select an “off-menu” project that is not one of the pre-defined projects, the hospital will be required to develop the project’s defined objective, high level methodology, anticipated outcomes, and project-specific metrics. The application contains descriptions for each field that the hospital must complete. Required application elements for “Other” Focus Area or off-menu projects are discussed in more detail in Section V of the Planning Protocol.

For each performance measure listed in Addendums 1 and 2, the Measure Steward is indicated. The Measure Steward is the entity that developed the performance measure and applicable measurement criteria. The calculation of the measure shall follow the technical specifications established by the Measure Steward. These technical specifications will be strictly followed, except for deviation as necessary based on patient population (e.g. Medicare vs New Jersey Low Income) and as approved by the Department and CMS. Each Stage 3 performance measure indicates whether it is tied to pay for performance (P4P).

Measurement specification instructions will be included in the Planning Protocol, Attachment 1: Toolkit. The Toolkit will be updated no later than November 15, 2013 with the standardized reporting form and databook. The databook will include measure reporting periods, baseline periods and will denote any modifications to the Measure Steward’s technical specifications in order to comply with the New Jersey Low Income attribution model.

D. Pre-Defined Quality Projects

The pre-defined quality projects, from which the hospitals may choose, are included on the following pages.



New Jersey DSRIP Toolkit

Condition	Asthma		
Project Count	1		
Project Title	Hospital-Based Educators Teach Optimal Asthma Care ²		
Project Objective			
Hospital-Based Asthma Educators provide education to patients, providers, and community members on optimum asthma care resulting in a decrease in inpatient admissions and Emergency Department visits.			
Project Methodology			
Develop a program where hospital-based certified asthma educators may perform any of the following:			
<ul style="list-style-type: none"> • Internal training of hospital staff on up-to-date asthma care including new medications and/or guidelines; educators also participate in grand rounds and provide copies of literature (i.e. Heart, Lung and Blood Institute clinical guidelines or other evidence-based literature) for the treatment of asthma in the Emergency Department and inpatient care settings. • Training of Primary Care Practices on up-to-date asthma care including new medications and/or guidelines. Staff also provides practices with various tools to assist clinicians with the management of asthma patients such as: clinical guidelines, patient questionnaires, triage questions, new asthma encounter forms, patient flow models, follow-up encounter forms, and/or a template for review of the chart, including billing and coding. • Education sessions with staff in childcare centers. • Work with nurses within the school system(s) to provide education on up-to-date asthma care and champion use of asthma action management and school plans. • Provide pharmacists with a web-based form they can use to alert physicians when a patient is frequently refilling a quick-relief asthma medication or has failed to refill an asthma controller medication. • Face-to-face meetings with individuals with asthma and their families to provide self-management instructions. Educator also contacts patient or parent/guardian for minors XX month(s) after the initial session to check on the patient's status and assess further educational needs. • Work with patient to ensure he or she has access to medications. 			
Project Outcomes			
<ol style="list-style-type: none"> 1. Reduce admissions 2. Reduce emergency department visits 3. Improve medication management 4. Increase patient satisfaction 			
Project Specific Metrics		P4P	Measure Steward
1. <i>CAC-1: Relievers for Inpatient Asthma:</i> Use of relievers in pediatric patients, age 2 years through 17 years, admitted for inpatient treatment of asthma.		No	Joint Commission
2. <i>CAC-2 systemic corticosteroids for Inpatient Asthma:</i> Use of systemic corticosteroids in pediatric asthma patients (age 2 through 17 years) admitted for inpatient treatment of asthma.		No	Joint Commission
3. <i>Use of Appropriate Medications for People with Asthma:</i> The percentage of members 5-64 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.		No	NCQA
4. <i>Medication Management for People with Asthma:</i> The percentage members 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period.		P4P	NCQA

² Based on a project study found on the (AHRQ) website: <http://www.innovations.ahrq.gov/content.aspx?id=2476>



New Jersey DSRIP Toolkit

Condition	Asthma		
Project Count	1		
Project Title	Hospital-Based Educators Teach Optimal Asthma Care²		
	<i>The percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.</i>		
5.	The percent of patients who have had a visit to an Emergency Department (ED) for asthma in the past six months.	P4P	HRSA
6.	CMS Core Adult measure PQI-15 (Asthma admission rate)	P4P	AHRQ
7.	<i>Adult Asthma Admission Rate:</i> This measure is used to assess the number of admissions for asthma in adults under the age of 40 per a 100,000 population.	P4P	NCQA

Agency for Healthcare Research and Quality (AHRQ) Evidence Rating: Moderate - *The evidence consists of pre- and post-implementation comparisons of key asthma outcomes, including medication compliance, asthma-related ED visits and hospitalizations, and workplace absenteeism, along with post-implementation patient survey results.*



New Jersey DSRIP Toolkit

Condition	Asthma	
Project Count	2	
Project Title	Pediatric Asthma Case Management and Home Evaluations ³	
Project Objective		
To implement Case Management and Home Evaluations in an effort to reduce admissions, Emergency Department visits and missed school days related to Asthma		
Project Methodology		
<p>Hospital develops (utilizes national asthma guidelines) asthma education program. Hospital electronic data system identifies children who had an inpatient admission or emergency department visit for asthma or asthma-related symptoms and generates a list. This list is sent to a Nurse Case Manager or Asthma Educator who may perform any the following services:</p> <ul style="list-style-type: none"> • Complete a patient needs assessment using a standardized questionnaire (may be performed while patient is inpatient or at home) • Perform allergy testing if deemed appropriate by the physician • Conduct Home visits which may include: <ul style="list-style-type: none"> ○ Asthma medication education ○ Development of a asthma action plan (includes information regarding symptoms and appropriate treatment for symptoms) ○ Assessment of environmental triggers ○ Removal of environmental triggers as appropriate (e.g. extermination services) ○ Providing equipment (e.g. garbage can with lids, air conditioning units, vacuum cleaners) and supplies (cleaning supplies etc.) ○ Education on available community resources and specialty care services • Communication with primary care physicians on patient care and referrals as needed • Perform educational workshops at various locations within the community • Advocacy for public policy asthma care issues <p>Hospital may consider having a number of parents of children who have participated in the program participate on a board to offer input on the program and plan community forums.</p>		
Project Outcomes		
<ol style="list-style-type: none"> 1. Reduce admissions 2. Reduce emergency department visits 3. Improve medication management 4. Reduce missed school days 5. Improve care processes 		
Project Specific Metrics	P4P	Measure Steward
1. <i>CAC-1: Relievers for Inpatient Asthma:</i> Use of relievers in pediatric patients, age 2 years through 17 years, admitted for inpatient treatment of asthma.	No	The Joint Commission
2. <i>CAC-2 systemic corticosteroids for Inpatient Asthma:</i> Use of systemic corticosteroids in pediatric asthma patients (age 2 through 17 years) admitted for inpatient treatment of asthma.	No	The Joint Commission
3. <i>Use of Appropriate Medications for People with Asthma:</i> The percentage of members 5-64 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.	No	NCQA
4. <i>Medication Management for People with Asthma:</i> The percentage of members (patients) 5-64 years of age during the measurement year who were identified as having persistent asthma and were dispensed appropriate medications that they remained on during the treatment period.	P4P	NCQA

³ Based on a project study performed in an urban setting found on the AHRQ website: <http://www.innovations.ahrq.gov/content.aspx?id=3220>



New Jersey DSRIP Toolkit

Condition	Asthma		
Project Count	2		
Project Title	Pediatric Asthma Case Management and Home Evaluations ³		
	<i>The percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.</i>		
5.	The percent of patients who have had a visit to an Emergency Department (ED) for asthma in the past six months.	P4P	HRSA
6.	The percent of patients evaluated for environmental triggers other than environmental tobacco smoke (dust mites, cats, dogs, molds/fungi, cockroaches) either by history of exposure and/or by allergy testing.	P4P	HRSA
7.	<i>Adult Asthma Admission Rate:</i> This measure is used to assess the number of admissions for asthma in adults under the age of 40 per a 100,000 population.	P4P	NCQA

AHRQ Evidence Rating: Moderate - *The evidence consists primarily of pre- and post-implementation comparisons of key outcomes measures, including asthma-related hospitalizations, ED visits, physical activity limitations, and missed school and parent work days, along with estimates of associated cost savings and the return on investment to all stakeholders.*



New Jersey DSRIP Toolkit

Condition	Behavioral Health		
Project Count	3		
Project Title	Integrated Health Home for the Seriously Mentally Ill (SMI) ⁴		
Project Objective			
To fully integrate behavioral health and physical health services for those with a serious mental illness (SMI) diagnosis in order to provide evidence-based whole-person care.			
Project Methodology			
<ul style="list-style-type: none"> • Ensure that each SMI-diagnosed patient has an ongoing relationship with a Medical and Psychiatric Licensed Independent Practitioner (LIP) in a co-located facility. • Ensure coordination and access to chronic disease management, including self-management support to those SMI individuals and their families. • Ensure the development of a single Treatment Plan that includes the member’s behavioral health issues, medical issues, substance abuse and social needs. This includes incorporating traditional medical interventions, such as gym memberships, nutrition monitoring and healthy lifestyle coaching. • Ensure that the Plan is maintained in one ambulatory Electronic Health Record (EHR) to ensure that information is shared across the treatment team and continuum of care spectrum. • Ensure that the treatment outcomes are evaluated and monitored for quality and safety for each patient. 			
Project Outcomes			
<ol style="list-style-type: none"> 1. Reduce readmissions 2. Reduce emergency department visits 3. Improve patient adherence to their treatment regimen 4. Improve care processes 			
Project Specific Metrics		P4P	Measure Steward
1. <i>Follow-up After Hospitalization for Mental Illness 30 days post discharge:</i> The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, in intensive outpatient encounter or partial hospitalization with a mental health practitioner.		No	NCQA
2. <i>Antidepressant Medication Management – Effective Continuation Phase Treatment:</i> The percentage of members 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment.		No	NCQA
3. Diabetes screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications (SSD)		No	NCQA
4. <i>Major Depressive Disorder (MDD):</i> Suicide Risk Assessment		No	AMA-PCPI
5. <i>Mental Health Utilization:</i> The number and percentage of members receiving the following mental health services during the measurement year. – any service, inpatient, intensive outpatient or partial hospitalization, outpatient or ED.		No	NCQA
6. <i>Follow-up After Hospitalization for Mental Illness 7 days post discharge:</i> The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, in intensive outpatient encounter or partial hospitalization with a mental health practitioner.		P4P	NCQA
7. <i>Antidepressant Medication Management – Effective Acute Phase Treatment:</i> The percentage of members 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment.		P4P	NCQA

⁴ Based on a project submitted by a New Jersey hospital.



New Jersey DSRIP Toolkit

Condition	Behavioral Health		
Project Count	3		
Project Title	Integrated Health Home for the Seriously Mentally Ill (SMI) ⁴		
8. <i>Bipolar Disorder and Major Depression</i> : Appraisal for alcohol or chemical substance use.		P4P	CQAIMH
9. <i>Depression Remission at 12 Months</i> : Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as a PHQ-9 score less than 5.		P4P	Minnesota Community Measurement



New Jersey DSRIP Toolkit

Condition	Behavioral Health		
Project Count	4		
Project Title	Day Program and School Support Expansion ⁵		
Project Objective			
<p>School aged children and adolescents suspended from classrooms due to severe behavioral health issues may be left unsupervised pending approval to return to school. Failure to properly manage the suspension of these students impedes treatment and can delay their return to the school setting.</p> <p>This pilot program has two primary objectives. The first is to provide space, therapy and instruction at the hospital’s ambulatory behavioral health center until the students are able to return to full-day attendance within the school setting. Treatment is provided by certified therapists and psychiatrists using evidence-based protocols for pediatric and adolescent care. The second is to expand the relationships and linkages between the behavioral health provider and the school district to ensure that the schools are supported in their efforts to assist students with behavioral health diagnoses.</p>			
Project Methodology			
<p>Children aged 6 through 19 years of age who have been suspended from classrooms due to severe behavioral health issues (i.e. violence, uncontrolled anger, inability to work in the school environment) will receive therapy through an expanded day program. All patients receive evidence-based therapeutic care and grade-appropriate education instruction. Children eligible for full-day sessions with progression to step down to half-day sessions (half-day attendance at the school) will receive care at the health center.</p> <p>This pilot program provides space, therapy and instruction at the hospital’s ambulatory behavioral health center until the students are able to return to school. Treatment is provided by certified therapists and psychiatrists using evidence-based protocols for pediatric and adolescent care. Lesson plans are per the school district, therapeutic intervention is per established evidence-based practice. The school district provides staff for instruction. Children return to school on the recommendation of the behavioral health staff and in consultation with school staff.</p> <p>In addition to enhancement of support for the individual student, the program will increase support mechanisms with the school district. This will ensure, at a minimum that the school personnel have effective referral, communication and education linkages available to assist them with supporting their students with behavioral health diagnoses in the school setting.</p>			
Project Outcomes			
<ol style="list-style-type: none"> 1. Reduce readmissions 2. Improve patient adherence to their treatment regimen 3. Improve care processes 4. Improve school education regarding behavioral health programming and referral processes 5. Lengthen the uninterrupted student tenure within the school setting 			
Project Specific Metrics		P4P	Measure Steward
1. <i>Follow-up After Hospitalization for Mental Illness 30 days post discharge:</i> The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, in intensive outpatient encounter or partial hospitalization with a mental health practitioner.		No	NCQA
2. <i>Mental Health Utilization:</i> The number and percentage of members receiving the following mental health services during the measurement year. – any service, inpatient, intensive outpatient or partial hospitalization, outpatient or ED		No	NCQA
3. <i>Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment:</i> Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk.		No	AMA-PCPI
4. <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents:</i> The percentage of members 3–17 years of age who had an outpatient		No	NCQA

⁵ Based on a project submitted by a New Jersey hospital.



New Jersey DSRIP Toolkit

Condition	Behavioral Health		
Project Count	4		
Project Title	Day Program and School Support Expansion ⁵		
visit with a PCP or OB/GYN and who had evidence of the following during the measurement year: <ul style="list-style-type: none"> • BMI percentile documentation* • Counseling for nutrition • Counseling for physical activity *Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.			
5. <i>Follow-up After Hospitalization for Mental Illness 7 days post discharge:</i> The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, in intensive outpatient encounter or partial hospitalization with a mental health practitioner.	P4P		NCQA
6. <i>Screening for Clinical Depression and Follow-up Plan:</i> Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	P4P		CMS
7. <i>Follow-Up Care for Children Prescribed ADHD Medication (ADD):</i> The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported- initiation and continuation phases.	P4P		NCQA
8. <i>Adolescent Well-Care Visit:</i> The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	No		NCQA



New Jersey DSRIP Toolkit

Condition	Behavioral Health			
Project Count	5			
Project Title	Electronic Self-Assessment Decision Support Tool ⁶			
Project Objective				
Implement an electronic self-assessment decision support tool that patients complete prior to visits with outpatient mental health providers in order to improve mental health consultations and treatment including efficiency and effectiveness of treatment planning, adherence and communication between the patient and the provider.				
Project Methodology				
Create, or implement an off-the-shelf decision support tool that a client completes immediately prior to their outpatient mental health visit. This tool would be available and utilized at the practitioner's office (via a private computer terminal, I-pad, etc.).				
<p>This tool should have the ability to generate a consultation report that both the clinician and the client may immediately refer to during the office visit. The electronic tool must allow the patient to report on their symptoms and functioning, medication compliance, concerns related to psychiatric medicine side-effects, eating, sleeping and social support network. The tool should immediately graph and trend the key indicators allowing the clinician to quickly determine areas of concern that must be addressed during the visit. This tool should allow the client to list and rate the relative importance of the benefits and drawbacks of recommended treatment regimens, recommend solutions to offset the drawbacks, and provide educational resources for the client to access.</p> <p>This survey allows the communication between the client and clinician to be focused as well as improve discussions around treatment plan options and efficacy. This shared decision-making allows the client to more fully engage in treatment planning, identifying both non-pharmacological strategies and medication therapies to improve patient wellness. This can improve adherence due to the patient's stronger sense of engagement, control and responsibility to the treatment regimen. Because the survey is completed at each visit, the tool helps clients monitor their recovery. At subsequent visits, clients and clinicians can use the tool to track trends in symptoms and links between symptoms and medication use.</p>				
Project Outcomes				
<ol style="list-style-type: none"> 1. Reduce readmissions 2. Improve patient-provider communication 3. Increase shared decision-making 4. Improve patient adherence to their treatment regimen 5. Improve care processes 				
Project Specific Metrics			P4P	Measure Steward
1. <i>Follow-up After Hospitalization for Mental Illness 30 days post discharge:</i> The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, in intensive outpatient encounter or partial hospitalization with a mental health practitioner.			No	NCQA
2. <i>Bipolar Disorder and Major Depression:</i> Appraisal for alcohol or chemical substance use			No	CQAIMH
3. <i>Screening for Clinical Depression and Follow-up Plan:</i> Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.			No	CMS
4. <i>Mental Health Utilization:</i> The number and percentage of members receiving the following mental health services during the measurement year. – any service, inpatient, intensive outpatient or partial hospitalization, outpatient or ED			No	NCQA
5. <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents:</i> The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year:			No	NCQA

⁶ Based on a project study found on the AHRQ website: <http://www.innovations.ahrq.gov/content.aspx?id=2870>



New Jersey DSRIP Toolkit

Condition	Behavioral Health		
Project Count	5		
Project Title	Electronic Self-Assessment Decision Support Tool ⁶		
	<ul style="list-style-type: none"> • BMI percentile documentation* • Counseling for nutrition • Counseling for physical activity <p>*Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.</p>		
6. <i>Adult BMI Assessment:</i>	This measure is used to assess the percentage of members 18 to 74 years of age who had an outpatient visit and whose body mass index (BMI) was documented during the measurement year or the year prior to the measurement year.	No	NCQA
7. <i>Adolescent Well-Care Visit:</i>	The percentage of enrolled members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	No	NCQA
8. <i>Follow-up After Hospitalization for Mental Illness 7 days post discharge:</i>	The percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, in intensive outpatient encounter or partial hospitalization with a mental health practitioner.	P4P	NCQA
9. <i>Depression Remission at 12 Months:</i>	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at twelve months defined as a PHQ-9 score less than 5.	P4P	Minnesota Community Measurement
10. <i>Follow-Up Care for Children Prescribed ADHD Medication (ADD):</i>	The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported- initiation and continuation phases.	P4P	NCQA
11. <i>Antidepressant Medication Management – Effective Acute Phase Treatment:</i>	The percentage of members 18 years of age and older who were diagnosed with a new episode of major depression and treated with antidepressant medication, and who remained on an antidepressant medication treatment.	P4P	NCQA

AHRQ Evidence Rating: Suggestive - The evidence consists of post-implementation analysis of use of the program and the shared decision-making approach (including analysis of 98 audiotaped transcripts from clinic visits), feedback from clinician and client focus groups on the efficiency and effectiveness of consultations, and the results from client surveys exploring various aspects of their satisfaction with the program.



New Jersey DSRIP Toolkit

Condition	Cardiac Care	
Project Count	6	
Project Title	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions ^{7,8}	
Project Objective		
To create an evidence-based Care Transitions Intervention Model for cardiac care. This includes the development and support of the use of hospital Patient Navigators to assist in accessing prevention and follow-up treatment for patients experiencing chronic cardiac illness.		
Project Methodology		
<p>The hospital will implement an evidence-based Care Transitions Intervention Model for cardiac care, such as the model developed by Dr. Eric A Coleman, MD, MPH, Associate Professor of Medicine within the Divisions of Health Care Policy and Research and Geriatric Medicine at the University of Colorado Health Sciences, aimed at improving quality and safety during times of care “hand-offs”.</p> <p>The model will focus on patient education before and after they leave the hospital to ensure the patient and caregivers are knowledgeable about medications and their uses, as well as red-flag indications in their condition and how to respond.</p> <p>The model is composed of the following components:</p> <ul style="list-style-type: none"> • A patient-centered health record that may include productive interdisciplinary communication during the care transition. • A discharge preparation checklist of critical activities <p>A patient self-activation and management session with a hospital-based cardiac care coach or navigator. This session is designed to help patients and their caregivers understand their role in managing the transition. The coach will follow-up with visits in the Skilled Nursing Facility (SNF) and/or in the home and accompanying phone calls designed to provide continuity across the transition.</p> <p>The hospital-based cardiac care coach will:</p> <ul style="list-style-type: none"> • Provide linkage to services. • Provide innovative outreach to public and private sectors to effectively link discharged hospital patients to educational and clinical services for ongoing prevention and treatment. • Will collaborate with inpatient Social Workers and Nurse Case Managers to coordinate the proposed discharge planning with the outpatient service, public or private, and/or agency needed to ensure positive outcome after discharge. 		
Project Outcomes		
<ol style="list-style-type: none"> 1. Reduce readmissions 2. Reduce admissions 3. Increase patient satisfaction 4. Improve medication management 5. Improve care processes 		
Project Specific Metrics	P4P	Measure Steward
1. <i>Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (Outpatient and Inpatient Setting):</i> Percentage of patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting or at hospital discharge (exclude those contra-indicated).	No	AMA-PCPI
2. <i>Controlling High Blood Pressure:</i> The percentage of members 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure (BP) was adequately	No	NCQA

⁷ As submitted by a New Jersey Hospital modeled by: http://innovativecaremodels.com/care_models/12/leaders Eric A. Coleman, MD, MPH, is Associate Professor of Medicine within the Divisions of Health Care Policy and Research and Geriatric Medicine at the University of Colorado Health Sciences Center. Dr. Coleman is the Director of the Care Transitions Program, aimed at improving quality and safety during times of care “hand-offs”. As a board-certified geriatrician, Dr. Coleman maintains direct patient care responsibility for older adults in ambulatory, acute, and subacute care settings.

⁸ Based on a project submitted by a New Jersey hospital.



New Jersey DSRIP Toolkit

Condition	Cardiac Care		
Project Count	6		
Project Title	Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions ^{7,8}		
	controlled (BP less than 140/90 mm Hg) during the measurement year.		
3.	<i>Post-Discharge Appointment for Heart Failure Patients</i> : Percentage of patients, regardless of age, discharged from an inpatient facility to ambulatory care or home health care with a principal discharge diagnosis of heart failure for whom a follow up appointment was scheduled and documented prior to discharge (as specified).	No	AMA-PCPI
4.	<i>Medication Reconciliation</i> : Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.	No	NCQA
5.	<i>Care Transition Measure (CTM-3)</i> : <i>Care Transition Measure- CTM-3</i> : 3 question survey assessing patients' perspectives on coordination of hospital discharge care.	P4P	University of Colorado Health Sciences Center
6.	<i>30- Day All-Cause Readmission Following Heart Failure (HF) Hospitalization</i> : The measure estimates a hospital-level, risk-standardized, all-cause 30-day readmission rate for patients discharged from the hospital with a principal discharge diagnosis of Heart Failure (HF).	P4P	The Joint Commission
7.	<i>30- Day All-Cause Readmission Following Acute Myocardial Infarction (AMI) Hospitalization</i> : The percent of all 30 day all-cause readmission rate for patients with AMI.	P4P	The Joint Commission
8.	<i>Heart Failure Admission Rate</i> : Percent of county population with an admission for heart failure.	P4P	AHRQ
9.	Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	P4P	AMA-PCPI



New Jersey DSRIP Toolkit

Condition	Cardiac Care		
Project Count	7		
Project Title	Extensive Patient CHF-Focused Multi-Therapeutic Model ⁹		
Project Objective			
To decrease the number of readmissions for patients with Congestive Heart Failure.			
Project Methodology			
The hospital will develop an extensive patient Congestive Heart Failure focused multi-therapeutic medical home.			
<p>The patients will be identified at the point of admission through a newly designed system that captures the patients who present to the hospital with acute CHF. The program begins immediately by the initiation of a focused assessment by inpatient and outpatient Nurse Practitioners. Inpatient and Outpatient Nurse Practitioners will be specifically recruited to allow for an extensive patient congestive heart failure-focused multi-therapeutic approach. The program may include:</p> <ul style="list-style-type: none"> • Education and introduction to the outpatient program involving caregivers, family, and primary physicians. • Prior to discharge, there will be a careful reconciliation of all medications for adherence and appropriateness. • An immediate discharge follow-up at the free clinic will be scheduled prior to discharge. The clinic will provide referrals to a cardiologist, as needed. • Home visits by dedicated outpatient Nurse Practitioners that begin on discharge day-one and coordination with the primary physician through the early identification and education about the program benefits amongst the community physician. • A nurse practitioner and physician contract involving continuous communication for each targeted program participant. 			
Project Outcomes			
<ol style="list-style-type: none"> 1. Reduce readmissions 2. Reduce admissions 3. Increase patient satisfaction 4. Improve medication management 5. Improve care processes 			
Project Specific Metrics		P4P	Measure Steward
1. <i>Left Ventricular Ejection Fraction (LVEF) Assessment</i> : Percentage of patients aged 18 years and older with a principal discharge diagnosis of heart failure with documentation in the hospital record of the results of an LVEF assessment that was performed either before arrival or during hospitalization, OR documentation in the hospital record that LVEF assessment is planned for after discharge.		No	AMA-PCPI
2. <i>Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (Outpatient and Inpatient Setting)</i> : Percentage of patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12 month period when seen in the outpatient setting or at hospital discharge (exclude those contra-indicated).		No	AMA-PCPI
3. <i>Controlling High Blood Pressure</i> : The percentage of members 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (BP less than 140/90 mm Hg) during the measurement year.		No	NCQA
4. <i>Post-Discharge Appointment for Heart Failure Patients</i> : Percentage of patients, regardless of age, discharged from an inpatient facility to ambulatory care or home health care with a principal discharge diagnosis of heart failure for whom a follow up appointment was scheduled and documented prior to discharge (as specified).		No	AMA-PCPI
5. <i>Medication Reconciliation</i> : Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.		No	NCQA

⁹ Based on a project submitted by a New Jersey hospital.



New Jersey DSRIP Toolkit

Condition	Cardiac Care		
Project Count	7		
Project Title	Extensive Patient CHF-Focused Multi-Therapeutic Model ⁹		
6. <i>Care Transition Measure (CTM-3): Care Transition Measure- CTM-3: 3 question survey assessing patients' perspectives on coordination of hospital discharge care.</i>	P4P	University of Colorado Health Sciences Center	
7. <i>30- Day All-Cause Readmission Following Heart Failure (HF) Hospitalization: The measure estimates a hospital-level, risk-standardized, all-cause 30-day readmission rate for patients discharged from the hospital with a principal discharge diagnosis of Heart Failure (HF).</i>	P4P	The Joint Commission	
8. <i>30- Day All-Cause Readmission Following Acute Myocardial Infarction (AMI) Hospitalization: The percent of all 30 day all-cause readmission rate for patients with AMI.</i>	P4P	The Joint Commission	
9. <i>Heart Failure Admission Rate: Percent of county population with an admission for heart failure.</i>	P4P	AHRQ	



New Jersey DSRIP Toolkit

Condition	Cardiac Care		
Project Count	8		
Project Title	The Congestive Heart Failure Transition Program (CHF-TP) ^{10,11}		
Project Objective			
The hospital will develop an intensive outpatient Congestive Heart Failure Transition Program (CHF-TP) through an enhanced admission assessment and guidance at discharge.			
Project Methodology			
<p>The Congestive Heart Failure Transition Program (CHF-TP) will incorporate a number of components to ensure a safe transition to home or another health care setting. Key elements of the program include, but are not limited to:</p> <ul style="list-style-type: none"> • Enhanced admission assessment • Enhanced discharge planning through inpatient education and caregiver communication process • Early and ongoing assessment of a patient’s medical and educational needs • Providing patient/family friendly handoff communication tools that may include written instructions and a Congestive Heart Failure-TP (CHF) teaching booklet • An established medical home through the development of an outpatient Congestive Heart Failure Transition Program (CHF-TP) with a patient-centered multi-disciplinary team • Follow-up appointments in the outpatient CHF-TP clinic are scheduled prior to discharge • Patients will be invited to attend a class held XX per month • Patients will be provided a scale and calendar and taught the appropriate methods for logging their weight as well as other information to help patients maintain awareness of critical self-management issues. 			
Project Outcomes			
<ol style="list-style-type: none"> 1. Reduce readmissions 2. Reduce admissions 3. Increase patient satisfaction 4. Improve medication management 5. Improve care processes 			
Project Specific Metrics		P4P	Measure Steward
1. <i>Left Ventricular Ejection Fraction (LVEF) Assessment:</i> Percentage of patients aged 18 years and older with a principal discharge diagnosis of heart failure with documentation in the hospital record of the results of an LVEF assessment that was performed either before arrival or during hospitalization, OR documentation in the hospital record that LVEF assessment is planned for after discharge.		No	AMA-PCPI
2. <i>Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (Outpatient and Inpatient Setting):</i> Percentage of patients aged 18 years and older with a diagnosis of heart failure with a current or prior LVEF < 40% who were prescribed ACE inhibitor or ARB therapy either within a 12-month period when seen in the outpatient setting or at hospital discharge (exclude those contra-indicated).		No	AMA-PCPI
3. <i>Controlling High Blood Pressure:</i> The percentage of members 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (BP less than 140/90 mm Hg) during the measurement year.		No	NCQA
4. <i>Post-Discharge Appointment for Heart Failure Patients:</i> Percentage of patients, regardless of age, discharged from an inpatient facility to ambulatory care or home health care with a principal discharge diagnosis of heart failure for whom a follow up appointment was scheduled and documented prior to discharge (as specified).		No	AMA-PCPI
5. <i>Medication Reconciliation:</i> Percentage of patients aged 65 years and older discharged from any inpatient facility (e.g. hospital, skilled nursing facility, or rehabilitation		No	NCQA

¹⁰ Based on a project submitted by a New Jersey hospital.

¹¹ Based on a project study found on the AHRQ website <http://www.innovations.ahrq.gov/content.aspx?id=2206>



New Jersey DSRIP Toolkit

Condition	Cardiac Care		
Project Count	8		
Project Title	The Congestive Heart Failure Transition Program (CHF-TP) ^{10,11}		
	facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.		
6.	<i>Care Transition Measure (CTM-3): Care Transition Measure- CTM-3: 3 question survey assessing patients' perspectives on coordination of hospital discharge care.</i>	P4P	University of Colorado Health Sciences Center
7.	<i>30- Day All-Cause Readmission Following Heart Failure (HF) Hospitalization:</i> The measure estimates a hospital-level, risk-standardized, all-cause 30-day readmission rate for patients discharged from the hospital with a principal discharge diagnosis of Heart Failure (HF).	P4P	The Joint Commission
8.	<i>30- Day All-Cause Readmission Following Acute Myocardial Infarction (AMI) Hospitalization:</i> The percent of all 30 day all-cause readmission rate for patients with AMI.	P4P	The Joint Commission
9.	<i>Heart Failure Admission Rate:</i> Percent of county population with an admission for heart failure.	P4P	AHRQ

AHRQ Evidence Rating: Moderate - The evidence consists of a before-and-after comparison of heart failure readmission rate within 30 days.



New Jersey DSRIP Toolkit

Condition	Chemical Addiction/Substance Abuse			
Project Count	9			
Project Title	Hospital–Wide Screening for Substance Use Disorder ¹²			
Project Objective				
<p>Hospital wide-screening tools to assess the severity of substance use disorder, detect for withdrawal for inpatient admissions and identification of level of treatment needed. Hospital may provide any of the following services:</p> <ul style="list-style-type: none"> • Brief intervention to focus on increasing the patient’s knowledge about substance use and motivation toward behavioral change. • Algorithm-based treatment included in order sets for withdrawal, if required. • Referral to treatment provides those identified as needing more extensive treatment with access to specialty care 				
Project Methodology				
<p>Hospital workgroup would need to be established to determine screening tools, interventions, and algorithms to be included in the order sets to achieve hospital-wide screening for substance abuse disorder. Workgroup to educate clinicians on tools and algorithms.</p> <p>Program may include the following elements:</p> <ul style="list-style-type: none"> • Upon inpatient admission, the nurse administers a validated risk assessment tool for substance use disorder. If the screening is positive, the nurse asks the patient additional questions and performs an assessment for withdrawal symptoms; if screening is positive the physician is notified. • The physician may initiate either a precaution or treatment algorithm. <ul style="list-style-type: none"> ○ The Precaution algorithm directs nurses to continue to assess for withdrawal symptoms and if the patient's score changes to be greater than a pre-determined threshold, then the nurse initiates the treatment algorithm. ○ The Treatment Algorithm specifies medication to be administered and continued assessment of patient’s response to medication for possible medication adjustments. The nurse also monitors vital signs and performs other assessments as ordered in the algorithm. • Brief intervention will be performed to assess the patient’s awareness about their substance use and willingness to change these behaviors. • Nurses are to notify the physician if specified issues with the patient arise. • Prior to discharge, patients are referred to participate in more extensive treatment with access to specialty care. 				
Project Outcomes				
<ol style="list-style-type: none"> 1. Decrease length of stay 2. Decrease use of restraints 3. Decrease in transfer of patients with delirium tremens or other complications to the intensive care unit (ICU) 4. Increased referral/ admissions to substance abuse treatment programs/ facilities 5. Improve care processes 				
Project Specific Metrics			P4P	Measure Steward
1. Percent of hospitalized patients who are screened during the hospital stay using a validated screening questionnaire for unhealthy alcohol use.			No	Joint Commission
2. Percentage of patients aged 18 years and older with a diagnosis of current substance abuse or dependence who were screened for depression within the 12 month reporting period.			No	AMA-PCPI
3. <i>Initiation of alcohol and other drug treatment</i> : Percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis.			P4P	NCQA
4. <i>Engagement of alcohol and other drug treatment</i> : The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who initiated AOD treatment and who had two or more inpatient admissions, outpatient visits, intensive outpatient encounters, or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive).			P4P	NCQA

¹¹ Based on a project study found on the AHRQ website: <http://www.innovations.ahrq.gov/content.aspx?id=3164>



New Jersey DSRIP Toolkit

AHRQ Evidence Rating: Moderate - The evidence consists of pre- and post-implementation comparisons of key outcome measures, including the percentage of patients diagnosed with alcohol withdrawal, the percentage of patients with alcohol withdrawal developing delirium tremens, length of stay, restraint use, and intensive care unit transfers of patients with delirium tremens.



New Jersey DSRIP Toolkit

Condition	Chemical Addiction/ Substance Abuse		
Project Count	10		
Project Title	Hospital Partners with Residential Treatment Facility to Offer Alternative Setting to Intoxicated Patients ¹³		
Project Objective			
Offer alternative treatment setting for acute alcohol intoxicated patients in order to lower the emergency department length of stay and offer immediate access to treatment.			
Project Methodology			
<ul style="list-style-type: none"> An ED nurse conducts an initial examination of all patients who present to the ED with acute alcohol intoxication, assessing his or her intoxication level and performing a preliminary health evaluation. If the patient has any acute health issues aside from alcohol intoxication (e.g., open wounds, broken bones, breathing difficulties), ED staff deliver all necessary medical care. If the nurse concludes that the patient does not have any acute health issues, the next available physician examines the patient to verify that he or she is medically stable. If so, a nurse calls staff at the Residential Treatment Facility to let them know that a medically stable, intoxicated patient has come to the ED. The Residential Treatment Facility sends a staff member who has successfully completed treatment for alcoholism to the ED in a transport van. Upon arrival, the representative introduces himself or herself to the patient, describes the programs available at the Residential Treatment Facility (which include an overnight shelter, a detoxification program lasting several weeks, and an X- month residential treatment program), and offers to transport the patient to the center. Their past experience with alcoholism helps them to develop a rapport with the patient. Patients, who agree to be transferred, are discharged from the ED to the treatment facility. The residential treatment facility staff member drives them to the facility, where they receive support and treatment in a safe environment. Patients who decline transfer to the residential treatment facility stay in the ED until their blood alcohol level reaches the legal limit and ED staff determines they have another safe environment to which they can return. 			
Project Outcomes			
<ol style="list-style-type: none"> Lower emergency department length of stay for intoxicated patients Increased referral/ admissions to substance abuse treatment programs/ facilities Improve care processes 			
Project Specific Metrics		P4P	Measure Steward
1. Percentage of patients aged 18 years and older with a diagnosis of current alcohol dependence who were counseled regarding psychosocial and pharmacologic treatment options for alcohol dependence within the 12 month reporting period.		No	AMA-PCPI
2. <i>Screening for Clinical Depression and Follow-up Plan</i> : Percentage of patients aged 12 years and older screened for clinical depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.		No	CMS
3. <i>Initiation of alcohol and other drug treatment</i> : Percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the diagnosis.		P4P	NCQA
4. <i>Engagement of alcohol and other drug treatment</i> : The percentage of adolescent and adult members with a new episode of alcohol or other drug (AOD) dependence who initiated AOD treatment and who had two or more inpatient admissions, outpatient visits, intensive outpatient encounters, or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive).		P4P	NCQA

AHRQ Evidence Rating: Moderate - The evidence consists of pre- and post-implementation comparisons of emergency department length of stay for acutely intoxicated patients, along with estimates of cost savings due to this reduced length of stay and post-implementation anecdotal reports from The Healing Place staff.

¹³ Based on a project study found on the AHRQ website: <http://www.innovations.ahrq.gov/content.aspx?id=3250&tab=1>



New Jersey DSRIP Toolkit

Condition	Diabetes		
Project Count	11		
Project Title	Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension ¹⁴		
Project Objective			
The objective for this project is to develop and implement a patient centered medical home for patients with diabetes mellitus and hypertension resulting in improved overall quality of care.			
Project Methodology			
Develop and implement a patient centered medical home for patients with diabetes mellitus and hypertension. Patients will be entered into the program via the ambulatory care department, emergency department, inpatient services, same day service locations and community health screenings conducted by hospital staff.			
The program may include:			
<ul style="list-style-type: none"> • Utilizing multi-therapeutic outpatient evidence based management, • Lifestyle modification, • Nutritional consultation, • Intensive hospital discharge planning, • A dedicated patient navigation system, • Improve social services 			
Project Outcomes			
<ol style="list-style-type: none"> 1. Reduce admissions 2. Reduce emergency department visits 3. Improve care processes 4. Increase patient satisfaction 			
Project Specific Metrics		P4P	Measure Steward
1. <i>Lipid Management</i> : Percentage of patients who received at least one lipid profile (or ALL component tests).		No	AMA-PCPI
2. <i>Foot Examination</i> : Percentage of patients who received at least one complete foot exam (visual inspection, sensory exam with monofilament, and pulse exam).		No	AMA-PCPI
3. <i>Eye Examination</i> : Percentage of patients who received a dilated retinal eye exam by an ophthalmologist or optometrist.		No	AMA-PCPI
4. <i>Comprehensive Diabetes Care (CDC): Hemoglobin A1C (HbA1C) testing</i> : The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.		No	NCQA
5. <i>Uncontrolled Diabetes Admission Rate (PQI 14)</i> : The number of discharges for uncontrolled diabetes per 100,000 population age 18 years and older in a Metro Area or county in a one year time period.		P4P	AHRQ
6. <i>Diabetes Short-Term Complications Admission Rate (PQI 1)</i> : The number of discharges for diabetes short-term complications per 100,000 age 18 years and older population in a Metro Area or county in a one year period.		P4P	AHRQ
7. <i>Hypertension Admission Rate</i> : All discharges of age 18 years and older with ICD-9-CM principal diagnosis code for hypertension (see below).		P4P	AHRQ
8. <i>Controlling High Blood Pressure</i> : The percentage of members 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (BP less than 140/90 mm Hg) during the measurement year.		P4P	NCQA
9. <i>Diabetes Long-Term Complications Admission Rate (PQI 3)</i> : The number of discharges for long-term diabetes complications per 100,000 population age 18 years and older in a Metro Area or county in a one year time period.		P4P	AHRQ

¹⁴ Based on a project submitted by a New Jersey hospital.



New Jersey DSRIP Toolkit

Condition	Diabetes		
Project Count	12		
Project Title	Diabetes Group Visits for Patients and Community Education ¹⁵		
Project Objective			
The objective for this project is twofold, first, to ensure that all newly diagnosed diabetics have a clear understanding of their plan of care and are knowledgeable regarding expected outcomes and disease management. Secondly, to improve the opportunity for medical staff to gain continued and ongoing education from endocrinology areas.			
Project Methodology			
<ul style="list-style-type: none"> Develop a diabetic education model that serves to education patients as well as to facilitate endocrinologists educating Primary Care Physicians (PCPs) and other medical staff on best-practice guidelines in Diabetes care, and move towards an innovative model of inter-professional learning in undergraduate and graduate medical education. Enroll patients to participate in a new group visit model for managing chronic disease. Patients will be enrolled in group visits; sessions of xx minutes each, whereby a primary care physician along with medical specialists that could include an endocrinologist, medical students, residents, fellows, RN, LPN, psychologist, and nurse practitioner provide a ‘focused care model that is patient-centered, evidenced-based, and enables peer-to-peer empowerment and education.’ Group visit patients receive not only medical therapy during the sessions, but also screening for depression and individual counseling services. 			
Project Outcomes			
<ol style="list-style-type: none"> Reduce admissions Reduce emergency department visits Improve care processes Increase patient satisfaction 			
Project Specific Metrics		P4P	Measure Steward
1. <i>Lipid Management</i> : Percentage of patients who received at least one lipid profile (or ALL component tests).		No	AMA-PCPI
2. <i>Foot Examination</i> : Percentage of patients who received at least one complete foot exam (visual inspection, sensory exam with monofilament, and pulse exam).		No	AMA-PCPI
3. <i>Eye Examination</i> : Percentage of patients who received a dilated retinal eye exam by an ophthalmologist or optometrist.		No	AMA-PCPI
4. <i>Comprehensive Diabetes Care (CDC): Hemoglobin A1C (HbA1C) testing</i> : The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.		No	NCQA
5. <i>Hemoglobin A1c Testing for Pediatric Patients</i> : Percentage of pediatric patients aged 5-17 years of age with diabetes who received an HbA1c test during the measurement year.		No	NCQA
6. <i>Controlling High Blood Pressure</i> : The percentage of members 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (BP less than 140/90 mm Hg) during the measurement year.		P4P	NCQA
7. <i>Diabetes Short-Term Complications Admission Rate (PQI 1)</i> : The number of discharges for diabetes short-term complications per 100,000 age 18 years and older population in a Metro Area or county in a one year period.		P4P	AHRQ
8. <i>Uncontrolled Diabetes Admission Rate (PQI 14)</i> : The number of discharges for uncontrolled diabetes per 100,000 population age 18 years and older in a Metro Area or county in a one year time period.		P4P	AHRQ

¹⁵ Based on a project submitted by a New Jersey hospital.



New Jersey DSRIP Toolkit

Condition	Diabetes		
Project Count	12		
Project Title	Diabetes Group Visits for Patients and Community Education ¹⁵		
9. <i>Diabetes Long-Term Complications Admission Rate (PQI 3):</i> The number of discharges for long-term diabetes complications per 100,000 population age 18 years and older in a Metro Area or county in a one year time period.	P4P	AHRQ	



New Jersey DSRIP Toolkit

Condition	Diabetes		
Project Count	13		
Project Title	Develop Intensive Case Management for Medically Complex High Cost Patients ¹⁶		
Project Objective			
Implement a comprehensive, intensive case management and care coordination program for the most costly (top 1 percent), medically complex patients who lack insurance.			
Project Methodology			
<ul style="list-style-type: none"> • Key elements of the program include identification of the target population. To qualify for inclusion in the program, a patient must have a diagnosis of diabetes and be among the costliest X percent of inpatient admissions and emergency department patients. (Exclusions to the target could include patients admitted with a primary diagnosis of trauma or those who live outside of the hospital's treating area, both may indicate a one-time treatment event rather than an ongoing cost). • The identified population is made available to the program for contact. This may be via letter or phone contact which will include a description of the program and an invitation to participate. • Each participant is assigned to a care team that includes a physician/medical director (who serves as team leader), pharmacist, shepherd/case manager, social worker, and behavioral health specialist. Each patient also has a primary care physician. The team serves as a support for the primary care physician, providing intensive case management and often taking the lead in managing the patient's care and appointments. Each patient meets with the entire team for an initial assessment to identify and prioritize needs, define health and life goals, and outline next steps. The team also uses the meeting to begin scheduling any necessary medical appointments with the patient's primary care physician or appropriate specialists. The team will provide each patient with ongoing case management and care coordination services. The frequency with which a patient receives services is determined by the patient's individual health needs and may include assistance with any of the following areas: financial, medication, counseling, appointment scheduling, and community resources. • At defined intervals, the program participants who have not been in contact with the team will be contacted, verifying their health status and determining whether they need ongoing services and thus should remain in the program. 			
Project Outcomes			
<ol style="list-style-type: none"> 1. Reduce admissions 2. Reduce emergency department visits 3. Improve care processes 4. Increase patient satisfaction 			
Project Specific Metrics		P4P	Measure Steward
1. <i>Lipid Management</i> : Percentage of patients who received at least one lipid profile (or ALL component tests).		No	AMA-PCPI
2. <i>Foot Examination</i> : Percentage of patients who received at least one complete foot exam (visual inspection, sensory exam with monofilament, and pulse exam).		No	AMA-PCPI
3. <i>Eye Examination</i> : Percentage of patients who received a dilated retinal eye exam by an ophthalmologist or optometrist.		No	AMA-PCPI
4. <i>Comprehensive Diabetes Care (CDC): Hemoglobin A1C (HbA1C) testing</i> : The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year.		No	NCQA
5. <i>Hemoglobin A1c Testing for Pediatric Patients</i> : Percentage of pediatric patients aged 5-17 years of age with diabetes who received an HbA1c test during the measurement year.		No	NCQA
6. <i>Controlling High Blood Pressure</i> : The percentage of members 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure (BP) was adequately controlled (BP less than 140/90 mm Hg) during the measurement year.		P4P	NCQA

¹⁶ Based on a project study found on the AHRQ website: <http://www.innovations.ahrq.gov/content.aspx?id=2675>



New Jersey DSRIP Toolkit

Condition	Diabetes		
Project Count	13		
Project Title	Develop Intensive Case Management for Medically Complex High Cost Patients ¹⁶		
7. <i>Diabetes Short-Term Complications Admission Rate</i> : The number of discharges for diabetes short-term complications per 100,000 age 18 years and older population in a Metro Area or county in a one year period.	P4P	AHRQ	
8. <i>Uncontrolled Diabetes Admission Rate (PQI 14)</i> : The number of discharges for uncontrolled diabetes per 100,000 population age 18 years and older in a Metro Area or county in a one year time period.	P4P	AHRQ	
9. <i>Diabetes Long-Term Complications Admission Rate (PQI 3)</i> : The number of discharges for long-term diabetes complications per 100,000 population age 18 years and older in a Metro Area or county in a one year time period.	P4P	AHRQ	

AHRQ Evidence Rating: Moderate - The evidence consists of pre- and post-implementation comparisons of inpatient admissions and emergency department (ED) visits, along with anecdotal feedback from program participants.



New Jersey DSRIP Toolkit

Condition	HIV/ AIDS
Project Count	14
Project Title	Patient Centered Medical Home for Patients with HIV/AIDS ^{17,18}
Project Objective	
Improve the overall quality of care for patients who have been diagnosed with HIV through the development and implementation of a patient centered medical home.	
Project Methodology	
<p>Develop and implement a patient centered medical home for patient with HIV by utilizing interdisciplinary outpatient management, intensive hospital discharge planning and dedicated patient navigation and social services. Services may include: screening and education regarding high risk sexual behaviors and injection drug use; Screening and treatment for Tuberculosis (TB) and Depression; Assessment of need for Hepatitis B and Hepatitis C vaccinations.</p> <p>Specifically, plan may including the following services:</p> <ul style="list-style-type: none"> • Develop a multi-therapeutic support model whereby community-based PCPs working in different health centers receive support in the ongoing management and treatment of HIV-positive patients. • Depending on doctor needs and patient circumstances, support includes: <ul style="list-style-type: none"> ○ Case discussions between PCP and a specialist physician, ○ Patient visits to the specialist, and/or ○ Patient visits to members of a dedicated multi-therapeutic HIV team • PCPs also receive regular reminders and updates from a center-based clinical champion. • Support from a physician specializing in HIV care: Physicians and residents will work at community-based internal and family medicine practices and receive ongoing support from a physician specializing in HIV care with training in internal or family medicine. Available support includes as-needed case discussions and direct specialist-patient contact, as outlined below: <ul style="list-style-type: none"> ○ As needed, PCP’s hold case discussions with specialists. While they can ask for a consultation at any time, protocols specify that consultations be held whenever the PCP is considering a change to the HIV treatment regimen. Consultations may occur in person at larger centers (which have a physician specializing in HIV care onsite), often as part of weekly meetings with PCPs and residents. At the smaller sites, consultations and case discussions may generally occur via e-mail or phone, with communication facilitated through an electronic health record (EHR). Once every few months, the lead physician specializing in HIV care should visit the smaller sites to hold case discussions, often with members of the multidisciplinary team (see bullet below for more details on this team). ○ As the PCP sees fit, patients can have direct visits with a specialist. If no specialist works regularly in the health center, a visit with a specialist should be arranged at the center for a scheduled time. Following the visit, the specialist briefs the PCP on his or her findings and recommendations. • Access to traveling multidisciplinary team: A multidisciplinary team dedicated to HIV care travels to the centers according to a set schedule, with the larger centers hosting the team up to several days a week and the smaller centers hosting team members less frequently (weekly, biweekly, or monthly) depending on the volume of HIV patients. Led by a medical director, the team includes a psychiatrist, psychologist, clinical consultation pharmacist, nutritionist, treatment educator, and several patient navigators, all with expertise in HIV care. PCPs coordinate team services and set up appointments for their patients with one or more team members based on the visit schedule. If a patient needs team services before the next scheduled visit, the doctor notifies relevant team members via email about the need to set up a separate appointment. <p>Clinic-based champion to support colleagues: At each participating clinic, a clinical champion (usually a physician, but could be a nurse practitioner) keeps up with the latest HIV treatment information and disseminates it to colleagues. The Champion also reminds physicians to consult with experts as necessary, particularly if their patients’ viral loads do not</p>	

¹⁶Based on a project study found on the AHRQ website: <http://www.innovations.ahrq.gov/content.aspx?id=3296&tab=1>

¹⁷Based on a project submitted by a New Jersey hospital.



New Jersey DSRIP Toolkit

Condition	HIV/ AIDS		
Project Count	14		
Project Title	Patient Centered Medical Home for Patients with HIV/AIDS ^{17,18}		
react as expected after initiation (or change in) treatment.			
Project Outcomes			
<ol style="list-style-type: none"> 1. Reduce readmissions 2. Improve patient adherence to their treatment regimen 3. Improve care processes 4. Increase patient satisfaction 			
Project Specific Metrics		P4P	Measure Steward
1. <i>CD4 T-Cell Count</i> : Percentage of clients with HIV infection who had 2 or more CD4 T-cell counts performed in the measurement year.		No	HRSA-HAB
2. <i>HARRT</i> : Percentage of clients with AIDS who are prescribed HAART		No	HRSA-HAB
3. <i>Hepatitis C Screening</i> : Percentage of patients aged 13 years and older with a diagnosis of HIV/AIDS for whom Hepatitis C screening was performed at least once since the diagnosis of HIV infection, or for whom there is documented immunity.		No	AMA-PCPI
4. <i>Gap in HIV Visits</i> : Percentage of patients, regardless of age, with a diagnosis of HIV who did not have a medical visit in the last 6 months of the measurement year.		P4P	HRSA-HAB
5. <i>Medical Case Management</i> : Percentage of HIV-infected medical case management clients who had a medical case management care plan developed and/or updated two or more times in the measurement year.		P4P	HRSA-HAB
6. <i>HIV viral load suppression</i> : Percentage of patients, regardless of age, with a diagnosis of HIV with a HIV viral load less than 200 copies/mL at last HIV viral load test during the measurement year.		P4P	HRSA-HAB
7. <i>PCP Prophylaxis</i> : Percentage of patients aged 6 weeks or older with a diagnosis of HIV/AIDS, who were prescribed Pneumocystis jiroveci pneumonia (PCP) prophylaxis		P4P	NCQA

AHRQ Evidence Rating: Moderate - The evidence consists of a retrospective, nonrandomized cohort study that compared key treatment outcomes and disease progression at initiation of treatment in 423 HIV-positive patients seen in participating primary care clinics to 431 similar patients treated in a hospital-based specialty clinic.



New Jersey DSRIP Toolkit

Condition	Obesity			
Project Count	15			
Project Title	After-School Obesity Program ¹⁹			
Project Objective				
Develop community partnership to create a school-based wellness program for overweight children between the ages of X yrs to X yrs old that provide education, exercise, medical assistance and support.				
Project Methodology				
To implement this program, the hospital must determine the number of weeks the program will run and the number of X days after school per week. The target population for this program is school age children ages X-X years of age with a BMI of X percentile.				
Development and maintenance of the program may include the following:				
<ul style="list-style-type: none"> • Determination of staffing needs which may include, but may not be limited to physicians, dietitian(s) and exercise physiologist(s). • Determination of pre-program assessment participants must complete (i.e. physical, cholesterol and lipid screening, hypertension screening). • Development of education materials. • Assessment of technology needs and if/how technology will be utilized. • Monitoring attendance, compliance and BMI of participants. • Develop a survey for the patient/guardian on identifying overweight children and caring for them. Survey parent/guardian using a pre- and post-education assessment. • Maintain a current referral management system for referrals to access care options (physicians, social worker, pharmacists, counselors, etc.). • Supply equipment such as daily logs and exercise equipment (water bottles, jump ropes, balls, pedometers, etc.). • Educate school administrators, teachers, students, parents and/or guardians. 				
Project Outcomes				
<ol style="list-style-type: none"> 1. Reduce patient body mass index (BMI) 2. Improve patient adherence to their treatment regimen 3. Improve care processes 				
Project Specific Metrics			P4P	Measure Steward
1. Percentage of mature adolescent and adult patients with an elevated body mass index (BMI greater than or equal to 25) who have set an individualized goal along with target date for reduction in BMI.			No	ICSI
2. <i>Children and Adolescents' Access to Primary Care Practitioners:</i> The percentage of members 12 months–19 years of age who had a visit with a PCP.			No	NCQA
3. <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents:</i> The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year: <ul style="list-style-type: none"> • BMI percentile documentation* • Counseling for nutrition • Counseling for physical activity *Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.			P4P	NCQA
4. <i>Children Age 6-17 Years who Engage in Weekly Physical Activity:</i> Measures how many times per week child 6-17 years exercises vigorously (based on AAP and CDC recommendations)			P4P	HRSA – MCHB
Condition	Obesity			
Project Count	16			

¹⁹ Based on a project submitted by a New Jersey hospital



Project Title	Wellness Program for Parents and Preschoolers ^{20,21}
Project Objective	
Develop wellness program to help obese preschoolers and overweight parents improve eating habits and reduce body mass index.	
Project Methodology	
<p>Behavioral health clinicians to lead a XX-week program for obese preschoolers and their overweight or obese parent(s). Known as LAUNCH (Learning about Activity and Understanding Nutrition for Child Health)²¹, the program consists of alternating group-based sessions focused on improving behaviors related to diet and physical activity and in-home, one-on-one consultations designed to support, demonstrate, reinforce, and build on the concepts and strategies covered in the group sessions. The initial phase consists of XX weekly sessions focused on dietary education, physical activity, and parenting skills, followed by a second phase of X sessions designed to help families continue to make and maintain positive changes.</p> <ul style="list-style-type: none"> Identifying and enrolling participants by using a systematic chart review, the medical center identifies preschool-aged children with a BMI at or above the 95th percentile at their last well-child visit. The parents of eligible children receive a letter from their child’s pediatrician introducing them to the program and inviting them to enroll. Those interested undergo a baseline assessment. <p>Intensive, initial phase focused on promoting and reinforcing healthy behaviors:</p> <ul style="list-style-type: none"> The initial, intensive phase consists of XX weekly sessions that alternate between group-based clinic sessions and in-home visits in which a therapist meets one-on-one with individual families. Focusing on teaching strategies and skills for improving behaviors related to diet and physical activity for parents and preschoolers, while the in-home sessions strive to provide practical assistance to help parents implement the general lessons and concepts discussed in the group sessions. <p>Clinic-based group visits:</p> <ul style="list-style-type: none"> These XX minute sessions feature two concurrent groups-one for parents and one for preschools. <p>Sessions for parents:</p> <ul style="list-style-type: none"> These XX sessions led by licensed clinical psychologist focus on dietary education, physical activity and parenting skills. These sessions serve to demonstrate, reinforce, and build on the themes and behavior management strategies taught in the group sessions. Features could include separate sessions targeting snack and beverage intake, breakfast and lunch, and dinner. The psychologist or dietitian works with parents to set calorie goals for the child. Intensive, initial phase focused on promoting and reinforcing healthy behaviors. <p>In-home sessions:</p> <ul style="list-style-type: none"> During weeks when group sessions do not meet, a home therapist (a psychology postdoctoral fellow) leads a XX to XX minute session in the home with parent and child. These sessions serve to demonstrate, reinforce, and build on the themes and behavior management strategies taught in the group sessions related to diet and to physical activity. <p>Then the second phase focused on maintaining progress:</p> <ul style="list-style-type: none"> The second XX-week period consists of six biweekly sessions that again alternate between clinic-based group visits and in-home, one-on-one sessions between therapist and family. This phase focuses on helping parents identify ongoing barriers to engaging in healthy behaviors, along with strategies for overcoming them, typically based on the material taught during the initial phase. <p>Staff to include clinical psychologist, pediatric psychologist, master’s level professional or trained graduate student in psychology; the key is to use someone training and experience in child behavioral management, dietitian, and social worker.</p>	
Project Outcomes	
<ol style="list-style-type: none"> Reduce patient body mass index (BMI) Improve patient adherence to their treatment regimen 	

²⁰ Based on a project found on the AHRQ website: <http://www.innovations.ahrq.gov/content.aspx?id=2914>

²¹ LAUNCH (Learning about Activity and Understanding Nutrition for Child Health)² project submitted by hospital



New Jersey DSRIP Toolkit

Condition	Obesity		
Project Count	16		
Project Title	Wellness Program for Parents and Preschoolers ^{20,21}		
3. Improve care processes			
Project Specific Metrics	P4P	Measure Steward	
1. Percentage of mature adolescent and adult patient with an elevated body mass index (BMI greater than or equal to 25) who have set an individualized goal along with target date for reduction in BMI.	No	ICSI	
2. <i>Children and Adolescents' Access to Primary Care Practitioners:</i> The percentage of members 12 months–19 years of age who had a visit with a PCP. The organization reports four separate percentages for each product line. Children 12–24 months and 25 months–6 years who had a visit with a PCP during the measurement year Children 7–11 years and adolescents 12–19 years who had a visit with a PCP during the measurement year or the year prior to the measurement year	No	NCQA	
3. Percentage of mature adolescent and adult patients with an elevated body mass index (BMI greater than or equal to 25) who receive education and counseling for weight loss strategies that include nutrition, physical activity, life style changes, medication therapy and/or surgery.	P4P	ICSI	
4. <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents:</i> The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year: <ul style="list-style-type: none"> • BMI percentile documentation* • Counseling for nutrition • Counseling for physical activity *Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.	P4P	NCQA	

AHRQ Evidence Rating: Strong - The evidence consists primarily of an RCT that compared key metrics for 7 families (parent and preschooler) participating in the LAUNCH program and 10 families receiving "enhanced" usual care, which consisted of one 45-minute counseling session led by a pediatrician; metrics evaluated include changes in dietary habits (e.g., caloric intake, availability of high-calorie foods, fruits, and vegetables in the home), level of physical activity, weight, BMI z-score, and BMI percentile.



New Jersey DSRIP Toolkit

Condition	Pneumonia			
Project Count	17			
Project Title	Patients Receive Recommended Care for Community-Acquired Pneumonia ²²			
Project Objective				
Implement a set of strategies to ensure that all patients with community-acquired pneumonia receive recommended care as measured by The Joint Commission/ CMS Pneumonia Core Measure Set.				
Project Methodology				
Develop a hospital-based program for patients with community-acquired pneumonia (CAP) that may include the following elements:				
<ul style="list-style-type: none"> • Establish a multi-therapeutic hospital workgroup (including physicians, pharmacists, respiratory therapists etc.) to determine interventions to be included on the standardized order forms. Order sets include: <ul style="list-style-type: none"> ○ ED Order set to include algorithm to assist clinicians in identification of appropriate care setting (i.e. outpatient vs. inpatient). ○ Medication order forms one for the ED and one for the inpatient setting which would include checklist of recommended medications as determined by the workgroup. ○ Diagnostic testing order form (one for the ED and one for the inpatient setting) containing a checklist of tests, as determined to be appropriate by the workgroup. • Inclusion of prompt for smoking cessation and vaccine administration to appropriate hospital forms and checklists. • Hospital to perform chart reviews to determine physician compliance with meeting CAP performance measures and report findings to the physician with XX hours. • Development of individual laminated pocket cards with listings of formulary appropriate drugs of choice dependent on patient type. 				
Project Outcomes				
<ol style="list-style-type: none"> 1. Reduce readmissions 2. Decrease length of stay for Community-Acquired Pneumonia (CAP) 3. Improve care processes 				
Project Specific Metrics			P4P	Measure Steward
1. Percentage of patients aged greater than or equal to 18 years diagnosed with community-acquired bacterial pneumonia who had a chest x-ray performed.			No	AMA
2. Percentage of patients aged greater than or equal to 18 years diagnosed with community-acquired bacterial pneumonia for whom mental status is assessed.			No	AMA
3. To assess non-intensive care unit (ICU) pneumonia patients who received an initial antibiotic regimen consistent with program guidelines during the first 24 hours of their hospitalization.			No	The Joint Commission
4. To assess intensive care unit (ICU) pneumonia patients who received an initial antibiotic regimen consistent with program guidelines during the first 24 hours of their hospitalization.			No	The Joint Commission
5. To assess pneumonia patients who received an initial antibiotic regiment consistent with current guidelines during the first 24 hours of their hospitalization.			P4P	CMS
6. <i>30-Day All-Cause Readmission Following Pneumonia (PN) Hospitalization:</i> Hospital-specific 30-day all-cause risk standardized readmission rate following hospitalization for pneumonia at the time of index hospitalization			P4P	The Joint Commission

AHRQ Evidence Rating: Moderate - The evidence consists of before-and-after comparisons of key outcomes measures related to pneumonia care, including antibiotic administration, performance of blood cultures, assessment of arterial oxygenation, smoking cessation counseling, and pneumococcal vaccination.

²² Based on a project study found on the AHRQ website: <http://www.innovations.ahrq.gov/content.aspx?id=2565>



IV. Hospital DSRIP Plan Template

The Hospital DSRIP Plan Template was developed to serve as a companion document to the application. The Template's purpose is to assist hospital DSRIP participants in the completion of their DSRIP application. The menu of activities for each stage, including the application stage, is included in the Hospital DSRIP Plan Template, along with the associated metric(s) and minimum documentation requirements for each activity/metric. For each stage, the Hospital DSRIP Plan Template lists the required and/or elective activities, the associated actions/milestones for each activity, as well as the guideline for completion by month and year. While the targeted completion by month/year will be determined by the participating hospital for most action/milestones in the DSRIP Plan, the noted completion date by month/year in the Hospital DSRIP Plan Template will serve as a guide for the Department's expected completion date for each stage's activities.



Hospital DSRIP Plan – Executive Summary

Focus Area: [Pre-populates based on initial selection]

Project Title – [The user is prompted to select from a pre-defined menu.]

Objective – [Pre-populated based on project selected, however the user will be required to enter the specific outcome they intend to accomplish with obtainable resources.]

Methodology – [Pre-populated based on project selected, however the user will be required to enter how they will achieve the outcome(s). The methodology must be clear and detailed as to how the hospital plans to achieve their stated objective and outcomes.]

Goals/ Outcomes – [Pre-populated based on project selected, however the user will be required to enter the goal(s) of their project for both their hospital and the targeted population. Goals for each Demonstration Year are to be included.]

Significance – [The user will be prompted to enter the rationale for their project selection based on significance of the population their hospital serves and results of their community needs assessment (for further detail on the Community Needs Assessment please see the Application Instructions and the Planning Protocol). User must state how the project will measurably improve health outcomes for their patient population, how the activities selected will demonstrate significant measurable improvement in health outcomes, and how the DSRIP project they selected is consistent with their hospital’s mission or quality goals and the Department’s DSRIP vision. Significant measurable improvement will be based on the hospital’s baseline project-specific measures meeting the Baseline Performance Threshold provision. The user should present a case that its chosen project is in an area that shows an opportunity for improvement. This case must include supporting evidence and data.]

Challenges – [The user will be prompted to enter what they consider to be the challenges in implementing their projects. Hospitals will need to include a brief description of the major delivery system solution identified to address those challenges. If one of the hospital’s challenges is that it cannot provide all or part of the baseline data, the hospital will be required to describe in this section, the hospital’s plan, including a timeline for obtaining and submitting the baseline data for non-claim based measures to the Department. Please note, all hospital metric data submissions must be received by the Department no later than **October 31, 2014, unless otherwise stated in the databook**. Challenges must be specifically listed such as “search for additional qualified staff to hire” or “large population of uninsured patients” etc.]

Starting Point – [The user will be prompted to enter their starting point for their selected project. The starting point should include the identification of project needs, such as funding, data, the project team, etc., and how those needs will be met to begin the project. Participating hospitals must demonstrate whether the project is a new initiative for the hospital, or significantly enhances an existing health care initiative.]



Hospital DSRIP Plan – Executive Summary

Focus Area: [Pre-populates based on initial selection]

Hospitals must identify all parts of the DSRIP project currently or expected to be funded by other CMS, U.S. Department of Health and Human Services (HHS), or other government funded initiatives in which they participate. Hospitals must explain how their proposed DSRIP activities are not duplicative of the activities already funded or expected to be funded in the future.]

Public Input – [The user will be prompted to enter a description of the processes used to engage and reach out to stakeholders (as defined in the Application Instructions and Planning Protocol) regarding the DSRIP plan. At a minimum the processes used to solicit public input should include a description of public meetings that were held, the process for receiving public comment on the hospital DSRIP plan, and a plan for ongoing engagement with public stakeholders.]

Project Monitoring – [The user will be prompted to enter a description of the efforts that will be used to review and manage DSRIP outcomes, make rapid-cycle changes, identify lessons learned, contribute to and implement best practices from the learning collaboration, and link to the Department's quality improvement efforts. Project monitoring description will also include efforts that will be used to review and document project budget, and return on investment.]

(Special Terms and Conditions, 93.g.i., page 77)



New Jersey DSRIP Toolkit
Hospital DSRIP Plan Template

Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Application DY 2: The following are required to be completed as part of the DSRIP Plan

Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metric(s) (Minimum Documentation Requirements)
1.	Identify key program components and goals.	Conduct a gap analysis in preparation for the inception of the project.	September 20, 2013	<i>Gap analysis conducted and results reported</i> <ul style="list-style-type: none"> • State hospital's current competencies and performance levels • Identify the hospital's current and expected clinical performance • Description of how the project selected will reduce the gap between current and expected clinical performance
		Complete budget analysis to be performed for project.		<i>Budget analysis developed and completed</i> <ul style="list-style-type: none"> • Provide project budget estimation that includes line item expenditure information. • Provide estimates of health-care dollars savings.
		Identify partners who would be beneficial to the project development and maintenance.		<i>Identification of partners for the project completed</i> <ul style="list-style-type: none"> • Provide comprehensive documentation on partner(s) including name, address, business type (for profit, non profit), services provided, National Provider Identifier (NPI) number, Tax ID # and corporate ownership information. • State how the partner will participate in the plan.



New Jersey DSRIP Toolkit
Hospital DSRIP Plan Template

Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Application DY 2: The following are required to be completed as part of the DSRIP Plan

Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metric(s) (Minimum Documentation Requirements)
1.	Identify key program components and goals. Continued.	Identify target population to include in the project.	September 20, 2013	<i>Project target population documented</i> <ul style="list-style-type: none"> • Target population inclusion/exclusion criteria and size • Documentation of rationale for <ul style="list-style-type: none"> ○ Target population ○ Target population size
2.	Identify project protocols and interventions.	Develop discharge planning interventions.	September 20, 2013	<i>Discharge planning interventions are described</i> <ul style="list-style-type: none"> • Description of current and updated discharge planning processes • Description of expected outcomes
		Determine case management/care coordination needs of the target population for the project.		<i>Case management/care coordination processes documented</i> <ul style="list-style-type: none"> • Description of current and updated case management processes • Description of expected outcomes
		Determine patient/caregiver education tools to be utilized for the project.		<i>Patient/caregiver education tools to be utilized are documented</i> <ul style="list-style-type: none"> • Description of patient/caregiver education plan including rationale for plan selection and anticipated tools to provide effective patient/caregiver education
		Determine provider education tools to be utilized for the project.		<i>Provider education plan is outlined</i> <ul style="list-style-type: none"> • Description of provider education plan, including rationale for plan selection and anticipated tools to provide effective provider education



New Jersey DSRIP Toolkit
Hospital DSRIP Plan Template

Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Application DY 2: The following are required to be completed as part of the DSRIP Plan

Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metric(s) (Minimum Documentation Requirements)
2.	Identify project protocols and interventions. Continued.	Perform social support assessment and identify referral interventions to be developed for the project.	September 20, 2013	<i>Social support assessment completed and referral interventions identified</i> <ul style="list-style-type: none"> • Description of current social support assessment and referral processes • Outline of new/revised social support assessment and referral process • Description of expected outcome based on social support assessment and referral process changes
		Outline patient self care skills plan.		<i>Patient self care plan is outlined</i> <ul style="list-style-type: none"> • Documentation of objectives for a patient self care plan, including rationale for plan. • Description of expected patient outcomes
		Outline scope and design of the telemedicine program.		<i>Telemedicine program assessment completed</i> <ul style="list-style-type: none"> • Completed needs assessment, which includes technology to be utilized, telecommunication processes, development of an infrastructure, operational challenges and staffing resources and expected training. • Description of expected program goals and patient outcomes



New Jersey DSRIP Toolkit
Hospital DSRIP Plan Template

Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Application DY 2: The following are required to be completed as part of the DSRIP Plan

Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metric(s) (Minimum Documentation Requirements)
2.	Identify project protocols and interventions. Continued.	Determine assessment/ checklist/ screening tools required to meet the objectives of the project.	September 20, 2013	<i>Determination of assessment/checklist and/or screening tools</i> <ul style="list-style-type: none"> Documentation requirements include: <ul style="list-style-type: none"> Number of tools to be developed or modified Modifications made if applicable Rationale for new or modified tools Documentation standards for tools
		Outline a medical home model.		<i>Medical home model outline developed</i> <ul style="list-style-type: none"> Provide plan that addresses the following: <ul style="list-style-type: none"> Identification of access to care issues Description of expected patient outcome based on medical home implementation Identification of Medical Home project team and champions Project plan implementation timeframes
		Outline patient group visits plan assessment.		<i>Patient group visit plan outline completed</i> <ul style="list-style-type: none"> Provide plan that addresses the following: <ul style="list-style-type: none"> Identification of access to care issues Description of expected patient outcomes
		Outline a nutritional support plan.		<i>Nutritional support plan outline completed</i> <ul style="list-style-type: none"> Nutritional support plan outline, including rationale for plan selection and implementation strategy. Description of expected patient outcomes



New Jersey DSRIP Toolkit
Hospital DSRIP Plan Template

Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Application DY 2: The following are required to be completed as part of the DSRIP Plan

Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metric(s) (Minimum Documentation Requirements)
2.	Identify project protocols and interventions. Continued.	Outline a plan for a home visits program.	September 20, 2013	<i>Home visit plan outline completed</i> <ul style="list-style-type: none"> • Provide comprehensive plan of care detailing what anticipated activities will be performed during each home visit. • Description of expected patient outcomes
3.	Identify multi-therapeutic medical and support team.	Determine project staffing needs, including identifying whether project requires utilizing existing staff or hiring new staff or a combination of the two.	September 20, 2013	<i>Staffing needs are documented</i> <ul style="list-style-type: none"> • Provide staffing plan that includes: <ul style="list-style-type: none"> ○ Type and number of health care professionals required (MD, RN, and RD etc.) ○ Type and number of administrative/support staff needed ○ Estimated project time per week per project staff member ○ Identification of project leader ○ Identification of need of project champion ○ Project organization chart
4.	Identify staff education needs.	Assess education needs and determine education/communication methods, including duration, frequency and timelines.	September 20, 2013	<i>Education plan design completed</i> <ul style="list-style-type: none"> • Describe staffing education needs, training methods, duration and frequency. • Plan includes a timeline for education plan to be completed and implemented.



New Jersey DSRIP Toolkit
Hospital DSRIP Plan Template

Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Application DY 2: The following are required to be completed as part of the DSRIP Plan

Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metric(s) (Minimum Documentation Requirements)
5.	Identify physical space/ settings/ supplies.	Determine program requirement for physical space/ setting/ supplies or a combination of both.	September 20, 2013	<p><i>Physical space, setting and supplies assessment completed</i></p> <ul style="list-style-type: none"> • Description of physical space(s) including operational tasks (e.g. setting up phone line, and purchase of office equipment) • Description of the project setting(s) • Listing of any supplies required for the project
6.	Identify patient supplies and equipment.	Determine the patient supplies and equipment required for the project in the outpatient and home settings.	September 20, 2013	<p><i>Necessary patient supplies and equipment for implementation of the project have been determined</i></p> <ul style="list-style-type: none"> • Description of patient supplies and equipment needed, as well as, the means to procure the supplies and equipment (as applicable). • Statement as to whether the member supplies or equipment will be billable or a hospital absorbed cost.
7.	Identify technical needs.	Assess available software/ hardware and determine need for new software/hardware or other technology.	September 20, 2013	<p><i>Software/hardware and technology needs for the project have been determined</i></p> <ul style="list-style-type: none"> • Description of existing software/hardware sources • Description of new technology, including software/hardware to be utilized, including the method for obtaining the new technology, the estimated cost, timeline for acquisition, and rationale



Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Application DY 2: The following are required to be completed as part of the DSRIP Plan

Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metric(s) (Minimum Documentation Requirements)
8.	Identify data needs.	Assess available data sources to determine if additional data sources are required.	September 20, 2013	<i>Data sources required for the project are documented</i> <ul style="list-style-type: none"> • Description of existing data sources to be utilized for the project • Description of new data, including the method for obtaining the data source, the estimated cost, timeline for acquisition, and rationale
9.	Identify marketing/ outreach needs.	Assess and determine marketing and outreach materials needed for the project.	September 20, 2013	<i>Completion of an assessment of required marketing/outreach needs</i> <ul style="list-style-type: none"> • Anticipated marketing/outreach plan, including the intended audience (e.g. patient, provider, or community), communication methods, communication frequency and timelines.
10.	Report Baseline Data for Non-Claims Based Stage 3 and Stage 4 Metrics.	Provide baseline data in accordance to the directives from the Department.	September 20, 2013 ²³	<i>Submission of baseline data</i> <ul style="list-style-type: none"> • Baseline data information for non-claims based metrics • For any baseline data that is not currently being collected, the hospital shall provide a plan outlining the means and timeline to collect and submit the data per the reporting requirements

²³ If hospital cannot provide one or more non-claim based metrics, the hospital will be required to include in the application and future progress reports the rationale for omission of the metric and a plan for obtaining the metric by the **October 31, 2014 (DY3)**, unless otherwise stated in the databook.



Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Stage I. Infrastructure Development

Project Stage I: Lays the foundation for delivery system transformation through increased use in technology, tools, and human resources

Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metrics (Minimum Submission Requirements)
1.	Develop methodology to identify pilot population.	Select all applicable population criteria (e.g. setting, age, diagnosis, gender, payer status, total count, data sources) and develop algorithms to determine pilot population.	User will be prompted to enter the expected month/year <u>each</u> activity will be completed.	<i>Target population determined</i> <ul style="list-style-type: none"> Documentation of the target population criteria (e.g. setting, age, diagnosis, gender, payer status, total count, data sources)
2.	Develop health assessment/ risk stratification tool to assist in identifying the health risk of project participants.	Develop algorithms and/or decision tree to assist clinician in identifying the health risk of project participants.	Stage I Activities must be completed by September 30, 2014.	<i>Algorithms and/or decision tree developed</i> <ul style="list-style-type: none"> Documentation of the algorithms and/or decision tree



New Jersey DSRIP Toolkit
Hospital DSRIP Plan Template

Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Stage I. Infrastructure Development

Project Stage I: Lays the foundation for delivery system transformation through increased use in technology, tools, and human resources

Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metrics (Minimum Submission Requirements)
3.	Procure multi-therapeutic medical and support team that will be dedicated to the DSRIP project.	Utilize existing staff. Utilize new staff.	User will be prompted to enter the expected month/year <u>each</u> activity will be completed. Stage I Activities must be completed by September 30, 2014]	<i>Staffing in place for initiation of the project</i> <ul style="list-style-type: none"> List the number of health care professionals initially identified in the application as required (MD, RN, RD etc.) and for each professional, indicate <ul style="list-style-type: none"> The health care professionals hired The employment status (full-time, part-time, contracted) The approximate expected project hours worked per week List the number of administrative/support staff initially identified in the application as required and for each staff. List the administrative/support staff hired and for each, indicate <ul style="list-style-type: none"> Employment status (full-time, part-time, contracted) The approximate expected project hours worked per week Project leader(s)' credentials and weekly project time commitment Project champion(s)' credentials and weekly project time commitment
4.	Procure partners.	Partnerships required to conducting the project are established.		<i>Partnerships are in place for initiation of the project</i> <ul style="list-style-type: none"> Contracts/memorandums of understanding/letters of engagement with partners



New Jersey DSRIP Toolkit
Hospital DSRIP Plan Template

Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Stage I. Infrastructure Development

Project Stage I: Lays the foundation for delivery system transformation through increased use in technology, tools, and human resources

Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metrics (Minimum Submission Requirements)
5.	Procure staff education needs.	Determine education/communication method. Determine education groups (Governing Board, Medical Staff, Management, etc.) Determine education duration and frequency and timelines.	[User will be prompted to enter the expected month/year each activity will be completed. Stage I Activities must be completed by September 30, 2014]	<i>Staff education plan documented</i> <ul style="list-style-type: none"> • Provide completed educational plan. Documentation should include: <ul style="list-style-type: none"> ○ Training topic ○ An overview of the training topic, including the overall goal of the training ○ Identification of education group ○ Staff level required to attend ○ Estimated training dates and times ○ Place of training
6.	Procure physical space/ settings/ supplies.	Physical space, setting and/or supplies are in place.		<i>Physical space, setting and/or supplies are utilized</i> <ul style="list-style-type: none"> • Floor plan of existing space that will be used for the project • Lease agreement for new space • Purchase orders for supplies and equipment
7.	Procure patient supplies and equipment.	Patient supplies for both the outpatient and home setting are purchased.		<i>Patient supplies inventory completed</i> <ul style="list-style-type: none"> • List of patient supplies procured • Purchase orders for patient supplies and equipment
8.	Procure technical needs.	Technical resources are in place (may include software, hardware or other technology).		<i>Technical resources are operational</i> <ul style="list-style-type: none"> • List of technical resources procured. • Purchase order for technical resources (software, hardware, other technology, etc)
9.	Procure data needs.	Existing and new data sources are in place.		<i>Data sources are operational</i> <ul style="list-style-type: none"> • List of data sources acquired • Documentation on data query development and data validation processes



New Jersey DSRIP Toolkit
Hospital DSRIP Plan Template

Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Stage I. Infrastructure Development

Project Stage I: Lays the foundation for delivery system transformation through increased use in technology, tools, and human resources

Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metrics (Minimum Submission Requirements)
10.	Procure marketing/ outreach needs.	Marketing and outreach tools are produced.	[User will be prompted to enter the expected month/year <u>each</u> activity will be completed. Stage I Activities must be completed by September 30, 2014]	<i>Marketing materials are sent to intended audience</i> <ul style="list-style-type: none"> • Copies of materials developed • Advertisements for outreach events • Dates for outreach events and number of attendees
11.	Establish project protocols and interventions.	Develop new or enhanced discharge planning tools.		<i>Discharge planning tool completed</i> <ul style="list-style-type: none"> • All discharge planning documents developed for project
		Establish new or enhanced care coordination processes.		<i>Care coordination processes plan completed.</i> <ul style="list-style-type: none"> • All documentation pertaining to the care coordination processes plan for project
		Establish patient/caregiver education.		<i>Patient/caregiver education completed</i> <ul style="list-style-type: none"> • Examples of patient/caregiver materials given to patients and/or caregivers
		Establish provider education.		<i>Provider education plan completed.</i> <ul style="list-style-type: none"> • Provide documentation of completed educational offerings. Documentation should include date, time and place of training, an overview of the training topic, number of staff trained and number of staff to yet be trained
		Establish social support and referral processes.		<i>Social support and referral processes plan completed</i> <ul style="list-style-type: none"> • Documentation of social support and referral processes developed for project
		Develop patient self care skills plan.		<i>Patient self care skills plan completed.</i> <ul style="list-style-type: none"> • Submit patient care skills plan



New Jersey DSRIP Toolkit
Hospital DSRIP Plan Template

Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Stage I. Infrastructure Development

Project Stage I: Lays the foundation for delivery system transformation through increased use in technology, tools, and human resources

Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metrics (Minimum Submission Requirements)
11.	Establish project protocols and interventions. Continued.	Determine telemedicine program.	[User will be prompted to enter the expected month/year <u>each</u> activity will be completed. Stage I Activities must be completed by September 30, 2014]	<i>Telemedicine program plan completed</i> <ul style="list-style-type: none"> • Provide documentation that equipment has been ordered and installed, testing of the equipment performed and staff training completed
		Develop or enhance hospital and/or patient screening tools (checklists, assessments etc.).		<i>Hospital and/or patient screening tools development completed</i> <ul style="list-style-type: none"> • Copies of hospital screening tools • Copies of patient checklists
		Establish medical home plan.		<i>Medical home plan completed</i> <ul style="list-style-type: none"> • List of physician participants • Description of care improvement strategies • Project roll-out timelines • Description of physician education on initiative • Description of community outreach plan
		Establish patient group visit(s) plan.		<i>Patient group visits plan developed</i> <ul style="list-style-type: none"> • Number of staff who will conduct visits • Frequency of visits • Expected patient outcomes
		Establish nutritional support plan.		<i>Nutritional support plan completed.</i> <ul style="list-style-type: none"> • Nutritional support plan including documentation on roll-out procedures of the plan
		Determine home visit plan.		<i>Home visits plan developed</i> <ul style="list-style-type: none"> • Home visits plan including services to be performed and expected patient outcomes



New Jersey DSRIP Toolkit
Hospital DSRIP Plan Template

Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Stage I. Infrastructure Development

Project Stage I: Lays the foundation for delivery system transformation through increased use in technology, tools, and human resources

Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metrics (Minimum Submission Requirements)
12.	Develop quality improvement activities.	Development of a comprehensive quality improvement plan.	[User will be prompted to enter the expected month/year <u>each</u> activity will be completed. Stage I Activities must be completed by September 30, 2014]	<i>Completion of quality improvement plan</i> <ul style="list-style-type: none"> • Quality improvement plan including: <ul style="list-style-type: none"> ○ Aim statement ○ Rationale for quality plan tools and methods ○ Any documentation used from other sources to create the plan ○ Driver diagram ○ Rapid-cycle evaluation
13.	Conduct patient satisfaction survey.	Conduct patient satisfaction survey to track the patient satisfaction of DSRIP patients.	Quarterly throughout the Demonstration	<i>Patient satisfaction surveys conducted.</i> <ul style="list-style-type: none"> • Provide documentation of the patient satisfaction survey results. Documentation should include: <ul style="list-style-type: none"> ○ The number of surveys sent to patients ○ The method of survey delivery (email, text, mail, etc) ○ Incentives provided to patients/family members to complete the survey ○ The number of surveys returned ○ The satisfaction scale (satisfied/not satisfied; good/fair/bad) used ○ Summary of survey results, by question



Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Stage I. Infrastructure Development

Project Stage I: Lays the foundation for delivery system transformation through increased use in technology, tools, and human resources

Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metrics (Minimum Submission Requirements)
14.	Conduct staff education/training sessions on all applicable project tools, checklists, processes, protocols and intervention procedures.	Training/education sessions on applicable project tools, checklists, processes, protocols and intervention procedures are conducted.	Quarterly throughout the Demonstration	<i>Project staff education/training conducted</i> <ul style="list-style-type: none"> • Documentation should include: <ul style="list-style-type: none"> ○ Name and overview of the training topic, including the overall goal of the training ○ Staff level required to attend ○ Training dates and times ○ Place of training ○ List of attendees (i.e. sign in sheets) ○ Plan for training project staff members who were absent during training



Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Stage I. Infrastructure Development

Project Stage I: Lays the foundation for delivery system transformation through increased use in technology, tools, and human resources

Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metrics (Minimum Submission Requirements)
15.	Project Staff Evaluation/Assessment.	Perform an evaluation of project staff member's performance on the project.	Quarterly throughout the Demonstration	<i>Evaluation completed for each project staff member</i> <ul style="list-style-type: none"> • List of all project staff members • Identify whether staff member should be retained for project and the rationale for the decision to retain • Identify whether staff member's project hours should be increased, reduced or eliminated and the rationale • Identify the number (if any) additional staff members required for the project, noting the type of staff required (i.e. health care professional, administrative/support) and the rationale for the addition • Identify additional project staff hired since last submission and for each, indicate <ul style="list-style-type: none"> ○ Employment status (full-time, part-time, contracted) ○ The approximate expected project hours worked per week



New Jersey DSRIP Toolkit
Hospital DSRIP Plan Template

Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]				
Stage II. Chronic Medical Condition Redesign and Management				
Project Stage II: Piloting, testing and replicating of innovative care models				
Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metrics (Minimum Submission Requirements)
1.	Initiate pilot program.	Pilot program started.	User will be prompted to enter the expected month/year <u>each</u> Stage II activity will be completed. These Stage II Activities must be completed by March 31, 2015.	<i>Pilot program initiated</i> <ul style="list-style-type: none"> Documentation supporting pilot program was started including any challenges encountered during the start-up process
2.	Evaluate pilot program and re-engineer and/or re-design based on pilot results.	Determine metric-driven changes and initiate adjustments and redesign of program requirements as needed.		<i>Evaluation documented</i> <ul style="list-style-type: none"> Documentation indicating all project changes made and the rationale for those changes Documentation supporting the decision-making process for changes to DSRIP project plan including program requirements and collection of data for metrics
3.	Initiate program protocols and interventions for entire population.	Full implementation of the project performed.		<i>Implementation of the project to the entire population completed</i> <ul style="list-style-type: none"> Documentation showing total number of patients in the program Documentation supporting protocols and interviews have been initiated for the entire population Documentation indicating that the intervention(s) has been initiated for the entire population Please note: Protected Health Information (PHI) should not be included in submitted documentation.



New Jersey DSRIP Toolkit
Hospital DSRIP Plan Template

Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]				
Stage II. Chronic Medical Condition Redesign and Management				
Project Stage II: Piloting, testing and replicating of innovative care models				
Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metrics (Minimum Submission Requirements)
4.	Ongoing monitoring of program outcomes.	Trending and tracking of data reporting.	These Stage II Activities are required to be completed on a quarterly basis throughout the Demonstration, starting with the first quarter DY3 (Sept. 30, 2014).	<i>Trend report developed and implemented</i> <ul style="list-style-type: none"> • Number of data points being monitoring • Trending monitored • Frequency of monitoring
5.	Provide feedback to hospital administrators and participating providers.	Provide review of project to hospital administration and participating providers.		<i>Communication on project achievement to hospital administrators and participating providers completed</i> <ul style="list-style-type: none"> • Documentation, such as meeting minutes, attendees, and supporting correspondence providing feedback with hospital administrators and participating providers
6.	Provide feedback to the learning collaborative.	Participating providers engage in learning collaborative for the DSRIP program to promote sharing of best practices and resolutions to problems encountered.		<i>Number of monthly phone calls attended</i> <i>Number of attended quarterly webinars</i> <ul style="list-style-type: none"> • Documentation supporting participation with the New Jersey Learning Collaborative such as copies of correspondence and meeting attendance/attendees • Summary of Learning Collaborative engagement and results



Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Stage III. Quality Improvements

Project Stage III: Requires hospitals to implement interventions to achieve clinical improvement.

Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metrics (Minimum Submission Requirements)
1.	Report Stage III Project-Specific Metrics for DY2.	Report Stage III Project-Specific Metrics for DY2.	April 2014	<i>Stage III project-specific Metrics are reported for DY2</i> <ul style="list-style-type: none"> ○ Databook containing project-specific metrics for DY2 ○ Attestation of verification for all DY2 metrics (both claims-based and non-claims based) ○ For any metric which cannot be reported, hospital shall submit an updated status report on its plan for reporting the metric by October 31, 2014.
2.	Report Stage III Project-Specific Metrics for DY3.	Report Stage III Project-Specific Metrics for DY3.	October 2014 April 2015	<i>Stage III project-specific metrics are reported for DY3</i> <ul style="list-style-type: none"> ○ Databook containing project-specific metrics for DY3 ○ Attestation of verification for all DY3 metrics (both claims-based and non-claims based)



New Jersey DSRIP Toolkit
Hospital DSRIP Plan Template

Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Stage III. Quality Improvements

Project Stage III: Requires hospitals to implement interventions to achieve clinical improvement.

Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metrics (Minimum Submission Requirements)
3.	Report and Meet Stage III Project-Specific Metric Improvement Target for DY4.	Report and Meet Stage III Project-Specific Metric Improvement Target for DY4.	October 2015 April 2016	<p><i>Stage III project-specific metrics are reported and improvement target for metric is met or exceeded</i></p> <ul style="list-style-type: none"> ○ Databook containing project-specific metrics for DY4 ○ Attestation of verification for all DY4 metrics (both claims-based and non-claims based) <p>Note: All Stage III metrics are required to be reported for pay for performance (P4P) funding. Funding is available if the hospital meets at least one P4P project-specific metric improvement target. See FMP for further detail.</p>
4.	Report and Meet Stage III Project-Specific Metric Improvement Target for DY5.	Report and Meet Stage III Project-Specific Metric Improvement Target for DY5.	October 2016 April 2017	<p><i>Stage III project-specific metrics are reported and improvement target for metric is met or exceeded</i></p> <ul style="list-style-type: none"> ○ Databook containing project-specific metrics for DY5 ○ Attestation of verification for all DY5 metrics (both claims-based and non-claims based) <p>Note: All Stage III metrics are required to be reported for pay for performance (P4P) funding. Funding is available if the hospital meets at least one P4P project-specific metric improvement target. See FMP for further detail.</p>



New Jersey DSRIP Toolkit Hospital DSRIP Plan Template



Focus Area: [Pre-populates based on initial selection]

Project Title: [Pre-populates based on initial selection]

Stage IV. Population Focused Improvements

Project Stage IV: Requires hospitals to report on population-focused activities which could include the patient's experience, the effectiveness of care coordination, prevention and health outcomes of at-risk populations.

Row ID	Column 1	Column 2		Column 3
	Activity	Actions/ Milestones	Completion Month/Year	Metrics (Minimum Submission Requirements)
1.	Report Stage IV Universal Metrics for DY2.	Report Stage IV Universal Metrics for DY2.	April 2014	<i>Stage III Universal Metrics are reported for DY2.</i> <ul style="list-style-type: none"> ○ Databook containing universal metrics ○ For any metric which cannot be reported, hospital shall submit a plan for reporting the metric by October 31, 2014.
2.	Report Stage IV Universal Metrics for DY3.	Report Stage IV Universal Metrics for DY3.	October 2014 April 2015	<i>Stage IV Universal Metrics are reported for DY3.</i> <ul style="list-style-type: none"> ○ Databook containing universal metrics
3.	Report Stage IV Universal Metrics for DY4.	Report Stage IV Universal Metrics for DY4.	October 2015 April 2016	<i>Stage Universal Metrics are reported for DY4.</i> <ul style="list-style-type: none"> ○ Databook containing universal metrics
4.	Report Stage IV Universal Metrics for DY5.	Report Stage IV Universal Metrics for DY5.	October 2016 April 2017	<i>Stage IV Universal Metrics are reported for DY5.</i> <ul style="list-style-type: none"> ○ Databook containing universal metrics



V. Acronym Key

1. AHRQ Agency for Healthcare Research and Quality
2. AMA American Medical Association
3. AMA-PCPI American Medical Association – Physician Consortium for Performance Improvement
4. CDC Centers for Disease Control and Prevention
5. CMS Centers for Medicare & Medicaid Services
6. CQAIHM Center for Quality Assessment and Improvement in Mental Health
7. EHR Electronic Health Record
8. HAB HIV/AIDS Bureau
9. HRSA Health Resources and Services Administration
10. ICSI Institute for Clinical Systems Improvement
11. MCHB Maternal and Child Health Bureau
12. MMIS Medicaid Management Information System
13. NCQA National Committee for Quality Assurance
14. P4P Pay for Performance
15. UPP Universal Performance Pool



VI. Hospital DSRIP Plan Submission Requirements

Each hospital must submit their initial DSRIP documents to the New Jersey Department of Health no later than 5:00 p.m. Eastern Time on **September 20, 2013**. The initial submission must include ALL of the following completed deliverables:

A. *DSRIP Checklist*

The Checklist, to be included with the hospital's submission of their DSRIP plan, is on the following page.

B. *DSRIP Project Application*

The Hospital DSRIP Plan must be completed in its entirety and must include the following which may be sent as addendums:

a. Community Needs Assessment

- i. Demographic information (e.g., race/ethnicity, income, education, employment, etc.)
- ii. Insurance coverage (e.g., commercial, Medicaid, Medicare, uncompensated care)
- iii. Description of the current health care infrastructure and environment (e.g., number/types of providers, services, systems, and costs; Health Professional Shortage Area [HPSA]).
- iv. Description of any initiatives in which the hospital is participating in that are funded by the U.S. Department of Health and Human Services and any other relevant delivery system reform initiatives underway.
- v. Description of changes in the above areas that are expected to occur during the waiver period (especially those related to changes in health care coverage anticipated in 2014, such as Medicaid expansion).
- vi. Description of how hospitals will include and/or coordinate with their local health officials in the DSRIP project and community needs assessment. The Department strongly encourages collaboration between participating hospitals and public health.
- vii. Key health challenges specific to the hospital's surrounding area supported by data (e.g., high diabetes rates, access issues, high emergency department utilization, etc.).

b. Public Input Process

- i. Hospitals must consider local public health departments as part of the public input process.
- ii. Public stakeholders and consumers, including processes used to solicit public input into hospital DSRIP Plan development and opportunities for public discussions and review prior to plan submission.
- iii. A plan for ongoing engagement with public stakeholders.
- iv. At a minimum, a description of public meetings that were held and the process for submitting public comment on the hospital DSRIP plan.



C. Signed Attestation

The Attestation, to be included with the hospital's submission of their DSRIP plan, is included after the New Jersey Hospital DSRIP Checklist. This attestation must be signed by a hospital corporate executive, such as the Chief Executive Officer (CEO), Chief Operating Officer (COO), etc.

D. DSRIP Plan Submission

All submissions will be date and time stamped when received by The New Jersey Department of Health. The preferred method of submission is via the Myers and Stauffer Secure File Transfer Protocol (FTP) site: <https://transfer.mslc.com/>

- Use of the FTP requires user to provide Myers and Stauffer with basic information and sign an user agreement form
- Upon receipt of these documents, each individual user would receive a private username and password in order to upload documents to the site; limited to two users per hospital
- User Agreement Forms must be received by August 16, 2013 in order to ensure access to the FTP site
- Request for FTP access may be sent to NJDSRIP@mslc.com

If a hospital cannot access the FTP site, the Hospital DSRIP Applications may be sent by:

Regular Mail

Attention: Brian O'Neill, Executive Director, Office of Healthcare Financing
NJ Department of Health
PO Box 360
Trenton, NJ 08625-0360

OR

Overnight or Hand Deliveries

Attention: Brian O'Neill, Executive Director, Office of Healthcare Financing
NJ Department of Health
8th Floor, Health and Agriculture Building
369 South Warren Street
Trenton, NJ 08608



New Jersey Hospital DSRIP Checklist

Hospital Name:	
Hospital Medicaid ID Number:	
Hospital Contact:	
Hospital Contact Telephone Number:	
Hospital Contact Email Address:	

This checklist must be completed for this submission. This submission to the Myers and Stauffer FTP must include the following:

- The copy of the signed attestation form
- The copy of the completed New Jersey Hospital DSRIP Checklist
- Application, to include the following tabs from the Application file:
 - Executive Summary
 - Application DY2
 - Application Stage I
 - Application Stage II
 - Application Stage III
 - Application Stage IV
- Attachments supporting the application
- Baseline data for non-claim based metrics for Stage III and Stage IV, or a plan documenting the means and timeline to collect and submit the data per reporting requirements

Submissions submitted **via mail or hand delivery** should include:

- 2 hardbound copies of the above Hospital DSRIP Plans
- A CD with:
 - Word¹ file copy or PDF² of the completed New Jersey Hospital DSRIP Checklist
 - Word¹ file copy or PDF² of the signed attestation form
 - Application saved in Excel¹ format
 - Any Addendums submitted as Word¹, Excel¹ or PDF² files

¹ Word and Excel files must be in a Microsoft® Office 2003 or a later version.

² PDF files should allow for OCR text recognition.



ATTESTATION OF FINANCIAL AND OTHER DATA REPORTED BY [HOSPITAL ORGANIZATION] PARTICIPATING IN THE DELIVERY SYSTEM REFORM INCENTIVE PAYMENT (DSRIP) PROGRAM TO THE NEW JERSEY DEPARTMENT OF HEALTH (NJ DOH)

Pursuant to the Provider Agreement between the State of New Jersey and [*Hospital Organization*], the undersigned states and warrants, based on its best knowledge, information, and belief, that the information provided by [*Hospital Organization*] to the State is accurate, complete, and truthful, and is consistent with the ethics statements and policies of the New Jersey Department of Health (DOH). This attestation includes information provided by the [*Hospital Organization*] in response to the DOH request for documentation. This attestation also includes data and documentation provided, and statements made to the DOH, Myers and Stauffer, and/or other DOH designated representatives by the management or staff of [*Hospital Organization*] or its subcontractors.

As it pertains to information provided by the undersigned [*Hospital Organization*] I, _____, do hereby attest that the information provided is true and correct to the best of my knowledge, that I will submit data and reports as specified by the DOH, that I will cooperate fully with the DOH (and its contractors) on its evaluation and improvement collaboration efforts, and that I will cooperate fully with any evaluation that the DOH or CMS might conduct. I further acknowledge and understand that I may be subject to sanctions and/or penalties, if I knowingly and willfully make a false or fraudulent statement or representation to the Department regarding Data, Financial, or other information pursuant to Section 1909 of P.L. 92-603, Section 2428.

Printed Name of Organization

Date

Printed Name of Signatory

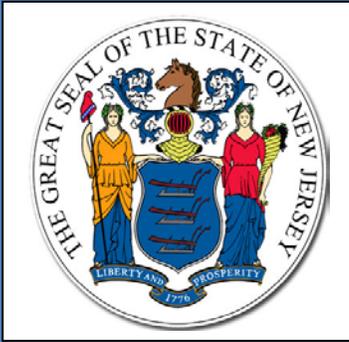
Signature

Title (CEO, COO, etc.)



VII. Contact Information

Questions regarding the New Jersey DSRIP Toolkit or NJ DSRIP Plan Application may be forwarded to NJDSRIP@mslc.com or contact Brian O’Neill at (609) 292-7874.



STATE OF NEW JERSEY DEPARTMENT OF HUMAN SERVICES

Section 93(f) of the Special Terms and Conditions (STCs) for New Jersey's "Comprehensive Waiver" section 1115(a) Medicaid and Children's Health Insurance Plan (CHIP) demonstration operated by the New Jersey Department of Human Services, Division of Medical Assistance and Health Services (the "Department") requires the development of "a DSRIP Program Funding and Mechanics Protocol to be submitted to CMS for approval... This document represents the Department's initial draft to the Centers for Medicare and Medicaid Services (CMS).

*Delivery System
Reform Incentive
Payment (DSRIP)
Program Funding
and Mechanics
Protocol*

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I. Preface

A. DSRIP Planning Protocol and Program Funding and Mechanics Protocol

This document is the DSRIP Funding and Mechanics Protocol submitted for approval by the New Jersey Department of Human Services (Department) to the Centers for Medicare & Medicaid Services. This document is Version 0.8, dated July 29, 2013.

Unless otherwise specified, denoted dates refer to calendar days, and any specified date that falls on a weekend or holiday is due the prior business day.

B. High Level Organization of "Attachment I: Program Funding and Mechanics Protocol"

Attachment I has been organized into the following sections.

- I. Preface
- II. Hospital DSRIP Plan Guidelines and Approval Process
- III. Reporting Requirements
- IV. Hospital's DSRIP Target Funding Amount
- V. Allocation of Hospital's Adjusted DSRIP Target Funding Amount to DSRIP Stages
- VI. DSRIP Payment Based on Achievement of Milestones and Metrics
- VII. DSRIP Payment Calculations
- VIII. Plan Modifications

C. DSRIP Eligibility Criteria

The hospitals eligible to receive funding under the DSRIP program during Demonstration Year (DY) 2 through DY5 are general acute care hospitals shown in the table below.

Table I. HOSPITALS ELIGIBLE FOR TRANSITION AND DSRIP PAYMENTS

Medicaid No.	Medicare No.	Hospital Name	County
4139402	310064	ATLANTICARE REG'L MEDICAL CENTER	ATLANTIC
4136705/0167011	310025	BAYONNE HOSPITAL	HUDSON
4141105	310112	BAYSHORE COMMUNITY HOSPITAL	MONMOUTH
4139003	310058	BERGEN REG'L MEDICAL CENTER	BERGEN
4135709	310011	CAPE REGIONAL MEDICAL CENTER	CAPE MAY

Medicaid No.	Medicare No.	Hospital Name	County
3676609	310092	CAPITAL HEALTH SYSTEM - FULD CAMPUS	MERCER
4138201	310044	CAPITAL HEALTH SYSTEM - HOPEWELL	MERCER
4141008	310111	CENTRASTATE MEDICAL CENTER	MONMOUTH
4136209	310017	CHILTON MEMORIAL HOSPITAL	MORRIS
3674207	310016	CHRIST HOSPITAL	HUDSON
4135504	310009	CLARA MAASS MEDICAL CENTER	ESSEX
3674606	310041	COMMUNITY MEDICAL CENTER	OCEAN
4136004	310014	COOPER UNIVERSITY MEDICAL CTR	CAMDEN
4137205	310031	DEBORAH HEART & LUNG CENTER	BURLINGTON
4140001	310083	EAST ORANGE GENERAL HOSPITAL	ESSEX
4138309	310045	ENGLEWOOD HOSPITAL ASSOCIATION	BERGEN
3674100	310001	HACKENSACK UNIVERSITY MEDICAL CENTER	BERGEN
4141300	310115	HACKETTSTOWN COMMUNITY HOSPITAL	WARREN
4137906/0249297	310040	HOBOKEN HOSPITAL CENTER	HUDSON
4135407	310008	HOLY NAME HOSPITAL	BERGEN
4135202	310005	HUNTERDON MEDICAL CENTER	HUNTERDON
4139801	310074	JERSEY CITY MEDICAL CENTER	HUDSON
3675700	310073	JERSEY SHORE MEDICAL CENTER	MONMOUTH
3676803	310108	JFK MEDICAL CENTER {EDISON} / Anthony M. Yelencsics	MIDDLESEX
4140206	310086	KENNEDY MEMORIAL HOSPITALS AT STRATFORD	CAMDEN
3676200	310084	KIMBALL MEDICAL CENTER	OCEAN
3675203	310061	LOURDES MED CTR OF BURLINGTON CNTY	BURLINGTON
4141504/0249297	310118	MEADOWLANDS HOSPITAL MEDICAL CENTER	HUDSON
3674908	310052	MEDICAL CENTER OF OCEAN COUNTY	OCEAN
4138902	310057	MEMORIAL HOSP OF BURLINGTON CTY (Virtua)	BURLINGTON
9031308	310091	MEMORIAL HOSPITAL OF SALEM COUNTY	SALEM
3675807	310075	MONMOUTH MEDICAL CENTER	MONMOUTH
4136101	310015	MORRISTOWN MEMORIAL HOSPITAL	MORRIS
4138708/0139564	310054	MOUNTAINSIDE HOSPITAL	ESSEX
4135008	310002	NEWARK BETH ISRAEL MEDICAL CENTER	ESSEX
4137001	310028	NEWTON MEMORIAL HOSPITAL	SUSSEX
4137108	310029	OUR LADY OF LOURDES MEDICAL CENTER	CAMDEN
3674801	310051	OVERLOOK HOSPITAL	UNION
4135105	310003	PALISADES GENERAL HOSPITAL	HUDSON
4137701	310038	R. W. JOHNSON UNIVERSITY HOSPITAL	MIDDLESEX
4137809	310039	RARITAN BAY MEDICAL CENTER	MIDDLESEX
4137400	310034	RIVERVIEW MEDICAL CENTER	MONMOUTH
3674401	310024	ROBERT WOOD JOHNSON AT RAHWAY HOSPITAL	UNION
3676901	310110	RWJ UNIVERSITY MEDICAL CTR AT HAMILTON	MERCER
3674703	310047	SHORE MEMORIAL HOSPITAL	ATLANTIC

Medicaid No.	Medicare No.	Hospital Name	County
4138406	310048	SOMERSET MEDICAL CENTER	SOMERSET
3674509	310032	SOUTH JERSEY HEALTH SYSTEM	CUMBERLAND
3675602	310069	SOUTH JERSEY HEALTH SYSTEM - ELMER	SALEM
4141202	310113	SOUTHERN OCEAN COUNTY HOSPITAL	OCEAN
3675904	310076	ST. BARNABAS MEDICAL CENTER	ESSEX
4138601	310050	ST. CLARE'S-RIVERSIDE MED CTR DENVILLE	MORRIS
4136608	310021	ST. FRANCIS MEDICAL CENTER (TRENTON)	MERCER
4136403	310019	ST. JOSEPH'S HOSPITAL MEDICAL CENTER	PASSAIC
4135300	310006	ST. MARY'S HOSPITAL (PASSAIC)	PASSAIC
4140508	310096	ST. MICHAEL'S MEDICAL CENTER	ESSEX
4139500	310070	ST. PETER'S MEDICAL CENTER	MIDDLESEX
4136900	310027	TRINITAS - ELIZABETH GENERAL	UNION
3676102	310081	UNDERWOOD MEMORIAL HOSPITAL	GLOUCESTER
3677001	310119	UNIVERSITY HOSPITAL	ESSEX
4135601	310010	UNIVERSITY MED CTR PRINCETON @ PLAINSBORO	MIDDLESEX
4135806	310012	VALLEY HOSPITAL	BERGEN
4139208	310060	ST. LUKE'S HOSPITAL (formerly Warren Hospital)	WARREN
3674304	310022	VIRTUA - WEST JERSEY HEALTH SYSTEM	CAMDEN
Hospital Count	63		

Note: St. Clare's Sussex #310120 closed Inpatient operations in Oct 2012.

II. Hospital DSRIP Plan Guidelines and Approval Process

A. Hospital DSRIP Plans

Each hospital that elects to participate in the DSRIP program must submit a Hospital DSRIP Plan in accordance with the Hospital DSRIP Plan guidelines outlined in Attachment H: DSRIP Planning Protocol and the accompanying Attachment 1: DSRIP Toolkit. In summary, hospitals will be required to submit a Hospital DSRIP Plan using a Department approved application that identifies the project, objectives, and specific milestones/metrics that meets all requirements pursuant to the Special Terms and Conditions (STCs) and Attachment H: DSRIP Planning Protocol.

Hospitals who do not submit a Hospital DSRIP Plan to the Department by September 20, 2013, with exception of hospitals meeting the criteria in subsection E below, will be precluded from participating in New Jersey DSRIP in subsequent demonstration years 2 through 5.

B. State of New Jersey Department of Health (Department) Review and Approval Process

On or before September 20, 2013, each eligible hospital, identified above in the list in subsection I.C, "DSRIP Eligibility Criteria," who decides to participate in DSRIP will submit a 3 1/2-year Hospital DSRIP Plan to the Department for review. The Department will review all Hospital DSRIP Plan applications prior to submission to CMS for final approval according to the schedule below.

On or before August 20, 2013, the Department will submit the Department's approach and review criteria for reviewing Hospital DSRIP Plan applications, as well as a draft DSRIP Plan Initial Review Checklist outlining the state's initial review of the DSRIP Plans to CMS. CMS will provide comments within one week of the Department's submission. CMS and the Department will work collaboratively to refine the criteria, approach, and DSRIP Plan Checklist to support a robust review process and compelling justification for approval of each project. In order to ensure the hospitals submit plans in accordance with the review criteria established, the Department and CMS will participate in periodic webcasts with the hospitals to provide training on the development and completion of the Hospital DSRIP Plan and applications, as well as to answer hospital questions on the review process. The Department will apply this review process to ensure that Hospital DSRIP Plans are thoroughly and consistently reviewed.

At a minimum, the Department shall review and assess each plan according to the following criteria using the DSRIP Plan Checklist:

- The plan is in the prescribed format and contains all required elements described herein and is consistent with special terms and conditions including STCs 93(g).
- The plan conforms to the requirements for Stages 1, 2, 3, and 4, as described herein, as well as in Attachment H: DSRIP Planning Protocol, and Attachment 1: DSRIP Toolkit, Section VI (Hospital DSRIP Plan Submission Requirements), Subsection A, "DSRIP Checklist."
- Stages 1 and 2 clearly identify goals, milestones, metrics, and expected results. Stage 3 clearly identifies the project-specific metrics to be reported. Stage 4 clearly identifies the population-focused health improvement measures (i.e. universal metrics) to be reported.
- The description of the project is coherent and comprehensive and includes a logic map clearly representing the relationship between the goals, the interventions and the measures of progress and outcome.
- The project selection is grounded in a demonstrated need for improvement at the time that the project is submitted and is sufficiently

comprehensive to meaningfully contribute to the CMS three part aim for better care for individuals, better health for the population, lower costs through improvement (i.e. Triple Aim).

- The goals are mapped to a robust and appropriate set of research hypotheses to support the evaluation.
- There is a coherent discussion of the hospital's participation in a learning collaborative that is strongly associated with the project and demonstrates a commitment to collaborative learning that is designed to accelerate progress and mid-course correction to achieve the goals of the project and to make significant improvement in the stage 3 and 4 outcome measures.
- The amount and distribution of funding is in accordance with Section VI: "DSRIP Payment Based on Achievement of Milestones and Metrics," included in this protocol.
- The plan, project, milestones, and metrics are consistent with the overall goals of the DSRIP program.

By November 4, 2013, the Department will submit two or three Hospital DSRIP Plans that the Department has approved, based on the agreed approach, review criteria, and DSRIP Plan Checklist. CMS will review the approved Plans, and by November 12, 2013, submit to the Department and comments or requests for modifications to the approach, review criteria, or checklist. The Department and CMS will agree to any modifications to the approach, review criteria, and checklist by November 18, 2013.

During the time the Department is reviewing Hospital DSRIP Plans, the Department and CMS will hold bi-weekly half-hour conference calls to share progress updates and discuss challenges and concerns.

Within 45 days of initial Hospital DSRIP Plan submission, the Department will complete its initial review of each timely submitted Hospital DSRIP Plan application using the DSRIP Plan Checklist, the Funding and Mechanics Protocol, the DSRIP Planning Protocol, and the STCs. The Department will notify the hospital in writing of any questions or concerns identified with the hospital's submitted DSRIP Plan.

The requesting hospital shall respond in writing to any notifications of questions or concerns by the Department. The hospital's responses must be received by the dates specified in the aforementioned notification. The requesting hospital's initial response may consist of a request for additional time to address the Department's comments provided that the hospital's revised (i.e., final) DSRIP plan addresses the Department's comments and is submitted to the Department within 15 days of the notification.

No later than December 13, 2013, the Department will take action on each timely submitted Hospital DSRIP Plan; will approve each plan that it deems has met the criteria outlined in Attachment H: DSRIP Planning Protocol, Attachment I: DSRIP Program Funding and Mechanics Protocol, and “DSRIP Plan Checklist”; and submit approved plans (along with their completed DSRIP Plan Checklists and supporting documentation) to CMS for final review and approval. The Department will notify the hospital in writing that the plan has been approved and submitted to CMS for consideration.

It is the Department’s intent to submit plans continuously in batches to CMS upon the Department’s approval of the Hospital’s DSRIP Plan in order to incorporate meaningful feedback from CMS into the Department’s DSRIP Plan review process.

C. CMS Review and Approval Process

CMS will review the hospitals’ 3 1/2-year Hospital DSRIP Plan upon receipt from the Department. CMS may at its discretion return any Hospital DSRIP Plan to the Department without review if it is received by CMS after December 13, 2013. Hospitals whose plans are returned by CMS for this reason are excluded from DSRIP, unless the hospital qualifies to submit a plan under subsection E, “Consideration of a Hospital’s DSRIP Plan Due to Exceptional Circumstance.”

CMS will conduct an initial review of the submitted Hospital DSRIP Plans, in order to validate the Department’s assessment based on the results from the Department’s DSRIP Plan review process and DSRIP Plan Checklist. CMS will notify the Department within 15 days of receipt, if based on its initial review it concludes that there were systemic gaps or weaknesses in the Department’s review of the Hospital DSRIP Plans. CMS and the Department will work together to develop guidance to the hospitals to revise and resubmit their plans, if necessary.

No later than January 31, 2014, CMS will complete its review of Department-approved Hospital DSRIP Plans, and will either:

- Approve the Hospital DSRIP Plan;
- Notify the Department if approval will not be granted for all or for a component of the Hospital DSRIP Plan.
 - Notice will be in writing and will include any questions, concerns, or issues identified in the application.

In the event CMS fails to take action by the deadline, the Plan shall be considered conditionally approved, however, the requesting hospital will not receive DSRIP payments until formal approval is rendered by CMS. The

Department will send written notification to the hospital within five business days following notice from CMS related to Hospital DSRIP Plan decisions.

In the event that CMS determines that a Hospital DSRIP Plan, or component thereof, requires revision, CMS may conditionally approve, but require modification to the deficient components of the plan. The hospital may then revise and resubmit its plan to the Department to remedy the deficiencies. The revised plan must be received by the Department no later than 15 days following the notification date of the conditional approval. During the resubmission period, the conditionally approved hospital will not receive DSRIP payments until formal approval is rendered by CMS.

Within 30 days of CMS notification, the Department shall submit the revised Hospital DSRIP Plans to CMS and CMS shall approve or deny the plans in writing to the Department by March 17, 2014. The Department will not draw any federal financial participation for DSRIP payments to a hospital prior to the date that CMS has approved the hospital's DSRIP Plan.

D. Review Process for Hospital-Specific Focus Area or Off-Menu Project

A pre-defined list of projects have been developed to move the cost and quality curve for eight prevalent or chronic conditions, or Focus Areas, listed in the Special Terms and Conditions. These Focus Areas are as follows:

- 1) Asthma
- 2) Behavioral Health
- 3) Cardiac Care
- 4) Chemical Addiction/Substance Abuse
- 5) Diabetes
- 6) HIV/AIDS
- 7) Obesity
- 8) Pneumonia

If a hospital chooses to develop a project that is not from the pre-defined list in Attachment H: DSRIP Planning Protocol, the hospital shall submit a 3 1/2-year Hospital DSRIP Plan to the Department for review on or before September 9, 2013.

In addition to the Hospital DSRIP Plan guidelines and the review and approval processes identified in subparagraphs B and C of this section, the hospital shall conduct an analysis and submit with the Hospital DSRIP Plan application a strong and compelling justification for the project selection by:

- i. Reviewing the menu of projects included in the DSRIP Planning Protocol, Attachment 1: DSRIP Toolkit (toolkit), and showing that the proposed

project could not be accommodated within any of the model projects of the toolkit.

- ii. Providing internal and external data to demonstrate that the new hospital project is beyond those listed in the toolkit, has an outpatient focus, and that it would achieve the Triple Aim.
- iii. Providing data demonstrating that the hospital-specific focus area or project is responsive to local data and community needs, and provides a greater opportunity to improve patient care for New Jersey's low income population by addressing an area of poor performance and/or health care disparity that is important to the Medicaid, CHIP and/or uninsured population.
- iv. Explaining why this "off-menu" project is particularly innovative or promising, and that it employs an evidence-based approach (with literature clearly cited).
- v. Identifying at least four Stage 3 project-specific metrics based on nationally recognized metrics (such as NQF-endorsed or NCQA-endorsed metrics) that will be used to monitor the clinical processes and outcomes of the project. The hospital should select from the Stage 3 catalogue of approved metrics, as applicable. The hospital must propose which outcome metrics should be tied to pay for performance (e.g. pay for improvement). There must be, at a minimum, two clinical measures that are outcomes-based measurements. Outcome measures monitor patient health and should be tied to pay for performance. Process measures, which measure the quality of health care provided to patients, may be chosen but will be tied to pay for reporting only.¹ The hospital will need to describe the sources of the data that will be used in the measurement of Stage 3 project-specific metrics.
- vi. Showing (using the proposed project-specific metrics) that there is demonstrable need for improvement, and having clearly identified improvement objectives that can be measured with the proposed metrics.
- vii. Identify and provide justification for how the hospital-specific focus area of the hospital project is intended to achieve one or more of the Core Achievement Themes listed in Attachment H: DSRIP Planning Protocol.

E. Consideration of a Hospital's DSRIP Plan Due to Exceptional Circumstance

¹ Mant, Jonathon. "Process versus outcome indicators in the assessment of quality of health care." *International Journal for Quality in Health Care* (2001) 13(6): 475-480 doi:10.1093/intqhc/13.6.475

In the event that a hospital provides documentation that they meet one of the following criteria, the Department will review a Hospital DSRIP Plan outside the schedule described above:

- i. If a hospital failed to submit a Hospital DSRIP Plan by September 20, 2013 because of a significant adverse unforeseen circumstance (e.g. hurricane, emergency event) and the hospital's prior year HRSF payment was not less than 0.5% of the hospital's annual Net Patient Service Revenues as shown on the most recent year audited Financial Statements. A significant adverse unforeseen circumstance is one not commonly experienced by hospitals.
- ii. If a hospital did not receive approval of its Hospital DSRIP Plan or failed to submit a plan and the hospital received certificate of need approval of a merger, acquisition, or other business combination of a hospital within the State of New Jersey, provided the successor hospital is a participating provider contracted with any Medicaid Managed Care Insurers licensed and operating in their service area.

To qualify under (ii) above, the application for certificate of need must have been received by the Department on or after the approval of these protocols.

Documentation would include audited financial statements that identify net patient service revenues, copy of the hospital's certificate of need approval of a merger, acquisition or other business combination, and description of perceived unforeseen circumstance with justification. The Department will not consider the Hospital DSRIP Plan for approval if it is determined that the hospital does not meet one of the above criteria.

The Hospital DSRIP Plan shall demonstrate that participation in the DSRIP Program shall begin no later than July 1, 2014, which would allow the hospital to qualify for DSRIP payments in DY3 through DY5, if approved by the Department and CMS.

The Department and CMS approvals will follow the processes described above in subparagraphs B and C of this section except for the following changes.

- The Hospital DSRIP Plan must be submitted to the Department no later than May 15, 2014.
- The Department will take action on each timely submitted reconsiderations no later than June 13, 2014; will approve each plan that it deems meets the criteria outlined in Attachment H: DSRIP Planning Protocol, Attachment I: DSRIP Program Funding and Mechanics Protocol, and "DSRIP Plan Checklist"; and will submit approved plans (along with their

completed DSRIP Plan Checklists and supporting documentation) to CMS for final review and approval.

- In the event CMS requests additional information, the Department shall submit revised Hospital DSRIP Plans to CMS within 30 days of request from CMS and CMS shall approve or deny the plans in writing to the Department by August 29, 2014.
- Hospitals submitting a plan under this section would be eligible to begin receiving DSRIP payments in DY3.

F. Revisions to the DSRIP Planning Protocol

If the CMS review process of Hospital DSRIP Plans results in the modification of any component of a hospital's DSRIP Plan, including but not limited to projects, milestones, metrics, or data sources, that was not originally included in the DSRIP Planning Protocol, New Jersey may revise the DSRIP Planning Protocol accordingly. CMS will review these proposed revisions within 30 days of submission by the Department and approve those it finds to be in accordance with the final approved Hospital DSRIP Plan(s) prompting the revision(s) and all applicable STC requirements. Such revisions² to the DSRIP Planning Protocol do not require a waiver amendment.

G. DSRIP Review Process Flow

The diagram on the following page summarizes the above process.

² Based on waiver protocol, any modification to the planning or funding protocols or waiver, STCs must follow a formal amendment process and changes are only effective prospectively. Therefore, if through the review of DSRIP plans, CMS approves an element of the Hospital DSRIP Plan that is not in the DSRIP Planning Protocol or is contradictory to the DSRIP Planning Protocol, these approved items should be incorporated into the protocols without having to go through the formal waiver amendment process. Any changes need to be effective September 6, 2013. However, due to the timing of the approval process, these changes could occur between September 20, 2013 and January 31, 2014.

III. Reporting Requirements

A. Participating Hospital Reporting for Payment in DY2

i. Hospital DSRIP Plan Submission

Submission of a Department-approved Hospital DSRIP Plan to CMS shall serve as the basis for payment of 50 percent of the DY2 Target Funding Amount. The state will not claim FFP for any monthly DSRIP payments made to a hospital until CMS has approved a Hospital DSRIP Plan for that hospital.

ii. Hospital DSRIP Plans Not Approved by CMS on or after January 31, 2014

All hospitals whose Hospital DSRIP Plan is not approved in full by CMS shall be at risk for recoupment of their entire DY2 DSRIP monthly payments paid out in DY2. (Transition Payments are not subject to recoupment.) Within 60 business days of CMS written denial of a Hospital DSRIP Plan, the Department shall recoup the DY2 DSRIP monthly payments previously paid to the hospital. Hospital DSRIP payments recouped shall be added to the Universal Performance Pool and will be disbursed to qualifying facilities.

iii. DY2 Baseline Verification

Participating hospitals are required to affirm concurrence of the baseline claim-based measures through an attestation to the Department by January 7th, 2014. If no attestation is received by January 7th, 2014, the Department will consider the baseline measurements finalized.

iv. DSRIP Progress Report Submission for DY2

Participating hospitals seeking payment under the DSRIP program in DY2 shall submit a progress report to the Department by April 30, 2014, demonstrating progress on their project as measured by stage-specific activities/milestones and metrics achieved during the reporting period. Should a participating hospital fail to submit its report by the indicated due date, all metrics will be deemed unmet, and incentive payments associated with those metrics will be forfeited.

The progress report shall be submitted using the standardized reporting form approved by the Department and CMS, which shall include a databook for metric reporting. The standardized reporting form with measure performance and baseline information will be provided to the hospital industry by November 15, 2013. The progress report shall also include all supporting data and back-up documentation. Based on this

report, participating hospitals shall earn DSRIP payments, calculated by the Department, based on meeting performance metrics as prescribed in Section VI: “DSRIP Payment Based on Achievement of Milestones and Metrics.” The submitted progress report shall include:

- The progress of each process metric
- Verification of State calculated claims-based Stage 3 and Stage 4 metrics, including a description of how the hospital verified the reported metrics and an attestation of the verification
- The progress of all current and planned activities, including whether the stage activity has been completed, is in progress, or has not been started
- Documentation supporting the completion of milestones during the report period
- The infrastructure developments made and outcomes of those developments
- The project developments and outcomes as they relate to the pilot populations
- How rapid-cycle evaluation was used for improvement
- Summary of the hospital’s stakeholder engagement and activities
- Work accomplished with external partners
- How the project tools and processes were modified based on the pilot testing results
- A timeline of future activities
- Budget and return on investment analysis

Specifically, the DY2 Progress Report will include:

- List of Stage 1 and 2 activities completed during the experience period from **the date the Hospital’s plan was approved through March 31, 2014**. Experience period is discussed further in Section VI, subsection C. “Experience Period.”
- Documentation to support the completion of Stage 1 and/or Stage 2 milestones/metrics reported as completed during the experience period from **the date the Hospital’s plan was approved through March 31, 2014**
- Stage 3 and Stage 4 metrics for the experience period listed for each metric in the DSRIP Planning Protocol Addendums 1 and 2
 - This is to include both non-claims based metrics and claims based metrics provided by the Department and verified by the hospital
 - If hospital cannot provide one or more metrics, the progress

report should include rationale for omission of the metric and a plan for obtaining the metric by October 31, 2014 (DY3), unless otherwise stated in the databook. Once available, omitted metrics shall be reported in the next progress report and no later than October 31, 2014 (DY3), unless otherwise stated in the databook.

- If the hospital fails to submit the metrics or a plan to submit the metrics by the deadline, the funding shall be considered not earned and forfeited and moved to the Universal Performance Pool to be redistributed. See section VI, subsection F, “DSRIP Universal Performance Pool” for more information.

Any DSRIP funds tied to DY2 Stage 1 or 2 activities which were targeted for completion by March 31, 2014, but were not otherwise reported as completed by March 31, 2014, will be forfeited and moved to the Universal Performance Pool to be redistributed. Quarterly activities must be completed in the designated quarter or funding tied to such activities will be forfeited and moved to the Universal Performance Pool to be redistributed. See section VI, subsection F, “DSRIP Universal Performance Pool” for more information.

Once the report is accepted by the Department, the Department and CMS shall have a total of 45 days to review and approve, or request additional information regarding the data reported for each milestone/metric and measure. Initial approval will be completed by the Department before submission to CMS, which will occur no later than 21 days following the Department’s acceptance of the report. If additional information is requested, the participating hospital shall respond within 15 days and both the Department and CMS shall have an additional 15 days to review, approve, or deny the request for payment, based on the data provided.

B. Participating Hospital Reporting for Payment in DY3-DY5

i. Annual DSRIP Application Renewal

- For participation in DSRIP in DY3-DY5, the hospital will be required to submit an annual DSRIP Application Renewal due on April 30th of the demonstration year prior to the participation year, as noted below.
 - DY3: Annual DSRIP Application Renewal due April 30, 2014
 - DY4: Annual DSRIP Application Renewal due April 30, 2015
 - DY5: Annual DSRIP Application Renewal due April 30, 2016
- Each Annual DSRIP Application Renewal for DY3-DY5 will include the

following:

- Hospital's notification of intent to continue in the DSRIP Program
- Indication of any changes or modifications that are required to be made to the DSRIP Plan in order to continue participation
- Annual Status Report outlining the hospital's progress in the current demonstration year
- Updated annual project budget analysis

ii. *Approval of DSRIP Application by the Department/CMS*

If a hospital's DSRIP Plan was approved for DY2, DSRIP Hospital Plans submitted with the annual DSRIP Application in DY3-DY5 will not require re-approval by the Department/CMS, unless the hospital's recommended changes or modifications from the approved DY2 Hospital DSRIP Plan would alter the DSRIP project goals or departures from the approved DY2 Plan would affect payment and/or change the valuation of any measure. If such modifications to, or departures from, the original DY2 DSRIP Hospital Plan are noted, the Department/CMS approvals will follow the processes described above Section II, subsections B and C except for the following changes.

- The Department will take action on each timely submitted modified DSRIP Plan no later than 45 days after date of submission (June 15); will approve each plan that it deems meets the criteria outlined in Attachment H: "DSRIP Planning Protocol," Attachment I: "DSRIP Program Funding and Mechanics Protocol," and "DSRIP Plan Checklist"; and will submit approved plans (along with their completed DSRIP Plan Checklists) to CMS for final review and approval.
- In the event CMS requests additional information, the Department shall submit revised Hospital DSRIP Plans to CMS within 30 days of request from CMS and CMS shall approve or deny the plans in writing to the Department with 15 days.

iii. *Modified Hospital DSRIP Plans Not Approved by CMS*

All hospitals submitting a modified Hospital DSRIP Plan for DY3, DY4, or DY5 which is not approved in full by the Department or CMS shall be at risk for recoupment of their entire demonstration year incentive payment paid out in the demonstration year for which the plan was modified. Within 60 business days of CMS written denial of a modified Hospital DSRIP Plan, the Department shall recoup the demonstration year payments previously paid to the hospital. Hospital DSRIP payments recouped shall be added to the Universal Performance Pool and will be disbursed to qualifying facilities.

iv. DSRIP Progress Report Submission for DY3-DY5

Four times per year in DY3-DY5, participating hospitals seeking payment under the DSRIP program shall submit progress reports to the Department demonstrating progress on their project as measured by stage-specific activities/milestones and metrics achieved during the reporting period.

The reports shall be submitted using the standardized reporting form approved by the Department and CMS which shall include a databook for metric reporting. The reports shall also include all supporting data and back-up documentation. Based on these reports, participating hospitals shall earn DSRIP payments, calculated by the Department, based on meeting performance metrics as prescribed in Section VI: "DSRIP Payment Based on Achievement of Milestones and Metrics." Submitted progress reports shall include:

- The progress of each process metric
- Verification of State calculated claims-based Stage 3 and Stage 4 metrics, including a description of how the hospital verified the reported metrics and an attestation of the verification (October and April progress reports)
- The progress of all current and planned activities, including whether the stage activity has been completed, is in progress, or has not been started
- Documentation supporting the completion of milestones during the report period
- The infrastructure developments made and outcomes of those developments
- The project developments and outcomes as they relate to the pilot populations
- How rapid-cycle evaluation was used for improvement
- Summary of the hospital's stakeholder engagement and activities
- Work accomplished with external partners
- How the project tools and processes were modified based on the pilot testing results
- A timeline of future activities
- Budget and return on investment analysis

These reports will be due as indicated below at the end of each reporting period. These reports shall include Stage 3 and 4 non-claims based performance metrics data, as well as verification of the Department provided claims-based performance metrics data:

- **DY3-DY5 Progress Report 1:** This report is due no later than **July 31 of the current DY** and shall include the following,
 - List of Stage 1 and 2 activities completed during the experience period **April 1 of prior DY through June 30 of the prior DY**
 - Documentation to support the completion of Stage 1 and/or Stage 2 milestones/metrics reported as completed on the current DY Progress Report 1

- **DY3-DY5 Progress Report 2:** This report is due no later than **October 31 of the current DY** and shall include the following,
 - List of Stage 1 and 2 activities completed during the experience period **July 1 through September 30 of the current DY**
 - List of Stage 1 and 2 activities completed during the experience period **April 1 of prior DY through June 30 of prior DY**, but not otherwise claimed as completed in current DY Progress Report 1
 - Documentation to support the completion of Stage 1 and/or Stage 2 milestones/metrics reported as completed on the current DY Progress Report 2
 - Stage 3 and Stage 4 metrics for the experience period listed for each metric in the DSRIP Planning Protocol Addendums 1 and 2
 - To include both non-claims based metrics and claims based metrics provided by the Department and verified by the hospital
 - For DY3, unless otherwise stated in the databook, all measures must be reported by October 31, 2014. If a measure is required to be reported October 31, 2014 and is not included in DY3 Progress Report 2, funding shall be considered not earned and forfeited. If the databook indicates otherwise for a given metric, the progress report should include rationale for omission of the metric and a plan for obtaining the metric by April 30, 2015, otherwise funding for the metric will be forfeited.
 - For DY4 and DY5, if the hospital fails to submit the metrics by the deadline, the funding shall be considered not earned and forfeited.

- **DY3-DY5 Progress Report 3:** This report is due no later than **January 31 of the current DY** and shall include the following,
 - List of Stage 1 and 2 activities completed during the experience period **October 1 through December 31 of the current DY**
 - List of Stage 1 and 2 activities completed during the experience period **April 1 of prior DY through September 30 of current DY**, but not otherwise claimed as completed in current DY Progress Reports 1 and 2
 - Documentation to support the completion of Stage 1 and/or Stage 2 milestones/metrics reported as completed in the current DY Progress Report 3

- **DY3-DY5 Progress Report 4:** This report is due no later than **April 30 of the current DY** and shall include the following,
 - List of Stage 1 and 2 activities completed during the experience period **January 1 through March 31 of the current DY**
 - List of Stage 1 and 2 activities completed during the experience period **April 1 of prior DY through December 31 of current DY**, but not otherwise claimed as completed in current DY Progress Reports 1, 2, and 3.
 - Documentation to support the completion of Stage 1 and/or Stage 2 milestones/metrics reported as completed in the current DY Progress Report 4
 - Stage 3 and Stage 4 metrics for the experience period listed for each metric in the DSRIP Planning Protocol Addendums 1 and 2
 - To include both non-claims based metrics and claims based metrics provided by the Department and verified by the hospital
 - If the hospital fails to submit the metrics by the deadline, the funding shall be considered not earned and forfeited
 - In DY5, the Progress Report 4 reporting submission deadline and review period will be adjusted to ensure that all DSRIP monies, including the UPP payment will be paid no later than the end of the final demonstration year, June 30th, 2017. Therefore, the hospital must submit their final DY5 report

one week prior to normal submission deadline, April 21, 2017.

Any DSRIP funds tied to Stage 1 or 2 activities that were targeted to be completed between the period April 1 of the prior DY through March 31 of the current DY, but were not otherwise reported as having been completed during that time period in Progress Report 4, will be forfeited and moved to the Universal Performance Pool to be redistributed. Quarterly activities must be completed in the designated quarter or funding tied to such activities will be forfeited and moved to the Universal Performance Pool to be redistributed. See section VI, subsection F, "DSRIP Universal Performance Pool" for more information.

For DY3, unless otherwise indicated in the databook, any DSRIP funds tied to Stage 3 and 4 metrics which were not reported in DY3 Progress Report 2 will be forfeited and moved to the Universal Performance Pool to be redistributed. Any DY3 DSRIP funds tied to Stage 3 and 4 metrics which were not reported in DY3 Progress Report 4 will be forfeited and moved to the Universal Performance Pool to be redistributed. See section VI, subsection F, "DSRIP Universal Performance Pool" for more information.

For DY4 and DY5, all Stage 3 metrics, whether a pay for performance metric or not, are required to be reported for release of any Stage 3 pay for performance funding. If any Stage 3 metric, including Stage 3 replacement metrics, is not reported, all Stage 3 funding for the DY will be forfeited and moved to the Universal Performance Pool. If pay for performance is not met on a Stage 3 pay for performance metric, funding for the metric will be forfeited and moved to the Universal Performance Pool to be redistributed.

Once the report is accepted by the Department, the Department and CMS shall have a total of 45 days to review and approve or request additional information regarding the data reported for each milestone/metric and measure. Initial approval will be completed by the Department before submission to CMS, which will occur no later than 21 days following the Department's acceptance of the report. If additional information is requested, the participating hospital shall respond within 15 days and both the Department and CMS shall have an additional 15 days to concurrently review, approve, or deny the request for payment, based on the data

provided.

C. State Reporting and Communications with CMS

The Department and CMS will use a portion of the Monthly Monitoring Calls (see paragraph 101 of the STCs) for March, June, September, and December of each year for an update and discussion of progress in meeting DSRIP goals, performance, challenges, mid-course corrections, successes, and evaluation.

IV. Hospital's DSRIP Target Funding Amount

A. Demonstration Year (DY) 2

In DY2, DSRIP funding amounts identified in paragraphs 95 and 96 of the Special Terms and Conditions (STCs) will be allocated to eligible hospitals per the list in subsection I.C., "DSRIP Eligibility Criteria," according to the following formula:

Step 1 – The initial DSRIP target funding amount for each hospital shall be one half of their SFY 2013 Hospital Relief Subsidy Fund (HRSF) amount (DY1 Transition Payments plus UPL payments made under the Medicaid state plan in SFY 2013) and subjected to the adjustments noted in Steps 2 and 3 below.

Although all DSRIP payments are at risk to the participating hospital (i.e., payments are reward-based for documented achievement on project milestones and metrics), providing a target funding amount provides a degree of predictability to hospitals and ensures that hospitals are able to manage their finances with reasonable stability while incentivizing and rewarding investment in quality improvement.

Step 2 – For those hospitals whose State Fiscal Year (SFY) 2013 Hospital Subsidy Relief Fund amount is less than a floor amount of \$125,000, the DSRIP target funding amount will be adjusted to the floor amount. For these hospitals, this shall be their Adjusted DSRIP Target Funding Amount for DY2. Providing for a floor amount appropriately incentivizes every hospital to participate and invest in quality improvement.

Step 3 – For those hospitals whose SFY 2013 HRSF amount is greater than or equal to the floor, the hospitals shall have their initial DSRIP target funding amount decreased proportionately in order to maintain total statewide DSRIP funding amount per the STCs (i.e., \$83,300,000). The result of this reduction yields their Adjusted DSRIP Target Funding Amount for DY2.

B. Demonstration Years 3-5

For Demonstration Years 3-5, DSRIP funding amounts identified in paragraphs 95 and 96 of the STCs shall be allocated to eligible hospitals per the list in subsection I.C, “DSRIP Eligibility Criteria,” according to the following formula:

Step 1 – The Initial DSRIP Target Funding Amount for each hospital shall be the hospital’s final DSRIP Target Funding Amount for DY2 times 2 and will then be subjected to the adjustment in Step 2.

- If a hospital did not participate in DY2 due to circumstances described in Section II, subsection E above, and the hospital’s plan was approved to participate in DY3, the hospital’s Initial DSRIP Target Funding Amount will be the forfeited DY2 final DSRIP Target Funding Amount times 2 and will then be subjected to the adjustment in Step 2.

Step 2 – A proportionate share of the target funding amounts (Step 1) shall be directed to a Universal Performance Pool (UPP), which shall be available to hospitals that successfully maintain or improve on a subset of Stage 4 DSRIP Performance Indicators. The initial DSRIP Target Funding Amount after the reduction for the UPP shall be the hospital’s Adjusted DSRIP Target Funding Amount for DY3-DY5. The UPP allows for greater rewards to hospitals that meet or improve their universal performance metrics. The carved out amount for the UPP is as follows for each demonstration year:

DY3	DY4	DY5
10%	15%	25%

Funds in the UPP shall be distributed to qualifying hospitals using the formula described in Section VII, subsection E, “DSRIP Universal Performance Pool” below.

V. Allocation of Hospital’s Adjusted DSRIP Target Funding Amount to DSRIP Stages

For DY2, transition payments will continue for six months from July 1, 2013 through December 31, 2013. The DSRIP Target Funding Amounts for DY2, representing potential DSRIP payments for January 2014 through June 2014, is the amount that will be distributable for the approved DY2 DSRIP Hospital Plan/Application and Stages 1, 2, 3, and 4 funding. The DY2 DSRIP Target Funding amount will be equally allocated (50/50) to the approved Hospital DSRIP Plan/Application and project stages.

For DY3-DY5, the DSRIP Target Funding Amount less the UPP carve out will be distributable to Stages 1-4 only.

Table II below illustrates, by demonstration year, the overall amounts allocated to Stages 1-4, considering transition payments (DY2), carve out for UPP (DY3-5), and funding tied to the approval of the Hospital DSRIP Plan Application (DY2).

Table II. TOTAL DSRIP FUNDING DISTRIBUTABLE TO STAGES 1-4

<i>In Thousands</i>	DY2	DY3	DY4	DY5
Transition Payments (6 months)	\$83,300	\$0	\$0	\$0
DSRIP Target Funding	\$83,300	\$166,600	\$166,600	\$166,600
Total Demonstration Year Funding	\$166,600	\$166,600	\$166,600	\$166,600
DSRIP Target Funding	\$83,300	\$166,600	\$166,600	\$166,600
<i>Less UPP "Carve Out"</i>	0%	10%	15%	25%
	\$0	\$16,660	\$24,990	\$41,650
Adjusted DSRIP Target Funding Amount	\$83,300	\$149,940	\$141,610	\$124,950
<i>Less Funding for DSRIP Application</i>	50%	0%	0%	0%
	\$41,650	\$0	\$0	\$0
Total Distributable Amount for Stages 1-4	\$41,650	\$149,940	\$141,610	\$124,950

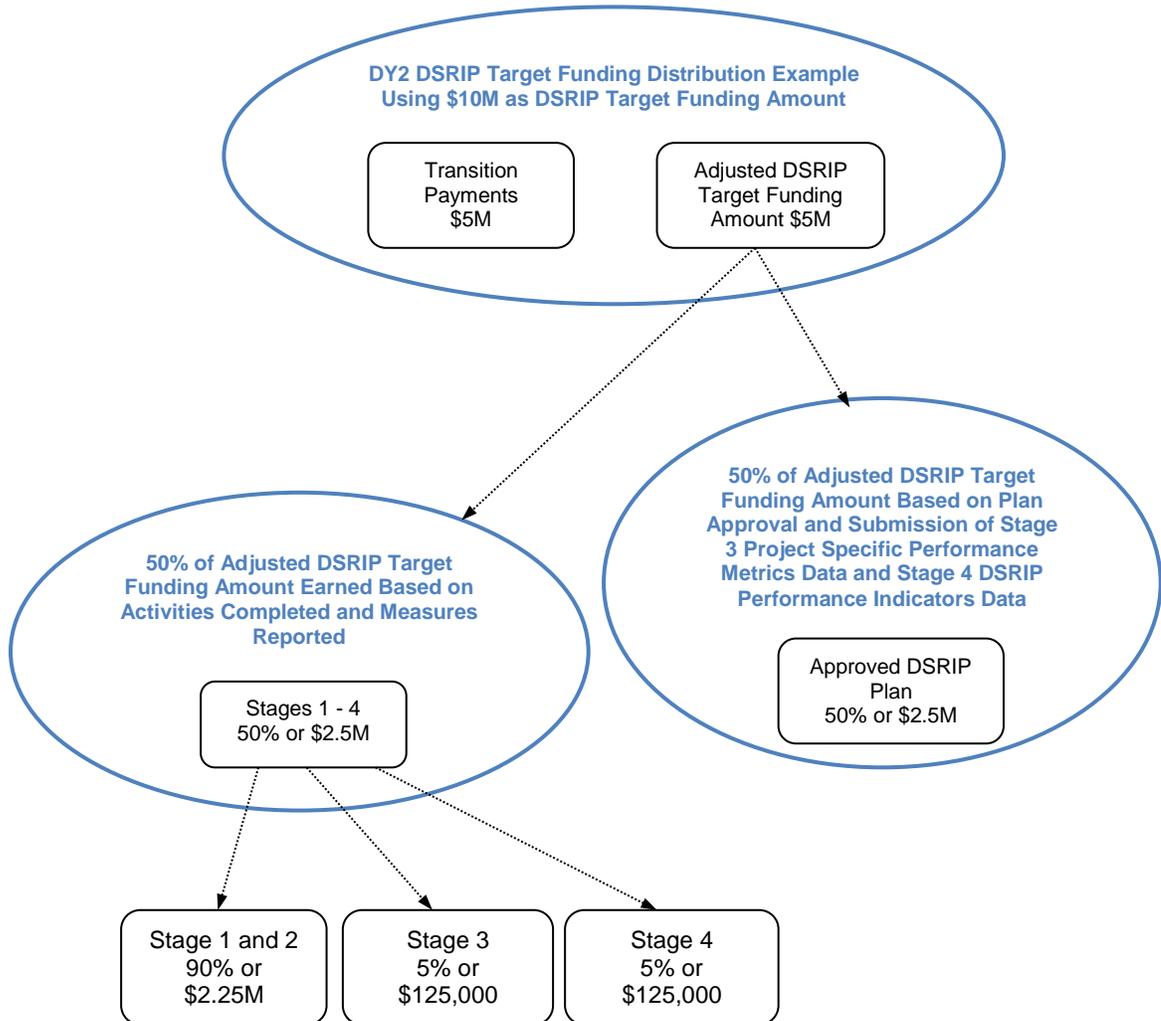
Based on the above table, the Total Distributable Amount for Stages 1-4 are then further allocated to each stage as follows:

Table III. DSRIP STAGE FUNDING DISTRIBUTION

Stages	DY2	DY3	DY4	DY5
1 & 2	90%	75%	50%	25%
3	5%	15%	35%	50%
4	5%	10%	15%	25%
Total	100%	100%	100%	100%

The following provides an illustration of how a hospital's DSRIP Target Funding Amount, calculated in accordance with Section IV: "Hospital's DSRIP Target Funding Amount," is both distributed and earned in DY2. A hospital DSRIP Target Funding Amount of \$10 million is used in the illustration.

Figure II. DY2 DSRIP Target Funding Distribution Example³



³ Example assumes no adjustment for floor (\$125,000) was required. Adjusted DSRIP Target Funding amount of \$5,000,000 would most likely be adjusted down to account for participating hospitals whose Initial DSRIP Target Funding amounts were below \$125,000 floor.

VI. DSRIP Payment Based on Achievement of Milestones and Metrics

Hospital DSRIP Plans shall include a narrative that describes the stages and activities selected by hospitals for their project. Each activity will have at least one milestone/metric that will be used to determine payment.

A. General Requirements

As described in the New Jersey DSRIP Planning Protocol, a DSRIP participating hospital will select one project, from a menu of projects based on eight focus areas or will propose a unique focus area or an off-menu project. The hospital will then select activities from a pre-determined menu of activities. Hospitals are encouraged to use innovative and value-driven approaches in accomplishing the project activities. As discussed in the DSRIP Planning Protocol, Section V: “DSRIP Project Array,” Department and CMS approval will be required for all hospital unique focus areas and off-menu projects.

B. Milestone and Measure Valuation

The Hospital DSRIP Plan will include sections on each of the 4 stages and the activities included in each stage as specified in the DSRIP Planning Protocol. For each milestone associated with a stage activity, the participating hospital will include in the hospital’s progress reports the progress made in completing each metric associated with the milestone. A participating hospital must fully achieve a milestone/metric in order to receive payment (i.e., no payment for partial completion). These metrics/milestones will be valued as follows:

i. Stage 1: Infrastructure Development

Activities in this stage will develop the foundation for delivery system transformation through investments in technology, tools, and human resources that will strengthen the ability of providers to serve populations and continuously improve services. Each milestone/metric targeted for completion in the demonstration year’s Stage 1 experience period will be valued equally. For Stage 1 experience periods, see section C.

Experience Period below.

- All Stage 1 activities targeted for completion within the demonstration year’s Stage 1 experience period must be completed within that timeframe for payment. A hospital completing a Stage 1 activity which was targeted for the current demonstration year’s experience period but was completed in a subsequent demonstration year’s experience period, will not achieve payment for this activity.

ii. *Stage 2: Chronic Medical Condition Redesign and Management*

Activities in this stage include the piloting, testing, and replicating of chronic patient care models. Each milestone/metric targeted for completion in the demonstration year's Stage 2 experience period will be valued equally. For Stage 2 experience periods, see section C.

Experience Period below.

- All Stage 2 activities targeted for completion within the demonstration year's Stage 2 experience period must be completed within that timeframe for payment. A hospital completing a Stage 2 activity which was targeted for the current demonstration year's experience period but was completed in a subsequent demonstration year's experience period, will not achieve payment for this activity.

iii. *Stage 3: Quality Improvement*

This stage involves the broad dissemination of Stage 1 and Stage 2 activities. Stage 3 measures the clinical performance of the hospital's DSRIP project and thus, valuation of this stage will be equally based on the reporting of clinical (Stage 3) measures in DY2 and DY3 for the project. For DY4 and DY5, Stage 3 valuation will be equally based on performance as described in Section VII, subsection B, "Calculating DSRIP Payments for Stage 3 Project-Specific Metrics" below. If a measure is reported more frequently than annually or pay for performance is determined more frequently than annually by the Department, the measure's valuation will be divisible by the frequency.

iv. *Stage 4: Population Focused Improvements*

Activities in this stage include reporting measures across several domains selected by the Department based on community readmission rates and hospital acquired infections, which will allow the impact of activities performed under Stages 1 through 3 to be measured, and may include: patient experience; care outcomes; and population health. Pursuant to the STC, all hospitals are expected to report Stage 4 DSRIP Performance Indicators selected by the Department and CMS. In accordance with the Hospital DSRIP Plan Guidelines, Stage 4 DSRIP Performance Indicators data will be due with the submission of the Hospital DSRIP Plan application. If the measure cannot be provided, the hospital must submit a plan to provide the measure by October 31, 2014 (DY3), unless otherwise stated in the databook. No later than the end of DY3, hospitals shall establish a baseline for all Stage 4 DSRIP Performance Indicators, including those attributed to the UPP.

Valuation of metrics included in Stage 4 will be equally funded based on reporting Stage 4 universal measures. If a measure is reported more frequently than annually, the measure's valuation will be divisible by the frequency. If a Stage 4 measure is not reported according to reporting requirements, the valuation of that measure will be considered forfeited and moved to the Universal Performance Pool to be redistributed.

C. Experience Period

The experience period for completing a milestone/measure will vary from the demonstration year period due to such factors as reporting, review, and claim lag. For certain Stage 1 and 2 activities and milestones, hospitals will be required in their Hospital DSRIP Plan to identify the targeted date of completion. This targeted date will be required to be completed within a specified experience period. The activity can be completed within a given demonstration year, but in order for payment to occur before the demonstration year ends, reporting and review time must be factored in for the hospital, the Department, and CMS. Additionally, due to claims lag, the experience period for Stages 3 and 4 activities will also differ from the demonstration period. For these reasons, the experience period may not necessarily coincide with the demonstration year.

Although some Stage 1 and 2 activities must be completed by a specified date, the following experience periods will be used as a guide for most Stage 1 and 2 activities.

Table IV. STAGES 1 AND 2 EXPERIENCE PERIODS, BY DEMONSTRATION YEAR
Demonstration Year

Demonstration Year	Begin	End
DY2	Hospital DSRIP Plan Approval Date	March 31, 2014
DY3	April 1, 2014	March 31, 2015
DY4	April 1, 2015	March 31, 2016
DY5	April 1, 2016	March 31, 2017

Since Stages 3 and 4 are based on metric reporting/performance, experience periods will vary from metric to metric, depending on the technical specifications and on whether the metric is reported annually or semi-annually. The DSRIP Planning Protocol Addendums 1 and 2 will be updated with the specific experience periods for these metrics no later than November 15, 2013.

D. Reporting Completion of Measures/Milestones

In the Hospital's DSRIP Plan, for certain activities in Stage 1 and Stage 2, the hospital will be required to indicate the targeted date of completion. Hospitals will be required to report the progress of completing these activities in periodic

progress reports. Minimum submission requirements for each milestone/metric are documented in the Planning Protocol, Attachment A: Toolkit. Payment for completion of a milestone/metric will not be received for incomplete submissions. Completion of Stage 1 and Stage 2 activities must be included in quarterly progress reports. Stage 3 and Stage 4 measures must be reported in the semi-annual progress reports on either an annual or semi-annual basis, depending on the measure. See III. Reporting Requirements above for further reporting requirements.

VII. DSRIP Payment Calculations

Hospitals will receive DSRIP payments based on expected completion of activities and measurement performance. The frequency of these payments will be dependent on the stage and reporting. Although completion of Stage 1 and 2 activities will be reported quarterly, New Jersey intends to provide payment to the participating hospitals for these stage activities on a monthly basis in order to maintain adequate cash flow to the hospitals during the demonstration. Monthly payments will be adjusted by the Department if review of a quarterly progress report reveals that sufficient activities have not been completed to support amounts paid to date. The draw of the federal financial participation (FFP) match for Stage 1 and 2 activities, or reporting of payments on the CMS-64 form, will not occur until the activity has been verified by both the Department and CMS as complete. The CMS-64 form is used by the State to claim federal matching funds. Therefore, any payment for Stage 1 and 2 activities which were not completed (not earned) by the targeted completion date, will be at risk to the Department and subject to recoupment from the hospital if not completed within the demonstration year's experience period.

Stage 3 metrics will be reported either annually or semi-annually, depending on the metric. In DY2 and DY3, payment to hospitals for reporting Stage 3 metrics will coincide with the metric reporting frequency. Federal match for payments to hospitals for reporting Stage 3 metrics, or reporting of such payments on the CMS-64, will not occur until the metric has been reported and verified by both the Department and CMS. Therefore, in DY2 and DY3 any payment for Stage 3 metrics which were not reported as outlined in the databook (as updated in the Planning Protocol, Attachment A: Toolkit, no later than November 15, 2013), will be at risk to the Department and subject to recoupment from the hospital.

For DY4 and DY5, although only a subset of Stage 3 metrics will be based on pay for performance (P4P), all Stage 3 metrics are required to be reported to earn any payment tied to performance. Payment for the P4P metrics will

coincide with the metric reporting frequency. Federal match for Stage 3 P4P metrics will not occur until performance has been met and verified by both the Department and CMS for the P4P metric and all required Stage 3 metrics have been reported. Therefore, in DY4 and DY5 any payment for Stage 3 P4P metrics which were earned will be at risk to the Department and subject to recoupment from the hospital.

Stage 4 metrics will be reported either annually or semi-annually, depending on the metric. Payment for reporting these metrics will coincide with the metric reporting frequency. Federal match for reporting Stage 4 metrics will not occur until the metric has been reported and verified by both the Department and CMS. Therefore, any payment for Stage 4 metrics which were not reported as outlined in the databook (as updated in the Planning Protocol, Attachment A: Toolkit, no later than November 15, 2013) will be at risk to the Department and subject to recoupment from the hospital.

As shown below, based on reporting and verification of completion and performance, the Department will calculate the DSRIP payment earned for each stage activity/metric and will reconcile the earned DSRIP payment to the cumulative DSRIP payment made to the hospital. Adjustments to monthly payments to DSRIP participating hospitals will be made as needed.

A. Calculating DSRIP Payments for Stages 1 and 2

The Achievement Value (AV) for each Stage 1 and 2 metric will be calculated as a 0 or 1 value. A Stage 1 or 2 metric considered by the Department and/or CMS to be incomplete will receive an AV of 0. A metric considered by the Department and CMS as complete, will receive an AV of 1. The AV for each metric will be summed to determine the Total Achievement Value (TAV) for the stage. The Percentage Achievement Value (PAV) is then calculated by dividing the TAV by the maximum AV (the total number of metrics).

A participating hospital is eligible to receive a DSRIP payment for Stage 1 and 2 activities determined by multiplying the total amount of funding allocated to Stage 1 and 2 by the PAV.

Example:

The hospital's Stage 1 and 2 activities in DY3 is valued at \$10 million and has five metrics. Under the payment formula, the five metrics represent a maximum TAV of five. The participating hospital reports the following progress at six months:

Metric	Status	AV
Stage 1: Metric 1	Complete	1
Stage 1: Metric 2	Complete	1
Stage 1: Metric 3	Not Complete	0
Stage 2: Metric 1	Not Complete	0
Stage 2: Metric 2	Not Complete	0
TAV		2
PAV (2/5)		40%

At the 6 months reporting period, the hospital has only earned 40% of Stage 1 and 2 funding or \$4,000,000. Since Stage 1 and 2 is paid monthly, the hospital has already received \$5,000,000 (\$10 million/12*6 months). The Department will adjust remaining demonstration year monthly payments going forward.

At the end of the DY3, the participating hospital successfully completes the remaining metrics. The hospital has satisfied the requirements to receive the balance of the DSRIP payments related to Stages 1 and 2.

B. Calculating DSRIP Payments for Stage 3 Project-Specific Metrics

Stage 3 Project-Specific Metrics are required to be reported all years of the demonstration, however, specific Stage 3 metrics will be tied to performance in DY4 and DY5. As described above in Section VI, subsection B, "Milestone and Measure Valuation," DSRIP payment in DY2 and DY3 will be based on the metrics reported, whereas DSRIP payments for DY4 and DY5 primarily will be based on performance.

i. DY2 and DY3

The DSRIP payment for Stage 3 to a participating hospital will be based on the hospital successfully reporting all Stage 3 metrics when required. Each metric will be valued equally. With the exception of DY2, since some Stage 3 metrics require a semi-annual reporting frequency, the value of those metrics will then be halved. Therefore, the AV for each Stage 3 metric will be calculated as:

- 0 if metric is not reported
- 1 if annual metric is reported
- 0.5 if semi-annual metric is reported

For DY2 the reported Stage 3 metric will receive an AV of 1 for annual metrics and for semi-annual metrics since there is only one reporting period for DY2. Additionally in DY2, if a measure is not reported but the hospital has provided a plan to report the metric by October 31, 2014, the measure will receive an AV of 1. Any Stage 3 metric not reported on October 31, 2014, unless otherwise stated in the databook, will receive an AV of 0 in DY3.

The AV for each metric will be summed to determine the TAV for the stage. The PAV is then calculated by dividing the TAV by the maximum AV (the total number of metrics).

A participating hospital is eligible to receive a DSRIP payment for Stage 3 metric determined by multiplying the total amount of funding allocated to Stage 3 by the PAV.

ii. DY4 and DY5

In order to receive an incentive payment during the Stage 3 pay for performance demonstration years, DY4 and DY5, the Department will first require the hospital to report all Stage 3 measures. The DSRIP payment will then be based on the requirement that the hospital will make measurable improvement in a core set of the hospital's Stage 3 performance measures. A measurable improvement is considered to be a minimum of a ten percent reduction in the difference between the hospital's baseline performance and an improvement target goal. All performance metrics will be rounded to the hundredth place according to normal rounding practices. Four and below will be rounded down; five and above will be rounded up.

The following steps will be performed to determine Stage 3 pay for performance improvement targeting for each suitable measure:

Step 1 – For each claim-based measure, the Department will calculate the current New Jersey Low Income hospital performance for all Stage 3 P4P measures for every project by December 31, 2013. This performance will be used to determine the Improvement Target Goal described further in Step 2. For non-claim based measures, a hospital cannot receive incentive payments in DY 4 or DY5 for any measure for which the hospital has not reported a baseline value. The baseline performance will represent the most recent performance available following the measure's technical specifications and be no older than calendar year 2010 dates of service.

Step 2 – The performance results will be shared with the Quality & Measures Committee in order to select the New Jersey Low Income Improvement Target Goal for all Stage 3 P4P measures. The Improvement Target Goal serves as the standard level of performance that New Jersey hospitals will strive to obtain as recommended by the

Quality & Measures Committee (see Planning Protocol, Section IX) and agreed to by the Department and CMS. The Improvement Target Goal for any given metric will be no less than the 75th percentile and no higher than the 90th percentile.

For measures that have insufficient data to compile a New Jersey Low Income Improvement Target Goal, the Department, or its designee, will determine if there are publicly available benchmarks (e.g. national, Medicare-only, or commercial) that may be substituted for the New Jersey Low Income Improvement Target Goal.

The New Jersey Low Income Improvement Target Goal will remain stable for the life of the demonstration to maintain predictability for the hospitals.

Step 3 – For each suitable core measure tied to pay for performance, the Department will incentivize the hospital to reduce the difference between their hospital’s baseline performance and the Improvement Target Goal, otherwise known as the “Gap.” The hospital’s baseline used for pay for performance is the initial starting point from which the hospital’s future performance will be compared. This P4P baseline will be from each metric’s most current reporting period reported in DY3.

To compute the Gap, the Department will subtract the hospital’s P4P baseline performance rate from the Improvement Target Goal.

Step 4 - In order to receive an incentive payment, the Department requires the hospital’s gap in performance to be reduced by ten percent (10%) during the pay for performance demonstration years. Therefore, in DY4 and DY5, the hospital must reduce its gap at a minimum by ten percent. This will result in a minimum overall total reduction for the demonstration of twenty percent (20%).

The Department will multiply the Gap by the required annual reduction (10%) to determine the rate of improvement required.

If a measure’s performance period is less than an annual period (i.e. calendar, state fiscal year, or federal fiscal year), the required reduction percentage will be adjusted accordingly in order to achieve the same annual reduction total (e.g. semi-annual measures require a 5% reduction in the Gap per performance period).

Step 5 – The Department will add this rate of improvement to the hospital’s baseline rate of performance in order to establish the “Expected Improvement Rate.”

Step 6 – Upon close of an applicable performance period, the Department will re-compute the measure to determine the hospital’s Actual Performance Result.

The Department will then compare the Actual Performance Result to the Improvement Target Goal. If the Actual Performance Result is at, or above, the Improvement Target Goal, the hospital is eligible to receive an incentive payment for that performance period.

If it is not, the Department will compare the Actual Performance Result to the Expected Improvement Rate. If the Actual Performance Rate is at, or above, the Expected Improvement Rate the hospital is eligible to receive an incentive payment for that performance period.

The improvement calculation will initially be performed at the end of DY3 for future DY4 performance and then repeated for each subsequent performance period. When the Expected Improvement Target is calculated for subsequent performance periods, the better of the Actual Performance Result or the Expected Improvement Target will be utilized as the baseline performance.

The above calculation is further illustrated in Table V.

Table V. DSRIP PAY FOR PERFORMANCE IMPROVEMENT CALCULATION

Line 1	Improvement Target Goal
Line 2	Better of the Hospital Rate in the prior performance period or the Expected Improvement Target (Baseline)
Line 3	Subtract the hospital’s rate (line 2) from the improvement target goal (line 1). This is the gap between the hospital’s prior performance period rate and the improvement target goal. (Gap)
Line 4	Required annual reduction in the gap (10%)
Line 5	Multiply the gap (line 3) by the 10% required annual reduction in the gap (line 4). This results in the rate of improvement required.
Line 6	Add the hospital’s baseline rate (line 2) to the rate of improvement (line 5). (Expected Improvement Target)
Line 7	Compare Expected Improvement Target to Actual Performance Result; Is the Actual Performance Result at the Improvement Target Goal? Is the Actual Performance Result at the Expected Improvement Target? If either are Yes – then the Payment Incentive is Awarded.

If a measure's performance period is less than an annual period, the Department may compute a year-to-date performance rate along with the rate for the specified performance period. Upon review of the actual performance data, the Department may determine, with CMS concurrence, that the better of performance between these two rates will be used to compare against the Expected Improvement Rate for determining eligibility for payment. This has the effect of smoothing inconsistent and irregular data patterns that may be seen over a shorter performance period.

To determine the amount of incentive payment that the hospital will receive an allocation amount is calculated for each measure. Each P4P measure will have equal allocation over the demonstration year.

In each demonstration year for which pay for performance applies, the Department will compute the payment allocation for each P4P measure for each hospital. The Department will divide the hospital's total Stage 3 allocation amount by the total number of P4P measures tied to the project the hospital has selected.

$$\frac{\text{Stage 3 Allocation}}{\text{Total P4P measures}}$$

For any measure that has less than an annual performance period and requires reporting and computing of improvement results more than once, that measure's allocation will be divided by the number of times this computation must occur. (e.g. The allocation for semi-annual measures will be divided by two to determine how much the hospital can receive for each performance period.)

For any measure that the Department determines, with CMS concurrence, that the above calculation cannot be computed, the Department will authorize a simple ten percent rate of improvement over the hospital's baseline performance rate per year as the Expected Improvement Target for that measure. This may occur if there is insufficient data to develop a New Jersey Low Income Improvement Target Goal, or if national benchmarking data is unavailable.

C. Calculating DSRIP Payments for Stage 4 DSRIP Performance Indicators (i.e. Universal Metrics)

The DSRIP payment for Stage 4 to a participating hospital will be based on the hospital successfully reporting all Stage 4 metrics. Each metric will be valued equally. With the exception of DY2, since some Stage 4 metrics require a semi-annual reporting frequency, the value of those metrics will then be halved. Therefore, the AV for each Stage 4 metric will be calculated as:

- 0 if metric is not reported
- 1 if annual metric is reported
- 0.5 if semi-annual metric is reported

For DY2 the reported Stage 4 metric will receive an AV of 1 for annual metrics and for semi-annual metrics since there is only one reporting period for DY2. Additionally in DY2, if a measure is not reported but the hospital has provided a plan to report the metric by October 31, 2014, the measure will receive an AV of 1. Any Stage 4 metric not reported on October 31, 2014, unless otherwise stated in the databook, will receive an AV of 0 in DY4. If a hospital cannot report an obstetrical or pediatric related measure because the hospital does not have an obstetrical or pediatric department, the hospital will be required to indicate in the progress report why the measure cannot be reported. The AV value for these measures will be 1 so long as the hospital has indicated why the measure cannot be reported.

The AV for each metric will be summed to determine the TAV for the stage. The PAV is then calculated by dividing the TAV by the maximum AV (the total number of metrics).

A participating hospital is eligible to receive a DSRIP payment for Stage 4 metric determined by multiplying the total amount of funding allocated to Stage 4 by the PAV.

Example:

The hospital's Stage 4 in DY3 is valued at \$5 million. A total of 45 metrics are required to be reported. Under the payment formula, the 45 metrics represent a maximum TAV of 45. Therefore, each Stage 4 metric is valued at \$111,111.11 (\$5 million/45). Any Stage 4 metric required to be reported on a semi-annual reporting frequency will have a value of \$55,555.56 (\$111,111.11*0.5). At six months, the participating hospital reports 20 annual metrics and 10 semi-annual metrics. The hospital has earned \$2,777,777.80 for stage 4 as shown below:

	(A) Reported	(B) Value	(A*B) Total Earned
Annual Metrics	20	\$111,111.11	\$2,222,222.20
Semi-Annual Metrics	10	\$55,555.56	\$555,555.60
Total Stage 4 Earned			\$2,777,777.80

Since Stage 4 is paid semi-annually, the hospital would receive \$2,500,000 (\$5 million/2) at the 6 month reporting period. The hospital has therefore earned more than the 6 month Stage 4 payment. The Department may therefore determine if an additional payment shall be made at that time or held until the last reporting period.

D. Forfeiture of DSRIP Payments

Scoring and evaluation of metrics will be completed based on the submission and review process describe above in Section III: "Reporting Requirements."

Participating hospitals must fully achieve all milestones and metrics as described in their Hospital DSRIP Plans within a particular demonstration year's experience period in order to receive a DSRIP payment. Failure to achieve a metric within a given demonstration year's experience period will permanently forfeit the otherwise available DSRIP funding. All DSRIP funds that are forfeited by a hospital shall be added to the Universal Performance Pool and distributed according to the methodology described in subsection E, "DSRIP Universal Performance Pool" below.

Once the scoring and evaluation of metrics has been completed by the Department and CMS, each hospital will be notified of the amount of DSRIP Incentive Payments earned. Upon approval from CMS, the Department may claim FFP for DSRIP payments earned and paid to the hospitals. If at any time the Department determines that a hospital will not achieve all their metrics and receive 100% of their DSRIP Incentive Target amount based on submitted progress reports, the Department will reduce the hospital's monthly DSRIP payment to ensure that the hospital is not overpaid. Any overpayment determined by the Department will be recouped from the hospital.

Upon notification by the Department of the final amount earned for the applicable demonstration year, a hospital shall have 30 days to submit a reconsideration request to the Department. The reconsideration period is available to address reporting or computational errors. Because the outcome of a reconsideration, as determined final by the Department and/or CMS, could impact the amount of funding that is forfeited and available for deposit in the DSRIP Universal Performance Pool (UPP), distribution of the UPP shall not occur until after the 30 day reconsideration period has ended.

With the exception of DY5, the Department will make all final DSRIP payments for the SFY and DY no later than 31 days following the end of the SFY. Upon making those final payments, funding attributable to that DSRIP year will be considered closed and final, and no subsequent adjustments will be made. DSRIP funds are not fungible between SFYs or DYs. For DY5, the Department will make all final DSRIP payments by June 30, 2017.

E. DSRIP Universal Performance Pool

All hospitals with approved Hospital DSRIP Plans will be eligible for the Universal Performance Pool (UPP). The UPP will be made up of the following funds:

- For DY3 – DY5, the percentage of the total DSRIP funds set aside for the UPP, known as the Carve Out Allocation amount. See Section IV: “Hospital’s DSRIP Target Funding Amount,” paragraph B, step 2 above, applicable to DYs 3-5. There will be no Carve Out Allocation amount for DY2.
- Hospital DSRIP Target Funds from hospitals that elected to not participate
- Target Funds that are forfeited from hospitals that do not achieve project milestones and metrics, less any prior year appealed forfeited funds where the appeal was settled in the current demonstration year in favor of the hospital.

The total UPP amount determined above shall be distributed to qualifying hospitals based on maintaining or improving on a specific set of twelve Stage 4 metrics identified as a UPP metric. As some hospitals may not have service areas required to calculate one or more of the twelve UPP metrics, these hospitals must substitute those metrics for one or more of the four replacement UPP metrics, not to exceed twelve total metrics. See DSRIP Planning Protocol, Addendum 2 for a list of the twelve UPP metrics and the four UPP replacement metrics. The baseline performance periods from which the UPP will be calculated will be included in the Planning Protocol, Attachment 1: DSRIP Toolkit as it is updated with the databook, no later than November 15, 2013.

All hospitals must have a total of twelve UPP measures and only those hospitals that lack obstetrical (OB) or pediatric departments must choose substitute measures from the substitution list. These (non-OB/non-pediatric) hospitals must indicate its substitution choice in its submitted Hospital DSRIP Plan. Hospitals that have obstetrical and pediatric departments cannot substitute UPP measures and therefore must use the set of twelve UPP measures indicated.

The UPP amount will be distributed based on the sum of achievement values of these twelve metrics along with the hospital’s state-wide Low Income Discharge percentage. The UPP metric AV will be determined as follows:

- UPP Metric is at or improves from baseline, AV = 1
- UPP Metric has regressed from baseline, AV = -0.5

For DY2, the AV will automatically be calculated as 1 for each UPP metric since the experience period for each UPP metric would be pre-DSRIP implementation.

For DY3-DY5, payment will be earned based on outcome of the 12 Universal Stage 4 metrics designated as UPP metrics (or replacement UPP metric, if applicable). Each of the 12 metrics will be evaluated separately and receive an achievement value (AV) score of either 1 or -0.5.

For each hospital, a total AV (TAV) score will be established by summing the AV scores for each metric. The TAV score will be no higher than 12 and no lower than 0. The Percentage Achievement Value (PAV) is then calculated by dividing the TAV by the maximum AV (12).

The hospital's PAV will then be weighted based the hospital's percent of Low Income discharges, using the percentage rate of the hospital's Low Income (Medicaid/CHIP/Charity Care from the MMIS data source) discharges to all statewide Low Income discharges. The result will be reflected as a percentage to total and the UPP will be distributed accordingly

The statewide Low Income discharge totals will be updated regularly, to occur no more frequently than on an annual basis, to reflect current hospital discharge data. Prior to UPP payment distribution, the Department will provide to CMS the calculation of the discharge distribution and the resulting discharge report that will be used.

VIII. Plan Modifications

Consistent with the recognized need to offer participating hospitals with flexibility to modify their plans over time considering evidence and learning from their own experience, as well as unforeseen circumstances or other good cause, a participating hospital may request prospective changes to its Hospital DSRIP Plan through a plan modification process.

Participating hospitals may submit requests to the Department to modify elements of an existing project prospectively, including changes to milestones and metrics with good cause. Modifications require re-approval by the Department/CMS if the hospital's recommended changes or modifications from the approved DY2 Hospital DSRIP Plan would alter the DSRIP project goals or departures from the approved DY2 Plan would affect payment and/or change the valuation of any measure. Such requests must be submitted to the Department with the annual DSRIP Renewal Form due April 30 of the current demonstration year for changes to go into effect the following demonstration year.

If such modifications to or departures from the original DY2 DSRIP Hospital Plan are noted, the Department/CMS approvals will follow the processes described above Section II, subsections B and C and Section III, subsection B.i. "Approval of DSRIP Application by the Department/CMS."

Timeline of Follow-up Activities for Department and CMS

DSRIP Activity	Start Date	End Date
Development of Hospital Plan Review program: Department submits the Department's approach and review criteria for reviewing Hospital DSRIP Plan applications, as well as a draft DSRIP Plan Initial Review Checklist. The Department and CMS hold bi-weekly calls to finalize the Review program.	08/20/2013	09/20/2013
Hospital Plan Review Process: Department and CMS hold bi-weekly conference calls in order to review and approve Hospital DSRIP Plans.	09/20/2013	01/31/2013
Attribution Model: Department submits attribution model to CMS by 9/30/2013. CMS reviews and provides feedback to the Department, with goal for CMS approval by 10/14/2013.	9/30/2013	10/14/2013
Hospital Databook and Reporting Template: Department submits the revised Toolkit with the addition of the databook and hospital reporting template to CMS by 10/31/2013, with goal to finalize by 11/15/2013. The Measure Catalogue Addendums are updated with the reporting periods.	10/31/2013	11/15/2013
CMS Reporting Template: Department submits a CMS Reporting Template that provides key information related to DSRIP activities and results to CMS by 11/15/2013 with goal to finalize by 12/31/2013.	11/15/2013	12/31/2013
Improvement Target Goal and Baseline Performance Threshold: Department receives recommendations from the Committee by 1/31/2014 and submits to CMS for approval. The Measure Catalogue Addendum 1 is updated.	12/31/2013	01/31/2014
Review of Quarterly Progress Report: Within 21 days of receipt of each progress report, the Department will complete an initial review of the data. Within 45 days, the Department and CMS will review/ approve or request additional information regarding the data that supports completion of the metric/ milestone.	04/2014	06/2017
Low Income Statewide Discharge Report: Any instance that the Low Income discharge data is adjusted, the Department will submit to CMS the statewide discharge report prior to payment of the UPP.	07/2014	04/2017
Quarterly Conference Call: March, June, September, and December	04/2014	06/2017

Attachment I

Hospitals Eligible For Transition And DSRIP Payments

Medicaid No.	Medicare No.	Hospital Name
3674100	310001	HACKENSACK UNIVERSITY MEDICAL CENTER
4135008	310002	NEWARK BETH ISRAEL MEDICAL CENTER
4135105	310003	PALISADES GENERAL HOSPITAL
4135202	310005	HUNTERDON MEDICAL CENTER
4135300	310006	ST. MARY'S HOSPITAL (PASSAIC)
4135407	310008	HOLY NAME HOSPITAL
4135504	310009	CLARA MAASS MEDICAL CENTER
4135601	310010	UNIVERSITY MED CTR PRINCETON
4135709	310011	CAPE REGIONAL MEDICAL CENTER
4135806	310012	VALLEY HOSPITAL
4136004	310014	COOPER HOSPITAL/UNIVERSITY MEDICAL CTR
4136101	310015	MORRISTOWN MEMORIAL HOSPITAL
3674207	310016	CHRIST HOSPITAL
4136209	310017	CHILTON MEMORIAL HOSPITAL
4136403	310019	ST. JOSEPH'S HOSPITAL MEDICAL CENTER
4136403	310019	ST. JOSEPH'S HOSPITAL - Wayne
4136608	310021	ST. FRANCIS MEDICAL CENTER (TRENTON)
3674304	310022	VIRTUA - WEST JERSEY HOSPITAL Voorhees
3674304	310022	VIRTUA - WEST JERSEY HOSPITAL Berlin
3674304	310022	VIRTUA - WEST JERSEY HOSPITAL Marlton
3674401	310024	ROBERT WOOD JOHNSON AT RAHWAY HOSPITAL
4136705/0167011	310025	BAYONNE HOSPITAL
4136900	310027	TRINITAS - ELIZABETH GENERAL
4137001	310028	NEWTON MEMORIAL HOSPITAL
4137108	310029	OUR LADY OF LOURDES MEDICAL CENTER
4137205	310031	DEBORAH HEART & LUNG CENTER
3674509	310032	SOUTH JERSEY HEALTH SYSTEM
4137400	310034	RIVERVIEW MEDICAL CENTER
4137701	310038	R. W. JOHNSON UNIVERSITY HOSPITAL
4137809	310039	RARITAN BAY MED CTR - Perth Amboy Div.
4137809	310039	RARITAN BAY MED CTR - Old Bridge Div.
4137906/0249297	310040	HOBOKEN UNIV MED CTR
3674606	310041	COMMUNITY MEDICAL CENTER
4138201	310044	CAPITAL HEALTH SYSTEM - MERCER CAMPUS
4138309	310045	ENGLEWOOD HOSPITAL ASSOCIATION
3674703	310047	SHORE MEMORIAL HOSPITAL
4138406	310048	SOMERSET MEDICAL CENTER
4138601	310050	ST. CLARE'S-RIVERSIDE MEDICAL CTR DENVL
4138601	310050	ST. CLARE'S - Dover
3674801	310051	OVERLOOK HOSPITAL
3674908	310052	MEDICAL CENTER OF OCEAN COUNTY
4138708/0139564	310054	MOUNTAINSIDE HOSPITAL
4138902	310057	MEMORIAL HOSP OF BURLINGTON CTY (Virtua)

Attachment I

Hospitals Eligible For Transition And DSRIP Payments

Medicaid No.	Medicare No.	Hospital Name
4139003	310058	BERGEN PINES COUNTY (Bergen Reg'l) HOSPITAL
4139208	310060	ST. LUKE'S HOSPITAL (formerly Warren Hospital)
3675203	310061	LOURDES MED CTR OF BURLINGTON CNTY
4139402	310064	ATLANTICARE REG'L MED CTR - Mainland Div.
4139402	310064	ATLANTICARE REG'L MED CTR - City Div.
3675602	310069	SOUTH JERSEY HEALTH SYSTEM - ELMER
4139500	310070	ST. PETER'S MEDICAL CENTER
3675700	310073	JERSEY SHORE MEDICAL CENTER
4139801	310074	JERSEY CITY MEDICAL CENTER
3675807	310075	MONMOUTH MEDICAL CENTER
3675904	310076	ST. BARNABAS MEDICAL CENTER
3676102	310081	UNDERWOOD MEMORIAL HOSPITAL
4140001	310083	EAST ORANGE GENERAL HOSPITAL
3676200	310084	KIMBALL MEDICAL CENTER
4140206	310086	KENNEDY MEMORIAL HOSPITALS - Stratford
4140206	310086	KENNEDY MEMORIAL HOSPITALS - Cherry Hill
4140206	310086	KENNEDY MEMORIAL HOSPITALS - Washington Twp.
9031308	310091	MEMORIAL HOSPITAL OF SALEM COUNTY
3676609	310092	CAPITAL HEALTH SYSTEM - FULD CAMPUS
4140508	310096	ST. MICHAEL'S MEDICAL CENTER
3676803	310108	JFK MEDICAL CENTER {EDISON} / Anthony M. Yelencics
3676901	310110	RWJ UNIVERSITY MEDICAL CTR AT HAMILTON
4141008	310111	CENTRASTATE MEDICAL CENTER
4141105	310112	BAYSHORE COMMUNITY HOSPITAL
4141202	310113	SOUTHERN OCEAN COUNTY HOSPITAL
4141300	310115	HACKETTSTOWN COMMUNITY HOSPITAL
4141504/0249297	310118	MEADOWLANDS HOSPITAL MEDICAL CENTER
3677001	310119	UNIVERSITY HOSPITAL (UMDNJ)
4141601	310120	ST. CLARE'S HOSP SUSSEX (WALLKILL VALLEY)



State of New Jersey

DEPARTMENT OF HUMAN SERVICES

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

PO Box 712

TRENTON, NJ 08625-0712

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

JENNIFER VELEZ
Commissioner

VALERIE HARR
Director

November 13, 2013

NJ 1115 Comprehensive Waiver Amendments/Technical Corrections
Lane Terwilliger, Esq.
Technical Director
Center for Medicaid, CHIP, and Survey and Certification
Center for Medicare & Medicaid Services
7500 Security Blvd., Mail Stop S2-01-16
Baltimore, MD 21244-1850

Dear Ms. Terwilliger:

This letter is official written notice that the Division of Medical Assistance and Health Services (DMAHS) is requesting to amend and technically correct the special terms and conditions (STCs) of the 1115 New Jersey Comprehensive Waiver demonstration (waiver).

The first amendment pertains to the Graduate Medical Education (GME). DMAHS is proposing to remove the dollar amount listed for GME. We are requesting to amend STC 92 paragraph (h) to remove "\$90 million in".

The second amendment we are requesting is to add the new Medicaid Expansion VIII group - 1902(a)(10)(A)(i)(VIII) to the waiver. Our existing MEGs for the Title XIX CHIP parents, NJ Childless Adults and AWDC would move to the new VIII group MEG. We understand that there may be additional changes and clean up required to the STCs that are impacted by the federal health care law.

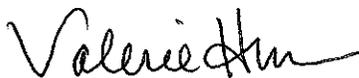
We are requesting a technical correction to add an eligibility group for the blind. The correction is to add the blind to STC #19, page 20 under New Jersey Care...Special Medicaid Program ABD. We would like to add the following language under program description and statutory/regulatory citations; "eligibility group includes blind individuals – (1902)(r)(2)". Since all of our populations will be included in the waiver for their managed care authority, we are also requesting to add language to the waiver to restrict the number of provider agreements with managed care entities. The language we are recommending is, "The Director of the Division of Medical Assistance and Health Services may restrict the number of provider agreements with managed care entities, in accordance with 42 USC 1396u-2(a)(1)(A)(iii), if such restriction does not substantially impair access to services". We originally submitted a State Plan Amendment but have been asked to withdraw and use waiver authority.

NJ 1115 Comprehensive Waiver Amendments/Technical Corrections
Lane Terwilliger, Esq.
November 13, 2013
Page 2

Enclosed please find updated budget neutrality to reflect amendments 1 and 2. Please note that these are the only changes made to Budget Neutrality and all of the other assumptions in the original neutrality are still reflected in this document. The technical correction does not impact budget neutrality as this group was already included in an existing MEG.

Please contact me at 609-588-2600 if you have any questions or need additional information.

Sincerely,

A handwritten signature in black ink, appearing to read "Valerie Harr". The signature is fluid and cursive, with a long horizontal stroke at the end.

Valerie Harr
Director

VH:D

Enclosure

c: Jennifer Velez
Michael Melendez

Title XDR	SFY06	SFY07	SFY08	SFY09	SFY10	5-YEARS	
	(7/1/05-6/30/06)	(7/1/06-6/30/07)	(7/1/07-6/30/08)	(7/1/08-6/30/09)	(7/1/09-6/30/10)		
TOTAL EXPENDITURES							
Eligible Member Months	5,973,070	6,125,419	6,234,297	6,473,325	6,913,288		
PM/PM Cost	237.53 \$	263.85 \$	273.80 \$	273.69 \$	276.14 \$		
Total Expenditure	1,418,762,365 \$	1,616,223,248 \$	1,706,942,729 \$	1,771,680,972 \$	1,909,050,522 \$	8,422,659,837	5-YEAR AVERAGE
TREND RATES							
Eligible Member Months		2.6%	1.8%	3.8%	6.8%	3.7%	3.8%
PM/PM Cost		11.1%	3.9%	0.0%	0.9%	3.8%	3.8%
Total Expenditure		13.9%	5.6%	3.8%	7.8%	7.7%	7.7%
ASD							
TOTAL EXPENDITURES							
Eligible Member Months	2,544,655	2,588,658	2,629,516	2,707,935	2,772,548		
PM/PM Cost	807.93 \$	824.24 \$	867.13 \$	860.04 \$	867.29 \$		
Total Expenditure	2,055,890,843 \$	2,133,670,382 \$	2,280,143,421 \$	2,328,932,545 \$	2,404,599,339 \$	11,203,236,631	5-YEAR AVERAGE
TREND RATES							
Eligible Member Months		1.7%	1.6%	3.0%	2.4%	2.2%	2.2%
PM/PM Cost		2.0%	5.2%	-0.8%	0.8%	1.8%	1.8%
Total Expenditure		3.8%	6.9%	2.1%	3.2%	4.0%	4.0%
LYC							
TOTAL EXPENDITURES							
Eligible Member Months	411,744	408,358	402,758	399,256	395,194		
PM/PM Cost	6,518.26 \$	6,662.25 \$	7,092.83 \$	7,381.79 \$	7,700.28 \$		
Total Expenditure	2,683,855,602 \$	2,720,584,478 \$	2,832,528,184 \$	2,947,224,883 \$	3,043,105,497 \$	14,227,298,644	5-YEAR AVERAGE
TREND RATES							
Eligible Member Months		-0.8%	-1.4%	-0.9%	-1.0%	-1.0%	-1.0%
PM/PM Cost		2.2%	5.6%	5.0%	4.3%	4.3%	4.3%
Total Expenditure		1.4%	4.1%	4.0%	3.3%	3.2%	3.2%
MCBS							
TOTAL EXPENDITURES							
Eligible Member Months	12,840	13,149	13,594	14,713	15,614		
PM/PM Cost	1,764.60 \$	1,808.97 \$	1,899.32 \$	1,983.82 \$	2,023.66 \$		
Total Expenditure	22,658,072 \$	23,786,536 \$	25,819,706 \$	29,187,842 \$	33,621,907 \$	135,074,014	5-YEAR AVERAGE
TREND RATES							
Eligible Member Months		2.4%	3.4%	8.2%	12.9%	6.7%	6.7%
PM/PM Cost		2.5%	5.0%	4.4%	2.0%	3.5%	3.5%
Total Expenditure		5.0%	8.5%	13.0%	15.2%	10.4%	10.4%
HCS Waivers (All)							
TOTAL EXPENDITURES							
Eligible Member Months	84,435	86,466	89,392	96,749	109,253		
PM/PM Cost	1,764.60 \$	1,808.97 \$	1,899.32 \$	1,983.82 \$	2,023.66 \$		
Total Expenditure	148,993,659 \$	156,414,497 \$	169,784,130 \$	191,932,176 \$	221,089,510 \$	888,213,972	5-YEAR AVERAGE
TREND RATES							
Eligible Member Months		2.4%	3.4%	8.2%	12.9%	6.7%	6.7%
PM/PM Cost		2.5%	5.0%	4.4%	2.0%	3.5%	3.5%
Total Expenditure		5.0%	8.5%	13.0%	15.2%	10.4%	10.4%

Trend Rate 2	Projected	CMS Proposed
PMPM Cost		
Title XIX	5.53%	5.80%
ABD	4.10%	3.60%
LTC	4.30%	3.90%
HCBS Waivers (State plan eligibles)	4.30%	3.70%
GA Employable & Unemployable (July-March)	3.71%	3.71%
GA Employable & Unemployable (April-Jun)	3.71%	3.71%
HCBS Waivers (217-Like)	3.70%	3.70%
Children with SED (217-Like)	6.00%	6.00%
MI/DD (217-Like)	6.00%	6.00%
Adults w/o Dependent Children	6.98%	6.98%
SED (At Risk)	6.00%	6.00%
MATI (At Risk)	4.70%	4.70%
Eligible Member Months		
Title XIX	3.63%	3.63%
ABD	2.64%	2.64%
LTC	2.64%	2.64%
HCBS Waivers (State plan eligibles)	2.64%	2.64%
GA Employable & Unemployable (July-March)	7.90%	7.90%
GA Employable & Unemployable (April-Jun)	7.90%	7.90%
HCBS Waivers (217-Like)	2.64%	2.64%
Children with SED (217-Like)	2.64%	2.64%
MI/DD (217-Like)	2.64%	2.64%
Adults w/o Dependent Children	-12.00%	-12.00%
SED (At Risk)	2.64%	2.64%
MATI (At Risk)	2.64%	2.64%

DEMONSTRATION WITHOUT WAIVER (WOW) BUDGET PROJECTION - Using CMS Proposed Trends
TOTAL SHARE

MEDICAID POPULATIONS

ELIGIBILITY GROUP	TREND RATE 1	MONTHS OF AGING	BASE YEAR DY 00 (Jul11-Jun12)	TREND RATE 2 ¹	DEMONSTRATION YEARS (DY)					TOTAL WOW
					DY 01 (Oct12-Jun13)	DY 02 (Jul13-Jun14)	DY 03 (Jul14-Jun15)	DY 04 (Jul15-Jun16)	DY 05 (Jul16-Jun17)	
Title XIX										
Eligible Member Months	3.6%	12	7,423,742	2.7%	5,769,701	7,905,782	8,118,745	8,331,733	8,544,710	
PMPM Cost	5.8%	12	\$ 309.10	5.8%	\$ 327.03	\$ 346.69	\$ 366.74	\$ 387.95	\$ 410.40	
Total Expenditure					\$ 1,886,874,709	\$ 2,740,816,552	\$ 2,977,428,181	\$ 3,232,294,669	\$ 3,506,723,729	\$ 14,344,137,840

ABD										
Eligible Member Months	2.6%	12	2,921,020	1.8%	2,254,869	3,063,373	3,120,015	3,176,708	3,233,392	
PMPM Cost	3.6%	12	\$ 930.86	4.6%	\$ 1,045.04	\$ 1,124.49	\$ 1,164.91	\$ 1,206.78	\$ 1,250.17	
Total Expenditure					\$ 2,356,431,066	\$ 3,444,721,335	\$ 3,634,525,930	\$ 3,833,598,754	\$ 4,042,287,989	\$ 17,311,565,075

LTC										
Eligible Member Months	2.6%	12	416,357	1.8%	320,520	435,445	443,497	451,555	459,613	
PMPM Cost	3.9%	12	\$ 8,312.62	3.9%	\$ 8,636.81	\$ 9,975.89	\$ 9,325.83	\$ 9,689.41	\$ 10,067.17	
Total Expenditure					\$ 2,768,267,856	\$ 3,908,510,327	\$ 4,135,971,577	\$ 4,375,302,456	\$ 4,626,999,256	\$ 19,815,051,473

HCBS Waivers (State plan eligibles)										
Eligible Member Months	2.6%	12	17,504	1.8%	13,475	18,307	18,645	18,984	19,323	
PMPM Cost	3.7%	12	\$ 2,176.18	3.8%	\$ 2,256.69	\$ 2,347.84	\$ 2,434.29	\$ 2,523.94	\$ 2,616.93	
Total Expenditure					\$ 30,409,065	\$ 42,981,092	\$ 45,387,648	\$ 47,914,416	\$ 50,566,083	\$ 217,258,303

HYPOTHETICAL GROUPS

GA Employable & Unemployable (July-March)										
Eligible Member Months				7.9%	351,302	379,055	-	-	-	
PMPM Cost				3.7%	\$ 277.00	\$ 288.00	\$ -	\$ -	\$ -	
Total Expenditure					\$ 97,310,621	\$ 109,167,762	\$ -	\$ -	\$ -	\$ 206,478,382

GA Employable & Unemployable (April-Jun)										
Eligible Member Months				7.9%	175,651	-	-	-	-	
PMPM Cost				3.7%	\$ 288.00	\$ -	\$ -	\$ -	\$ -	
Total Expenditure					\$ 50,587,471	\$ -	\$ -	\$ -	\$ -	\$ 50,587,471

HCBS Waivers (217-Like)										
Eligible Member Months			115,103	1.8%	88,609	120,380	122,606	124,834	127,061	
PMPM Cost			\$ 2,176.18	3.7%	\$ 2,256.69	\$ 2,340.19	\$ 2,426.78	\$ 2,516.57	\$ 2,609.68	
Total Expenditure					\$ 199,962,642	\$ 281,712,633	\$ 297,537,564	\$ 314,152,975	\$ 331,589,697	\$ 1,424,955,510

Children with SFD (217-Like)										
Eligible Member Months				1.8%	12,552	17,052	17,368	17,683	17,999	
PMPM Cost				6.0%	\$ 2,246.37	\$ 2,381.15	\$ 2,524.02	\$ 2,675.46	\$ 2,835.99	
Total Expenditure					\$ 28,195,837	\$ 40,604,069	\$ 43,836,124	\$ 47,310,619	\$ 51,044,105	\$ 210,990,755

MI/DO (217-Like)										
Eligible Member Months				1.8%	259	351	358	364	371	
PMPM Cost				6.0%	\$ 9,839.39	\$ 10,429.75	\$ 11,055.53	\$ 11,718.87	\$ 12,422.00	
Total Expenditure					\$ 2,545,050	\$ 3,665,058	\$ 3,956,794	\$ 4,270,413	\$ 4,607,410	\$ 19,044,725

Formerly CHIP Parents										
Eligible Member Months					-	491,948	-	-	-	
PMPM Cost					\$ -	\$ 307.24	\$ -	\$ -	\$ -	
Total Expenditure					\$ -	\$ 151,147,785	\$ -	\$ -	\$ -	\$ 151,147,785

Medicaid Expansion Childless Adults										
Eligible Member Months				21.3%	-	655,791	2,186,198	2,295,331	2,343,026	
PMPM Cost					\$ -	\$ 662.68	\$ 681.07	\$ 706.27	\$ 732.40	
Total Expenditure					\$ -	\$ 434,579,678	\$ 1,488,952,564	\$ 1,621,121,136	\$ 1,716,034,369	\$ 5,260,687,747

Medicaid Expansion (Parents)										
Eligible Member Months				7.1%	-	969,398	2,236,152	2,317,222	2,380,316	
PMPM Cost					\$ -	\$ 334.82	\$ 352.40	\$ 377.07	\$ 403.46	
Total Expenditure					\$ -	\$ 324,573,812	\$ 788,015,519	\$ 873,745,340	\$ 960,363,386	\$ 2,946,698,056

Medicaid Expansion										
Eligible Member Months				13.3%	-	1,625,189	4,422,350	4,612,553	4,723,342	
PMPM Cost					\$ -	\$ 467.12	\$ 514.88	\$ 540.89	\$ 566.63	
Total Expenditure					\$ -	\$ 759,153,490	\$ 2,276,968,083	\$ 2,494,866,475	\$ 2,676,397,755	\$ 8,207,385,803

CHANGE FROM ORIGINAL BUDGET NEUTRALITY:

Increased the annual amount paid for Graduate Medical Education (GME) for Dys 2-5 in the amount of: \$ 10,000,000
Included projected costs and member months for Medicaid Expansion populations in Hypothetical Groups effective January 1, 2014

- Medicaid Expansion PMPMs are subject to change as final DY2 rates are still under development

Footnotes:

1 - The 5 year annualized trend rate is reflected in this column. Year to year "PMPM Cost" trends will vary due to physician fee increase and the ABD add-on benefit costs. The 5 year annualized trend rate calculated for "Eligible Member Months" will vary due to the year to year trends.

DEMONTATION WITH WATER REUSE DIVERSIFICATION - BONE FINGERED TRAIL

Table with columns for DEMONSTRATION YEAR (D1, D2, D3, D4, D5, D6, D7, D8, D9, D10, D11, D12, D13, D14, D15, D16, D17, D18, D19, D20, D21, D22, D23, D24, D25, D26, D27, D28, D29, D30, D31, D32, D33, D34, D35, D36, D37, D38, D39, D40, D41, D42, D43, D44, D45, D46, D47, D48, D49, D50, D51, D52, D53, D54, D55, D56, D57, D58, D59, D60, D61, D62, D63, D64, D65, D66, D67, D68, D69, D70, D71, D72, D73, D74, D75, D76, D77, D78, D79, D80, D81, D82, D83, D84, D85, D86, D87, D88, D89, D90, D91, D92, D93, D94, D95, D96, D97, D98, D99, D100) and rows for various categories like MEDICAL POPULATIONS, DEMONSTRATION YEAR (D1-D100), and TOTAL.

CHANGES FROM DRAFTING IN PROGRESS... MEDICAL POPULATIONS... DEMONSTRATION YEAR (D1-D100)...

1 - The 5 year annualized trend rate is calculated for "Medical Populations" from the year to next trend year.

DEMONSTRATION WITH WAIVER (DW) BUDGET PROJECTION - Using Projected Trends
TOTAL SHARE

MEDICAID POPULATIONS

ELIGIBILITY GROUP	DEMO TREND RATE	DEMONSTRATION YEARS (DY)					TOTAL WW
		DY 01 (Oct12-Jun13)	DY 02 (Jul13-Jun14)	DY 03 (Jul14-Jun15)	DY 04 (Jul15-Jun16)	DY 05 (Jul16-Jun17)	
Title XIX							
Eligible Member Months	2.7%	5,769,701	7,905,782	8,118,745	8,331,733	8,544,710	
PMPM Cost	5.4%	\$ 304.01	\$ 319.40	\$ 335.49	\$ 355.06	\$ 374.74	
Total Expenditure		\$ 1,754,034,319	\$ 2,525,084,791	\$ 2,731,866,803	\$ 2,958,275,550	\$ 3,202,041,603	\$ 13,171,303,065
ABD							
Eligible Member Months	1.8%	2,254,869	3,063,373	3,120,015	3,176,708	3,233,392	
PMPM Cost	4.9%	\$ 1,018.66	\$ 1,095.88	\$ 1,139.16	\$ 1,187.07	\$ 1,234.22	
Total Expenditure		\$ 2,296,955,008	\$ 3,357,403,597	\$ 3,554,200,761	\$ 3,770,961,790	\$ 3,990,727,257	\$ 16,970,248,413
LTC							
Eligible Member Months	1.8%	320,520	435,445	443,497	451,555	459,613	
PMPM Cost	3.4%	\$ 8,635.25	\$ 8,912.37	\$ 9,193.86	\$ 9,488.06	\$ 9,860.68	
Total Expenditure		\$ 2,768,089,726	\$ 3,880,847,576	\$ 4,077,444,481	\$ 4,284,384,408	\$ 4,532,055,073	\$ 19,542,851,264
HCBS Waivers (State plan eligibles)							
Eligible Member Months	1.8%	13,475	18,307	18,645	18,984	19,323	
PMPM Cost	4.3%	\$ 2,289.95	\$ 2,388.41	\$ 2,491.12	\$ 2,598.23	\$ 2,709.96	
Total Expenditure		\$ 30,857,129	\$ 43,723,862	\$ 46,447,202	\$ 49,324,703	\$ 52,883,646	\$ 222,716,542

HYPOTHETICAL GROUPS

GA Employable & Unemployable (July-March)							
Eligible Member Months	7.9%	351,302	379,055	-	-	-	
PMPM Cost		\$ 277.00	\$ 288.00	\$ -	\$ -	\$ -	
Total Expenditure		\$ 97,310,621	\$ 109,167,762	\$ -	\$ -	\$ -	\$ 206,478,382
GA Employable & Unemployable (April-Jun)							
Eligible Member Months	7.9%	175,651	-	-	-	-	
PMPM Cost		\$ 288.00	\$ -	\$ -	\$ -	\$ -	
Total Expenditure		\$ 50,587,471	\$ -	\$ -	\$ -	\$ -	\$ 50,587,471
HCBS Waivers (217-Like)							
Eligible Member Months		88,609	120,380	122,608	124,834	127,061	
PMPM Cost		\$ 2,356.69	\$ 2,340.19	\$ 2,426.78	\$ 2,516.57	\$ 2,609.68	
Total Expenditure		\$ 199,962,642	\$ 281,712,633	\$ 297,537,564	\$ 314,152,575	\$ 331,585,697	\$ 1,424,955,510
Children with SED (217-Like)							
Eligible Member Months		12,552	17,052	17,368	17,688	17,999	
PMPM Cost		\$ 2,346.37	\$ 2,381.25	\$ 2,524.02	\$ 2,675.46	\$ 2,835.99	
Total Expenditure		\$ 28,135,837	\$ 40,604,069	\$ 43,836,124	\$ 47,310,619	\$ 51,044,105	\$ 210,990,755
MI/DD (217-Like)							
Eligible Member Months		259	351	358	364	371	
PMPM Cost		\$ 9,839.39	\$ 10,429.75	\$ 11,055.53	\$ 11,718.87	\$ 12,422.00	
Total Expenditure		\$ 2,545,050	\$ 3,665,058	\$ 3,956,794	\$ 4,270,413	\$ 4,607,410	\$ 19,044,715
Formerly CHIP Parents							
Eligible Member Months		-	491,948	-	-	-	
PMPM Cost		\$ -	\$ 307.24	\$ -	\$ -	\$ -	
Total Expenditure		\$ -	\$ 151,147,785	\$ -	\$ -	\$ -	\$ 151,147,785
Medicaid Expansion Childless Adults							
Eligible Member Months		-	635,791	2,185,168	2,295,331	2,345,026	
PMPM Cost		\$ -	\$ 662.68	\$ 681.07	\$ 706.27	\$ 732.40	
Total Expenditure		\$ -	\$ 424,579,678	\$ 1,488,952,584	\$ 1,621,121,196	\$ 1,716,034,560	\$ 5,260,687,747
Medicaid Expansion (Parents)							
Eligible Member Months		-	569,398	2,236,152	2,317,212	2,380,316	
PMPM Cost		\$ -	\$ 394.32	\$ 352.40	\$ 377.07	\$ 403.46	
Total Expenditure		\$ -	\$ 224,573,812	\$ 788,015,519	\$ 873,745,340	\$ 960,361,336	\$ 2,946,696,656
Medicaid Expansion							
Eligible Member Months		-	1,625,189	4,422,350	4,612,553	4,723,347	
PMPM Cost		\$ -	\$ 467.12	\$ 514.88	\$ 540.89	\$ 566.63	
Total Expenditure		\$ -	\$ 759,153,490	\$ 2,276,968,083	\$ 2,494,866,475	\$ 2,678,397,755	\$ 8,207,385,803

NEW GROUPS AND EXPENDITURE CATEGORIES

Adults w/o Dependent Children							
Eligible Member Months		9,828	5,962	-	-	-	
PMPM Cost		\$ 296.82	\$ 317.54	\$ -	\$ -	\$ -	
Total Expenditure		\$ 2,916,994	\$ 1,893,163	\$ -	\$ -	\$ -	\$ 4,810,157
Children with SED (At Risk)							
Eligible Member Months		37,655	51,157	52,103	53,049	53,996	
PMPM Cost		\$ 1,160.83	\$ 1,230.48	\$ 1,304.31	\$ 1,382.57	\$ 1,465.53	
Total Expenditure		\$ 43,711,472	\$ 62,947,719	\$ 67,958,313	\$ 73,344,757	\$ 79,132,709	\$ 327,084,971
MATI (At Risk)							
Eligible Member Months		-	47,288	48,173	49,048	49,923	
PMPM Cost		\$ -	\$ 441.04	\$ 461.77	\$ 483.48	\$ 506.20	
Total Expenditure		\$ -	\$ 20,860,581	\$ 22,244,867	\$ 23,713,579	\$ 25,271,143	\$ 92,090,170

CHANGE FROM ORIGINAL BUDGET NEUTRALITY:
 Increased the annual amount paid for Graduate Medical Education (GME) for DYS 2-5 in the amount of \$ 10,000,000
 Included projected costs and member months for Medicaid Expansion populations in Hypothetical Groups effective January 1, 2014
 - Medicaid Expansion PMPMs are subject to change as final DY2 rates are still under development

Budget Neutrality Summary - Using CMS Proposed (WOW) & Projected (WW) Trends

TOTAL SHARE

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01*	DY 02	DY 03	DY 04	DY 05	
Title XIX	\$ 1,886,874,709	\$ 2,740,816,552	\$ 2,977,428,181	\$ 3,232,294,669	\$ 3,506,723,729	\$ 14,344,137,840
ABD	\$ 2,356,431,066	\$ 3,444,721,335	\$ 3,634,525,930	\$ 3,833,598,754	\$ 4,042,287,989	\$ 17,311,565,075
LTC	\$ 2,768,267,856	\$ 3,908,510,327	\$ 4,135,971,577	\$ 4,375,302,456	\$ 4,626,999,256	\$ 19,815,051,473
HCBS Waivers (State plan eligibles)	\$ 30,409,065	\$ 42,981,092	\$ 45,387,648	\$ 47,914,416	\$ 50,566,083	\$ 217,258,303
TOTAL	\$ 7,041,982,697	\$ 10,137,029,306	\$ 10,793,313,337	\$ 11,489,110,295	\$ 12,226,577,057	\$ 51,688,012,691

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01*	DY 02	DY 03	DY 04	DY 05	
Title XIX	\$ 1,754,034,319	\$ 2,525,084,791	\$ 2,731,866,803	\$ 2,958,275,550	\$ 3,202,041,603	\$ 13,171,303,065
ABD	\$ 2,296,955,008	\$ 3,357,403,597	\$ 3,554,200,761	\$ 3,770,961,790	\$ 3,990,727,257	\$ 16,970,248,413
LTC	\$ 2,768,089,726	\$ 3,880,847,576	\$ 4,077,444,481	\$ 4,284,384,408	\$ 4,532,095,073	\$ 19,542,861,264
HCBS Waivers (State plan eligibles)	\$ 30,857,129	\$ 43,723,862	\$ 46,447,202	\$ 49,324,703	\$ 52,363,646	\$ 222,716,542
Excess Spending From Hypotheticals						\$ -
Adults w/o Dependent Children	\$ 2,916,994	\$ 1,893,163	\$ -	\$ -	\$ -	\$ 4,810,157
Children with SED (At Risk)	\$ 43,711,472	\$ 62,947,719	\$ 67,958,313	\$ 73,344,757	\$ 79,132,709	\$ 327,094,971
MATI (At Risk)	\$ -	\$ 20,860,581	\$ 22,244,867	\$ 23,713,579	\$ 25,271,143	\$ 92,090,170
Transition Payments SFY 2012	\$ -					\$ -
Pools	\$ 192,450,000	\$ 266,600,000	\$ 266,600,000	\$ 266,600,000	\$ 266,600,000	\$ 1,258,850,000
TOTAL	\$ 7,089,014,648	\$ 10,159,361,289	\$ 10,766,762,427	\$ 11,426,604,787	\$ 12,148,231,431	\$ 51,589,974,582

VARIANCE	\$ (47,031,951)	\$ (22,331,984)	\$ 26,550,909	\$ 62,505,507	\$ 78,345,627	\$ 98,038,109
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HYPOTHETICALS ANALYSIS

Without-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01*	DY 02	DY 03	DY 04	DY 05	
GA Employable & Unemployable (July-March)	\$ 97,310,621	\$ 109,167,762	\$ -	\$ -	\$ -	\$ 206,478,382
GA Employable & Unemployable (April-Jun)	\$ 50,587,471	\$ -	\$ -	\$ -	\$ -	\$ 50,587,471
HCBS Waivers (217-Like)	\$ 199,962,642	\$ 281,712,633	\$ 297,537,564	\$ 314,152,975	\$ 331,589,697	\$ 1,424,955,510
Children with SED (217-Like)	\$ 28,195,837	\$ 40,604,069	\$ 43,836,124	\$ 47,310,619	\$ 51,044,105	\$ 210,990,755
MI/DD (217-Like)	\$ 2,545,050	\$ 3,665,058	\$ 3,956,794	\$ 4,270,413	\$ 4,607,410	\$ 19,044,725
Formerly CHIP Parents	\$ -	\$ 151,147,785	\$ -	\$ -	\$ -	\$ 151,147,785
Medicaid Expansion	\$ -	\$ 759,153,490	\$ 2,276,968,083	\$ 2,494,866,475	\$ 2,676,397,755	\$ 8,207,385,803
TOTAL	\$ 378,601,620	\$ 1,345,450,797	\$ 2,622,298,565	\$ 2,860,600,483	\$ 3,063,638,966	\$ 10,270,590,431

With-Waiver Total Expenditures

	DEMONSTRATION YEARS (DY)					TOTAL
	DY 01*	DY 02	DY 03	DY 04	DY 05	
GA Employable & Unemployable (July-March)	\$ 97,310,621	\$ 109,167,762	\$ -	\$ -	\$ -	\$ 206,478,382
GA Employable & Unemployable (April-Jun)	\$ 50,587,471	\$ -	\$ -	\$ -	\$ -	\$ 50,587,471
HCBS Waivers (217-Like)	\$ 199,962,642	\$ 281,712,633	\$ 297,537,564	\$ 314,152,975	\$ 331,589,697	\$ 1,424,955,510
Children with SED (217-Like)	\$ 28,195,837	\$ 40,604,069	\$ 43,836,124	\$ 47,310,619	\$ 51,044,105	\$ 210,990,755
MI/DD (217-Like)	\$ 2,545,050	\$ 3,665,058	\$ 3,956,794	\$ 4,270,413	\$ 4,607,410	\$ 19,044,725
Formerly CHIP Parents	\$ -	\$ 151,147,785	\$ -	\$ -	\$ -	\$ 151,147,785
Medicaid Expansion	\$ -	\$ 759,153,490	\$ 2,276,968,083	\$ 2,494,866,475	\$ 2,676,397,755	\$ 8,207,385,803
TOTAL	\$ 378,601,620	\$ 1,345,450,797	\$ 2,622,298,565	\$ 2,860,600,483	\$ 3,063,638,966	\$ 10,270,590,431

HYPOTHETICALS VARIANCE	\$ -					
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CHANGE FROM ORIGINAL BUDGET NEUTRALITY:

Increased the annual amount paid for Graduate Medical Education (GME) for DY's 2-5 in the amount of: \$ 10,000,000
 Included projected costs and member months for Medicaid Expansion populations in Hypothetical Groups effective January 1, 2014
 - Medicaid Expansion PMPMs are subject to change as final DY2 rates are still under development

* DY 01 equals the nine month period of October 1, 2012 through June 30, 2013.

New Jersey Comprehensive Medicaid Waiver Amendment

Budget Neutrality Adjustment Notes

October 18th, 2013

1) Graduate Medical Education: Increased the annual amount paid for Graduate Medical Education (GME) by \$10,000,000 annually for DY's 2-5.

With Waiver:

\$10m was broken out proportionately as follows:

Title XIX	54.20%
ABD	34.60%
LTC	9.80%
HCBS	1.40%

Without Waiver:

\$10m was added to the transition pool payments for DY's 2-5.

2) Medicaid Expansion: Included projected expansion costs as of 10/18/2013 in the Hypothetical Analysis with enrollment beginning 1/1/2014.

PMPM: As initial capitation rates are still under development, PMPMs are preliminary and subject to change once final rates are established.

DY 2 Initial rates include both preliminary capitated payments as well as costs for services remaining in FFS.

Growth Rates:

Childless Adults: 3.7% annually was based on the increase for the General Assistance increase prior to Medicaid Expansion.

Parents: 7.0% annually was based on the increase projected in the PMPM for the CHIP Allotment Neutrality.

Enrollment:

Trends are based upon current enrollment forecasts of the General Assistance and Formerly CHIP Parents populations.

Projected newly eligible Medicaid Expansion population was added to existing trends.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850



AUG 08 2013

Valerie Harr
Director, Division of Medical Assistance and Health Services
P.O. Box 712
Trenton NJ 08625-0712

Dear Ms. Harr:

I am writing to inform you that the Centers for Medicare & Medicaid Services (CMS) has granted your request to amend New Jersey's section 1115(a) demonstration (11-W- 00279/2) entitled "New Jersey Comprehensive Waiver." Approval of this amendment is under the authority of section 1115(a) of the Social Security Act, and is effective from the date of this letter.

This amendment proposes that the Hospital Relief Subsidy Fund (HRSF) transition payments be extended through December 31, 2013 due to unforeseeable delays in completing the DSRIP Planning Protocol and DSRIP Funding & Mechanics protocol, as required by paragraphs 93(e) and 93(f) of the Special Terms and Conditions (STCs). This extension will ease the burden of the hospitals in the development of their DSRIP plans as they transition from the HRSF subsidy to the performance-based DSRIP program.

CMS approval of this demonstration amendment is conditioned on continued compliance with the enclosed set of STCs that define the nature, character, and extent of anticipated federal involvement in the project. This award is subject to your written acknowledgement of the award and acceptance of the STCs within 30 days of the date of this letter.

A copy of the revised STCs is enclosed. The existing waiver and expenditure authorities for this demonstration are also enclosed and are unchanged by this amendment, and remain in force.

Your project officer for this demonstration is Mr. Ed Francell. He is available to answer any questions concerning your section 1115 demonstration and this amendment. Mr. Francell's contact information is:

Mr. Ed Francell
Center for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Mail Stop: S2-01-16

7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-1342
E-mail: ed.francell@cms.hhs.gov

Official communications regarding this demonstration should be sent simultaneously to Mr. Francell and Mr. Michael Melendez, Associate Regional Administrator for the Division of Medicaid and Children's Health in our New York Regional Office. Mr. Melendez's contact information is as follows:

Mr. Michael Melendez
Center for Medicare & Medicaid Services
Jacob K. Javits Federal Building
26 Federal Plaza, Room 3811
New York, NY 10278-0063

If you have any questions regarding this approval, please contact Mr. Eliot Fishman, Director, Children and Adults Health Programs Group, Center for Medicaid & CHIP Services at (410) 786-5647.

Sincerely,

A solid black rectangular box redacting the signature of the sender.

Cindy Mann
Director

Enclosure

cc: Michael Melendez, ARA Region II

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS (STCs)

NUMBER: 11-W-00279/2 (Titles XIX and XXI)

TITLE: New Jersey Comprehensive Waiver (NJCW) Demonstration

AWARDEE: New Jersey Department Human Services
Division of Medical Assistance and Health Services

DEMONSTRATION
PERIOD: October 1, 2012 through June 30, 2017

I. PREFACE

The following are the Special Terms and Conditions (STCs) for New Jersey’s “Comprehensive Waiver” section 1115(a) Medicaid and Children’s Health Insurance Plan (CHIP) demonstration (hereinafter “demonstration”), to enable the New Jersey Department Human Services, Division of Medical Assistance and Health Services (State) to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act (Act), and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth conditions and limitations on those waivers and expenditure authorities, and describe in detail the nature, character, and extent of Federal involvement in the demonstration and the State’s obligations to CMS during the life of the demonstration. These STCs neither grant additional waivers or expenditure authorities, nor expand upon those separately granted.

The STCs related to the programs for those state plan and demonstration populations affected by the demonstration are effective from the date indicated above through June 30, 2017.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Historical Context
- III. General Program Requirements
- IV. Eligibility
- V. Benefits
- VI. Cost Sharing
- VII. Delivery System I – Managed Care Requirements
- VIII. Delivery System II – Additional Delivery System Requirements for Home and Community Based Services and Managed Long Term Services and Supports
- IX. Delivery System III - Behavioral Health
- X. Transition Requirements for Managed Long Term Services and Supports
- XI. New Home and Community Based Service Programs
- XII. Premium Assistance

- XIII. Quality
- XIV. Funding Pools
- XV. General Reporting Requirements
- XVI. Administrative Requirements
- XVII. General Financial Requirements Under Title XIX
- XVIII. General Financial Requirements Under Title XXI
- XIX. Monitoring Budget Neutrality for the Demonstration
- XX. Evaluation Plan and Design
- XXI. Scheduled Deliverables

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A	Quarterly Report Template
Attachment B	State Plan Benefits
Attachment C.1	Non-MLTSS HCBS Benefits
Attachment C.2	HCBS Benefits
Attachment D	Serious Emotional Disturbance (SED) Program Benefits
Attachment E	Medication Assisted Treatment Initiative (MATI) Program Benefits
Attachment F	Behavioral Health Organization (BHO) and Administrative Services Organization (ASO)
Attachment G	DSRIP Planning Protocol
Attachment H	DSRIP Plan
Attachment I	Hospitals Eligible for Transition and DSRIP Payments

II. PROGRAM DESCRIPTION AND HISTORICAL CONTEXT

On September 14, 2011 the State of New Jersey submitted a Medicaid section 1115 demonstration proposal which seeks to provide comprehensive health care benefits for approximately 1.3 million individuals, including individuals eligible for benefits under New Jersey’s Medicaid Program and additional populations eligible only under the demonstration. The new demonstration will consolidate the delivery of services under a number of separate State initiatives, including its Medicaid State plan, existing CHIP State plan, its previous Childless Adults section 1115 demonstration, four previous 1915(c) waiver programs and a previous State-funded Childless Adult program. The demonstration will require approximately 98 percent or 1.3 million beneficiaries to enroll in Managed Care Organizations (MCOs), with approximately 75,000 beneficiaries enrolled in Medicaid fee-for-service (FFS).

This five year demonstration will:

- Maintain Medicaid and CHIP State plan benefits without change;
- Continue the expanded eligibility and service delivery system under four existing 1915(c) home and community-based services (HCBS) waivers that:
 - Offer HCBS services and supports through a Traumatic Brain Injury Program (TBI) to certain individuals between the ages of 21 to 64 years of age who have acquired, non-degenerative, structural brain damage and who meet the Social

- Security Administration's (SSA) disability standard.
- Offer HCBS services through an AIDS Community Care Alternative program (ACCAP) to certain individuals diagnosed with AIDS that support them and their primary caregivers.
- Offers HCBS services and supports through a Community Resources for People with Disabilities program (CRPD) to certain individuals with physical disabilities who need assistance with at least 3 activities of daily living; and,
- Offers HCBS services and supports through a Global Options (GO) program for certain individuals 65 years of age and older and physically disabled persons between 21 years of age and 64, who are assessed as needing nursing facility level of care.
- Continue the service delivery system under two previous 1915(b) managed care waiver programs that:
 - Require Medicare and Medicaid eligible beneficiaries to mandatorily enroll in an MCO for Medicaid services only.
 - Require disabled and foster care children to enroll in an MCO for care.
- Streamline eligibility requirements with a projected spend down for individuals who meet the nursing facility level of care
- Eliminate the five year look back at time of application for applicants or beneficiaries seeking long term services and supports who have income at or below 100 percent of the Federal Poverty Level (FPL);”
- Cover additional home and community-based services to Medicaid and CHIP beneficiaries with serious emotional disturbance, opioid addiction, pervasive developmental disabilities, and intellectual disabilities/developmental disabilities;
- Cover outpatient treatment for opioid addiction or mental illness for an expanded population of adults with household incomes up to 150 percent FPL;
- Expand eligibility to include a population of individuals between 18 and 65 who are not otherwise eligible for Medicaid, have household incomes between 25 and 100 percent of the FPL and are in satisfactory immigration status;
- Transform the State's behavioral health system for adults by delivering behavioral health through behavioral health administrative service organizations.
- Furnish premium assistance options to individuals with access to employer-based coverage.

Demonstration Goals:

Ensure continued coverage for groups of individuals currently under the Medicaid and CHIP State plans, previous waiver programs, and previously state-funded programs. In this demonstration the State seeks to achieve the following goals:

- Create “no wrong door” access and less complexity in accessing services for integrated health and Long-Term Care (LTC) care services;
- Provide community supports for LTC and mental health and addiction services;
- Provide in-home community supports for an expanded population of individuals with intellectual and developmental disabilities;
- Provide needed services and HCBS supports for an expanded population of youth with severe emotional disabilities; and
- Provide need services and HCBS supports for an expanded population of individuals with

- co-occurring developmental/mental health disabilities.
- Encourage structural improvements in the health care delivery system through DSRIP funding.

Demonstration Hypothesis:

The State will test the following hypotheses in its evaluation of the demonstration:

- Expanding Medicaid managed care to include long-term care services and supports will result in improved access to care and quality of care and reduced costs, and allow more individuals to live in their communities instead of institutions.
- Providing home and community-based services to Medicaid and CHIP beneficiaries and others with serious emotional disturbance, opioid addiction, pervasive developmental disabilities, or intellectual disabilities/developmental disabilities will lead to better care outcomes.
- Utilizing a projected spend-down provision and eliminating the look back period at time of application for transfer of assets for applicants or beneficiaries seeking long term services and supports whose income is at or below 100% of the FPL will simplify Medicaid eligibility and enrollment processes without compromising program integrity.
- The Delivery System Reform Incentive Payment (DSRIP) Program will result in better care for individuals (including access to care, quality of care, health outcomes), better health for the population, and lower cost through improvement.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
2. **Compliance with Medicaid and Child Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid program, or the Children's Health Insurance Program (CHIP) for the separate CHIP population, expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.
3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.
4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

- a. To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this demonstration, the State must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.
 - b. If mandated changes in the Federal law require State legislation, the changes must take effect on the earlier of the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
5. **State Plan Amendments.** The State will not be required to submit title XIX or XXI State plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP State plan is affected by a change to the demonstration, a conforming amendment to the appropriate State Plan is required, except as otherwise noted in these STCs.
6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, delivery systems, cost sharing, evaluation design, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in paragraph 7 below.
7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. Amendment requests must include, but are not limited to, the following:
- a. An explanation of the public process used by the State, consistent with the requirements of paragraph 15 to reach a decision regarding the requested amendment;
 - b. A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
 - c. An up-to-date CHIP allotment worksheet, if necessary.

- d. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and
- e. If applicable, a description of how the evaluation designs will be modified to incorporate the amendment provisions.

8. Extension of the Demonstration.

- a. States that intend to request demonstration extensions under sections 1115(a), 1115(e) or 1115(f) must submit an extension request no later than 12 months prior to the expiration date of the demonstration. The chief executive officer of the State must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9.
- b. Compliance with Transparency Requirements 42 CFR Section 431.412:
Effective April 27, 2012, as part of the demonstration extension requests the State must provide documentation of compliance with the transparency requirements 42 CFR Section 431.412 and the public notice and tribal consultation requirements outlined in paragraph 15, as well as include the following supporting documentation:
 - i. **Historical Narrative Summary of the demonstration Project:** The State must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.
 - ii. **Special Terms and Conditions (STCs):** The State must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.
 - iii. **Waiver and Expenditure Authorities:** The State must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.
 - iv. **Quality:** The State must provide summaries of: External Quality Review Organization (EQRO) reports; managed care organization (MCO) and Coordinated Care Organization (CCO) reports; State quality assurance monitoring; and any other documentation that validates of the quality of care provided or corrective action taken under the demonstration.
 - v. **Financial Data:** The State must provide financial data (as set forth in the current STCs) demonstrating the State's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension as well as

cumulatively over the lifetime of the demonstration. CMS will work with the State to ensure that Federal expenditures under the extension of this project do not exceed the Federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension. In addition, the State must provide up to date responses to the CMS Financial Management standard questions. If title XXI funding is used in the demonstration, a CHIP Allotment Neutrality worksheet must be included.

- vi. **Evaluation Report:** The State must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.
- vii. **Documentation of Public Notice 42 CFR section 431.408:** The State must provide documentation of the State's compliance with public notice process as specified in 42 CFR section 431.408 including the post-award public input process described in 431.420(c) with a report of the issues raised by the public during the comment period and how the State considered the comments when developing the demonstration extension application.

9. **Demonstration Phase-Out.** The State may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

- a. **Notification of Suspension or Termination:** The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The State must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the State must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the State must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the State must provide a summary of each public comment received the State's response to the comment and how the State incorporated the received comment into a revised phase-out plan.
- b. The State must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.
- c. **Phase-out Plan Requirements:** The State must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the State will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

- d. **Phase-out Procedures:** The State must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the State must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR §431.230. In addition, the State must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.
- e. **Federal Financial Participation (FFP):** If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.
- f. **Post Award Forum:** Within six months of the demonstration’s implementation, and annually thereafter, the State will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the State must publish the date, time and location of the forum in a prominent location on its website. The State can use either its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The State must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly report, as specified in paragraph 102, associated with the quarter in which the forum was held. The State must also include the summary in its annual report as required in paragraph 103.

10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing that the State has materially failed to comply with the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

11. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge CMS’ finding that the State materially failed to comply.

12. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS’ determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

13. Submission of State Plan and Demonstration Amendments, and Transition Plan, Related to Implementation of the Affordable Care Act (ACA).

Upon implementation of the Affordable Care Act (ACA) in January 2014, expenditure authority for many demonstration Expansion populations will end. To the extent that the State seeks authority for the eligibility, benefits and cost sharing for these populations under the Medicaid or CHIP State plan, the State will, by April 1, 2013, submit proposed State plan amendments for any such populations. Concurrently, the State will submit proposed amendments to the demonstration to the extent that such populations will be subject to the demonstration. In addition, the State will submit by October 1, 2013, a transition plan consistent with the provisions of the Affordable Care Act for individuals enrolled in the demonstration, including how the State plans to coordinate the transition of these individuals to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. The plan must contain the required elements and milestones described in subparagraphs outlined below. In addition, the Plan will include a schedule of implementation activities that the State will use to operationalize the Transition Plan and meet the requirements of regulations and other CMS guidance related to ACA implementation.

- a. Transition plan must assure seamless transitions: Consistent with the provisions of the Affordable Care Act, the Transition Plan will include details on how the State will obtain and review any additional information needed from each individual to determine eligibility under all eligibility groups, and coordinate the transition of individuals enrolled in the demonstration (by FPL) (or newly applying for Medicaid) to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. Specifically, the State must:
 - i. Determine eligibility under all January 1, 2014, eligibility groups for which the State is required or has opted to provide medical assistance, including the group described in §1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL.
 - ii. Identify demonstration populations not eligible for coverage under the Affordable Care Act and explain what coverage options and benefits these individuals will have effective January 1, 2014.
 - iii. Implement a process for considering, reviewing, and making preliminary determinations under all January 1, 2014 eligibility groups for new applicants for Medicaid eligibility.
 - iv. Conduct an analysis that identifies populations in the demonstration that may not be eligible for or affected by the Affordable Care Act and the authorities the State identifies that may be necessary to continue coverage for these individuals.

- v. Develop a modified adjusted gross income (MAGI) conversion for program eligibility.
- b. Cost-sharing Transition: The Plan must include the State's process to come into compliance with all applicable Federal cost-sharing requirements,
- c. Transition Plan Implementation:
 - i. By October 1, 2013, the State must begin to implement a simplified, streamlined process for transitioning eligible enrollees in the demonstration to Medicaid, the Exchange or other coverage options in 2014. In transitioning these individuals from coverage under the waiver to coverage under the State plan, the State will not require these individuals to submit a new application.
 - ii. On or before December 31, 2013, the State must provide notice to the individual of the eligibility determination using a process that minimizes demands on the enrollees.

14. **Adequacy of Infrastructure.** The State will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

15. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The State must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009 and the tribal consultation requirements contained in the State's approved State plan, when any program changes to the demonstration, including (but not limited to) those referenced in paragraph 7, are proposed by the State. In States with Federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the State's approved Medicaid State plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)). In States with Federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, and/or renewal of this demonstration (42 C.F.R. §431.408(b)(3)). The State must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

16. **Federal Financial Participation (FFP).** Federal funds are not available for expenditures for this demonstration until the effective date identified in the demonstration approval letter.

IV. ELIGIBILITY

The NJCW maintains Medicaid and CHIP eligibility for populations eligible prior to the demonstration, including eligibility under the prior CHIP and childless adult demonstrations, four 1915(c) waiver programs, and two 1915(b) waiver programs. In addition, this demonstration provides for some expanded eligibility for some additional populations, as indicated below. In addition, populations eligible under the state plan, as identified below, may be affected by the demonstration through requirements to enroll in the Medicaid managed care program under the demonstration to receive state plan benefits. Individuals eligible for both Medicare and Medicaid (duals) are covered under this demonstration for Medicaid services.

17. **Eligibility Groups Affected By the Demonstration.** Benefits and service delivery options for the mandatory and optional State plan groups described in STC 19(a) and (b) below are affected by the demonstration. To the extent indicated in STC 32, these groups receive covered benefits through managed care organizations (MCOs).

18. **Expansion Groups:** Non-Medicaid eligible groups described in STC 19(c) and (d) are eligible under the demonstration, to the extent included in expenditure authorities separately granted to facilitate this demonstration. To the extent indicated in STC 32, these groups receive covered benefits through managed care organizations (MCOs).

19. **Demonstration Population Summary.** The Following Chart Describes the Populations Affected and the Demonstration Expansion Populations.

a. Medicaid State Plan Mandatory Groups

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
AFDC including Pregnant women	<ul style="list-style-type: none"> ▪ Section 1931 low-income families with children- §1902(a)(10)(A)(i)(I) §1931 ▪ Individuals who lose eligibility under §1931 due to increased earned income or working hours - §1902(a)(10)(A)(i)(I) §408(a)(11)(A), §1925, 1931(c)(2), 1902(a)(52), 1902(e)(1)(B) ▪ Individuals who lose eligibility under §1931 because of income from child or spousal support - §1902(a)(10)(A)(i)(I), §1931(c)(1), §408(a)(11)(B) ▪ Qualified pregnant women - §1902(a)(10)(A)(i)(III) §1905(n)(1) ▪ Qualified children - §1902(a)(10)(A)(i)(III) §1905(n)(2) ▪ Newborns deemed eligible for one year - §1902(e)(4) ▪ Pregnant women who lose eligibility receive 60 days coverage for pregnancy-related and post-partum services - §1902(e)(5) ▪ Pregnant women losing eligibility because of a change in income remain eligible 60 days post-partum - 	<p>AFDC standard and methodologies or more liberal</p> <p>The monthly income limit for a family of four is \$507. No resource limit</p>	Plan A (See Attachment B)	“Title XIX”

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	§1902(e)(6)			
Foster Care	<ul style="list-style-type: none"> ▪ Children receiving IV-E foster care payments or with IV-E adoption assistance agreements - §1902(a)(10)(i)(I), §473(b)(3) 	Auto-eligible	Plan A (see Attachment B)	“Title XIX”
SSI recipients	<ul style="list-style-type: none"> ▪ Individuals receiving SSI cash benefits - §1902(a)(10)(A)(i)(I) ▪ Disabled children no longer eligible for SSI benefits because of a change in definition of disability - §1902(a)(10)(A)(i)(II)(aa) ▪ Individuals under age 21 eligible for Medicaid in the month they apply for SSI - §1902(a)(10)(A)(i)(II)(cc) ▪ Disabled individuals whose earnings exceed SSI substantial gainful activity level - §1619(a) ▪ Disabled widows and widowers - §1634(b) §1939(a)(2)(C) ▪ Disabled adult children - §1634(c) §1939(a)(2)(D) ▪ Early widows/widowers - §1634(d) §1939(a)(2)(E) ▪ Individuals receiving mandatory State supplements - 42 CFR 435.130 ▪ Individuals eligible as essential spouses in December 1973 - 42 CFR 435.131 ▪ Institutionalized individuals who 	<p>SSI standards and methodologies</p> <p>SSI amount and NJ includes a state supplement</p>	Plan A (see Attachment B)	<p>(1) If enrolled in TBI, ACCAP, CRPD, or GO, then “HCBS (State plan).”</p> <p>(2) If residing in a NF, ICF/MR, or other institutional setting, then “LTC.”</p> <p>(3) If not (1) or (2), then “ABD.”</p>

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	<p>were eligible in December 1973 - 42 CFR 435.132</p> <ul style="list-style-type: none"> ▪ Blind and disabled individuals eligible in December 1973 - 42 CFR 435.133 ▪ Individuals who would be eligible except for the increase in OASDI benefits under Public Law 92-336 - 42 CFR 435.134 ▪ Individuals who become ineligible for cash assistance as a result of OASDI cost-of- living increases received after April 1977 - 42 CFR 435.135 ▪ Individuals ineligible for SSI or optional state supplement because of requirements that do not apply for Title XIX – 42 CFR 435.122 			
1619 (b)	<ul style="list-style-type: none"> ▪ Disabled individuals whose earnings are too high to receive SSI cash - §1619(b) 	<p>Earned income is less than the threshold amount as defined by Social Security</p> <p>Unearned income is the SSI amount</p> <p>The resource amount is the SSI limit of 2,000 for an individual and 3000 for a couple.</p>	Plan A (see Attachment B)	<p>(1) If enrolled in TBI, ACCAP, CRPD, or GO, then “HCBS (State plan).”</p> <p>(2) If residing in a NF, ICF/MR, or other institutional setting, then “LTC.”</p> <p>(3) If not (1) or (2), then “ABD.”</p>

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
New Jersey Care Special Medicaid Programs	<ul style="list-style-type: none"> ▪ Poverty level pregnant women - §1902(a)(10)(A)(i)(IV) §1902(1)(1)(A) ▪ Poverty level infants - §1902(a)(10)(A)(i)(IV) §1902(1)(1)(B) ▪ Poverty level children age 1-5 §1902(a)(10)(A)(i)(VI) §1902(1)(1)(C) ▪ Poverty level children age 6-18 - §1902(a)(10)(A)(i)(VII) §1902(1)(1)(D) ▪ Poverty level infants and children receiving inpatient services who lose eligibility because of age must be covered through an inpatient stay - §1902(e)(7) 	Pregnant Women and Infants: Income less than or equal to 133% FPL Children age 1-5: Family income less than or equal to 133% FPL Children age 6-18: Family income less than or equal to 100% FPL	Plan A (see Attachment B)	"Title XIX"

b. Medicaid State Plan Optional Groups

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
AFDC including Pregnant women	<ul style="list-style-type: none"> ▪ Individuals who are eligible for but not receiving IV-A, SSI or State supplement cash assistance - §1902(a)(10)(A)(ii)(I) ▪ Individuals who would have been eligible for IV-A cash assistance, SSI, or State supplement if not in a medical institution - §1902(a)(10)(A)(ii)(IV) 	<ul style="list-style-type: none"> ▪ AFDC methodology <p>The monthly income limit for a family of four is \$507. AFDC resource limit.</p>	Plan A (see Attachment B)	“Title XIX”
Medicaid Special	<ul style="list-style-type: none"> ▪ All individuals under 21 who are not covered as mandatory categorically needy - §1902(a)(10)(A)(ii)(I) and (IV) §1905(a)(i) 	<ul style="list-style-type: none"> ▪ AFDC methodology ▪ The difference between the 1996 AFDC income standard and 133% FPL is disregarded from the remaining earned income. 	Plan A (see Attachment B)	“Title XIX”
SSI recipients	<ul style="list-style-type: none"> ▪ Individuals receiving only an optional state supp. 42 CFR 435.232 ▪ Individuals who meet the SSI requirements but do not receive cash – 42 CFR 435.210 ▪ Individuals who would be eligible for cash if not in an institution – 42 CFR 435.211 	<p>NJ state supplement only – determined annually and based on living arrangement</p> <p>Resources - SSI SSI methodology</p> <p>Income standard – SSI and SSI supplement payment</p> <p>Resource: SSI</p>	Plan A (see Attachment B)	<p>(1) If enrolled in TBI, ACCAP, CRPD, or GO, then “HCBS (State plan).”</p> <p>(2) If residing in a NF, ICF/MR, or other institutional setting, then</p>

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
				<p>“LTC.”</p> <p>(3) If not (1) or (2), then “ABD.”</p>
Institutional Medicaid	<p><i>Special income level group:</i> Individuals who are in a medical institution for at least 30 consecutive days with gross income that does not exceed 300% of the SSI income standard, or state-specified standard - §1902(a)(10)(A)(ii)(V)</p> <p><i>Hospice Group:</i> Individuals who are terminally ill, would be eligible if they were in a medical institution, and will receive hospice care - §1902(a)(10)(A)(ii)(VII)</p> <p><i>Special Home and Community Based Services Group:</i> Individuals who would be eligible in an institution and receiving services under the State’s current 1915(c) waivers specifically: (1) Global Options Waiver (GO) # NJ.0032; (2) Community Resources for People with Disabilities (CRPD) Waiver #NJ.4133; (3) AIDS Community Care Alternatives Program (ACCAP) NJ#06-160; (4) and</p>	<p><i>Special income level group:</i> Income less 300% of SSI/Federal Benefit Rate (FBR) per month; Resources SSI Standard; Individuals must meet institutional LOC requirements</p> <p><i>Hospice Group:</i> Individuals Income less 300% of SSI/Federal Benefit Rate (FBR) per month. Resources SSI Standard</p>	Plan A (see Attachment B)	<p>(1) If enrolled in TBI, ACCAP, CRPD, or GO, then “HCBS (State plan).”</p> <p>(2) If residing in a NF, ICF/MR, or other institutional setting, then “LTC.”</p>

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	Traumatic Brain Injury (TBI) Program NJ# 4174			
New Jersey Care Special Medicaid Programs Pregnant Women and Children	<ul style="list-style-type: none"> ▪ Poverty level pregnant women not mandatorily eligible - §1902(a)(10)(A)(ii)(IX) §1902(l)(1)(A) ▪ Poverty level infants not mandatorily eligible - §1902(a)(10)(A)(ii)(IX) §1902(l)(1)(B) ▪ Optional targeted low income children age 6-18 – 1902(a)(10)(A)(ii)(XIV) 	<ul style="list-style-type: none"> ▪ Pregnant women: Income less than or equal to 185% FPL ▪ Infants: Family income less than or equal to 185% FPL ▪ Children: Family income more than 100% and less than or equal to 133% FPL 	Attachment B	“Title XIX”
New Jersey Care Special Medicaid Programs ABD	<ul style="list-style-type: none"> ▪ Individuals receiving COBRA continuation benefits - §1902(a)(10)(F) 1902(u) ▪ Eligibility group only includes aged and disabled individuals - §1902(a)(10)(A)(ii)(X) 	Income must be less than or equal to 100% FPL. Resources up to \$4,000 for individual, \$6,000 for couple	Plan A (see Attachment B)	<p>(1) If enrolled in TBI, ACCAP, CRPD, or GO, then “HCBS (State plan).”</p> <p>(2) If residing in a NF, ICF/MR, or other institutional setting, then “LTC.”</p> <p>(3) If not (1) or (2), then “ABD.”</p>

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
Chafee Kids	<ul style="list-style-type: none"> ▪ Children under age 21 who were in foster care on their 18th birthday – 1902(a)(10)(A)(ii)(XVII) 	Children 18 up to 21 who were in foster care at the age of 18. On their 18 th birthday must be in DCF out of home placement supported in whole or in part by public funds No income or resource test	Plan A (see Attachment B)	“Title XIX”
Subsidized Adoption Services	<ul style="list-style-type: none"> ▪ Children under 21 who are under State adoption agreements - §1902(a)(10)(A)(ii)(VIII) 	Must be considered to have special needs	Plan A (see Attachment B)	“Title XIX”
Medically Needy Children and Pregnant Women	<ul style="list-style-type: none"> ▪ Individuals under 18 who would be mandatorily categorically eligible except for income and resources - §1902(a)(10)(C)(ii)(I) ▪ Pregnant women who would be categorically eligible except for income and resources - §1902(a)(10)(C)(ii)(II) ▪ Pregnant women who lose eligibility receive 60 days coverage for pregnancy-related and post-partum services - §1902(a)(10)(C) §1905(e)(5) 	<p>AFDC methodology – including spend down provision outlined in the state plan</p> <p>Income after spend down is equal to or less than \$367 for an individual, \$434 for a couple, two person household or pregnant woman, etc. Up to \$4,000 in resources allowed for an individual, \$6,000 for a couple</p>	Limited Plan A Services (see Attachment B)	“Title XIX”
Medically Needy Aged, Blind or	<ul style="list-style-type: none"> ▪ Medically Needy - §1902(a)(10)(C) ▪ Blind and disabled individuals 	SSI methodology – including spend down	Attachment B	“ABD”

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
Disabled	eligible in December 1973 - 42 CFR 435.340	provision outlined in the state plan Income after spend down is equal to or less than \$367 for an individual, \$434 for a couple, two person household or pregnant woman, etc. Up to \$4,000 in resources allowed for an individual, \$6,000 for a couple		
New Jersey WorkAbility	<ul style="list-style-type: none"> ▪ §1902(a)(10)(A)(ii)(XV) 	<p>Individual must be between the ages of 16 and 65, have a permanent disability, as determined by the SSA or DMAHS and be employed</p> <p>Countable unearned income (after disregards) up to 100% FPL, countable income with earnings up to 250% FPL; resources up to \$20,000 for an individual, \$30,000 for a couple</p>	Plan A (see Attachment B)	“ABD”

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
Breast and Cervical Cancer	<ul style="list-style-type: none"> ▪ §1902(a)(10)(A)(ii)(XVIII) 	<p>Uninsured low income women under the age of 65 who have been screened at a NJ cancer education and early detection site and needs treatment</p> <p>No Medicaid income or resource limit</p>	Plan A (Attachment B)	“ABD”
Title XXI Medicaid Expansion Children		The Medicaid expansion is for children 6 to 18 years of age whose family income is above 100 percent up to and including 133 percent of the FPL.	Plan A (see Attachment B)	“Title XXI Exp Child”
Parents/Caretakers up to 133% FPL		Uninsured custodial parents and caretaker relatives of Medicaid and CHIP children with family incomes above the previous Medicaid standard up to and including 133 percent off the FPL	Plan D (see Attachment B)	Title XXI until 9/30/2013 then XIX until 12/31/ “XIX CHIP Parents”
Parent Caretakers between 134 & 200% FPL		Uninsured custodial parents and caretaker relatives with	Plan D (see Attachment B)	Title XXI until 9/30/2013 then

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
		income at or above 134 percent of the FPL, and up to and including 200 percent of the FPL. (Enrollment into this group was frozen March 1, 2010)		XIX until 12/31/13 “XIX CHIP Parents”

c. Expansion Eligibility Groups

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
Work First (Childless Adults)		Childless non-pregnant adults ages 19 through 64 years who are not otherwise eligible under the Medicaid State plan, do not have other health insurance coverage, are residents of New Jersey, are citizens or eligible aliens, have limited assets, and either: 1) cooperate with applicable work requirements and have countable monthly household incomes up to \$140 for a childless adult and \$193 for a childless adult couple; or 2) have a medical deferral from work requirements based on a physical or mental condition, which prevents them from work requirements and have countable monthly household incomes up to \$210 for a childless adult and \$289 for a childless	Plan G (see Attachment B)	“NJ Childless Adults”

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
		couple.		
Childless Adults		Adults between 25 and 100% FPL who were enrolled in the program as of September 2001.	Plan D (see Attachment B)	“AWDC” ”
MATI New HCBS program Medication Assisted Treatment Initiative (MATI)	Adults 18 years and older at risk of institutionalization.	Income 150% FPL for adults who do not otherwise qualify for Medicaid Resources SSI Use financial institutional eligibility and post eligibility rules in the community for individuals who would not be eligible in the community because of community deeming rules in the same manner that would be used under a 1915(c) waiver program.	HCBS MATI services only (see Attachment E)	“MATI At Risk”

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
New HCBS program Serious Emotional Disturbance (SED)	SED children under age 21 at risk of hospitalization who have been diagnosed as seriously emotionally disturbed. (1115)	Income 150% FPL Resources SSI. Use financial institutional eligibility and post eligibility rules for individuals who would not be eligible in the community because of community deeming rules in the same manner that would be used under a 1915(c) waiver program.	3 HCBS services plus State Plan Behavioral Health Services (Children otherwise eligible for Medicaid will receive the full Medicaid benefit package + the three HCBS services)	“SED At Risk”

d. Expansion 217 –Like Eligibility Groups

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
217-like Existing .217 under HCBS	<p>Special income level (SIL) group receiving HCBW-like or services.</p> <p>42 CFR 435.217, 435.236 and 435.726 of and section 1924 of the Social Security Act, if the State had 1915(c) waivers</p> <p>(formerly served through the Community Resources for People with Disabilities, AIDS Community Care Alternatives , Traumatic Brain Injury, and Global Options for Long Term Care 1915(c) Waivers)</p> <p>Prior to transition of TBI, ACCAP, CRPD, and GO to MLTSS, this group includes individuals participating in those programs who are eligible for Medicaid under 42 CFR 435.217,</p>	<p>Income up to 300% of SSI/FBR</p> <p>Resources SSI</p> <p>Methodology SSI</p> <p>Use institutional eligibility and post eligibility rules for individuals who would only be eligible in the institution in the same manner as specified as if the State had 1915(c) waiver programs</p>	<p>State plan services with additional waiver services (see Attachment D)</p>	<p>“HCBS (217-Like)”</p>
217-like Existing .217 under HCBS	<p>A subset of the aged and disabled (Aged and Disabled) poverty level group who would only be eligible in the institution and receive HCBW-like services.</p>	<p>Income up to 100% of FPL</p> <p>Resources SSI</p> <p>Methodology SSI</p> <p>Use institutional eligibility and post eligibility rules for individuals who would</p>	<p>State plan services with additional waiver services.</p>	<p>“HCBS (217-Like)”</p>

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	<p>42 CFR 435.217, 435.726, 1902(m) and section 1924 of the Social Security Act</p> <p>(formerly served through the Community Resources for People with Disabilities, AIDS Community Care Alternatives , Traumatic Brain Injury, and Global Options for Long Term Care 1915(c) Waivers)</p> <p>Prior to transition of TBI, ACCAP, CRPD, and GO to MLTSS, this group includes individuals participating in those programs who are eligible for Medicaid under 42 CFR 435.217,</p>	<p>only be eligible in the institution in the same manner as if the State had 1915(c) waiver programs.</p>		
New 217-like Medically Needy	<p>The medically needy with a “hypothetical” spend down receiving HCBW--like services.</p> <p>42 CFR 435.217, 435.726, 1902(a)(10)(C)(i)(III) and section 1924 of the Social Security Act</p> <p>(Medically Needy With A Spenddown under the 435.217 group. These individuals were not previously covered under the</p>	<p>Use institutional eligibility and post eligibility rules for individuals who would only be eligible in the institution in the same manner as specified under, if the State had 1915(c) waiver programs.</p> <p>In order for medically needy individuals with a spenddown to be covered under the 217 like HCBS</p>	State plan services with additional waiver services	“HCBS (217-Like)”

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	State's 1915(c) Waiver Programs)	<p>group the State must develop as hypothetical spenddown to demonstrate that these individuals would be eligible if in an institution. New Jersey's hypothetical spenddown uses the annual average nursing facility costs which are the statewide average cost of institutional care. This amount will be adjusted annually in accordance with the change in the Consumer Price Index all Urban Consumers, rounded up to the nearest dollar. If the individual's hypothetical cost exceeds the individual's monthly income, individual is Medicaid eligible. However, the individual's is considered categorically needy because he/she is eligible in the 217 like group and has no spenddown. Post eligibility treatment of</p>		

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
		income rules apply in accordance with 435.726 and 1924 of the Act.		
217 like New HCBS program Serious Emotional Disturbance (SED) that is optional under State Plan	SED children under age 21 meeting hospital level of care who have been diagnosed as seriously emotionally disturbed. 42 CFR 435.217, 435.726, 435.236 and 1924 of the Social Security Act	Income 300% of the SSI/FBR Resources SSI. Use institutional eligibility and post eligibility rules for individuals who would only be eligible in the institution in the same manner as specified under, if the State had 1915(c) waiver programs.	3 HCBS services plus State Plan Services	“SED (217-Like)”
Expansion group 217 like New HCBS program Intellectual Disabilities/Developmental Disabilities with Co-occurring Mental Health	IDD/MI children under age 21 meeting state mental hospital level of care 42 CFR 435.217, 435.726, 435.236 and 1924 of the Social Security Act	Income 300% SSI/FBR Resources SSI. Use institutional eligibility and post eligibility rules for individuals who would only be eligible in the institution in the same manner as specified under, if the State had 1915(c) waiver programs.	Medicaid Benefit package +HCBS services	“IDD/MI (217-Like)”

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
Diagnosis (IDD/MI)				

20. Eligibility/Post-Eligibility Treatment of Income and Resources for Institutionalized Individuals. In determining eligibility (except for short term stays) for institutionalized individuals, the State must use the rules specified in the currently approved Medicaid State plan. All individuals receiving institutional services must be subject to post-eligibility treatment of income rules set forth in section 1924 of the Act and 42 CFR Section 435.725 of the Federal regulations.

a. Individuals Receiving Home and Community Based Services or Managed Long Term Services and Supports

i. 217-Like Group of Individuals Receiving HCBS Services. Institutional eligibility and post eligibility rules apply in the same manner as specified under 42 CFR 435.217, 435.236, 435.726 and 1902(m)(1), and 1924 of the Social Security Act, if the State had 1915(c) waivers. These groups of individuals were previously included under the State’s existing 1915(c) waivers #0032, #0160, #4133 and #4174.

- The State will use the portion of the capitated payment rate that is attributable to HCBS/MLTSS as the “dollar” amount of HCBS/MLTSS services that the individual is liable for since the capitated portion of the rate that is attributable HCBS/MLTSS is the actual amount the State pays to the managed care organization/entity for these services.

ii. 217-like Medically Needy Individuals Eligible for HCBS /MLTSS Programs. Institutional eligibility and post eligibility rules apply in the same manner as specified under 42 CFR 435.217, 435.236, 435.726 and 1902(m)(1), and 1924 of the Social Security Act, if the State had 1915(c) waivers, except that a projected spend down using nursing home costs is applied to determine eligibility And, in the post-eligibility process, a maintenance amount is disregarded . This applies to individuals who could have been included under the State’s existing 1915(c) waivers #0032, #0160, #4133 and 4174 had the State elected to cover these individuals under these 1915(c) waivers and had the waiver programs not been rolled into the 1115 waiver.

- The State will use the portion of the capitated payment rate that is attributable HCBS/MLTSS as the “dollar” amount of HCBS/MLTSS services that the individual is liable for since the capitated portion of the rate that is attributable HCBS/MLTSS is the actual amount the State pays to the managed care organization/entity for these services.

iii. 217 Like Groups of Individuals Receiving HCBS Like Services Under New Medicaid Programs. Institutional eligibility and post eligibility rules apply in the same manner as specified under 42 CFR 435.217, 435.236, 435.726 and 1924 of the Social Security Act, if the State had 1915(c) waivers. The State uses the SSI resource standard.

21. **Transfer of Assets.** At the time of application for long term care and home and community based services, based on self-attestation, New Jersey will not review assets pursuant to section 1917 of the Act for applicants or beneficiaries seeking long term services and supports with income at or below 100 percent of the FPL.
22. **Excluded Populations.** The following populations are excluded from the demonstration:
- a. QMBs – 1902(a)(10)(E)(i); 1905(p)
 - b. SLMBs – 1902(a)(10)(E)(iii); 1905(p)
 - c. QIs – 1902(a)(10)(E)(iv); 1905(p)
 - d. QDWIs – 1902(a)(10)(E)(iii); 1905(s)
 - e. PACE Participants

V. BENEFITS

Individuals affected by, or eligible under, the demonstration will receive benefits as specified in Attachment B, as outlined in the table in paragraph 19 above. For populations eligible under the State plan, these benefits should equal the benefits available under the State plan. Individuals may receive additional benefits as described below to the extent that they are enrolled in the referenced programs that are set forth in sections VIII, IX, X and XI of these STCs.

23. Individuals enrolled in the Managed Long Term Services and Supports Program described in section X of these STCs receive all Medicaid and CHIP State Plan services, including behavioral health, through their Medicaid MCO listed in Attachment B. This population also receives a HCBS package of benefits listed in Attachment C.2.
24. Individuals enrolled in the Supports Program described in STC 78 receive all Medicaid and CHIP State Plan services through their Medicaid MCO listed in Attachment B. This population also receives a HCBS package of benefits listed in Attachment C.1.
25. Individuals enrolled in the Pervasive Developmental Disorders (PDD) Program described in STC 79 receive all Medicaid and CHIP State Plan services through their Medicaid MCO listed in Attachment B and behavioral health demonstration services through the children's Administrative Services Organization listed in Attachment F. This population also receives a HCBS package of benefits listed in Attachment C.1.
26. Individuals enrolled in the Pilot for Individuals with Intellectual Disabilities/ Development Disabilities with Co-Occurring Mental Health Diagnoses (ID-DD/MI) described in STC 80 receive all Medicaid State Plan services through their Medicaid MCO listed in Attachment B and behavioral health demonstration services through the children's Administrative Services Organization listed in Attachment F. This population also receives a HCBS package of benefits listed in Attachment C.1.
27. Individuals enrolled in the Intellectual Developmental Disability Program for Out of State (IDD/OOS) New Jersey Residents described in STC 81 receive all Medicaid State plan services listed in Attachment B. In addition to Medicaid State Plan services in Plan A this population receives HCBS service package of benefits designed to provide the appropriate supports to maintain the participants safely in the community listed in Attachment C.1.
28. Individuals enrolled in the Program for Children diagnosed with Serious Emotional Disturbance (SED) described in STC 82 receive all Medicaid and CHIP State Plan services through their Medicaid MCO listed in Attachment B and SED program services listed in Attachment D.
29. Individuals enrolled in the Medication Assisted Treatment Initiative (MATI) described in STC 83 receive all Medicaid and CHIP State Plan services through their Medicaid MCO listed in Attachment B and MATI services through the adult behavioral health ASO listed in Attachment E.
30. **Short term Nursing Facility Stays.** Short term nursing facility stays are covered for

individuals receiving HCBS or Managed Long Term Services and Supports. Coverage of nursing facility care for up to no more than 180 days is available to a HCBS/MLTSS demonstration participant receiving home and community-based services upon admission who requires temporary placement in a nursing facility when such participant is reasonably expected to be discharged and to resume HCBS participation within no more than 180 days including situations when a participant needs skilled or rehabilitative services for no more than 180 days due either to the temporary illness of the participant or absence of a primary caregiver.

- Such HCBS/MLTSS demonstration participants must meet the nursing facility level of care upon admission, and in such case, while receiving short-term nursing facility care may continue enrollment in the demonstration pending discharge from the nursing facility within no more than 180 days or until such time it is determined that discharge within 180 days from admission is not likely to occur, at which time the person shall be transitioned to an institution, as appropriate.
- The community maintenance needs allowance shall continue to apply during the provision of short-term nursing facility care in order to allow sufficient resources for the member to maintain his or her community residence for transition back to the community.

VI. COST SHARING

31. Costs sharing for the Medicaid and CHIP programs are reflected in Attachment B. Notwithstanding Attachment B, all cost-sharing for State plan populations must be in compliance with Medicaid and CHIP requirements that are set forth in statute, regulation and polices. In addition, aggregate cost sharing imposed on any individual adult demonstration participant on an annual basis must be limited to five percent of the individual's aggregate family income.

VIII. DELIVERY SYSTEMS I -- MANAGED CARE REQUIREMENTS

32. **Applicability of Managed Care Requirements to Populations Affected by and Eligible Under the Demonstration.** All populations affected by, or eligible under the Demonstration that receive State plan benefits (Attachment B) are enrolled in managed care organizations that comply with the managed care regulations published at 42 CFR 438 to receive such benefits, except as expressly waived or specified as not applicable to an expenditure authority. Capitation rates shall be developed and certified as actuarially sound, in accordance with 42 CFR 438.6. The certification shall identify historical utilization of State Plan and HCBS services, as appropriate, which were used in the rate development process. The following populations are excepted from mandatory enrollment in managed care:
- a. Work First (Childless Adults),
 - b. MATI At Risk,
 - c. SED At Risk,

- d. American Indians and Alaska Natives, and
- e. Medicaid eligible not listed in paragraphs 19(a) or 19(b).

33. **Benefits Excepted from Managed Care Delivery System:** Benefits that are excepted from the Managed Care Delivery System are those that are designated as FFS in Attachment B.
34. **Care Coordination and Referral Under Managed Care.** As noted in plan readiness and contract requirements, the State must require that each MCO refer and/or coordinate, as appropriate, enrollees to any needed State plan services that are excluded from the managed care delivery system but available through a fee for service delivery system, and must also assure referral and coordination with services not included in the established benefit package.
35. **Managed Care Contracts.** No FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR 438 requirements prior to CMS approval of such contracts and/or contract amendments. The State shall submit any supporting documentation deemed necessary by CMS. The State must provide CMS with a minimum of 60 days to review and approve changes. CMS reserves the right, as a corrective action, to withhold FFP (either partial or full) for the demonstration, until the contract compliance requirement is met.
36. **Public Contracts.** Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).
37. **Network Requirements.** The State must ensure the delivery of all covered benefits, including high quality care. Services must be delivered in a culturally competent manner, and the MCO network must be sufficient to provide access to covered services to the low-income population. In addition, the MCO must coordinate health care services for demonstration populations. The following requirements must be included in the State's MCO contracts:
- a. **Special Health Care Needs.** Enrollees with special health care needs must have direct access to a specialist, as appropriate for the individual's health care condition, as specified in 42 C.F.R. 438.208(c)(4).
 - b. **Out of Network Requirements.** Each MCO must provide demonstration populations with all demonstration program benefits described within these STCs and must allow access to non-network providers when services cannot be provided consistent with the timeliness standards required by the State.
38. **Demonstrating Network Adequacy.** Annually, each MCO must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area and offers an adequate range of preventive, primary, pharmacy, and specialty and HCBS services for the anticipated number of enrollees in the service area.

- a. The State must verify these assurances by reviewing demographic, utilization and enrollment data for enrollees in the demonstration as well as:
 - i. The number and types of primary care, pharmacy, and specialty providers available to provide covered services to the demonstration population;
 - ii. The number of network providers accepting the new demonstration population; and
 - iii. The geographic location of providers and demonstration populations, as shown through GeoAccess or similar software.
 - b. The State must submit the documentation required in subparagraphs i – iii above to CMS with initial MCO contract submission as well as with each annual report.
39. **Provider Credentialing.** The provider credentialing criteria described at 42 CFR 438.214 must apply to MLTSS providers. If the MCO’s credentialing policies and procedures do not address non-licensed/non-certified providers, the MCO must create alternative mechanisms to ensure enrollee health and safety.
40. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Compliance.** The State must ensure that the MCOs are fulfilling the State’s responsibilities for coverage, outreach, and assistance with respect to EPSDT services that are described in the requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements), and 1905(r) (definitions).
41. **Advisory Committee as required in 42 CFR 438.** The State must maintain for the duration of the demonstration a managed care advisory group comprised of individuals and interested parties impacted by the demonstration’s use of managed care, regarding the impact and effective implementation of these changes to seniors and persons with disabilities. Membership on this group should be periodically updated to ensure adequate representation of individuals receiving MLTSS.
42. **Mandatory Enrollment.** The State will require that individuals served through this demonstration enroll in managed care programs to receive benefits only when the plans in the applicable geographic area have been determined by the State to meet certain readiness and network requirements and require plans to ensure sufficient access, quality of care, and care coordination for beneficiaries established by the State, as required by 42 CFR 438 and approved by CMS. The State may not mandatorily enroll individuals into any plan that does not meet network adequacy requirements as defined in 42 CFR 438.206.
43. **Choice of MCO.** The State must ensure that at the time of initial enrollment and on an ongoing basis, the individuals have a minimum of 2 MCOs meeting all readiness requirements from which to choose. If at any time, the State is unable to offer 2 plans, an alternative delivery system must be available within 60 days of loss of plan choice.

44. **MCO Selection.** Demonstration participants who are enrolled in Medicaid and Medicaid Expansion populations are required to enroll in an MCO and must have no less than 10 days to make an active selection of an MCO upon notification that a selection must be made. Any demonstration participant that does not make an active selection will be assigned, by default, to a participating MCO. That assignment shall be based on 42 CFR 438.50. Once the participant is advised of the State's MCO assignment, the participant, consistent with 42 CFR section 438.56, is permitted up to 90 days to disenroll from the assigned MCO and select another. The participant then receives a second 90-day period to disenroll after enrolling in that MCO, if other MCO choices are available. Once the participant remains in an MCO beyond 90 days, disenrollment may only occur for cause (as defined by the State) or at least every 12 months during an open enrollment period.
45. **Required Notice for Change in MCO Network.** The State must provide notice to CMS as soon as it becomes aware of (or at least 90 days prior if possible) a potential change in the number of plans available for choice within an area, or any other changes impacting proposed network adequacy. The State must provide network updates through its regular meetings with CMS and submit regular documentation as requested.

VIII. DELIVERY SYSTEM --II – ADDITIONAL DELIVERY SYSTEM REQUIREMENTS FOR HOME AND COMMUNITY BASED SERVICES (HCBS) AND MANAGED LONG TERM SUPPORT SERVICES (MLTSS) PROGRAM

In addition to the requirements described in Section VII Delivery System I, the following additional delivery system requirements apply to all the HCBS programs and MLTSS programs in this demonstration.

46. **Administrative Authority.** There are multiple State agencies involved in the administration of the HCBS; therefore, the Single State Medicaid Agency (SSMA) must maintain authority over the programs. The SMA must exercise appropriate monitoring and oversight over the State agencies involved, the MCO's, and other contracted entities.
47. **Home and Community-Based Characteristics.** Residential settings located in the community will provide members with the following:
- a. Private or semi-private bedrooms including decisions associated with sharing a bedroom.
 - b. All participants must be given an option to receive home and community based services in more than one residential setting appropriate to their needs.
 - c. Private or semi-private bathrooms that include provisions for privacy.
 - d. Common living areas and shared common space for interaction between participants, their guests, and other residents.
 - e. Enrollees must have access to a food storage or food pantry area at all times.

- f. Enrollees must be provided with an opportunity to make decisions about their day to day activities including visitors, when and what to eat, in their home and in the community.
 - g. Enrollees will be treated with respect, choose to wear their own clothing, have private space for their personal items, have privacy to visit with friends, family, be able to use a telephone with privacy, choose how and when to spend their free time, and have opportunities to participate in community activities of their choosing.
48. **Health and Welfare of Enrollees.** The State, or the MCO for MLTSS enrolled individuals, through an MCO contract, shall be required on a continuous basis to identify, address, and seek to prevent instances of abuse, neglect and exploitation through the Critical Incident Management System referenced in paragraph 50.
49. **Demonstration Participant Protections.** The State will assure that children, youth, and adults in MLTSS and HCBS programs are afforded linkages to protective services (e.g., Ombudsman services, Protection and Advocacy, Division of Child Protection and Permanency) through all service entities, including the MCOs.
- a. The State will ensure that these linkages are in place before, during, and after the transition to MLTSS as applicable.
 - b. The State/MCOs will develop and implement a process for community-based providers to conduct efficient, effective, and economical background checks on all prospective employees/providers with direct physical access to enrollees.
50. **Critical Incident Management System.** The State must operate a critical incident management system according to the State’s established policies, procedures and regulations and as described in section XIII.
51. **Managed Care Grievance/Complaint System.** The MCO must operate a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services.
52. **Fair Hearings.** All enrollees must have access to the State fair hearing process as required by 42 CFR 431 Subpart E. In addition, the requirements governing MCO appeals and grievances in 42 CFR 438 Subpart F shall apply.
53. **Plan of Care (PoC).** A “Plan of Care” is a written plan designed to provide the demonstration enrollee with appropriate services and supports in accordance with his or her individual needs. All individuals receiving HCBS or MLTSS under the demonstration must have a PoC and will be provided services in accordance with their plan. The State must establish minimum guidelines regarding the PoC that will be reflected in contracts and/or provider agreements. These must include at a minimum: 1) a description of qualification for individuals who will develop the PoC; 2) timing of the PoC including how and when it will be updated and including mechanisms to address changing circumstances and needs; 3) types

of assessments; 4) how enrollees are informed of the services available to them; 5) the MCOs' responsibilities for implementing and monitoring the PoC.

- a. Each member's PoC must include team-based Person-Centered Planning, which is a highly individualized and ongoing process to develop care plans that focus on the person's abilities and preferences. Person-Centered Planning includes consideration of the current and unique bio-psycho-social and medical needs and history of the enrollee, as well as the person's functional level, and support systems.
 - b. The State or the MCO, for those enrolled in MLTSS will emphasize services provided in home and community-based settings, maximizing health and safety, whenever possible.
 - c. Meetings related to the enrollee's PoC will be held at a location, date, and time convenient to the enrollee and his/her invited participants.
 - d. A back-up plan must be developed and incorporated into the plan to assure that the needed assistance will be provided in the event that the regular services and supports identified in the PoC are temporarily unavailable. The back-up plan may include other assistance or agency services.
 - e. The State (not the MCOs) will be responsible for the PoC developed for each enrollee transitioning from an institutional setting to a community-based setting through the State's Money Follows the Person demonstration.
 - f. The State or the MCO for those enrolled in MLTSS must ensure that services are delivered in accordance with the PoC including the type, scope, amount and frequency.
 - g. The State or the MCO, for those enrolled in MLTSS must ensure that enrollees have the choice of participating providers within the plan network as well as access to non-participating providers when the appropriate provider type is not on the MCO's network.
 - h. Individuals served in ID/DD programs must have the choice of institutional placements and community settings.
 - i. Each enrollee's PoC must be reviewed annually at a minimum, or more frequently with individual circumstances as warranted.
54. **Option for Participant Direction of certain HCBS and MLTSS.** NJCW participants who elect the self-direction opportunity must have the option to self-direct the HCBS or MLTSS, Participant direction affords NJCW participants the opportunity to have choice and control over how services are provided and who provides the service. Member participation in participant direction is voluntary, and members may participate in or withdraw from participant direction at any time.

The services, goods, and supports that a participant self-directs must be included in the calculations of the participant's budget. Participant's budget plans must reflect the plan for

purchasing these needed services.

- a. Information and Assistance in Support of Participant Direction. The State/MCO shall have a support system that provides participants with information, training, counseling, and assistance, as needed or desired by each participant, to assist the participant to effectively direct and manage their self-directed services and budgets. Participants shall be informed about self-directed care, including feasible alternatives, before electing the self-direction option. Participants shall also have access to the support system throughout the time that they are self-directing their care. Support activities must include, but is not limited to Support for Participant Direction service which includes two components: Financial Management Services and Support Brokerage. Providers of Support for Participant Direction must carry out activities associated with both components. The Support for Participant Direction service provides assistance to participants who elect to self-direct their personal care services.
- b. Participant Direction by Representative. The participant who self-directs the personal care service may appoint a volunteer designated representative to assist with or perform employer responsibilities to the extent approved by the participant. Waiver services may be directed by a legal representative of the participant. Waiver services may be directed by a non-legal representative freely chosen by an adult participant. A person who serves as a representative of a participant for the purpose of directing personal care services cannot serve as a provider of personal attendant services for that participant.
- c. Independent Advocacy. Each enrollee shall have access to an independent advocate or advocacy system in the State. This function is performed by individuals or entities that do not provide direct services, perform assessments, or have monitoring, oversight or fiscal responsibilities for the demonstration. The plans will provide participants with information regarding independent advocacy such as the Ombudsman for Institutionalized Elderly and State staff who approved LOC determination and did options counseling.
- d. Participant Employer Authority. The participant (or the participant's representative) must have decision-making authority over workers who provide personal care services.
 - i. Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide personal care services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.
 - ii. Decision Making Authorities. The participant exercises the following decision making authorities: Recruit staff, select staff from worker registry, hire staff as common law employer, verify staff qualifications, obtain criminal history and/or background investigation of staff, specify additional staff qualifications based on participant needs and preferences, evaluate staff

performance, verify time worked by staff and approve time sheets, and discharge staff.

- e. **Disenrollment from Participant-Direction.** A participant may voluntarily disenroll from the self-directed option at any time and return to a traditional service delivery system. To the extent possible, the member shall provide his/her provider ten (10) days advance notice regarding his/her intent to withdraw from participant direction. A participant may also be involuntarily disenrolled from the self-directed option for cause, if continued participation in the participant-directed services option would not permit the participant's health, safety, or welfare needs to be met, or the participant demonstrates the inability to self-direct by consistently demonstrating a lack of ability to carry out the tasks needed to self-direct personal care services, or if there is fraudulent use of funds such as substantial evidence that a participant has falsified documents related to participant directed services. If a participant is terminated voluntarily or involuntarily from the self-directed service delivery option, the MCO must transition the participant to the traditional agency direction option and must have safeguards in place to ensure continuity of services.
- f. **Appeals.** The following actions shall be considered an adverse action under both 42 CFR 431 Subpart E (state fair hearing) and 42 CFR 438 Subpart F (MCO grievance process):
 - i. A reduction in services;
 - ii. A denial of a requested adjustment to the budget; or
 - iii. A reduction in amount of the budget.

Participants may use either the State fair hearing process or the MCO appeal process to request reconsideration of these adverse actions.

IX. DELIVERY SYSTEM -- III - BEHAVIORAL HEALTH

- 55. **Behavioral Health Organization.** Coverage of behavioral health services will vary depending on population and level of care as described in the Benefits section above and in Attachments B and F. In general, behavioral health for demonstration beneficiaries will be excluded from the coverage furnished through the primary managed care organization, but instead will be covered through a behavioral health organization (BHO). The State will contract with BHOs on a non-risk basis as an Administrative Services Organization (ASO). Exceptions to this service delivery system, under which behavioral health will be included in the MCO benefit package include; dual eligibles enrolled in a SNP and individuals enrolled in a MLTSS MCO furnishing long term supports and services/HCBS services.
- 56. **Behavioral Health for Children.** Upon the effective date of this demonstration, children who are not in a HCBS/MLTSS/SNP population will have their behavioral health care coordinated by a behavioral health ASO.

a. The ASO shall perform the following functions on behalf of the State:

1. 24/7 Call Center
2. Member services
3. Medical Management
4. Provide and manage MIS/EMR for Children's System of Care
5. Dispatch Mobile Response/Crisis Response
6. Clinical Phone Triage (performed by licensed clinicians)
7. Facilitate Needs Assessments
8. Clinical Reviews of Needs Assessments
9. Care Coordination
10. Intensity of Service Determinations
11. Treatment Plan Reviews
12. Prior Authorizations
13. Quality Monitoring in Coordination with DCF
14. Utilization Management
15. Data Sharing and Reporting
16. Grievance and Intensity of Service Dispute Resolution
17. Behavioral Health and Primary Health Coordination

b. Excluded Children's ASO functions.

1. Provider Network Management
2. Claims payment
3. Rate Setting

c. Should the State decide to implement an at-risk arrangement for the BHO the State will submit an amendment to CMS in accordance with paragraph 7.

57. Behavioral Health for Adults. Behavioral health services will not be included in the benefit package provided by the primary managed care organization. Effective July 1, 2013 or a date thereafter, adults will have their behavioral health care coordinated by a behavioral health ASO. Prior to that date, behavioral health services will be covered on a fee for service basis.

a. Functions of the Adult ASO. The ASO shall perform the following functions:

1. 24/7 Call Center
2. Member services
3. Screening and assessment
4. Prior authorization
5. Network management
6. Utilization management, including level of care determination and continuing care review
7. Care management
8. Medical management
9. Care coordination
10. Quality management

11. Information technology
12. Data submission and reporting requirements
13. Financial management, including claims processing and payment
14. Development of care models and service arrays for consumers with intellectual and developmental disabilities; non-SNP dual eligibles (Medicare and Medicaid), and Medicaid expansion populations
15. Coordination with the MCOs regarding high-utilizing consumers and consumers screened with behavioral health/medical conditions

b. Excluded Adult ASO function.

1. Adult populations currently enrolled in the 1915(c) programs who are moving to MLTSS program will be excluded from the ASO since their behavioral health care will be managed by the MCO.
2. Should the State decide to implement an at-risk arrangement for the BHO the State will submit an amendment to CMS in accordance with paragraph 7.

58. **Behavioral Health Home.** The State is seeking to implement a behavioral health home through the State Plan Amendment process. Upon implementation of the health home the ASO(s) will coordinate with the provider for comprehensive behavioral health care.

59. **Services Provided by the BHO/ASO.** The services provided by the BHO/ASO are listed in Attachment F.

60. **Duplication of Payment.** To avoid duplication of payment for services for demonstration participants who require behavioral health, the Behavioral Health Service and Payer table in Attachment F will determine who the payer for behavioral health care is.

X. MANAGED LONG TERM SERVICES AND SUPPORTS (MLTSS) PROGRAM

61. **Transition of Existing section 1915(c) Programs.** Prior to the implementation of MLTSS, the State provided HCBS through section 1915(c) waivers using a fee-for-service delivery system for long-term care services and supports. The following 1915(c) waivers that will be transitioned into the demonstration and into a mandated managed care delivery systems upon CMS review and approval of a transition plan, the State completion of managed care readiness reviews, and providing notice of transition to program participants are:

- Traumatic Brain Injury (TBI) Program, NJ4174;
- Community Resources for People with Disabilities (CRPD) Program, NJ 4133;
- Global Options for Long Term Care (GO) Program, NJ 0032; and
- AIDS Community Care Alternatives Program (ACCAP) Program, NJ0160.

62. **Notice of Transition to Program Participants.** The State will provide notice to participants of current 1915 (c) waiver authority to the demonstration, that no action is required on behalf of the participant, and that there is no disruption of services. Such notice must be provided to said beneficiaries 30 days prior to the transfer of waiver authorities from section 1915(c) to

the section 1115 demonstration. (42 CFR 431.210) requires States to notify 1915(c) waiver participants 30 days prior to waiver termination.

63. Transition Plan from FFS Programs to Managed Care Delivery System. To ensure a seamless transition of HCBS waiver participants and those currently in a nursing facility from fee for service delivery systems and section 1915(c) waivers to MLTSS, the State must:

- a. Prepare a MLTSS Transition Plan to be reviewed by CMS.
- b. Meet regularly with the MCOs during transition process and thereafter. Complete an outreach and communication strategy to HCBS demonstration participants impacted by MLTSS to include multiple contacts and notice with HCBS/MLTSS participants in a staggered manner to commence 90 days prior to the implementation of MLTSS.
- c. Provide materials for enrollees in languages, formats, and reading levels to meet enrollee needs.
- d. Make available to the MCOs sufficient data to assist them in developing appropriate care plans for each enrollee.
 - i. The data will include past claims data, providers, including HCBS and the individual's past and current Plan of Care (PoC).
 - ii. The State will ensure participants will receive the same type and level of services they received in section 1915(c) programs until the MCO has completed an assessment.
 - iii. Enrollees transitioning from one plan to another will continue to receive the same services until the new MCO is able to perform its own Assessment, and develop an updated Plan of Care (PoC).
- e. To facilitate the establishment of a smooth transition process, the State will develop a readiness certification tool to be used to assess the readiness of the MCOs to assume the provision of the MLTSS. The State will submit its MCO readiness certification tool for the provision of the MLTSS to CMS prior to its use.
- f. The State will submit to CMS for review all informing notices that will be sent to participants outlining their new services, changes in the service delivery system, and due process rights. Informing notices will be sent to beneficiaries no less than 45 days prior to the transition to MLTSS.
- g. To facilitate collaboration with case management functions, the State agencies will require each MCO to have a MLTSS Consumer Advisory Committee including representation of MLTSS stakeholders, including participants, case managers, and others, and will address issues related to MLTSS.

- h. Upon receipt of a plan acceptable by the State Medicaid Agency, it will perform a desk-level review of the MCO's policies and procedures, an on-site review to validate readiness.
- i. The State will develop a readiness certification /review tool to assure uniformity in the determinations made about each MCO's compliance and its ability to perform under the MLTSS contract provisions.

64. Readiness Review Requirements. The State shall begin a readiness review of each MCO at least 90 days prior to program implementation.

- a. Readiness reviews shall address each MCO's capacity to serve the enrollees, including, but not limited to, adequate network capacity, and operational readiness to provide the intensive level of support and care management to this population as well as the ability to implement a self-direction program.
- b. At least 30 days prior to the State's planned implementation date for the expansion, the State must submit the following to CMS review, according to the timelines specified below:
 - i. A list of deliverables and submissions the State will request from health plans to establish their readiness, with a description of the State's approach to analysis and verification;
 - ii. Plans for ongoing monitoring and oversight of MCO contract compliance;
 - iii. A contingency plan for addressing insufficient network issues;
 - iv. A plan for the transition from the section 1915(c) waiver program to the demonstration HCBS programs as described in STC 63;
 - v. Proposed managed care contracts or contract amendments, as needed, to implement the Expansion.
- c. CMS reserves the right to request additional documentation and impose additional milestones on the Expansion in light of findings from the readiness review activities.
- d. The transition plan terminating 1915(c) waiver services for these populations must be submitted to notify CMS as part of the Readiness Review specified in STC 63 and with the "intent to terminate 1915(c) waivers" letter that must be sent to the CMS Regional Office writing at least 30 days prior to waiver termination, per 42 CFR 441.307.

65. Steering Committee. For a period of time, DMAHS will authorize a MLTSS Steering Committee that will include adequate representation of stakeholders. Additionally, it's Medical Care Advisory Committee per 42 CFR 431.12 will include MLTSS representation.

66. Transition of Care Period from FFS to Managed Care. Each enrollee who is receiving HCBS and who continues to meet the appropriate level of care criteria in place at the time of MLTSS implementation must continue to receive services under the enrollee's pre-existing service plan until a care assessment has been completed by the MCO. During this assessment, should the MCO determine that the enrollee's circumstances have changed sufficiently to warrant a complete re-evaluation, such a re-evaluation shall be initiated. Any reduction, suspension, denial or termination of previously authorized services shall trigger the required notice under 42 CFR 438.404.

67. Money Follows the Person (MFP). The State will continue to operate its MFP demonstration program outside of the section 1115 demonstration. Under New Jersey's MFP program, the State will continue its responsibilities for developing transitional plans of services for enrollees. With the implementation of MLTSS on January 1, 2013 or at a date thereafter, the State must update the MFP demonstration's Operational Protocols. A draft of the revised Operational Protocol will be due to CMS by 30 days prior to implementation of MLTSS.

a. The MLTSS plans' responsibilities include:

1. Identifying enrollees who may be appropriate to transition from nursing homes;
2. Referring enrollees to State staff in the MFP office;
3. Providing ongoing care, case management and coordination when the enrollee returns to the community;
4. The delivery of MLTSS, and
5. Reassessing the MFP participant prior to the 365th day in the MFP program and designating which HCBS services are the most appropriate.

68. Nursing Facility Diversion. Each MCO, with assistance from the State, will develop and implement a "NF Diversion Plan" to include processes for enrollees receiving HCBS and enrollees at risk for NF placement, including short-term stays. The diversion plan will comply with requirements established by the State and be prior approved by the State, and CMS. The Plan will include a requirement for the MCOs to monitor hospitalizations and short-stay NF admission for at-risk enrollees, and identify issues and strategies to improve diversion outcomes.

69. Nursing Facility Transition to Community Plan. Each MCO, with assistance from the State, will develop and implement a "NF to Community Transition Plan" for each enrollee placed in a NF when the enrollee can be safely transitioned to the community, and has requested transition to the community. The Plan will include a requirement for the MCOs to work with State entities overseeing services to older adults and other special populations utilizing NF services. Each MCO will have a process to identify NF residents with the ability and desire to transition to a community setting. MCOs will also be required to monitor hospitalizations, re-hospitalizations, and NF admissions to identify issues and implement strategies to improve enrollee outcomes.

70. Level of Care Assessment for MLTSS Enrollees. The following procedures and policies shall be applied to enrollees receiving MLTSS:

- a. An evaluation for LOC must be given to all applicants for whom there is reasonable indication that services may be needed by either the State or the MCO.
 - i. The plans and the State will use the “NJ Choice” tool as the standardized functional assessment for determining a LOC.
 - ii. In addition to the NJ Choice tool, the State and the MCOs may also utilize the "Home and Community-Based Long Term Care Assessment" Form (CP-CM-1).
- b. The State must perform the assessment function for individuals not presently enrolled in managed care. The MCO must complete the LOC assessment as part of its comprehensive needs assessment for its members and will forward to the State for final approval for those individuals determined to meet NF LOC.
- c. The MCOs must not fundamentally alter the nature of the NJ Choice tool when accommodating it to their electronic/database needs.
- d. The MCOs and, or the State must perform functional assessments within 30 days of the time a referral is received.
- e. All enrollees must be reevaluated at least annually or as otherwise specified by the State, as a contractual requirement by the MCO.

71. Demonstration Participant Protections under MLTSS. The State will assure that children, youth, and adults in MLTSS and HCBS programs are afforded linkages to protective services through all service entities, including the MCOs.

- a. The State will ensure that these linkages are in place before, during, and after the transition to MLTSS.
- b. The State/MCO’s will develop and implement a process for community-based providers to conduct efficient, effective, and economical background checks on all prospective employees/providers with direct physical access to enrollees.

72. Institutional and Community-Based MLTSS. The provisions related to institutional and community-based MLTSS are as follows:

- a. Enrollees receiving MLTSS will most often receive a cost-effective placement, which will usually be in a community environment.
- b. Enrollees receiving MLTSS will typically have costs limited/aligned to the annual expenditure associated with their LOC assessment (e.g. Hospital, Nursing Facility).

- c. Exceptions are permitted to the above provisions in situations where a) an enrollee is transitioning from institutional care to community-based placement; b) the enrollee experiences a change in health condition expected to last no more than six months that involve additional significant costs; c) special circumstances where the State determines an exception must be made to accommodate an enrollee's unique needs. The State will establish a review procedure to describe the criteria for exceptional service determinations between the State and the MCOs which shall be approved by CMS.
- d. MCOs may require community-based placements, provided the enrollee's PoC provides for adequate and appropriate protections to assure the enrollee's health and safety.
- e. If the estimated cost of providing the necessary community-based MLTSS to the enrollee exceeds the estimated cost of providing care in an institutional setting, the MCO may refuse to offer the community-based MLTSS. However, as described in (c) above, exceptions may be made in individual special circumstances where the State determines the enrollee's community costs shall be permitted to exceed the institutional costs.
- f. If an enrollee whose community-based costs exceed the costs of institutional care refuses to live in an institutional setting and chooses to remain in a community-based setting, the enrollee and the MCO will complete a special risk assessment detailing the risks of the enrollee in remaining in a community-based setting, and outlining the safeguards that have been put in place. The risk assessment will include a detailed back-up plan to assure the health and safety of the enrollee under the cost cap that has been imposed by the State.
- g. Nothing in these STCs relieves the State of its responsibility to comply with the Supreme Court *Olmstead* decision, and the Americans with Disabilities Act.

73. Care Coordination for MLTSS. Care Coordination is services to assist enrollees in gaining access to needed demonstration and other services, regardless of the funding source. Care Coordinators are responsible for ongoing monitoring of the provision of services included in the PoC and assuring enrollee health and safety. Care Coordinators initiate the process to evaluate or re-evaluate the enrollee's PoC, his or her level of care determination (where appropriate), and other service needs.

- a. Integrated care coordination for physical health and MLTSS will be provided by the MCOs in a manner that is "conflict-free."
- b. The State will establish a process for conflict free care coordination, to be approved by CMS that will include safeguards, such as separation of services and other structural requirements, State/enrollee oversight, and administrative review.
- c. Each MCO shall also assign a Behavioral Health Administrator to develop processes to coordinate behavioral health care with physical health care and MLTSS, in collaboration

with the care coordinators.

- d. The State will assure that there are standard, established timelines for initial contact, assessment, development of the PoC, the individual service agreement, and authorization and implementation of services between the state and the MCOs.
- e. Care coordinators must monitor the adequacy and appropriateness of services provided through self-direction, and the adequacy of payment rates for self-directed services.

XI. SPECIAL TARGETED HCBS PROGRAMS

74. New HCBS Programs. HCBS is provided outside of the Managed Long Term Services and Supports (MLTSS) MCO in the following programs: The Supports Program; Persons with Pervasive Developmental Disorders (PDD); Persons with intellectual disabilities and mental illness (IDD/MI): Persons with intellectual developmental disabilities who live out of state (IDD OOS) but in an HCBS setting; Serious emotional disturbance (SED) and Medication Assisted Treatment Initiative (MATI).

75. Network Adequacy and Access Requirements. The State must ensure that the fee-for service network complies with network adequacy and access requirements, including that services are delivered in a culturally competent manner that is sufficient to provide access to covered services to the low-income population. Providers must meet standards for timely access to care and services, considering the urgency of the service needed.

- a. Accessibility to primary health care services will be provided at a location in accordance at least equal to those offered to the Medicaid fee-for-service participants.
- b. Primary care and Urgent Care appointments will be provided at least equal to those offered to the Medicaid fee-for-service participants.
- c. Specialty care access will be provided at least equal to those offered to the Medicaid fee-for-service participants.
- d. FFS providers must offer office hours at least equal to those offered to the Medicaid fee-for-service participants.
- e. The State must establish mechanisms to ensure and monitor provider compliance and must take corrective action when noncompliance occurs.
- f. The State must establish alternative primary and specialty access standards for rural areas in accordance with the Medicaid State Plan.

76. Provider Credentialing. The provider credentialing criteria are included for each separate service as outlined in Attachment C. To assure the health and welfare of the demonstration

participants, the State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to furnishing services. The State also monitors non-licensed/non-certified providers to assure adherence to other standards prior to their furnishing waiver services.

77. **Non-duplication of Services.** HCBS will not duplicate services included in an enrollee's Individualized Education Program under the Individuals with Disabilities Education Act, or services provided under the Rehabilitation Act of 1973.

78. **Supports Program**

- a. Program Overview: The Supports Program is to provide a basic level of support services to individuals who live with family members or who live in their own homes that are not licensed by the State.
- b. Operations: The administration of the program is through the Division of Developmental Disabilities (DDD).
- c. Eligibility:
 - i. Are Medicaid eligible;
 - ii. Are at least 21 years of age and have completed their educational entitlement;
 - iii. Live in an unlicensed setting, such as on their own or with their family; and
 - iv. Meet all criteria for functional eligibility for DDD services including the following definition of "developmental disability": Developmental disability is defined as: "a severe, chronic disability of an individual which:
 1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
 2. Is manifest before age 22;
 3. Is likely to continue indefinitely;
 4. Results in substantial functional limitations in three of more of the following areas of major life activity, that is: self-care, receptive and expressive language, learning, mobility, self-direction capacity for independent living and economic self-sufficiency;
 5. Reflects the need for a combination and sequences of special interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and are individually planned and coordinated; and

6. Includes but is not limited to severe disabilities attributable to intellectual disability, autism, cerebral palsy, epilepsy, spina bifida and other neurological impairments where the above criteria are met.”
- d. POC Referral. When it has been confirmed that a candidate has met all of the requirements for enrollment, DDD will refer the case to the appropriate support coordination provider for development of the Participant's plan of care (PoC) and initiation of services.
 - e. Exclusions: Individuals may not enroll in the Supports Program if:
 - i. They are enrolled in another HCBS/MLTSS program, the Out-of-State IDD programs, or the Community Care Waiver.
 - ii. They require institutional care and cannot be maintained safely in the community.
 - f. Expenditure Cap. Participants in the program will have an individual expenditure cap per person per year that is based on functional assessment. This expenditure cap is reevaluated annually during development of the annual plan of care.
 - g. Case Management. Every Participant will have access to Support Coordination (case management) which is outside of the expenditure cap. Every Participant will have access (if they choose) to Financial Management Services (fiscal intermediary) if he/she chooses to self-direct services. This will also be outside of the expenditure cap.
 - h. Bump-Up. This program also contains a unique feature whereby Participants who experience a major change in life circumstances which results in a need for additional temporary services may be eligible to receive a short-term “bump up” in their expenditure cap. This “bump up” is capped at \$5,000 per Participant. The bump up will be effective for up to one year. Participants may only seek bump up services once every three years. The services that may be purchased with bump up dollars are any services described in Attachment C-1 under Supports Program, with the exception of the Day Program Related Services described above.
 - i. Enrollment: All referrals for the Supports Program are screened by DDD to determine if the individual meets the target population criteria, is Medicaid eligible, meets LOC clinical criteria, is in need of support services, and participant’s needs can be safely met in the community. Individuals who currently receive state-funded day services and/or state-funded support services as of the effective date of the demonstration will be assessed for Medicaid eligibility and LOC clinical criteria and enrolled into the program in phases. When potential new participants are referred, they will be assessed for eligibility and enrolled based on availability of annual state budget allocations.
 - j. Level of Care (LOC) Assessment: The participant has a developmental disability and substantial functional limitations in three or more major life activities.

- k. Assessment tool: DDD is in the process of streamlining their current multiple assessment instruments that will be used to assess clinical LOC and functional level for budget determination(s). A statement will be included certifying that an individual meets the functional criteria for DDD and is eligible for the Supports Program.
- l. LOC Reassessment: Reassessment will occur when there is a noted change in a participant's functional level that warrants less supports.. The initial LOC assessment is based on an individual being diagnosed with a developmental disability and substantial functional limitation in three or more major life activities. This is unlikely to change from year to year.
- m. Transition: If health and safety cannot be maintained for a participant on this program because s/he requires a higher level of services than are available, the IDT will make the recommendation and the participant will voluntarily disenroll from the program. The IDT will commence transition planning to identify service needs and necessary resources. Referrals will be made to all services, as applicable including the Community Care Waiver.
- n. Disenrollment: Participants will disenroll from the program if they lose Medicaid eligibility, choose to decline participation in the program, enroll on the CCW, no longer need support services, or no longer reside in New Jersey.
- o. Benefits/Services, Limitations, and Provider Specifications: In addition to Plan A services in Attachment B, Supports program participants receive the benefits outlined in Attachment C.
- p. Cost Sharing: See Attachment B.
- o. Delivery System: Medicaid State Plan services for this population will be delivered and coordinated through their Medicaid MCO. HCBS services available to this population will be delivered either through providers that are enrolled as Medicaid providers and are approved by DDD or through non-traditional service providers that are approved by DDD and bill for services through a fiscal intermediary. Services can be either provider-managed, self-directed, or a combination thereof, as approved in the participant's Plan of Care.

79. Pervasive Developmental Disorders (PDD) Pilot Program

- a. Program Overview: This program is intended to provide NJ FamilyCare/Medicaid eligible children with needed therapies that they are unable to access via the State plan that are available to other children via private health insurance. The State will provide children up to their 13th birthday who have a diagnosis of Pervasive Developmental Disability (PDD), with habilitation services. Through the assessment process, PDD participants will be screened by DCF to determine eligibility, LOC, and to determine their level of need. Those with the highest need will receive up to \$27,000 in services;

those with moderate needs will receive up to \$18,000 in services and the lowest needs participants will receive \$9,000 in PDD services. If the participant's needs change at any time, she/he can be reassessed to determine the current acuity level and the service package would be adjusted accordingly. Services will be coordinated and managed through the participant's Plan of Care, as developed by the Care Managers with the Medicaid MCOs.

- b. Eligibility: Children up to their 13th birthday who are eligible for either the New Jersey Medicaid or CHIP programs and have a PDD diagnosis covered under the *DSM IV* (soon to be *DSM V*) as determined by a medical doctor, doctor of osteopathy, or Ph.D. psychologist using an approved assessment tool referenced below:
 - i. Approved Assessment Tools include:
 1. ABAS – Adaptive Behavior Assessment System II
 2. CARS – Childhood Autism Rating Scale
 3. DDRT – Developmental Disabilities Resource Tool
 4. GARS – Gilliam Autism Rating Scale
 5. ADOS – Autism Diagnostic Observation Scale
 6. ADI – Autism Diagnostic Interview-Revised
 7. ASDS – Asperger's Syndrome Diagnostic Scale
 - ii. Meet the ICF/MR level of care criteria
- c. Exclusions:
 - i. Individuals over the age of 13
 - ii. Individuals without a PDD diagnosis
 - iii. Children with private insurance that offers these types of benefits, whether or not they have exhausted the benefits.
- d. Enrollment: Potential PDD program participants are referred to DCF for screening and assessment. Once a child has been determined to have a PDD and assessed for LOC clinical eligibility and acuity level by DCF, she/he will be referred to DMAHS for enrollment onto the demonstration.
- e. Enrollment Cap: In cases where the State determines, based on advance budget projections that it cannot continue to enroll PDD Program participants without exceeding the funding available for the program the State can establish an enrollment cap for the PDD Program.
 - i. *Notice* - before affirmatively implementing the caps authorized in subparagraph (e), the State must notify CMS at least 60 days in advance. This notice must also include the impact on budget neutrality.
 - ii. *Implementing the Limit* - if the State imposes an enrollment cap, it will implement a waiting list whereby applicants will be added to the

demonstration based on date of application starting with the oldest date. Should there be several applicants with the same application date, the State will enroll based on date of birth starting with the oldest applicant

- iii. *Outreach for those on the Wait Lists* - the State will conduct outreach for those individuals who are on the PDD Program wait list for at least 6 months, to afford those individuals the opportunity to sign up for other programs if they are continuing to seek coverage. Outreach materials will remind individuals they can apply for Medicaid.
 - iv. *Removing the Limit* – the State must notify CMS in writing at least 30 days in advance when removing the limit.
- f. LOC Criteria: The participant has substantial functional limitations in three or more major life activities, one of which is self care, which require care and/or treatment in an ICF/MR or alternatively, in a community setting. The substantial functional limitations shall be evaluated according to the expectations based upon the child’s chronological age. When evaluating very young children, a showing of substantial functional limitations in two or more major life activities can be enough to qualify the child, due to the lack of relevance of some of the major life activities to young children (e.g., economic sufficiency).
- i. *LOC Assessment*: Administration, by a licensed clinical professional approved and/or employed by the State, of the assessment tool to be developed by the State prior to implementation will be used to determine ICF/MR LOC will be performed prior to enrollment into the program and a minimum of annually thereafter.
 - ii. *LOC Reassessment*: A reassessment will be conducted a minimum of annually and will use the same tool.
- g. Transition: The services offered under this program are targeted for young children. When a child in the demonstration reaches 12 years of age, transition planning will be initiated by the Interdisciplinary Team and the Medicaid MCO to identify service needs & available resources, support the participant, and maintain health and safety. Referrals will be made to all services as applicable. Should an individual require continued HCBS services, enrollment will be facilitated to other programs.
- h. Disenrollment: A participant will be disenrolled from the demonstration for the following reasons:
- i. Age out at age 13
 - ii. Participant is deemed no longer in need of services, as per the reassessment process.

- iii. Loss of NJ FamilyCare/Medicaid eligibility
- iv. Participant no longer resides in New Jersey
- i. Benefits/Services, Limitations, and Provider Qualifications: In addition to Medicaid and CHIP State Plan services listed in Attachment B, this demonstration population receives a PDD service package of benefits. The full list of services may be found in Attachment C. Services rendered in a school setting are not included in this program.
- j. Cost sharing: See Attachment B.
- k. Delivery System: All State plan and PDD services for this population will be delivered and coordinated through their Medicaid MCO. Behavioral health services will be delivered and coordinated through the children's ASO. The Plan of Care will be developed and overseen by the Medicaid MCOs care management staff.

80. Intellectual Disabilities/ Development Disabilities with Co-Occurring Mental Health Diagnoses (ID-DD/MI) Pilot

- a. Program Overview: The primary goal of the program is to provide a safe, stable, and therapeutically supportive environment for children with developmental disabilities and co-occurring mental health diagnoses, ages five (5) up to twenty-one (21), with significantly challenging behaviors. This program provides intensive in-home and out-of-home services.
- b. Delivery System and Benefits: All Medicaid State Plan services through their Medicaid MCO; behavioral health and demonstration services through the children's ASO.
- c. Eligibility: Medicaid-eligible children with developmental disabilities and co-occurring mental health diagnoses, age five (5) up to twenty-one (21), who are still in their educational entitlement, have significantly challenging behaviors, and meet the LOC clinical criteria. Developmental disability is defined as: "a severe, chronic disability of an individual which:
 - i. is attributable to a mental or physical impairment or combination of mental and physical impairments;
 - ii. is manifest before age 21;
 - iii. is likely to continue indefinitely;
 - iv. results in substantial functional limitations in three or more of the following areas of major life activity, that is: self-care, receptive and expressive language, learning, mobility, self-direction capacity for independent living and economic self-sufficiency;

- v. reflects the need for a combination and sequences of special interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and are individually planned and coordinated;
 - vi. includes but is not limited to severe disabilities attributable to intellectual disability, autism, cerebral palsy, epilepsy, spina bifida and other neurological impairments where the above criteria are met;”
 - vii. the substantial functional limitations shall be evaluated according to the expectations based upon the child’s chronological age; and
 - viii. Mental health diagnosis is defined as: “ a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within DSM-IV-TR with the exception of other V codes, substance use, and developmental disorders, unless these disorders co-occur with another diagnosable disturbance.”
- d. Exclusions:
- i. Individuals who are not residents of New Jersey
 - ii. Services eligible to be provided through their educational entitlement are not covered under this demonstration
 - iii. For in-home services, these cannot be provided if the family/caregiver is unwilling or unable to comply with all program requirements. In these instances, individuals will be provided with out-of-home services if necessary.
- e. LOC Assessment: Co-occurring developmental disability and mental health diagnosis that meets the state mental hospital level of care. The participant will be assessed at least annually, using the New Jersey System of Care Strengths and Needs Assessment tool.
- f. Enrollment: All referrals for the program are screened to determine if the individual meets the target population criteria, is Medicaid eligible, meets LOC clinical criteria, is in need of program services, and participant’s needs can be safely met in the community.
- g. Enrollment Cap: In cases where the State determines, based on advance budget projections that it cannot continue to enroll ID-DD/MI participants without exceeding the funding available for the program the State can establish an enrollment cap for the ID-DD/MI program.
- i. *Notice:* Before affirmatively implementing the caps authorized in subparagraph (g), the State must notify CMS at least 60 days in advance. This notice must also include the impact on budget neutrality.
 - ii. *Implementing the Limit* - if the State imposes an enrollment cap, it will

implement a waiting list whereby applicants will be added to the demonstration based on date of application starting with the oldest date. Should there be several applicants with the same application date, the State will enroll based on date of birth starting with the oldest applicant

- iii. *Outreach for those on the Wait Lists* - the State will conduct outreach for those individuals who are on the IDD Out-of-State wait list for at least 6 months, to afford those individuals the opportunity to sign up for other programs if they are continuing to seek coverage. Outreach materials will remind individuals they can apply for Medicaid.
 - iv. *Removing the Limit* – the State must notify CMS in writing at least 30 days in advance when removing the limit.
- h. **Disenrollment:** An individual will be disenrolled from the program for the following reasons:
- i. The family/caregiver declines participation or requests to be disenrolled from the program; or
 - ii. The family/caregiver is unable or unwilling to implement the treatment plan or fails to comply with the terms as outlined in the plan. Prior to disenrollment, the team will collaborate and make substantial efforts to ensure the individual’s success in the program, including working to remedy any barriers or issues that have arisen. An individual will only be disenrolled after significant efforts have been made to achieve success. If they will be disenrolled, the team will make recommendations and identify alternative local community and other resources for the individual prior to disenrollment; or
 - iii. The individual’s documented treatment plan goals and objectives have been met.
- i. **Transition:** At least one year in advance of an individual aging out of this program, the Interdisciplinary Team and Medicaid MCO will commence transition planning to identify service needs and necessary resources. Referrals will be made to all services, as applicable. Should an individual require continued HCBS services, enrollment will be facilitated to the other program.
- j. **Benefits/Services, Limitations, and Provider Qualifications:** In addition to Medicaid State Plan services, this population receives HCBS service package of benefits designed to provide the appropriate supports to maintain the participants safely in the community. The full list of program services may be found in Attachment C.
- k. **Cost Sharing: For out of home services:** The family of the individuals receiving ID/DD-MI out of home services will be assessed for their ability to contribute towards the cost of care and maintenance. The amount paid by the family is based both on earned (wages

over minimum wage) and unearned income.

81. **Intellectual Developmental Disability Program for Out of State (IDD/OOS) New Jersey Residents**

- a. Program Overview: This program consists of individuals who receive out-of-state HCBS coordinated by DDD. Services claimed through this program will not duplicate services provided through a participant's educational entitlement or via the Rehabilitation Act. Other than the individuals currently living in an eligible out of state setting who will be enrolled onto the IDD/OOS program. The only additional demonstration participants who will be added to this program are those who DDD has been court-ordered to provide the services in an out-of-state setting.
- b. Eligibility: An individual must be Medicaid eligible and meet all criteria for DDD eligibility for services. Specifically, an individual must be determined functionally eligible, based on a determination that they have a developmental disability and must apply for all other benefits for which he or she may be entitled. Developmental disability is defined as: "a severe, chronic disability of an individual which: (1) is attributable to a mental or physical impairment or combination of mental and physical impairments; (2) is manifest before age 22; (3) is likely to continue indefinitely; (4) results in substantial functional limitations in three or more of the following areas of major life activity, that is: self-care, receptive and expressive language, learning, mobility, self-direction capacity for independent living and economic self-sufficiency (e.g.5) reflects the need for a combination and sequences of special interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and are individually planned and coordinated; and (6) includes but is not limited to severe disabilities attributable to intellectual disability, autism, cerebral palsy, epilepsy, spina bifida and other neurological impairments where the above criteria are met."
- c. Exclusionary Criteria:
 - i. Individuals who live in New Jersey;
 - ii. Individuals who are enrolled in another HCBS program;
 - iii. Individuals who have declared residency in another state;
 - iv. Individuals who require institutional care and cannot be maintained safely in the community; and
 - v. Individuals who do not meet ICF/MR-DD level of care
- d. Enrollment: New enrollments in the IDD Out-of-State program will only include those demonstration participants who are currently residing in an eligible out of state setting or those individuals who are court ordered after the effective date of this program to receive services outside of New Jersey.

- e. LOC Assessment: The LOC criteria: The participant has substantial functional limitations in three or more major life activities, one of which is self care, which require care and/or treatment in an ICF/MR-DD or alternatively, in a community setting. The LOC tool will be developed prior to the program being implemented.
- f. LOC Reassessment: The reassessment is made as part of the annual Service Plan for each participant. Functional assessment tools are utilized to confirm LOC assessment and to determine service needs. Goals and training in the Service Plan are based on the needs identified at the time of the reassessment.
- g. Transition: New individuals will not transition into this program, except per court order. Individuals will transition out of this program as outlined in Program Overview and Disenrollment. The majority of individuals transitioning out of this program will transition into community-based settings in New Jersey and will then be enrolled on the Community Care Waiver or the Supports Program.
- h. Disenrollment: An individual will be disenrolled from the program for the following reasons:
 - i. Acceptable alternative services are identified in state and the individual is returned to New Jersey;
 - ii. Residency in the state in which they are currently receiving services can be established and/or the individual transfers to services funded by that state;
 - iii. An individual declines participation/requests to be disenrolled;
 - iv. The agency serving the individual notifies the individual and DDD (30 days advance notice is required) that they can no longer serve the individual for one of the following reasons:
 - 1) The individual's medical needs have increased and the provider is no longer able to manage their care;
 - 2) The individual's behaviors have escalated and the provider is no longer able to manage their care.
- i. Benefits: In addition to Medicaid State Plan services Plan A in Attachment B, this population receives HCBS service package of benefits designed to provide the appropriate supports to maintain the participants safely in the community.
- j. Delivery System: Medicaid State Plan and HCBS services are delivered through fee-for-service, coordinated by New Jersey's DDD. The State assures CMS that 100 percent of the payment to providers is maintained by the provider. The State shall only claim its federal match rate for any out of State services rendered, based upon the federal match rate of NJ.

82. Program for Children diagnosed with Serious Emotional Disturbance (SED)

- a. Program Overview: The SED Program provides behavioral health services for

demonstration enrollees who have been diagnosed as seriously emotionally disturbed which places them at risk for hospitalization and out-of-home placement.

- b. Eligibility: Enrollees in the SED Program must meet the following criteria:
- i. All children served under this population who are eligible for Medicaid or CHIP State plan populations, or,
 - ii. NJ will use the Institutional Medicaid financial eligibility standards of:
 - 1) Children from age of a SED diagnosis up to age 21 years will be eligible for the services;
 - 2) The child must meet a hospital level of care up to 300% of FBR or at risk of hospitalization up to 150% FPL;
 - 3) Must be a US Citizen or lawfully residing alien;
 - 4) Must be a resident in the State of New Jersey; and
 - 5) For the purposes of this program, "family" is defined as the persons who live with or provide care to a person served in the SED Program, and may include a parent, step parent, legal guardian, siblings, relatives, grandparents, or foster parents.
- c. Functional Eligibility: To be functionally eligible for the SED program, the enrollee must meet one of the two programmatic criteria for participation:
- i. Acute Stabilization Program– the enrollee must meet the following criteria necessary for participation in this LOC.
 - 1) The enrollee must be between the ages of 5 and up to 21 years. Special consideration will be given to children under age five which include:
 - a. The child meets the clinical criteria for the services for which are being sought.
 - b. The child cannot obtain the needed services through the NJ Early Intervention Program through the Department of Health
 - c. The Medical Director at the ASO reviews determines the service is appropriate, and authorizes the service.
 - 2) The DCBHS Assessment and other relevant information must indicate that the enrollee has a need that can be served by the Care Management Organization or the Mobile Response Stabilization Services LOC.

- 3) The enrollee exhibits at-risk behaviors.
 - 4) The enrollee exhibits behavioral/emotional symptoms based on the NJ System of Care Needs Assessment Tool.
 - 5) The enrollee is at risk of being placed out of his/her home or present living arrangement.
 - 6) The enrollee requires immediate intervention in order to be maintained in his/her home or present living arrangement.
- d. Enrollment: SED Program enrollees are initially referred to the children’s ASO by providers, parents, or schools. The ASO performs a clinical triage performed by an appropriately licensed clinician and screens for insurance including Medicaid and CHIP programs. Any youth that is determined in the initial screening to potentially be SED must receive a complete “in-community” bio-psycho-social assessment that includes the completion of the Child and Adolescent Needs and Strengths (CANS) Assessment. This assessment, reviewed by the ASO, will be used to determine enrollment.
- e. Reassessment: The Care Management Organization must submit an updated Individualized Service Plan (ISP) at least every 90 days and the ASO must make a determination for continued eligibility with each submitted ISP.
- f. Exclusion criteria. Include at least one of the following:
- i. The person(s) with authority to consent to treatment for the youth refuses to participate
 - ii. Current assessment or other relevant information indicates that the enrollee/young adult can be safely maintained and effectively supported at a less intensive LOC.
 - iii. The behavioral symptoms are the result of a medical condition that warrants a medical setting for treatment as determined and documented by the child’s primary care physician and or the ASO Medical Director.
 - iv. The enrollee has a sole diagnosis of Substance Abuse and there is no identified, co-occurring emotional or behavioral disturbances consistent with a DSM IV-TR Axis I Disorder.
 - v. The enrollee’s sole diagnosis is a Developmental Disability that may include one of the following:
 - 1) The enrollee has a sole diagnosis of Autism and there are no co-occurring DSM IV-TR Axis I Diagnoses or symptoms/behaviors consistent with a DSM IV-TR Axis I Diagnosis.

- 2) The enrollee has a sole diagnosis of Intellectual Disability/Cognitive Impairment and there are no co-occurring DSM IV-TR Axis I Diagnoses or symptoms/behaviors consistent with a DSM IV-TR Axis I Diagnosis.

83. Medication Assisted Treatment Initiative (MATI)

- a. Program Overview. Effective July 1, 2013, or a date thereafter, the treatment program delivers a comprehensive array of medication-assisted treatment and other clinical services through MATI provider mobile and office-based sites. The program goals include:
 - i. The reduction in the spread of blood borne diseases through sharing of syringes;
 - ii. The reduction of opioid and other drug dependence among eligible participants;
 - iii. The stabilization of chronic mental health and physical health conditions; and,
 - iv. Improved housing and employment outcomes among program participants.
- b. Eligibility: Demonstration enrollees applying for services must be screened by the mobile or fixed site service provider using a standardized clinical and functional assessment tool that will be independently reviewed by appropriate qualified clinicians to determine if the applicant meets the following program eligibility criteria:
 - i. Be a resident of New Jersey and at least 18 years old;
 - ii. Have household income at or below 150% of FPL;
 - iii. Have a history of injectable drug use;
 - iv. Test positive for opiates or have a documented one-year history of opiate dependence; this requirement may be waived for individuals who have recently been incarcerated and subsequently released or in residential treatment.
 - v. Provide proof of identification (to prevent dual enrollment in medication assisted treatment)
 - vi. Not currently enrolled as a client in an Opioid Treatment Program (OTP) or a client under the care of a Center for Substance Abuse Treatment (CSAT) waived physician providing Office-Based Opioid Treatment Services (OBTS)
- c. Programmatic Eligibility - Applicants must also meet at least two of the following criteria:
 - i. Diagnosed with a mental illness or a substance use disorder at least once in their lifetime by a licensed professional in the state of New Jersey qualified to render such a diagnosis within their scope of practice.

- 1) A mental illness diagnosis may be rendered by: an MD or DO Board Certified or Board eligible in psychiatry; a Certified Nurse Practitioner-Psychiatry and Mental Health (CNP-PMH); an Advanced Practice Nurse-Psychiatry and Mental Health (APN-PMH); a Physician's Assistant (PA) w/Psychiatric and Mental Health certification; a Licensed Clinical Social Worker (LCSW); Licensed Professional Counselor (LPC); Licensed Psychologist; or Licensed Marriage and Family Therapist (LMFT).
 - 2) A substance use disorder diagnosis may be rendered by one of the qualified licensed professionals listed above or a Licensed Clinical Alcohol and Drug Counselor (LCADC).
- ii. Diagnosed with one or more chronic medical conditions (e.g., Chronic Obstructive Pulmonary Disease (COPD), Diabetes, HIV/AIDS, Hepatitis C, Asthma, etc.).
 - iii. Homeless or lacking stable housing for one year or longer.
 - iv. Unemployed or lacking stable employment for two years or longer.
- d. Enrollment: Enrollees in the MATI program who are not eligible for other demonstration populations and only gain demonstration eligibility for MATI services by enrollment into the MATI program. The MATI population is able to enroll in the program directly at the MATI provider agency mobile medication unit or office-based site. The MATI provider, in collaboration with the ASO, will facilitate Medicaid enrollment.
- e. Level of Care Assessment: The provider must conduct an initial assessment of the program applicant, including documentation of eligibility criteria, on the mobile unit or at the office-based site using an American Society of Addiction Medicine (ASAM)-based standardized clinical assessment tool to determine appropriateness for medication-assisted treatment and level of care placement. If the applicant is deemed clinically appropriate for medication assisted treatment he/she will meet with a qualified physician within 48 hours to determine the specific medication protocol.
- i. Documentation of program eligibility and clinical assessment results will be electronically submitted to the ASO for independent review.
 - ii. Within one business day, a determination of eligibility will be rendered from the ASO to both the provider and applicant.
 - iii. Upon enrollment in the MATI the ASO will provide for continued care management.
- f. LOC Reassessment: A reassessment of eligibility requirements will be conducted quarterly for each enrollee by the provider and sent to the ASO for review and approval

of continuation in the program. Reassessment for eligibility will include review of the following criteria:

- i. The enrollee continues to demonstrate need for medication assisted treatment (MAT) services to support recovery; and
 - ii. The enrollee continues to be at or below 150% of FLP; or
 - iii. The enrollee is above 150% FLP with no identified alternative payer.
- g. Disenrollment: A consumer will be considered no longer enrolled in the MATI program if they meet one of the following criteria:
- i. The enrollee is no longer appropriate for MATI services to support recovery; as determined by consultation among the clinician, the physician and the consumer; or
 - ii. The enrollee continues to be appropriate for MATI services and has another identified payer.
- h. Benefits: Please refer to attachment F for a comprehensive list of MATI services and benefits.
- i. Delivery System: MATI services are reimbursed at fee-for-service through the ASO.

XII. PREMIUM ASSISTANCE PROGRAMS

84. New Jersey Family Care/Premium Support Program (PSP) – Title XXI Funded

- a. Program Overview: The PSP is designed to cover individuals eligible for NJ FamilyCare (and under certain conditions, non-eligible family members) who have access to cost effective employer-sponsored health plans. Some uninsured families have access to health insurance coverage through an employer, but have not purchased the coverage because they cannot afford the premiums. Assistance is provided in the form of a direct reimbursement to the beneficiary for the entire premium deduction, or a portion thereof, required for participation in the employer-sponsored health insurance plan. Beneficiaries are reimbursed on a regular schedule, to coincide with their employer's payroll deduction, so as to minimize any adverse financial impact on the beneficiary. Note that this program operates under title 2105(c)(3) of the Social Security Act, but has waived certain title XXI provisions for children and families by virtue of this Section 1115 demonstration.
- b. Eligibility Requirements: Parents and/or their children must be determined eligible for NJ FamilyCare in order to participate in the PSP. If the PSP unit determines that the parents have a cost-effective employer-sponsored plan available to them, the parents must enroll in the plan as a condition of participation in the NJ FamilyCare program. The PSP will

reimburse the premiums for the non-eligible family members only if it is cost-effective in the aggregate. Children and parents must *not* have had coverage under a group health plan for three months prior to enrollment in the PSP. If proven cost effective, family members are required to enroll in ESI as their primary healthcare plan rather than direct state plan coverage.

- c. **Benefit Package:** NJ's Plan D mirrors the benchmark health plan offered through an HMO with the largest commercial, non-Medicaid enrollment in the state. If the employer's health plan is not equal to Plan D, then the state provides wraparound services for children and adults through its managed care organizations. "Wraparound service" means any service that is not covered by the enrollee's employer plan that is an eligible service covered by NJ FamilyCare for the enrollee's category of eligibility. This process is no different than how NJ currently handles all other beneficiaries who have TPL. Assurances to that effect will also be inserted in the Managed Care contract.
- i. **Process for Benefit Analysis:** If an uninsured parent has access to employer-sponsored insurance, the PSP Unit evaluates the application and assesses the employer's plan and a description of the benefits covered by the employer's plan. The PSP reviews the employer's response and compares the services to NJ FamilyCare services, taking into account any limitations on coverage.
- d. **Cost Sharing:** Premiums and co-payments vary under employer-sponsored plans regardless of FPL, but cost sharing is capped at 5 percent of the individual or family's gross income. This protection applies equally to parents enrolled in NJ FamilyCare and to parents enrolled in an employer-sponsored plan through the PSP.
- i. The PSP will reimburse the beneficiary for the difference between the NJFC/PSP co-payment amount and that of the employer-sponsored plan co-payment amount. For example, if the NJFC/PSP co-payment amount for a physician's office visit is \$5.00 and the employer-sponsored plan co-pay charge is \$15.00 for the same service, the PSP will reimburse the beneficiary the difference in excess of the NJFC/PSP co-payment amount (\$10.00).
 - ii. When the 5 percent limit is reached for the year, the parent's NJ FamilyCare identification card is revised to indicate that no cost-sharing can be imposed for the rest of the calendar year.
 - iii. If the PSP participant makes an out-of-pocket payment after the 5 percent limit is reached, any additional charges submitted to the PSP for the remainder of the calendar year are reimbursed at 100 percent as long as the parent submits proof of additional expenses.
 - iv. Parents may also request that the PSP notify medical service providers that a voucher can be submitted to the PSP for any cost sharing charges for the remainder of the year.
- e. **Employer Contribution:** Each plan must provide an employer contribution amount as required under 2105(c)(3). The amount will not be specified by the State and can vary by plan. The contribution amount may range from 5% to 100%.

f. Cost Effectiveness Test –

- i. Cost-effectiveness shall be determined in the aggregate by comparing the cost of all eligible family members' participation in the NJ FamilyCare program against the total cost to the State, including administrative costs, (e.g. Office of Premium Support and Office of Information Technology staff, as well as phone, postage, computers, and printers), of reimbursing eligible members for their employer-sponsored insurance. The amounts used for the calculations shall be derived from actuarial tables used by the NJ FamilyCare program and actual costs reported by the employee/employer during the processing of the Premium Support Program (PSP) application.
- ii. The cost of the employer-sponsored plans shall be determined by totaling the amount of the employee's premiums plus the actuarial value of all "wraparound" services, if applicable, minus any NJFC premium contributions owed the state under the CHIP state plan.
- iii. As a condition of PSP approval, the result of the cost-effectiveness test in the aggregate shall indicate a cost savings difference of, at a minimum, five percent between what the State would pay for the beneficiaries' participation in the employer- sponsored health plan vs. what the State would pay for their participation in the NJ FamilyCare program alone.
- iv. If the employer-sponsored plans are determined by the Division to be cost- effective in the aggregate in accordance with (i) above, the applicants shall participate in the Premium Support Program. If the employer-sponsored plan is determined not cost- effective, in accordance with (i) above, the beneficiary will continue to participate solely in the NJ FamilyCare program.

XIII. QUALITY

85. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency shall maintain authority, accountability, and oversight of the program. The State Medicaid Agency shall exercise oversight of all delegated functions to operating agencies, MCOs and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.
86. **Quality for Managed Care/MLTSS.** The State must develop a comprehensive Quality Strategy with measures related to behavioral health and Managed Care measures to reflect all CHIP, Medicaid, Behavioral Health Programs, (including SED, PDD, and MATI Programs) acute and primary health care, and MLTSS operating under the programs proposed through this demonstration and submit to CMS for approval 90 days prior to implementation. The State must obtain the input of recipients and other stakeholders in the development of its comprehensive Quality Strategy and make the Strategy available for public comment.
87. **Quality for Fee for Service HCBS Programs.** The State must develop Quality Strategies to reflect all Programs operated under this demonstration through the Division of Developmental Disabilities and the Division of Children and Families. The State must obtain

the input of recipients and other stakeholders in the development of its comprehensive Quality Strategy and make the Strategy available for public comment.

- a. FFS HCBS Programs under the Division of Developmental Disabilities (Supports, and IDD-OOS) will submit a quality plan to CMS for approval 60 days prior to the implementation of any programs.
- b. FFS or ASO HCBS Programs - (ID-DD/MI) under the Division of Children and Families will submit a quality plan for CMS approval 60 days prior to the implementation of any programs.

88. Content of Quality Strategy(ies). All Managed Care, MLTSS (Comprehensive) and HCBS Quality Strategies for all services must include the application of a continuous quality improvement process, representative sampling methodology, frequency of data collections and analysis, and performance measure in the following areas:

- a. Outcomes related to qualities of life; and,
- b. Health and welfare of participants receiving services including:
 - i. Development and monitoring of each participant's person-centered service plan to ensure that the State and MCOs are appropriately creating and implementing service plans based on enrollee's identified needs.
 - ii. Specific eligibility criteria for each identified HCBS program that addresses level of care determinations – to ensure that approved instruments are being used and applied appropriately and as necessary, and to ensure that individuals being served with HCBS or MLTSS have been assessed to meet the required level of care for those services.
 - iii. Adherence to provider qualifications and/or licensure for HCBS programs and MCO credentialing and/or verification policies for managed care and MLTSS are provided by qualified providers. Also need to indicate specifications when the participant self directs. While these providers frequently are not credentialed or licensed, some have alternative provisions for assuring qualifications are in place.
 - iv. Assurance of health and safety and participant safeguards for demonstration participants to ensure that the State or the MCO operates a critical incident management system according to the State's established policies, procedures and regulations. Specifically, on an ongoing basis the State ensures that all entities, including the MCO identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation, and ensures participant safeguards concerning seclusion, restraint, risk mitigation, and medication management.

- v. The State shall incorporate by reference its policies, procedures and regulations for health, safety and participant safeguards into MCO contracts with adherence expectations defined. Any changes to the policies, procedures and regulations must be submitted to CMS for review prior to implementation.
- vi. Administrative oversight by the State Medicaid Agency of State Operating Agencies, the Managed Care Plans, and any other entities performing delegated administrative functions.

89. Oversight process: Required Monitoring Activities related to the areas above shall be conducted by State and/or External Quality Review Organization (EQRO). As defined and delegated by the State Medicaid Agency, the State's EQRO process shall meet all the requirements of 42 CFR 438 Subpart E. The State, or its EQRO, shall monitor and annually evaluate the MCOs' performance on specific requirements under MLTSS. The State shall also include minimum oversight expectations of the Managed Care Organizations' oversight of providers in the contracts. These include the areas in the Quality Strategy(ies) as applicable.

90. Revision of the State Quality Strategy(ies) and Reporting. The Single State Medicaid Agency shall update its Quality Strategy(ies) whenever significant changes are made, including changes through this demonstration, and submit to CMS for approval. The State must obtain the input of recipients and other stakeholders in the development of revised Quality Strategy(ies) and make the Strategy(ies) available for public comment. In addition, the State must provide CMS with annual reports on the implementation and effectiveness of the updated Quality Strategy(ies) as it impacts the beneficiaries in the demonstration. Specifically, the annual reports shall include summaries of analyzed and aggregated data on measures and quality improvements.

XIII. FUNDING POOLS

The terms and conditions in Section IX apply to the State's exercise of the following Expenditure Authorities: (7) Expenditures Related to Transition Payments, and Expenditures Related to the Delivery System Reform Incentive Payment (DSRIP) Pool.

91. Terms and Conditions Applying to Pools Generally.

- a. The non-Federal share of pool payments to providers may be funded by state general revenue funds and transfers from units of local government that are compliant with section 1903(w) of the Act. Any payments funded by intergovernmental transfers from governmental providers must remain with the provider, and may not be transferred back to any unit of government. CMS reserves the right to withhold or reclaim FFP based on a finding that the provisions of this subparagraph have not been followed.
- b. The State must inform CMS of the funding of all payments from the pools to hospitals through a quarterly payment report, in coordination with the quarterly operational report

required by paragraph 102, to be submitted to CMS within 60 days after the end of each quarter. This report must identify and fully disclose all the underlying primary and secondary funding sources of the non-Federal share (including health care related taxes, certified public expenditures, intergovernmental transfers, general revenue appropriations, and any other mechanism) for each type of payment received by each provider.

- c. On or before December 31, 2012, the State must submit Medicaid State plan amendments to CMS to remove all supplemental payments for inpatient and outpatient hospital services from its State plan, with an effective date the same as the approval date for this demonstration. Except as discussed in paragraph 92(h), the State may not subsequently amend its Medicaid State plan to authorize supplemental payments for hospitals, so long as the expenditure authorities for pool payments under this demonstration remain in force.
- d. The State will ensure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of services available under the State plan or this demonstration. The preceding sentence is not intended to preclude the State from modifying the Medicaid benefit through the State Plan amendment process.
- e. Each quarter the State makes DSRIP Payments or Transition payments (as described below) and claims FFP, appropriate supporting documentation will be made available for CMS to determine the allowability of the payments. Supporting documentation may include, but is not limited to, summary electronic records containing all relevant data fields such as Payee, Program Name, Program ID, Amount, Payment Date, Liability Date, Warrant/Check Number, and Fund Source. Documentation regarding the Funds revenue source for payments will also identify all other funds transferred to such fund making the payment.

92. **Transition Payments.** During the Transition Period (which is the period between the approval date for this demonstration and December 31, 2013), the State will make Transition Payments to hospitals that received supplemental payments under the Medicaid State plan for SFY 2012 (July 1, 2011 through June 30, 2012). The Transition Period ensures that providers are eligible to secure historical Medicaid funding as the State develops the Delivery System Reform Incentive Payment Pool. Transition Payments may be made only during the Transition Period, and are subject to the following requirements.

- a. The hospitals eligible to receive Transition Payments are listed in Attachment K. These hospitals meet the following criteria:
 - i. Is enrolled as a New Jersey Medicaid provider, and
 - ii. Received a supplemental payment under the Medicaid State plan during SFY 12.
- b. Qualifying hospitals may receive two distinct types of Transition Payments, as described

in (i) and (ii) below.

- i. 2013 HRSF Transition Payments may be paid to hospitals in proportion to the supplemental payments that each hospital received from the Hospital Relief Subsidy Fund in SFY 2012. The total amount of 2013 HRSF Transition Payments for all hospitals combined may not exceed the following amount: \$166,600,000, less any payments that hospitals received in Hospital Relief Subsidy Fund payments under the State plan in SFY 2013. 2014 HRSF Transition Payments shall be paid to hospitals in proportion to the supplemental payments that each hospital received from the Hospital Relief Subsidy Fund (HRSF) in SFY 2012. The total amount of 2014 HRSF Transition Payments for all hospitals combined shall not exceed \$83,300,000.
 - ii. 2013 GME Transition Payments may be paid to hospitals in proportion to the supplemental payments that each hospital received for GME in SFY 2012. The total amount of 2013 GME Transition Payments for all hospitals combined may not exceed the following amount: \$90,000,000 less any payments that hospitals received in Graduate Medical Education payments under the State plan in SFY 2013.
- c. Participating providers are eligible to receive one-ninth of their total 2013 Transition Payment amount each month in the Transition Period, beginning October 1, 2012, through the quarter ending June 30, 2013. Participating providers are eligible to receive one-sixth of their total 2014 Transition Payment amount each month in the Transition Period, beginning July 1, 2013 and ending December 31, 2013.
- d. As part of the first Quarterly Progress Report submitted under this demonstration, the State must provide a table showing the amounts of 2012 State plan supplemental payments received by each hospital listed in Attachment K (by type of payment), the amounts of 2013 State plan supplemental payments received by each hospital, and the total of each type of Transition Payments each hospital can expect to receive in DY 1 and DY 2. The State must identify the source of funding for each Transition Payment as a part of this list. Should the State determine that any of the hospitals listed in Attachment K will not receive Transition Payments; the State must provide an explanation for this in its report.
- e. In the first Annual Report submitted by the State after the end of the Transition Period, the State must provide a list of hospitals that received Transition Payments DY 1 and DY 2, and the amounts actually paid to each hospital, along with an explanation for how the payment amounts were determined.
- f. The State may alter the list of hospitals eligible to receive Transition Payments, or change the formula for determining the amounts to be paid, by submitting a request to amend the demonstration, following the process described in paragraph 7.
- g. Transition Payments received by a hospital provider count as title XIX revenue, and must be included as offsetting revenue in the State's annual DSH audit reports.

- h. During the Transition Period, CMS shall work with the State to get a State Plan Amendment approved by July 1, 2013 that allows the State to pay \$90 million in Graduate Medical Education (GME) payments directly to hospitals per 42 CFR 438.60, starting in DY 2. These payments will not be subject to federal fee-for-service upper payment limit restriction, but will be subject to the budget neutrality test for this demonstration.

93. Delivery System Reform Incentive Payment (DSRIP) Pool. The DSRIP Pool is available in DY 2 (following the end of the Transition Period) through the end of DY 5 for the development of a program of activity that supports hospitals' efforts to enhance access to health care, the quality of care, and the health of the patients and families they serve. The program of activity funded by the DSRIP will be those activities that are directly responsive to the needs and characteristics of the populations and communities served by each hospital. Each participating hospital will develop a Hospital DSRIP Plan, consistent with the DSRIP Planning Protocol, that is rooted in the intensive learning and sharing that will accelerate meaningful improvement. The Individual Hospital DSRIP Plan will be consistent with the hospital's mission and quality goals, as well as CMS's overarching approach for improving health care through the simultaneous pursuit of three aims: better care for individuals (including access to care, quality of care, and health outcomes), better health for the population, and lower cost through improvement (without any harm whatsoever to individuals, families or communities). In its Hospital DSRIP Plan, each hospital will describe how it will carry out a *project* that is designed to improve the quality of care provided, the efficiency with which care is provided, or population health. Each project will consist of a series of *activities* drawn from a predetermined menu of activities grouped according to four *Project Stages*. Hospitals may qualify to receive incentive payments (*DSRIP Payments*) for fully meeting performance *metrics* (as specified in the Hospital DSRIP Plan), which represent measurable, incremental steps toward the completion of project activities, or demonstration of their impact on health system performance or quality of care.

- a. **Eligibility.** The program of activity funded by the DSRIP shall take place in the general acute care hospitals listed and shown in Attachment K.

- b. **Project Focus Areas:** Each eligible hospital will select a project from the menu of focus areas listed below. Projects may include those based on regional planning needs as part of its DSRIP plan. Each focus area has an explicit connection to the achievement of the Three Part Aim:

- Behavioral Health,
- HIV/AIDS,
- Chemical Addiction/Substance Abuse,
- Cardiac Care,
- Asthma,
- Diabetes,
- Obesity,

- Pneumonia, or
 - Another medical condition that is unique to a specific hospital, if approved by CMS. (The DSRIP Program Funding and Mechanics Protocol must specify a process for the State to obtain CMS approval for hospital-specific Focus Areas.)
- c. **Project Stages.** Hospital projects will consist of activities that can be grouped into four stages.
- i. *Stage 1: Infrastructure Development* – Activities in this stage lay the foundation for delivery system transformation through investments in technology, tools, and human resources that will strengthen the ability of providers to serve populations and continuously improve services.
 - ii. *Stage 2: Chronic Medical Condition Redesign and Management.* Activities in this stage include the piloting, testing, and replicating of chronic patient care models.
 - iii. *Stage 3: Quality Improvements* – This stage involves the broad dissemination of interventions from a list of activities identified by the State, in which major improvements in care can be achieved within four years. To the extent possible the interventions will rely on the work of the New Jersey Hospital Engagement Network currently under development. These are hospital-specific initiatives and will be jointly developed by hospitals, the State, and CMS and are unlikely to be uniform across all of the hospitals.
 - iv. *Stage 4: Population Focused Improvements* – Activities in this stage include reporting measures across several domains selected by the State based on community readmission rates and hospital acquired infections, which will allow the impact of activities performed under Stages 1 through 3 to be measured, and may include:
 - (A) Patient experience,
 - (B) Care outcomes, and
 - (C) Population health.
- d. **DSRIP Performance Indicators.** The State will choose performance indicators that are connected to the achievement of providing better care, better access to care, and enhanced prevention of chronic medical conditions and population improvement. The DSRIP Performance Indicators will comprise the list of reporting measures that hospitals will be required to report under Stage 4: Population Focused Improvements.
- e. **DSRIP Planning Protocol.** The State must develop and submit to CMS for approval a DSRIP Planning Protocol, following the timeline specified in paragraph 95(a). Once approved by CMS, this document will be incorporated as Attachment H of these STCs, and once incorporated may be altered only by amending the demonstration through the process described in paragraph 7. The Protocol must:

- i. Outline the global context, goals and outcomes that the State seeks to achieve through the combined implementation of individual projects by hospitals;
 - ii. Specify the Project Stages, as shown in subparagraph (c) above, and for each Stage specify a menu of activities, along with their associated population-focused objectives and evaluation metrics, from which each eligible hospital will select to create its own projects;
 - iii. Detail the requirements of the Hospital DSRIP Plans, consistent with subparagraph (g); and
 - iv. Specify a set of Stage 4 measures that must be collected and reported by all hospitals, regardless of the specific projects that they choose to undertake.
- f. **DSRIP Program Funding and Mechanics Protocol.** The State must develop a DSRIP Program Funding and Mechanics Protocol to be submitted to CMS for approval, following the timeline specified in paragraph 95(a). Once approved by CMS, this document will be incorporated as Attachment I of these STCs, and once incorporated may be altered only by amending the demonstration through the process described in paragraph 7. DSRIP payments for each participating hospital are contingent on the hospital fully meeting project metrics defined in the approved hospital-specific Hospital DSRIP Plan. In order to receive incentive funding relating to any metric, the hospital must submit all required reporting, as outlined in the DSRIP Program Funding and Mechanics Protocol. In addition, the DSRIP Program Funding and Mechanics Protocol must:
- i. Include guidelines requiring hospitals to develop individual Hospital DSRIP Plans, which shall include timelines and deadlines for the meeting of metrics associated with the projects and activities undertaken to ensure timely performance;
 - ii. Provide minimum standards for the process by which hospitals seek public input in the development of their Hospital DSRIP Plans, and provide that hospitals must include documentation of public input in their Hospital DSRIP Plans;
 - iii. Specify a State review process and criteria to evaluate each hospital's individual DSRIP plan and develop its recommendation for approval or disapproval prior to submission to CMS for final approval;
 - iv. Specify a process for obtaining CMS approval for hospital-specific Focus Areas that do not appear on the list in paragraph 93(b);
 - v. Allow sufficient time for CMS to conduct its review of the Hospital DSRIP Plans;

- vi. Describe, and specify the role and function, of a standardized, hospital-specific application to be submitted to the State on an annual basis for the utilization of DSRIP funds that outlines the hospital's specific DSRIP plan, as well as any data books or reports that hospitals may be required to submit to report baseline information or substantiate progress;
- vii. Specify that hospitals must submit semi-annual reports to the State using a standardized reporting form to document their progress (as measured by the specific metrics applicable to the projects that the hospitals have chosen), and qualify to receive DSRIP Payments if the specified performance levels were achieved;
- viii. Specify a review process and timeline to evaluate hospital progress on its DSRIP plan metrics in which first the State and then CMS must certify that a hospital has met its approved metrics as a condition for the release of associated DSRIP funds to the hospital;
- ix. Specify an incentive payment formula to determine the total annual amount of DSRIP incentive payments each participating hospital may be eligible to receive during the implementation of the DSRIP project, consistent with subparagraphs (i) and (j) below, and a formula for determining the incentive payment amounts associated with the specific activities and metrics selected by each hospital, such that the amount of incentive payment is commensurate with the value and level of effort required;
- x. Specify that hospital's failure to fully meet a performance metric under its Hospital DSRIP Plan within the time frame specified will result in forfeiture of the associated incentive payment (i.e., no payment for partial fulfillment);
- xi. Describe a process by which a hospital that fails to meet a performance metric in a timely fashion (and thereby forfeits the associated DSRIP Payment) can reclaim the payment at a later point in time (not to exceed one year after the original performance deadline) by fully achieving the original metric in combination with timely performance on a subsequent related metric, or by which a payment missed by one hospital can be redistributed to other hospitals, including rules governing when missed payments can be reclaimed or must be redistributed;
- xii. Include a process that allows for potential hospital plan modification (including possible reclamation, or redistribution, pending State and CMS approval) and an identification of circumstances under which a plan modification may be considered, which shall stipulate that CMS may require that a plan be modified if it becomes evident that the previous targeting/estimation is no longer appropriate or that targets were greatly exceeded or underachieved; and

- xiii. Include a State process of developing an evaluation of DSRIP as a component of the draft evaluation design as required by paragraph 134. When developing the DSRIP Planning Protocol, the State should consider ways to structure the different projects that will facilitate the collection, dissemination, and comparison of valid quantitative data to support the Evaluation Design required in section XVI of the STCs. The State must select a preferred evaluation plan for the applicable evaluation question, and provide a rationale for its selection. To the extent possible, participating hospitals should use similar metrics for similar projects to enhance evaluation and learning experience between hospitals. To facilitate evaluation, the DSRIP Planning Protocol must identify a core set of Category 4 metrics that all participating hospitals must be required to report even if the participating hospital chooses not to undertake that project. The intent of this data set is to enable cross hospital comparison even if the hospital did not elect the intervention.

- g. **Hospital DSRIP Plans.** The hospitals will develop hospital specific Hospital DSRIP Plans in good faith, to leverage hospital and other community resources to best achieve delivery system transformation goals of the State consistent with the demonstration's requirements.
 - i. Each hospital's DSRIP plan must identify the project, population-focused objectives, and specific activities and metrics, which must be chosen from the approved DSRIP Planning Protocol, and meet all the requirements pursuant to this waiver.
 - ii. Each project must feature activities from all four Stages, and require the hospital to report at least two metrics in each reporting cycle and report metrics for all four Stages in each DY 3 through 5.
 - iii. For each stated goal or objective of a project, there must be an associated outcome (Stage 4) metric that must be reported in all years. The initially submitted Hospital DSRIP Plan must include baseline data on all Stage 4 measures.
 - iv. Hospital DSRIP Plans shall include estimated funding available by year to support DSRIP payments, and specific allocation of funding to DSRIP activities proposed within the Hospital DSRIP Plan, with greater weight of payment on Stage 1 and 2 metrics in the early years, and on Stage 3 and 4 metrics in the later years.
 - v. Payment of funds allocated in a Hospital DSRIP Plan to Stage 4 may be contingent on the hospital reporting DSRIP Performance Indicators to the State and CMS, on the hospital meeting a target level of improvement in the DSRIP Performance Indicator relative to baseline, or both. At least some of

the funds so allocated in DY 3 and DY 4, and all such funds allocated in DY 5, must be contingent on meeting a target level of improvement.

- vi. Hospitals shall provide opportunities for public input to the development of Hospital DSRIP Plans, and shall provide opportunities for discussion and review of proposed Hospital DSRIP Plans prior to plan submission to the State.
 - vii. Participating hospitals must implement new, or significantly enhance existing health care initiatives; to this end, hospitals must identify the CMS and HHS funded initiatives in which they participate, and explain how their proposed DSRIP activities are not duplicative of activities that are already funded.
 - viii. Each individual Hospital DSRIP Plan must report on progress to receive DSRIP funding. Eligibility for DSRIP Payments will be based on successfully meeting metrics associated with approved activities as outlined in the Hospital DSRIP Plans. Hospitals may not receive credit for metrics achieved prior to CMS approval of their Hospital DSRIP Plans.
- h. **Status of DSRIP Payments.** DSRIP payments are not direct reimbursement for expenditures or payments for services. Payments from the DSRIP pool are intended to support and reward hospital systems and other providers for improvements in their delivery systems that support the simultaneous pursuit of improving the experience of care, improving the health of populations, and reducing per capita costs of health care. Payments from the DSRIP Pool are not considered patient care revenue, and shall not be offset against disproportionate share hospital expenditures or other Medicaid expenditures that are related to the cost of patient care (including stepped down costs of administration of such care) as defined under these Special Terms and Conditions, and/or under the State Plan.
- i. **Demonstration Year 2 DSRIP Payments.** Each hospital's DSRIP payments for DY 2 shall equal two-thirds of the following sum: the total amount of the 2013 HRSF Transition Payments it received in DY 1 plus HRSF payments paid to the hospital under the state plan during SFY 2013. In addition, adjustments may be made to each hospital's DSRIP payment to ensure that a floor amount is available to each hospital or to make additional payments available from a supplemental pool, as defined in the Program Funding and Mechanics Protocol. Payments are further contingent on the hospital's submission of a Hospital DSRIP Plan, and its acceptance by the State and CMS. Total DY 2 DSRIP payments to all hospitals combined shall not exceed \$83,300,000.
- i. Upon receiving each Hospital DSRIP Plan, the State will conduct a review to determine whether the plan meets the requirements outlined in the DSRIP Planning Protocol, DSRIP Program Funding and Mechanics Protocol, and these STCs.

- ii. If a hospital's Hospital DSRIP Plan is not accepted by the State and not approved by CMS by January 31, 2014, the State may not claim FFP for DSRIP Payments made to that hospital for DY 2 or any subsequent DY, except under the circumstances described in subparagraph (iv).
- iii. A hospital may receive no more than one-half of its maximum of DY 2 DSRIP Payments (not including payments made during the transition period) upon CMS approval of its Hospital DSRIP Plan, and may receive the remainder based on its performance on metrics included in its approved Hospital DSRIP Plan.
- iv. If either (A) or (B) applies, the State may submit a Hospital DSRIP Plan to CMS no later than September 30, 2014 for a hospital that did not receive approval of a plan under subparagraph (ii), which would allow the hospital to qualify for DSRIP Payments in DY 3 through 5 if approved by CMS. The State must notify CMS at least 30 days in advance of its intention to submit a Hospital DSRIP Plan under this provision.

(A) If a hospital failed to submit a DSRIP plan by September 20, 2013, because of a significant adverse unforeseen circumstance and the hospital's prior year HRSF payment was not less than 0.5% of the hospital's annual Net Patient Service Revenues as shown on the most recent year audited Financial Statements, the Hospital may submit a DSRIP plan. A significant adverse unforeseen circumstance is one not commonly experienced by hospitals.

(B) If a Hospital did not receive approval of its Hospital DSRIP Plan or failed to submit a plan and the hospital received certificate of need approval of a merger, acquisition, or other business combination of a hospital within the State of New Jersey, the hospital may submit a Hospital DSRIP Plan in the year the merger, acquisition, or business combination is completed, provided the successor hospital is a participating provider contracted with all Managed Care Insurers licensed and operating in the State of New Jersey.

j. **Demonstration Years 3 through 5 Payments.** Each hospital with a State and CMS approved Hospital DSRIP Plan may receive DSRIP Payments in DY 3, DY 4, and DY 5. The total amount of DSRIP Payments available to each hospital in DY 3, 4, and 5 will be determined based on the parameters listed below. The determination of weighting factors to be used will be based on discussions with hospital industry as to what will best accelerate meaningful improvement.

- i. Percentage of Medicaid, NJ FamilyCare and Charity Care admissions, patient days, and revenues;
- ii. Trends in absolute percentage changes in the Medicaid, NJ FamilyCare and

Charity Care admissions, patient days, and revenues;

- iii. Trends in absolute percentage changes in the Medicaid, NJ FamilyCare and Charity Care admissions, patient days, and revenues from the base period of budget neutrality measurement; and
- iv. Geographic location: urban vs. suburban.

94. Federal Financial Participation (FFP) For DSRIP. The following terms govern the State's eligibility to claim FFP for DSRIP.

- a. The State may not claim FFP for DSRIP until after CMS has approved the DSRIP Planning Protocol and DSRIP Funding and Mechanics Protocol.
- b. The State may claim FFP for payments to hospitals during the Transition Period in accordance with the provisions of paragraph 92, above. The State may claim FFP for payments to hospitals for submission of their Hospital DSRIP Plans in DY 2 upon approval of those plans by CMS. The State may claim FFP for the remaining DY 2 incentive payments to hospitals on the same conditions applicable to DY 3 through 5 DSRIP Payments as presented in subparagraph (c) below.
- c. The State may not claim FFP for DSRIP Payments in DY 3 through 5 until both the State and CMS have concluded that the hospitals have met the performance indicated for each payment. Hospitals' reports must contain sufficient data and documentation to allow the State and CMS to determine if the hospital has fully met the specified metric, and hospitals must have available for review by the State or CMS, upon request, all supporting data and back-up documentation. FFP will be available only for payments related to activities listed in an approved Hospital DSRIP Plan.
- d. In addition to the documentation discussed in paragraph 91(e), the State must use the documentation discussed in paragraph 93(f)(vii) to support claims made for FFP for DSRIP Payments that are made on the CMS-64.9 Waiver forms.

95. Life Cycle of Five-Year Demonstration. This is a synopsis of anticipated funding pool activities planned for this demonstration.

- a. *Demonstration Year 1 – Planning and Design*
 - i. Payment Type: Transition Payments, in the amounts discussed in paragraph 92(b)
 - ii. The State will work with the hospital industry to establish priorities for the DSRIP program.

- iii The program application, status reports and data books will be developed. These will be submitted to the State annually as part of the hospitals' formal DSRIP application process.
 - iv Starting no later than January 1, 2013, the State must submit to CMS its initial drafts of the DSRIP Planning Protocol and DSRIP Funding and Mechanics Protocol, and CMS, the State, and hospitals will begin a collaborative process to develop and finalize these documents. The State and CMS agree to a target date of February 28, 2013 for CMS to issue its final approval of these protocols.
 - v Hospitals will begin drafting their Hospital DSRIP Plans after the DSRIP Planning Protocol and DSRIP Funding and Mechanics Protocol are approved by CMS.
- b. *Demonstration Year 2 – Transition through December 31, 2013, the Infrastructure Development*
- i Payment Type: Transition Payments through December 31, 2013 and DSRIP Payments thereafter, totaling \$166.6 million. If a hospital does not submit a Hospital DSRIP Plan and application approved by the state and CMS, all of its DY 2 DSRIP payment (not transition payment) must be withheld, consistent with paragraph 93(i).
 - ii On or before September 20, 2013, 2013, Hospitals will submit their initial DSRIP applications, data books and DSRIP plans that will include:
 - a. Infrastructure investments that will be made;
 - b. How it specifically sees these investments leading to efficient and more effective care in accordance with the State's DSRIP vision;
 - c. Baseline performance metrics.
 - iii By December 13, 2013, the State must submit all accepted Hospital DSRIP Plans to CMS, as well as a list of eligible hospitals that will be excluded from DSRIP for failure to submit an acceptable Hospital DSRIP Plan.
 - iv CMS and the State will work diligently to review the Hospital DSRIP Plans, with a goal of making final decisions by January 31, 2014.
 - v Note that hospitals can begin to make infrastructure improvements in this year.
- c. *Demonstration Year 3 – Chronic Medical Condition Redesign and Management Begins*

- i Payment Type: DSRIP totaling \$166.6 million.
- ii Hospitals are fully engaged in infrastructure investments as specified in their DSRIP plans.
- iii Hospitals will begin utilizing them to improve upon the baseline performance data submitted with the DSRIP plan.
- iv Hospitals will submit to the State the semi-annual status of their DSRIP progress and infrastructure developments. A hospital's progress, or lack of progress, will be the determining factor for their receipt of DSRIP Payments over the course of the year.
- v By the end of this year, hospitals will submit a status report on the infrastructure developments and its plan to begin utilizing them. As part of the status report, the hospital will submit updates to performance metrics identified in the DSRIP plan.

d. *Demonstration Year 4 – Quality Improvement and Measurements*

- i. Payment Type: DSRIP totaling \$166.6 million.
- ii. Hospitals' infrastructure improvements are complete or nearly complete.
- iii. Hospitals will update the State on a quarterly basis to demonstrate progress towards the desired outcome measures. A hospital's progress, or lack of progress, will be the determining factor for their receipt of DSRIP Payments over the course of the year.
- iv. Hospitals will submit a status report outlining progress as part of its application for the next demonstration year.

e. *Demonstration Year 5 – Quality Improvement and Measurements*

- i. Payment Type: DSRIP totaling \$166.6 million
- ii. The State reviews the progress hospitals have made on their desired outcomes.
- iii. Initial DSRIP payments for this year will be based on hospitals' overall performances in DY 4 along with any other projects they may want to undertake.
- iv. Hospitals will update the State on a semi-annual basis to demonstrate progress towards the desired outcome measures. A hospital's progress, or lack of progress, will be the determining factor for their receipt of DSRIP payment

over the course of the year

- v. Hospitals will submit a status report on the project five-year DSRIP plan outcome.

96. Limits on Pool Payments. The State can claim FFP for Transition Payments and DSRIP Payments in each DY up to the limits on total computable payments shown in the table below. The \$256.6 million that the State had budgeted to provide to hospitals in the forms of Hospital Relief Subsidy Fund and Graduate Medical Education supplemental payments in SFY 2012 (less amounts paid to hospitals in State plan supplemental payments in SFY 2013) establish the limit on the Transition Payments in DY 1. The \$166.6 million that the State provided to hospitals in SFY 2012 in the form of Hospital Relief Subsidy Fund supplemental payments equals the limit on transition payments plus the DSRIP pool payments in DY 2, then DSRIP payments through DY 5. GME payments made in DY 2 or later under a State plan amendment are not subject to the limits shown below. If the state wishes to change any provision of the DSRIP program, it must submit a waiver amendment to CMS. The waiver amendment must be approved by CMS before any changes are made to the program. Except as permitted under paragraph 93(f)(xii) above, the State may not carry over DSRIP funds from one Demonstration Year to the next.

Pool Allocations According to Demonstration Year (All figures are total computable dollars.)

Type of Pool	DY 1 Approval to 6/30/13	DY 2 7/1/13 to 6/30/14	DY 3 7/1/14 to 6/30/15	DY 4 7/1/15 to 6/30/16	DY 5 7/1/16 to 6/30/17	Totals
DSRIP	n/a	\$83.3 Million	\$166.6 Million	\$166.6 Million	\$166.6 Million	\$583.1 Million
Transition Payments	\$256.6 Million minus State plan supplemental payments in SFY 2013	\$83.3 Million	n/a	n/a	n/a	\$339.9 Million minus State plan supplemental payments in SFY 2013
Total/DY	\$256.6 Million minus State plan supplemental payments in SFY 2013	\$166.6 Million	\$166.6 Million	\$166.6 Million	\$166.6 Million	\$923 Million less SFY 2013 state supplemental payments

97. Transition Plan for Funding Pools No later than June 30, 2016, the State shall submit a transition plan to CMS based on the experience with the DSRIP pool, actual uncompensated care trends in the State, and investment in value based purchasing or other payment reform options.

XIV. GENERAL REPORTING REQUIREMENTS

98. General Financial Requirements. The State must comply with all general financial requirements, including reporting requirements related to monitoring budget neutrality, set forth in section 0 of these STCs. The State must submit any corrected budget and/or allotment neutrality data upon request.

99. MLTSS Data Plan for Quality. The State will collect and submit MLTSS data as follows:

a. Reporting on:

- i. Numbers of beneficiaries receiving HCBS and NF services just prior to implementation;
- ii. Numbers of enrollees receiving HCBS and NF services during each twelve month period;
- iii. HCBS and NF expenditures for MLTSS during a twelve month period as percentages of total long-term services and supports expenditures;
- iv. Average HCBS and NF expenditures per enrollee during a twelve month period;
- v. Average length of stay in HCBS and NFs during a twelve month period
- vi. Percent of new MLTSS enrollees admitted to NFs during a twelve month period
- vii. Number of transitioning individuals from NFs to the community, and the community to NFs, during a twelve month period;
- viii. Other data relevant to system rebalancing;
- ix. The State will assure that appropriate electronic collection of MLTSS data systems will be in place to record identified data elements prior to the implementation of MLTSS.
- x. Baseline data will be submitted to CMS within 18 months of the last day of the twelve month period prior to MLTSS implementation. Thereafter, an electronic copy of the MLTSS data for each demonstration year will be submitted to CMS within a year of the last day of each demonstration year.
- xi. The State will require the MCOs to revise all existing applicable policies and plans for quality to account for MLTSS requirements. Quality measures that need revising and submission at least 45 days prior to implementation

of MLTSS by each MCO.

- xii. The State will also require the MCOs to establish processes and provide assurances to the State regarding access standards described in 42 CFR.438, Subpart D including availability of services, adequate capacity and services, coordination and continuity of care, and coverage and authorization of services.
- xiii. The State Medicaid Agency will make a preliminary selection of HEDIS, OASIS, Medicaid Adult and Child Quality Measures and other performance measures as appropriate, and may adjust the underlying methodology to account for the unique features of the MLTSS. These may include: reductions in NF placements, timely initiation of MLTSS, reduction in hospital readmissions, and percent of Medicaid funding spent on HCBS including MLTSS. The measures will take into consideration particular programs, groups, geographic areas, and characteristics of the MCO.

100. **Monthly Enrollment Report.** Within 20 days following the first day of each month, the State must report via e-mail the demonstration enrollment figures for the month just completed to the CMS Project Officer, the Regional Office contact, and the CMS CAHPG Enrollment mailbox, using the table below.

The data requested under this subparagraph is similar to the data requested for the Quarterly Report in Attachment A, except that they are compiled on a monthly basis.

Demonstration Populations (as hard coded in the CMS 64)	Point In Time Enrollment (last day of month)	Newly Enrolled Last Month	Disenrolled Last Month
MEG			
MEG			
Totals			

101. **Monthly Monitoring Calls.** CMS will convene monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to: transition and implementation activities, health care delivery, enrollment, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, legislative developments, and any demonstration amendments the State is considering submitting. CMS will provide updates on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the demonstration. The State and CMS will jointly develop the agenda for the calls.

102. **Quarterly Progress Reports.** The State must submit quarterly progress reports in accordance with the guidelines in Attachment A no later than 60 days following the end of each quarter. The intent of these reports is to present the State's analysis and the status of the various operational areas. These quarterly reports must include the following, but are not limited to:

- a. An updated budget neutrality monitoring spreadsheet;
- b. A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including, but not limited to: benefits, enrollment and disenrollment, provider enrollment and transition from FFS to managed care complaints and grievances, quality of care, and access that is relevant to the demonstration, pertinent legislative or litigation activity, and other operational issues;
- c. HCBS/MLTSS activities including reporting for each program operating under the demonstration including the PDD pilot program;
- d. Adverse incidents including abuse, neglect, exploitation, morality reviews and critical incidents that result in death;
- e. Action plans for addressing any policy, administrative, or budget issues identified;
- f. Medical Loss Ratio (MLR) reports for each participating MCO;
- g. A description of any actions or sanctions taken by the State against any MCO, SNP, PACE organization, or ASO;
- h. Quarterly enrollment reports for demonstration participants, that include the member months and end of quarter, point-in-time enrollment for each demonstration population, and other statistical reports listed in Attachment A;
- i. Number of participants who chose an MCO and the number of participants who change plans after being auto-assigned;
- j. Hotline Reporting (from MCOs) – Complaints, Grievances and Appeals by type including access to urgent, routine, specialty and MLTSS; and,
- k. Evaluation activities and interim findings.

103. **Annual Report.**

- a. The State must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the demonstration.

- b. The State must submit the draft annual report no later than 120 days after the close of the demonstration year (DY).
- c. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.
- d. Elements of the Annual report should include:
 - i. A report of service use by program including each HCBS program (encounter data);
 - ii. a summary of the use of self-directed service delivery options in the State;
 - iii. a general update on the collection, analysis and reporting of data by the plans at the aggregate level;
 - iv. monitoring of the quality and accuracy of screening and assessment of participants who qualify for HCBS/MLTSS;
 - v. GEO access reports from each participating MCO;
 - vi. waiting list(s) information by program including number of people on the list and the amount of time it takes to reach the top of the list where applicable;
 - vii. the various service modalities employed by the State, including updated service models, opportunities for self-direction in additional program, etc.;
 - viii. specific examples of how HCBS have been used to assist participants;
 - ix. a description of the intersection between demonstration MLTSS and any other State programs or services aimed at assisting high-needs populations and rebalancing institutional expenditures (e.g. New Jersey's Money Follows the Person demonstration, other Federal grants, optional Medicaid Health Home benefit, behavioral health programs, etc.);
 - x. A summary of the outcomes of the State's Quality Strategy for HCBS as outlined above;
 - xi. Efforts and outcomes regarding the establishment of cost-effective MLTSS in community settings using industry best practices and guidelines;
 - xii. policies for any waiting lists where applicable;
 - xiii. Other topics of mutual interest between CMS and the State related to the HCBS included in the demonstration;

- xiv. The State may also provide CMS with any other information it believes pertinent to the provision of the HCBS and their inclusion in the demonstration, including innovative practices, certification activity, provider enrollment and transition to managed care special populations, workforce development, access to services, the intersection between the provision of HCBS and Medicaid behavioral health services, rebalancing goals, cost-effectiveness, and short and long-term outcomes.
- xv. A report of the results of the State's monitoring activities of critical incident reports
- xvi. An updated budget neutrality analysis, incorporating the most recent actual data on expenditures and member months, with updated projections of expenditures and member months through the end of the demonstration, and proposals for corrective action should the projections show that the demonstration will not be budget neutral on its scheduled end date.

XVI. ADMINISTRATIVE REQUIREMENTS

104. General Requirements

- a. **Medicaid Administrative Requirements.** Unless otherwise specified in these STCs, all processes (e.g., eligibility, enrollment, redeterminations, terminations, appeals) must comply with Federal law and regulations governing Medicaid program.
- b. **Facilitating Medicaid Enrollment.** The State must screen new applicants for Medicaid eligibility, and if determined eligible, enroll the individual in Medicaid, and must screen current the General Assistance participants at least annually upon recertification / renewal of enrollment.
 - i. The State must ensure that new applicants for the New Jersey Childless Adults demonstration who meet the categorical requirements for Medicaid will be processed and enrolled in the State's Medicaid program. The application packets for the New Jersey Childless Adults program must continue to provide information regarding Medicaid eligibility and application that is subject to CMS review.

XVII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

- 105. **Reporting Expenditures under the Demonstration.** The State will provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures

applicable to services rendered during the demonstration period. The CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs. FFP will be provided for expenditures net of collections in the form of pharmacy rebates, cost sharing, or third party liability.

- a. **Use of Waiver Forms.** In order to track expenditures under this demonstration, the State must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All demonstration expenditures claimed under authority of title XIX and section 1115 and subject to the budget neutrality expenditure limit (as defined in Section XVIII below) must be reported on separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration Project Number assigned by CMS.
- b. **Reporting by Demonstration Year (DY) by Date of Service.** In each quarter, demonstration expenditures (including prior period adjustments) must be reported separately by DY (as defined in subparagraph (h) below). Separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted for each DY for which expenditures are reported. The DY is identified using the Project Number Extension, which is a 2-digit number appended to the Demonstration Project Number. Capitation and premium payments must be reported in the DY that includes the month for which the payment was principally made. Pool payments are subject to annual limits by DY, and must be reported in DY corresponding to the limit under which the payment was made. All other expenditures must be assigned to DYs according to date of service,
- c. **Use of Waiver Names.** In each quarter, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted for the following categories of expenditures, identified using the Waiver Names shown in “quotes.” Waiver Names (i) through (xiii) are to be used to report all expenditures for individuals identified with those names in the MEG columns in the tables in paragraph 22, except as noted. For the other Waiver Names, a description of the expenditures to be reported is included in each subparagraph.
 - i. “Title XIX”
 - ii. “ABD”
 - iii. “LTC” This waiver name will be used following the transition to MLTSS.
 - iv. “HCBS (State plan)”: Excludes expenditures described in subparagraphs (xiv) through (xvii)
 - v. “HCBS (217-like)”: Excludes expenditures described in subparagraphs (xviii) through (xxi)
 - vi. “SED (217-like)”

- vii. “IDD/MI (217-like)”
- viii. “NJ childless adults
- ix. “XIX CHIP Parents”
- x. “AWDC”
- xi. “SED At Risk”
- xii. “MATI At Risk”
- xiii. “TBI 1915(c) SP”: Expenditures for HCBS services provided to non-435.217 eligibles under TBI 1915(c) waiver with dates of service from October 1, 2012 through transition to MLTSS are to be reported here.
- xiv. “ACCAP 1915(c)”: Expenditures for HCBS services provided to non-435.217 eligibles under ACCAP 1915(c) waiver with dates of service from October 1, 2012 through transition to MLTSS are to be reported here.
- xv. “CRPD 1915(c)”: Expenditures for HCBS services provided to non-435.217 eligibles under CRPD 1915(c) waiver with dates of service from October 1, 2012 through transition to MLTSS are to be reported here.
- xvi. “GO 1915(c)”: Expenditures for HCBS services provided to non-435.217 eligibles under GO 1915(c) waiver with dates of service from October 1, 2012 through transition to MLTSS are to be reported here.
- xvii. “TBI 1915(c) 217”: Expenditures for HCBS services provided to 435.217 eligibles under TBI 1915(c) waiver with dates of service from October 1, 2012 through transition to MLTSS are to be reported here
- xviii. “ACCAP 1915(c) 217”: Expenditures for HCBS services provided to 435.217 eligibles under ACCAP 1915(c) waiver with dates of service from October 1, 2012 through transition to MLTSS are to be reported here
- xix. “CRPD 1915(c) 217”: Expenditures for HCBS services provided to 435.217 eligibles under CRPD 1915(c) waiver with dates of service from October 1, 2012 through transition to MLTSS are to be reported here
- xx. “GO 1915(c) 217”: Expenditures for HCBS services provided to 435.217 eligibles under GO 1915(c) waiver with dates of service from October 1, 2012 through transition to MLTSS are to be reported here.
- xxi. “Transition HRSF and GME”: 2013 HRSF Transition Payments and GME are to be reported here.

- xxii. “State Plan GME”: GME payments made under a State plan amendment described in paragraph 92(h) are to be reported here.
- xxiii. “DSRIP”: All DSRIP Payments are to be reported here.
- d. For monitoring purposes, cost settlements related to demonstration expenditures must be recorded on Line 10.b, in lieu of Lines 9 or 10.c. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10.c, as instructed in the State Medicaid Manual.
- e. **Pharmacy Rebates.** By November 30, 2012, the State must propose a methodology to CMS for assigning a portion of pharmacy rebates to the demonstration, in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which reasonably identifies pharmacy rebate amounts with DYs and with MEGs. Pharmacy rebates cannot be reported on Waiver forms for budget neutrality purposes until an assignment methodology is approved by the CMS Regional Office. Changes to the methodology must also be approved in advance by the Regional Office. The portion of pharmacy rebates assigned to the demonstration using the approved methodology will be reported on the appropriate Forms CMS-64.9 Waiver for the demonstration and not on any other CMS 64.9 form to avoid double-counting.
- f. **Premium and Cost Sharing Adjustments.** Premiums and other applicable cost-sharing contributions that are collected by the State from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet Line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and Federal share) should also be reported separately by demonstration Year on the Form CMS-64 Narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to demonstration populations will be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration’s actual expenditures on a quarterly basis.
- g. **Mandated Increase in Physician Payment Rates in 2013 and 2014.** Section 1202 of the Health Care and Education Reconciliation Act of 2010 (Pub. Law 110-152) requires State Medicaid programs to reimburse physicians for primary care services at rates that are no less than what Medicare pays, for services furnished in 2013 and 2014, with the Federal Government paying 100 percent of the increase. The entire amount of this increase will be excluded from the budget neutrality test for this demonstration. The specifics of separate reporting of these expenditures will be described in guidance to be issued by CMS at a later date,
- h. **Demonstration Years.** The first Demonstration Year (DY1) will be the year effective date of the approval letter through June 30, 2017, and subsequent DYs will be defined as follows:

Demonstration Year 1 (DY1)	October 1, 2012 to June 30,	9 months
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	2013	
Demonstration Year 2 (DY2)	July 1, 2013 to June 30, 2014	12 months
Demonstration Year 3 (DY3)	July 1, 2014 to June 30, 2015	12 months
Demonstration Year 4 (DY4)	July 1, 2015 to June 30, 2016	12 months
Demonstration Year 5 (DY5)	July 1, 2016 to June 30, 2017	12 months

106. **Expenditures Subject to the Budget Agreement.** For the purpose of this section, the term “expenditures subject to the budget neutrality limit” will include the following:
- a. All medical assistance expenditures (including those authorized in the Medicaid State plan, through section 1915(c) waivers, and through section 1115 waivers and expenditure authorities, but excluding the increased expenditures resulting from the mandated increase in payments to physicians) made on behalf of all demonstration participants listed in the table in paragraph 22, with dates of service within the demonstration’s approval period;
 - b. GME payments made under a State plan amendment described in paragraph 92(h) and
 - c. All Transition Payments and DSRIP Payments.
107. **Administrative Costs.** Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the demonstration, using separate CMS-64.10 waiver and 64.10 waiver forms, with waiver name “ADM”.
108. **Claiming Period.** All claims for expenditures subject to the budget neutrality limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the Form CMS-64 in order to properly account for these expenditures in determining budget neutrality.
109. **Reporting Member Months.** For the purpose of calculating the budget neutrality expenditure limit and other purposes, the State must provide to CMS on a quarterly basis the actual number of eligible member/months for demonstration participants. Enrollment information should be provided to CMS in conjunction with the quarterly and monthly enrollment reports referred to in section XV of these STCs. If a quarter overlaps the end of one DY and the beginning of another DY, member/months pertaining to the first DY must be distinguished from those pertaining to the second.
- a. The term “eligible member/months” refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member/months to the total. Two individuals who are eligible

for 2 months each contribute two eligible member months to the total, for a total of four eligible member/months.

- b. The demonstration populations will be reported for the purpose of calculating the without waiver baseline (budget neutrality expenditure limit) using the following Waiver Names, following the cross-walk shown in paragraph 22:
 - i. Title XIX,
 - ii. ABD,
 - iii. LTC (Reporting for this waiver name will begin following the transition to MLTSS),
 - iv. HCBS (State plan),
 - v. NJ Childless Adults (July-March only)
 - vi. NJ Childless Adults (April-June only)
 - vii. HCBS (217-like),
 - viii. SED (217-like),
 - ix. IDD/MI (217-like), and
 - x. XIX CHIP Parents (October-December 2013 only).

110. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used during the demonstration. The State must estimate matchable Medicaid expenditures on the quarterly Form CMS-37. As a supplement to the Form CMS-37, the State will provide updated estimates of expenditures subject to the budget neutrality limit. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 quarterly with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

111. **Extent of FFP for the Demonstration.** The CMS will provide FFP at the applicable Federal matching rate for the following, subject to the limits described in paragraph 133:Section XVIII:

- a. Administrative costs, including those associated with the administration of the demonstration.

- b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State plan.
- c. Medical Assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

112. **Sources of Non-Federal Share.** The State certifies that the matching non-Federal share of funds for the demonstration is State/local monies. The State further certifies that such funds shall not be used as the match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

- a. CMS may review the sources of the non-Federal share of funding for the demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
- b. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

113. **State Certification of Funding Conditions.** Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the State as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the State government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes—including health care provider-related taxes—fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

XVIII GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI

114. The State shall provide quarterly expenditure reports using the Form CMS-21 to report total expenditures for services provided under the approved CHIP plan and those provided through the New Jersey demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS will provide Federal financial participation (FFP) only for allowable New Jersey demonstration expenditures that do not exceed the State's available title XXI funding.

115. In order to track expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-21 reporting instructions outlined in section 2115 of the State Medicaid Manual. Title XXI

demonstration expenditures will be reported on separate Form CMS-64-21U Waiver and/or CMS-21P Waiver, identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services rendered or for which capitation payments were made). All expenditures under this demonstration must be reported on separate Forms CMS-21 Waiver and/or CMS-21P Waiver for each of the demonstration populations using the information in the drop-down listing as follows:

- a. CHIP Expansion Children up to 133 percent of the FPL
 - b. CHIP Parents/Caretakers above AFDC limit up to and including 133 percent of the FPL
 - c. CHIP Parents/Caretakers 134 up to and including 200 percent of the FPL
 - d. Premium Support Program
116. All claims for expenditures related to the demonstration (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the Form CMS-21.
117. The standard CHIP funding process will be used during the demonstration. New Jersey must estimate matchable CHIP expenditures on the quarterly Form CMS-21B. As a footnote to the CMS 21B, the State shall provide updated estimates of expenditures for the demonstration populations. CMS will determine the availability of Federal funds based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-21 quarterly CHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-21 with Federal funding previously made available to the State, and including the reconciling adjustment in the finalization of the grant award to the State, if appropriate.
118. The State will certify State/local monies used as matching funds for the demonstration and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.
119. New Jersey will be subject to a limit on the amount of Federal title XXI funding that the State may receive on demonstration expenditures during the demonstration period. Federal title XXI funding available for demonstration expenditures is limited to the State's available allotment, including currently available reallocated funds. Should the State expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of the approved title XXI child health program or

demonstration until the next allotment becomes available.

120. Total Federal title XXI funds for the State's CHIP program (i.e., the approved title XXI State plan and this demonstration) are restricted to the State's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with the State plan population. Demonstration expenditures are limited to remaining funds.
121. Total expenditures for outreach and other reasonable costs to administer the title XXI State plan and the demonstration that are applied against the State's title XXI allotment may not exceed 10 percent of total title XXI expenditures.
122. If the State exhausts the available title XXI Federal funds for the claiming period, the State will continue to provide coverage to the approved title XXI State plan separate child health program population and to the Uninsured custodial parents and caretaker relatives of Medicaid and CHIP children with incomes above the previous Medicaid standard up to and including 133 percent of the FPL and the uninsured custodial parents and caretaker relatives with income at or above 134 percent of the FPL, and up to and including 200 percent of the FPL. Title XIX Federal matching funds will be provided for these populations when title XXI allotment is no longer available after September 30, 2013, pursuant to the State's budget neutrality monitoring agreement, appended as Attachment C of this document.
123. The State shall provide CMS with 60 days notification before it begins to draw down title XIX matching funds for Medicaid expansion if appropriate, in accordance with the terms of the demonstration.
124. All Federal rules shall continue to apply during the period of the demonstration that title XXI Federal funds are not available. The State may close enrollment or institute a waiting list with respect to Uninsured custodial parents and caretaker relatives of Medicaid and CHIP children with incomes above the previous Medicaid standard up to and including 133 percent of the FPL and the uninsured custodial parents and caretaker relatives with income at or above 134 percent of the FPL, and up to and including 200 percent of the FPL upon 60 days' notice to CMS.

XIX. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

125. **Limit on Title XIX Funding.** The State will be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using the per capita cost method described in paragraph 128, and budget neutrality expenditure limits are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the State to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the State's compliance with these annual limits will be done using the Schedule C report from the CMS-64.

126. **Risk.** The State will be at risk for the per capita cost (as determined by the method described below) for state plan and hypothetical populations, but not at risk for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration populations, CMS will not place the State at risk for changing economic conditions. However, by placing the State at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.

127. **Calculation of the Budget Neutrality Limit and How It Is Applied.** For the purpose of calculating the overall budget neutrality limit for the demonstration, separate annual budget limits will be calculated for each DY on a total computable basis, by multiplying the predetermined PMPM cost for each EG (shown on the table in paragraph 127) by the corresponding actual member months total, and summing the results of those calculations. The annual limits will then be added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality limit by Composite Federal Share 1, which is defined in paragraph 133 below. The demonstration expenditures subject to the budget neutrality limit are those reported under the following Waiver Names (Title XIX, ABD, LTC, HCBS (State plan), AWDC, SED At Risk, MATI At Risk, TBI 1915(c) SP, ACCAP 1915(c) SP, CRPD 1915(c) SP, GO 1915(c) SP, Transition HRSF, Transition GME, State Plan GME, DSRIP), plus any excess spending from the Hypotheticals Test described in paragraph 130.

128. **Impermissible DSH, Taxes, or Donations.** CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of laws and policy statements, including regulations and letters regarding impermissible provider payments, health care related taxes, or other payments (if necessary adjustments must be made). CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

129. The trend rates and per capita cost estimates for each EG for each year of the demonstration are listed in the table below. The PMPM cost estimates are based on actual Medicaid PMPM costs in SFY 2012, trended forward using trends based on the lower of state historical trends from SFY 2006 to 2008 and the FFY 2012 President’s Budget trends. Year-to-year changes in the ABD MEG differ from the stated percentage in the early years of the demonstration due to the effect of adjustments made to the PMPMs after trending.

MEG	TREND	DY 1 - PMPM	DY 2 – PMPM	DY3 – PMPM	DY4 – PMPM	–DY5 – PMPM
Title XIX	5.8%	\$327.03	\$346.00	\$366.07	\$387.30	\$409.76
ABD	3.6%	\$1,045.04	\$1,123.36	\$1,163.80	\$1,205.69	\$1,249.10

LTC	3.9%	\$8,636.81	\$8,973.64	\$9,323.62	\$9,687.24	\$10,065.04
HCBS (State Plan)	3.7%	\$2,256.69	\$2,340.19	\$2,426.78	\$2,516.57	\$2,609.68

130. **Hypothetical Eligibility Groups and the Hypotheticals Test.** Budget neutrality agreements may include optional Medicaid populations that could be added under the State plan but have not been and are not included in current expenditures. However, the agreement will not permit accumulate or access to budget neutrality "savings." A prospective per capita cap on Federal financial risk is established for these groups based on the costs that the population is expected to incur under the demonstration.

a. The MEGs listed in the table below are the hypothetical groups.

MEG	TREND	DY 1 – PMPM	DY 2 – PMPM	DY3 – PMPM	DY4 – PMPM	–DY5 – PMPM
HCBS (217-like)	3.7%	\$2,256.69	\$2,340.19	\$2,426.78	\$2,516.57	\$2,609.68
SED (217-like)	6.0%	\$2,246.37	\$2,381.15	\$2,524.02	\$2,675.46	\$2,835.99
IDD/MI (217-like)	6.0%	\$9,839.39	\$10,429.75	\$11,055.53	\$11,718.87	\$12,422.00
Employable AND Unemployable	3.7%	\$277.00 (October 2012- March 2013)	\$288.00 (July- December 2013)			
Employable AND Unemployable	3.7%	\$288.00 (April- June 2013)				
XIX CHIP Parents			\$307.24 (October- December 2013)			

b. The Hypotheticals Cap is calculated by taking the PMPM cost projection for each group and in each DY times the number of eligible member months for that group in that DY, and adding the products together across groups and DYs. The Federal share of the Hypotheticals Cap is obtained by multiplying the Hypotheticals Cap by the Composite Federal Share 2.

c. The Hypotheticals Test is a comparison between the Federal share of the Hypotheticals Cap and total FFP reported by the State for hypothetical groups under the following Waiver Names (HCBS (217-like), SED (217-like), IDD/MI (217-like), Employable, Unemployable, XIX CHIP Parents, TBI 1915(c) 217, ACCAP 1915(c) 217, CRPD 1915(c) 217, GO 1915(c) 217).

d. If total FFP for hypothetical groups should exceed the Federal share of the

Hypotheticals Cap, the difference must be reported as a cost against the budget neutrality limit described in paragraph 10927 of these STCs.

131. **Composite Federal Share Ratios.** The Composite Federal Share is the ratio calculated by dividing the sum total of Federal financial participation (FFP) received by the State on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. There are two Composite Federal Share Ratios for this demonstration: Composite Federal Share 1, based on the expenditures reported under the Waiver Names listed in paragraph 127, and Composite Federal Share 2, based on paragraph 130(c). For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.
132. **Exceeding Budget Neutrality.** The budget neutrality limits calculated in paragraphs 127 and 130 will apply to actual expenditures for demonstration services as reported by the State under section XV of these STCs. If at the end of the demonstration period the budget neutrality limit has been exceeded, the excess Federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the demonstration period, the budget neutrality test will be based on the time period through the termination date.
133. **Enforcement of Budget Neutrality.** If the State exceeds the calculated cumulative target limit by the percentage identified below for any of the DYs, the State shall submit a corrective action plan to CMS for approval. .

Year	Cumulative target definition	Percentage
DY 1	Cumulative budget neutrality cap plus:	0.25 percent
DY 2	Cumulative budget neutrality cap plus:	0.25 percent
DY 3, 4, & 5	Cumulative budget neutrality cap plus:	0 percent

XX. EVALUATION OF THE DEMONSTRATION

134. **Submission of a Draft Evaluation Design.** The State shall submit to CMS for approval a draft Evaluation Design for an overall evaluation of the demonstration no later than 120 days after CMS approval of the demonstration. The draft Evaluation Design must include a discussion of the goals, objectives, and specific hypotheses that are being tested, and identify outcome measures that shall be used to evaluate the demonstration’s impact. It shall discuss the data sources, including the use of Medicaid encounter data, and sampling methodology for assessing these outcomes. The draft Evaluation Design must describe how the effects of the demonstration will be isolated from other initiatives occurring in the State. The draft

Evaluation Design shall identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

- a. Domains of Focus. The Evaluation Design must, at a minimum, address the research questions listed below. For questions that cover broad subject areas, the State may propose a more narrow focus for the evaluation.
 - i What is the impact of the managed care expansion on access to care, the quality, efficiency, and coordination of care, and the cost of care?
 - ii What is the impact of including long-term care services in the capitated managed care benefit on access to care, quality of care, and mix of care settings employed?
 - iii What is the impact of the hypothetical spend-down provision on the Medicaid eligibility and enrollment process? What economies or efficiencies were achieved, and if so, what were they? Was there a change in the number of individuals or on the mix of individuals qualifying for Medicaid due to this provision?
 - iv What is the impact of using self-attestation on the Transfer of assets look-back period of long term care and home and community based services for individuals who are at or below 100 percent of the FPL. Was there a change in the number of individuals or on the mix of individuals qualifying for Medicaid due to this provision?
 - v What is the impact of providing additional home and community-based services to Medicaid and CHIP beneficiaries with serious emotional disturbance, opioid addiction, pervasive developmental disabilities, or intellectual disabilities/developmental disabilities?
 - vi What is the impact of the program to provide a safe, stable, and therapeutically supportive environment for children from age 5 up to age 21 with serious emotional disturbance who have, or who would otherwise be at risk for, institutionalization?
 - vii What is the impact of providing adults who do not qualify for Medicaid or the Work First Childless Adults population with outpatient treatment for their opioid addiction or mental illness?
 - viii Was the DSRIP program effective in achieving the goals of better care for individuals (including access to care, quality of care, health outcomes), better health for the population, or lower cost through improvement? To what degree can improvements be attributed to the activities undertaken under DSRIP?
 - ix What is the impact of the transition from supplemental payments to DSRIP on hospitals' finances and the distribution of payments across hospitals?

- iv. What do key stakeholders (covered individuals and families, advocacy groups, providers, health plans) perceive to be the strengths and weaknesses, successes and challenges of the expanded managed care program, and of the DSRIP pool? What changes would these stakeholders recommend to improve program operations and outcomes?
- b. Evaluation Design Process: Addressing the research questions listed above will require a mix of quantitative and qualitative research methodologies. When developing the DSRIP Planning Protocol, the State should consider ways to structure the different projects that will facilitate the collection, dissemination, and comparison of valid quantitative data to support the Evaluation Design. From these, the State must select a preferred research plan for the applicable research question, and provide a rationale for its selection.

To the extent applicable, the following items must be specified for each design option that is proposed:

- i. Quantitative or qualitative outcome measures;
 - ii. Baseline and/or control comparisons;
 - iii. Process and improvement outcome measures and specifications;
 - iv. Data sources and collection frequency;
 - v. Robust sampling designs (e.g., controlled before-and-after studies, interrupted time series design, and comparison group analyses);
 - vi. Cost estimates;
 - vii. Timelines for deliverables.
- c. Levels of Analysis: The evaluation designs proposed for each question may include analysis at the beneficiary, provider, and aggregate program level, as appropriate, and include population stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups. In its review of the draft evaluation plan, CMS reserves the right to request additional levels of analysis.

135. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft Evaluation Design within 60 days of receipt, and the State shall submit a final Evaluation Design within 60 days after receipt of CMS comments. The State shall implement the Evaluation Design and submit its progress in each of the quarterly and annual reports.

136. **Evaluation Reports.**

- a. **Interim Evaluation Report.** The State must submit a Draft Interim Evaluation Report by July 1, 2016, or in conjunction with the State’s application for renewal of the demonstration, whichever is earlier. The purpose of the Interim Evaluation Report is to present preliminary evaluation findings, and plans for completing the evaluation design and submitting a Final Evaluation Report according to the schedule outlined in (b). The State shall submit the final Interim Evaluation Report within 60 days after receipt of CMS comments.
- b. **Final Evaluation Report.** The State shall submit to CMS a draft of the Final Evaluation Report by July 1, 2017. The State shall submit the final evaluation report within 60 days after receipt of CMS comments.

137. **Cooperation with Federal Evaluators.** Should CMS undertake an independent evaluation of any component of the demonstration, the State shall cooperate fully with CMS or the independent evaluator selected by CMS. The State shall submit the required data to CMS or the contractor.

XXI. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Date	Deliverable	Paragraph
Administrative		
30 days after approval date	State acceptance of demonstration Waivers, STCs, and Expenditure Authorities	Approval letter
30 days prior to implementation	Termination of authority notice regarding the 1915(c) waivers	Paragraph 62
30 days after approval date	Termination of authority notice regarding the 1915(b) waivers	
30 days after approval date	Termination of authority notice regarding the existing section 1115 demonstrations	
120 days after approval date	Submit Draft Design for Evaluation Report	Paragraph 134
See quality section STC	A revised Quality Strategy	Paragraph 85
60 days prior to (August 1, 2013)	Letter notifying CMS of transition from title XXI funds to title XIX funds	Paragraph 123
July 1, 2013	ACA Transition Plan	Paragraph
July 1, 2016, or with renewal application	Submit Draft Interim Evaluation Report	Paragraph 136(a)
60 days after receipt of CMS comments	Submit Final Interim Evaluation Report	Paragraph 136(a)

July 1, 2017	Submit Draft Final Evaluation Report	Paragraph 136(b)
60 days after receipt of CMS comments	Submit Final Evaluation Report	Paragraph 136(b)
DSRIP Pool		
	Medicaid State plan amendment to remove supplemental payments from the State Plan	Paragraph 91
	DSRIP Planning Protocol	Paragraph 93
	Submit a Transition Plan for DSRIP Pool	Paragraph 93
	DSRIP Plan	Paragraph 93
HCBS/MLTSS		
90days prior to implementation	MLTSS Transition Plan	Paragraph 63
30 days prior the implementation of MLTSS	Readiness Review Plan for the MLTSS	Paragraph 64
Monthly Deliverables	Monitoring Call	Paragraph 101
	Monthly Enrollment Report	Paragraph 100
Quarterly Deliverables Due 60 days after end of each quarter, except 4 th quarter	Quarterly Progress Reports	Paragraph 102 and Attachment A
	Quarterly Expenditure Reports	Paragraph 105
Annual Deliverables - Due 120 days after end of each 4 th quarter	Annual Reports	Paragraph 103 and Attachment A

ATTACHMENT A

Pursuant to paragraph 102 (*Quarterly Progress Report*) of these STCs, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook must be provided.

NARRATIVE REPORT FORMAT:

Title Line One –New Jersey Comprehensive Waiver Demonstration

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example: Demonstration Year: 1 (4/1/2011 – 3/31/2012)

Federal Fiscal Quarter: 3/2011 (4/11 - 7/11)

Footer: Date on the approval letter through June 30, 2017

I. Introduction

Present information describing the goal of the demonstration, what it does, and the status of key dates of approval/operation.

II. Enrollment and Benefits Information

Discuss the following:

- Trends and any issues related to eligibility, enrollment, disenrollment, access, and delivery network.
- Any changes or anticipated changes in populations served and benefits. Progress on implementing any demonstration amendments related to eligibility or benefits.

Please complete the following table that outlines all enrollment activity under the demonstration. The State should indicate “N/A” where appropriate. If there was no activity under a particular enrollment category, the State should indicate that by “0”.

III. Enrollment Counts for Quarter

Note: Enrollment counts should be unique enrollee counts, not member months

Demonstration Populations by MEG	Total Number of Demonstration participants Quarter Ending – MM/YY	Total Number of Demonstration participants Quarter Ending – MM/YY	Total Number of Demonstration participants Quarter Ending – MM/YY	Total Number of Demonstration participants Quarter Ending – MM/YY
Title XIX				
ABD				
LTC				
HCBS (State plan)				
HCBS (217-like)				
SED (217-like)				
IDD/MI (217-like)				
NJ childless adults				
AwDC				
XIX CHIP Parents				
SED At Risk				
MATI At Risk				
Title XXI Exp Child				
XIX CHIP Parents				
XIX CHIP Parents				

IV. Outreach/Innovative Activities to Assure Access

Summarize marketing, outreach, or advocacy activities to potential eligibles and/or promising practices for the current quarter to assure access for demonstration participants or potential eligibles.

V. Collection and Verification of Encounter Data and Enrollment Data

Summarize any issues, activities, or findings related to the collection and verification of encounter data and enrollment data.

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

A status update that identifies all other significant program developments/issues/problems that have occurred in the current quarter or are anticipated to occur in the near future that affect health care delivery, including but not limited to program development, quality of care, approval

and contracting with new plans, health plan contract compliance and financial performance relevant to the demonstration, fiscal issues, systems issues, and pertinent legislative or litigation activity.

VII. Action Plans for Addressing Any Issues Identified

Summarize the development, implementation, and administration of any action plans for addressing issues related to the demonstration. Include a discussion of the status of action plans implemented in previous periods until resolved.

VIII. Financial/Budget Neutrality Development/Issues

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 and budget neutrality reporting for the current quarter. Identify the State’s actions to address these issues.

IX. Member Month Reporting

Enter the member months for each of the EGs for the quarter.

A. For Use in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Title XIX				
ABD				
LTC (following transition to MLTSS)				
HCBS (State plan)				
HCBS (217-like)				
SED (217-like)				
IDD/MI (217-like)				
NJ childless adults				
AwDC				
SED At Risk				
MATI At Risk				
Title XXI Exp Child				
XIX CHIP Parents				
XIX CHIP Parents				

X. Consumer Issues

A summary of the types of complaints or problems consumers identified about the program or grievances in the current quarter. Include any trends discovered, the resolution of complaints or grievances, and any actions taken or to be taken to prevent other occurrences.

XI. Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity or any other quality of care findings and issues in current quarter.

XII. Demonstration Evaluation

Discuss progress of evaluation plan and planning, evaluation activities, and interim findings.

XIII. Enclosures/Attachments

Identify by title the budget neutrality monitoring tables and any other attachments along with a brief description of what information the document contains.

XIV. State Contact(s)

Identify the individual(s) by name, title, phone, fax, and address that CMS may contact should any questions arise.

XV. Date Submitted to CMS.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850



AUG 08 2013

Commissioner Jennifer Velez
Department of Human Services
State of New Jersey
P. O. Box 700
Trenton, NJ 08625-0700

Dear Commissioner Velez:

Thank you to you and your staff for your work on the protocols for the Delivery System Reform Incentive Payment (DSRIP) pool, which is a component of the New Jersey's section 1115 demonstration, entitled "New Jersey Comprehensive Waiver." CMS approves the enclosed Planning Protocol and Program Funding and Mechanics Protocol, which will be incorporated into the Special Terms and Conditions for the demonstration as Attachments G and H, respectively.

We look forward to continuing our collaboration with respect to DSRIP, and we are confident that our efforts and those of the participating hospitals will result in significant improvement in the health care available the state's Medicaid and low income populations.

If you have additional questions or concerns, please contact your assigned project officer, Mr. Ed Francell. His contact information is as follows:

Ed Francell
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-1342
E-mail: Ed.Francell@cms.hhs.gov

Official communications regarding program matters should also be sent simultaneously to Mr. Michael Melendez, Associate Regional Administrator for our New York Regional Office. His contact information is as follows:

Mr. Michael Melendez
Associate Regional Administrator
Division of Medicaid and Children's Health Operations
26 Federal Plaza, Room 37-100 North

New York, NY 10278
Phone: (212)616-2430
Facsimile: (212)312-8652
Email: Michael.Melendez@cms.hhs.gov

We look forward to continuing to work together to insure that the investment we have made contributes to meaningful transformation of the health care delivery system within the demonstration period.

Sincerely,



Cindy Manh
Director

cc: Michael Melendez, ARA, CMS New York Regional Office

STATE OF NEW JERSEY DEPARTMENT OF HEALTH

Section 93(e) of the Special Terms and Conditions (STCs) for New Jersey's "Comprehensive Waiver" section 1115(a) Medicaid and Children's Health Insurance Plan (CHIP) demonstration operated by the New Jersey Department of Human Services, Division of Medical Assistance and Health Services requires the development of "a DSRIP Planning Protocol" to be submitted to CMS for approval. The Department of Health designed and shall administer the DSRIP program. This document represents the Department's final draft to the Centers for Medicaid & Medicaid Services (CMS).

*Delivery System
Reform Incentive
Payment (DSRIP)
Program Planning
Protocol*

Version 0.9- 07-30-2013

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I. Preface

A. Delivery System Reform Incentive Payment Program

The Delivery System Reform Incentive Payment (DSRIP) Program is one component of New Jersey's Comprehensive Medicaid Waiver as approved by the Centers for Medicare & Medicaid Services (CMS) in October 2012. DSRIP seeks to result in better care for individuals (including access to care, quality of care, health outcomes), better health for the population, and lower cost through improvement by transitioning funding from the current Hospital Relief Subsidy Fund (HRSF) to a model where payment is contingent on achieving health improvement goals by hospitals. Hospitals designated as DSRIP participating hospitals will receive 2013 HRSF Transition Payments in demonstration year (DY) 1 and in July through December 2013 of DY2. The DSRIP Funding Pool is available after the Transition Payment period through the end of DY5 for the development of a project which includes activities that support the hospitals' efforts to enhance access to health care, the quality of care, and the health of the patients and families they serve.

The project activities funded by the DSRIP Program will be those activities that are directly responsive to the needs and characteristics of the populations and communities served by each hospital. Each participating hospital will develop a Hospital DSRIP Plan, consistent with this DSRIP Planning Protocol, that is rooted in the intensive learning and sharing that will accelerate meaningful improvement. The individual Hospital DSRIP Plan will be consistent with the hospital's mission and quality goals, as well as CMS's overarching approach for improving health care through the simultaneous pursuit of three aims: better care for individuals (including access to care, quality of care, and health outcomes), better health for the population, and lower cost through improvement (without any harm whatsoever to individuals, families or communities). In its Hospital DSRIP Plan, each hospital will describe how it will carry out a project that is designed to improve the quality of care provided, the efficiency with which care is provided, and the overall population health.

Hospitals may qualify to receive incentive payments (DSRIP payments) for fully meeting performance and outcome metrics (as specified in this Planning Protocol, as well as the Funding and Mechanics Protocol), which represent measurable, incremental steps toward the completion of project activities, or demonstration of their impact on health system performance or quality of care.

B. DSRIP Planning Protocol and Program Funding and Mechanics Protocol

This document is the DSRIP Planning Protocol submitted for approval by the New Jersey Department of Human Services to the Centers for Medicare &

Medicaid Services. This document is Version 0.8, dated July 10, 2013. Please also refer to the accompanying Attachment 1: DSRIP Toolkit containing the framework for each project, the clinical and quality protocols developed for this initiative, as well as the reporting requirements for the DSRIP Program.

C. High Level Organization of “Attachment H: Planning Protocol”

Attachment H has been organized into the following sections.

- I. Preface
- II. DSRIP Eligibility Criteria
- III. Global Context, Goals, and Outcomes
- IV. Project Stages
- V. DSRIP Project Array
- VI. Stage 3 Measures (Project-Specific Metrics)
- VII. Stage 4 Measures (Universal Metrics)
- VIII. Requirements of the Hospital DSRIP Plans
- IX. Quality & Measures Committee
- X. DSRIP Program Performance Management

II. DSRIP Eligibility Criteria

The hospitals eligible to receive funding under the DSRIP program are those general acute care hospitals and are listed and shown in the table below.

Table I. HOSPITALS ELIGIBLE FOR TRANSITION AND DSRIP PAYMENTS

Medicaid No.	Medicare No.	Hospital Name	County
4139402	310064	ATLANTICARE REG'L MEDICAL CENTER	ATLANTIC
4136705/0167011	310025	BAYONNE HOSPITAL	HUDSON
4141105	310112	BAYSHORE COMMUNITY HOSPITAL	MONMOUTH
4139003	310058	BERGEN REG'L MEDICAL CENTER	BERGEN
4135709	310011	CAPE REGIONAL MEDICAL CENTER	CAPE MAY
3676609	310092	CAPITAL HEALTH SYSTEM - FULD CAMPUS	MERCER
4138201	310044	CAPITAL HEALTH SYSTEM - HOPEWELL	MERCER
4141008	310111	CENTRASTATE MEDICAL CENTER	MONMOUTH
4136209	310017	CHILTON MEMORIAL HOSPITAL	MORRIS
3674207	310016	CHRIST HOSPITAL	HUDSON
4135504	310009	CLARA MAASS MEDICAL CENTER	ESSEX
3674606	310041	COMMUNITY MEDICAL CENTER	OCEAN
4136004	310014	COOPER UNIVERSITY MEDICAL CTR	CAMDEN
4137205	310031	DEBORAH HEART & LUNG CENTER	BURLINGTON
4140001	310083	EAST ORANGE GENERAL HOSPITAL	ESSEX
4138309	310045	ENGLEWOOD HOSPITAL ASSOCIATION	BERGEN

Medicaid No.	Medicare No.	Hospital Name	County
3674100	310001	HACKENSACK UNIVERSITY MEDICAL CENTER	BERGEN
4141300	310115	HACKETTSTOWN COMMUNITY HOSPITAL	WARREN
4137906/0249297	310040	HOBOKEN HOSPITAL CENTER	HUDSON
4135407	310008	HOLY NAME HOSPITAL	BERGEN
4135202	310005	HUNTERDON MEDICAL CENTER	HUNTERDON
4139801	310074	JERSEY CITY MEDICAL CENTER	HUDSON
3675700	310073	JERSEY SHORE MEDICAL CENTER	MONMOUTH
3676803	310108	JFK MEDICAL CENTER {EDISON} / Anthony M. Yelencsics	MIDDLESEX
4140206	310086	KENNEDY MEMORIAL HOSPITALS AT STRATFORD	CAMDEN
3676200	310084	KIMBALL MEDICAL CENTER	OCEAN
3675203	310061	LOURDES MED CTR OF BURLINGTON CNTY	BURLINGTON
4141504/0249297	310118	MEADOWLANDS HOSPITAL MEDICAL CENTER	HUDSON
3674908	310052	MEDICAL CENTER OF OCEAN COUNTY	OCEAN
4138902	310057	MEMORIAL HOSP OF BURLINGTON CTY (Virtua)	BURLINGTON
9031308	310091	MEMORIAL HOSPITAL OF SALEM COUNTY	SALEM
3675807	310075	MONMOUTH MEDICAL CENTER	MONMOUTH
4136101	310015	MORRISTOWN MEMORIAL HOSPITAL	MORRIS
4138708/0139564	310054	MOUNTAINSIDE HOSPITAL	ESSEX
4135008	310002	NEWARK BETH ISRAEL MEDICAL CENTER	ESSEX
4137001	310028	NEWTON MEMORIAL HOSPITAL	SUSSEX
4137108	310029	OUR LADY OF LOURDES MEDICAL CENTER	CAMDEN
3674801	310051	OVERLOOK HOSPITAL	UNION
4135105	310003	PALISADES GENERAL HOSPITAL	HUDSON
4137701	310038	R. W. JOHNSON UNIVERSITY HOSPITAL	MIDDLESEX
4137809	310039	RARITAN BAY MEDICAL CENTER	MIDDLESEX
4137400	310034	RIVERVIEW MEDICAL CENTER	MONMOUTH
3674401	310024	ROBERT WOOD JOHNSON AT RAHWAY HOSPITAL	UNION
3676901	310110	RWJ UNIVERSITY MEDICAL CTR AT HAMILTON	MERCER
3674703	310047	SHORE MEMORIAL HOSPITAL	ATLANTIC
4138406	310048	SOMERSET MEDICAL CENTER	SOMERSET
3674509	310032	SOUTH JERSEY HEALTH SYSTEM	CUMBERLAND
3675602	310069	SOUTH JERSEY HEALTH SYSTEM - ELMER	SALEM
4141202	310113	SOUTHERN OCEAN COUNTY HOSPITAL	OCEAN
3675904	310076	ST. BARNABAS MEDICAL CENTER	ESSEX
4138601	310050	ST. CLARE'S-RIVERSIDE MED CTR DENVILLE	MORRIS
4136608	310021	ST. FRANCIS MEDICAL CENTER (TRENTON)	MERCER
4136403	310019	ST. JOSEPH'S HOSPITAL MEDICAL CENTER	PASSAIC
4135300	310006	ST. MARY'S HOSPITAL (PASSAIC)	PASSAIC
4140508	310096	ST. MICHAEL'S MEDICAL CENTER	ESSEX
4139500	310070	ST. PETER'S MEDICAL CENTER	MIDDLESEX

Medicaid No.	Medicare No.	Hospital Name	County
4136900	310027	TRINITAS - ELIZABETH GENERAL	UNION
3676102	310081	UNDERWOOD MEMORIAL HOSPITAL	GLOUCESTER
3677001	310119	UNIVERSITY HOSPITAL	ESSEX
4135601	310010	UNIVERSITY MED CTR PRINCETON @ PLAINSBORO	MIDDLESEX
4135806	310012	VALLEY HOSPITAL	BERGEN
4139208	310060	ST. LUKE'S HOSPITAL (formerly Warren Hospital)	WARREN
3674304	310022	VIRTUA - WEST JERSEY HEALTH SYSTEM	CAMDEN
Hospital Count	63		

Note: St. Clare's Sussex #310120 closed Inpatient operations in Oct 2012.

III. Global Context, Goals, and Outcomes

The current landscape of New Jersey health starts with the state's vision for all New Jerseyans. As specified in the Healthy New Jersey 2020 (HNJ2020) plan, that vision is for New Jersey to be a state in which all people live long, healthy lives. This vision applies to 8.7 million¹ residents of the state.

Healthy New Jersey is the state's health improvement plan and sets the agenda for comprehensive disease prevention and health promotion for New Jersey for the next decade. It is modeled after the federal Healthy People 2020 initiative and is the result of a multiyear process that reflects the input from a diverse group of individuals and organizations.

The HNJ2020 objectives communicate high-priority health issues. A principal goal stated in the HNJ2020 is to: *"Attain high-quality, longer lives free of preventable disease, disability, injury, and premature deaths."*

Specifically, New Jersey's Leading Health Indicators reflect the state's major public health concerns. New Jersey's Leading Health Indicators are the product of an extensive external and internal feedback process. Over 200 partners participated in a poll and a refined list was vetted and presented to the Department of Health's HNJ2020 Advisory Committee. The five Leading Health Indicators include 1) access to primary care, 2) birth outcomes, 3) childhood immunizations, 4) heart disease and 5) obesity.

The Department believes that the goals for three of the five leading health indicators will be influenced by the DSRIP program through implementing interventions that impact chronic care within New Jersey. As specified in the HNJ2020, the table below represents baseline and target rates for access to primary care, heart disease and obesity.

¹ The Kaiser Family Foundation, "State Health Facts, Demographics and the Economy" kff.org/statedata/, accessed June 25, 2013

Table II. HN2020 Baseline and Target Rates for Access to Primary Care, Heart Disease and Obesity

Leading Health Indicator	Measurement	Baseline	Target
Access to Primary Care	Increase the proportion of adults with a personal doctor or health care provider	(2011) 83.0%	(2020) 90.0%
Heart Disease	Reduce the death rate due to coronary heart disease	(2007) 140.1 per 100,000 population (age-adjusted)	(2020) 112.1 per 100,000 population (age-adjusted)
Obesity	Prevent an increase in the proportion of the population that is obese	Adults (20+; 2011) 23.8%	Adults (2020) 23.8%

Although the HN2020 is set to improve the lives of all residents, particular attention must be spent on the most vulnerable population groups to ensure that quality care is received by everyone in the most cost effective manner. Approximately 17 percent² of the population lives below the poverty line. The number of residents that remain uninsured in the state is above 1.3 million³ and nearly the same number is currently covered by Medicaid. All residents, but particularly these vulnerable populations, rely on the safety net of New Jersey hospitals to provide quality health services. The state recognizes the integral role and efforts of the state’s hospital systems with attainment of these goals.

As the burden of care for all residents continues to rise, new methods to achieve excellence in health care is an important factor in obtaining value for the health care dollar. Currently, 38 cents of every New Jersey dollar is being spent in the Medicaid program on emergency department, inpatient and outpatient services.⁴ Charity Care patients alone consume more than \$1.35 billion in hospital care services annually in New Jersey.⁵

The DSRIP program provides an opportunity to improve patient care for New Jersey’s low income population by incentivizing delivery system reforms that improve access, enhance quality of care, and promote the health of patients and the families they serve. These investments contribute directly to CMS’s overarching “Triple Aim” and position safety net providers for the emerging healthcare market where data, quality, and pay for performance initiatives foster competition among facilities and bend the health care cost curve.

In addition to the HN2020 data, the Department has observed that cardiac care, pneumonia, mood disorders, diabetes and asthma all routinely rank in the top 20

² The Kaiser Family Foundation, “State Health Facts: Health Coverage,” kff.org/statedata/, accessed June 25, 2013

³ The Kaiser Family Foundation, “State Health Facts: Health Coverage,” kff.org/statedata/, accessed June 25, 2013

⁴ Data based on SFY 2011 CRCS NJ Medicaid Managed Care Capitation Rates

⁵ New Jersey Hospital Association (2010). “Charity Care Patient Profile: A Deeper Exploration”

for total number of inpatient discharges by principal diagnosis as shown on Table III.

Table III. State Statistics - 2011 New Jersey - Principal Diagnosis Only

Rank order of Clinical Classifications Software (CCS) principal diagnosis category by number of discharges			
Rank	CCS Principal Diagnosis	CCS Category Name	Total Number of Discharges
1	218	Liveborn	101,469
2	108	Congestive heart failure, nonhypertensive	29,519
3	2	Septicemia (except in labor)	28,166
4	122	Pneumonia (except that caused by tuberculosis and sexually transmitted diseases)	27,861
5	657	Mood disorders	25,414
6	106	Cardiac dysrhythmias	24,784
7	197	Skin and subcutaneous tissue infections	21,495
8	101	Coronary atherosclerosis	19,457
9	127	Chronic obstructive pulmonary disease and bronchiectasis	19,030
10	203	Osteoarthritis	18,626
11	102	Nonspecific chest pain	18,317
12	100	Acute myocardial infarction	18,224
13	159	Urinary tract infections	18,028
14	195	Other complications of birth, puerperium affecting management of the mother	17,258
15	109	Acute cerebrovascular disease	16,217
16	50	Diabetes mellitus with complications	16,156
17	237	Complication of device, implant or graft	15,877
18	189	Previous C-section	15,226
19	128	Asthma	15,106
20	149	Biliary tract disease	14,031

State statistics from the Healthcare Cost and Utilization Project (HCUP) State Inpatient Databases 2011, Agency for Healthcare Research and Quality (AHRQ), Based on data collected by the New Jersey Department of Health and Senior Services and provided to AHRQ. These data reflect 2010 hospital characteristics.

Therefore, in order to focus the DSRIP incentive budget and resources to meet the state's vision, New Jersey is seeking to move the cost and quality curve for eight prevalent or chronic conditions. These focus areas are as follows:

- 1) Asthma
- 2) Behavioral Health
- 3) Cardiac Care
- 4) Chemical Addiction/Substance Abuse
- 5) Diabetes
- 6) HIV/AIDS
- 7) Obesity
- 8) Pneumonia

Chronic diseases are responsible for about 70% of all deaths nationally even while patients with chronic disease consume 83% of all health care spending in the United States.⁶ This experience is observed in New Jersey where seven of the ten leading causes of death are due to chronic diseases as shown in Figure I below.

Figure I. Leading Causes of Death, New Jersey and the United States, 2009⁷

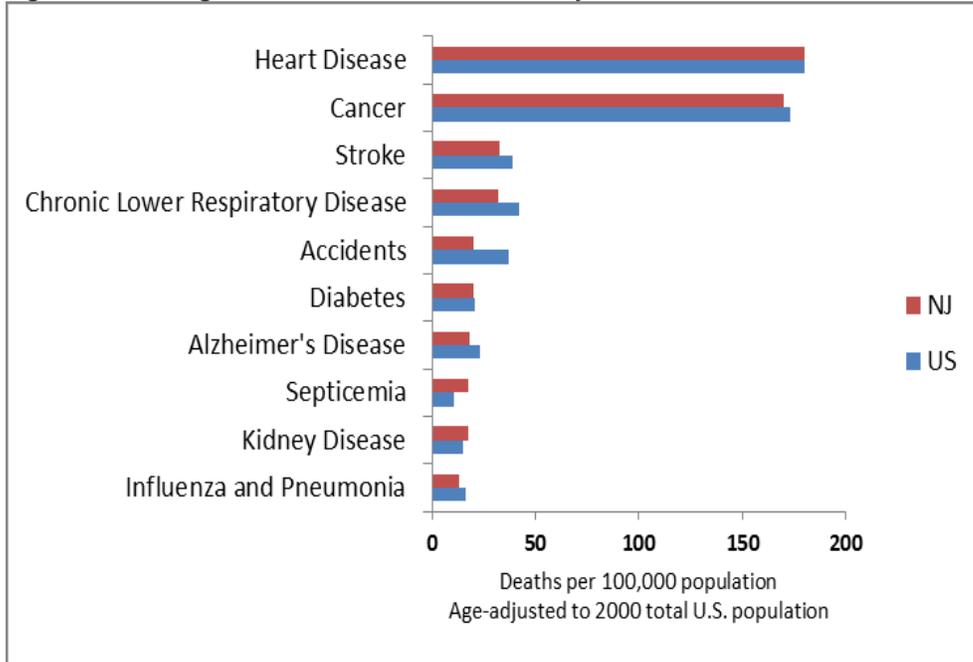
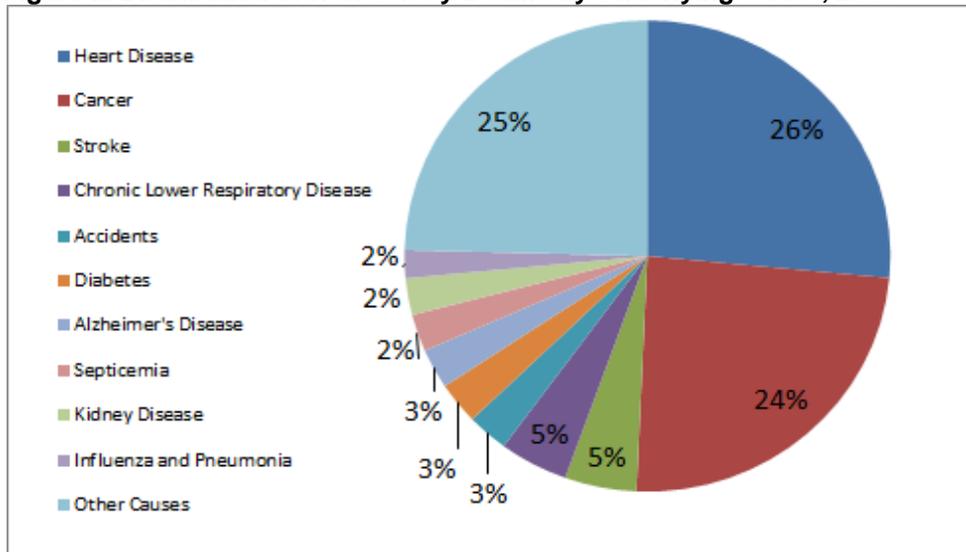


Figure II, below, demonstrates that heart disease, cancer, stroke, and diabetes caused 58% of New Jersey deaths in 2009.

⁶ New Jersey Department of Health, "Introduction to CD Burden"

⁷ Ibid.

Figure II. Distribution of New Jersey Deaths by Underlying Cause, 2009⁸



Fiscally, the impact is sizeable. New Jersey spent \$21,936 per disabled enrollee in 2009. Compared to the national average of \$15,840,⁹ this annual per enrollee cost is unsustainable. In order to bring this average down, particular attention must be spent on the at-risk disabled population that may rely on government-funded medical assistance over the course of their lifetime.

Better health management, particularly in members that have multiple chronic conditions, results in improved health outcomes, reduced cost and improved patient satisfaction in treatment. There is a great deal of emerging data to support that these chronic conditions, when effectively managed, could produce cost savings by up to five percent.¹⁰ This is accomplished by improving population health through ensuring that the continuum of patient care is holistic in nature, improving transitions between settings of care and providing optimum care in acute circumstances which are all major features of DSRIP.

Clinical protocols or projects that will be completed by participating hospitals have been designed to achieve one or more core achievement themes, which are specific aims of the New Jersey Department of Health. These core achievement themes guided the selection of the projects within each focus area. These include:

- Improved Care/Case Management
- Improved Discharge Planning
- Expansion of Primary Care
- Improved Quality of Care

⁸ New Jersey Department of Health, "Introduction to CD Burden"

⁹ The Kaiser Family Foundation, statehealthfacts.org "Health Coverage" accessed January 31, 2013

¹⁰ Urban Institute, www.urban.org, "The Potential Savings from Enhanced Chronic Care Management Policies," John Holahan, Cathy Schoen, and Stacey McMorro, November 2011.

- Improved Access to Care
- Improved Patient Education
- Improved Delivery of Care
- Improved Training and Efficiency
- Any Combination of the Above

This Planning Protocol includes a menu of 17 pre-defined projects with activities that will create financial incentives for New Jersey hospitals to implement programs and interventions to improve care for residents within the eight focus areas. These projects were identified and developed by the Department and the hospital industry because they represent realistic and achievable improvement opportunities for New Jersey.

IV. Project Stages

This section describes the project stages per subparagraph (c) of the STCs, as well as the menu of activities, along with their associated population-focused objectives and evaluation metrics, from which each eligible hospital will select to create its own projects.

As specified by the STCs, and as further developed in the DSRIP protocols, the project stages are as follows:

- Stage 1: Infrastructure Development – Activities in this stage develop the foundation for delivery system transformation through investments in technology, tools, and human resources that will strengthen the ability of providers to serve populations and continuously improve services.
- Stage 2: Chronic Medical Condition Redesign and Management – Activities in this stage include the piloting, testing, and replicating of chronic patient care models.
- Stage 3: Quality Improvements – This stage involves the measurement of care processes and outcomes that reflect the impact of Stage 1 and Stage 2 activities, in which major improvements in care can be achieved from January 1, 2014 through DY5. Stage 3 measures the clinical performance of the hospital's DSRIP project.
- Stage 4: Population Focused Improvements – Activities in this stage include reporting measures across several domains selected by the Department, in consultation with the New Jersey hospital industry and CMS.

The menu of activities for each stage, including the application stage, is included in the Hospital DSRIP Plan Template, along with the associated metric(s) and minimum documentation requirements for each activity/metric. For each stage, the Hospital DSRIP Plan Template lists the required and/or elective activities, the associated actions/milestones for each activity, as well as the guideline for completion by month and year. While the targeted completion by month/year will

be determined by the participating hospital for most action/milestones in the DSRIP Plan, the noted completion date by month/year in the Hospital DSRIP Plan Template will serve as a guide for the Department's expected completion date for each stage's activities.

The Hospital DSRIP Plan Template includes all high-level Stage 1, 2, 3 and 4 activities, milestones and metrics and provides New Jersey hospitals with the universal format (framework) for the content that is needed, at a minimum, for completing their hospital-specific DSRIP plan submission. This universal application process allows for assuring all projects incorporate required activities resulting in a simplified Department and CMS review process.

Upon project selection by the hospital, it is the duty of the hospital to complete the application so that it fully describes the hospital-specific implementation. The template directs the hospital to insert pre-defined information and also requires the hospital to insert free-form text in order to describe, in more detail, the hospital's plan in accomplishing the activities, actions and milestones.

On the hospital DSRIP Plan application, the participating hospital will be required to identify key project components and goals. This initial activity acts as the foundation for completing DSRIP project planning and goal-setting. In Stage 1, some activities may, or may not, apply to the chosen project based on the methodology scope. Each hospital must assess whether the listed activity is applicable to their chosen project. If the activity applies to their chosen project, the hospital will be required to provide additional narrative that fully describes how the activity will be fulfilled. If the activity does not apply, the hospital will denote N/A or Not Applicable for that activity, as well as provide a brief explanation for why the activity is not appropriate. All Stage 2, 3 and 4 activities are required.

For additional information regarding the project stages, menu of activities, projects, associated population-focused objectives and evaluation metrics, please refer to Attachment 1: DSRIP Toolkit.

V. DSRIP Project Array

As mentioned, a project array of condition-specific projects has been chosen and developed based on the eight conditions listed in the Special Terms and Conditions. These conditions represent prevalent, high cost, and/ or preventable conditions that impact the underserved populations and New Jersey's systems of healthcare.

By implementing the core achievement themes for the selected focus areas, DSRIP will provide an unprecedented opportunity to improve patient care for low-income populations in New Jersey. The New Jersey health care system will

move from serving these patients separately at different sites of care, to one that effectively and seamlessly manages transitions of care as they occur. DSRIP projects engage inpatient and outpatient providers to share accountability in improving the overall patient health of the low-income population. Improving the care for this specific population will positively advance the overall health of the state in order to achieve the HNJ2020 goals.

Project detail for each pre-defined condition-specific project is included in Attachment 1: DSRIP Toolkit, Section III. These project detail sheets are modeled using the Hospital DSRIP Plan Template and will be used by the hospitals as a reference when completing their individual DSRIP plan. Each project detail sheet presents the project's defined objective, high level methodology, and anticipated outcomes. This information must be included within the hospital's application submission and will be pre-populated based on the pre-defined project selected. The hospital is responsible for describing in further detail the manner and means by which the hospital will fulfill the project.

If the hospital chooses to select a "off-menu" or "unique" project that is not one of the pre-defined projects under the eight Focus Areas listed in the Special Terms and Conditions or chooses to select a project that is for a condition other than the eight Focus Area conditions, the hospital will be required to develop the project's defined objective, high level methodology, anticipated outcomes, and project-specific metrics. The hospital's analysis must present strong and compelling justification for the "off-menu" project, showing that the hospital reviewed the menu projects and found that the proposed project could not be accommodated within any of the model projects of the toolkit, and that the hospital should implement the proposed off-menu project instead of a menu project.

With this justification, the hospital must show, using internal and external data, that the new hospital project is beyond those in the toolkit, that it would achieve the Triple Aim, that it is responsive to local data and community needs, and that it addresses an area of poor performance and/or health care disparity that is important to the Medicaid and/or uninsured population. The hospital must explain why this "off-menu" project is particularly innovative or promising, and that it employs an evidence-based approach (with literature clearly cited).

"Off-menu" projects must be focused on an area or condition in which there is demonstrable need for improvement, be outpatient focused, and have clearly identified improvement objectives that can be measured using nationally-endorsed (primarily outcome) metrics (such as those endorsed by the National Quality Forum (NQF) or National Committee for Quality Assurance (NCQA)). A reasonable explanation must be established that the project will result in measurable improvements in the patient population's clinical outcomes.

Hospitals choosing to submit this type of plan are advised that the plan will be subject to higher scrutiny as the project has not been pre-approved by both the

Department and CMS.

Further rationale behind the selection of each of the eight conditions, as well as an overview of each pre-defined condition-specific project, is described below.

A. Asthma

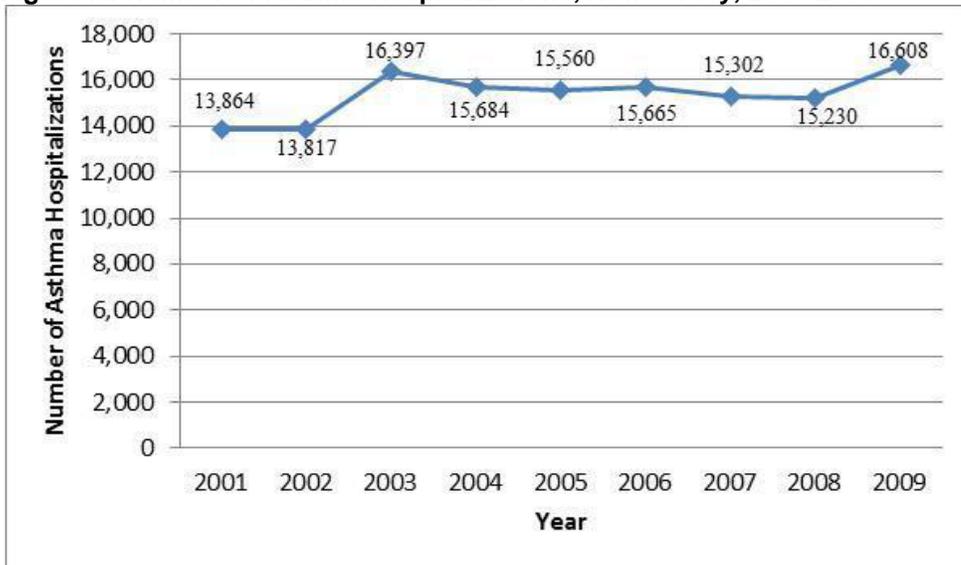
In New Jersey, over 500,000 adults and over 180,000 children are estimated to currently have asthma.¹¹ Asthma is a chronic respiratory disease that is characterized by inflammation and episodic narrowing of the airways that carry oxygen in and out of the lungs. Asthma is a chronic disease that cannot be cured, but it can be controlled with an effective medical management plan, treatment of coexisting medical conditions and avoidance of environmental or occupational triggers.

As shown in the following graphs, hospitalization due to asthma was at 16,608 in 2009, though hospitalization rates for asthma do not represent the total burden of the illness. The total number of asthma emergency department (ED) visits per year ranged from 49,237 to 52,753 during 2004-2009¹².

¹¹ NJDOH, "Addressing Asthma in New Jersey Factsheet": http://nj.gov/health/fhs/asthma/documents/aaep_summary.pdf

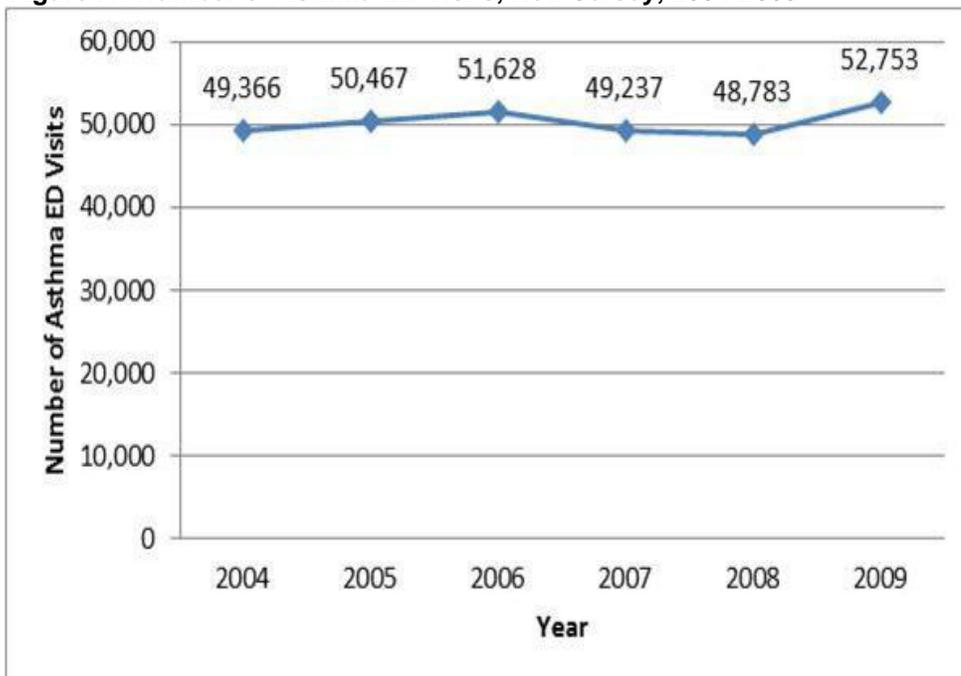
¹² NJDOH, New Jersey Asthma Awareness and Education Program: <http://nj.gov/health/fhs/asthma/documents/chapter6.pdf>

Figure III. Number of Asthma Hospitalizations, New Jersey, 2000-2009



Data Source – 2001-2009 New Jersey Hospital Discharge Files.

Figure IV. Number of Asthma ED Visits, New Jersey, 2004-2009



Data Source – 2004-2009 New Jersey ED Discharge File

Of particular concern, children ages 0-4 have the highest asthma hospitalization and emergency department (ED) visit rates compared to all age groups; however, about 62% of all asthma ED visits and about 74% of all asthma

hospitalizations are for adults¹³. Additionally,

- About 9.1% of New Jersey children 0-17 years have asthma.¹⁴
- Approximately 7.7% of adults in New Jersey have asthma.¹⁵
- Annual asthma hospitalization and ED visit rates vary widely by county in New Jersey. Age-adjusted asthma ED visit rates range from 232 per 100,000 (Hunterdon) to 1,254 per 100,000 (Essex).¹⁶
- 57% of children with asthma who attend school or child care miss at least one day per year for their asthma.¹⁷
- Among children with asthma:¹⁸
 - 52% have received an asthma action plan from a health professional.
 - 38% were advised by a health professional to make environmental changes.
 - 40% of those who use long-term control medication report proper use.
 - 59% of those who use quick relief medication report proper use.
- Among adults with asthma:¹⁹
 - 31% have received an asthma action plan from a health professional.
 - 34% were advised by a health professional to make environmental changes.
 - 52% of those who use long-term control medication report proper use.
 - 61% of those who use quick relief medication report proper use.

Strong evidence indicates that more can be done to help those with asthma control their symptoms. The goals for the HNJ2020 pertaining to asthma include reducing the death rate due to asthma, reducing hospitalizations, reducing emergency department (ED) visits and reducing the proportion of persons with asthma who miss school or work days, and to increase education by health professionals regarding positive changes a patient with asthma can make in the home, school, or work settings.

In order to improve these rates and meet the HNJ2020 goals, supporting individual patients and performing home evaluations can improve their targeted treatment regimen. Additionally, ensuring that designated treatment educators are made available to patients, the community and providers at large will allow for sufficient support to a greater range of patients geographically. The following two projects serve to address these issues.

¹³ NJDOH, Asthma Awareness and Education Program (Analysis of 2011 Hospital and ED Files)

¹⁴ NJDOH, "Asthma in New Jersey": http://www.nj.gov/health/fhs/asthma/asthma_resources.shtml#publications

¹⁵ Ibid.

¹⁶ Ibid.

¹⁷ Ibid.

¹⁸ Ibid.

¹⁹ Ibid.

Hospital-Based Educators Teach Optimal Asthma Care

The purpose of this project is to implement a hospital-based asthma educator program in order to provide education to patients, providers and community members on optimum asthma care. In this program, improving training and education is not limited to patient self care. This project is geared to ensure evidence-based training to inpatient providers, as well as education to targeted staff that routinely interact with asthma patients such as childcare centers and schools. This ensures that the community recognizes asthma triggers and supports asthma action plans in order to effectively respond with medication treatment protocols in lieu of exacerbating manageable symptoms.

The goals of this project are to 1) reduce admissions, 2) reduce emergency department visits, 3) improve medication management, and 4) increase patient satisfaction.

Pediatric Asthma Case Management and Home Evaluations

The purpose of this project is to provide case management and home evaluations in an effort to reduce admissions, ED visits and missed school days related to asthma.

The primary component of this project is to support the patient by completing a standardized needs assessment along with a home evaluation where a case manager completes an asthma action plan with the goal to remediate exacerbating environmental triggers. This case management allows for targeted support and linkages of care between primary and specialty care services.

The objectives of this project are to 1) reduce admissions, 2) reduce emergency department visits, 3) improve medication management, 4) reduce missed school days, and 5) improve care processes.

B. Behavioral Health

Of New Jersey's residents, nearly 259,000 adults live with serious mental illness.²⁰

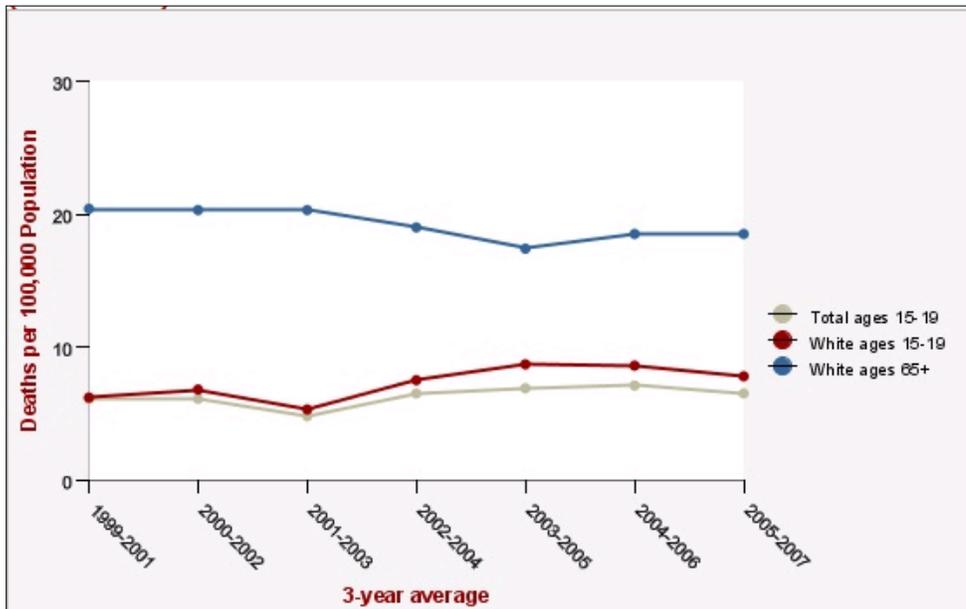
National studies estimate that during a one year period up to 30 percent of the US adult population meets criteria for one or more behavioral health diagnoses, particularly mood (19%), anxiety (11%) and substance abuse (25%).²¹ Consumers living with serious mental illnesses are dying years earlier than the

²⁰ National Association of Mental Illness (NAMI) : "NAMI State Advocacy 2010: State Statistics: New Jersey" www.nami.org/ accessed January 31, 2013

²¹ NJDMHS, "The Comprehensive Waiver Application Overview & Health Care Reform": <http://www.state.nj.us/humanservices/dmhs/news/publications/MBHO%20ASO.ppt>

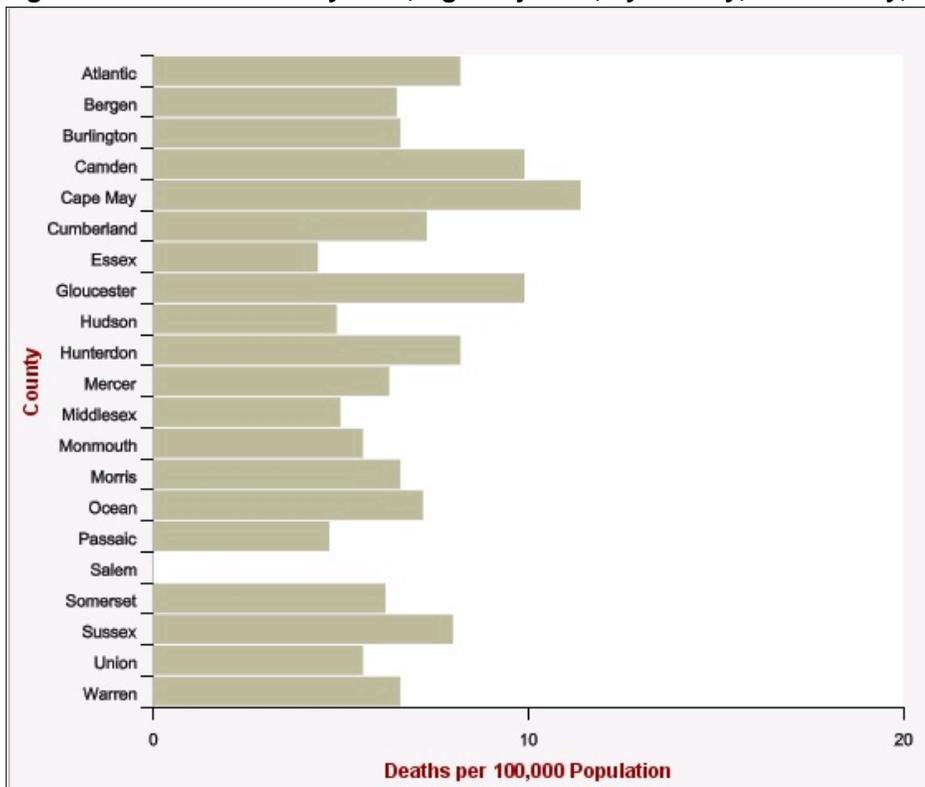
general population, often with unmanaged physical health conditions. The incidence of suicide points to untreated or under-treated mental illness.

Figure V. Suicide Mortality Rate among Males in High Risk Groups, New Jersey, 2000-2007²²



²² NJDOH, New Jersey State Health Assessment Data, Available at: <http://www4.state.nj.us/dhss-shad/indicator/view/Suicide.HighRisk.html>

Figure VI. Suicide Mortality Rate, Age-Adjusted, by County, New Jersey, 2005-2007²³



Left untreated, behavioral health problems are associated with considerable functional impairment, poor adherence to treatment, adverse health behaviors that complicate physical health problems and increase healthcare costs. Generally, these individuals use about eight times more healthcare services than the average population. For Medicaid specifically, approximately two-thirds of Medicaid’s highest cost adult beneficiaries have a behavioral health diagnosis.²⁴

Behavioral health conditions are implicated in all major chronic diseases. Mental health problems are two to three times more common for people with chronic medical illnesses such as diabetes, arthritis, chronic pain, and heart disease. As a result, holistic, condition management is a key feature in the following behavioral health projects.

Integrated Health Home for the Seriously Mentally Ill (SMI)

The objective of this project is to fully integrate behavioral health and physical health services for those with a serious mental illness (SMI) diagnosis in order to provide evidence-based whole-person care.

²³ NJDOH, New Jersey State Health Assessment Data, Available at: <http://www4.state.nj.us/dhss-shad/indicator/view/Suicide.HighRisk.html>

²⁴ NJDMHS, “The Comprehensive Waiver Application Overview & Health Care Reform”: <http://www.state.nj.us/humanservices/dmhs/news/publications/MBHO%20ASO.ppt>

Integration will be provided in a client-centered model creating one place to access all services and ensuring patients have ongoing relationships with a medical and psychiatric practitioner. Allowing for all services to be co-located increases the attendance and coordination of needed services. A single treatment plan will be developed with goal setting that includes traditional medication interventions, such as gym memberships, nutrition monitoring and healthy lifestyle coaching to improve overall health.

As a result, the objectives of the project are to 1) reduce readmissions, 2) reduce emergency department visits, 3) improve patient adherence to their treatment regimen, and 4) improve care processes.

Day Program and School Support Expansion

School aged children and adolescents suspended from classrooms due to severe behavioral health issues may be left unsupervised pending approval to return to school. Failure to properly manage the suspension of these students impedes treatment and can delay their return to the school setting. This pilot program provides space, therapy and instruction at the hospital's ambulatory behavioral health center until the students are able to return to full-day attendance within the school setting. Treatment is provided by certified therapists and psychiatrists using evidence-based protocols for pediatric and adolescent care. Relationships and linkages between the behavioral health provider and the school district are expanded to ensure that the schools are supported in their efforts to assist students with behavioral health diagnoses. It is expected with improved support for both the individual and the school, the following objectives will be realized.

These objectives of the project are to 1) reduce readmissions, 2) improve patient adherence to their treatment regimen, 3) improve care processes, 4) improve school education regarding behavioral health programming and referral processes, and 4) lengthen the uninterrupted student tenure within the school setting.

Electronic Self-Assessment Decision Support Tool

The objective of this project is for the hospital to work with outpatient facilities to implement an electronic self-assessment decision support tool to improve the continuum of care treatment provided to mental health patients by improving the efficiency and effectiveness of treatment planning, adherence and communication between the patient and the mental health provider.

This tool should be utilized by patients in the practitioner's office immediately prior to their outpatient mental health visit. The assessment must allow the patient to report on key symptoms and functioning, along with medication

compliance. The tool must immediately generate a consultation report that both the clinician and the client may refer to during the visit that graphs and trends the key indicators allowing the clinician to quickly identify areas of mental and physical health concern that should be addressed.

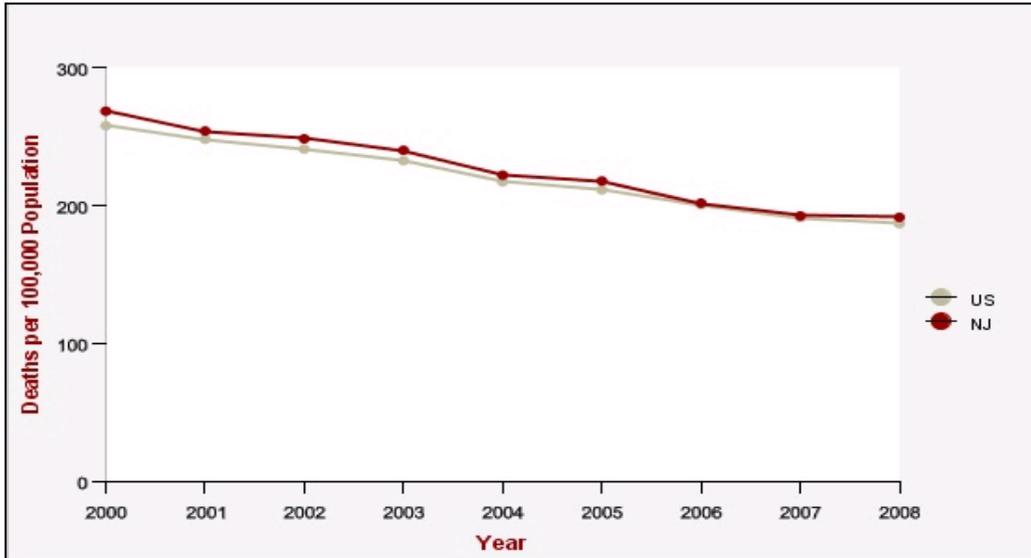
The goals of the assessment report are to 1) reduce readmissions, 2) improve patient-provider communication, 3) increase shared decision-making, 4) improve patient adherence to their treatment regimen, and 4) improve care processes.

C. Cardiac Care

In New Jersey, although age-adjusted mortality rates for heart disease decreased nearly 29% from the year 2000 to the year 2008, heart disease, remained the leading cause of death in 2008²⁵ among all Americans, all New Jerseyans, men and women. It is the leading cause of death among Whites and Blacks and the second leading cause of death among Hispanics and Asians.

Figure VII below shows the age-adjusted death rate due to heart disease for both the United States and New Jersey between 2000 and 2008. Although there has been a decline over the years, the rate still remains at near 200 deaths per 100,000 population.

Figure VII. Age-Adjusted Death Rate due to Heart Disease by Year, New Jersey and the United States, 2000-2008²⁶



Age-adjusted mortality rates for heart disease are:

- Higher for males (242 per 100,000) as compared to females (156)²⁷ and

²⁵ NJDOH, "Heart Disease and Stroke in New Jersey"

²⁶ NJDOH, New Jersey State Health Assessment Data; Available at: <http://www4.state.nj.us/dhss-shad/indicator/view/HeartDisDeath.Trend.html>

- Highest for Blacks (225) followed by Whites (196), Hispanics (116) and Asians (84).²⁸

Other cardiac related statistics considered included:

- 85% of heart disease and stroke deaths were for residents aged 65 years and older. Estimated lifetime history of cardiovascular disease among adults is²⁹:
 - 3.9% for coronary heart disease or angina
 - 3.8% for heart attack
 - 2.4% for stroke
- Estimated prevalence of cardiovascular disease risk factors among adults is³⁰:
 - 52.5% for not meeting recommended physical activity levels
 - 37.0% for ever been diagnosed with high cholesterol
 - 30.6% for ever been diagnosed with hypertension
 - 23.7% for obesity
 - 16.8% for current smoking
 - 9.2% for having diabetes

There is a great deal of evidence that indicates that co-morbid and the aging “baby-boomer” populations will continue to drive medical costs in the area of cardiac care. New Jersey has set goals to improve heart health over the course of the next decade. These include moving mortality rates as well as cholesterol checks. The two goals listed in the following table relate to the DSRIP cardiac care projects.

Table IV. HN2020 Goals for Cardiac Care Improvement

Goals for Cardiac Care Condition Improvement	
HDS-1: Reduce the death rate due to coronary heart disease	
Target:	112.1 per 100,000 standard population (age-adjusted)
Baseline (Year):	140.1 per 100,000 standard population (age-adjusted) (2007)
Data source:	Death Certificate Database, Center for Health Statistics, New Jersey Department of Health
HDS-3: Increase the proportion of adults who have had their blood cholesterol checked within the preceding 5 years	
Target:	86.7 percent (age-adjusted)
Baseline:	78.8 percent (age-adjusted) (2011)
Data source:	New Jersey Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health

²⁷ NJDOH, “Heart Disease and Stroke in New Jersey”

²⁸ NJDOH, “Heart Disease and Stroke in New Jersey”

²⁹ Ibid.

³⁰ Ibid.

The cardiac care projects below seek to improve care coordination, increase consistent evidence-based treatment and improve continuum of care through more supportive patient centered practices in order to improve overall care and treatment in the most appropriate treatment setting.

Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions

The purpose of this project is to create an evidence-based Care Transitions Intervention model for cardiac care. This model will focus on the use of hospital Patient Navigators to assist in supporting the patient education process before and after they leave the hospital to ensure the patient and caregivers are knowledgeable about medications, red-flag indications and how to respond to identified concerns.

The objectives for this project are to 1) reduce readmissions, 2) reduce admissions, 3) increase patient satisfaction, 4) improve medication management, and 5) improve care processes.

Extensive Patient CHF-focused Multi-Therapeutic Model

The purpose of this project is to decrease the number of readmissions by developing a multi-therapeutic medical home. Nurse practitioners with CHF experience will lead patient education and coordinate home visits to ensure care management.

The goals for this program include 1) reduce readmissions, 2) reduce admissions, 3) increase patient satisfaction, 4) improve medication management, and 5) improve care processes.

The Congestive Heart Failure Transition Program (CHF-TP)

The purpose of this project is to develop an intensive outpatient Congestive Heart Failure Transition Program (CHF-TP) through an enhanced admission assessment and guidance at discharge.

Through this project, the hospital will incorporate a number of components to ensure a safe patient transition to home or other appropriate health care setting. Key elements include enhanced admission and discharge processes, improved communication and education related to self-care, and the development of a patient centered multi-disciplinary team which effectively completes ongoing medical assessments.

The objectives for this project are to 1) reduce readmissions, 2) reduce admissions, 3) increase patient satisfaction, 4) improve medication management, and 5) improve care processes.

D. Chemical Addiction/Substance Abuse

Individuals with untreated substance abuse disorders have higher medical costs than those without such disorders, especially for emergency department visits and hospitalizations. Similarly, families of untreated individuals with substance use disorders also have significantly higher medical costs than other families. These family members use up to five times more health care services driven by hospitalizations, pharmacy costs and primary care visits.³¹ Reducing the substance use and dependence rate in every county therefore has significant potential to drive health care costs down while improving the long term health outlook for New Jersey families.

³¹ NJDMHS, "The Comprehensive Waiver Application Overview & Health Care Reform": <http://www.state.nj.us/humanservices/dmhs/news/publications/MBHO%20ASO.ppt>

**Table V. Substance abuse and dependence rate per 100,000 population.
Emergency Admissions of Uniform Bill Patients (UB-04) Data, 2009**

	Population	Drug Abuse & Dependence		Alcohol Abuse & Dependence	
	2009 [1]	Count	Rate	Count	Rate
ATLANTIC	208,403	1543	740	3280	1574
BERGEN	696,505	1469	211	4648	667
BURLINGTON	343,949	1024	298	1875	545
CAMDEN	392,034	2656	677	2702	689
CAPE MAY	77738	292	376	694	893
CUMBERLAND	118,466	349	295	927	783
ESSEX	576,463	10286	1784	11531	2000
GLOUCESTER	221,209	975	441	1125	509
HUDSON	475,350	1582	333	6837	1438
HUNTERDON	99346	197	198	548	552
MERCER	282,357	1567	555	3328	1179
MIDDLESEX	606,496	1752	289	3886	641
MONMOUTH	490,164	2445	499	3919	800
MORRIS	371,762	853	229	2323	625
OCEAN	441,732	2814	637	3656	828
PASSAIC	367,358	1577	429	3708	1009
SALEM	50752	244	481	208	410
SOMERSET	246,132	606	246	1354	550
SUSSEX	115,303	392	340	687	596
UNION	396,925	1488	375	3331	839
WARREN	83983	229	273	481	573
New Jersey	6,662,427	34340	515	61048	916

[1] Source: U.S. Census Bureau, Population Estimates Program, July 1, 2009.
Prepared by: Office of Research, Planning, Evaluation, Information Systems and Technology
Division of Addiction Services, New Jersey Department of Human Services

The complications related to addiction and abuse for self-management cause an important need for overall health management support. Ensuring medical management screenings and treatment for addiction allows improved whole person care. The following projects strive to ensure more immediate symptomatic treatment for withdrawal and a pathway to long term treatment and recovery.

Hospital-Wide Screening for Substance Use Disorder

The objective of this project is to ensure the utilization of hospital-wide screening tools to detect alcohol or substance withdrawal for all patients admitted to the

hospital regardless of the admitting diagnosis or event in order to effectively manage these symptoms. Upon screening, precautionary or treatment algorithms will be initiated as needed. Proper identification of withdrawal symptoms allows management of the symptoms prior to more serious complications.

The objectives of this project are to 1) decrease length of stay, 2) decrease use of restraints, 3) decrease in transfer of patients with delirium tremens or other complications to the intensive care unit (ICU), 4) increased referral/ admissions to substance abuse treatment programs/ facilities, and 5) improve care processes.

Hospital Partners with Residential Treatment Facility to Offer Alternative Setting to Intoxicated Patients

The purpose of this project is to offer an alternative treatment setting for acute alcohol intoxicated patients in order to lower the emergency department length of stay and offer immediate access to treatment.

This project requires a partnership between emergency departments and addiction service providers in order to allow stabilized patients suffering from acute intoxication to be transferred to a treatment setting.

The objectives for this project include 1) lower emergency department length of stays for intoxicated patients, 2) increase referral/ admissions to substance abuse treatment programs/ facilities, and 3) improve care processes.

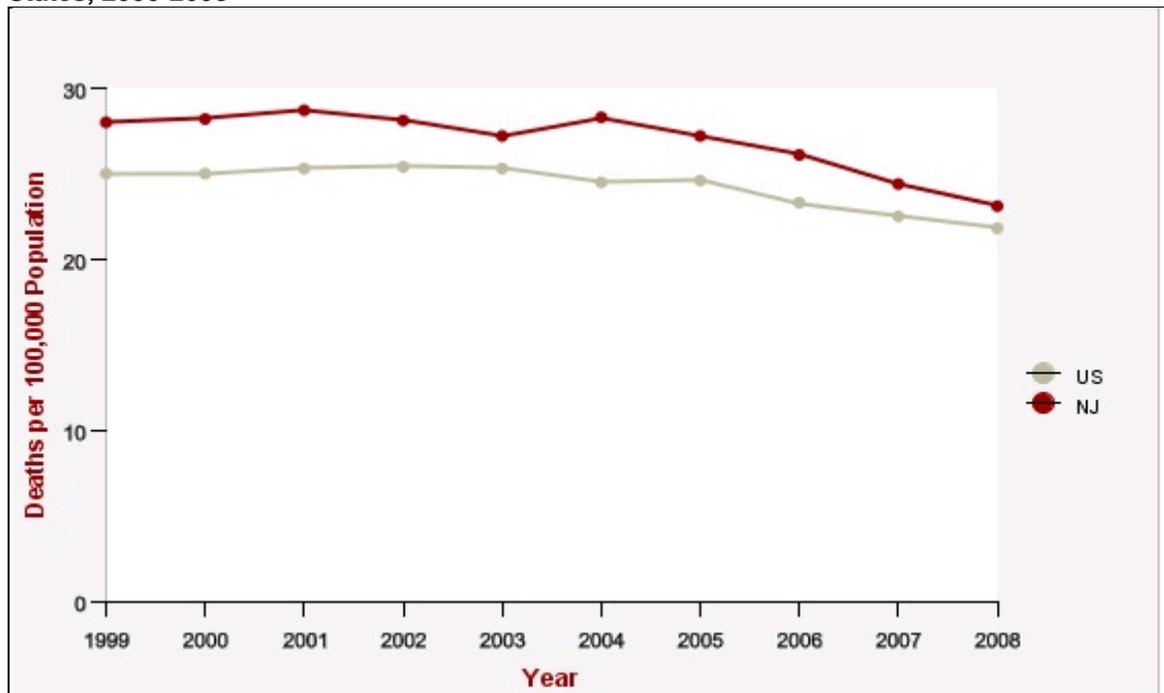
E. Diabetes

In New Jersey, diabetes is not only common, it is also costly and significant in its impact on health. Diabetes was the sixth leading cause of death in 2008 and about 77% of diabetes-related deaths were for residents aged 65 years and older.³²

Figure VIII below shows the age-adjusted death rate due to diabetes for both the United States and New Jersey between 2000 and 2008. Over the years, the rate has declined for both New Jersey and the United States; however the rate continues to be more than 20 deaths per 100,000 population for this manageable condition.

³² New Jersey Death Certificate Database, NJDOH, Center for Health Statistics, New Jersey State Health Assessment Data: <http://nj.gov/health/shad>

Figure VIII. Age-Adjusted Death Rate due to Diabetes by Year, New Jersey and the United States, 2000-2008³³



Other diabetes related statistics considered included:

- Age-adjusted prevalence estimate for adults increased from 4.3% in 1993 to 8.3% in 2010.³⁴
- About 9.2% of adults have diabetes. Diabetes prevalence estimates for adults are³⁵:
 - Highest for 65 years and older (21.5%) and lowest for 18-24 years (1.4%)
 - Highest for Black (15.4%) followed by Hispanic (9.5%), and then White (8.1%)
 - Highest in the lowest income households of less than \$15,000 annually (15.1%)
 - Highest for those who did not graduate high school (18.0%)
- Among adults with diabetes³⁶ approximately:
 - 65.4% were ever diagnosed with hypertension
 - 54.7% were ever diagnosed with high cholesterol
 - 47.5% are obese
 - 13.6% are current smokers
 - 72.5% had two or more A1c tests in the prior year
 - 71.8% had a dilated eye exam in the prior year

³³ <http://www4.state.nj.us/dhss-shad/indicator/view/DiabetesDeath.Trend.html>

³⁴ NJDOH, "Diabetes in New Jersey"

³⁵ Ibid.

³⁶ Ibid.

- 68.1% had a foot exam in the prior year
- 59.9% perform daily self-monitoring of blood glucose
- 58.1% received an influenza immunization in the prior year
- 48.1% ever received a pneumococcal immunization
- 42.3% ever attended a diabetes self-management class
- In 2009, a total of 1,520 adults began treatment for diabetes-related end-stage renal disease.³⁷

As described in the HNJ2020, the goals set for diabetes improvement include:

Table VI. HNJ2020 Goals for Diabetes Improvement

Goals for Diabetes Improvement	
DM-1: Reduce the death rate due to diabetes	
Target:	15.8 per 100,000 standard population (age-adjusted)
Baseline (Year):	24.4 per 100,000 standard population (age-adjusted) (2007)
Data source:	Death Certificate Database, Center for Health Statistics, New Jersey Department of Health
DM-2: Reduce the rate of lower extremity amputations in persons with diagnosed diabetes	
Target:	28.6 per 1,000 persons diagnosed with diabetes
Baseline (Year):	31.8 per 1,000 persons diagnosed with diabetes (2009)
Data source:	Uniform Billing Patient Summary Data, Office of Health Care Quality Assessment, New Jersey Department of Health
DM-3: Increase the proportion of adults with diabetes who have an annual dilated eye examination	
Target:	72.2 percent (age-adjusted)
Baseline(Year):	65.6 percent (age-adjusted) (2009-2011)
Data source:	New Jersey Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health
DM-4: Increase the proportion of adults with diabetes who have a glycosylated hemoglobin measurement (AC1) at least twice a year	
Target:	59.4 percent (age-adjusted)
Baseline (Year):	54.0 percent (age-adjusted) (2009-2011)
Data source:	New Jersey Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health

Finding better and consistent methods to increase patient self care and training is critical to managing this chronic condition.

³⁷ Centers for Disease Control and Prevention: National Diabetes Surveillance System. Available online at: <http://www.cdc.gov/diabetes/statistics>. Retrieved [01/16/2013]

Improve Overall Quality of Care for Patients Diagnosed with Diabetes Mellitus and Hypertension

The purpose of this project is to develop and implement a patient centered medical home for patients with diabetes mellitus and hypertension resulting in improved overall quality of care.

The goals are to 1) reduce admissions, 2) reduce emergency department visits, 3) improve care processes, and 4) increase patient satisfaction.

Diabetes Group Visits for Patients and Community Education

The purpose of this project is first, to ensure that all newly diagnosed diabetic patients have a clear understanding of their plan of care. Second, that patients are knowledgeable regarding expected outcomes and disease management and third, to improve the opportunity for medical staff to gain continued and ongoing education from endocrinology areas.

The goals of this project are to 1) reduce admissions, 2) reduce emergency department visits, 3) improve care processes, and 4) increase patient satisfaction.

Develop Intensive Case Management for Medically Complex High Cost Patients

The purpose of this project is to reduce inpatient admissions and ED visits for the most costly medically complex patients with a primary diagnosis of diabetes through an intensive case management and care coordination program. This program assigns each enrolled patient to a physician-led team of multi-therapeutic providers. This team is available to help the individual navigate the health care system, access available financial assistance and utilize appropriate community resources.

The goals are to 1) reduce admissions, 2) reduce emergency department visits, 3) improve care processes, and 4) increase patient satisfaction.

F. HIV/AIDS

In 2012, 36,192 people were reported living with HIV or AIDS in New Jersey.³⁸ The data indicates that:

- Minorities account for 76% of adult/ adolescent cumulative (reported to the state) HIV/AIDS cases and 77% of all persons living with HIV/AIDS.³⁹

³⁸ NJDOH, "New Jersey HIV/AIDS Report, June 30, 2012": <http://www.state.nj.us/health/aids>

³⁹ Ibid.

- Seventy-nine percent (79%) of those persons living with HIV/AIDS are 40 years of age or older.⁴⁰
- Injection drug use and sexual contact remain the major modes of exposure to HIV infection. The proportion of reported cases with HIV/AIDS who were exposed through injection drug use (IDU) is lower than in the past, while the proportion of cases that were exposed through sexual contact is increasing.⁴¹

**Table VII. New Jersey Residents Living with HIV/AIDS as of June 30, 2012
Racial/Ethnic Group by Gender⁴²**

Race/Ethnicity	MALE		FEMALE		TOTAL		% of Prevalent Cases Who Are Female
	No.	%	No.	%	No.	%	
White	6,032	25%	1,937	16%	7,969	22%	24%
Black	11,550	48%	7,805	63%	19,355	53%	40%
Hispanic	5,818	24%	2,447	20%	8,265	23%	30%
Asian/Pac. Isl.	283	1%	101	1%	384	1%	26%
Other/Unknown	141	1%	78	1%	219	1%	36%
Total	23,824	100%	12,368	100%	36,192	100%	34%

Note: Percentages may not add to 100 due to rounding.

⁴⁰ NJDOH, "New Jersey HIV/AIDS Report, June 30, 2012": <http://www.state.nj.us/health/aids>

⁴¹ Ibid.

⁴² Ibid.

As described in the HN2020, some of the goals set for HIV/AIDS improvement include:

Table VIII. HN2020 Goals for HIV/AIDS

Goals for HIV/AIDS Improvement	
<u>HIV-1:</u> Reduce the rate of HIV transmission among adolescents and adults	
Target:	12.5 per 100,000 population
Baseline (Year):	15.6 per 100,000 population (2008)
Data source:	Enhanced HIV/AIDS Reporting System, Division of HIV/AIDS, STD, and TB Services, New Jersey Department of Health
<u>HIV-2:</u> Increase the proportion of HIV-infected adolescents and adults who receive HIV care and treatment consistent with current standards	
Target:	65 percent
Baseline (Year):	54 percent (2008)
Data source:	Enhanced HIV/AIDS Reporting System, Division of HIV/AIDS, STD, and TB Services, New Jersey Department of Health
<u>HIV-3:</u> Reduce the death rate due to HIV infection	
Target:	4.2 per 100,000 standard population (age-adjusted)
Baseline (Year):	5.3 per 100,000 standard population (age-adjusted) (2007)
Data source:	Death Certificate Database, Center for Health Statistics, New Jersey Department of Health

As new therapies become available, a larger percentage of patients will remain HIV positive for longer periods of time before developing AIDS. Ensuring that these patients are managed effectively is important to reduce incidence and prevalence of exposure. This population is dealing with complex social issues and medication regimens due to their illness, however with effective support, the condition can be managed by improving the overall quality of life for people living with HIV/AIDS. This project is geared to assisting the individual patient and the community at-large.

Patient Centered Medical Home for Patients with HIV/AIDS

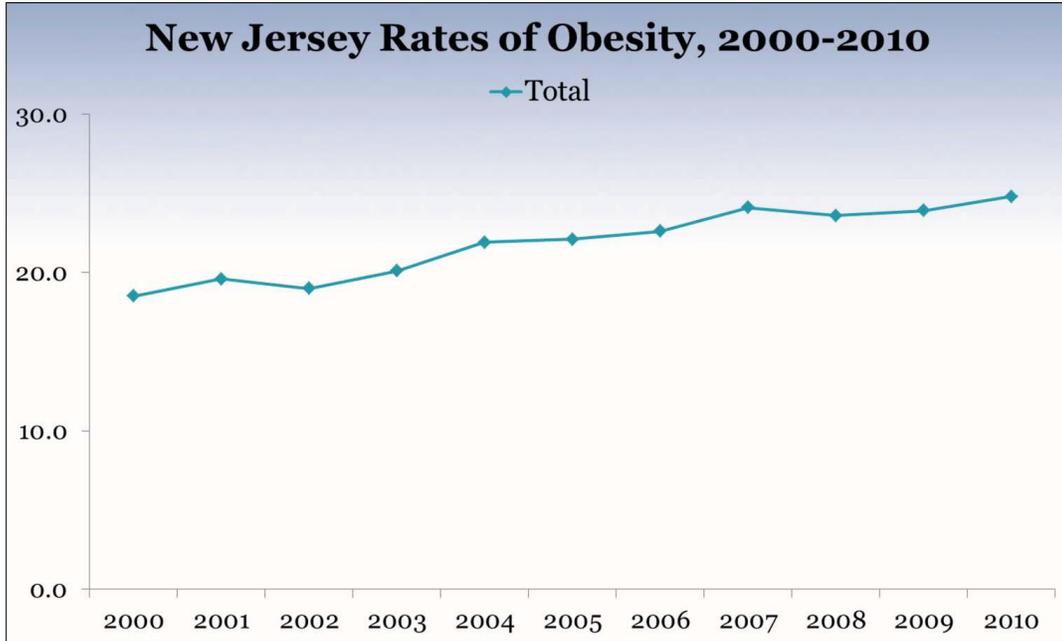
The objective of this project is to develop and implement a patient centered medical home for patients with HIV ensuring interdisciplinary outpatient management, intensive hospital discharge planning, and dedicated patient navigation services to ensure the receipt of optimal social services.

With increased support, it is expected that these objectives will be met: 1) reduce readmissions, 2) improve patient adherence to their treatment regimen, 3) improve care processes, and 4) increase patient satisfaction.

G. Obesity

Nearly one out of four (23.7%) New Jersey adults are obese.⁴³ As shown in Figure IX, over the last 10 years, rates of adult obesity increased 40%⁴⁴.

Figure IX. New Jersey Rates of Obesity, 2000-2010



Particularly New Jersey counties, Salem (33.8%), Cumberland (33.2%), and Atlantic (28.0%), have the highest rates of adult obesity in New Jersey while Hunterdon (20.5%), Somerset (21.3%), and Monmouth (21.3%) counties have the lowest rates⁴⁵.

If obesity rates continue to increase at their current pace, nearly half (48.6%) of New Jersey adults will be obese in 2030. Unfortunately, New Jersey has one of the three highest obesity rates in the nation among low-income children, ages 2-5 (16.5%).⁴⁶

Nearly one out of three (31%) children, ages 10-17 are overweight or obese in New Jersey. Eleven percent (11%) of New Jersey high school students are obese⁴⁷. Today's childhood obesity rates are putting New Jersey children on course to be the first generation in this country to live shorter and less healthy lives than their parents.

⁴³ NJDOH, "Physical Activity, Nutrition and Obesity New Jersey Fact Sheet"

⁴⁴ Ibid.

⁴⁵ NJDOH, "Physical Activity, Nutrition and Obesity New Jersey Fact Sheet"

⁴⁶ Ibid.

⁴⁷ Ibid.

In 2008, New Jersey spent \$2.2 billion on obesity-related health care. If obesity rates continue to increase, New Jersey’s obesity-related healthcare spending will quadruple to \$9.3 billion by 2018.⁴⁸

As indicated in the HNJ2020, some of the New Jersey goals in this topic area, shown in Table IX below, include ensuring that these target rates move or continue to match the benchmark.

Table IX. HNJ2020 Goals for Obesity

Goals for Obesity Condition Improvement	
NF-1: Prevent an increase in the proportion of the population that is obese	
NF-1a: adults aged 18 years and older	
Target:	23.8 percent
Baseline (Year):	23.8 percent (2011)
Data source:	New Jersey Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health
NF-1b: high school students (grades 9-12)	
Target:	10.3 percent
Baseline (Year):	10.3 percent (2009)
Data source:	New Jersey Student Health Survey of High School Students, New Jersey Department of Education
NF-2: Increase the proportion of the population consuming five or more servings of fruits and vegetables per day	
NF-2a: adults aged 18 years and older	
Target:	28.7 percent
Baseline (Year):	26.1 percent (2011)
Data source:	New Jersey Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health
NF-2b: high school students (grades 9-12)	
Target:	22.1 percent
Baseline (Year):	20.1 percent (2009)
Data source:	New Jersey Student Health Survey of High School Students, New Jersey Department of Education
NF-3: Increase aerobic physical activity	
NF-3a: Proportion of adults who meet current Federal physical activity guidelines for moderate or vigorous physical activity	
Target:	58.5 percent (age-adjusted)
Baseline (Year):	53.2 percent (age-adjusted) (2011)
Data source:	New Jersey Behavioral Risk Factor Survey, Center for Health Statistics, New Jersey Department of Health

⁴⁸ NJDOH, “Physical Activity, Nutrition and Obesity New Jersey Fact Sheet”

Goals for Obesity Condition Improvement	
NF-3b: Proportion of high school students that meet current physical activity guidelines for moderate or vigorous physical activity	
Target:	23.4 percent
Baseline (Year):	21.3 percent (2009)
Data source:	New Jersey Student Health Survey of High School Students, New Jersey Department of Education

The following DSRIP projects are primarily geared to children and developing healthy habits for those less than 18 years of age in New Jersey.

After School Obesity Program

The purpose of this project is to develop community partnerships to create school-based wellness programs for overweight children. The program is to provide education, exercise and medical services, such as targeted screenings (e.g. cholesterol and lipid screening, hypertension screening) by licensed practitioners.

The goals for this project are to 1) reduce patient body mass index (BMI), 2) improve patient adherence to their treatment regimen, and 3) improve care processes.

Wellness Program for Parents and Preschoolers

The purpose of this project is to develop a wellness program to help obese preschoolers and overweight parents improve eating habits and reduce body mass index. The program consists of alternating group-based sessions and in-home, one-on-one consultations.

The goals are to 1) reduce patient body mass index (BMI), 2) improve patient adherence to their treatment regimen, and improve care processes.

H. Pneumonia

Influenza and pneumonia combined are the tenth leading cause of death among New Jersey residents. Annual influenza vaccination is the most effective method for preventing influenza virus infection and its complications. Vaccination against pneumococcal disease has been effective in reducing infections among seniors and persons with medical conditions. Table X provides an overview of how New Jersey performed from years 2006-2010 for several quality measures for pneumonia care from 2006-2010.

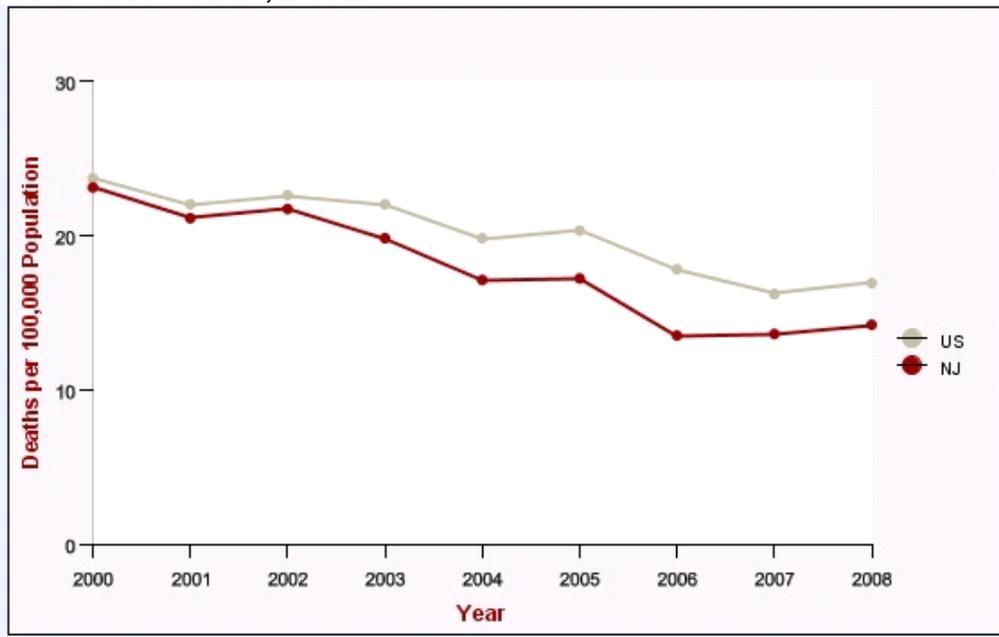
Table X. New Jersey Hospital Quality Scores

QUALITY MEASURE	2006	2007	2008	2009	2010
PNEUMOCOCCAL VACCINATION	87	91	93	95	96
ANTIBIOTIC SELECTION	89	92	92	94	95
ANTIBIOTIC TIMING			95	96	97
BLOOD CULTURES	94	94	95	97	97
SMOKING CESSATION ADVICE	94	96	97	99	100
INFLUENZA VACCINATION		87	90	93	95

The age-adjusted death rate due to influenza and pneumonia for both the United States and New Jersey between 2000 and 2008, shown in Figure X below, has declined over the years, but New Jersey continues to look for ways to decrease this rate. Current measurement results indicate that the New Jersey influenza and pneumonia death rate of 11.0 was below the United States average of 15.1 per 100,000. However, this rate reflects 1,128 deaths which suggests that more can be done.⁴⁹

⁴⁹ National Vital Statistics System, www.cdc.gov/nchs/pressroom/stats/FLU_PNEUMONIA_STATE_2010.pdf .

Figure X. Age-Adjusted Death Rate due to Influenza and Pneumonia by Year, New Jersey and the United States, 2000-2008⁵⁰



The following project will work towards improving recommended pneumonia care.

Patients Receive Recommended Care for Community-Acquired Pneumonia

The purpose of this project is to ensure that patients with community-acquired pneumonia (CAP) receive recommended care as measured by the Joint Commission/CMS Pneumonia Core Measure Set. A multi-therapeutic workgroup will ensure the implementation of standardized order sets for both the emergency department and the inpatient setting to ensure a consistent, evidence-based care approach.

The objectives are expected to 1) reduce readmissions, 2) decrease length of stay for Community-Acquired Pneumonia (CAP), and 3) improve care processes.

VI. Stage 3 Measures (Project-Specific Metrics)

As noted above, it is the goal of the DSRIP program to positively affect the health outcomes for all New Jersey residents. In order to monitor the performance of the DSRIP projects, a set of clinical process and outcome measures have been chosen that can demonstrate measureable improvement towards meeting the project objectives. Stage 3 of the DSRIP program focuses on measuring this improvement.

⁵⁰ NJDOH, New Jersey Health Assessment Data; Available at: <http://www4.state.nj.us/dhss-shad/indicator/view/PneuFluDeath.Trend.html>

Stage 3 metrics have been selected based on nationally recognized measurements related to the project condition. The metrics chosen are recognized by national bodies including the American Academy of Pediatrics, the American Medical Association, the National Committee on Quality Assurance (NCQA) and the National Quality Forum (NQF).

The Stage 3 measures that will be collected are listed in Addendum 1 of this protocol.

In order to determine the performance of Stage 3 measures, data capture of medical record charts, electronic health records, or data captured and submitted on a claim to the state's Medicaid Management Information System (MMIS) may be required. To support efficient analysis of performance reporting, the Department will calculate the performance rate for measures that utilize claims-based data. It will be the responsibility of the hospital, to capture and submit all other measures. The baseline performance periods for each Stage 3 measure will be based on the measure's technical specifications and will be detailed in a measurement databook that will be developed and made available to the hospitals in the toolkit no later than November 15, 2013.

However, it is expected that for any Stage 3 measure that is currently being collected by the hospital, that baseline data be supplied with the submission of the DSRIP application. For any data that is not currently being collected, the hospital will be required to submit a plan outlining the means and timeline to collect and submit the data per the reporting requirements described in Attachment 1: DSRIP Toolkit.

Payment for reporting all measures will occur during demonstration years 2 and 3. Certain Stage 3 measures will be tied to pay for performance (P4P) (e.g. pay for improvement) incentive payments during demonstration years 4 and 5 as outlined in the Funding and Mechanics Protocol (FMP).

VII. Stage 4 Measures (Universal Metrics)

The purpose of this section is to specify a set of Stage 4 measures that must be collected and reported by all hospitals regardless of the specific project that they choose to undertake. A catalogue of the Stage 4 measures is included in Addendum 2 to this protocol.

It is expected that for any universal Stage 4 measure currently being collected, baseline data will be supplied with the submission of the DSRIP application. For any data that is not currently being collected, the hospital will be required to submit a plan outlining when the hospital will be able to collect and submit the data per the reporting requirements described in the DSRIP Toolkit. The baseline

performance periods for each Stage 3 measure will be based on the measure's technical specifications and will be detailed in a measurement databook that will be developed and made available to the hospitals in the toolkit no later than November 15, 2013.

Funding will be tied to the reporting of Stage 4 measures throughout the demonstration period as outlined in the Funding and Mechanics Protocol (FMP). Hospitals may be able to obtain additional funding through the Universal Performance Pool for certain Stage 4 measures, also outlined in the FMP.

A. Attribution

Performance measurement for both Stage 3 and 4 metrics will measure improvement for specified population groups, including the Charity Care, Medicaid and CHIP populations, collectively referred to as the Low Income population.

An attribution model to link the Low Income (Charity Care, Medicaid and CHIP) population with DSRIP project partners for Stage 3 and 4 performance measurement will be developed by the Department with the input and support by the hospital industry.

The Low Income attribution model will be based on one of the following models:

- a) The CMS Pioneer Accountable Care Organization (ACO) Program or Medicare Shared Savings Program, if suitable using MMIS data
- b) An ACO model if operational at a NJ hospital system or Medicaid Managed Care Organization (MCO)

This model will be submitted to CMS by September 30, 2013 for review and approval by CMS by October 14, 2013.

VIII. Requirements of the Hospital DSRIP Plans

This section details the requirements of the Hospital DSRIP Plans, consistent with subparagraph (g) of the STCs.

A. DSRIP Plans

Each hospital that elects to participate in the DSRIP program must submit a Hospital-specific DSRIP Plan using a Department approved application that identifies the project, objectives, specific milestones, and metrics and meets all requirements pursuant to the STCs. The following provides a description of the organizational structure of the DSRIP Plan.

i. General Requirements

Hospitals will first select one of the nine focus areas. The focus areas are:

- Asthma
- Behavioral Health
- Cardiac Care
- Chemical Addiction/Substance Abuse
- Diabetes
- HIV/AIDS
- Obesity
- Pneumonia
- A medical condition unique to the hospital

CMS approval will be required for all hospital unique focus areas.

Once the focus area is determined, the DSRIP participating hospital will choose a project from the project array for the focus area selected. The hospital will then select activities from a pre-determined menu of activities related to the development and implementation of the project. Hospitals are encouraged to use innovative and value-driven approaches in accomplishing the project activities.

As stated before, hospitals may select an “off-menu” or “unique” project related to the focus area selected, however, this project will need to be completely developed by the hospital and will be subject to higher levels of scrutiny and review by the Department and CMS during the approval process and include the justifications described in Section V.

ii. Framework for the Development of the Hospital DSRIP Plan (i.e. Hospital DSRIP Plan Template)

The Hospital DSRIP Plan Template included in Attachment 1: DSRIP Toolkit, Section IV. provides a framework for each DSRIP Project and the development of the hospital’s DSRIP Plan. It includes several required elements, including those described below in the Executive Summary and Other DSRIP Plan Required Components. The Hospital DSRIP Plan Template includes the menu of activities, the associated actions/milestones, the associated metrics, and the minimum submission requirements. It also provides guidance to the hospitals as to when each activity is expected to be completed.

iii. High Performing Hospitals - Baseline Performance Threshold

It is the expectation of the Department and CMS that a hospital select a project for which substantial need for improvement in the Focus Area is reflected. Therefore, for each Stage 3 pay for performance metric, a baseline performance threshold will be established in order to determine if a hospital can use the metric for pay for performance payments. The performance threshold is calculated using baseline data.

This baseline performance threshold will be calculated at:

- the lower of 20 percentile points below the metric's high performance level (improvement target goal), based on New Jersey hospital's data, *or*
- 20 percentile points below the 95th percentile of national performance data, if national data is available for the low income population.

For example, if the metric's improvement target goal is the 90th percentile, the metric's baseline performance threshold will be set at the 70th percentile (90th percentile – 20 percentile points = 70th percentile). However, there will be no minimum performance cut-off for low performance on these metrics.

If a hospital's metric baseline year performance for any given Stage 3 pay for performance measure exceeds the metric's baseline performance threshold, the following rules will apply:

a. Exceeds All Measures –

- *Non-cardiac project* - If a hospital exceeds the performance threshold for all project-specific Stage 3 pay for performance measures for a non-cardiac project at baseline, the hospital will be required to select a different project.
- *Cardiac project* - If the hospital exceeds the performance threshold for all project-specific Stage 3 pay for performance measures for a cardiac care project at baseline, the hospital may either (1) select a different project, or (2) substitute an equal number of measures from the Million Hearts Campaign. These are to be selected based on which of the hospital's baseline performance among New Jersey hospitals is lowest in terms of percentile, and consistent with (iii.d.) below.

From the time the hospital is notified it exceeds all Stage 3 measures until a new project application or project expansion is approved by the Department and CMS, the hospital will receive no DSRIP payments.

b. Exceeds Multiple Measures -

- If a hospital exceeds the performance threshold for more than one project-specific pay for performance measure, but not all project-specific P4P measures, the hospital will be required to substitute measures as provided under item (iii.d.) below.

Also, as part of its next required quarterly report, the hospital will be required to document the project integrity including the applicability of Stage 1 and Stage 2 activity plans and additional measures the hospital will institute to measure project improvement.

- c. Exceeds a Single Measure –
 - If a hospital exceeds the performance threshold for only one project-specific pay for performance measure, the hospital will have the option of (1) receiving payment using one less measure, or (2) substituting the measure as provided under item (iii.d.) below provided the hospital has at least two Stage 3 P4P measures.
- d. Measure substitution:
 - *Non-cardiac project* - For projects other than cardiac care projects, the substitution measure may be either:
 - The hospital's lowest performing Stage 4 metric, or
 - Other outcomes metrics, as recommended by the Quality & Measures Committee and as approved by the Department and CMS. The hospital's baseline performance for this substitution metric must be lower than the measure's baseline performance threshold.
 - *Cardiac project* - Hospitals who selected a cardiac care project must select from one of the Million Hearts metrics where the hospital's baseline performance is lower than the metric baseline performance threshold for the given Million Hearts metric.
- e. Reinstatement of Stage 3 Pay for Performance Measure - For any performance metric where the performance was higher than the metric's Baseline Performance Threshold at the baseline and substitution occurred, but later the hospital regresses on the measure to below the Baseline Performance Threshold, pay for performance for the measure may apply the following demonstration year.

For reference to the improvement target goal calculation please review the Funding and Mechanics Protocol Section VII.B.

iv. Executive Summary

The Executive Summary shall provide a summary of the hospital's DSRIP Plan, including a description of the health system, a description of the hospital's patient population and a description of the hospital's vision of delivery system transformation. It shall also describe the significance of the project as it relates to the hospital, and the community, share key challenges facing the hospital, and convey how the DSRIP Plan realizes the hospital's vision and mission.

a. Significance

As part of this subsection, each hospital will provide the rationale for selecting the project and project activities based on the significance to the population their hospital serves and their community needs as determined through a community needs assessment. The hospital must show how the project will measurably improve health for their

patient population, how the activities selected will demonstrate improvement, and how the DSRIP project they selected is consistent with their hospital's mission, quality goals and the Department's DSRIP vision.

The community needs assessment should consider the greater needs of the community. It should include the following elements:

- Demographic information (e.g., race/ethnicity, income, education, employment, etc.)
- Description of the current health care infrastructure and environment (e.g., number/types of providers, services, systems, and costs; Health Professional Shortage Area [HPSA], federally qualified health centers, state funded health centers, department of health facilities, health care for the homeless)
- Insurance coverage (e.g., commercial, Medicaid, Medicare, uncompensated care)
- Description of changes in the above areas that are expected to occur during the waiver period
- Key health challenges specific to the hospital's surrounding area supported by data (e.g., high diabetes rates, access issues, high emergency department utilization, etc.)
- Description of how hospitals will include and/or coordinate with their local health officials in the DSRIP project and community needs assessment. The Department strongly encourages collaboration between participating hospitals and public health.

The participating hospital's community needs assessment should guide the selection of a project and be reflected in the DSRIP Plan. The community needs assessment may be compiled from existing data sources.

b. Challenges

Participating hospitals are required to describe the current and expected challenges or issues the hospital faces or will face while implementing their project. Hospitals will also need to include a brief description of the delivery system solution identified to address those challenges. If one of the hospital's challenges is that it cannot provide all or part of the baseline data requirement, the hospital will be required to describe in this section, the hospital's plan, including a timeline, for implementing the necessary means for obtaining and submitting the baseline data to the Department.

c. Starting Point

The starting point should include the identification of project needs, such as funding, data, members of the project plan, etc., and how those needs will be met to begin the project. Participating hospitals must demonstrate whether the project is a new initiative for the

hospital, or significantly enhances an existing health care initiative. Hospitals must identify all parts of the DSRIP project currently or expected to be funded by other CMS, U.S. Department of Health and Human Services (HHS), or other government funded initiatives in which they participate. The hospital must explain how their proposed DSRIP activities are not duplicative of the activities already funded or expected to be funded in the future.

d. Public Input

The Hospital-specific DSRIP Plan shall include a description of the processes used to engage the following stakeholders:

- Hospitals and other providers in the region
- Local public health departments. Hospitals must consider local public health departments as part of the public input process
- Public stakeholders and consumers
- Any other project stakeholders identified by the hospital

At a minimum the processes used to solicit public input should include a description of public meetings that were held, the process for receiving public comment on the hospital DSRIP plan, and a plan for ongoing engagement with public stakeholders (including the Quality & Measures Committee described in Section IX).

Each project in New Jersey's DSRIP project array generally identifies the population-focused objectives, the methodology by which the hospital will conduct the project, and anticipated outcomes of the project. As outlined in the Hospital DSRIP Plan Template, the hospital will be required to identify each elective stage activity and when the elective and required activities will be completed in the demonstration. For each activity, hospitals will also be required to include its hospital-specific objectives, methodologies, and goals/outcomes.

v. ***Other DSRIP Plan Required Components***

As part of the DSRIP Plan, the DSRIP application will require hospitals to identify several key program components that will be needed for Stage 1 Infrastructure Development. These include conducting a gap analysis, identifying partners, identifying the target population, and identifying interventions.

The menu of pre-defined project activities includes the required steps to develop and implement the hospital's project plan. In the application, hospitals will be required to prepare for key project components such as the identification of the multi-therapeutic medical and social support team needed, staff education needs, technical needs, logistical and supply needs, data needs, and marketing/outreach needs. Stage 1 activities will be related to procuring these needs.

The menu of activities includes the quality improvement interventions required to achieve the outcomes of the project (e.g. improving treatment protocols, discharge planning and care transitions, instituting population registries and case management systems, developing patient centered and integrated medical/ behavioral health homes).

vi. *Milestones and Metrics Table*

The DSRIP Plan will indicate by demonstration year when project activities and milestones will be achieved and indicate the data source that will be used to document and verify achievement.

- Hospitals must select a minimum of 7 activities from Stage 1.
- Hospitals will complete all of the defined activities in Stage 2.
- Stage 3 and Stage 4 activities consist of reporting the project-specific metrics and the universal metrics, respectively. Hospitals will be required to report these metrics throughout the demonstration period. Funding for this activity is based on reporting and/or meeting improvement targets. Further detail on how this reporting activity ties to funding is included in the FMP.

B. Project Activities, Milestones, and Metrics

The DSRIP Plan will include sections for each of the 4 stages specified above in Section IV. Project Stages. The following are the requirements for the DSRIP application and each of the four stages.

i. Stage 1 Requirements: Infrastructure Development

Stage 1 involves procuring the necessary resources identified in the application and the infrastructure needed to conduct the project.

ii. Stage 2 Requirements: Chronic Medical Condition Redesign and Management

Stage 2 involves activities related to piloting the project to the hospital selected pilot population, as well as re-designing the project based on the results of the pilot. All Stage 2 activities, identified in the Hospital DSRIP Plan Template (Attachment 1: DSRIP Toolkit), are required.

iii. Stage 3 Requirements: Outcome Reporting and Quality Improvements

Stage 3 involves the monitoring of project-specific clinical measures that are associated with the achievement of implementing Stage 1 and 2 project activities and meeting milestones. All participating hospitals shall report these project-specific outcomes in each demonstration year at a frequency indicated in Attachment 1: DSRIP Toolkit, Section II. Calendar - Timelines.

Improvement target goals for selected measures will be established based on the methodology described in the FMP. The metrics shall assess the results of care experienced by patients, including patient's clinical events, patient's recovery and health status, patient's experiences in the health system, and efficiency/cost.

As part of the DSRIP Plan application, hospitals are required to submit baseline data for each project-specific metric that is the responsibility of the hospital (e.g. non-claims based measure). If the hospital is unable to provide baseline data at the time of application due to a lack of infrastructure, the hospital will be required to describe the hospital's plan, including a timeline, for implementing the infrastructure to obtain the data. Such baselines must be established no later than DY 3.

iv. Stage 4 Requirements: DSRIP Performance Indicators (i.e. Universal Metrics)

Pursuant to the STCs, hospitals will be required to report DSRIP performance indicators as a Stage 4 activity. These universal metrics will be reported across several domains selected by the Department based on community readmission rates and hospital acquired infections. DSRIP performance indicators will be connected to the achievement of providing better care, better access to care, and enhanced prevention of chronic medical conditions and population improvement. In accordance with this requirement, by the end of DY 3, hospitals must include reporting of all defined DSRIP universal metrics.

In addition to reporting and payment of Stage 4 measures, hospitals will be eligible to receive payments for a core set of Stage 4 measures through a financial performance pool. The Universal Performance Pool (UPP) rewards hospitals that maintain, or improve hospital performance across a broad spectrum of critical domains of inpatient care. The measures eligible for this pool are denoted in the Addendum 2: Stage 4 Measures Catalogue.

IX. Quality & Measures Committee (Committee)

The Department will develop and put into action a committee of stakeholders who will be responsible for supporting the clinical performance improvement cycle of DSRIP activities. The Committee will serve as an advisory group offering expertise in health care quality measures, clinical measurement and clinical data used in performance improvement initiatives.

Final decision-making authority will be retained by the Department and CMS, although all recommendations of the committee will be considered by the Department and CMS.

Specifically, the Quality & Measures Committee will provide feedback to the Department regarding:

- Development of the Low income attribution model
- Selection of additional metrics for hospitals who have reached the Metric Baseline Performance Threshold
- Selection of the Improvement Target Goal for Stage 3 performance metrics tied to incentive payments

A. Composition of the Committee

The membership of the committee shall consist of between seven and nine members with no more than three members employed by New Jersey hospitals. All members will be appointed by the Commissioner of Health based on the following composition criteria:

- Representation from community health centers serving the low income population.
- Several members shall be clinical experts in one of the following specialty care areas: Behavioral Health, Cardiology, HIV/AIDS, Pulmonology, and Primary Care. Clinical experts are physicians, physician assistants, nurse practitioners, and registered nurses.
- At least two members shall have significant expertise in clinical quality measurement of hospitals. Significant expertise is defined as not less than five years of recent full time employment in quality measurement in government service or from companies providing quality measurement services to hospitals.
- A member from the New Jersey Hospital Association, the largest trade association in New Jersey, with current expertise and engagement in quality management services provided to New Jersey hospitals.
- A member as a consumer.

X. DSRIP Program Performance Management

Performance management and assessment of the DSRIP program will occur throughout the duration of the waiver and will take on several forms. Each area of assessment is interrelated to ensure a continuous cycle of quality improvement and shared learning.

- 1) A formative evaluation of DSRIP will occur on a regular basis which seeks to provide timely and actionable feedback on the initiative's progress, in terms of both implementation activities and outcomes. The formative evaluation, or performance management, will track and report regularly on actions, progress towards achieving a health care system based on the Triple Aim, and progress toward achieving the primary goals of DSRIP.
- 2) Learning collaboratives will be implemented to seek peer-to-peer (hospital-to-hospital) input on project level development of action plans, implementation approaches and project assessment. The Department will be responsible for leading the collaborative approach to ensure effective sharing of information (e.g. best practices, case studies, challenges, results).
- 3) A mid-point assessment of DSRIP will be completed by the independent DSRIP evaluator to provide broader learning both within the state and within the national landscape. Part of the midpoint assessment will examine issues overlapping with the formative evaluations, and part of this effort will examine questions overlapping with the final summative evaluation.
- 4) A final summative assessment of DSRIP will be completed by the independent DSRIP evaluator describing changes in quality and access outcomes resulting from DSRIP, as well as other outcomes of interest and identifying the changes in outcomes resulting from transformation activities.

A. New Jersey DSRIP Performance Management

The Department, or its designee, will conduct robust monitoring and assessment of all submitted reports, hospital progress, challenges and completion no less frequently than quarterly, and as appropriate in order to monitor DSRIP implementation and activities.

Upon this review, an analysis will be made regarding:

- the extent of progress each hospital is making towards meeting each milestone
- the specific activities that appear to be driving measureable change
- the key implementation challenges associated with specific activities designed to drive improvement
- the identification of adjustments to the DSRIP program, and/or projects as observed through the analysis of submitted hospital-level data and/or onsite findings as they occur

Comparative analysis and findings will be performed and summarized into actionable reports that provide the right level of information to various program stakeholders to help facilitate learning at the hospital level, as well as the DSRIP

program level. The reports will be used to drive peer-to-peer hospital discussion regarding opportunities for improvement and methods for course correction through the use of the Learning Collaborative. The results of these assessments will be disseminated to the independent DSRIP evaluation contractor and CMS. This information is expected to inform the DSRIP evaluation during both the mid-point and summative evaluations to understand key factors related to the performance and progression of the DSRIP program to date.

The Department, or its designee, will take effective action, as needed, to remedy a finding to promote fulfillment of the DSRIP goals. This may include providing feedback to the hospital industry at-large, or individual project participants if significant issues are observed.

B. Learning Collaborative

One facet of the DSRIP program is the development of the Learning Collaborative. The purpose of the Learning Collaborative is to promote and support a continuous environment of learning and sharing within the New Jersey healthcare industry in an effort to bring meaningful improvement to the landscape of healthcare in New Jersey.

The Learning Collaborative will be managed by the Department through both virtual and in-person collaboration that both builds relationships as well as facilitates program analysis and measurement. The Learning Collaborative will be designed to promote and/or perform the following:

- Sharing of DSRIP project development including data, challenges, and proposed solutions based on the hospitals' quarterly progress reports
- Collaborating based on shared ability and experience
- Identifying key project personnel
- Identification of best practices
- Provide updates on DSRIP program and outcomes
- Track and produce a "Frequently Asked Questions" document
- Encourage the principles of continuous quality improvement cycles

There will be multiple collaboratives developed based on the number and type of projects chosen by hospitals. For each collaborative, the Department will designate personnel to be responsible for guiding and facilitating the Learning Collaborative.

An online, web-based tool will be utilized in order to effectively manage the collection and the dissemination of information related to the DSRIP program and projects. A key component of the online tool will be a reporting feature that allows tiered-level reporting that conveys key information to the various levels of stakeholder groups interested in learning and tracking performance of the DSRIP

program. This tool will act as a repository with reporting capability for various audiences including that of the general public, the Department, CMS, and the healthcare industry.

The tool will deliver data in ways that can be 1) easily interpreted by various stakeholders, 2) promote self-evaluation, and 3) promote the diffusion of effective intervention models.

i. Operational Report

An operational report at the project level will be the primary report to manage and report DSRIP performance. The operational report will have the functionality to report on project-level data related to hospitals performing the same project. This may include such data elements as:

- Identification of participating hospitals
- Completion factor of hospitals, by Stage by hospital
- Dashboard of project-specific Stage 3 measure results
- Summary of applied interventions
- Summary of pilot models
- Summary of reported challenges
- Summary of reported successes
- Noted best practices

This report will be used to inform and direct the Learning Collaboratives. It will be used to ensure consistent analysis on key implementation activities across hospitals and act as a platform for discussion during monthly conference calls and quarterly in-person collaboration meetings. This report may be utilized by the hospital project personnel as a primary tool to aid routine collaboration among hospitals implementing the same project. This level of reporting may also show progress of the learning process itself by tracking the frequency of meetings by activity and participation in order to confirm that the learning collaborative activity is being fulfilled by the hospital.

It will be the responsibility of each project participant to ensure effective diffusion of learning amongst hospitals who have selected the same project focus area. This includes discussing the types of innovations, strategies and Plan-Do-Study-Act (PDSA) cycles that have been implemented throughout the demonstration.

ii. Executive Level Report

An executive level report will have the functionality to report on high-level summary statistics related to the most recent quarter's DSRIP reports. This may include such data components as:

- Number of participating hospitals
- Number of approved/ rejected plans
- Count of plans by focus area and by project
- Completion factor of plans by Stage
- Dashboard of universal Stage 4 measure results

This report may be utilized by the public, CMS and the Department to track the overall progress of the DSRIP program.

iii. Consumer Level Report

A consumer level report will have the functionality to report on high-level geographic and project-specific data elements in order to understand which hospitals in their area are driving to improve quality and the area of focus for that hospital. The report may include:

- County-level map that indicates all New Jersey hospitals
- County-level map that indicates all participating hospitals and participating outpatient providers

This report may also have drill-down functionality to learn summary detail about the objective, methodology and expected results of each hospital.

C. DSRIP Program Evaluation

i. Evaluation Objectives and Research Questions

The Center for State Health Policy (CSHP) at Rutgers University will provide a mid-point assessment and a final, summative evaluation of the DSRIP program, answering research questions detailed in the “Special Terms and Conditions” (STCs) issued by CMS upon approval of the Comprehensive Waiver.

This evaluation has two components, both of which will utilize a mix of quantitative and qualitative methods:

1. A midpoint assessment which will provide independent quantitative analysis of DSRIP planning and implementation through December 2013, as well as timely qualitative research findings which will provide context for reports on hospitals’ progress in planning and implementing selected DSRIP programs. The qualitative findings will contribute to understanding implementation issues which go beyond the quantitative analyses. In

addition, the qualitative analysis will inform and sharpen analytic plans for the summative evaluation.

2. The summative evaluation is designed to provide an independent analysis of key metrics to address how well the DSRIP Program achieves better care and better health for populations in the hospital catchment areas, as well as lower costs through improvement. Qualitative analysis, including key informant interviews and document review, will be conducted throughout planning and implementation of the DSRIP Program, to provide stakeholder perceptions of improvements in care and strengths and weaknesses of the program.

The mid-point assessment will be submitted by the end of June 2015. The final, summative evaluation will be completed by the end of March 2018.

The evaluation will use quantitative and qualitative research methodologies to test New Jersey's global hypothesis about the effectiveness of the DSRIP program.

"The DSRIP Program will result in better care for individuals (including access to care, quality of care, health outcomes), better health for populations and lower cost through improvement."

The following overall research questions (detailed in the STCs) guide the scope for the evaluation:

- 1) To what extent does the program achieve better care?
- 2) To what extent does the program achieve better health?
- 3) To what extent does the program lower costs?
- 4) To what extent did the program affect hospital finances?
- 5) To what extent did stakeholders report improvement in consumer care and population health?
- 6) How do key stakeholders perceive the strengths and weaknesses of the program?

Quantitative process and outcome measures along with inputs from qualitative analyses will be utilized to independently analyze data evaluating items 1-4. A qualitative approach will answer questions 5 and 6 based on stakeholder interviews, observations of program meetings, and review of relevant documents.

The mid-point and summative evaluation will meet all standards of leading academic institutions and academic peer review, as appropriate for both aspects of the DSRIP program evaluation, including standards for the evaluation design, conduct, interpretation, and reporting of findings.

ii. Evaluation Hypotheses and Metrics

Hypotheses and sub-hypotheses will be tested relating to specific program interventions and population-focused health improvement initiatives.

Hypothesis 1: The adoption of projects in a specific focus area (e.g., cardiac care, asthma) will result in greater improvements in those outcomes for patients in hospitals adopting these interventions compared to hospitals which do not adopt these interventions.

After hospital projects are approved and finalized, this general hypothesis can be broken down into sub-hypotheses, tailored to specific projects; e.g.,

Hypothesis 1a: Rates of 30-day hospital readmissions arising from heart failure, and associated costs will decrease in hospitals adopting cardiac care interventions during the DSRIP program.

Hypothesis 1b: Rates of asthma admissions and ED visits will decrease for patients in hospitals adopting asthma management programs.

Hypothesis 2: During implementation of the DSRIP, population-based rates of potentially avoidable inpatient hospitalizations and treat-and-release emergency department visits (that reflect inadequate care) and associated costs will decrease among hospitals participating in the DSRIP.

Hypothesis 3: Hospitals which participate in the DSRIP program will improve racial/ethnic and gender disparities in avoidable hospital admissions, treat and release ED visits, and hospital readmissions.

Hypothesis 4: Hospitals which achieve their performance objectives and receive incentive payments under the DSRIP will experience no adverse impact on their finances.

Hypothesis 5: Stakeholders will report improvements in consumer care.

Hypothesis 6: Stakeholders will report improvements in population health.

Hypothesis 1 will examine the effectiveness of the individual projects by assessing hospital performance on the basis of selected metrics (See Table XI) which will be calculated for all hospitals. Calculation of project-specific metrics for all hospitals irrespective of the program chosen by them will facilitate evaluation of these programs by ensuring comparison groups. Table XII lists additional measures (relating to hypothesis 2) that reflect quality of care within the overall delivery system, such as rates of ambulatory care sensitive hospitalizations, and treatment costs at the hospital inpatient and ED care settings. These measures can be independently calculated from hospital discharge and/or claims based

data for comparison with hospital-reported data. In addition, these measures will be reported for all waiver populations, facilitating comparisons as appropriate.

Measures have been selected which can be independently calculated by the evaluator from hospital discharge and/or claims-based data and are thus available for all hospitals to facilitate comparison with hospital-reported data. Metrics that require medical charts and cannot be calculated from administrative data e.g., those related to screening for depression, are not included, since they cannot be independently calculated.

Measures are intended to reflect the effect of the intervention on the overall delivery system, e.g., readmissions or ambulatory care sensitive admissions. The measures were chosen to assess inpatient as well as ambulatory care received by patients, in contrast to much narrower inpatient process measures which are further removed from patient outcomes.

The list of metrics include those chosen to reflect the current policy changes related to hospital financing, such as rates of all-cause readmissions from initial hospitalizations of heart failure, AMI and pneumonia. The measures of potentially avoidable inpatient hospitalizations and primary care preventable/avoidable treat-and-release ED visits will be used across all populations covered by the Comprehensive Waiver Demonstration.

In addition, the evaluators will examine changes over the DSRIP years in up to ten (10) measures reported by hospitals or the State. For each metric, we will require the magnitude (N) of the population denominators used by each hospital as the basis for each measure in order to generate standard errors and compute statistically significant differences. The (N) refers to the actual number of the population denominator used for each measure that is required to calculate the standard errors for statistical comparisons. The ten measures chosen for evaluation reporting should not require adjustment for patient characteristics. A list of candidate measures might include:

- COPD Admission Rate
- CHF Admission Rate
- Controlling High Blood Pressure
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening in Women Age 21-24
- Diabetes Screening for people with schizophrenia or bipolar disorder who are prescribed with antipsychotic medications
- Measures relating to childhood immunization status; well-child visits; and access to primary care.

The final list may differ.

Table XI: Project-Specific Metrics

Stage III-Project	Metric	Data source
Asthma	Percent of patients who have had a visit to an Emergency Department (ED) for asthma in the past six months.*	UB; MC
	<i>Adult Asthma Admission Rate</i>	UB; MC
Behavioral Health	Follow-up After Hospitalization for Mental Illness (30 days post discharge)	MC
	<i>Follow-up After Hospitalization for Mental Illness (7 days post discharge)</i>	MC
<u>Cardiac Care</u>	30-Day All-Cause Readmission Following Heart Failure (HF) Hospitalization**	UB; MC
	<i>30-Day All-Cause Readmission Following Acute Myocardial Infarction (AMI) Hospitalization**</i>	UB; MC
<u>Chemical Addiction/ Substance Abuse</u>	Engagement of alcohol and other drug treatment	MC
	<i>Initiation of alcohol and other drug treatment</i>	MC
<u>Diabetes</u>	Diabetes Short-Term Complications Admission Rate	UB; MC
HIV/AIDS	Percentage of HIV patients who had 2 or more CD4 T-cell counts performed during the measurement year	MC
<u>Pneumonia</u>	30-Day All-Cause Readmission Following Pneumonia (PN) Hospitalization	UB; MC

Notes:

Metrics adapted from the 'Catalogue of Project Specific Metrics' accompanying the DSRIP planning protocol

UB-All-payer uniform billing discharge data for inpatient stays and/or emergency department visits

MC- Medicaid Claims & Encounter Data

Some metrics reflecting outpatient services can only be calculated with Medicaid claims data

*original metric included visits to urgent care office; which cannot be identified all-payer discharge data or Medicaid claims/encounter data

Table XII: Metrics for Overall Evaluation of the DSRIP Program

Stage IV Metrics	Description	Data Source
Mental Health Utilization	The number and percentage of patients receiving inpatient mental health services during the measurement year.	UB; MC
30-Day All-Cause Readmission Following Heart Failure (HF) Hospitalization	The measure estimates a hospital-level, risk-standardized, all-cause 30-day readmission rate for patients discharged from the hospital with a principal discharge diagnosis of Heart Failure (HF).	UB; MC
30-Day All-Cause Readmission Following Acute Myocardial Infarction (AMI) Hospitalization	The percent of 30 day all-cause readmission rate for patients with AMI.	UB; MC
30-Day All-Cause Readmission Following Pneumonia (PN) Hospitalization	The percent of 30 day all-cause readmission rate for patients with pneumonia.	UB; MC
30-Day All-Cause Readmission Following Chronic Obstructive Pulmonary Disease (COPD) Hospitalization	The percent of 30 day all-cause readmission rate for patients with COPD.	UB; MC
Hospital Acquired Potentially-Preventable Venous Thromboembolism	The number of patients diagnosed with confirmed VTE during hospitalization (not present at admission) who did not receive VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date.	MC
Rate of potentially avoidable inpatient hospitalizations reflecting inadequate level of ambulatory care. Based on AHRQ methodology for calculating Prevention Quality Indicators. ⁵¹		UB
Rate of Primary Care Preventable/Avoidable Treat and Release ED visits. Based on methodology by John Billings, New York University. ⁵²		UB
Total hospital inpatient , and treat-and-release Emergency Department costs stratified by patient age and race/ethnicity		UB
Hospital Total and Operating Margin		Hospital Financial Statements

Notes:

Metrics adapted from the Catalogue of Universal Metrics accompanying the DSRIP planning protocol
 UB-All-payer uniform billing discharge data for inpatient stays and/or emergency department visits
 MC- Medicaid Claims & Encounter Data
 Some metrics reflecting outpatient services can only be calculated with Medicaid claims data

⁵¹ Bindman AB, K Grumbach, D Osmond, M Komaromy, K Vranizan, N Lurie, J Billings, and A Stewart. "Preventable Hospitalizations and Access to Health Care." *Journal of the American Medical Association* 274, no. 4 (1995): 305–11.

⁵² Billings J, N Parikh, and T Mijanovich. *Emergency Department Use: The New York Story*. New York: Commonwealth Fund, 2000.

The qualitative methods used to gather and analyze data to address Hypotheses 5 and 6 are detailed in section D.ii. below.

iii. Data Sources and Collection

The evaluation metrics (with the exception of hospital total and operating margin) can be consistently calculated across hospitals and for the state as a whole using all-payer, uniform billing (UB) NJ hospital discharge data, or NJ Medicaid paid claims and managed care encounter data. Those measures utilizing UB data can be calculated for all payers, while those using Medicaid paid claims/encounters can be calculated for Medicaid only. UB data will be used to identify trends in hospital utilization that may differ across payers.

UB data can be obtained approximately nine months after the end of each calendar year, although the data years can be aggregated to calculate measures using time periods which span successive years, e.g. federal fiscal years or other definitions used in endorsed specifications. CSHP has had an existing arrangement with the New Jersey Department of Health, Center for Health Statistics to merge multiple years of UB data to identify patient level utilization/readmissions over time and provide the data without personal identifiers. This will provide the ability to track patients and utilization over time. We will work with the Department of Health to obtain approval to extend this arrangement for the DSRIP evaluation. CSHP is executing a Data Use Agreement with Medicaid which will provide paid claims and encounter data every six months during the period of the evaluation. Medicaid has advised us that all claims are subject to retroactive adjustment and have suggested that CSHP apply a lag period of nine months to allow for updates to the data for the most accurate measurement of utilization, costs and payments. Use of this approach would provide consistency and comparability with other parts of the evaluation.

The baseline period for the evaluation will be calendar years 2010-2012, and UB and Medicaid data for this period is expected to be available in late 2013. UB data can be updated annually, although the latest year for which annual hospital all-payer data will be available for the evaluation is 2016. Both the standard UB and the merged readmissions data which include calendar year 2016 should be available in the third quarter of 2017. Medicaid data will be available on a six-month basis throughout the evaluation through June 2017, although the final six months of data received in the third quarter of 2017 will not be updated with retroactive adjustments.

For the mid-point assessment, by the end of DY3, data on selected outcomes will be available from all-payer hospital data and Medicaid claims data.

- Rates of preventable hospitalizations (based on AHRQ Patient Quality Indicators) such as population based rates of asthma, COPD, diabetes and CHF admissions and rates of avoidable ED visits will be available for all payers for the baseline period (CY 2010 – 2012) and CY 2013. This will provide context about the overall NJ state population’s use and access to hospital services, and allow comparison among subpopulations defined by demographic and payer groups. We will also calculate metrics detailed in the above tables for the baseline period and expect the necessary data to be available at that time.
- The metrics specified for evaluation will be calculated over the period from the start of the DSRIP project till the latest period for which data are available (expected to be CY 2013). Trends in metrics will be assessed by comparing their current values to those in the baseline period.

For the summative evaluation, 2016 data is expected in the third calendar quarter

Rates and population denominators for the ten hospital or State reported measures selected for the evaluation should be provided to the evaluators at the time State reports are due.

Acute Care Hospital Financial Reports will be used to assess financial performance. All acute care hospitals submit these annually to the Department of Health by June 30 for the previous year. The reports are available after processing and auditing, approximately three months later.

iv. Evaluation Method and Design

The evaluation will identify the effects of the DSRIP program by measuring changes in the levels and trends of health care-related outcomes, and indicators of hospital financial performance (detailed in Tables XI and XII above) over time using comparison groups, wherever available. For this analysis, the various outcomes of interest will be analyzed at the hospital as well as patient level. The evaluation team will independently calculate all these evaluation-related measures for all hospitals using New Jersey all-payer discharge data or NJ Medicaid claims. The methods chosen will support measurement of the impact of the demonstration’s interventions on the demonstration goals and sub-hypotheses, explain causal relationships, and explore the effect of other interventions in the state that may have interacted with this demonstration, such as the implementation of the Accountable Care Organizations and the effect of potential 2014 Medicaid expansion.

a. Quantitative

The evaluation will utilize a *difference-in-differences* estimation technique that examines specific performance measures in time periods *before* and *after* the implementation of the program/policy comparing DSRIP hospitals in specific programs and comparison hospitals not engaged in those interventions.

Such estimation strategy adjusts for temporal variations in outcomes, thereby distinguishing program impacts from secular trends. In order to generate comparison hospitals that are necessary to implement this approach, a selected number of project-specific metrics (see table XII) will be calculated for all hospitals using the NJ uniform billing data, or Medicaid claims, as described above. For example, trends in adult asthma admission rates will be calculated for all hospitals, comparing hospitals that selected asthma as one of the focus areas to those which did not. For both sets of hospitals, those with interventions for management of asthma and the comparison groups, we will use a baseline/ pre-intervention period of 3 years over 2010-2012.

For the measures used to evaluate all DSRIP hospitals, NJ-based comparison hospitals will be unavailable (unless some hospitals decline to participate in DSRIP). For those measures, segmented regression analysis/interrupted time series modeling will be used to allow inferences about DSRIP impact. Interrupted time series modeling will also be used to identify the effect of DSRIP on financial performance of hospitals. We will use operating margin, total margin and other indicators of financial performance that will be available to assess hospital finances. Our estimation procedures will be conducted using standard inferential statistical techniques employing STATA 12.1 or SAS 9.2 software.

The evaluation questions will involve calculation and examination of performance metrics for individual hospitals – comprising intervention and comparison groups. All these rates will be stratified by race/ethnicity and age. Because of the diversity of the New Jersey population, we expect to find differences in the effect of the DSRIP program among demographic groups and we will document these differences.

We also will replicate the statistical analysis for these subpopulations of hospital patients to further identify the effects of the intervention within patient groups classified by these demographic characteristics to the extent that sample sizes permit. Finally, we will examine the metrics for all payers combined and also, where supported by the data, separately for Medicaid patients. Hospital-level trends will also be compared to benchmark statewide trends. For population-based measures (e.g., adult asthma discharge rate), we will define market catchment areas for each hospitals defined as the

smallest number of zip codes accounting for 80% of the respective hospital's total inpatient admissions. Age-sex adjustment, whenever appropriate, will be applied in calculating these measures. We will also review hospital-reported data relating to our selected evaluation metrics for accuracy and consistency in measurement across hospitals.

b. Qualitative

To address research questions 5 and 6, assessing stakeholder perceptions, the evaluation team will develop interview protocols and web surveys to gather views of stakeholder perceptions about DSRIP program effectiveness in improving access, quality of care, and population health outcomes.

Qualitative data will be collected in two phases. Information from phase 1 will be utilized to enhance and expand quantitative findings for the mid-point assessment, and information from phase 2 will be added to phase 1 for the summative evaluation:

Phase 1) Stakeholder feedback regarding the process of planning and implementing the DSRIP, to be collected from September 2014 to February 2015; and

Phase 2) Stakeholder feedback about the successes and challenges of the DSRIP program, to be collected January 2017 to April 2017.

Both phases will utilize key informant interviews and a web survey, as well as the analysis of information from hospital projects, such as program materials, community outreach materials, and presentations. The evaluation team will also review planning and implementation documents and reports from participating hospitals to provide background for the stakeholder feedback. Our reports will draw on the monitoring and award information as we fully describe DSRIP activities and outcomes. Interview and survey protocols will be approved by the Rutgers University Institutional Review Board, and interviewers will be trained to ensure privacy and confidentiality.

During phase 1, the evaluation team will gather information regarding the questions detailed below, as well as others suggested by DSRIP stakeholders.

- What positive impacts are expected from the DSRIP project? Which patient and/or community groups are expected to benefit?
- Are any spillover effects expected which could affect other hospital programs or hospital finances positively or negatively?
- What difficulties were encountered in developing a DSRIP project, e.g., obtaining resources, engaging community partners, sharing clinical data, etc.?

- What difficulties were encountered in applying for approval of a DSRIP project? Can the process be improved?
- What additional information would have been helpful in applying for the DSRIP program?
- What difficulties were encountered in initial implementation of the DSRIP project?
- What difficulties were encountered in collecting accurate data about the project?
- What changes in policy or practice external to the DSRIP have affected implementation of the DSRIP or made it difficult to gather accurate information?
- What problems or improvements in consumer care have been noted in your community?
- What problems or improvements in the health of specific population groups have been noted in your community?
- What improvements in health care were made as a result of the DSRIP projects?
- What new clinical partnerships were developed?
- How were real time data used to support the efforts of hospitals to refine their programs?
- How did the learning collaborative support change?
- What other rapid-cycle improvement tools were used and how effective were they in supporting quality improvement? Was there adequate support for hospitals for these activities? What could make the rapid-cycle tools (e.g. learning collaborative, dashboards, real time data exchanges, etc.) more effective?

Key informant interviews will be conducted with officials from the Department of Health and the Department of Human Services, as well as executives who served on the DSRIP steering committee from the New Jersey Hospital Association, the Hospital Alliance, and the Council of Teaching Hospitals. If any acute-care hospitals do not participate in the DSRIP, we will seek key informant interviews with representatives of those hospitals. Interviews will also be conducted with representatives from hospitals' community partners to obtain viewpoints about expected benefits and unanticipated consequences for patients and families.

Interviewers will use a semi-structured guide containing key questions to ensure data collection consistency while allowing for follow-up questions and

probes to elicit more in-depth responses to the primary questions. Data from key informant interviews will be transcribed and de-identified, then independently coded by two researchers to identify themes and patterns in the data. Ongoing analysis of completed interviews will inform subsequent interviews.

A web survey will be developed, informed by a review of the approved DSRIP project plans and information from the key informant interviews. The survey will be administered to a purposive sample of clinical, administrative, and financial leadership from all participating hospitals. Hospitals will provide valid contact information. In addition to the topics noted, questions may include asking about previous activities relating to the hospital's focus area, approaches to enrolling patients, responses from different groups within the community, unexpected successes, and recommendations for other hospitals. Advance communication about the survey will be sent in collaboration with the Department of Health and the hospital associations. Two follow-ups will be sent in addition to the original distribution of the surveys.

Data from the web survey will be analyzed using statistical software for closed-ended questions and items which can be coded into simple categories. If open-ended questions requiring complex responses are used, these responses will be analyzed along with the key informant data.

A report summarizing findings from phase 1 will be completed by June 2015, which will be incorporated in the mid-point assessment.

For the summative evaluation during phase 2, the primary objectives will be to gather information regarding the following questions, along with others which will emerge during the implementation of the DSRIP:

- What improvements in health care were made as a result of the DSRIP projects?
- Which community/patient groups benefitted most?
- What new clinical partnerships were developed?
- What new community partnerships were developed?
- What difficulties were encountered during the DSRIP implementation?
- How were difficulties addressed? Which strategies were most successful?

- How did community members react to the DSRIP project? Were there different reactions from different parts of the community?
- What problems or improvements in consumer care have been noted in your community?
- What problems or improvements in the health of specific population groups have been noted in your community?
- What help was provided by the Learning Collaborative? What could have made the Learning Collaborative more successful?
- Were there unanticipated consequences in hospital operations, other programs, or financial status?

Key informant interviews will be conducted with community advocates, officials from the Department of Health and the Department of Human Services, staff of the Learning Collaborative, and members of the DSRIP steering committee. The information from these interviews will inform the development of the web survey.

A web survey will be developed to gather information about implementation of DSRIP over time, experiences with the Learning Collaborative, successes achieved by DSRIP projects, and suggestions for improvement. As in phase 1, the survey will be administered to a purposive sample of clinical, administrative, and financial leadership from all participating hospitals.

Data from key information interviews and web surveys in phase 2 will be analyzed in accordance with the methods in phase 1, and the summative review will be completed by August 30, 2017.

v. Evaluation Reports and CMS Opportunity to Comment

On or before the date by which CMS must make its final decision on Hospital DSRIP Plans, the Department will submit the detailed plans and protocols for the mid-point and summative evaluations for review and comment. CMS will return comments to the Department within 60 days of receipt, and the Department will submit its revised plans and protocols to CMS within 60 days of its receipt of CMS comments.

For the mid-point and summative evaluations, CMS will have 60 days to review and comment before they are made final. The evaluation contractor shall not be required to accept comments by the Department or CMS challenging the underlying methods or results, to the extent that the contractor finds such comments inconsistent with applicable academic standards for such analyses, interpretation and reporting. Final reports will be submitted to CMS within 60 days after CMS has submitted its comments to the Department. Draft versions of

reports related to the midpoint and summative evaluations will not be routinely released, except as required by state and Federal law.

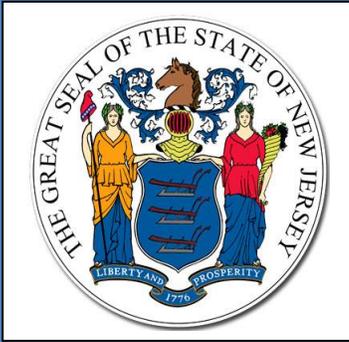
Data and findings resulting from all stages of the evaluation will be publicly shared as part of the Department's commitment to feedback and continuous improvement. Key pathways for dissemination and use of the evaluation findings beyond the required reporting to CMS include:

- Posting to publicly available websites
- Making copies of the mid-point and summative evaluations available to the Quality & Measures Committee

Prior to July 1, 2019 (two years after the end of the demonstration), or 12 months from the date that the final reports for these evaluations are provided to CMS (if later), CMS will be notified prior to the release or presentation of these reports, and related journal articles, by the evaluator or any other third party. For this same period of time, and prior to release of these reports, articles and other documents, CMS will be provided a copy including press materials. For this same period, CMS will be given 30 days to review and comment on journal articles before they are released. CMS may choose to decline to review, some or all, of these notifications and reports.

New Jersey agrees that, when draft and final midpoint and summative evaluation reports are due, CMS may issue deferrals for an amount equal to 5 percent of one quarter of the total annual amount available for DSRIP (which is equal to \$1,041,250 in FFP) for any such reports that are not provided timely to CMS or are found by CMS not to be consistent with the evaluation design as approved by CMS.

DSRIP Evaluation Activities	2013		2014				2015				2016				2017				2018	
	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
Design protocols/IRB submission	■																			
Document review		■		■		■		■		■		■		■						
Design web survey		■									■									
Administer web survey			■	■								■	■							
Analyze web survey data					■								■							
Submit request for special UB linked data		■																		
Receive UB annual hospital discharge data					■				■				■				■			
Execute DUA for Medicaid data	■																			
Receive Medicaid claims data		■		■		■		■		■		■		■		■				
Receive linked hospital UB data					■			■		■		■		■						
Data preparation			■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■	■
Data analysis			■																	■
Conduct key informant interviews			■	■	■	■	■		■	■	■	■	■	■	■	■	■	■	■	■
Analyze interview data							■								■					
Prepare Mid-Point Assessment Report								■												
Prepare Final Evaluation Report																				■



STATE OF NEW JERSEY DEPARTMENT OF HUMAN SERVICES

Section 93(f) of the Special Terms and Conditions (STCs) for New Jersey's "Comprehensive Waiver" section 1115(a) Medicaid and Children's Health Insurance Plan (CHIP) demonstration operated by the New Jersey Department of Human Services, Division of Medical Assistance and Health Services (the "Department") requires the development of "a DSRIP Program Funding and Mechanics Protocol to be submitted to CMS for approval... This document represents the Department's initial draft to the Centers for Medicare and Medicaid Services (CMS).

*Delivery System
Reform Incentive
Payment (DSRIP)
Program Funding
and Mechanics
Protocol*

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I. Preface

A. DSRIP Planning Protocol and Program Funding and Mechanics Protocol

This document is the DSRIP Funding and Mechanics Protocol submitted for approval by the New Jersey Department of Human Services (Department) to the Centers for Medicare & Medicaid Services. This document is Version 0.8, dated July 29, 2013.

Unless otherwise specified, denoted dates refer to calendar days, and any specified date that falls on a weekend or holiday is due the prior business day.

B. High Level Organization of "Attachment I: Program Funding and Mechanics Protocol"

Attachment I has been organized into the following sections.

- I. Preface
- II. Hospital DSRIP Plan Guidelines and Approval Process
- III. Reporting Requirements
- IV. Hospital's DSRIP Target Funding Amount
- V. Allocation of Hospital's Adjusted DSRIP Target Funding Amount to DSRIP Stages
- VI. DSRIP Payment Based on Achievement of Milestones and Metrics
- VII. DSRIP Payment Calculations
- VIII. Plan Modifications

C. DSRIP Eligibility Criteria

The hospitals eligible to receive funding under the DSRIP program during Demonstration Year (DY) 2 through DY5 are general acute care hospitals shown in the table below.

Table I. HOSPITALS ELIGIBLE FOR TRANSITION AND DSRIP PAYMENTS

Medicaid No.	Medicare No.	Hospital Name	County
4139402	310064	ATLANTICARE REG'L MEDICAL CENTER	ATLANTIC
4136705/0167011	310025	BAYONNE HOSPITAL	HUDSON
4141105	310112	BAYSHORE COMMUNITY HOSPITAL	MONMOUTH
4139003	310058	BERGEN REG'L MEDICAL CENTER	BERGEN
4135709	310011	CAPE REGIONAL MEDICAL CENTER	CAPE MAY

Medicaid No.	Medicare No.	Hospital Name	County
3676609	310092	CAPITAL HEALTH SYSTEM - FULD CAMPUS	MERCER
4138201	310044	CAPITAL HEALTH SYSTEM - HOPEWELL	MERCER
4141008	310111	CENTRASTATE MEDICAL CENTER	MONMOUTH
4136209	310017	CHILTON MEMORIAL HOSPITAL	MORRIS
3674207	310016	CHRIST HOSPITAL	HUDSON
4135504	310009	CLARA MAASS MEDICAL CENTER	ESSEX
3674606	310041	COMMUNITY MEDICAL CENTER	OCEAN
4136004	310014	COOPER UNIVERSITY MEDICAL CTR	CAMDEN
4137205	310031	DEBORAH HEART & LUNG CENTER	BURLINGTON
4140001	310083	EAST ORANGE GENERAL HOSPITAL	ESSEX
4138309	310045	ENGLEWOOD HOSPITAL ASSOCIATION	BERGEN
3674100	310001	HACKENSACK UNIVERSITY MEDICAL CENTER	BERGEN
4141300	310115	HACKETTSTOWN COMMUNITY HOSPITAL	WARREN
4137906/0249297	310040	HOBOKEN HOSPITAL CENTER	HUDSON
4135407	310008	HOLY NAME HOSPITAL	BERGEN
4135202	310005	HUNTERDON MEDICAL CENTER	HUNTERDON
4139801	310074	JERSEY CITY MEDICAL CENTER	HUDSON
3675700	310073	JERSEY SHORE MEDICAL CENTER	MONMOUTH
3676803	310108	JFK MEDICAL CENTER {EDISON} / Anthony M. Yelencsics	MIDDLESEX
4140206	310086	KENNEDY MEMORIAL HOSPITALS AT STRATFORD	CAMDEN
3676200	310084	KIMBALL MEDICAL CENTER	OCEAN
3675203	310061	LOURDES MED CTR OF BURLINGTON CNTY	BURLINGTON
4141504/0249297	310118	MEADOWLANDS HOSPITAL MEDICAL CENTER	HUDSON
3674908	310052	MEDICAL CENTER OF OCEAN COUNTY	OCEAN
4138902	310057	MEMORIAL HOSP OF BURLINGTON CTY (Virtua)	BURLINGTON
9031308	310091	MEMORIAL HOSPITAL OF SALEM COUNTY	SALEM
3675807	310075	MONMOUTH MEDICAL CENTER	MONMOUTH
4136101	310015	MORRISTOWN MEMORIAL HOSPITAL	MORRIS
4138708/0139564	310054	MOUNTAINSIDE HOSPITAL	ESSEX
4135008	310002	NEWARK BETH ISRAEL MEDICAL CENTER	ESSEX
4137001	310028	NEWTON MEMORIAL HOSPITAL	SUSSEX
4137108	310029	OUR LADY OF LOURDES MEDICAL CENTER	CAMDEN
3674801	310051	OVERLOOK HOSPITAL	UNION
4135105	310003	PALISADES GENERAL HOSPITAL	HUDSON
4137701	310038	R. W. JOHNSON UNIVERSITY HOSPITAL	MIDDLESEX
4137809	310039	RARITAN BAY MEDICAL CENTER	MIDDLESEX
4137400	310034	RIVERVIEW MEDICAL CENTER	MONMOUTH
3674401	310024	ROBERT WOOD JOHNSON AT RAHWAY HOSPITAL	UNION
3676901	310110	RWJ UNIVERSITY MEDICAL CTR AT HAMILTON	MERCER
3674703	310047	SHORE MEMORIAL HOSPITAL	ATLANTIC

Medicaid No.	Medicare No.	Hospital Name	County
4138406	310048	SOMERSET MEDICAL CENTER	SOMERSET
3674509	310032	SOUTH JERSEY HEALTH SYSTEM	CUMBERLAND
3675602	310069	SOUTH JERSEY HEALTH SYSTEM - ELMER	SALEM
4141202	310113	SOUTHERN OCEAN COUNTY HOSPITAL	OCEAN
3675904	310076	ST. BARNABAS MEDICAL CENTER	ESSEX
4138601	310050	ST. CLARE'S-RIVERSIDE MED CTR DENVILLE	MORRIS
4136608	310021	ST. FRANCIS MEDICAL CENTER (TRENTON)	MERCER
4136403	310019	ST. JOSEPH'S HOSPITAL MEDICAL CENTER	PASSAIC
4135300	310006	ST. MARY'S HOSPITAL (PASSAIC)	PASSAIC
4140508	310096	ST. MICHAEL'S MEDICAL CENTER	ESSEX
4139500	310070	ST. PETER'S MEDICAL CENTER	MIDDLESEX
4136900	310027	TRINITAS - ELIZABETH GENERAL	UNION
3676102	310081	UNDERWOOD MEMORIAL HOSPITAL	GLOUCESTER
3677001	310119	UNIVERSITY HOSPITAL	ESSEX
4135601	310010	UNIVERSITY MED CTR PRINCETON @ PLAINSBORO	MIDDLESEX
4135806	310012	VALLEY HOSPITAL	BERGEN
4139208	310060	ST. LUKE'S HOSPITAL (formerly Warren Hospital)	WARREN
3674304	310022	VIRTUA - WEST JERSEY HEALTH SYSTEM	CAMDEN
Hospital Count	63		

Note: St. Clare's Sussex #310120 closed Inpatient operations in Oct 2012.

II. Hospital DSRIP Plan Guidelines and Approval Process

A. Hospital DSRIP Plans

Each hospital that elects to participate in the DSRIP program must submit a Hospital DSRIP Plan in accordance with the Hospital DSRIP Plan guidelines outlined in Attachment H: DSRIP Planning Protocol and the accompanying Attachment 1: DSRIP Toolkit. In summary, hospitals will be required to submit a Hospital DSRIP Plan using a Department approved application that identifies the project, objectives, and specific milestones/metrics that meets all requirements pursuant to the Special Terms and Conditions (STCs) and Attachment H: DSRIP Planning Protocol.

Hospitals who do not submit a Hospital DSRIP Plan to the Department by September 20, 2013, with exception of hospitals meeting the criteria in subsection E below, will be precluded from participating in New Jersey DSRIP in subsequent demonstration years 2 through 5.

B. State of New Jersey Department of Health (Department) Review and Approval Process

On or before September 20, 2013, each eligible hospital, identified above in the list in subsection I.C, "DSRIP Eligibility Criteria," who decides to participate in DSRIP will submit a 3 1/2-year Hospital DSRIP Plan to the Department for review. The Department will review all Hospital DSRIP Plan applications prior to submission to CMS for final approval according to the schedule below.

On or before August 20, 2013, the Department will submit the Department's approach and review criteria for reviewing Hospital DSRIP Plan applications, as well as a draft DSRIP Plan Initial Review Checklist outlining the state's initial review of the DSRIP Plans to CMS. CMS will provide comments within one week of the Department's submission. CMS and the Department will work collaboratively to refine the criteria, approach, and DSRIP Plan Checklist to support a robust review process and compelling justification for approval of each project. In order to ensure the hospitals submit plans in accordance with the review criteria established, the Department and CMS will participate in periodic webcasts with the hospitals to provide training on the development and completion of the Hospital DSRIP Plan and applications, as well as to answer hospital questions on the review process. The Department will apply this review process to ensure that Hospital DSRIP Plans are thoroughly and consistently reviewed.

At a minimum, the Department shall review and assess each plan according to the following criteria using the DSRIP Plan Checklist:

- The plan is in the prescribed format and contains all required elements described herein and is consistent with special terms and conditions including STCs 93(g).
- The plan conforms to the requirements for Stages 1, 2, 3, and 4, as described herein, as well as in Attachment H: DSRIP Planning Protocol, and Attachment 1: DSRIP Toolkit, Section VI (Hospital DSRIP Plan Submission Requirements), Subsection A, "DSRIP Checklist."
- Stages 1 and 2 clearly identify goals, milestones, metrics, and expected results. Stage 3 clearly identifies the project-specific metrics to be reported. Stage 4 clearly identifies the population-focused health improvement measures (i.e. universal metrics) to be reported.
- The description of the project is coherent and comprehensive and includes a logic map clearly representing the relationship between the goals, the interventions and the measures of progress and outcome.
- The project selection is grounded in a demonstrated need for improvement at the time that the project is submitted and is sufficiently

comprehensive to meaningfully contribute to the CMS three part aim for better care for individuals, better health for the population, lower costs through improvement (i.e. Triple Aim).

- The goals are mapped to a robust and appropriate set of research hypotheses to support the evaluation.
- There is a coherent discussion of the hospital's participation in a learning collaborative that is strongly associated with the project and demonstrates a commitment to collaborative learning that is designed to accelerate progress and mid-course correction to achieve the goals of the project and to make significant improvement in the stage 3 and 4 outcome measures.
- The amount and distribution of funding is in accordance with Section VI: "DSRIP Payment Based on Achievement of Milestones and Metrics," included in this protocol.
- The plan, project, milestones, and metrics are consistent with the overall goals of the DSRIP program.

By November 4, 2013, the Department will submit two or three Hospital DSRIP Plans that the Department has approved, based on the agreed approach, review criteria, and DSRIP Plan Checklist. CMS will review the approved Plans, and by November 12, 2013, submit to the Department and comments or requests for modifications to the approach, review criteria, or checklist. The Department and CMS will agree to any modifications to the approach, review criteria, and checklist by November 18, 2013.

During the time the Department is reviewing Hospital DSRIP Plans, the Department and CMS will hold bi-weekly half-hour conference calls to share progress updates and discuss challenges and concerns.

Within 45 days of initial Hospital DSRIP Plan submission, the Department will complete its initial review of each timely submitted Hospital DSRIP Plan application using the DSRIP Plan Checklist, the Funding and Mechanics Protocol, the DSRIP Planning Protocol, and the STCs. The Department will notify the hospital in writing of any questions or concerns identified with the hospital's submitted DSRIP Plan.

The requesting hospital shall respond in writing to any notifications of questions or concerns by the Department. The hospital's responses must be received by the dates specified in the aforementioned notification. The requesting hospital's initial response may consist of a request for additional time to address the Department's comments provided that the hospital's revised (i.e., final) DSRIP plan addresses the Department's comments and is submitted to the Department within 15 days of the notification.

No later than December 13, 2013, the Department will take action on each timely submitted Hospital DSRIP Plan; will approve each plan that it deems has met the criteria outlined in Attachment H: DSRIP Planning Protocol, Attachment I: DSRIP Program Funding and Mechanics Protocol, and “DSRIP Plan Checklist”; and submit approved plans (along with their completed DSRIP Plan Checklists and supporting documentation) to CMS for final review and approval. The Department will notify the hospital in writing that the plan has been approved and submitted to CMS for consideration.

It is the Department’s intent to submit plans continuously in batches to CMS upon the Department’s approval of the Hospital’s DSRIP Plan in order to incorporate meaningful feedback from CMS into the Department’s DSRIP Plan review process.

C. CMS Review and Approval Process

CMS will review the hospitals’ 3 1/2-year Hospital DSRIP Plan upon receipt from the Department. CMS may at its discretion return any Hospital DSRIP Plan to the Department without review if it is received by CMS after December 13, 2013. Hospitals whose plans are returned by CMS for this reason are excluded from DSRIP, unless the hospital qualifies to submit a plan under subsection E, “Consideration of a Hospital’s DSRIP Plan Due to Exceptional Circumstance.”

CMS will conduct an initial review of the submitted Hospital DSRIP Plans, in order to validate the Department’s assessment based on the results from the Department’s DSRIP Plan review process and DSRIP Plan Checklist. CMS will notify the Department within 15 days of receipt, if based on its initial review it concludes that there were systemic gaps or weaknesses in the Department’s review of the Hospital DSRIP Plans. CMS and the Department will work together to develop guidance to the hospitals to revise and resubmit their plans, if necessary.

No later than January 31, 2014, CMS will complete its review of Department-approved Hospital DSRIP Plans, and will either:

- Approve the Hospital DSRIP Plan;
- Notify the Department if approval will not be granted for all or for a component of the Hospital DSRIP Plan.
 - Notice will be in writing and will include any questions, concerns, or issues identified in the application.

In the event CMS fails to take action by the deadline, the Plan shall be considered conditionally approved, however, the requesting hospital will not receive DSRIP payments until formal approval is rendered by CMS. The

Department will send written notification to the hospital within five business days following notice from CMS related to Hospital DSRIP Plan decisions.

In the event that CMS determines that a Hospital DSRIP Plan, or component thereof, requires revision, CMS may conditionally approve, but require modification to the deficient components of the plan. The hospital may then revise and resubmit its plan to the Department to remedy the deficiencies. The revised plan must be received by the Department no later than 15 days following the notification date of the conditional approval. During the resubmission period, the conditionally approved hospital will not receive DSRIP payments until formal approval is rendered by CMS.

Within 30 days of CMS notification, the Department shall submit the revised Hospital DSRIP Plans to CMS and CMS shall approve or deny the plans in writing to the Department by March 17, 2014. The Department will not draw any federal financial participation for DSRIP payments to a hospital prior to the date that CMS has approved the hospital's DSRIP Plan.

D. Review Process for Hospital-Specific Focus Area or Off-Menu Project

A pre-defined list of projects have been developed to move the cost and quality curve for eight prevalent or chronic conditions, or Focus Areas, listed in the Special Terms and Conditions. These Focus Areas are as follows:

- 1) Asthma
- 2) Behavioral Health
- 3) Cardiac Care
- 4) Chemical Addiction/Substance Abuse
- 5) Diabetes
- 6) HIV/AIDS
- 7) Obesity
- 8) Pneumonia

If a hospital chooses to develop a project that is not from the pre-defined list in Attachment H: DSRIP Planning Protocol, the hospital shall submit a 3 1/2-year Hospital DSRIP Plan to the Department for review on or before September 9, 2013.

In addition to the Hospital DSRIP Plan guidelines and the review and approval processes identified in subparagraphs B and C of this section, the hospital shall conduct an analysis and submit with the Hospital DSRIP Plan application a strong and compelling justification for the project selection by:

- i. Reviewing the menu of projects included in the DSRIP Planning Protocol, Attachment 1: DSRIP Toolkit (toolkit), and showing that the proposed

project could not be accommodated within any of the model projects of the toolkit.

- ii. Providing internal and external data to demonstrate that the new hospital project is beyond those listed in the toolkit, has an outpatient focus, and that it would achieve the Triple Aim.
- iii. Providing data demonstrating that the hospital-specific focus area or project is responsive to local data and community needs, and provides a greater opportunity to improve patient care for New Jersey's low income population by addressing an area of poor performance and/or health care disparity that is important to the Medicaid, CHIP and/or uninsured population.
- iv. Explaining why this "off-menu" project is particularly innovative or promising, and that it employs an evidence-based approach (with literature clearly cited).
- v. Identifying at least four Stage 3 project-specific metrics based on nationally recognized metrics (such as NQF-endorsed or NCQA-endorsed metrics) that will be used to monitor the clinical processes and outcomes of the project. The hospital should select from the Stage 3 catalogue of approved metrics, as applicable. The hospital must propose which outcome metrics should be tied to pay for performance (e.g. pay for improvement). There must be, at a minimum, two clinical measures that are outcomes-based measurements. Outcome measures monitor patient health and should be tied to pay for performance. Process measures, which measure the quality of health care provided to patients, may be chosen but will be tied to pay for reporting only.¹ The hospital will need to describe the sources of the data that will be used in the measurement of Stage 3 project-specific metrics.
- vi. Showing (using the proposed project-specific metrics) that there is demonstrable need for improvement, and having clearly identified improvement objectives that can be measured with the proposed metrics.
- vii. Identify and provide justification for how the hospital-specific focus area of the hospital project is intended to achieve one or more of the Core Achievement Themes listed in Attachment H: DSRIP Planning Protocol.

E. Consideration of a Hospital's DSRIP Plan Due to Exceptional Circumstance

¹ Mant, Jonathon. "Process versus outcome indicators in the assessment of quality of health care." *International Journal for Quality in Health Care* (2001) 13(6): 475-480 doi:10.1093/intqhc/13.6.475

In the event that a hospital provides documentation that they meet one of the following criteria, the Department will review a Hospital DSRIP Plan outside the schedule described above:

- i. If a hospital failed to submit a Hospital DSRIP Plan by September 20, 2013 because of a significant adverse unforeseen circumstance (e.g. hurricane, emergency event) and the hospital's prior year HRSF payment was not less than 0.5% of the hospital's annual Net Patient Service Revenues as shown on the most recent year audited Financial Statements. A significant adverse unforeseen circumstance is one not commonly experienced by hospitals.
- ii. If a hospital did not receive approval of its Hospital DSRIP Plan or failed to submit a plan and the hospital received certificate of need approval of a merger, acquisition, or other business combination of a hospital within the State of New Jersey, provided the successor hospital is a participating provider contracted with any Medicaid Managed Care Insurers licensed and operating in their service area.

To qualify under (ii) above, the application for certificate of need must have been received by the Department on or after the approval of these protocols.

Documentation would include audited financial statements that identify net patient service revenues, copy of the hospital's certificate of need approval of a merger, acquisition or other business combination, and description of perceived unforeseen circumstance with justification. The Department will not consider the Hospital DSRIP Plan for approval if it is determined that the hospital does not meet one of the above criteria.

The Hospital DSRIP Plan shall demonstrate that participation in the DSRIP Program shall begin no later than July 1, 2014, which would allow the hospital to qualify for DSRIP payments in DY3 through DY5, if approved by the Department and CMS.

The Department and CMS approvals will follow the processes described above in subparagraphs B and C of this section except for the following changes.

- The Hospital DSRIP Plan must be submitted to the Department no later than May 15, 2014.
- The Department will take action on each timely submitted reconsiderations no later than June 13, 2014; will approve each plan that it deems meets the criteria outlined in Attachment H: DSRIP Planning Protocol, Attachment I: DSRIP Program Funding and Mechanics Protocol, and "DSRIP Plan Checklist"; and will submit approved plans (along with their

completed DSRIP Plan Checklists and supporting documentation) to CMS for final review and approval.

- In the event CMS requests additional information, the Department shall submit revised Hospital DSRIP Plans to CMS within 30 days of request from CMS and CMS shall approve or deny the plans in writing to the Department by August 29, 2014.
- Hospitals submitting a plan under this section would be eligible to begin receiving DSRIP payments in DY3.

F. Revisions to the DSRIP Planning Protocol

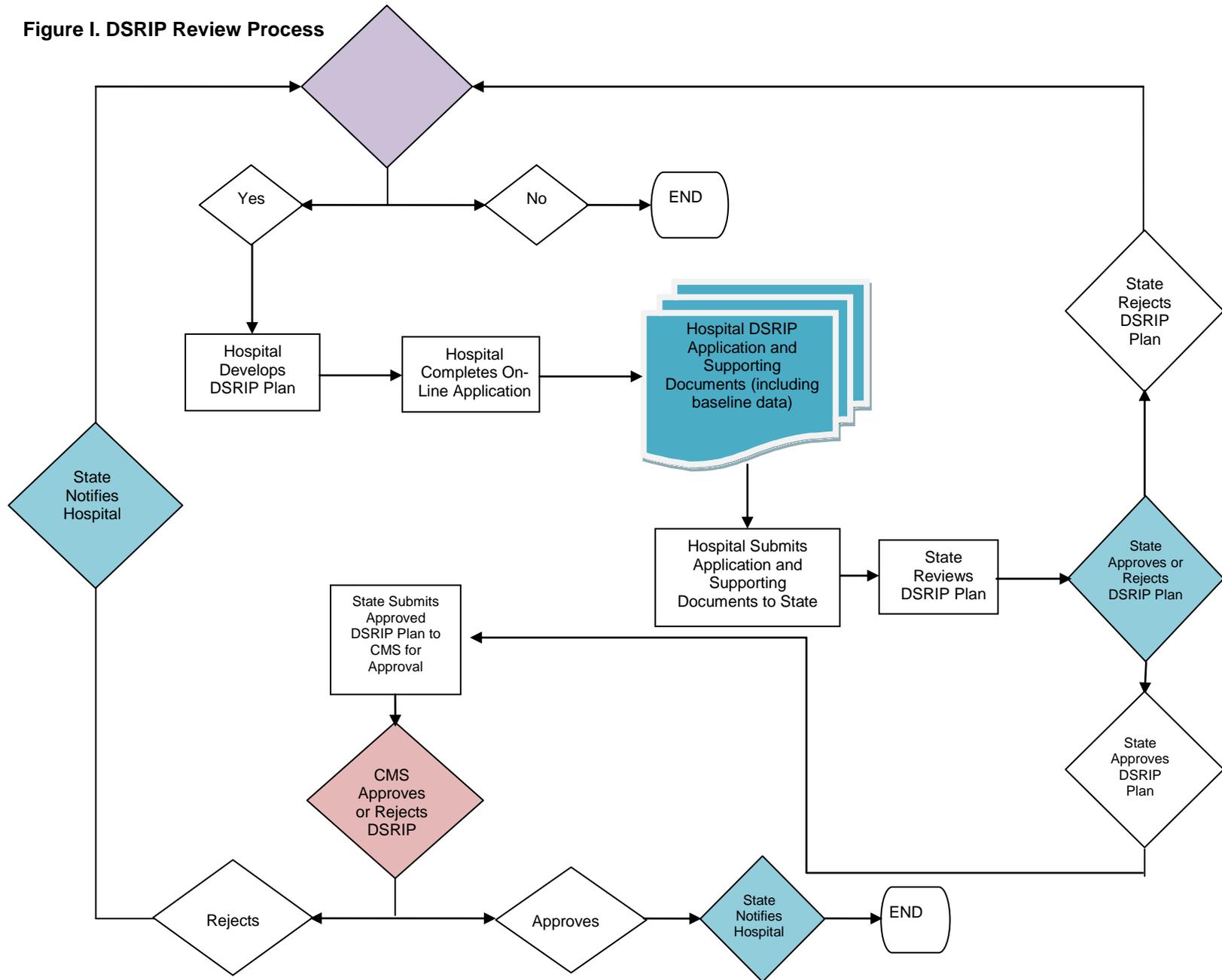
If the CMS review process of Hospital DSRIP Plans results in the modification of any component of a hospital's DSRIP Plan, including but not limited to projects, milestones, metrics, or data sources, that was not originally included in the DSRIP Planning Protocol, New Jersey may revise the DSRIP Planning Protocol accordingly. CMS will review these proposed revisions within 30 days of submission by the Department and approve those it finds to be in accordance with the final approved Hospital DSRIP Plan(s) prompting the revision(s) and all applicable STC requirements. Such revisions² to the DSRIP Planning Protocol do not require a waiver amendment.

G. DSRIP Review Process Flow

The diagram on the following page summarizes the above process.

² Based on waiver protocol, any modification to the planning or funding protocols or waiver, STCs must follow a formal amendment process and changes are only effective prospectively. Therefore, if through the review of DSRIP plans, CMS approves an element of the Hospital DSRIP Plan that is not in the DSRIP Planning Protocol or is contradictory to the DSRIP Planning Protocol, these approved items should be incorporated into the protocols without having to go through the formal waiver amendment process. Any changes need to be effective September 6, 2013. However, due to the timing of the approval process, these changes could occur between September 20, 2013 and January 31, 2014.

Figure I. DSRIP Review Process



III. Reporting Requirements

A. Participating Hospital Reporting for Payment in DY2

i. Hospital DSRIP Plan Submission

Submission of a Department-approved Hospital DSRIP Plan to CMS shall serve as the basis for payment of 50 percent of the DY2 Target Funding Amount. The state will not claim FFP for any monthly DSRIP payments made to a hospital until CMS has approved a Hospital DSRIP Plan for that hospital.

ii. Hospital DSRIP Plans Not Approved by CMS on or after January 31, 2014

All hospitals whose Hospital DSRIP Plan is not approved in full by CMS shall be at risk for recoupment of their entire DY2 DSRIP monthly payments paid out in DY2. (Transition Payments are not subject to recoupment.) Within 60 business days of CMS written denial of a Hospital DSRIP Plan, the Department shall recoup the DY2 DSRIP monthly payments previously paid to the hospital. Hospital DSRIP payments recouped shall be added to the Universal Performance Pool and will be disbursed to qualifying facilities.

iii. DY2 Baseline Verification

Participating hospitals are required to affirm concurrence of the baseline claim-based measures through an attestation to the Department by January 7th, 2014. If no attestation is received by January 7th, 2014, the Department will consider the baseline measurements finalized.

iv. DSRIP Progress Report Submission for DY2

Participating hospitals seeking payment under the DSRIP program in DY2 shall submit a progress report to the Department by April 30, 2014, demonstrating progress on their project as measured by stage-specific activities/milestones and metrics achieved during the reporting period. Should a participating hospital fail to submit its report by the indicated due date, all metrics will be deemed unmet, and incentive payments associated with those metrics will be forfeited.

The progress report shall be submitted using the standardized reporting form approved by the Department and CMS, which shall include a databook for metric reporting. The standardized reporting form with measure performance and baseline information will be provided to the hospital industry by November 15, 2013. The progress report shall also include all supporting data and back-up documentation. Based on this

report, participating hospitals shall earn DSRIP payments, calculated by the Department, based on meeting performance metrics as prescribed in Section VI: “DSRIP Payment Based on Achievement of Milestones and Metrics.” The submitted progress report shall include:

- The progress of each process metric
- Verification of State calculated claims-based Stage 3 and Stage 4 metrics, including a description of how the hospital verified the reported metrics and an attestation of the verification
- The progress of all current and planned activities, including whether the stage activity has been completed, is in progress, or has not been started
- Documentation supporting the completion of milestones during the report period
- The infrastructure developments made and outcomes of those developments
- The project developments and outcomes as they relate to the pilot populations
- How rapid-cycle evaluation was used for improvement
- Summary of the hospital’s stakeholder engagement and activities
- Work accomplished with external partners
- How the project tools and processes were modified based on the pilot testing results
- A timeline of future activities
- Budget and return on investment analysis

Specifically, the DY2 Progress Report will include:

- List of Stage 1 and 2 activities completed during the experience period from **the date the Hospital’s plan was approved through March 31, 2014**. Experience period is discussed further in Section VI, subsection C. “Experience Period.”
- Documentation to support the completion of Stage 1 and/or Stage 2 milestones/metrics reported as completed during the experience period from **the date the Hospital’s plan was approved through March 31, 2014**
- Stage 3 and Stage 4 metrics for the experience period listed for each metric in the DSRIP Planning Protocol Addendums 1 and 2
 - This is to include both non-claims based metrics and claims based metrics provided by the Department and verified by the hospital
 - If hospital cannot provide one or more metrics, the progress

report should include rationale for omission of the metric and a plan for obtaining the metric by October 31, 2014 (DY3), unless otherwise stated in the databook. Once available, omitted metrics shall be reported in the next progress report and no later than October 31, 2014 (DY3), unless otherwise stated in the databook.

- If the hospital fails to submit the metrics or a plan to submit the metrics by the deadline, the funding shall be considered not earned and forfeited and moved to the Universal Performance Pool to be redistributed. See section VI, subsection F, “DSRIP Universal Performance Pool” for more information.

Any DSRIP funds tied to DY2 Stage 1 or 2 activities which were targeted for completion by March 31, 2014, but were not otherwise reported as completed by March 31, 2014, will be forfeited and moved to the Universal Performance Pool to be redistributed. Quarterly activities must be completed in the designated quarter or funding tied to such activities will be forfeited and moved to the Universal Performance Pool to be redistributed. See section VI, subsection F, “DSRIP Universal Performance Pool” for more information.

Once the report is accepted by the Department, the Department and CMS shall have a total of 45 days to review and approve, or request additional information regarding the data reported for each milestone/metric and measure. Initial approval will be completed by the Department before submission to CMS, which will occur no later than 21 days following the Department’s acceptance of the report. If additional information is requested, the participating hospital shall respond within 15 days and both the Department and CMS shall have an additional 15 days to review, approve, or deny the request for payment, based on the data provided.

B. Participating Hospital Reporting for Payment in DY3-DY5

i. Annual DSRIP Application Renewal

- For participation in DSRIP in DY3-DY5, the hospital will be required to submit an annual DSRIP Application Renewal due on April 30th of the demonstration year prior to the participation year, as noted below.
 - DY3: Annual DSRIP Application Renewal due April 30, 2014
 - DY4: Annual DSRIP Application Renewal due April 30, 2015
 - DY5: Annual DSRIP Application Renewal due April 30, 2016
- Each Annual DSRIP Application Renewal for DY3-DY5 will include the

following:

- Hospital's notification of intent to continue in the DSRIP Program
- Indication of any changes or modifications that are required to be made to the DSRIP Plan in order to continue participation
- Annual Status Report outlining the hospital's progress in the current demonstration year
- Updated annual project budget analysis

ii. Approval of DSRIP Application by the Department/CMS

If a hospital's DSRIP Plan was approved for DY2, DSRIP Hospital Plans submitted with the annual DSRIP Application in DY3-DY5 will not require re-approval by the Department/CMS, unless the hospital's recommended changes or modifications from the approved DY2 Hospital DSRIP Plan would alter the DSRIP project goals or departures from the approved DY2 Plan would affect payment and/or change the valuation of any measure. If such modifications to, or departures from, the original DY2 DSRIP Hospital Plan are noted, the Department/CMS approvals will follow the processes described above Section II, subsections B and C except for the following changes.

- The Department will take action on each timely submitted modified DSRIP Plan no later than 45 days after date of submission (June 15); will approve each plan that it deems meets the criteria outlined in Attachment H: "DSRIP Planning Protocol," Attachment I: "DSRIP Program Funding and Mechanics Protocol," and "DSRIP Plan Checklist"; and will submit approved plans (along with their completed DSRIP Plan Checklists) to CMS for final review and approval.
- In the event CMS requests additional information, the Department shall submit revised Hospital DSRIP Plans to CMS within 30 days of request from CMS and CMS shall approve or deny the plans in writing to the Department with 15 days.

iii. Modified Hospital DSRIP Plans Not Approved by CMS

All hospitals submitting a modified Hospital DSRIP Plan for DY3, DY4, or DY5 which is not approved in full by the Department or CMS shall be at risk for recoupment of their entire demonstration year incentive payment paid out in the demonstration year for which the plan was modified. Within 60 business days of CMS written denial of a modified Hospital DSRIP Plan, the Department shall recoup the demonstration year payments previously paid to the hospital. Hospital DSRIP payments recouped shall be added to the Universal Performance Pool and will be disbursed to qualifying facilities.

iv. DSRIP Progress Report Submission for DY3-DY5

Four times per year in DY3-DY5, participating hospitals seeking payment under the DSRIP program shall submit progress reports to the Department demonstrating progress on their project as measured by stage-specific activities/milestones and metrics achieved during the reporting period.

The reports shall be submitted using the standardized reporting form approved by the Department and CMS which shall include a databook for metric reporting. The reports shall also include all supporting data and back-up documentation. Based on these reports, participating hospitals shall earn DSRIP payments, calculated by the Department, based on meeting performance metrics as prescribed in Section VI: "DSRIP Payment Based on Achievement of Milestones and Metrics." Submitted progress reports shall include:

- The progress of each process metric
- Verification of State calculated claims-based Stage 3 and Stage 4 metrics, including a description of how the hospital verified the reported metrics and an attestation of the verification (October and April progress reports)
- The progress of all current and planned activities, including whether the stage activity has been completed, is in progress, or has not been started
- Documentation supporting the completion of milestones during the report period
- The infrastructure developments made and outcomes of those developments
- The project developments and outcomes as they relate to the pilot populations
- How rapid-cycle evaluation was used for improvement
- Summary of the hospital's stakeholder engagement and activities
- Work accomplished with external partners
- How the project tools and processes were modified based on the pilot testing results
- A timeline of future activities
- Budget and return on investment analysis

These reports will be due as indicated below at the end of each reporting period. These reports shall include Stage 3 and 4 non-claims based performance metrics data, as well as verification of the Department provided claims-based performance metrics data:

- **DY3-DY5 Progress Report 1:** This report is due no later than **July 31 of the current DY** and shall include the following,
 - List of Stage 1 and 2 activities completed during the experience period **April 1 of prior DY through June 30 of the prior DY**
 - Documentation to support the completion of Stage 1 and/or Stage 2 milestones/metrics reported as completed on the current DY Progress Report 1

- **DY3-DY5 Progress Report 2:** This report is due no later than **October 31 of the current DY** and shall include the following,
 - List of Stage 1 and 2 activities completed during the experience period **July 1 through September 30 of the current DY**
 - List of Stage 1 and 2 activities completed during the experience period **April 1 of prior DY through June 30 of prior DY**, but not otherwise claimed as completed in current DY Progress Report 1
 - Documentation to support the completion of Stage 1 and/or Stage 2 milestones/metrics reported as completed on the current DY Progress Report 2
 - Stage 3 and Stage 4 metrics for the experience period listed for each metric in the DSRIP Planning Protocol Addendums 1 and 2
 - To include both non-claims based metrics and claims based metrics provided by the Department and verified by the hospital
 - For DY3, unless otherwise stated in the databook, all measures must be reported by October 31, 2014. If a measure is required to be reported October 31, 2014 and is not included in DY3 Progress Report 2, funding shall be considered not earned and forfeited. If the databook indicates otherwise for a given metric, the progress report should include rationale for omission of the metric and a plan for obtaining the metric by April 30, 2015, otherwise funding for the metric will be forfeited.
 - For DY4 and DY5, if the hospital fails to submit the metrics by the deadline, the funding shall be considered not earned and forfeited.

- **DY3-DY5 Progress Report 3:** This report is due no later than **January 31 of the current DY** and shall include the following,
 - List of Stage 1 and 2 activities completed during the experience period **October 1 through December 31 of the current DY**
 - List of Stage 1 and 2 activities completed during the experience period **April 1 of prior DY through September 30 of current DY**, but not otherwise claimed as completed in current DY Progress Reports 1 and 2
 - Documentation to support the completion of Stage 1 and/or Stage 2 milestones/metrics reported as completed in the current DY Progress Report 3

- **DY3-DY5 Progress Report 4:** This report is due no later than **April 30 of the current DY** and shall include the following,
 - List of Stage 1 and 2 activities completed during the experience period **January 1 through March 31 of the current DY**
 - List of Stage 1 and 2 activities completed during the experience period **April 1 of prior DY through December 31 of current DY**, but not otherwise claimed as completed in current DY Progress Reports 1, 2, and 3.
 - Documentation to support the completion of Stage 1 and/or Stage 2 milestones/metrics reported as completed in the current DY Progress Report 4
 - Stage 3 and Stage 4 metrics for the experience period listed for each metric in the DSRIP Planning Protocol Addendums 1 and 2
 - To include both non-claims based metrics and claims based metrics provided by the Department and verified by the hospital
 - If the hospital fails to submit the metrics by the deadline, the funding shall be considered not earned and forfeited
 - In DY5, the Progress Report 4 reporting submission deadline and review period will be adjusted to ensure that all DSRIP monies, including the UPP payment will be paid no later than the end of the final demonstration year, June 30th, 2017. Therefore, the hospital must submit their final DY5 report

one week prior to normal submission deadline, April 21, 2017.

Any DSRIP funds tied to Stage 1 or 2 activities that were targeted to be completed between the period April 1 of the prior DY through March 31 of the current DY, but were not otherwise reported as having been completed during that time period in Progress Report 4, will be forfeited and moved to the Universal Performance Pool to be redistributed. Quarterly activities must be completed in the designated quarter or funding tied to such activities will be forfeited and moved to the Universal Performance Pool to be redistributed. See section VI, subsection F, “DSRIP Universal Performance Pool” for more information.

For DY3, unless otherwise indicated in the databook, any DSRIP funds tied to Stage 3 and 4 metrics which were not reported in DY3 Progress Report 2 will be forfeited and moved to the Universal Performance Pool to be redistributed. Any DY3 DSRIP funds tied to Stage 3 and 4 metrics which were not reported in DY3 Progress Report 4 will be forfeited and moved to the Universal Performance Pool to be redistributed. See section VI, subsection F, “DSRIP Universal Performance Pool” for more information.

For DY4 and DY5, all Stage 3 metrics, whether a pay for performance metric or not, are required to be reported for release of any Stage 3 pay for performance funding. If any Stage 3 metric, including Stage 3 replacement metrics, is not reported, all Stage 3 funding for the DY will be forfeited and moved to the Universal Performance Pool. If pay for performance is not met on a Stage 3 pay for performance metric, funding for the metric will be forfeited and moved to the Universal Performance Pool to be redistributed.

Once the report is accepted by the Department, the Department and CMS shall have a total of 45 days to review and approve or request additional information regarding the data reported for each milestone/metric and measure. Initial approval will be completed by the Department before submission to CMS, which will occur no later than 21 days following the Department’s acceptance of the report. If additional information is requested, the participating hospital shall respond within 15 days and both the Department and CMS shall have an additional 15 days to concurrently review, approve, or deny the request for payment, based on the data

provided.

C. State Reporting and Communications with CMS

The Department and CMS will use a portion of the Monthly Monitoring Calls (see paragraph 101 of the STCs) for March, June, September, and December of each year for an update and discussion of progress in meeting DSRIP goals, performance, challenges, mid-course corrections, successes, and evaluation.

IV. Hospital's DSRIP Target Funding Amount

A. Demonstration Year (DY) 2

In DY2, DSRIP funding amounts identified in paragraphs 95 and 96 of the Special Terms and Conditions (STCs) will be allocated to eligible hospitals per the list in subsection I.C., "DSRIP Eligibility Criteria," according to the following formula:

Step 1 – The initial DSRIP target funding amount for each hospital shall be one half of their SFY 2013 Hospital Relief Subsidy Fund (HRSF) amount (DY1 Transition Payments plus UPL payments made under the Medicaid state plan in SFY 2013) and subjected to the adjustments noted in Steps 2 and 3 below.

Although all DSRIP payments are at risk to the participating hospital (i.e., payments are reward-based for documented achievement on project milestones and metrics), providing a target funding amount provides a degree of predictability to hospitals and ensures that hospitals are able to manage their finances with reasonable stability while incentivizing and rewarding investment in quality improvement.

Step 2 – For those hospitals whose State Fiscal Year (SFY) 2013 Hospital Subsidy Relief Fund amount is less than a floor amount of \$125,000, the DSRIP target funding amount will be adjusted to the floor amount. For these hospitals, this shall be their Adjusted DSRIP Target Funding Amount for DY2. Providing for a floor amount appropriately incentivizes every hospital to participate and invest in quality improvement.

Step 3 – For those hospitals whose SFY 2013 HRSF amount is greater than or equal to the floor, the hospitals shall have their initial DSRIP target funding amount decreased proportionately in order to maintain total statewide DSRIP funding amount per the STCs (i.e., \$83,300,000). The result of this reduction yields their Adjusted DSRIP Target Funding Amount for DY2.

B. Demonstration Years 3-5

For Demonstration Years 3-5, DSRIP funding amounts identified in paragraphs 95 and 96 of the STCs shall be allocated to eligible hospitals per the list in subsection I.C, “DSRIP Eligibility Criteria,” according to the following formula:

Step 1 – The Initial DSRIP Target Funding Amount for each hospital shall be the hospital’s final DSRIP Target Funding Amount for DY2 times 2 and will then be subjected to the adjustment in Step 2.

- If a hospital did not participate in DY2 due to circumstances described in Section II, subsection E above, and the hospital’s plan was approved to participate in DY3, the hospital’s Initial DSRIP Target Funding Amount will be the forfeited DY2 final DSRIP Target Funding Amount times 2 and will then be subjected to the adjustment in Step 2.

Step 2 – A proportionate share of the target funding amounts (Step 1) shall be directed to a Universal Performance Pool (UPP), which shall be available to hospitals that successfully maintain or improve on a subset of Stage 4 DSRIP Performance Indicators. The initial DSRIP Target Funding Amount after the reduction for the UPP shall be the hospital’s Adjusted DSRIP Target Funding Amount for DY3-DY5. The UPP allows for greater rewards to hospitals that meet or improve their universal performance metrics. The carved out amount for the UPP is as follows for each demonstration year:

DY3	DY4	DY5
10%	15%	25%

Funds in the UPP shall be distributed to qualifying hospitals using the formula described in Section VII, subsection E, “DSRIP Universal Performance Pool” below.

V. Allocation of Hospital’s Adjusted DSRIP Target Funding Amount to DSRIP Stages

For DY2, transition payments will continue for six months from July 1, 2013 through December 31, 2013. The DSRIP Target Funding Amounts for DY2, representing potential DSRIP payments for January 2014 through June 2014, is the amount that will be distributable for the approved DY2 DSRIP Hospital Plan/Application and Stages 1, 2, 3, and 4 funding. The DY2 DSRIP Target Funding amount will be equally allocated (50/50) to the approved Hospital DSRIP Plan/Application and project stages.

For DY3-DY5, the DSRIP Target Funding Amount less the UPP carve out will be distributable to Stages 1-4 only.

Table II below illustrates, by demonstration year, the overall amounts allocated to Stages 1-4, considering transition payments (DY2), carve out for UPP (DY3-5), and funding tied to the approval of the Hospital DSRIP Plan Application (DY2).

Table II. TOTAL DSRIP FUNDING DISTRIBUTABLE TO STAGES 1-4

<i>In Thousands</i>	DY2	DY3	DY4	DY5
Transition Payments (6 months)	\$83,300	\$0	\$0	\$0
DSRIP Target Funding	\$83,300	\$166,600	\$166,600	\$166,600
Total Demonstration Year Funding	\$166,600	\$166,600	\$166,600	\$166,600
DSRIP Target Funding	\$83,300	\$166,600	\$166,600	\$166,600
<i>Less UPP "Carve Out"</i>	0%	10%	15%	25%
	\$0	\$16,660	\$24,990	\$41,650
Adjusted DSRIP Target Funding Amount	\$83,300	\$149,940	\$141,610	\$124,950
<i>Less Funding for DSRIP Application</i>	50%	0%	0%	0%
	\$41,650	\$0	\$0	\$0
Total Distributable Amount for Stages 1-4	\$41,650	\$149,940	\$141,610	\$124,950

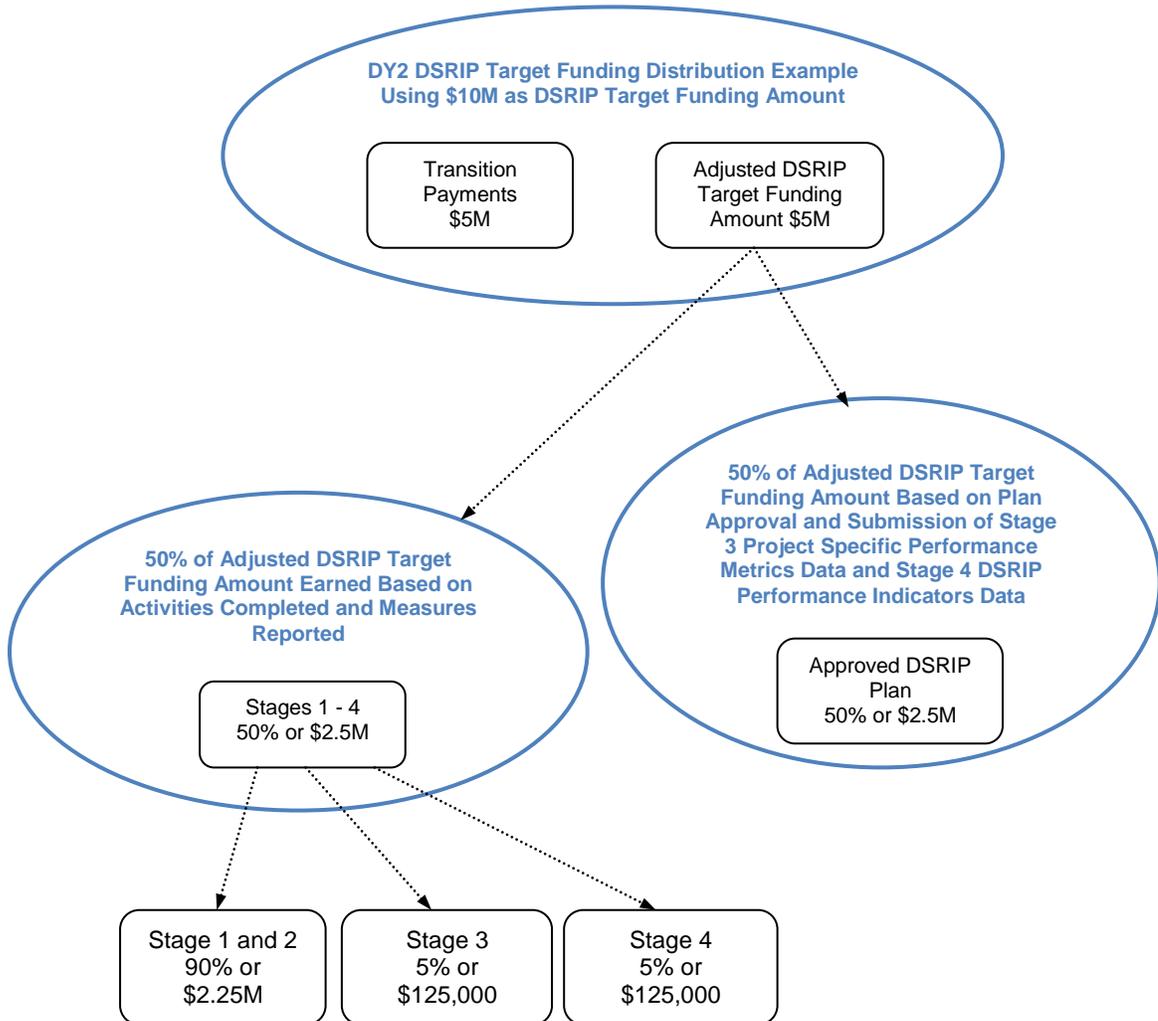
Based on the above table, the Total Distributable Amount for Stages 1-4 are then further allocated to each stage as follows:

Table III. DSRIP STAGE FUNDING DISTRIBUTION

Stages	DY2	DY3	DY4	DY5
1 & 2	90%	75%	50%	25%
3	5%	15%	35%	50%
4	5%	10%	15%	25%
Total	100%	100%	100%	100%

The following provides an illustration of how a hospital's DSRIP Target Funding Amount, calculated in accordance with Section IV: "Hospital's DSRIP Target Funding Amount," is both distributed and earned in DY2. A hospital DSRIP Target Funding Amount of \$10 million is used in the illustration.

Figure II. DY2 DSRIP Target Funding Distribution Example³



³ Example assumes no adjustment for floor (\$125,000) was required. Adjusted DSRIP Target Funding amount of \$5,000,000 would most likely be adjusted down to account for participating hospitals whose Initial DSRIP Target Funding amounts were below \$125,000 floor.

VI. DSRIP Payment Based on Achievement of Milestones and Metrics

Hospital DSRIP Plans shall include a narrative that describes the stages and activities selected by hospitals for their project. Each activity will have at least one milestone/metric that will be used to determine payment.

A. General Requirements

As described in the New Jersey DSRIP Planning Protocol, a DSRIP participating hospital will select one project, from a menu of projects based on eight focus areas or will propose a unique focus area or an off-menu project. The hospital will then select activities from a pre-determined menu of activities. Hospitals are encouraged to use innovative and value-driven approaches in accomplishing the project activities. As discussed in the DSRIP Planning Protocol, Section V: "DSRIP Project Array," Department and CMS approval will be required for all hospital unique focus areas and off-menu projects.

B. Milestone and Measure Valuation

The Hospital DSRIP Plan will include sections on each of the 4 stages and the activities included in each stage as specified in the DSRIP Planning Protocol. For each milestone associated with a stage activity, the participating hospital will include in the hospital's progress reports the progress made in completing each metric associated with the milestone. A participating hospital must fully achieve a milestone/metric in order to receive payment (i.e., no payment for partial completion). These metrics/milestones will be valued as follows:

i. Stage 1: Infrastructure Development

Activities in this stage will develop the foundation for delivery system transformation through investments in technology, tools, and human resources that will strengthen the ability of providers to serve populations and continuously improve services. Each milestone/metric targeted for completion in the demonstration year's Stage 1 experience period will be valued equally. For Stage 1 experience periods, see section C. Experience Period below.

- All Stage 1 activities targeted for completion within the demonstration year's Stage 1 experience period must be completed within that timeframe for payment. A hospital completing a Stage 1 activity which was targeted for the current demonstration year's experience period but was completed in a subsequent demonstration year's experience period, will not achieve payment for this activity.

ii. *Stage 2: Chronic Medical Condition Redesign and Management*

Activities in this stage include the piloting, testing, and replicating of chronic patient care models. Each milestone/metric targeted for completion in the demonstration year's Stage 2 experience period will be valued equally. For Stage 2 experience periods, see section C.

Experience Period below.

- All Stage 2 activities targeted for completion within the demonstration year's Stage 2 experience period must be completed within that timeframe for payment. A hospital completing a Stage 2 activity which was targeted for the current demonstration year's experience period but was completed in a subsequent demonstration year's experience period, will not achieve payment for this activity.

iii. *Stage 3: Quality Improvement*

This stage involves the broad dissemination of Stage 1 and Stage 2 activities. Stage 3 measures the clinical performance of the hospital's DSRIP project and thus, valuation of this stage will be equally based on the reporting of clinical (Stage 3) measures in DY2 and DY3 for the project. For DY4 and DY5, Stage 3 valuation will be equally based on performance as described in Section VII, subsection B, "Calculating DSRIP Payments for Stage 3 Project-Specific Metrics" below. If a measure is reported more frequently than annually or pay for performance is determined more frequently than annually by the Department, the measure's valuation will be divisible by the frequency.

iv. *Stage 4: Population Focused Improvements*

Activities in this stage include reporting measures across several domains selected by the Department based on community readmission rates and hospital acquired infections, which will allow the impact of activities performed under Stages 1 through 3 to be measured, and may include: patient experience; care outcomes; and population health. Pursuant to the STC, all hospitals are expected to report Stage 4 DSRIP Performance Indicators selected by the Department and CMS. In accordance with the Hospital DSRIP Plan Guidelines, Stage 4 DSRIP Performance Indicators data will be due with the submission of the Hospital DSRIP Plan application. If the measure cannot be provided, the hospital must submit a plan to provide the measure by October 31, 2014 (DY3), unless otherwise stated in the databook. No later than the end of DY3, hospitals shall establish a baseline for all Stage 4 DSRIP Performance Indicators, including those attributed to the UPP.

Valuation of metrics included in Stage 4 will be equally funded based on reporting Stage 4 universal measures. If a measure is reported more frequently than annually, the measure's valuation will be divisible by the frequency. If a Stage 4 measure is not reported according to reporting requirements, the valuation of that measure will be considered forfeited and moved to the Universal Performance Pool to be redistributed.

C. Experience Period

The experience period for completing a milestone/measure will vary from the demonstration year period due to such factors as reporting, review, and claim lag. For certain Stage 1 and 2 activities and milestones, hospitals will be required in their Hospital DSRIP Plan to identify the targeted date of completion. This targeted date will be required to be completed within a specified experience period. The activity can be completed within a given demonstration year, but in order for payment to occur before the demonstration year ends, reporting and review time must be factored in for the hospital, the Department, and CMS. Additionally, due to claims lag, the experience period for Stages 3 and 4 activities will also differ from the demonstration period. For these reasons, the experience period may not necessarily coincide with the demonstration year.

Although some Stage 1 and 2 activities must be completed by a specified date, the following experience periods will be used as a guide for most Stage 1 and 2 activities.

Table IV. STAGES 1 AND 2 EXPERIENCE PERIODS, BY DEMONSTRATION YEAR
Demonstration Year

Demonstration Year	Begin	End
DY2	Hospital DSRIP Plan Approval Date	March 31, 2014
DY3	April 1, 2014	March 31, 2015
DY4	April 1, 2015	March 31, 2016
DY5	April 1, 2016	March 31, 2017

Since Stages 3 and 4 are based on metric reporting/performance, experience periods will vary from metric to metric, depending on the technical specifications and on whether the metric is reported annually or semi-annually. The DSRIP Planning Protocol Addendums 1 and 2 will be updated with the specific experience periods for these metrics no later than November 15, 2013.

D. Reporting Completion of Measures/Milestones

In the Hospital's DSRIP Plan, for certain activities in Stage 1 and Stage 2, the hospital will be required to indicate the targeted date of completion. Hospitals will be required to report the progress of completing these activities in periodic

progress reports. Minimum submission requirements for each milestone/metric are documented in the Planning Protocol, Attachment A: Toolkit. Payment for completion of a milestone/metric will not be received for incomplete submissions. Completion of Stage 1 and Stage 2 activities must be included in quarterly progress reports. Stage 3 and Stage 4 measures must be reported in the semi-annual progress reports on either an annual or semi-annual basis, depending on the measure. See III. Reporting Requirements above for further reporting requirements.

VII. DSRIP Payment Calculations

Hospitals will receive DSRIP payments based on expected completion of activities and measurement performance. The frequency of these payments will be dependent on the stage and reporting. Although completion of Stage 1 and 2 activities will be reported quarterly, New Jersey intends to provide payment to the participating hospitals for these stage activities on a monthly basis in order to maintain adequate cash flow to the hospitals during the demonstration. Monthly payments will be adjusted by the Department if review of a quarterly progress report reveals that sufficient activities have not been completed to support amounts paid to date. The draw of the federal financial participation (FFP) match for Stage 1 and 2 activities, or reporting of payments on the CMS-64 form, will not occur until the activity has been verified by both the Department and CMS as complete. The CMS-64 form is used by the State to claim federal matching funds. Therefore, any payment for Stage 1 and 2 activities which were not completed (not earned) by the targeted completion date, will be at risk to the Department and subject to recoupment from the hospital if not completed within the demonstration year's experience period.

Stage 3 metrics will be reported either annually or semi-annually, depending on the metric. In DY2 and DY3, payment to hospitals for reporting Stage 3 metrics will coincide with the metric reporting frequency. Federal match for payments to hospitals for reporting Stage 3 metrics, or reporting of such payments on the CMS-64, will not occur until the metric has been reported and verified by both the Department and CMS. Therefore, in DY2 and DY3 any payment for Stage 3 metrics which were not reported as outlined in the databook (as updated in the Planning Protocol, Attachment A: Toolkit, no later than November 15, 2013), will be at risk to the Department and subject to recoupment from the hospital.

For DY4 and DY5, although only a subset of Stage 3 metrics will be based on pay for performance (P4P), all Stage 3 metrics are required to be reported to earn any payment tied to performance. Payment for the P4P metrics will

coincide with the metric reporting frequency. Federal match for Stage 3 P4P metrics will not occur until performance has been met and verified by both the Department and CMS for the P4P metric and all required Stage 3 metrics have been reported. Therefore, in DY4 and DY5 any payment for Stage 3 P4P metrics which were earned will be at risk to the Department and subject to recoupment from the hospital.

Stage 4 metrics will be reported either annually or semi-annually, depending on the metric. Payment for reporting these metrics will coincide with the metric reporting frequency. Federal match for reporting Stage 4 metrics will not occur until the metric has been reported and verified by both the Department and CMS. Therefore, any payment for Stage 4 metrics which were not reported as outlined in the databook (as updated in the Planning Protocol, Attachment A: Toolkit, no later than November 15, 2013) will be at risk to the Department and subject to recoupment from the hospital.

As shown below, based on reporting and verification of completion and performance, the Department will calculate the DSRIP payment earned for each stage activity/metric and will reconcile the earned DSRIP payment to the cumulative DSRIP payment made to the hospital. Adjustments to monthly payments to DSRIP participating hospitals will be made as needed.

A. Calculating DSRIP Payments for Stages 1 and 2

The Achievement Value (AV) for each Stage 1 and 2 metric will be calculated as a 0 or 1 value. A Stage 1 or 2 metric considered by the Department and/or CMS to be incomplete will receive an AV of 0. A metric considered by the Department and CMS as complete, will receive an AV of 1. The AV for each metric will be summed to determine the Total Achievement Value (TAV) for the stage. The Percentage Achievement Value (PAV) is then calculated by dividing the TAV by the maximum AV (the total number of metrics).

A participating hospital is eligible to receive a DSRIP payment for Stage 1 and 2 activities determined by multiplying the total amount of funding allocated to Stage 1 and 2 by the PAV.

Example:

The hospital's Stage 1 and 2 activities in DY3 is valued at \$10 million and has five metrics. Under the payment formula, the five metrics represent a maximum TAV of five. The participating hospital reports the following progress at six months:

Metric	Status	AV
Stage 1: Metric 1	Complete	1
Stage 1: Metric 2	Complete	1
Stage 1: Metric 3	Not Complete	0
Stage 2: Metric 1	Not Complete	0
Stage 2: Metric 2	Not Complete	0
TAV		2
PAV (2/5)		40%

At the 6 months reporting period, the hospital has only earned 40% of Stage 1 and 2 funding or \$4,000,000. Since Stage 1 and 2 is paid monthly, the hospital has already received \$5,000,000 (\$10 million/12*6 months). The Department will adjust remaining demonstration year monthly payments going forward.

At the end of the DY3, the participating hospital successfully completes the remaining metrics. The hospital has satisfied the requirements to receive the balance of the DSRIP payments related to Stages 1 and 2.

B. Calculating DSRIP Payments for Stage 3 Project-Specific Metrics

Stage 3 Project-Specific Metrics are required to be reported all years of the demonstration, however, specific Stage 3 metrics will be tied to performance in DY4 and DY5. As described above in Section VI, subsection B, "Milestone and Measure Valuation," DSRIP payment in DY2 and DY3 will be based on the metrics reported, whereas DSRIP payments for DY4 and DY5 primarily will be based on performance.

i. DY2 and DY3

The DSRIP payment for Stage 3 to a participating hospital will be based on the hospital successfully reporting all Stage 3 metrics when required. Each metric will be valued equally. With the exception of DY2, since some Stage 3 metrics require a semi-annual reporting frequency, the value of those metrics will then be halved. Therefore, the AV for each Stage 3 metric will be calculated as:

- 0 if metric is not reported
- 1 if annual metric is reported
- 0.5 if semi-annual metric is reported

For DY2 the reported Stage 3 metric will receive an AV of 1 for annual metrics and for semi-annual metrics since there is only one reporting period for DY2. Additionally in DY2, if a measure is not reported but the hospital has provided a plan to report the metric by October 31, 2014, the measure will receive an AV of 1. Any Stage 3 metric not reported on October 31, 2014, unless otherwise stated in the databook, will receive an AV of 0 in DY3.

The AV for each metric will be summed to determine the TAV for the stage. The PAV is then calculated by dividing the TAV by the maximum AV (the total number of metrics).

A participating hospital is eligible to receive a DSRIP payment for Stage 3 metric determined by multiplying the total amount of funding allocated to Stage 3 by the PAV.

ii. DY4 and DY5

In order to receive an incentive payment during the Stage 3 pay for performance demonstration years, DY4 and DY5, the Department will first require the hospital to report all Stage 3 measures. The DSRIP payment will then be based on the requirement that the hospital will make measurable improvement in a core set of the hospital's Stage 3 performance measures. A measurable improvement is considered to be a minimum of a ten percent reduction in the difference between the hospital's baseline performance and an improvement target goal. All performance metrics will be rounded to the hundredth place according to normal rounding practices. Four and below will be rounded down; five and above will be rounded up.

The following steps will be performed to determine Stage 3 pay for performance improvement targeting for each suitable measure:

Step 1 – For each claim-based measure, the Department will calculate the current New Jersey Low Income hospital performance for all Stage 3 P4P measures for every project by December 31, 2013. This performance will be used to determine the Improvement Target Goal described further in Step 2. For non-claim based measures, a hospital cannot receive incentive payments in DY 4 or DY5 for any measure for which the hospital has not reported a baseline value. The baseline performance will represent the most recent performance available following the measure's technical specifications and be no older than calendar year 2010 dates of service.

Step 2 – The performance results will be shared with the Quality & Measures Committee in order to select the New Jersey Low Income Improvement Target Goal for all Stage 3 P4P measures. The Improvement Target Goal serves as the standard level of performance that New Jersey hospitals will strive to obtain as recommended by the

Quality & Measures Committee (see Planning Protocol, Section IX) and agreed to by the Department and CMS. The Improvement Target Goal for any given metric will be no less than the 75th percentile and no higher than the 90th percentile.

For measures that have insufficient data to compile a New Jersey Low Income Improvement Target Goal, the Department, or its designee, will determine if there are publicly available benchmarks (e.g. national, Medicare-only, or commercial) that may be substituted for the New Jersey Low Income Improvement Target Goal.

The New Jersey Low Income Improvement Target Goal will remain stable for the life of the demonstration to maintain predictability for the hospitals.

Step 3 – For each suitable core measure tied to pay for performance, the Department will incentivize the hospital to reduce the difference between their hospital’s baseline performance and the Improvement Target Goal, otherwise known as the “Gap.” The hospital’s baseline used for pay for performance is the initial starting point from which the hospital’s future performance will be compared. This P4P baseline will be from each metric’s most current reporting period reported in DY3.

To compute the Gap, the Department will subtract the hospital’s P4P baseline performance rate from the Improvement Target Goal.

Step 4 - In order to receive an incentive payment, the Department requires the hospital’s gap in performance to be reduced by ten percent (10%) during the pay for performance demonstration years. Therefore, in DY4 and DY5, the hospital must reduce its gap at a minimum by ten percent. This will result in a minimum overall total reduction for the demonstration of twenty percent (20%).

The Department will multiply the Gap by the required annual reduction (10%) to determine the rate of improvement required.

If a measure’s performance period is less than an annual period (i.e. calendar, state fiscal year, or federal fiscal year), the required reduction percentage will be adjusted accordingly in order to achieve the same annual reduction total (e.g. semi-annual measures require a 5% reduction in the Gap per performance period).

Step 5 – The Department will add this rate of improvement to the hospital’s baseline rate of performance in order to establish the “Expected Improvement Rate.”

Step 6 – Upon close of an applicable performance period, the Department will re-compute the measure to determine the hospital’s Actual Performance Result.

The Department will then compare the Actual Performance Result to the Improvement Target Goal. If the Actual Performance Result is at, or above, the Improvement Target Goal, the hospital is eligible to receive an incentive payment for that performance period.

If it is not, the Department will compare the Actual Performance Result to the Expected Improvement Rate. If the Actual Performance Rate is at, or above, the Expected Improvement Rate the hospital is eligible to receive an incentive payment for that performance period.

The improvement calculation will initially be performed at the end of DY3 for future DY4 performance and then repeated for each subsequent performance period. When the Expected Improvement Target is calculated for subsequent performance periods, the better of the Actual Performance Result or the Expected Improvement Target will be utilized as the baseline performance.

The above calculation is further illustrated in Table V.

Table V. DSRIP PAY FOR PERFORMANCE IMPROVEMENT CALCULATION

Line 1	Improvement Target Goal
Line 2	Better of the Hospital Rate in the prior performance period or the Expected Improvement Target (Baseline)
Line 3	Subtract the hospital’s rate (line 2) from the improvement target goal (line 1). This is the gap between the hospital’s prior performance period rate and the improvement target goal. (Gap)
Line 4	Required annual reduction in the gap (10%)
Line 5	Multiply the gap (line 3) by the 10% required annual reduction in the gap (line 4). This results in the rate of improvement required.
Line 6	Add the hospital’s baseline rate (line 2) to the rate of improvement (line 5). (Expected Improvement Target)
Line 7	Compare Expected Improvement Target to Actual Performance Result; Is the Actual Performance Result at the Improvement Target Goal? Is the Actual Performance Result at the Expected Improvement Target? If either are Yes – then the Payment Incentive is Awarded.

If a measure's performance period is less than an annual period, the Department may compute a year-to-date performance rate along with the rate for the specified performance period. Upon review of the actual performance data, the Department may determine, with CMS concurrence, that the better of performance between these two rates will be used to compare against the Expected Improvement Rate for determining eligibility for payment. This has the effect of smoothing inconsistent and irregular data patterns that may be seen over a shorter performance period.

To determine the amount of incentive payment that the hospital will receive an allocation amount is calculated for each measure. Each P4P measure will have equal allocation over the demonstration year.

In each demonstration year for which pay for performance applies, the Department will compute the payment allocation for each P4P measure for each hospital. The Department will divide the hospital's total Stage 3 allocation amount by the total number of P4P measures tied to the project the hospital has selected.

$$\frac{\text{Stage 3 Allocation}}{\text{Total P4P measures}}$$

For any measure that has less than an annual performance period and requires reporting and computing of improvement results more than once, that measure's allocation will be divided by the number of times this computation must occur. (e.g. The allocation for semi-annual measures will be divided by two to determine how much the hospital can receive for each performance period.)

For any measure that the Department determines, with CMS concurrence, that the above calculation cannot be computed, the Department will authorize a simple ten percent rate of improvement over the hospital's baseline performance rate per year as the Expected Improvement Target for that measure. This may occur if there is insufficient data to develop a New Jersey Low Income Improvement Target Goal, or if national benchmarking data is unavailable.

C. Calculating DSRIP Payments for Stage 4 DSRIP Performance Indicators (i.e. Universal Metrics)

The DSRIP payment for Stage 4 to a participating hospital will be based on the hospital successfully reporting all Stage 4 metrics. Each metric will be valued equally. With the exception of DY2, since some Stage 4 metrics require a semi-annual reporting frequency, the value of those metrics will then be halved. Therefore, the AV for each Stage 4 metric will be calculated as:

- 0 if metric is not reported
- 1 if annual metric is reported
- 0.5 if semi-annual metric is reported

For DY2 the reported Stage 4 metric will receive an AV of 1 for annual metrics and for semi-annual metrics since there is only one reporting period for DY2. Additionally in DY2, if a measure is not reported but the hospital has provided a plan to report the metric by October 31, 2014, the measure will receive an AV of 1. Any Stage 4 metric not reported on October 31, 2014, unless otherwise stated in the databook, will receive an AV of 0 in DY4. If a hospital cannot report an obstetrical or pediatric related measure because the hospital does not have an obstetrical or pediatric department, the hospital will be required to indicate in the progress report why the measure cannot be reported. The AV value for these measures will be 1 so long as the hospital has indicated why the measure cannot be reported.

The AV for each metric will be summed to determine the TAV for the stage. The PAV is then calculated by dividing the TAV by the maximum AV (the total number of metrics).

A participating hospital is eligible to receive a DSRIP payment for Stage 4 metric determined by multiplying the total amount of funding allocated to Stage 4 by the PAV.

Example:

The hospital's Stage 4 in DY3 is valued at \$5 million. A total of 45 metrics are required to be reported. Under the payment formula, the 45 metrics represent a maximum TAV of 45. Therefore, each Stage 4 metric is valued at \$111,111.11 (\$5 million/45). Any Stage 4 metric required to be reported on a semi-annual reporting frequency will have a value of \$55,555.56 (\$111,111.11*0.5). At six months, the participating hospital reports 20 annual metrics and 10 semi-annual metrics. The hospital has earned \$2,777,777.80 for stage 4 as shown below:

	(A) Reported	(B) Value	(A*B) Total Earned
Annual Metrics	20	\$111,111.11	\$2,222,222.20
Semi-Annual Metrics	10	\$55,555.56	\$555,555.60
Total Stage 4 Earned			\$2,777,777.80

Since Stage 4 is paid semi-annually, the hospital would receive \$2,500,000 (\$5 million/2) at the 6 month reporting period. The hospital has therefore earned more than the 6 month Stage 4 payment. The Department may therefore determine if an additional payment shall be made at that time or held until the last reporting period.

D. Forfeiture of DSRIP Payments

Scoring and evaluation of metrics will be completed based on the submission and review process describe above in Section III: "Reporting Requirements."

Participating hospitals must fully achieve all milestones and metrics as described in their Hospital DSRIP Plans within a particular demonstration year's experience period in order to receive a DSRIP payment. Failure to achieve a metric within a given demonstration year's experience period will permanently forfeit the otherwise available DSRIP funding. All DSRIP funds that are forfeited by a hospital shall be added to the Universal Performance Pool and distributed according to the methodology described in subsection E, "DSRIP Universal Performance Pool" below.

Once the scoring and evaluation of metrics has been completed by the Department and CMS, each hospital will be notified of the amount of DSRIP Incentive Payments earned. Upon approval from CMS, the Department may claim FFP for DSRIP payments earned and paid to the hospitals. If at any time the Department determines that a hospital will not achieve all their metrics and receive 100% of their DSRIP Incentive Target amount based on submitted progress reports, the Department will reduce the hospital's monthly DSRIP payment to ensure that the hospital is not overpaid. Any overpayment determined by the Department will be recouped from the hospital.

Upon notification by the Department of the final amount earned for the applicable demonstration year, a hospital shall have 30 days to submit a reconsideration request to the Department. The reconsideration period is available to address reporting or computational errors. Because the outcome of a reconsideration, as determined final by the Department and/or CMS, could impact the amount of funding that is forfeited and available for deposit in the DSRIP Universal Performance Pool (UPP), distribution of the UPP shall not occur until after the 30 day reconsideration period has ended.

With the exception of DY5, the Department will make all final DSRIP payments for the SFY and DY no later than 31 days following the end of the SFY. Upon making those final payments, funding attributable to that DSRIP year will be considered closed and final, and no subsequent adjustments will be made. DSRIP funds are not fungible between SFYs or DYs. For DY5, the Department will make all final DSRIP payments by June 30, 2017.

E. DSRIP Universal Performance Pool

All hospitals with approved Hospital DSRIP Plans will be eligible for the Universal Performance Pool (UPP). The UPP will be made up of the following funds:

- For DY3 – DY5, the percentage of the total DSRIP funds set aside for the UPP, known as the Carve Out Allocation amount. See Section IV: “Hospital’s DSRIP Target Funding Amount,” paragraph B, step 2 above, applicable to DYs 3-5. There will be no Carve Out Allocation amount for DY2.
- Hospital DSRIP Target Funds from hospitals that elected to not participate
- Target Funds that are forfeited from hospitals that do not achieve project milestones and metrics, less any prior year appealed forfeited funds where the appeal was settled in the current demonstration year in favor of the hospital.

The total UPP amount determined above shall be distributed to qualifying hospitals based on maintaining or improving on a specific set of twelve Stage 4 metrics identified as a UPP metric. As some hospitals may not have service areas required to calculate one or more of the twelve UPP metrics, these hospitals must substitute those metrics for one or more of the four replacement UPP metrics, not to exceed twelve total metrics. See DSRIP Planning Protocol, Addendum 2 for a list of the twelve UPP metrics and the four UPP replacement metrics. The baseline performance periods from which the UPP will be calculated will be included in the Planning Protocol, Attachment 1: DSRIP Toolkit as it is updated with the databook, no later than November 15, 2013.

All hospitals must have a total of twelve UPP measures and only those hospitals that lack obstetrical (OB) or pediatric departments must choose substitute measures from the substitution list. These (non-OB/non-pediatric) hospitals must indicate its substitution choice in its submitted Hospital DSRIP Plan. Hospitals that have obstetrical and pediatric departments cannot substitute UPP measures and therefore must use the set of twelve UPP measures indicated.

The UPP amount will be distributed based on the sum of achievement values of these twelve metrics along with the hospital’s state-wide Low Income Discharge percentage. The UPP metric AV will be determined as follows:

- UPP Metric is at or improves from baseline, AV = 1
- UPP Metric has regressed from baseline, AV = -0.5

For DY2, the AV will automatically be calculated as 1 for each UPP metric since the experience period for each UPP metric would be pre-DSRIP implementation.

For DY3-DY5, payment will be earned based on outcome of the 12 Universal Stage 4 metrics designated as UPP metrics (or replacement UPP metric, if applicable). Each of the 12 metrics will be evaluated separately and receive an achievement value (AV) score of either 1 or -0.5.

For each hospital, a total AV (TAV) score will be established by summing the AV scores for each metric. The TAV score will be no higher than 12 and no lower than 0. The Percentage Achievement Value (PAV) is then calculated by dividing the TAV by the maximum AV (12).

The hospital's PAV will then be weighted based the hospital's percent of Low Income discharges, using the percentage rate of the hospital's Low Income (Medicaid/CHIP/Charity Care from the MMIS data source) discharges to all statewide Low Income discharges. The result will be reflected as a percentage to total and the UPP will be distributed accordingly

The statewide Low Income discharge totals will be updated regularly, to occur no more frequently than on an annual basis, to reflect current hospital discharge data. Prior to UPP payment distribution, the Department will provide to CMS the calculation of the discharge distribution and the resulting discharge report that will be used.

VIII. Plan Modifications

Consistent with the recognized need to offer participating hospitals with flexibility to modify their plans over time considering evidence and learning from their own experience, as well as unforeseen circumstances or other good cause, a participating hospital may request prospective changes to its Hospital DSRIP Plan through a plan modification process.

Participating hospitals may submit requests to the Department to modify elements of an existing project prospectively, including changes to milestones and metrics with good cause. Modifications require re-approval by the Department/CMS if the hospital's recommended changes or modifications from the approved DY2 Hospital DSRIP Plan would alter the DSRIP project goals or departures from the approved DY2 Plan would affect payment and/or change the valuation of any measure. Such requests must be submitted to the Department with the annual DSRIP Renewal Form due April 30 of the current demonstration year for changes to go into effect the following demonstration year.

If such modifications to or departures from the original DY2 DSRIP Hospital Plan are noted, the Department/CMS approvals will follow the processes described above Section II, subsections B and C and Section III, subsection B.i. "Approval of DSRIP Application by the Department/CMS."

Timeline of Follow-up Activities for Department and CMS

DSRIP Activity	Start Date	End Date
Development of Hospital Plan Review program: Department submits the Department's approach and review criteria for reviewing Hospital DSRIP Plan applications, as well as a draft DSRIP Plan Initial Review Checklist. The Department and CMS hold bi-weekly calls to finalize the Review program.	08/20/2013	09/20/2013
Hospital Plan Review Process: Department and CMS hold bi-weekly conference calls in order to review and approve Hospital DSRIP Plans.	09/20/2013	01/31/2013
Attribution Model: Department submits attribution model to CMS by 9/30/2013. CMS reviews and provides feedback to the Department, with goal for CMS approval by 10/14/2013.	9/30/2013	10/14/2013
Hospital Databook and Reporting Template: Department submits the revised Toolkit with the addition of the databook and hospital reporting template to CMS by 10/31/2013, with goal to finalize by 11/15/2013. The Measure Catalogue Addendums are updated with the reporting periods.	10/31/2013	11/15/2013
CMS Reporting Template: Department submits a CMS Reporting Template that provides key information related to DSRIP activities and results to CMS by 11/15/2013 with goal to finalize by 12/31/2013.	11/15/2013	12/31/2013
Improvement Target Goal and Baseline Performance Threshold: Department receives recommendations from the Committee by 1/31/2014 and submits to CMS for approval. The Measure Catalogue Addendum 1 is updated.	12/31/2013	01/31/2014
Review of Quarterly Progress Report: Within 21 days of receipt of each progress report, the Department will complete an initial review of the data. Within 45 days, the Department and CMS will review/ approve or request additional information regarding the data that supports completion of the metric/ milestone.	04/2014	06/2017
Low Income Statewide Discharge Report: Any instance that the Low Income discharge data is adjusted, the Department will submit to CMS the statewide discharge report prior to payment of the UPP.	07/2014	04/2017
Quarterly Conference Call: March, June, September, and December	04/2014	06/2017



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CHRIS CHRISTIE
GOVERNOR

September 9, 2011

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
Washington, D.C. 20201

Dear Madam Secretary,

I am pleased to present New Jersey's vision for preserving our Medicaid/NJ FamilyCare program as an essential health insurance safety net that can be sustained long into the future. The Section 1115 Demonstration Comprehensive Waiver we are submitting today to the Centers for Medicare and Medicaid Services has been designed to make Medicaid/NJ Family Care more flexible, more effective, more affordable to our taxpayers and more comprehensive in the services it offers.

We are proposing administrative and operational efficiencies that will make the program sustainable for decades to come and nimble enough to respond quickly to changing circumstances. We plan to use this additional flexibility to experiment with new modes of health care delivery such as Accountable Care Organizations and medical homes, which hold the promise of providing better care at less cost. We intend to employ a substantial part of the resulting savings to improve Medicaid/NJ FamilyCare services to populations that currently are underserved, notably our citizens with developmental disabilities, mental health disorders, or both. We are committed to rebalancing our spending on long-term care so that we rely less on institutionalization and more on services that will help keep our aging citizens and those with disabilities in their own homes, which is where they have told us they want to stay.

While this admittedly is an ambitious agenda, our vision is not limited to improving Medicaid/NJ FamilyCare. We hope that our initiatives with managed long-term care, medical homes, Accountable Care Organizations and other efforts to deliver coordinated health care will provide workable models that can be replicated by other payers and other states.

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The Comprehensive Medicaid Waiver we are submitting is not merely a compilation of best ideas for improving Medicaid/NJ FamilyCare. It is the product of concerted collaboration among three state departments—Human Services, Health & Senior Services and Children & Families—as well as extensive consultation with our Medicaid/NJ FamilyCare clients and their health care providers and advocates. One of my first acts as Governor was to sign an Executive Order requiring state agencies proposing new regulations to consult their stakeholders. Our Administration has faithfully observed this directive by publishing the concept paper that outlined our proposed waiver, convening numerous stakeholder forums and carefully evaluating the feedback it received. As a result, the proposals outlined in the original concept paper have been refined and, in some cases, substantially revised. I would like to highlight two of these changes.

We no longer propose freezing enrollment of parents earning below 133 percent of the federal poverty level into NJ FamilyCare. This was not an idea we originated; previous administrations in New Jersey had frozen enrollment of adults in order to cope with financial downturns less serious than the one we face now. We initially viewed freezing enrollment of parents as a way to conserve limited resources and preserve New Jersey's very generous eligibility standards—up to 350 percent of the federal poverty level -- for enrolling children into NJ FamilyCare. We reasoned that this would be a temporary hardship for parents earning less than 133 percent of poverty who are not already enrolled in NJ FamilyCare, as they will become categorically eligible for Medicaid in 2014. Our stakeholders, however, told us that in these turbulent economic times, freezing NJ FamilyCare would be a very substantial hardship on parents who become newly eligible, perhaps because they have lost a job. Our stakeholders also made a convincing argument that freezing enrollment of parents would harm our efforts to provide health care coverage for every child in the state, because parents signing up for NJ FamilyCare will enroll their children as well. We take these concerns very seriously and have concluded that, on balance, maintaining current eligibility standards for parents is the right thing to do.

I do feel compelled to point out that under current law, in 2014 the Medicaid program nationwide will expand to cover everyone up to 133 percent of the federal poverty level, with the federal government initially paying 100 percent of the cost for those who are "newly eligible." This means the cost of covering parents up to 133 percent of poverty will be borne entirely by the federal government in those states that have never covered this population, while New Jersey will actually see its federal matching rate for covering these parents drop from 65 percent to 50 percent. In effect, New Jersey will be punished for doing the right thing. I hope you agree that this represents an inequity and that you will assist us in our efforts to obtain enhanced federal matching funds for covering parents up to 133 percent of poverty.

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We also are changing our strategy for reducing the inappropriate use of hospital emergency rooms for non-emergency conditions. We originally proposed charging Medicaid clients a \$25 co-pay if they went to a hospital emergency room with a "low-acuity, non-emergency" condition; we intended this to create a financial incentive to seek care in a more appropriate setting such as a primary care provider or Federally Qualified Health Center. During our discussions with stakeholders, however, we were presented with convincing evidence that a co-payment would not change patient behavior and that hospitals would be unable to collect these co-payments and would have to absorb the cost. Accordingly, we are dropping the proposed \$25 co-payment and will instead pursue our goal of reducing inappropriate use of hospital emergency rooms through other initiatives.

Accountable Care Organizations are one example of such an initiative. You have probably read of the pioneering work that Dr. Jeffrey Brenner is doing here in New Jersey through the Camden Coalition of Healthcare Providers. Dr. Brenner's work so far indicates that health care costs can be substantially reduced by providing good primary care to poor and marginalized patients before they show up in our hospital emergency rooms with serious conditions. More importantly, the quality of these patients' lives can be improved immeasurably. It was to foster innovative programs such as this that I signed a law authorizing our Department of Human Services to establish Medicaid Accountable Care Organization pilot programs. Making these pilot programs a reality will require additional approvals from your office, which we intend to pursue through our Comprehensive Medicaid Waiver.

Other pilot programs proposed in our waiver application would extend Medicaid services to citizens with unmet medical needs. As one example, New Jersey is continuing its commitment to individuals and their families who are dually diagnosed with developmental disabilities and mental illness. The State will develop a 200-person pilot program for children and young adults who are dually diagnosed with developmental disabilities and mental illness who meet the state psychiatric hospital level of care. The primary goal of the pilot is to provide a safe, stable, and therapeutically supportive environment in the community for children and young adults with significantly challenging behaviors and medical needs. This pilot also will increase the community capacity in New Jersey to serve this vulnerable population.

New Jersey also recognizes that a number of individuals with Medicaid coverage have Pervasive Developmental Disabilities (PDD) diagnoses, such as autism, and are unable to receive PDD-related habilitation services through the Medicaid State Plan that are available to New Jerseyans with private health insurance. In 2009, New Jersey mandated coverage for PDD-related habilitation, such as applied behavioral analysis (ABA), in private health insurance for children with autism and other developmental disabilities. Our waiver includes a pilot program for 200 children to receive services such as ABA, discrete trial and pivotal response, family training and nutritional consultations; these services are identical to those mandated under private health insurance. This is an important first step in ensuring

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that children with autism and other developmental disabilities that are covered by Medicaid receive the same medically necessary services as those with private insurance.

These are just a few of the innovations proposed in our Comprehensive Medicaid Waiver. It also includes programs to promote healthy behaviors and create incentives for our citizens to stay healthy, to encourage primary care providers to participate in Medicaid/NJ FamilyCare by increasing their reimbursement, and to coordinate care for our most expensive category of patients, those eligible for both Medicaid/NJ FamilyCare and Medicare. I look forward to cooperating with your office to make these possibilities a reality. Working together, we can improve the delivery of health care and the lives of our fellow citizens, both in New Jersey and throughout these United States.

Sincerely,

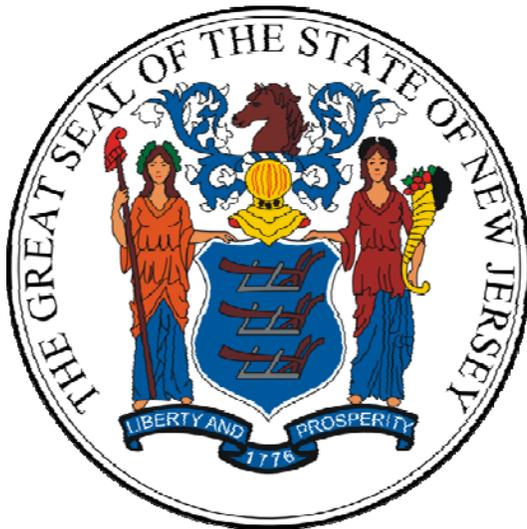

Chris Christie
Governor

September 9, 2011

Section 1115 Demonstration Comprehensive Waiver

State of New Jersey

Department of Human Services, in
Cooperation with the
Department of Health and Senior Services
and the Department of Children and
Families



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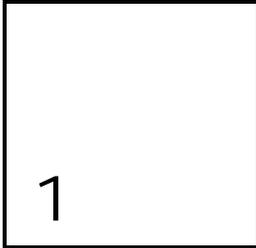
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Overview

Over the past decade, the State of New Jersey's (State) NJ FamilyCare/Medicaid program has made tremendous progress in establishing a well-managed, efficient delivery system of care for acute/medical services. The State's managed care program has been recognized nationally for its early use of innovative approaches, such as health-based risk adjustments, health plan efficiency adjustments and overall use of health plan encounter data within the capitation rate-setting process.

Today, however, much of the State Medicaid program remains outside of this efficient delivery system of care and is instead an unmanaged fee-for-service (FFS) delivery system. There are some features of managed care under FFS programs that include utilization and care management without the financial incentives of at risk managed care. Given the reality of the State's budget, the current program is not sustainable and does not best meet the needs of the individuals it serves. Successful expansion of delivery system care innovations to the services and populations that are presently covered under FFS will pave the way for better care, additional savings and management opportunities.

The State's current NJ FamilyCare/Medicaid program, eligibility and enrollment policies, benefit packages and provider payment rates are also in need of rebalancing. While the current program has generous eligibility levels and enrollment policies as well as relatively generous benefits, it nonetheless pays rates to some providers that may serve as a disincentive to participation in the program and limit accessibility to primary care and preventive services and community service options for both long-term care (LTC) and behavioral health (BH).

The State of New Jersey, Department of Human Services (DHS), in cooperation with the Department of Health and Senior Services (DHSS) and the Department of Children and Families (DCF), is seeking a five-year Medicaid and Children's Health Insurance Program (CHIP) Section 1115 research and demonstration waiver that encompasses nearly all services and eligible populations served under a single authority, which provides broad flexibility to manage the State's programs more efficiently. The waiver will

allow the State the flexibility to define who is eligible for services, the benefits they receive and the most cost-effective service delivery and purchasing strategies. The Comprehensive Waiver will:

- Consolidate New Jersey Medicaid and CHIP under a single waiver authority with a streamlined Centers for Medicare & Medicaid Services (CMS) approval process
- Commit the State to making key improvements to the Medicaid eligibility system (both processes and technology) going forward
- Promote increased utilization of home and community-based services (HCBS) for individuals in need of LTC
- Integrate primary, acute and LTC as well as behavioral health (BH) for some populations
- Enhance access to community-based mental health and addiction services
- Promote efficient and value-added health care through health homes and accountable care organizations (ACOs)
- Provide flexibility to promote primary and preventive care access by balancing eligibility and enrollment for services, the benefits received and the rate of payment for services
- Provide flexibility in administration of the program to implement management efficiencies and purchasing strategies
- Promote healthy behaviors and member responsibility for their health care

Beginning in State fiscal year (SFY) 2012, the NJ FamilyCare/Medicaid participating MCOs began taking responsibility for additional populations and services. As SFY 2012 continues, and under the Comprehensive Waiver, these MCOs will be responsible for additional NJ FamilyCare/Medicaid membership and additional costly services that were previously provided by the State through the FFS program. Key waiver components and proposed timeframes appear to the right.

Examples of the innovative changes to the programs' financing, delivery and design on the horizon for the State, include the following:

- Re-thinking the delivery system for LTC. As the influx of baby boomers reach retirement age and beyond, the corresponding demand for LTC services will increase

Timeline for Key Components of the Comprehensive Waiver

July 1, 2011

New managed care membership for acute/medical care (aged, blind and disabled (ABD)) and additional services (pharmacy, personal care, and medical day care)

August 1, 2011

Mandatory managed care for non-dual ABDs

October 1, 2011

New managed care membership for acute/medical care including Medicare/Medicaid dual eligibles and waiver participants

Coverage under Medicaid of treatment and support services for more adults with addiction disorders and adults with serious mental illness

January 1, 2012

Medicare special needs plans offered by NJ FamilyCare/Medicaid MCOs implemented to integrate Medicare and NJ FamilyCare/Medicaid services

Expanded support services for people with intellectual and developmental disabilities

July 1, 2012

Managed LTC through the contracted MCOs implemented including HCBS and nursing facility services and streamlined eligibility for LTC support

CSOC expanded to include community-based mental health and addiction services now paid directly by DMAHS

January 1, 2013

Managed BH organization implemented for adults expanding community-based mental health and addiction services

significantly. Further, most individuals want to receive LTC supports in their homes or in the community rather than in a nursing facility (NF).

- Addressing a growing body of evidence that unmet mental health and addiction service needs have a substantial impact on the high cost of acute/medical care.
- Evolving the role and structure of contracted managed care plans through medical homes and ACO models.
- Managing members with dual eligibility using creative approaches, such as a capitated special needs program (SNP).

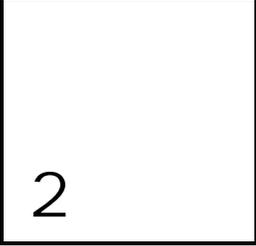
What the Comprehensive Waiver means to:

Our members

- ‘No wrong door’ access per the Affordable Care Act (ACA) and less complexity in accessing services because of integrated health and LTC care services
- Increased primary care provider participation in the program
- Expanded community supports for LTC and mental health and addiction services
- A citizens web portal which allows individuals to conduct self-service screenings to determine eligibility for any Medicaid program and complete an application online
- Stabilized eligibility for NJ FamilyCare/Medicaid by automating many of the processes required annually to maintain eligibility
- Access to a health home for managing all care needs
- Integration of Medicare and Medicaid benefits in the same plan
- Expanded in-home community supports for people with intellectual and developmental disabilities
- Expanded behavioral supports for children with developmental disabilities and mental health issues
- Promotion of member responsibility in using health care resources and rewarding healthy behaviors

Taxpayers

- Achieve significant program savings during the five years of the waiver
- Design a NJ FamilyCare/Medicaid program that is sustainable into the future with the flexibility to respond quickly to changing circumstances
- Consolidate State funding sources under Medicaid to efficiently share the cost with the federal government
- Improve the operational efficiency of NJ FamilyCare/Medicaid and reduce program administration costs
- Bend the health care cost curve and achieve savings through ACOs and health homes
- Position New Jersey for health care reform

2

Streamlined and efficient operations

Consolidation of New Jersey Medicaid under a single waiver with administrative flexibility

Currently, the State Division of Medical Assistance and Health Services (DMAHS) and its sister agencies, including divisions within DHS, DHSS and DCF, administer Title XIX and XXI programs under multiple authorities including:

- A Medicaid State Plan
- A Title XXI Children's Health Insurance Program (CHIP) State Plan
- Two Section 1115 demonstration waivers (one that covers parents and a second recently approved waiver that offers the formerly State-funded general assistance (GA) population an ambulatory benefit package under Title XIX)
- A Section 1915(b) waiver that allows mandatory managed care for certain populations
- Five Section 1915(c) Home and Community-Based Services (HCBS) waivers
- A 1915(j) State Plan authority for participant-directed personal care assistant services (formerly cash and counseling)
- Multiple contracts with managed care organizations (MCO)
- Multiple Program All-Inclusive Care for the Elderly (PACE) contracts
- A 1932 (a) State Plan authority for managed care for the aged, blind and disabled (ABD)
- A new Section 1915(b) waiver for mandatory managed care for duals

This section describes the current waivers, populations and services that will be consolidated under the proposed Comprehensive Waiver, as well as what will remain outside it (See Table 2.1).

Table 2.1 Consolidation of populations/programs under the Comprehensive Waiver

Population/Program	Consolidated in Comprehensive Waiver	Mandatory managed care	Effective date for managed care/managed LTC	Authority prior to Comprehensive Waiver
Aid to Families with Dependent Children (AFDC), including Pregnant Women	Yes	Yes	Current	State Plan Amendment (SPA)
NJ FamilyCare for Parents with Dependent Children	Yes	Yes	Current	1115 Waiver
NJ FamilyCare Pregnant Women	Yes	Yes	Current	SPA
NJ FamilyCare for Children	Yes	Yes	Current	SPA
Medicaid Special	Yes	Yes	Current	SPA
Work First New Jersey/General Assistance (WFNJ/GA)	Yes	No for acute/medical care Managed behavioral health organization (MBHO) for \BH		1115 Waiver
Medically Needy Children and Pregnant Women	Yes	Yes	August 1, 2011	1915(b)
Supplemental Security Income (SSI) Recipients Without Medicare	Yes	Yes	Current	Voluntary under SPA, currently mandatory under 1915(b)
SSI Recipients With Medicare	Yes	Yes	Mandatory October 1, 2011	1915(b)
New Jersey Care Special Medicaid Programs (Aged, Blind and Disabled to 100% of Federal Poverty Level (FPL))	Yes	Yes	Mandatory July 1, 2011	Voluntary under SPA, currently mandatory under 1915(b)
Medically Needy Aged, Blind, or Disabled (ABD)	Yes	Yes	Mandatory July 1, 2011	Voluntary under SPA, currently mandatory under 1915(b)

Population/Program	Consolidated in Comprehensive Waiver	Mandatory managed care	Effective date for managed care/managed LTC	Authority prior to Comprehensive Waiver
New Jersey WorkAbility	Yes	Yes	Current	SPA
Breast and Cervical Cancer (CEED)	Yes	Yes	August 1, 2011	SPA
Medical Emergency Payment Program for Aliens	No	No fee-for-service (FFS)		SPA
PACE	Discontinued	Existing programs can become part of network, receiving 100% of SFY12 capitation through June 30, 2013, receiving 75% of SFY12 capitation through June 30, 2014, and receiving capitation negotiated with MCOs beginning July 1, 2014	July 1, 2012	SPA
1915(j) Personal Care Assistant Services	Yes	Yes (Administrative and Consulting Components will remain with the Division of Disability Services (DSS) and MCOs will refer to DDS)	July 1, 2012	SPA
Institutional Medicaid	Yes	Yes	July 1, 2012	SPA
Traumatic Brain Injury (TBI) Waiver	Yes	Yes	October 1, 2011 for acute/ medical care and July 1, 2012 for managed LTC	1915(c)

Population/Program	Consolidated in Comprehensive Waiver	Mandatory managed care	Effective date for managed care/managed LTC	Authority prior to Comprehensive Waiver
AIDS Community Care Alternatives Program (ACCAP)	Yes	Yes	October 1, 2011 for acute/medical care and July 1, 2012 for managed LTC	1915(c)
Community Resources for People with Disabilities (CRPD)	Yes	Yes	October 1, 2011 for acute/medical care and July 1, 2012 for managed LTC	1915(c)
Global Options for LTC (GO)	Yes	Yes	October 1, 2011 for acute/medical care and July 1, 2012 for managed LTC	1915(c)
Community Care Waiver (CCW)	Yes	Yes for acute/medical care No for LTC/FFS	Current for acute/medical care	1915(c)
Supports Waiver	Yes	Yes for acute/medical care/FFS No for LTC/FFS	October 1, 2011	Supports Waiver will be submitted as a 1915(c) in the Fall 2011
Adult Mental Health and Substance Abuse Services (Division of Mental Health and Addition Services)	Yes	No FFS initially	MBHO January 1, 2013	SPA
Children's System of Care (CSOC) Initiative (DCF)	Yes	Administrative services only (ASO) since 2002	Current ASO accepts additional FFS children July 1, 2012	SPA

Under this proposal, the only populations and services that will remain outside the Comprehensive Waiver are:

- Emergency services only populations and services.
- Services for individuals who are eligible for Medicare but do not receive a "full" Medicaid benefit because their income is too high. These groups include Qualified

Medicare Beneficiaries, Supplemental Low Income Beneficiaries and Qualified Individuals.

- Medicaid administrative or any other expenditure claimed by schools (currently or in the future).

Roles and responsibilities

Under the current multiple authority framework, coordination of traditional SPAs, 1915(j), new State Plan options for offering HCBS waivers (e.g., 1915(i)), 1915(c), 1915(b), and 1115) present a significant challenge to the Department of Human Services designated single state agency, the Division of Medical Assistance and Health Services. While DMAHS retains its statutory authority over all SPAs and waivers involving Medicaid and CHIP funds, including any programs that are administered by other divisions or departments, this process is cumbersome and involves multiple hand-offs from one agency to another.

Consider for example the hand-offs required for each of the State’s five HCBS (soon to be six or more) waivers administered by three different agencies, as shown in Table 2.2.

Table 2.2 1915(c) Waiver hand-offs

	Sister agency	DMAHS	Centers for Medicare & Medicaid Services
Waiver development under consideration	Notifies Medicaid Director	Returns to sister agency designating required members of waiver development group	
Waiver development group convenes and determines waiver content and policies	Notifies Medicaid Director	Returns to sister agency	
Waiver application developed	Transmits to Medicaid Director 45 days prior to submittal to the Centers for Medicaid & Medicare Services (CMS)	Returns to sister agency with questions/issues	
Waiver application revised	Transmits to DMAHS	Transmits to CMS	CMS reviews and sends request for additional information (RAI) to DMAHS
Request for Additional Information (RAI)		DMAHS Legal/Regulatory office coordinates/schedules CMS calls and returns RAI to sister agency	

	Sister agency	DMAHS	Centers for Medicare & Medicaid Services
Response to RAI	Transmits to DMAHS 10 days prior to the 90 th day since waiver submittal	Reviews and submits to CMS	CMS accepts or returns to DMAHS
Waiver renewals and amendments	Notifies Medicaid Director six months prior to waiver expiration or 135 days (if renewal due to CMS 90 days prior to the end of the waiver), including rationale for amendments	Develops timeline based on complexity of amendments and discussions with CMS and returns to sister agency	
Waiver renewal/amendment prepared	Transmits to DMAHS 45 days prior to submittal to CMS	Reviews and resolves questions and transmits to CMS	CMS reviews and sends RAI to DMAHS
RAI		DMAHS Legal/Regulatory office coordinates/schedules CMS calls, and returns RAI to sister agency	
Response to RAI	Transmits to DMAHS 10 days prior to the 90 th day since waiver submittal	Reviews and submits to CMS	CMS accepts or returns to DMAHS
372 Report	Prepares and transmits to DMAHS	Reviews and transmits to CMS	CMS reviews and submits queries to DMAHS
Other 1915(c) reports, Interim Procedural Guidance and Plans of Corrections	Transmits to Medicaid Director for signature two weeks in advance	Transmits to CMS	CMS reviews and approves or requests additional explanation, a corrective action plan, etc.
Audits	Transmits to Medicaid Director for signature two weeks in advance	Transmits to CMS if CMS audit	CMS reviews and includes response in audit findings

Multiply these hand-offs times five for each HCBS waiver, all occurring at different times, and this offers insight into the State’s rationale for consolidation. The FFS structure of current HCBS waivers and the movement of DMAHS increasingly to managed care also argues for consolidation. Once implementation of managed care for LTC services occurs on July 1, 2012, four 1915(c) waivers will be discontinued under the Comprehensive Waiver and fall under the managed care contracts held by DMAHS.

Because the Comprehensive Waiver has components that are implemented at different times, the roles and responsibilities of DMAHS and sister agencies must be transitioned

as well. The reorganization of roles and responsibilities must balance the programmatic expertise of sister agencies needed particularly in the design and development phase, and DMAHS' role as the designated single state agency and its expertise in managed care.

As the departments and divisions implement program changes required by Comprehensive Waiver design and implementation, decisions will be made regarding:

- Timing of reorganization phases
- Identification of budget, staffing and mechanisms of reorganization
- Creating clear lines of accountability
- Impact on staffing roles and responsibilities
- Deciding the placement and structure of regulatory functions
- Deciding the placement and structure of non-regulatory programs
- Deciding who is responsible for policy

Not all of these decisions have been made at this time. The activities related to development, design and implementation will occur over at least two years. The roles and responsibilities will be documented in a Memorandum of Understanding (MOU), which may include the following, as well as any other appropriate terms:

- Milestones, deliverables and performance measures
- DMAHS' lead role in policy and rate-setting and communication with CMS
- Requirements related to procurement involving Medicaid clients/funding, including the involvement of DMAHS as lead or as a participant on Request for Proposal (RFP) committees and a co-signer of contracts
- Medicaid payments to providers must go through the DMAHS fiscal agent
- DMAHS quality oversight responsibility
- Internal audit/assessment procedures
- Procedures/protocol for working with CMS
- Evaluation requirements and data
- Organizational structure of the sister agency and the qualifications/responsibilities of key personnel
- Authority to update/modify timing of updates/modifications
- Duration
- Sister agency responsibilities
- Joint responsibilities

While not all of the changes in roles and responsibilities have been determined, as noted above, the State can provide two very specific examples. First, when the adult and pediatric medical day care (MDC) program transitioned from DHSS to managed care July 1, 2011, the managed care plans assumed the prior authorization and billing/claims processing functions previously conducted by Division of Aging and Community Services (DACS) nursing staff, and billing/claims processing performed by DACS clerical and administrative staff.

A second example is consolidation of HCBS quality assurance (QA) functions. Currently two divisions within DHS, the Division of Disability Services (DDS) and the Division of Developmental Disabilities (DDD) and one division within DHSS, the Division on Aging and Community Supports (DACs), have staff dedicated to QA functions. Providers participating in multiple waivers have different requirements. Under managed care, oversight of QA activities will be unified for maximum efficiency and cost effective operations.

Streamlining

The State intends to streamline its internal program operations to further support consolidation under this Comprehensive Waiver. This streamlining includes enhanced use of information technology (IT) tools, eliminating unnecessary or duplicative activities and improving the service provided to our members. These initiatives are described in detail throughout the remaining sections but include:

- Moving to a competitive bid process for managed care contracts effective with implementation of the Health Insurance Exchange, either by the State or federal government
- Working with the NJ Division of Purchase and Property to develop a streamlined, effective and timely procurement process that supports innovations under the waiver
- Allowing members to conduct a self service screening through a citizens web portal for eligibility to all DHS programs as well as complete an application
- Automate all or most of the eligibility determination and redetermination process
- Using the Master Client Index (MCI) to identify and apply child support enforcement orders for health care.
- Eliminating inconsistencies in operations statewide, particularly in the area of eligibility determinations
- Simultaneously processing clinical and financial eligibility to expedite enrollment in LTC
- Developing a single unified quality monitoring approach for LTC
- Allow exceptions for annual level of care (LOC) reviews and incentivizing MCOs under capitation to promote the least restrictive setting

Each of these initiatives is designed to accomplish specific objectives as detailed throughout this document. For example, the competitive procurement for MCOs aims to accomplish the following:

- Streamline the contract from the 'doorstop' version to one that incorporates the operational details by reference to statutes, regulations and operational manuals, and eliminates existing redundancies/inconsistencies that occurred over years of revision
- Promote cost-effective, participatory care in the most appropriate setting
- Introduce pay-for-performance (P4P)
- Update provider network access standards consistent with the needs of members and community standards
- Update the Early Periodic Screening, Diagnosis and Treatment (EPSDT) performance and sanction provisions (may be part of P4P)

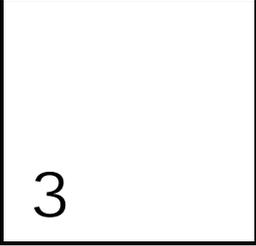
- Introduce managed care operational best practices
- Apply scientifically proven best practice treatment standards
- Apply quality criteria

Approval process

The Comprehensive Waiver seeks a single, unified federal authority that specifies the types of changes that the State can make with streamlined CMS approval and limits the changes that require more extensive and lengthy CMS review. The State seeks CMS' partnership in responding to changes quickly, which may be necessary to administer the most efficient Medicaid and CHIP program possible in a time of limited budget resources. The State requests the following CMS approval process:

- Level 1 changes – CMS approval will not be required. Level 1 changes would be reported by DMAHS in quarterly demonstration reporting. Examples of Level 1 changes include:
 - Administrative changes such as contract requirements for MCOs or ASO organizations (e.g., new performance measures, network requirements, care coordination requirements, quality indicators and/or reporting requirements)
 - Rate (FFS and capitation) increases or decreases less than five percent provided that in the case of FFS, the access study previously submitted demonstrated robust access to services (applicable to Intellectual Disability and Developmental Disabilities (I/DD), the Children's ASO and the managed behavioral health organization (MBHO))
 - New or revisions to existing assessment instruments for LTC (without impact on program eligibility)
 - Changes to professional standards and/or licensure
 - Change in home and community-based number of slots
 - Development or revisions of policies and procedures and operations
 - Revisions in evaluation of network adequacy and the network per se
 - Approval of health home pilots
 - Adding community-based services consistent with CMS guidance
 - Revisions to the disproportionate share hospital (DSH) methodology within the allotment subject to audit
 - Reductions in premiums or copayments
 - Tiered decisions
- Level 2 changes – CMS review and approval comparable to the review process for SPA changes is required. Similar to SPA changes, if CMS does not submit a RAI within 60 days, the change is deemed approved within 90 days. Level 2 does not include changes otherwise approved through the waiver and amendments to budget neutrality terms and conditions.
 - Addition or deletion of SPA, 1915(i), or 2703 defined services (consistent with benchmark flexibility in the Deficit Reduction Act (DRA))
 - Changes in rate methodology and rate increases or decreases greater than five percent for either FFS rates or capitation

- 1915(c) waiver amendments and new submittals for the I/DD population not under managed care
- Increases in premiums or copayments
- Changes to enrollment practices impacting member choice timeframes (e.g., change to the 90-day disenrollment without cause)
- Level 3 changes – CMS review and approval comparable to that for an amendment to a Section 1115 waiver would be required. The State would seek public input, submit these changes 120 days prior to the implementation date and *CMS would have 30 days to raise concerns and begin negotiations comparable to the current process*. Examples include:
 - All eligibility changes
 - Amendments to budget neutrality terms and conditions
 - Benefit changes outside of DRA flexibility

3

Eligibility and enrollment

The State requests broad flexibility for managing eligibility, enrollment, benefits and payment rates. Section 3 addresses eligibility and enrollment and is organized into five subsections:

- Enhanced Federal Medical Assistance Percentage
- New populations
- Reduce FFS periods
- Incorporate operational improvements and streamlining
- Ensure that Medicaid is the payer of last resort
 - Retroactive Medicare Part B
 - Health Insurance Premium Payment (HIPP) program

Enhanced Federal Medical Assistance Percentage

The State is committed to continuing to serve individuals who presently receive benefits under the State's Medicaid and CHIP programs. The State's initial proposal, outlined in the concept paper, was to freeze enrollment for NJ FamilyCare parents with income below 133% FPL. The program was previously closed to parents with income above 134% FPL effective March 1, 2010. After the public input process, this issue received many comments and the most negative feedback; therefore, we are proposing to maintain eligibility for this population given the necessary funds to sustain eligibility.

New Jersey has been in the forefront on expansion of parent coverage and we believe states that were early adopters are being penalized by the Affordable Care Act (ACA). We currently receive a 65% FMAP for our parent population enrolled through our NJ FamilyCare 1115 waiver. Because we began enrolling this population prior to the enactment of the ACA, beginning January 2014 this population will revert back to a 50% match – disenfranchising New Jersey for covering this population. Due to budget constraints it is difficult now to maintain this coverage and will be even more difficult in 2014 when we are slated to receive even less federal matching funds. States that did not

choose to cover parents prior to ACA will be eligible for 100% federal matching funds. Therefore, New Jersey is asking that upon approval of this waiver that we retain enhanced matching funds and are requesting an increase in FMAP from 65% to 75% until December 31, 2013 and then an increase to 85% on January 1, 2014. This amount of FMAP is still below the 90% floor that expansion states will be receiving.

Table 3.1 Eligibility and cost sharing proposed

Population	Non-financial eligibility	Financial eligibility	Service package	Eligible for retroactive Medicaid	Redetermination process	Cost share
AFDC including Pregnant Women	Low income families	The monthly income limit for a family of four is \$507. No resource limit	Plan A services	No	12 months	
NJ FamilyCare for Parents with Dependent Children	Low income parents with dependent children under the age of 19 who are not eligible for Medicaid at the 1996 AFDC income standard	Income is less than or equal to 200% FPL Closed to new applicants 3/1/2010 for applicants with incomes above 133% All resources are disregarded Those who satisfy the following financial eligibility are still eligible: the difference between the 1996 AFDC income standard and 133% FPL is disregarded from the remaining earned income	Plan D services	No	12 months	Yes – copayments and premiums at some income categories currently

Population	Non-financial eligibility	Financial eligibility	Service package	Eligible for retroactive Medicaid	Redetermination process	Cost share
NJ FamilyCare for Pregnant Women	Pregnant women	Income is less than or equal to 200% FPL. No resource limit	Plan A services	No	NA	
NJ FamilyCare for Children	Uninsured children up to the age of 19	Family income is equal to or less than 350% FPL. No resource limit	Income ≤ 133%: Plan A services; Income ≤ 150%: Plan B services; Income ≤ 200%: Plan C services; Income ≤ 350%: Plan D services	No	12 months	Yes – copayments and premiums at some income categories
Foster care	Children under 19	Based on AFDC related Medicaid	Plan A	Yes	12 months	No
Chafee kids	Children 19-21 who were in foster care at the age of 18	On their 18 th birthday must be in DYFS out of home placement supported in whole or in part by public funds.	Plan A	N/A	12 months	No
Subsidized Adoption services	Must be considered to have special needs	NA	Plan A	Yes	NA	No

Population	Non-financial eligibility	Financial eligibility	Service package	Eligible for retroactive Medicaid	Redetermination process	Cost share
Medicaid Special	Single adults age 19 through the end of the month that they turn 21	The difference between the 1996 AFDC income standard and 133% FPL is disregarded from the remaining earned income (this disregard is used instead of the normal AFDC earned income disregard). Countable unearned income must be ≤ the 1996 AFDC income standard. Countable income after all disregards must be ≤ the 1996 AFDC standard. No resource limit	Plan A services	No	12 months	Yes – copayments and premiums at some income categories
WFNJ/GA	Low income adults who may or may not be qualified to work	Monthly income is less than or equal to \$140 for an individual, \$210 for a couple for those able to work and \$193 for an individual and \$290 for a couple medically certified as unemployable	Plan G services	No	12 months	

Population	Non-financial eligibility	Financial eligibility	Service package	Eligible for retroactive Medicaid	Redetermination process	Cost share
Medically Needy Children and Pregnant Women	Children under the age of 21 and pregnant women who do not qualify for another Medicaid program	Income after spend down is equal to or less than \$367 for an individual, \$434 for a couple, two person household or pregnant woman, etc. Up to \$4,000 in resources allowed for an individual, \$6,000 for a couple	Limited Plan A services	No	6 months	Yes spend down
SSI Recipients	Individual or couple is eligible through the Social Security Administration (SSA) with or without Medicare	Financial eligibility through SSA	Plan A services	Yes	12 months	
New Jersey Care Special Medicaid Programs (ABD)	Aged, blind or disabled individuals	Income must be less than or equal to 100% FPL. Resources up to \$4,000/individual, \$6,000 couple	Plan A services	Yes for institutions No for community	12 months	
Medically Needy Aged, Blind, or Disabled	Aged, blind or disabled individuals who do not qualify for other Medicaid programs	Income after spend down is equal to or less than \$367 for an individual, \$434 for a couple, etc. Up to \$4,000 in resources allowed for an individual, \$6,000 for a couple	Plan A services	No	6 months	Yes spend down

Population	Non-financial eligibility	Financial eligibility	Service package	Eligible for retroactive Medicaid	Redetermination process	Cost share
New Jersey WorkAbility	Individual must be between the ages of 16 and 65, have a permanent disability, as determined by the SSA or DMAHS and be employed	Countable unearned income (after disregards) up to 100% FPL, countable income with earnings up to 250% FPL; resources up to \$20,000 for an individual, \$30,000 for a couple	Plan A services	Yes	12 months	
Breast and Cervical Cancer	Uninsured low income women under the age of 65 who have been screened at a NJ cancer education and early detection site	Income less than or equal to 250% FPL. No resource limit	Plan A services	No	12 months	
Medical Emergency Payment Program for Aliens	Individuals who would qualify for Medicaid but for their citizenship status	Individual who would qualify for Medicaid but for their citizenship status	Emergency services only	No	NA	N/A
Institutional Medicaid	Individuals must meet institutional LOC requirements	Income less than or equal to \$2,022 per month. Resources less than or equal to \$2,000	Plan A services	Yes	12 months	Yes
TBI Waiver	Individuals between ages 21 and 64 who have suffered trauma to the brain	Income less than or equal to \$2,022 per month. Resources less than or equal to \$2,000	Plan A services	Yes	12 months	Yes

Population	Non-financial eligibility	Financial eligibility	Service package	Eligible for retroactive Medicaid	Redetermination process	Cost share
ACCAP	Individuals of any age with AIDS	Financially eligible for: (1) SSI, (2) Income below 100% of FPL or (3) Medicaid Institutional criteria - Income less than or equal to \$2,022 per month. Resources less than or equal to \$2,000	Plan A services	Yes	12 months	Yes
CRPD	Individuals determined disabled who can remain in the community	Financially eligible for: (1) SSI, (2) Income below 100% of FPL or (3) Medicaid Institutional criteria - Income less than or equal to \$2,022 per month. Resources less than or equal to \$2,000	Plan A services	Yes	12 months	Yes
GO	Individuals who would qualify for placement in a NF but can use community services	Financially eligible for: (1) SSI, (2) Income below 100% of FPL or (3) Medicaid Institutional criteria - Income less than or equal to \$2,022 per month. Resources less than or equal to \$2,000	Plan A services	Yes	12 months	Yes
CCW	Individuals who are living in the community and are determined clinically eligible by DDD	Financially eligible for: (1) SSI, (2) Income below 100% of FPL or (3) Medicaid Institutional criteria - Income less than or equal to \$2,022 per month. Resources less than or equal to \$2,000	Plan A services	Yes	12 months	Yes

Population	Non-financial eligibility	Financial eligibility	Service package	Eligible for retroactive Medicaid	Redetermination process	Cost share
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All populations must meet the required citizenship status requirements, Social Security Number (SSN) requirements and residency requirements unless otherwise noted. Citizenship status requirements means that the individual is a US citizen or other qualified alien who has either met or is exempt from meeting a five-year US residency period. SSN requirements means that the individual must provide a valid SSN or proof of application for a SSN unless otherwise noted. Residency requirements means that the individual must be a resident of the State of New Jersey or intend to reside in the State of New Jersey.

New populations

The State will add two populations under the Comprehensive Waiver:

- Approximately 1,200 childless adults eligible for state funded services as of October 1, 2011
- Medication Assisted Treatment Initiative (MATI) services for opiate dependent State residents with incomes up to 150% under 1915(i)-like authority (this population is described in detail in Section 5 below)

Reduction of fee-for-service periods

The State also proposes two changes to reduce its FFS exposure for members during the time which they must navigate the health care system unguided. The first is to eliminate the requirement that the State provide coverage prior to the date of a Medicaid application for certain groups of new applicants. The State will continue to provide prior-quarter coverage for individuals who are retroactively determined eligible for SSI and certain individuals at the institutional LOC, including HCBS waivers. The State believes this request is consistent with similar requests that CMS has granted in other states under 1115 demonstration authority. It preserves retroactive eligibility for those most in need and is consistent with DMAHS' belief that care should be managed at the earliest point possible. Exhibit 3.1 identifies those populations that would continue to have prior quarter coverage under the Comprehensive Waiver. In addition to the populations identified on Exhibit 3.1, prior-quarter coverage would continue to be available for adults discharged from Institutes for Mental Disease (IMDs).

It should be noted that the State has a process in place to protect the application date in circumstances when a complete application is not feasible. The effective date of eligibility is the date of application or the date the Form PA1C is completed, whichever is earlier. The PA1C protects the filing date for those individuals admitted to a hospital. (Also, an application may be taken by the out-stationed worker at a hospital or other providers to protect the filing date.) As a component of the PA1C, the hospital or other provider must screen the individual to determine if he/she is already on Medicaid or whether the patient's income and/or resources meet the applicable public assistance standard.

The second change is to require new managed care enrollees to choose a Medicaid MCO upon eligibility application (or within 10 days of the eligibility determination) or be auto-assigned. Members will be allowed a 90-day period to change MCOs without cause. After the 90-day period, plan changes for cause will be allowed, and MCO disenrollment will be possible thereafter once a year during an open enrollment period. New populations added to managed care beginning July 1, 2011 or July 1, 2012 will not be eligible for open enrollment until fall 2012 or fall 2013 respectively.

Based on available statistics, the State has a very low rate of auto-assignment. Individuals processed through county welfare agencies (CWAs) have a 15.0% auto-assignment rate and NJ FamilyCare members have an auto-assignment rate of 0.3%. The State attributes its low auto-assignment rates to outreach. Formal outreach

consists of an introduction letter, enrollment kit and reminder cards. The Health Benefits Coordinator which serves as the choice counselor for the NJ FamilyCare/Medicaid programs also makes managed care program presentations in the community, emphasizing services, benefits, access, care management and the navigation of managed care. A question and answer period follows and individuals are provided an opportunity to enroll. A frequently asked question guide is also available on the DMAHS website, which provides individuals more specific information. And, the enrollment kit mentioned above includes information on what questions to ask of a potential plan (e.g., list the providers you use now so that you can ask each MCO if those providers are in the plan's network). The purpose of the current HBC contract is to screen and process applications, make determinations of NJ FamilyCare/Medicaid program eligibility, assess and collect premiums, provide outreach, marketing and education, and conduct and maintain enrollment with contracting MCOs in accordance with program requirements of the DMAHS programs. Additionally, the contractor shall provide and operate a system capable of performing tasks required of both an Eligibility Processing and Management System and a Managed Care Enrollment System.

The pricing of the contract is based upon actual per member per month enrollments at separate rates for NJ FamilyCare and Medicaid. The case mix will change based on the change in members moved to managed care.

A member will be automatically assigned to a MCO if they have not selected a plan after extensive and repeated outreach attempts. The automatic assignment process randomly assigns an entire NJ FamilyCare/Medicaid case to one of the MCOs operating in their county of residence. The algorithm alternates among each of the available plans, unless/until capacity has been reached. The State is currently discussing alternative algorithms with CMS that would include Medicaid and/or Medicare data to identify commonly used providers and auto-assign the member into a plan that includes his/her most commonly used providers.

It should also be noted that by the time managed LTC is implemented on July 1, 2012, every individual (including duals) receiving LTC care in a facility or in the community will be associated with a MCO for receipt of acute/medical care. Further, the transition plan for LTC (see Section 5) provides a time period during which an individual can receive services from his/her current provider even if that provider does not contract with the MCO.

The State also plans to begin the transition to LTC at least three months prior to July 1, 2012. During this period, DMAHS will provide claim level information to each MCO for its members. Provision of claim level detail allows the MCOs to use predictive modeling and risk assessment tools to design the appropriate care coordination strategy for each member before assuming financial risk on July 1, 2012.

The State continues to move its NJ FamilyCare/Medicaid program towards coordinated care provided in comprehensive managed care delivery systems. Each of the provisions above is consistent with this philosophy. A person's care should be managed from the

earliest point in time possible to ensure quality outcomes and the most effective utilization of resources.

Operational improvements and streamlining

In return for the requested NJ FamilyCare/Medicaid eligibility and enrollment flexibility, the State is committed to improving its performance throughout the NJ FamilyCare/Medicaid eligibility determination process. To this end, the State has or will initiate operational improvements and streamlining in the following areas:

- Reduce processing time for LTC applications
- Spend down options for the medically needy requiring HCBS
- Use IT tools available to automate processes
- Improve overall processing time for eligibility determinations through performance incentives for County Welfare Agencies (CWAs) and CASS implementation – the State's new eligibility determination system.

Reduce processing time for long-term care applications

As a component of the Comprehensive Waiver, the State initiated a review of processing times for financial and clinical eligibility determinations for individuals seeking LTC in Nursing Facilities (NFs) and, more importantly, in the community since prior quarter coverage is not available under 1915(c) waivers. The LTC Medicaid Advisory Council (MAC) brought to DMAHS' attention the potential delays in processing institutional and HCBS Medicaid applications. Upon investigation many reasons were identified for the delays including operational processes, incomplete information provided by the applicant and requirements of the DRA and the five-year look back.

This review produced a series of initiatives to minimize processing time. These initiatives will ensure that delays in receipt of HCBS do not result in institutionalization and include the following:

- Standardized processing statewide based on documented operational protocols
- Protecting the application date as the date of eligibility for receipt of HCBS, which is ninety days prior to date of application
- Simultaneous processing of clinical and financial eligibility for the elderly and physically disabled
- Streamlining the robust assessments conducted under FFS for the elderly and physically disabled under managed LTC where the MCO is responsible for care planning and coordination
- Obtaining authority to use preadmission screening instruments and historical case information and eligibility determinations for the elderly, physically disabled, those with Intellectual and Developmental Disabilities (I/DD), and those with mental illness as the disability determination for SSI from the Social Security Administration (SSA). This will allow the individual to be eligible for LTC services under 42 CFR 435.210 (would be eligible for SSI if they applied) well before the regular SSI eligibility determination is completed. Based on initial review, the assessment for the elderly

and physically disabled used by New Jersey meets the SSI disability criteria and discussions can begin.

- Allow prior quarter coverage for home and community based services under the Comprehensive Waiver provided that clinical eligibility is completed, there is a written plan of care (POC) and require placement choice options to be presented and documented
- Waive the look back for individuals already eligible for the program – those with income below 100% of FPL
- Allow those with income above 100% to receive HCBS based on their attestation regarding transfer of assets with repayment of the State and federal government if the attestation was incorrect

Spend down options for the medically needy seeking long-term care

The State has a medically needy program for LTC. Spend down for residents of NFs is relatively straightforward. However, for community residents spend down is problematic because beneficiaries often use several different HCBS providers, and because beneficiaries must pay shelter or room and board costs to remain in the community. In an effort to rebalance long term care expenditures and make community placements feasible for the LTC medically needy population, the State seeks to develop a new Medically Needy spend down process in a managed LTC environment.

HCBS eligible individuals, who meet nursing home level of care and who have exhausted their assets below the Medicaid eligibility resource level for long term care, may spend down their income by paying their share of the PMPM capitation to the MCO. The beneficiary’s share of the PMPM capitation amount will be equal to the difference between their total gross monthly income and the income standard (Medicaid “cap”) for long term care.

Medically Needy nursing home patients will utilize their monthly income (minus the Medicaid personal needs allowance) to pay their share of the PMPM capitation.

Use information technology tools available to automate processes

The State proposes two innovative initiatives that utilize existing IT tools to streamline eligibility and reduce Medicaid expenditures:

- Automation of all or most of the eligibility determination and redetermination process
- Using the MCI to identify and apply child support enforcement orders for health care

The State, under this Comprehensive Waiver, will automate most (if not all) of the financial eligibility determination and redetermination process using IRS, State tax, Child Support and all other sources of income; residency and eligibility information. In order for the State to accomplish this task the Social Security Number (SSN) of beneficiaries

(which NJ has required) and the SSN or acceptable alternative identifiers of the parents for children covered under Title XIX and XXI will be mandatory and maintained electronically for all programs

In addition, DMAHS is in the process of implementing a MCI to better integrate its data, serve county eligibility offices, and ultimately permit physicians and hospitals with a high proportion of Medicaid patients to view key, accurate information at the point of care. The MCI was funded using CMS Transformation Grant funding. The MCI provides an opportunity to match child support enforcement orders for health care and apply those amounts to reduce both State and federal Medicaid spending.

Improve overall processing time performance for eligibility determination

The Medicaid system currently used by the 21 CWAs does not track pending cases. However, the State is in the process of developing a new eligibility system known as CASS that is designed to determine eligibility for **all** of the State's Medicaid and social services programs. This system will be able to produce various reports so that DMAHS can track the processing of cases by the CWAs.

DMAHS has taken several steps to address this issue. In November 2010, a Medicaid Communication was issued to all eligibility determination agencies reiterating the importance of the timely processing of applications and what notices were needed. In addition, training sessions were held to educate providers on what information is needed to complete an application. Also, DMAHS entered into a MOU with all 21 CWAs agreeing to improve backlogs by 3% quarterly for all Medicaid applications. CWAs will receive an incentive for meeting this benchmark and for providing the requested reports within established timeframes. All the agreements were signed by the end of March 2011 and DMAHS is in the process of evaluating the first quarter reports.

CASS will enable CWAs to provide more effective and efficient service to clients through:

- Automated eligibility determinations based on documented rules
- Common front end edits
- Real-time processing
- Integrated cases and evidence sharing across multiple programs
- Automatic routing of tasks and approvals
- Reduced paper processing and automation of many current manual tasks
- Improved management and tracking reports
- Citizen and provider portals

CASS in cooperation with the Document Imaging Management System (DIMS) resolves many of the major problems of a paper-intensive system including:

- Lost or misplaced files and documents
- Difficulty sharing information among workers

- Inconvenience for clients who must supply the same information multiple times
- High costs of copying, locating and storing information

The State has designed CASS to be its eligibility rules engine for the Health Care Exchange. CASS will process all applications to Medicaid and the Exchange beginning January 1, 2014 and determine program eligibility and handle the expected churning between programs. As a result, the State does expect CASS will qualify for 90% federal Medical Assistance percentage (FMAP) for development for the entire cost of the system based on the Tri-Agency letter of August 10, 2011. Operational costs will continue to receive 75% FMAP for Medicaid's allocated share on an ongoing basis.

The State understands that these performance improvement steps will require a significant investment of time and resources on its part, but believes that the benefits to members and potential cost savings to the State are significant. These proposals reflect the State's commitment to a Medicaid program that operates more efficiently under a cohesive vision of eligibility and coverage.

Medicaid as payer of last resort

Under Title XIX of the Social Security Act, Medicaid is intended to be the payer of last resort with few exceptions, such as Title V and IHS funding. Medicaid continues to be available, however, to individuals who are insured through commercial and employer-based insurance and/or Medicare. On the other hand, Title XXI which authorizes the State CHIP is explicitly available only to the uninsured. Both Medicare and private insurers have avoided payment of millions of dollars in claims they should have rightfully paid, as explained below.

Retroactive Medicare Part B

For well over 30 years, state Medicaid programs provided health care services to individuals who were eligible for Medicare, but because of an error in eligibility determination by the SSA, were categorized as eligible for SSI rather than Social Security Disability Insurance. The error is reflected in the eligibility category known by states as SSI without Medicare. States observed that the SSI without Medicare population was growing at a rate far in excess of the elderly and disabled with Medicare. This error is acknowledged by CMS and the SSA.

The total amount paid by states was originally estimated at \$4.8 billion (state funds only), but this figure is expected to increase. At present, the State's share is estimated at \$107.3 million. In response to the error, CMS originally stated that it could not pay the states because the Medicare program only pays providers. States were asked to recoup payments from providers and then ask providers to bill Medicare. This would be a problem for two reasons. Most of the Medicare claims submitted by providers would no longer be considered timely filed and would be denied. This practice would also place a significant administrative burden on providers and the states.

As an alternative, many states have proposed that CMS allow states to pursue a solution through an 1115 waiver, and to use the amount owed (using the Medicare 222(b) authority) as the non-federal share of expenditures in their current programs. The State has incorporated this proposal into its comprehensive waiver, understanding the final disposition will be negotiated on behalf of a number of states.

At the same time, this Medicare Part B error points to the difficulty states have in ensuring that the Medicaid agency is the payer of last resort.

Health Insurance Premium Payment

The HIPP program has two components:

- POP – The New Jersey Medicaid program pays the entire medical benefit premium for fragile children and adults when such payment is determined to be cost effective.
- PSP – New Jersey Medicaid reimburses the employee portion of the employer-sponsored health insurance (ESI) premium for NJFC persons when the payment is determined to be cost-effective.

Currently, POP eligibility is based on manual evaluations of recipient diagnoses, Medicaid expenditures and TPL payments. PSP eligibility is based on ESI premium costs versus Medicaid MC costs. Under the waiver, the State is seeking to streamline the eligibility determination process, including the use of information already being developed through the risk adjustment process. Premium payments under both programs will include available COBRA coverage and LTC insurance, in addition to employer based insurance.

Risk adjustment

Payments to MCOs under the State's Medicaid Managed Care program are risk adjusted based on the diagnoses, demographic characteristics (i.e., age, gender and geographic area), and pharmacy drug utilization of the covered members. The information used is aggregated from the following sources:

- Encounter records for medical and pharmacy treatment provided through the MCO in which the recipient is currently enrolled
- Encounter records, if any, for medical and pharmacy treatment provided through any other MCOs in which the recipient was previously enrolled
- Claim records for the time period in which the recipient was covered under FFS Medicaid before being enrolled in the Medicaid MCO

Generally, risk adjustment scores are calculated for all recipients who have at least six months of eligibility (through the combination of FFS and MCO coverage) during a 12-month base period. This assures a reasonable opportunity for persons with disease conditions to have a professional or facility visit in which a diagnosis is recorded. In addition, risk adjustment scores are calculated for newborns, even if they have fewer

than six months of coverage during the base period, since they invariably have encounters at birth and during the first several months of life.

The State uses the Chronic Disability Payment System (CDPS)/Rx risk adjustment system. This system is calibrated from State-specific Medicaid and FamilyCare encounter data. There are four separate scales of risk adjustment – for seniors, Temporary Assistance for Needy Families (TANF) and related adults, TANF and related children, and the blind and disabled. The output of the risk adjustment system is a relative risk score compared to a 1.000 for an average adult, child, or disabled person. Adults, children and disabled persons are in separate rate categories in NJ Managed Care Medicaid and NJ FamilyCare.

In the determination of cost-effectiveness for POP or PSP, the risk adjustment score will be utilized for those persons for whom a score is available.

When no such risk adjustment score is available, an assumed risk score would be developed from information on the health status questionnaire that applicants will be required to complete, along with questions about potential sources of ESI. This self-reported health information will be used to develop a proxy risk adjustment score.

Payment of Premium Program

Through the waiver, the State is requesting an expansion of the eligibility group for the POP program. In addition to the current fragile children and adults, the following individuals would be eligible for POP:

- Pregnant women
- Persons in LTC, both in NFs and in community waivers
- Persons whose risk adjustment score (actual or proxy) exceeds a predetermined cost-effective threshold

LTC insurance (LTCL) is typically purchased as an individual insurance policy with no financial contribution by employers. Some persons who become eligible for Medicaid may have been paying LTCL premiums for years, but they will be unable to continue paying the premiums due to their financial circumstances. Having the POP program take over the payment of the LTCL premium may prove cost effective, especially if the person is currently receiving any LTCL benefits (including in-home services) or is currently in the elimination period (90 days is common) after having a qualifying condition

Premium Support Program

Through this waiver, the State is requesting that adults and children eligible for PSP be enrolled in both the ESI coverage and the NJ Medicaid/FamilyCare programs. The MCO will treat the ESI as primary, with the MCO being responsible only for those services that are permissible under these programs but not covered by the ESI. This is a change from

the current practice, in which PSP enrollees are enrolled in the ESI with Medicaid FFS providing wraparound services for those costs not covered by the ESI.

The State currently operates under Section 2105(c)(3) of CHIPRA and is requesting a waiver from the current requirement that an employer contribute at least 50% of the total premium. The State is requesting a waiver to allow enrollment of eligible individuals in their ESI as long as it is cost effective to do so.

The State would also like to implement a concurrent eligibility review process when persons first apply to FamilyCare. This method would permit concurrent processing of PSP and FamilyCare applications, thereby preventing PSP applicants from being covered first by FamilyCare for a few months and then being moved to PSP. If they are eligible for FamilyCare and their ESI is cost-effective, they would enroll directly into both FamilyCare and PSP.

In addition, the ESI must meet more requirements to be considered “qualified employer-sponsored coverage.” This includes qualification as creditable coverage under §2701(c) (1) of the Public Health Service Act. ESI that meets the definition of a high deductible health plan under §223(c) (2) of the Internal Revenue Code does not meet the requirements of “qualified employer-sponsored coverage.”

The minimum actuarial value of ESI that qualifies as “qualified employer-sponsored coverage” will need to be determined. Once ESI plans are given the metallic labels (bronze, silver, gold, or platinum) that will be used under Health Reform beginning in 2014, a minimum based on the metallic labels will be determined.

Employee contributions for benefit plans depend on which family members are to be covered. Typically, employees are (if they enroll any child) required to enroll all eligible children. The chart below provides a description of the various rate tier structures that are in common use. Note that the same label name can have different meanings, depending on the tier structure. The 4-tier structure is the most common structure being used currently.

Table 3.2

Covered persons	Rating tier definitions			
	5-tier structure	4-tier structure	3-tier structure	2-tier structure
Employee (Ee)	Ee only	Ee only	1 person	Single
Ee + Spouse (Sp)	Ee + Sp	Ee + Sp	2 person	Family
Ee + 1 Child	Ee + 1 Child	Ee + Child(ren)	2 person	Family
Ee + Children	Ee + Children	Ee + Child(ren)	3 or more	Family
Ee+Sp+Child(ren)	Family	Family	3 or more	Family

Determinations on whether to enroll persons in ESI in addition to their NJFC Managed Care will be based on evaluating the scope of services that persons on NJFC are eligible for as compared to the scope of services that their employers' plan provides. Some rate tier structures will result in a parent being enrolled along with the child or children, as long as it is cost effective to do so. Cost effectiveness will be evaluated in the aggregate. The MCO capitation payment reflects the average cost of the rate group and the average MCO risk assessment of the rate group.

The value of the Medicaid/FamilyCare coverage being shifted is specific to the covered person, as measured by his/her most recent risk adjustment score (or proxy score based on self-reported health status for those not yet scored). This could result in seemingly disparate determinations due to individuals having different risk adjustment scores. The following example shows how the difference in the risk adjustment information could alter the decision on reimbursement of the employee's portion of the ESI premium. With lower than average risk scores, the ESI premium component is cost effective for covering two (or more) children (Situation 3), but not for covering just one lower risk child (Situation 2). However, with a higher risk score for one child (Situation 1), the ESI coverage is cost-effective.

Table 3.3

	Situation 1	Situation 2	Situation 3
Person(s) being considered	One FamilyCare D child	One FamilyCare D child	Two FamilyCare D children
SFY 2012 monthly MCO premium (1.000 risk score)	\$150.00	\$150.00	\$300.00 (\$150.00 per child)
Risk score of person(s)	1.400	0.860	Average (0.900,0.820) = 0.860
Risk-adjusted SFY 2012 monthly premium	\$210.00	\$129.00	\$258.00
* Actuarial value of ESI (Plan D =1.000)	0.800	0.800	0.800
Risk-adjusted ESI value	\$168.00	\$103.20	\$206.40
ESI rate tier (4-tier structure)	Ee+Child(ren)	Ee+Child(ren)	Ee+Child(ren)
Employee portion of cost to move from current coverage tier to tier covering these persons	\$160.00	\$160.00	\$160.00
Potential monthly savings	\$8.00	(\$56.80)	\$46.40
Decision	Cost effective	Not cost effective	Cost effective

* This value is a comparison between the commercial plan benefit package and the State's Medicaid benefit package. The algorithm is developed in accordance with actuarial standards.

4

Benefits and provider payments

The State is requesting flexibility to define covered services; adopt limits on the amount, duration and scope of services; and impose copayments and other cost sharing under the Comprehensive Waiver as necessary. This section also describes provider payment initiatives under the Comprehensive Waiver.

Benefits

Tables 4.1 and 4.2 describe the current benefits for each of the Plan types tied to the eligible populations described in the previous section and the service delivery system under which the benefits are received. These exhibits also highlight the movement to managed care of certain benefits (under the Comprehensive Waiver) that are currently provided FFS (and 1915(b) waiver authority sought for changes applicable July/October 1, 2011 and January 1, 2012).

- *July 2011 Summary.* Previously carved-out services including ABD Pharmacy, Adult and Pediatric Medical Day Care, ABD Home Health Care, Physical Therapy/Occupational Therapy/Speech Therapy, and Personal Care Assistant services moved to MCOs
- *August 2011 Summary.* Mandatory managed care for non-dual ABDs
- *October 2011 Summary.* Mandatory managed care for dual eligibles
- *January 1, 2012 Summary.* Medicare Special Needs Plan (SNP) services provided through MCOs
- *July 1, 2012 Summary.* NF and HCBS (waivers), except for the Community Care Waiver, moved to MCOs and children's BH services paid by DMAHS moved to the CSOC ASO
- *January 1, 2013 Summary.* Adult mental health and addiction services moved to MBHO

As shown in these exhibits, the State has few limitations on the amount, duration and scope of services, but is seeking the flexibility to adopt such limitations under the

Comprehensive Waiver following the protocol for CMS review and approval described in Section 2 Streamlining and efficient operations.

New community-based services are contemplated under managed LTC, BH and DD programs as described in the applicable subsection of Section 5.

Table 4.1 – Benefits and copayments

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C ^{1, 2}	NJ FamilyCare Plan D ^{1, 2, 3}	Plan G GA
Abortions	Federal law covers only if mother's life is endangered if pregnancy goes to term, or in cases of rape or incest	Yes – FFS for therapeutic/induced abortions; MCO for spontaneous abortions/ miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes – FFS for therapeutic/induced abortions; MCO for spontaneous abortions/ miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes – FFS for therapeutic/induced abortions; MCO for spontaneous abortions/ miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes – FFS for therapeutic/induced abortions; MCO for spontaneous abortions/ miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes
Abortions – Induced/therapeutic	Mandatory - Federal law covers only if mother's life is endangered if pregnancy goes to term, or in cases of rape or incest	Yes – FFS for therapeutic/induced abortions; (dx: 623, 634.0-634.99, 635.9, 637.0-637.99)	Yes – FFS for therapeutic/induced abortions; (dx: 623, 634.0-634.99, 635.9, 637.0-637.99)	Yes – FFS for therapeutic/induced abortions; (dx: 623, 634.0-634.99, 635.9, 637.0-637.99)	Yes – FFS for therapeutic/induced abortions; (dx: 623, 634.0-634.99, 635.9, 637.0-637.99)	Yes
Abortions - Spontaneous	Mandatory - Federal law covers only if mother's life is endangered if pregnancy goes to term, or in cases of rape or incest	Yes – MCO for spontaneous abortions/ miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes – MCO for spontaneous abortions/ miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes – MCO for spontaneous abortions/ miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes – MCO for spontaneous abortions/ miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes
Biofeedback	Optional	No	No	No	No	No

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
Blood and Blood Plasma	Mandatory when needed for inpatient hospital and other mandatory services (e.g., home health, NF and outpatient hospital)	Yes	Yes	Yes	No	Yes
Blood Processing Administrative Cost	Mandatory when needed for inpatient hospital and other mandatory services (e.g., home health, NF and outpatient hospital); otherwise optional	Yes	Yes	Yes	Yes	Yes
Case Management (Targeted) - Chronically Ill	Optional	Yes	No	No	No	No
Case Management - Chronic mental illness	Optional	No	No	No	No	Yes

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
Certified Nurse Practitioner/Clinical Nurse Specialist	Mandatory when covered by State under physician, EPSDT, home health or certified nurse midwife; otherwise optional (e.g., if covered under Other Licensed Practitioner)	Yes	Yes	Yes - \$5 copayment except for preventive care services	Yes - \$5 copayment except for preventive services. \$10 copayment for non-office hours and home visits if indicated on the ID card	Yes
Chiropractor	Optional	Yes – spinal manipulation only	Yes – spinal manipulation only	Yes – spinal manipulation only – \$5 copayment	No	Yes
Clinic Services (free standing) - Ambulatory	Optional, other than Federally Qualified Health Centers (FQHC), RHCs and outpatient hospital which are mandatory	Yes	Yes	Yes – \$5 copayment except for preventive services	Yes – \$5 copayment except for preventive services	Yes
Clinic Services (free standing) - End Stage Renal Disease	Optional, other than FQHCs, RHCs and outpatient hospital which are mandatory	Yes	Yes	Yes	Yes	Yes

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
Clinic Services (free standing) - Family Planning	Mandatory	Yes - Family planning services and supplies from either the MCO's family planning provider network or from any other qualified Medicaid family planning provider for plans A, B and C - not available outside the MCO's provider network for Plan D (except for PSC 380)	Yes - Family planning services and supplies from either the MCO's family planning provider network or from any other qualified Medicaid family planning provider for plans A, B and C - not available outside the MCO's provider network for Plan D (except for PSC 380)	Yes - \$5 copayment except for PAP smear - family planning services and supplies from either the MCO's family planning provider network or from any other qualified Medicaid family planning provider for plans A, B and C - not available outside the MCO's provider network for Plan D (except for PSC 380)	Yes - \$5 copayment except for PAP smear - family planning services and supplies from either the MCO's family planning provider network or from any other qualified Medicaid family planning provider for plans A, B and C - not available outside the MCO's provider network for Plan D (except for PSC 380)	Yes
Clinic Services (free standing) - Mental Health	Optional, other than FQHCs, RHCs and outpatient hospital which are mandatory	Yes - MCO for DDD clients	Yes - FFS	Yes - FFS - \$5 copayment	Yes - FFS - \$5 copayment - 35 days inpatient and 20 visits outpatient per year; \$25 copayment for outpatient hospital mental health; \$5 copayment for psychologist services	Yes

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
Cosmetic Services	Optional	No – except cosmetic surgery when medically necessary and approved	No – except cosmetic surgery when medically necessary and approved	No – except cosmetic surgery when medically necessary and approved	No – except cosmetic surgery when medically necessary and approved	No – except cosmetic surgery when medically necessary and approved
Dental - Medical/Surgical Services of Dentist	Mandatory	Yes	Yes	Yes	Yes	Yes
Dental Services	Optional	Yes – MCO; FFS for specified codes when initiated by a Medicaid non-managed care provider prior to first time managed care enrollment (exemption only if initially received services during 60-120 day period immediately prior to initial managed care enrollment)	Yes – MCO; FFS for specified codes when initiated by a Medicaid non-managed care provider prior to first time managed care enrollment (exemption only if initially received services during 60-120 day period immediately prior to initial managed care enrollment)	Yes – \$5 copayment unless preventive care – MCO; FFS for specified codes when initiated by a Medicaid non-managed care provider prior to first time managed care enrollment (exemption only if initially received services during 60-120 day period immediately prior to initial managed care enrollment)	Yes – same level of dental services as provided to Plan A-C for children under the age of 19	NA

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
Dental Services - Orthodontia	Optional	Yes – limited to children with medical necessity to improve the craniofacial dysfunction and/or dentofacial deformity or orthodontia services initiated prior to July 1, 2010	Yes – limited to children with medical necessity to improve the craniofacial dysfunction and/or dentofacial deformity or orthodontia services initiated prior to July 1, 2010	Yes – limited to children with medical necessity to improve the craniofacial dysfunction and/or dentofacial deformity or orthodontia services initiated prior to July 1, 2010	Yes – limited to children with medical necessity to improve the craniofacial dysfunction and/or dentofacial deformity or orthodontia services initiated prior to July 1, 2010 (for children whose orthodontia services were initiated while enrolled in NJ FamilyCare)	NA
Diabetic Supplies and Equipment	Optional	Yes	Yes	Yes	Yes	Yes
Durable Medical Equipment (DME) for Vision Impairment	Optional	Yes	Yes	Yes	No	Yes
DME	Optional	Yes	Yes	Yes	Yes – limited to certain DME services that could prevent costly future inpatient admissions	Yes

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
Early Intervention	Optional	Yes - FFS	Yes - FFS	Yes - FFS	Yes - FFS	NA
Educational Services	Optional	No	No	No	No	NA
Emergency Services	Mandatory	Yes	Yes	Yes – \$10 copayment	Yes – \$35 copayment per visit; no copayment if results in an admission or if referred to ER by primary care provider (PCP)	Charity Care
EPSDT	Mandatory	Yes	Yes – EPSDT exams, dental, vision and hearing services are covered. Does not include all services identified through an EPSDT exam	Yes – EPSDT exams, dental, vision and hearing services are covered. Does not include all services identified through an EPSDT exam	Yes - Well child care only	Yes – under 21
Experimental Services	Optional	No	No	No	No	No
Family Planning Services	Mandatory	Yes – FFS when furnished by a non-participating provider and MCO when furnished by a participating provider	Yes – FFS when furnished by a non-participating provider and MCO when furnished by a participating provider	Yes – FFS when furnished by a non-participating provider and MCO when furnished by a participating provider	Yes – MCO provider only except for PSC 380	Yes

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
Family Planning Services - Infertility Services	Optional	No	No	No	No	No
FQHC	Mandatory	Yes	Yes	Yes – \$5 copayment for non-preventive care visits	Yes – \$5 copayment for non-preventive care visits	Yes
HealthStart	Mandatory	Yes	Yes	Yes	Yes	NA
Hearing Aid Services	Optional	Yes	Yes	Yes	Yes – only covered for children age 15 or younger in NJ FamilyCare D	Yes
Home Health	Mandatory for over age 21	Yes	Yes	Yes	Yes – limited to skilled nursing care for the home bound	Yes
Home Health - Rehabilitation Services	Optional	Yes	Yes – 60 consecutive business days per incident/injury per year	Yes – 60 consecutive business days per incident/injury per year	Yes – \$5 copayment – 60 consecutive business days per incident/injury per year	Yes
Hospice Services	Optional	Yes	Yes	Yes	Yes	Yes

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
Hospital – Inpatient	Mandatory	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Charity Care
Hospital - Inpatient - Religious Non-Medical Services - Mt. Carmel Guild Hospital and Christian Science Sanitaria Care	Optional	Yes - FFS	No	No	No	No
Hospital – Outpatient	Mandatory	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – \$5 copayment except for preventive services; institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – \$5 copayment except for preventive services; institutions owned or operated by federal government, such as VA hospitals, are excluded	Charity Care

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
Hospital – Rehabilitation	Mandatory	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Charity Care
Intermediate Care Facility for Persons with Mental Retardation (ICF/MR)	Optional	Yes – FFS	No	No	No	No
Laboratory	Mandatory	Yes	Yes	Yes	Yes – \$5 copayment	Yes
Maternity	Mandatory	Yes	Yes	Yes – \$5 copayment for first prenatal care visit only	Yes – \$5 copayment for first prenatal care visit only	No
Maternity - Midwifery Services (non-maternity)	Mandatory	Yes	Yes	Yes - \$5 copayment except for preventive care services	Yes - \$5 copayment except for preventive care services	Yes

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
Maternity - Midwifery Services (maternity)	Mandatory	Yes	Yes	Yes - \$5 copayment except for prenatal care visit	Yes - \$5 copayment except for prenatal care visit; \$10 copayment for non-office hours and home visits	No
Medical Day Care - Adult	Optional	Yes	No	No	No	No
Medical Day Care - pediatric	Optional	Yes	No	No	No	No
Medical Supplies	Optional	Yes	Yes	Yes	Yes – limited	Yes
Mental Health - Adult Rehabilitation	Optional	Yes – FFS; MCO for DDD clients	No	No	No	No
Mental Health – Inpatient	Optional	Yes – FFS; MCO for DDD clients	Yes – FFS	Yes – FFS	Yes – FFS; limited to 35 days per year.	Charity Care
Mental Health - Outpatient	Optional	Yes – FFS; MCO for DDD clients	Yes – FFS	Yes – FFS	Yes – FFS - \$25 copayment per visit	Charity Care
Methadone Maintenance	Optional	Yes - FFS	Yes - FFS	Yes - FFS	No	Yes
NF (or custodial care)	Mandatory for over age 21	Yes – MCO first 30 days and FFS after 30 days (moves to Managed Care July 1, 2012)	No	No	No	No

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
Ophthalmology Services	Mandatory	Yes	Yes	Yes	Yes	Yes
Optical Appliances	Optional	Yes	Yes	Yes	Yes – limited to one pair of glasses or contact lenses per 24 month period or as medically necessary	Yes
Optometrist	Optional	Yes	Yes	Yes – \$5 copayment per visit	Yes – \$5 copayment per visit; one routine eye exam per year	Yes
Organ Transplants	Optional	Yes – experimental organ transplants not covered	Yes – experimental organ transplants not covered			
Orthotics	Optional	Yes	Yes	Yes	No	Yes
Other Therapies	Optional	Yes	Yes	Yes - \$5 copayment	Yes	Yes
Partial Care	Optional	Yes – FFS	Yes – FFS	Yes – FFS	Yes – FFS – limitations apply – 20 outpatient visits per year	Yes

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
Partial Hospital	Optional	Yes – FFS	Yes – FFS	Yes – FFS	Yes – FFS – limitations apply – 35 inpatient visits per year	Yes – charity care
Personal Care Assistant	Optional	Yes	No	No	No	Yes
Personal Care Assistant - Mental Health	Optional	Yes – FFS with limit on hours	No	No	No	Yes
Pharmacy – (ADDP) Covered Anti-Retroviral Drugs	Optional - Pharmaceuticals on the Master Rebate List are mandatory	Yes	Yes	Yes	Yes	Yes
Pharmacy – Erectile Dysfunction Drugs	Optional	No	No	No	No	No
Pharmacy - Mental Health/Substance Abuse	Optional, other than FQHCs, RHCs and outpatient hospitals which are mandatory	Yes	Yes	Yes	No	Yes
Pharmacy - Atypical anti-psych	Optional	Yes	Yes	Yes	Yes	Yes

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
Pharmacy - High Cost Drugs	Optional - Pharmaceuticals on the Master Rebate List are mandatory	Yes	Yes	Yes	Yes	Yes
Pharmacy - Infertility	Optional - Pharmaceuticals on the Master Rebate List are mandatory	No	No	No	No	No
Pharmacy - Suboxone	Optional - Pharmaceuticals on the Master Rebate List are mandatory	Yes	Yes	Yes	Yes	Yes
Pharmacy – Over the Counter (OTC) Drugs and All Other OTC Products	Optional	Yes - for children (EPSDT service)	Yes - for children (EPSDT service)	Yes - for children (EPSDT service)	No	Yes – under 21 (EPSDT services)
Pharmacy – Over the Counter Drugs – Cough, Cold and Cosmetic Products	Optional	Yes - for children (EPSDT service)	Yes - for children (EPSDT service)	Yes - for children (EPSDT service)	No	Yes – under 21 (EPSDT services)
Pharmacy - Physician Administered Drugs	Optional	Yes	Yes	Yes	Yes	Yes

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
Pharmacy – Prescription Drugs Not Reimbursable	Optional	Yes - copayments for adults age 21 or older excluding NJCPW; FFS for ABD and all duals	Yes	Yes – \$1 copayment for generic/\$5 brand – includes insulin, needles and syringes	Yes – \$5 copayment/\$10 copayment>34 day supply for adults age 21 or older	Yes
Pharmacy – Prescription Drugs Reimbursable	Optional	Yes – copayments for adults age 21 or older excluding NJCPW; FFS for ABD and all duals	Yes	Yes – \$1 copayment for generic/\$5 brand – includes insulin, needles and syringes	Yes – \$5 copayment/\$10 copayment>34 day supply for adults age 21 or older	Yes
Pharmacy - Reimbursable Blood Factor	Optional - Pharmaceuticals on the Master Rebate List are mandatory	Yes	Yes	Yes	No	No
Physician/PCP Practitioner	Mandatory	Yes	Yes	Yes – \$5 copayment for non- preventive visits	Yes – \$5 copayment for non-preventive visits; \$10 copayment for after hours and home visits	Yes
Podiatrist	Optional	Yes – no routine care	Yes – no routine care	Yes – no routine care; \$5 copayment	Yes – no routine care; \$5 copayment	Yes - no routine care
Private Duty Nursing	Optional	Yes – when authorized; up to 21 years of age	Yes – when authorized	Yes – when authorized	Yes – when authorized	No

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
Prosthetics	Optional	Yes	Yes	Yes	Yes – limited to the initial provision of a prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease, injury or congenital defect	Yes
Psychiatric Hospital – Inpatient	Optional if covered by the SPA	Yes – FFS for under 21 and over 65 years of age	Yes – FFS for under 21 and over 65 years of age	Yes – FFS for under 21 and over 65 years of age	Yes – FFS for under 21 and over 65 years of age; limited to 35 days per year	Charity Care
Radial Keratotomy	Optional	No	No	No	No	No
Radiology	Mandatory	Yes	Yes	Yes	Yes – \$5 copayment	Yes
Recreational Therapy	Optional	No	No	No	No	No
Rehabilitation – Outpatient Physical, Occupational, Speech	Optional	Yes	Yes – 60 consecutive business days per incident/injury per year	Yes – 60 consecutive business days per incident/injury per year	Yes – \$5 copayment – 60 consecutive business days per incident/injury per year	Yes

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
RTC Services	Optional	Yes – FFS	Yes – FFS	Yes – FFS	No	No
Respite Care	Optional	Yes (moves to Managed LTC July 1, 2012)	Yes	Yes	Yes	Yes
School Based Services	Optional	Yes - FFS	Yes - FFS	Yes - FFS	Yes - FFS	No
Sex Abuse Exams	Mandatory	Yes – FFS	Yes – FFS	Yes – FFS	Yes – FFS	Yes
Skilled Nursing Facility	Mandatory	Yes – MCO first 30 days and FFS after 30 days (moves to Managed LTC July 1, 2012)	Yes	Yes	Yes	Yes
Sleep Therapy	Optional	No – excludes rest cures	No – excludes rest cures	No – excludes rest cures	No – excludes rest cures	No
Substance Abuse – Inpatient (SAI)*	Optional	Yes – FFS; MCO for DDD clients	Yes – FFS	Yes – FFS	Yes – FFS (detox only)	Only through the SAI
Substance Abuse – Outpatient*	Optional	Yes – FFS; MCO for DDD clients	Yes – FFS	Yes – FFS	Yes – FFS - \$5 copayment per visit (detox only)	Only through the SAI
Temporomandibular Joint Disorder Treatment	Optional	Yes	Yes	Yes	No	Yes
Thermograms and Thermography	Optional	Yes	Yes	Yes	No	Yes

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
Transportation – Emergent (Ambulance, Mobile Intensive Care Unit)	Mandatory	Yes	Yes	Yes	Yes	Yes
Transportation – Non-Emergent (Ambulance Non-Emergency, Medical Assistance Vehicles (MAV), Livery, Clinic)	Optional	Yes	Yes	Yes	No	Yes
Vaccines	Mandatory for EPSDT	Yes – While the vaccine administration costs remain the responsibility of the MCOs, the vaccination cost for Title XIX children (NJ FamilyCare A) are not the responsibility of the MCOs. These vaccine costs are covered under the Vaccines for Children (VFC) program.	Yes	Yes	Yes	NA

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
Vaccines - Administration	Mandatory for EPSDT	Yes – While the vaccine administration costs remain the responsibility of the MCOs, the vaccination cost for children (NJ FamilyCare A) are not the responsibility of the MCOs. These vaccine costs are covered under the VFC program.	Yes	Yes	Yes	
Vaccines - Vaccination	Mandatory for EPSDT	Yes – While the vaccine administration costs remain the responsibility of the MCOs, the vaccination cost for children (NJ FamilyCare A) are not the responsibility of the MCOs. These vaccine costs are covered under the VFC program.	Yes	Yes	Yes	

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C ^{1, 2}	NJ FamilyCare Plan D ^{1, 2, 3}	Plan G GA
1 - Both Eskimos and Native American Indian children under the age of 19, identified by Race Code 3, are not required to pay copayments.						
2 - The total family (regardless of family size) limit on all cost-sharing may not exceed 5% of the annual family income.						
3 - Plan D copayments limited only to adult enrollees with incomes greater than 150% FPL. All Plan D children have copayments.						
4 - Sources Covered Services - Article 4.1 of Volume I of Medicaid/NJ FamilyCare Managed Care Contract; and Section B.4.1 of Appendices (Volume II) of Medicaid/NJ FamilyCare Managed Care Contract.						
Copayments - Section B.5.2 of Appendices (Volume II) of Medicaid/NJ FamilyCare Managed Care Contract.						
Federal Medicaid Law - 42 CFR Part 440						

Table 4.2 Home and community based services under the Comprehensive Waiver

	GO	TBI	CRPD	ACCAP	CCW
1915(c) Waivers responsible for provision and payment until July 1, 2012 when MCOs become responsible Excluding CCW and Supports Waiver once submitted which remain FFS	Case Management	Case Management	Case Management	Case Management	Case Management
	Assisted Living		Private-Duty Nursing	Private-Duty Nursing	Support Coordination for People who Self-Direct
		Behavioral Program	Environmental/Residential Modification	Personal Care Assistant Services (beyond the 40 hour limit available through the MCO or Personal Preference program)	Assistive Technology Devices
		Environmental/Vehicular Modifications	Vehicular Modification		Day Habilitation
	Adult Family Care	Community Residential Services	Personal Emergency Response Systems		Environmental and Vehicle Adaptations
	ALP/Subsidized Housing	Counseling	Community Transitional Services		Individual Supports for Activities of Daily Living
	Caregiver/Participant Training	Cognitive Rehabilitative Therapy			Personal Emergency Response Systems

	GO	TBI	CRPD	ACCAP	CCW
	Chore Services	Structured Day Program			Respite Care
	Community Transition Services	Supported Day Program			Supported Employment Services
	Environmental Accessibility Adaptations	Physical Therapy			Transition Services
	Home Based Supportive Care	Occupational Therapy			Transportation Services to Waiver Services
	Home Delivered Meal Service	Speech, Language and Hearing Therapy			
	Personal Emergency Response Systems	Respite Care			
	PERS Medication Dispensing System				
	Respite Care				
	Special Medical Equipment and Supplies				
	Social Adult Day Care				
	Transitional Care Management- Up to 90 days in NFs to ensure transition back to HCBS				
	Transportation to Waiver and Non-State Plan Services				

Cost sharing

The Comprehensive Waiver also seeks authority to engage the population the State serves in using health care services appropriately. To this end, the State seeks the flexibility to implement enhanced cost sharing, including premiums and copayments. As shown in Exhibit 4.1, the State currently imposes copayments under Plans C and D. In the concept paper, the state was proposing a \$25 copayment for non-emergent emergency department (ED) use for Plans A, B and C (Plan D has a current \$35 copayment; Plan G does not have ED coverage). The stakeholder feedback was mixed regarding charging a \$25 copy for non-emergent use of the ED.

New Jersey Medicaid is not unique from other states in its challenge to reduce non-emergent use of the ED. An article in the Washington Post, 'Hospitals seek more ER patients even as Medicaid tries to lessen demand'¹, references the struggles of other states and some of the strategies states are implementing to combat this issue.

DHS will be establishing a task force, which will be comprised of representatives from hospitals, MCOs, providers groups and FQHCs. The task force will be asked to come up with recommendations on the best way to reduce non-emergent use of the ED in the Medicaid population. Their report will be due to the Commission of Human Services by January 1, 2012. Recommendations could include: co-payments, re-examining the current New Jersey statute 26:2H-12.8, which is more expansive than the federal Emergency Medical Treatment and Labor Act (EMTALA) law, tiered reimbursement and ED diversion programs.

Our MCOs have showed success in reducing ED use among NJ FamilyCare/Medicaid members, our most recent data show that 62% of visits to hospital EDs are still for Low Acuity Non-Emergent (LANE) conditions (SFY 2010 LANE Report). As a result, DMAHS has been and continues to be very aggressive in establishing MCO capitation rates and application of cost efficiency adjustments that reflect the State's expectation that MCOs will continue to reduce LANE ED utilization. Capitation rates set for July 1, 2011 include efficiency adjustments based on the SFY 2010 LANE data.

DMAHS has also taken into consideration the lessons learned from the partnership with the New Jersey Hospital Association's Health Research and Education Trust (HRET) and the New Jersey Primary Care Association to pilot test a model for providing alternate non-emergency services to patients who present with primary care needs in hospital EDs. This pilot included an express care process, connectivity to a community PCP, and expanded capacity of those providers. Of particular importance, the community care provider filled a health home role. (See Section 5 regarding adoption of health home pilots by MCOs.)

¹ Washington Post

http://www.washingtonpost.com/national/health-science/hospitals-seek-more-er-patients-even-as-medicare-tries-to-lessen-demand/2011/07/01/gIQADoB7WJ_story.html

The 13 most frequent reasons for an ED visit (adults and children combined) based on the State Fiscal Year 2010 report are:

- Acute upper respiratory infection unspecified
- Otitis media (ear infection)
- Unspecified viral infection
- Fever
- Ankle Sprain
- Pharyngitis
- Headache
- Rash (including diaper rash)
- Abdominal Pain
- Urinary tract infection
- Vomiting
- Asthma
- Cough

For children, the top 35 diagnosis codes associated with ED visits appear below.

Rank	Dx	Description	Frequency
1	465.9	ACUTE URIS OF UNSPECIFIED	20,979
2	382.9	UNSPECIFIED OTITIS MEDIA	17,464
3	780.60	FEVER, UNSPECIFIED	13,292
4	079.99	UNSPEC VIRAL INF CCE & UN	11,900
5	462	ACUTE PHARYNGITIS	8,143
6	558.9	UNS NONINF GASTROENTERIT&	7,103
7	787.03	VOMITING ALONE	5,201
8	493.90	UNS ASTHMA W/O ASTHMATICU	3,815
9	599.0	UTI SITE NOT SPECIFIED	3,728
10	920	CONTUS FACE SCALP&NECK EX	3,715
11	789.00	ABDOMINAL PAIN, UNSPECIFI	3,260
12	845.00	UNSPEC SITE ANKLE SPRAIN&	3,045
13	486	PNEUMONIA, ORGANISM UNSPE	2,831
14	782.1	RASH&OTH NONSPECIFIC SKIN	2,601
15	564.00	UNSPECIFIED CONSTIPATION	2,464

16	692.9	CONTACT DERMATIT&OTH ECZEM	2,047
17	372.30	UNSPECIFIED CONJUNCTIVITI	2,007
18	786.2	COUGH	1,896
19	466.19	ACUT BRONCHIOLITIS-OTH IN	1,888
20	034.0	STREPTOCOCCAL SORE THROAT	1,831
21	784.0	HEADACHE	1,819
22	463	ACUTE TONSILLITIS	1,783
23	995.3	ALLERGY UNSPECIFIED NEC	1,659
24	490	BRONCHITIS NOT SPEC AS AC	1,625
25	787.91	DIARRHEA	1,528
26	708.9	UNSPECIFIED URTICARIA	1,148
27	V58.32	ENCOUNTER FOR REMOVAL OF	1,057
28	844.9	SPRAIN&STRAIN UNSPEC SITE	1,028
29	784.7	EPISTAXIS	939
30	729.5	PAIN IN SOFT TISSUES OF L	742
31	842.00	SPRAIN&STRAIN UNSPEC SITE	638
32	787.01	NAUSEA WITH VOMITING	636
33	842.10	SPRAIN&STRAIN UNSPECIFIED	623
34	311	DEPRESSIVE DISORDER NEC	590
35	380.4	IMPACTED CERUMEN	217
Total of Top 35 Adjusted LANE Diagnosis Codes			135,242

It is important to note that more ED visits occur on Monday when office/clinics are available and not during weekend hours when office/clinic hours are more limited.

Provider payments

The Comprehensive Waiver includes components that revise payment rates to providers to achieve four objectives:

- Rebalance the service delivery system toward community based primary and specialty care
- Provide equity in payments to in-state and out-of-state hospitals
- Incentivize payment reforms between MCOs and hospitals
- Participate in the Affordable Care Act (ACA) provider payment reform demonstrations testing global and bundled payments

Rebalancing. While the current program has relatively generous eligibility policies and benefit packages, the program pays rates to some providers that serve as a disincentive to program participation and limit members' access to primary care. The New Jersey Medicaid program is in need of rebalancing with regard to the rates paid to PCPs and specialists. Physician FFS rates are approximately 41% of Medicare rates and are estimated to be less than 25% of usual and customary charges. MCOs are encouraged to delink themselves from the FFS rates and, in the case of primary care, the MCOs appear to have done so. Based on encounter data, payments for primary care CPT codes affected by ACA provisions exceed 53%. Through this waiver, New Jersey anticipates increasing reimbursement for certain specialists and psychiatrists.

Fairness in payments to in-state and out-of-state providers.

In addition to rebalancing, the State will also seek changes in payment rates that are designed to achieve fairness when making payments to out-of-state providers. Most states limit payments to out-of-state hospitals to the lesser of the average rate paid to in-state hospitals or the rates paid the hospital by the Medicaid program in their resident state. The State will adopt a similar policy as follows:

- Pay out-of-state providers the lesser of the New Jersey Medicaid rate or the servicing state's Medicaid rate or the provider's charge for the service.

Pennsylvania and New York have comparable policies for payment of out-of-state hospitals.

Incentivize payment reform between MCOs and hospitals

While DMAHS continues to encourage MCOs to delink themselves from the FFS rates, it is clear that FFS rates continue to influence MCO and hospital behavior. As the State moves more of its population to managed care, FFS rates will no longer be maintained. For this reason, the State is proposing to:

- Require that non-contracted hospitals providing emergency services to NJ FamilyCare/Medicaid members enrolled in the managed care program accept, as payment in full, 95% of the amount that the non-contracted hospital would receive from DMAHS for the emergency services and/or any related hospitalization if the beneficiary were enrolled in Medicaid FFS. (Until such time that DMAHS no longer maintains a fee schedule the rate would be a % of Medicare rate that is an equivalent fee schedule.) This is a modification to the New Jersey Appropriations Act.
- Continue setting Medicaid managed care capitation rates that reflect costs associated with an efficient/effective MCO as compared to rate development at a cost-plus calculation. Specifically, capitation rates will continue to include a LANE analysis, which is a clinical-supported approach that targets inefficient/unnecessary ED utilization, as discussed above. New Jersey Medicaid managed care data shows that about 62% of all ED services were deemed LANE visits in SFY 2010 with 24% determined to be preventable, accounting for 9.6% of the SFY 2010 ED expenditures. Prospectively, Medicaid managed care capitation rates will be reduced

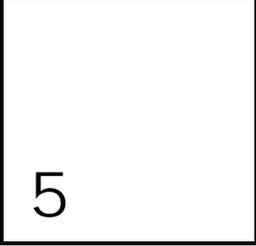
to reflect the expectation that MCOs must further reduce unnecessary ED utilization of its members.

- Under certain circumstances, require non-contracting hospitals and MCOs to enter into mediation.

Participate in provider payment reforms under ACA to pursue episodic pricing and linkages to outcomes. There are two payment reform opportunities under ACA in which the State will seek participation with its MCOs and hospitals if available to Medicaid and not just Medicare:

- Integrated Care Around Hospitalization – Section 2704 establishes a demonstration project, in up to eight states, to study the use of bundled payments for hospital and physician services under Medicaid. The demonstration is effective on January 1, 2012 and ends December 31, 2016.
- Medicaid Global Payment System – Section 2705 establishes a demonstration project, in coordination with the CMS Innovation Center, in up to five states that would allow participating states to adjust their current payment structure for safety net hospitals from a FFS model to a global-capitated payment structure. The demonstration will operate through 2012. The ACA authorizes this program but does not appropriate any funding.

The State is awaiting guidance from CMS on these issues.

5

Delivery system innovations

In April 2011, about 75% of all NJ FamilyCare/Medicaid clients were enrolled in a managed care plan, including over 100,000 individuals with complex medical needs. The SFY 2012 managed care enrollment initiative will result in nearly 92% of Medicaid enrollees being served through managed care.

August 1, 2011 Group – Approximately 45,000 individuals in the Aged, Blind or Disabled categories were enrolled in managed care.

October 1, 2011 Group – Approximately 110,000 individuals who receive both Medicare and Medicaid will be enrolled in managed care.

In addition to these expansions, the Comprehensive Waiver includes a series of delivery system innovations. These innovations include:

- Expansion and innovations through the State's MCOs
 - Duals Medicare SNPs
 - Additional managed care improvements/pilots
 - Health homes
 - Accountable Care Organizations
 - Pharmacy pilots
- Managed LTC
- Managing BH
 - BH for Adults/Children
 - 1915(i) MATI services
- Managing supports for intellectual and DD
 - Community and ICF MR supports
 - I/DD with dual mental health diagnosis 1915(c) like pilot program
 - Children with pervasive developmental disorders 1915(c) like pilot program
 - Medical necessity and developmental disabilities

Expansion and innovations using the State's MCOs

Medicare special needs plans

The integration of care for dual eligibles is part of the State's broader effort to transform its health care system. Beginning July 1, 2011, and into the fall, the State is transitioning from a FFS system to a managed care system for its dual eligibles. The dual eligibles use a wide array of services and the incidence of duplicative services and contraindicated therapies and drugs is heightened in a FFS system that lacks sufficient care coordination. This adversely impacts the quality of care and health outcomes of the dual eligibles, as well as contributes to inefficient and unsustainable health care spending for the State, Medicaid and Medicare. As a result, the primary and acute care needs of most Medicaid populations, including dual eligibles and the aged, blind and disabled, will be met through amendments to the current Medicaid MCOs. In so doing, the State will also include services such as pharmacy for the aged, blind and disabled, that have historically been carved out of managed care. Additionally, effective January 1, 2012, the State will contract with Medicare SNPs that are also Medicaid MCOs.

In addition to primary and acute care services, dual eligibles use LTC services. The care for these services is disconnected in the State's current FFS delivery system. For HCBS or Medicare Advantage plan management of acute Medicare services, there is concentrated case management on that particular service. However, comprehensive care management that addresses all aspects of care is limited. Therefore, effective July 1, 2012, the State will further amend its existing MCO contracts to manage all LTC services including HCBS and NFs for the elderly and physically disabled. Those dual eligibles in LTC or at risk of LTC will have integrated primary, LTC, HCBS, BH and acute care services in a coordinated managed care environment.

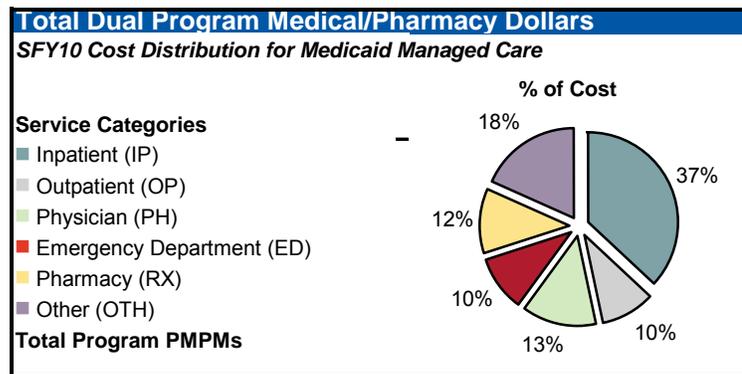
Further, the integration of BH and medical care is an important challenge in any health care system, but it is especially problematic for dual eligible individuals who need to navigate across different payers. BH services provided by New Jersey's current FFS system and Medicare lack the infrastructure to coordinate BH care services for dual eligibles. Beginning July 1, 2012 for children and January 1, 2013 for adult duals with BH needs will be managed by the SNPs for Medicare benefits including deductibles and coinsurance. The care coordination will support more effective care.

Eligibility requirements

The State will target for enrollment in the new integrated care model the Medicaid beneficiaries who receive full Medicaid benefits and who are also eligible for Medicare. There are currently 23,000 duals voluntarily enrolled in a MCO and another 117,000 in FFS and transitioning to Medicaid managed care effective October 1, 2011. Approximately 6,000 dual eligibles are enrolled in existing dual SNP health plans. About 500 of these SNP members are with MCOs other than those under contract with the State for its Medicaid managed care program. Through the comprehensive waiver, the State will require that dual eligibles enroll in a single Medicaid MCO/Medicare Advantage SNP for receipt of both Medicaid and Medicare benefits.

The State will be requesting Medicare data sets to further evaluate the dual eligible population using linked Medicare/Medicaid data. The Medicaid data currently available for this population indicates there are a wide array of care needs, health conditions and spending profiles.

Due to programmatic restrictions, limited provider access, and minimal financial resources, dual eligibles face some of the highest hurdles to getting the specialty care they need. At the same time, though, this group is the most expensive segment of the State's Medicaid population.



Many of the dual eligibles are chronically ill, seriously disabled, or both. Complex health care needs require access to an integrated system where the delivery of care is approached from a health home that promotes care management. Effective July 1, 2011, MCOs in the State are required to participate in health homes. The State will continue to conduct more in depth analyses on the dual eligible population to develop strategies, such as health homes, to more efficiently care for the duals. The State will also review LTC services that would be most effective for the duals. Integrating care has the potential to greatly contribute to quality improvements and potential savings which could be reallocated to better meet the needs of the dual eligibles.

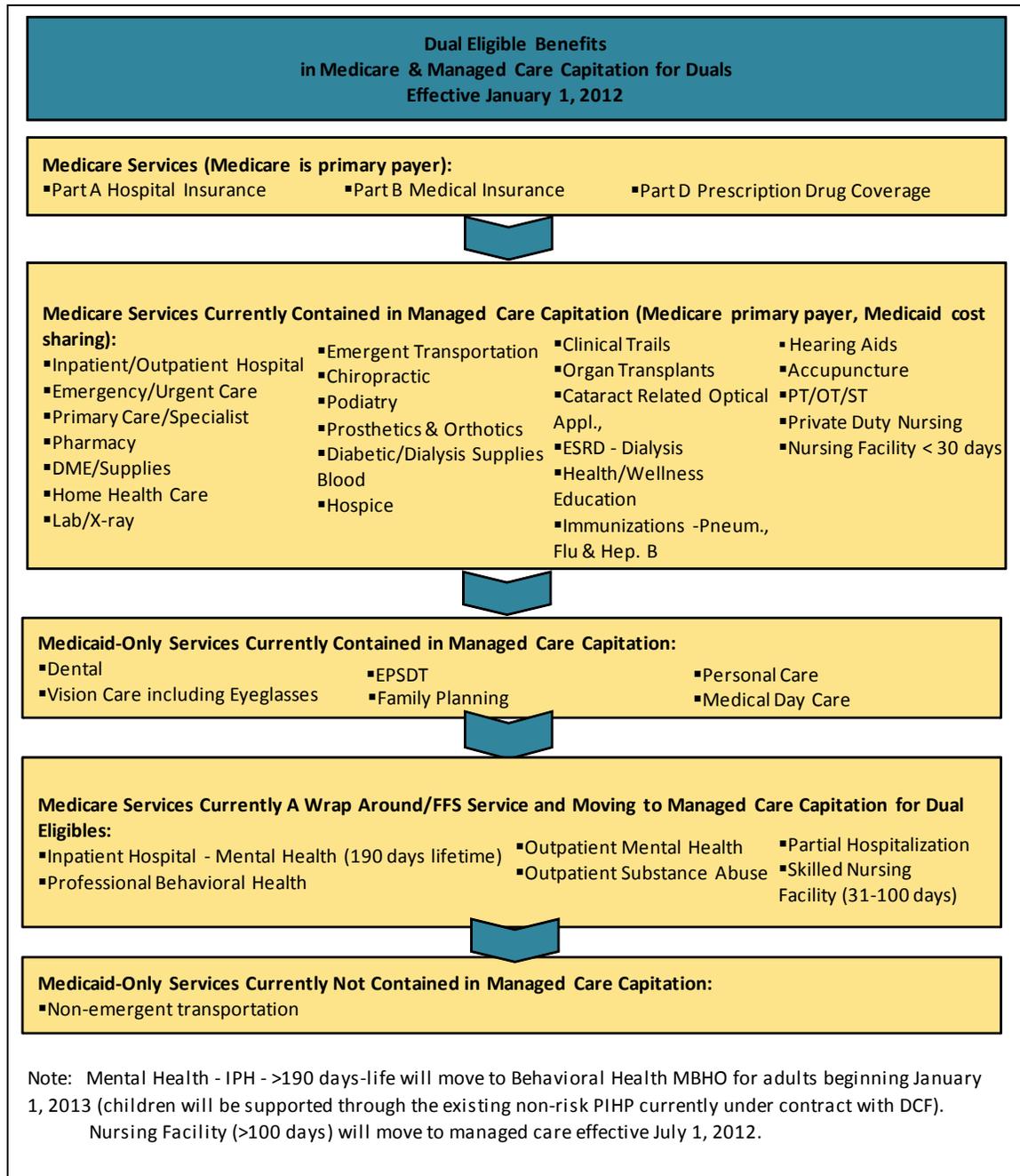
The State intends to design its integrated care model to ensure that a large enough number of dual eligible individuals participate to ensure the feasibility of the program. Enrollment by dual eligible individuals will be mandatory in Medicaid managed care effective October 1, 2011. Enrollment in Medicare SNP is voluntary. Sufficient levels of enrollment in this new model will be critical to expanding access to services and care coordination and improving quality of care and health outcomes. In addition, the savings potential is dependent on adequate enrollment in the integrated care entities. However, it appears that CMS does not have the authority to waive freedom of choice under Medicare. In the absence of such authority, the State requests the ability to auto-assign a member to the same Medicare and Medicaid plan with an opt out for Medicare and the authority to limit Medicaid payment of Medicare cost-sharing to only those Medicare providers that are within the Medicaid MCOs' network. This enhances the goal of encouraging dual eligibles to enroll in the same plan for their Medicaid and Medicare benefits. The State believes this is consistent with the requirements of seamless

conversion enrollment for newly Medicare Advantage (MA) eligibles available option for MA-eligible individuals currently enrolled in other health plans offered by an MA organization (i.e., commercial or Medicaid plan) at the time of their conversion to Medicare. Per the Medicare Managed Care Manual, CMS reviews an organization's proposal and must approve it before use.

Benefits

Dual eligibles participating in the program will have access to the full range of primary, acute, specialty, BH, pharmacy, HCBS and institutional services as currently covered and provided by Medicare and Medicaid. The State currently provides HCBS services to dual eligibles through the Medicaid State Plan and through a broad menu of services covered under Section 1915(c) waivers.

Effective January 1, 2012, DMAHS will contract with MCOs to deliver all Medicaid state plan services and Medicare covered services. The MCOs will administer Medicaid and Medicare benefits jointly so that enrollees will experience their coverage as a single, integrated care program. The MCOs offer enhanced benefits to SNP members to encourage enrollment instead of enrollment in the standard Medicaid MCO membership. For example, the State eliminated coverage of the Medicare Part D copayment for duals on July 1, 2011 and SNPs could cover this pharmacy copayment as an incentive for duals to enroll.



Medicare Advantage SNPs include all covered services – physical and behavioral. Further, Medicare does not allow simultaneous enrollment for BH services in FFS and acute medical capitated managed care. The ability to capture Medicare payments for BH is severely limited under a carve out. Therefore, Medicare BH benefits are in the dual eligible SNPs capitation.

Service delivery (including payment mechanism)

The State will build upon its extensive knowledge and experience with managed care programs for dual eligibles and Medicaid-only beneficiaries. Currently, DMAHS contracts with four Medicaid MCOs to manage the health services for 92% of its enrollees. In every area of the State, members have a choice of at least two MCOs. HealthFirst, who entered the New Jersey Medicaid managed care market in the fall of 2009, is expected to be statewide during 2012. All four MCOs have signed contracts with DMAHS to provide comprehensive care management for the Dual-SNP program with enrollment to begin January 1, 2012. The State's integrated care model for dual eligibles will be implemented statewide January 1, 2013.

The MCOs will deliver care that ensures that all of the health needs of dual eligibles are met and coordinated across the health care delivery system. MCOs have demonstrated their experience to deliver care to their current 23,000 voluntary dual eligibles. The State will significantly improve the alignment of services by providing a single capitated rate to the MCOs. Additionally, prior to the alignment of Medicaid and Medicare to begin on January 1, 2012, out of network claims are paid FFS subject to the Medicaid maximum allowable by the State. Following the implementation of the dual eligible SNP program, there will not be any out of network claims. The key design principles of the managed care model are:

- Comprehensive care coordination
- Accountability of a single entity for delivery of covered services
- Administrative Simplicity
- Financial integration

The State has an established infrastructure for actuarially sound capitation rate setting. DMAHS will provide an at-risk capitated payment to MCOs that reflects the full set of covered services, as well as administration and care management costs. The compensation of the contractors will consist of monthly premium payments. The financing model also assumes the MCOs will be building in new payment reform concepts, such as health homes. The State has extensive experience using both FFS claims data and MCO encounter data to support rate development and risk adjustment.

The State will use the experience gained with this integrated care model to make ongoing improvements to the service delivery of dual eligibles.

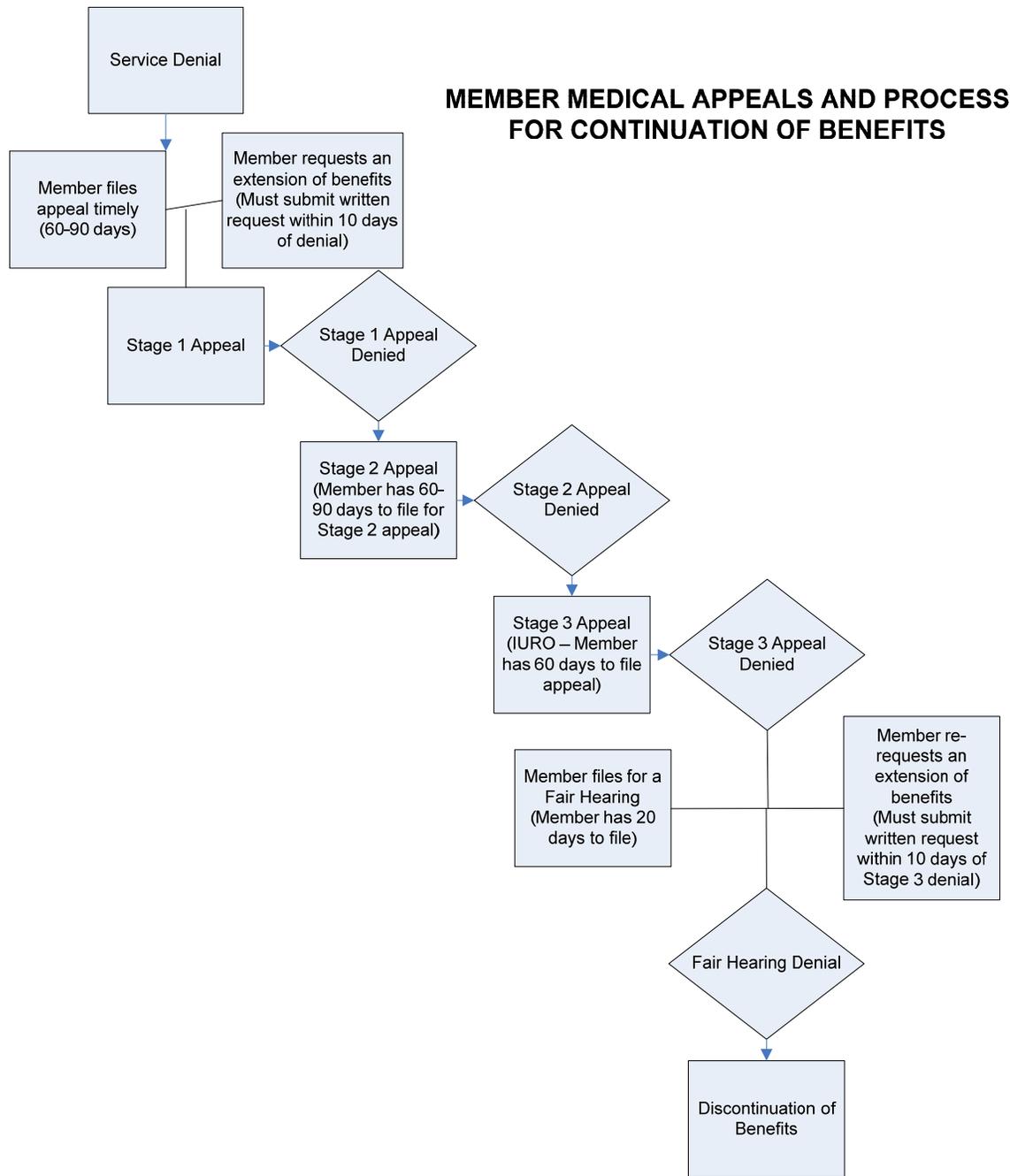
Reporting, program monitoring and quality management

The State has a long history of supporting the administration of services also covered under Medicare Parts A, B and D in both FFS and managed care. The State has an established infrastructure for program monitoring, quality improvement efforts, and capturing utilization through encounter and financial data. The State is well positioned to apply its knowledge and expertise to contract with MCOs.

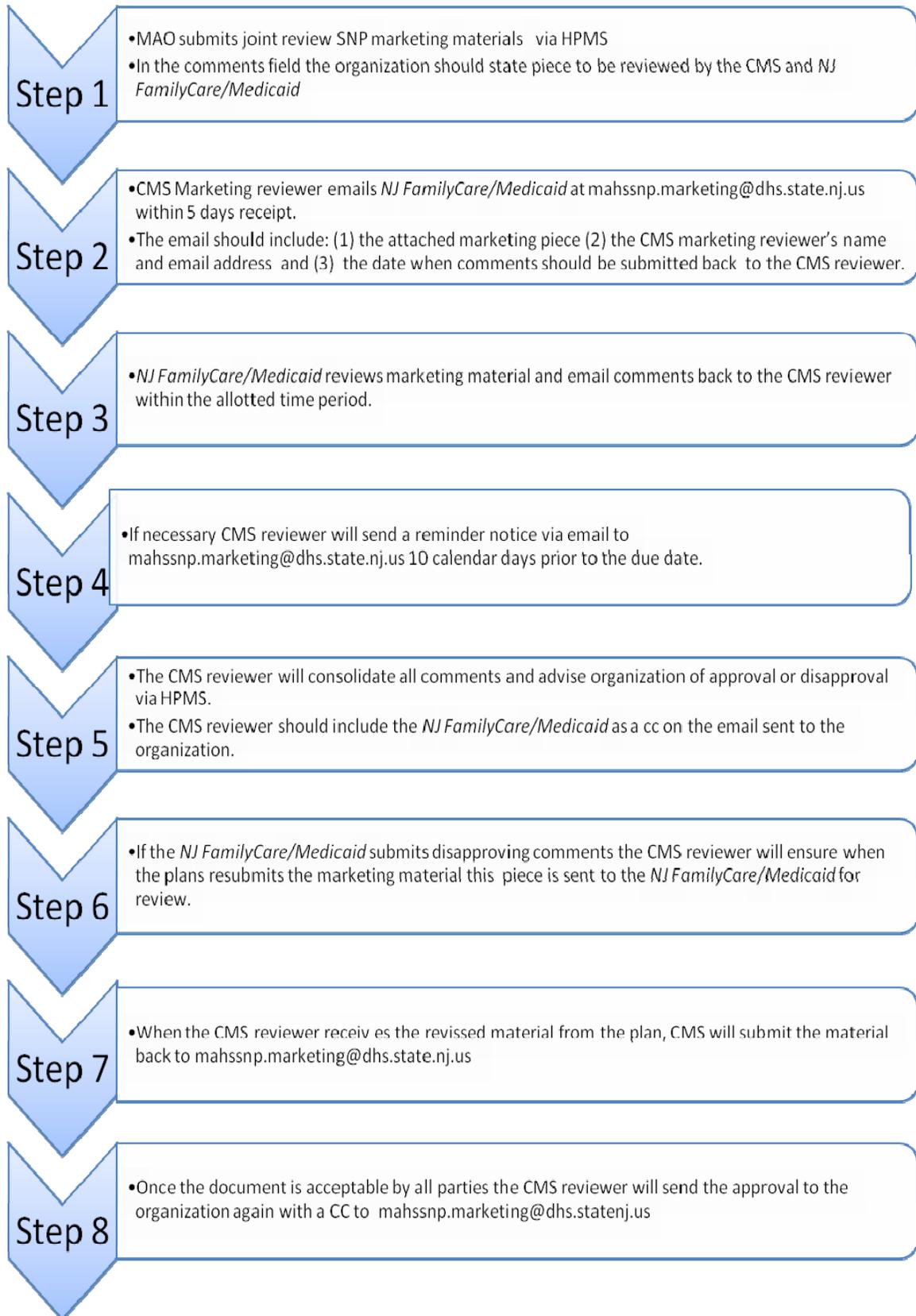
The contractors will be required to collect, analyze and report data to implement effective QA, utilization review and peer review programs. In addition to requiring MCOs to submit financial reports semi-annually and requesting Medicaid MCO encounter data for dual eligibles, the State intends to request the MCOs submit their Medicare SNP data. Given that the State does not currently have access to the full Medicare FFS data files, the State will pursue the attainment of the full Medicare data files through a data use agreement with CMS. The State has a data warehouse that allows for easy and timely access to all eligibility, Medicaid FFS and encounter claims data. This data will be integrated into the State’s data warehouse to allow for ease of analyses. The State plans to build on the studies previously undertaken to better understand the unique characteristics of the dual populations, identify potential areas to target for performance improvement, review the adequacy of the Medicare Advantage financing payments and assess various risk adjustment approaches for Medicaid. Performance measurement is a critical component of the demonstration and will be used to guide continuous improvements in service delivery and program effectiveness.

Quality management (QM) entails measuring health outcomes, adhering to evidence-based best practices and promoting continual quality improvements. SNP quality improvement must consider the specialized needs of the population served and conduct quality improvements activities tailored to dual eligibles. Pursuant to 42 CFR 422.152(c)-(d), SNPs shall conduct both a chronic condition improvement program (CCIP) and quality improvement program (QIP). Quality improvement activities shall be shared with the Division of Medical Assistance’s External Quality Review Organization. This builds off of DMAHS experience with the managed care program and will be administered by DMAHS.

Finally, the State seeks to streamline oversight requirements, and as such, will seek a single appeals process rather than the two processes – one under Medicare and one under Medicaid. Below is the Medicaid managed care appeals process flowchart.



Additionally, the State has prepared procedures to conduct reviews of dual SNP marketing materials. This is a concurrent review process with CMS. Below is a flowchart outlining the procedures.



Additional managed care improvements/pilots

Health homes

According to the 2008 Actuary Report issued by the Office of the Actuary, Center for Medicare and Medicaid Services, the Medicaid outlay for benefits is expected to grow at an annual average rate of 7.9% and enrollment is expected to increase at an annual rate of 1.2% over the next 10 years.² These figures cement the role of Medicaid becoming the single largest purchaser of health care at a time when the nation's health care system is considered, by most, to be inefficient and difficult to navigate; lacking the necessary infrastructure to drive significant changes in value and quality. These issues are even more significant for Medicaid recipients who often have fewer choices of physicians, longer wait times and greater disparities in health outcomes when compared to their commercial counterparts. In order to address these issues, given the complex nature of our health care system and the growing demand for services, Medicaid programs must develop innovative solutions to ensure both the sustainability of the program through streamlining program administration and by demanding greater value which can be measured through improved health outcomes and access to coordinated and integrated service delivery. The health care reform legislation passed in 2010 provides the necessary authority for states to explore new avenues of service delivery and provides the State with unique opportunities to develop greater synergies with many efforts currently underway within their Medicaid managed care delivery model.

In 2010, the Governor signed Public Law 2012, Chapter 74, which required DMAHS to establish a three year Medicaid Medical Home demonstration program with its managed care providers. The legislation mandated the following principles:

- Must be developed in consultation with the MCOs
- Restructure the payment system to support PCPs in adopting a medical home model
- Develop a system to support PCPs in developing the necessary infrastructure to provide a medical home
- Include Medicaid enrollees with chronic diseases and the frail elderly in the demonstration
- Employ health information technology (HIT) and chronic disease registries
- Develop a standard set of performance measures to assess cost savings, rates of health screenings and outcomes of care.

To provide additional context, the State's acute care program accounted for over 45% of Medicaid expenditures in 2009.² For this reason, transformation of the primary care network is an integral component in DMAHS' Medicaid reform package. Through partnership with their MCOs, DMAHS can leverage their purchasing power to help drive

² 2008 Actuarial Report, Office of the Actuary, Center for Medicare and Medicaid Services.
<http://www.centerforself-determination.com/docs/MedicaidReport2008.pdf>

² The Kaiser Foundation, State Health Facts, 2009:
<http://www.statehealthfacts.org/profileind.jsp?cat=4&sub=47&rgn=32>

the necessary delivery system reform. In short, primary care is viewed as the frontline of all service delivery; thus, transformation at this level will help to drive other delivery system innovations such as Accountable Care Organizations, which use medical homes as their building blocks. It is DMAHS' intent to continue to develop the current Medical Home demonstration pilot as legislated through S-665 into a Health Home program that comports with the requirements of Section 2703 of the ACA.

DMAHS has since signed Memoranda of Agreement (MOA) with each of the four MCOs operating within the program and included it in the managed care contract to develop medical home pilots within each of their networks that meet the components defined under the State's law. The MOA delineates additional requirements such as:

- Assuring that medical homes attain NCQA Level I accreditation by the end of the first year and Level II accreditation by the end of the 2nd year of the demonstration pilot; Level III is optional, at this point.
- Encourage medical home development aimed at persons that are chronically ill, DD and the frail elderly
- Assure the provision, at a minimum, of the following services:
 - Patient centered care using a multidisciplinary team of health care professionals that coordinate care through use of HIT and chronic disease registries across all domains of the health care system and the patient's community, including active participation by patient and family in decision-making and care planning
 - Individual customized care plans that promote self-management behaviors
 - Patient and family education for patients with chronic diseases
 - Home-based services
 - Telephonic communication
 - Group care
 - Oral health examination
 - Culturally and linguistically appropriate care
- Each medical home will collect and report data on:
 - A minimum of two quality measures
 - One patient perception of care survey
 - Efficiency measures

The current managed care pilots include various types of practices from individual group practices, a large hospital based IPA and several FQHCs. The initial medical home pilot is expected to target approximately 25,000 enrollees. FQHCs play a pivotal role in many of the State's delivery system innovations from health homes and ACOs to the pharmacy medication therapy management pilot and the Medicaid incentive program for the chronically ill. The New Jersey Primary Care Association, a non-profit corporation that represents the organizational providers and affiliates of community-based ambulatory health care statewide, has several members actively engaged with DMAHS and the MCOs to promote the patient centered medical home model of primary care delivery both as standalone centers and as part of an ACO.

Concurrent with implementing health home pilots under managed care, the State has developed two BH home pilots funded through Substance Abuse and Mental Health Services Administration (SAMHSA) grants. The pilots operate under two different clinical models. One is a fully integrated health home that is licensed to deliver both BH and primary care services. The other model is a partnership between a FQHC and four BH providers. The FQHC provides medical supervision and staff to deliver medical services at the four BH provider locations. Additional pilots are expected and may choose from the two current clinical models under the SAMHSA grant or offer a new model. Clinical models must be aligned with DMAHS health home goals, deliver the required services, meet all health home standards and be approved by DMAHS.

Based on the same principles of enhanced access, population health management and the use of HIT, enrollees engaged in a BH home will experience comprehensive care management to support building and maintaining self-care habits and engaging community supports. In addition to the services of a Health Home outlined above, the BH Home pilots provide wellness and recovery activities, peer supports to enhance engagement in services, prevention services, coordination of ancillary supports and a specific focus on the medical, emotional and social issues that commonly occur with individuals with SMI and substance use disorders. The success of this program highlights how delivery system innovations can improve the overall health and wellness of vulnerable populations residing within the State.

Under section 2703 of the ACA, States implementing a health home program are entitled to receive enhanced match for the basket of six (6) health home services; this enhanced funding is available for up to eight (8) quarters per target population to be included under the program. Thus, DMAHS anticipates ongoing discussion and collaboration with the MCOs, the MBHO and CMS to ensure that the populations, services and QM, reporting and monitoring requirements comport with those under section 2703 of the ACA.

Patient eligibility requirements

The MCOs have targeted both the adult and pediatric populations that include the chronically ill, special needs, DD and those with BH needs for participation in their individual pilot programs. The BH home will initially target adults, 18 years of age or older and who have a SMI, a co-occurring mental illness and substance use disorder and/or a substance use disorder who experience, or are at high risk for, other chronic health conditions. It is DMAHS' expectation that over time whether the health home targets BH or physical health (PH) as the primary issue – the whole person concept, which is the foundation of the health home, will be embraced by all health home providers and members experiencing co-occurring physical and BH issues will be treated in an integrated environment.

Benefits

The basket of six (6) health homes services outlined in the State Medicaid Director (SMD) letter dated November 16, 2010 are consistent with those required under the State's legislation S-665 and further defined under the MOA between DMAHS and the

MCOs. Service definitions related to the BH home will need to be more fully developed and provider qualifications defined so that the administrative oversight by DMAHS can reach certain economies of scale for ongoing monitoring and reporting. This may include but not be limited to service and provider qualification requirements that are comparable to those for health homes under managed care such as the timeline for Level I, II and III NCQA accreditation. DMAHS will continue to work with the MCOs and CMS to develop service definitions that comport with the health home services required under the ACA.

Service delivery (including payment mechanism)

Implementation of the health home under a managed care delivery system will require additional considerations to ensure a cohesive statewide strategy and to encompass an actuarial rate setting process that is inclusive of managed care strategies that incent the delivery of health home services. Given the various provider types currently engaged in the medical home demonstration pilot, DMAHS has not limited the types of health home provider arrangements but is preferential to those options that afford the greatest flexibility in meeting the overall Medicaid reform package goals. Development of ongoing capitation rates will take into account the various reimbursement methodologies of each of the MCOs in developing their medical home programs. Currently, DMAHS will provide initial start up funding to the MCOs to assist in building the health home framework within their individual networks and encouraging practices to attain NCQA accreditation for medical home Level I and II; Level III is currently optional. Under the current pilot program each of the MCOs require their medical home provider sites to be NCQA recognized prior to participating in pay-for-performance or other provider recognition programs. DMAHS will continue to work with its MCOs and CMS to ensure the evolution from the current State mandated Medical Home demonstration to a more encompassing Health Home program that comports with the ACA requirements.

BH homes are currently funded through a SAMHSA grant. The MCOs will be required to collaborate with DMAHS, DMHAS and the MBHO to develop an integrated financial and provider contracting strategy that addresses the following for the BH home providers:

- Submission of claims for PH services to the MCO
- Submission of claims for BH services to the MBHO
- Per member per month (PMPM) fees to cover BH home care coordination costs that are billed to the MBHO
- Expansion beyond the current SAMHSA grant to include the financial strategy for funding care coordination and financial incentives to support program goals; funding considerations will take into account the savings or other cost impact of the program

Reporting, monitoring and quality management

The MCOs will be responsible for implementing the required reporting and monitoring of health home services through their established health home provider network. Their requirements will be codified in contractual arrangements between the managed care entity and the individual health home practice. DMAHS will be responsible for tracking, calculating and monitoring the overall health home pilot outcomes. Through the use of

MOAs and contract amendments, DMAHS will ensure each managed care entity is in compliance with overall Health Home requirements. The use of EHR and/or patient care registries is required to meet NCQA recognition of a Patient Centered Medical Home. Additional use of HIT through the use of Health Information Exchanges and linked provider networks is also underway within the State. More detail can be found in the ACO section below. The MBHO will be required to assist DMAHS and DMHAS with administration of the BH homes, including but not limited to the two pilots under the SAMHSA grant. Responsibilities will include reporting and monitoring, provider contract and performance requirements and coordination with the MCOs regarding service delivery and financing.

Although many of the quality and efficiency measures under the State mandated Medical Home demonstration are congruent with those required under Section 2703 of the ACA, further alignment will be required to meet the full requirements of the Health Home program. DMAHS will continue to work with CMS to ensure the quality, monitoring and reporting program meets the requirements outlined under the ACA.

It is DMAHS' intent to convene a Health Home Transformation Steering Committee to help guide, direct and build synergies between multiple delivery system innovations currently under consideration as part of the Medicaid reform package. Additionally, DMAHS will convene a Statewide Health Home Transformation Collaborative aimed at providing assistance and technical support to those practices that wish to transform their current delivery model to meet the requirements established for a Health Home.

Accountable Care Organizations

Accountable Care Organizations (ACOs) take the health home concept from the individual primary practice setting and further organize it into a collective group of PCPs, specialists, hospitals and other health care delivery settings such as laboratory, radiology, home health and other community venues. ACOs can take on various shapes and forms but at the heart of each are shared principles aimed at improving the quality of care delivered to patients through implementation of patient focused care planning activities that are coordinated by providers who are held accountable for the cost and outcomes of care. Ultimately, ACOs provide for greater alignment of provider incentives throughout the health delivery system by implementing a transparent process to measure performance of the participating providers and to incent efficient service delivery through a model of shared savings. Shared savings can then be disseminated amongst the ACOs delivery network to those providers who have helped to drive improved health outcomes and greater system efficiency and to invest in and enhance the system infrastructure to create a more sustainable health care system.

On August 19, 2011, Governor Christie signed Public Law 2011, Chapter 114 requiring DMAHS to establish a Medicaid Accountable Care Organization Demonstration project. It is the intent of the project to increase access to primary and BH care, pharmaceuticals and dental care, improve health outcomes and quality and reduce unnecessary and

inefficient care without interfering with patients' access to their health care providers.³ The bill requires that ACOs develop networks that include primary care, BH, dental, pharmacy and other health care providers. The aims of the Medicaid ACO are as follows:

- Engage Medicaid recipients in treatment
- Promote medication adherence and use of medication therapy management and promote healthy lifestyles
- Develop skills in help-seeking behaviors including self-management and illness management
- Improve access to services for primary care and BH care through home-based services and telephonic and web-based communications
- Improve service coordination to ensure integrated care for primary, behavioral, dental and other health care needs.

Patient eligibility requirements

All Medicaid enrollees within the ACO's defined geographic service area are eligible to receive services. Each managed care entity that has contracted with a qualified Medicaid ACO will work with the ACO to determine the population by which outcome and performance measures will be collected. There is nothing to preclude a Medicaid recipient from seeking care outside of the ACO or from excluding individuals who live outside of the service area from seeking services from a participating ACO provider.

Benefits

Within the context of the State's managed care delivery model, ACOs will provide access to all the services currently available under the SPA; no additional services outside of the defined benefit package will be available at this time. However, it is the State's expectation that ACOs be integrated into their respective communities and to assist in the coordination of community based services that can close the gap between individual recipient need and available services under the SPA.

Service Delivery (including payment mechanisms)

Under the current state statute ACOs participating in the Medicaid demonstration shall be nonprofit corporations with governing boards that include representation including, but not limited to hospitals, clinics, private practices, physicians, BH care providers, dentists, patients and other social service agencies or organizations located in the designated service area with voting representation from at least two consumer organizations capable of advocating on behalf of patients residing within the designated service area.⁴

The service area is defined by a geographic area and the ACO must include all general hospitals and at a minimum 75% of qualified PCPs and four qualified BH care providers operating within the service area. ACO providers are entitled to continue to receive

³ State of New Jersey Public Law 2011, Chapter 114

⁴ State of New Jersey, Public Law 2011, Chapter 114

standard FFS reimbursement from managed care entities which contract with them and must establish a plan for gain sharing.

In the context of a managed care delivery model and under FFS, as these innovations begin to affect the Medicaid cost curve, New Jersey and other states will require the expenditure authority to share savings and redistribute dollars back into the system.

Reporting, monitoring and quality management

Each contract between the managed care entity and the ACO will define the scope of reporting and monitoring requirements. Timeframes for measurement, population identification, performance measures (i.e.: cost and quality) are further described and agreed to within these contract documents.

DMAHS will work with CMS to develop the appropriate evaluation criteria to comport with the requirements of section 2703 of ACA which will include measures including but not limited to: rates of health screening, outcomes of hospitalization rates for persons with chronic illnesses and the hospitalization and readmission rates for patients residing within the ACO service area. The State plans to compare the performance of the ACO service area for LANE use rates for ACO and non-ACO service areas.

Pharmacy pilot

The burden of chronic disease on our healthcare system is staggering, in fact the total healthcare expenditure for the treatment of chronic disease accounts for the majority of healthcare spending.⁵ It is estimated that 66% of total healthcare dollars are expended towards 27% of Americans with multiple chronic illnesses.⁶ An integrated approach directed toward this patient population would greatly reduce the current financial healthcare burden. The success of any intervention requires coordination across all health professionals, including pharmacists. The role of the pharmacist has changed drastically over the past decade.⁷ Today’s clinical pharmacists are specially trained, having comprehensive clinical expertise garnered through intensive patient-centered experiences throughout their education.

Pharmacists are uniquely qualified to *enhance healthcare* by⁸:

- Helping patients optimize medication use
 - Reducing medication errors
 - Minimizing drug-drug and drug-food interactions
 - Encouraging early reporting of adverse drug reactions

⁵ Medco: Drug Trend Report 2010. Accessed online July 9, 2011 at www.drugtrend.com/art/drug_trend/pdf/DT_Report_2010.pdf

⁶ Anderson G. Chronic Care: Making the Case for Ongoing Care. Princeton, NJ: Robert Wood Johnson Foundation; 2010

⁷ American College of Clinical Pharmacy. A vision of pharmacy’s future roles, responsibilities, and manpower needs in the United States. *Pharmacotherapy* 2000;20:991–1020.

⁸ Molloy C. Dean of Rutgers’ Ernest Mario School of Pharmacy. Letter to the commissioner of the Department of Human Services. dated 5/24/2011

- Providing direct patient care services, including:
 - Medication therapy management, especially for chronic diseases
 - Health promotion and education
 - Disease prevention recommendations

Pharmacists are uniquely qualified to *reduce healthcare costs* by⁹:

- Recommending cost savings in medication expenditures
- Reducing duplication in medication use and recommending alternative effective treatment regimens in collaboration with the prescriber
- Enhancing patient adherence with appropriate medications that:
 - Reduce hospital readmissions
 - Reduce lengths of stay in the hospital
 - Reduce ED visits.

Pharmacists are able to meet the demands of patients with chronic conditions to help them better understand their disease, their medications and, most importantly, their lifestyle modifications. A collaborative effort between pharmacists and physicians will ultimately benefit all three parties; the patient, the physician and the pharmacist. Pharmacists will triage patients and reduce the burden of follow-up visits on the PCPs.

One primary goal of this pharmacy pilot is to decrease the burden of chronic illness on a healthcare system through medication education, adherence and preventative intervention. The pharmacist plays an invaluable role in this regard. A clinical pharmacist would be placed in three of the currently operating FQHC in the State. The sites will be chosen based on demand and patient demographic data. A concerted effort should also be made to align this pilot with FQHCs operating in conjunction with an Accountable Care Organization (ACO) as this type of front-line practice redesign is a strategy discussed in current ACO legislation. It is estimated that this intervention model will reach approximately 110,000 Medicaid recipients throughout the State.

Patient eligibility requirements

A clinical pharmacist would be located in each of the three pilot FQHC practice sites. This pharmacist, student pharmacists and residents supervised by him/her would be available to all physicians and patients; however, this pilot would primarily be focused towards patients with chronic disease. This patient stratification based on chronic disease and preventative efforts could parallel with a similar stratification in the health home (2703) model should the FQHC choose to participate.

⁹ Molloy C. Dean of Rutgers' Ernest Mario School of Pharmacy. Letter to the commissioner of the Department of Human Services. dated 5/24/2011

Service delivery (including payment mechanism)

The entry point to this service is two-fold. Certain disease states will be targeted for pharmacist intervention such as; diabetes, cardiovascular disease, asthma, hemophilia, multiple sclerosis, depression, smoking cessation and DVT/PE prophylactic anticoagulation. Services will also be available to patients stratified by a protocol which would be based on indicators such as; number of disease states, number of medications, drug costs, total healthcare costs. Through collaborative efforts with the FQHC, Rutgers Ernest Mario School of Pharmacy and the MCOs, a predetermined program-wide treatment protocol should be established based on nationally recognized treatment guidelines and agreed upon by all parties participating in this pilot. Follow-up patient visits for these chronic diseases will be triaged to a pharmacist or pharmacy intern, where a complete and comprehensive medication reconciliation and disease assessment would take place. Triaging patients would allow non-emergent maintenance visits to flow through the pharmacist where any monitoring, education, counseling, or medication adjustments within the previously agreed upon guidelines can take place without the recurrent time burden to the physician. From a payer perspective (FFS or MCO), this should manifest cost savings through the shift to a less costly provider without decrease in value to the patient.

Upon reviewing charts and through patient interviews the pharmacist would perform tasks, such as:

- Assessing changes since the last visit, including medication use and transitions in care (care coordination in the health home model).
- Making subjective assessments of medication adherence, self-monitoring, disease control/progression and disease understanding.
- Monitoring drug therapy effectiveness and potential adverse events.
- Addressing any unresolved issues.
- Discussing the goals of prescribed and non-prescribed therapies, including lifestyle modifications.
- Providing an individualized written or printed "take-away," such as an action-plan or personal medication list, to the beneficiary.
- Creating a pharmaceutical treatment plan including any modifications to the patient's drug regimen and schedule a follow-up appointment, as deemed clinically appropriate. The frequency of visits throughout the year will be determined based on patient acuity and disease complexity.

In addition to obtaining a subjective assessment, the pharmacist can also be responsible for ordering or recommending examinations and follow-up lab work, within the permissibility of current law, as it relates to the progression of the disease state (e.g., diabetic monofilament foot assessment for neuropathy, A1C for long-term glycemic control, or FEV1 spirometry to track asthma severity). After the comprehensive review, should any subjective or objective assessment measure fall outside the parameters set forth in the collaborative practice agreement, the pharmacist would reach out to the supervising physician and/or healthcare team for further intervention. Each patient will have a thorough history of past goals, current metrics and future goals which can be

used as means of monitoring the patient through collaborative efforts of the entire clinical team. Patients would also have the opportunity to participate in programs aimed to incentivize healthy behavior, including gift cards for health related expenses. This program would offer incentives, such as gift cards, which could be used for health related expenses for recipients who habitually meet objective goals for their disease state.

Pharmacists will be required to seek additional certification in areas such as diabetes, asthma, hyperlipidemia, cardiovascular disease and smoking cessation. Basic professional requirements for a clinical pharmacist would include:

- Certification (BCPS, CGP) or ASHP Residency including two years clinical experience or
- PharmD degree with three years experience, plus completion of one NCCPC or ACPE Certificate Program or
- BS degree with five years experience, plus completion of two certificate programs.

The pharmacy team will also stay current on treatment guidelines as they pertain to new products, as well as products in the drug pipeline so as to encourage the use of the most cost effective therapies. Pharmacy best practices and medication use for each chronic disease targeted should be documented, updated and disseminated to the entire practitioner group on a regular basis. These best practices would also serve to update the FQHC's practice guidelines under the supervision of each physician specialty group.

In addition to meeting the clinical demands of patients, pharmacists are also uniquely qualified to maximize the healthcare through other mechanisms as well. The pharmacist will be available for consultation regarding polypharmacy as it relates to the overuse of narcotic analgesics, other drugs of abuse and general drug seeking behavior. The pharmacist will also work with pharmacy staff to ensure the FQHC achieves best-price on branded drugs by assuring the health system is adequately maximizing 340b pricing. For efficiency purposes, the FQHC can also defer vaccinations, a low-cost and high-utilization service to the pharmacist.

The State will continue to assess various payment structures for the pilot and will reach consensus on the most appropriate methodology with approval of all participating entities (Rutgers, FQHCs, MCOs).

Each pharmacist may be assisted by up to 3 pharmacy interns with the oversight of Rutgers Ernest Mario School of Pharmacy and no additional cost to the FQHC. These interns have the capacity to fulfill portions of the pharmacist role under the direct supervision of the pharmacist. These student pharmacists can play an important role in patient intake and outcome monitoring throughout the pilot. The opportunity for interns to rotate through the facility offers additional staff for the pilot while also allowing the College to directly participate in this collaboration. The internship program also allows future graduates to become immersed in this setting to pave the way for future PharmDs in expansion sites.

There are two foreseeable barriers to this model which would need to be addressed prior to full implementation. The first barrier is the acceptance of a pharmacist practitioner by the FQHC, physician group and medical directors. The intent of this model should not be misconstrued as a removal of the primary role of the physician, but rather a collaborative practice agreement orchestrated by the physician and implemented by the pharmacist. All exams, lab work and medication changes would be ordered on behalf of the physician within the practice guidelines set forth in the collaborative practice agreement. The adoption of this concept is paramount in the success of the program. The second barrier is the recognition of a pharmacist as a practitioner by the NJ State Board of Pharmacy and other regulatory boards which oversee the practice of medicine in the State.

Reporting, program monitoring and quality management

Assessing the success of an effective medication management intervention can be difficult in that the savings projections are often realized as estimated cost avoidance. There are several surrogate outcomes which can be tracked to monitor quality of care including, but not limited to; HbA1c control, frequency of eye exams in diabetic patients, LDL screening metrics, medication compliance and frequency/results of cardiovascular-related lab work. Most of these can be benchmarked against the regional and national NCQA reported benchmarks and thresholds for Healthcare Effectiveness Data and Information Set (HEDIS) measures. In addition, patient surveys will be created to analyze the success of the program as it relates to patient education and satisfaction. Encounters would need to be tracked for every patient receiving pharmacist services in order to assess outcomes on the backend. In parallel with a billing scenario, pharmacists could track/bill one of the three nationally recognized CPT codes for a pharmacy encounter. A fee schedule suitable for these codes would be agreed upon by the State and participating MCOs.

CPT Code	Service Description
99605	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face, with patient, initial 15 minutes, with assessment, and intervention if provided; initial 15 minutes, new patient.
99606	Initial 15 minutes, established patient visit.
99607 *	Each additional 15 minutes. List separately in addition to code for the primary service.
*Use 99607 in conjunction with 99605, 99606	

Rutgers Ernest Mario School of Pharmacy will work in concert with the three clinical pharmacists to track outcomes. All research efforts will be constructed in collaboration with the MCOs and implemented under the direction of the Dean of the School.

There are a few small studies in the literature which discuss the potential shift in drug utilization trends. A study conducted by the University of Wisconsin-Madison suggests that pharmacist intervention can substantially decrease the medication cost with a

Return on Investment (ROI) of 3.55:1 to the PBM.¹⁰ A smaller study completed by the University of North Carolina School of Pharmacy discusses the small fluctuations in drug costs as a result of pharmacist intervention.¹¹ University of North Carolina researchers found that drug costs can decrease for certain disease states as a result of the combining of drugs to a once-daily regimen for better compliance. They also found that this is offset by other disease states through the addition of new therapies and improved adherence. The savings associated with a pharmacist intervention model will be attributed to the overall improvement in the quality of care as it relates to the treatment of chronic disease. Prevention of disease progression as it pertains to the pharmacist intervention model will realize savings through a decrease in utilization of acute and emergent healthcare services. A recent study published in the *Journal of Managed Care Pharmacy* touts the success of a physician-pharmacist collaborative practice arrangement. This compared the proportion of patients meeting the criteria for metabolic syndrome in a “usual care” setting versus a collaborative arrangement. Researchers found that a higher proportion of patients no longer met the clinical criteria for metabolic syndrome when having pharmacist-provided recommendations and pharmaceutical care.¹² A similar study also found a clinically important decrease in blood pressure with a commensurate increase in patients reaching goal through an enhanced care model given by a pharmacist and nurse team.¹³ Patients were given additional education and counseling in the treatment arm and were referred to the PCP when further assessment was needed. By integrating a clinical pharmacist in the coordination of care on the front end, this care delivery model should realize additional value in the proactive management of chronic disease.

Managed long-term care

In 2010, the State spent more than \$3.5 billion on LTC services for seniors and individuals with physical disabilities under the existing FFS delivery system. Most of the State’s spending is for NFs not less costly home and community based care. The experience of other states suggests that managed LTC in a capitated framework can significantly impact cost and shift care to home and community based settings.

Managed care is a tool that the State has been employing to contain costs for well over a decade, although managed care has primarily been used to control the costs of Medicaid primary and acute care rather than LTC. Effective July 1, 2012, the State will further amend its existing MCO contracts to require management of all LTC services including HCBS and NF services for seniors and individuals with physical disabilities. This move to

10 Look KA, Mott DA, Kreling DH, et. al. Economic impact of pharmacist-reimbursed drug therapy modification. *J Am Pharm Assoc* (2003). 2011 Jan-Feb;51(1):58-64.

11 Branham A., Moose J., Ferreri S., et. al. Retrospective Analysis of Medication Adherence and Cost Following Medication Therapy Management. *Innovations in Pharmacy*. 2010, Vol. 1, No. 1, Article 12

12 Hammad EA., Yasein N., Tahaineh L. et. al. A Randomized Controlled Trial to Assess Pharmacist-Physician Collaborative Practice in the Management of Metabolic Syndrome in a University Medical Clinic in Jordan. *J Manag Care Pharm*. 2011;17(4):295-303

13 McLean DL., McAlister FA., Johnson JA., et. al. A Randomized Trial of the Effect of Community Pharmacist and Nurse Care on Improving Blood Pressure Management in Patients With Diabetes Mellitus. *ARCH INTERN MED/VOL 168 (NO. 21), NOV 24, 2008*

managed care for the State's LTC populations is being motivated by a desire to contain costs and reduce inefficiencies in the LTC system, such as cost-shifting among programs, which has resulted in higher overall costs for the system. The goal of the State's managed LTC program is to assist beneficiaries with LTC needs navigate a complex network of health and social support providers, reduce duplication and cost-shifting in the LTC system, and assist the State in better controlling and predicting LTC expenditures.

In order to ensure that the MCOs can meet the needs of these populations, the State will ask each MCO, among other things, to describe:

- How they will operationally satisfy specified requirements
- Their experience managing this population in other states
- Their provider network that is tailored to this population

A MCO will not be allowed to enroll LTC individuals until it has successfully passed a readiness review. MCOs must also submit plans for how they will delay or prevent their aged, blind and disabled (ABD) members, who do not currently meet at risk-of-institutionalization criteria, from reaching that LOC.

Managed LTC will include:

- Those at risk of LTC or meet the LOC criteria established by the State will have integrated NFs, HCBS (including alternative residential services), BH services, primary care and acute care services.
- The continuum of home-and-community based services will be expanded beyond the current 1915(c) and 1915(j) authority.
- Personal care attendant participant directed services now authorized under Section 1915(j) of the State Plan will be included under managed LTC (For a transition period, MCOs will be required to continue services that members are already receiving. At a later date yet to be determined these members will be transitioned to participant-directed services). The administrative and counseling functions, however, will remain with DDS.
- Participant-directed services will be offered through the MCO along with fiscal employer agency (FEA) services to allow members to manage their independent providers (the State will secure FEA services through a competitive bid and make the FEA available to MCOs to provide members with the most cost-effective services).
- PACE will be discontinued; existing PACE programs can become part of network, providing PACE-like services and receiving 100% of SFY12 capitation through June 30, 2013, receiving 75% of SFY12 capitation through June 30, 2014, and receiving capitation negotiated with MCOs beginning July 1, 2014 for delivery of PACE-like services in the context of a health home.
- MCOs will provide integrated case management and support coordination directly or through agreements with current care management agencies for PH, LTC and BH.
- MCOs will be required to implement information systems to automate care planning, tracking functions and predictive modeling.
- MCOs will be required to establish linkages and reporting to Adult Protective Services.

- MCOs have the authority to mandate the cost effective placement of a member in HCBS program or NF.

Termination and transition of the 1915(c) and 1915(j) State Plan Amendment

With the approval of this 1115 demonstration amendment, the State will terminate its 1915(j) SPA (the administrative and counseling components will remain with DDS) and its 1915(c) waivers for the TBI, ACCAP, CRPD and GO programs. Waivers will terminate but services will continue as they do today during the transition period from FFS to managed care. The State requests permission to cease operating these HCBS Waivers under Section 1915(c) and 1915(j) authorities upon approval of the Section 1115 demonstration waiver, but to continue these same programs under transitional 1115 authority until the MCOs implement these programs/services. Once the MCOs are determined ready, the State will cease operating these waivers under the demonstration.

The State is committed to a seamless process for transitioning the 1915(c) and 1915(j) Waiver programs into the Section 1115 demonstration and managed care. The State will submit to CMS and to waiver participants the notices required under section 1915(c). Comparable notices will be sent to 1915(j) SPA participants. The State is also preparing a transition plan for the termination of the Waiver authorities. As the transition between authorities should be seamless to Waiver and SPA participants, the notices will emphasize that there will be no loss of services. Waiver participants will be able to continue seeing their current providers when authority shifts from Section 1915(c) to Section 1115 demonstration authority. A transition period will also be provided when managed LTC is implemented.

Eligibility requirements

Medicaid enrollees (as defined in Exhibit 3.1) requiring health care services at a NF LOC are eligible to receive the Medicaid covered benefits summarized in Section 4 of this component of the waiver.

Financial eligibility: The ABD population must be financially eligible for managed LTC:

- Income below the SSI standard (72% of FPL) and meet the disability criteria established by the Social Security Administration (SSA)
- Income below 100% of FPL
- Income at the institutional level with income equal to or less than 300% of the Federal benefit rate (FBR), as used by the SSA to determine eligibility for SSI
- Spend down to the Medically Needy Income Level

The first two income categories may already be eligible for Medicaid and receive acute/medical care through a MCO. Other financial eligibility criteria include:

- The resource (cash, bank accounts, stocks, bonds, etc.) limit is \$2,000 for a single individual. Resources, such as a person's home, vehicle and irrevocable burial plan are not counted toward the resource limit.
- When the applicant has a spouse who resides in the community, the spouse can retain one-half of the couple's resources, up to the Federal maximum as specified in Section 1924(f)(2) of the Act. Resources, such as a person's home, vehicle and irrevocable burial plan are not counted toward the resource limit.
- The total gross income for a married couple is combined and divided by two. The resulting income may not exceed 300% of the single FBR. If the resulting income exceeds 300% of the single FBR, the income of the applicant only (name on check) is compared to 300% of the single FBR/SSI standard.
- Five year look back for transfer of assets
- Estate recovery

Functional eligibility: The approach to the functional eligibility determination differs for those ABD who are already eligible and enrolled for acute/medical care in a MCO and those who become eligible as result of needing LTC typically at the higher income level.

- *Those already eligible and enrolled in managed care.* MCOs will perform the LOC assessment for those at less than 100% of the FPL using the DHSS NJ Choice tool that will be modified to screen for LOC. Assessment components specific to care planning will be eliminated because the MCOs will assume this responsibility under managed LTC. The criteria for meeting a NF LOC are the same regardless of where the individual resides. The MCO will be allowed to determine which of these individuals have a need for LTC services including institutional services. The rationale for this approach aligns with the State's intent to allow the MCOs to provide HCBS to individuals to prevent a decline in health status and maintain individuals safely in their homes and communities. The State will not allow the MCO to establish functional criteria (to meet a NF LOC) that is stricter than what is established by the State.
- *Those who become eligible for Medicaid once they meet the LOC.* DHSS or its designee will be responsible for performing a clinical/functional LOC assessment for those at greater than 100% of the FPL to determine whether an individual meets a NF LOC for the purpose of the initial eligibility determination. LOC assessments will be performed at least annually or when there has been a significant change in the member's condition/circumstances. Through State-designed criteria, annual LOC assessments will be waived if a LOC assessment indicates an individual's condition will not improve absent a NF LOC.

Upon implementation of managed LTC, individuals currently enrolled will not need to undergo a new assessment to determine their ongoing financial and functional eligibility.

Waiver of preadmission screening and resident review for Medicaid

On an annual basis the State has approximately 100,000 discharges from hospitals to NFs. All of these individuals plus those moving from their home to a NF require a Preadmission Screening and Resident Review (PASRR) Level 1 screening for severe mental illness and/or I/DD. Those who screen positive for mental illness or I/DD require a Level 2 screen. With the implementation of managed LTC, the PASRR process becomes duplicative with inherent controls in the system. MCOs are not responsible for the care of those with severe mental illness or I/DD and capitation payments will not reflect such care. As a result, appropriate referrals to the MBHO and to DDD will occur in the absence of the PASRR process. As part of this application, the State will also seek a waiver of the PASRR requirements for the following reasons:

- MCOs will be incentivized through capitation to make appropriate and cost-effective placements of individuals enrolled in their plan and referrals to appropriate agencies.
- Individuals with a MI who do not meet a NF LOC will be enrolled with an ASO/MBHO as described later in Section 5. The ASO/MBHO will be responsible for ensuring the appropriate placement of members.
- Individuals with an I/DD diagnosis will be referred to the DHS/DDD to determine and authorize the most appropriate placement for the individual.
- *Non-Medicaid* admissions to a Medicare/Medicaid participating NF will be referred to the Level 2 authority if the Level 1 PASRR indicates the individual needs a referral for a Level 2 screening and he/she will have resided in a NF for 90 days.

Access to long-term care services

The State is in the process of transitioning Medicaid enrollees into capitated managed care for most services. Beginning July 1, 2011, and into the fall, the primary and acute care needs of the Medicaid populations, including dual eligibles and the aged, blind and disabled, will be met through amendments to the current Medicaid MCOs.

For the July 1, 2012 managed LTC program implementation the State will utilize its existing MCOs to manage all the Medicaid services, including HCBS, NF and BH services.

Prior to the implementation of managed LTC on July 1, 2012 all Medicaid enrollees currently receiving HCBS under a Section 1915(c) waiver (TBI, ACCAP, CRPD and GO), 1915(j) waiver or meet the NF LOC criteria and reside in a NF will be offered the opportunity to select a new MCO or remain with their current MCO.

The LTC services provided must be sufficient to meet the needs identified by the MCO's case manager's care assessment, taking into account the functional, medical, nursing and psychosocial needs of the individual as well as family and other supports available to the individual. To support the shift away from reliance on institutional services, the State will develop comprehensive contract and policies requirements.

The State will require the following of the MCOs:

- If, at the time of implementation, an individual is currently receiving HCBS under a Section 1915(c) waiver or 1915(j) SPA and meets a NF LOC, the individual must continue to receive HCBS from his/her current provider(s) for at least 90 days or longer if a care assessment has been completed by a MCO case manager. Based upon the services in place at the time of managed LTC implementation, the services need not be identical to the ones previously received under the Section 1915(c) or 1915(j) Waiver, but any change(s) must be based upon the care assessment.
- For all beneficiaries participating in HCBS, expenditures for individuals are limited to the most cost effective placement and in no case greater than the NF cost. Exceptions may be permitted if additional services are related to a transition from the facility or a change in condition that is not expected to last more than six months. If the estimated costs of providing necessary HCBS to the individual are less than the estimated costs of providing necessary care in an institution, the MCO can require the HCBS placement, provided the individual can be safely maintained at home.
- MCOs will have the authority to mandate the cost-effective placement of members in the HCBS program or a NF (HCBS can be more expensive for a short-term transition period post discharge from a NF).
- MCOs will be required to document good faith efforts to establish a cost-effective, person-centered POC in the community using industry best practices and guidelines. If the estimated cost of providing necessary HCBS to the individual exceeds the estimated cost of providing necessary care in an institution, a MCO may refuse to offer HCBS. If an individual in this situation chooses to remain in the community, the MCO will be required to complete with this individual a managed risk agreement detailing the risks to the member regarding his/her choice to remain in the community.
- MCOs will be required to establish an HCBS caregiver back-up system to provide caregivers in situations when an individual's regular caregiver is not available to provide services as scheduled.
- The State will establish specific criteria for the provision and coordination of BH services. Providing and coordinating the BH services of this population is critical to maintaining these individuals in the least restrictive and most integrated setting appropriate to their needs.
- MCOs will be required to have mechanisms in place to collaborate with State agencies that administer state-only funded HCBS programs with the intent for the MCOs to provide medically necessary HCBS rather than utilizing limited state-only HCBS funds.
- MCOs will be required to establish a LTC BH administrator position. This individual will be responsible for developing BH services and settings that can meet the needs of LTC individuals with BH needs, develop processes to coordinate BH care between PCPs and BH providers, coordinate behavioral care needs of LTC individuals with LTC service providers and coordinate behavioral care in collaboration with LTC case managers.
- For all LTC individuals the need for BH services shall be assessed and provided in collaboration with the member, the member's family and all others involved in the

member's care, including other agencies or systems. Services shall be accessible and provided by competent individuals who are adequately trained and supervised. The strengths and needs of the member and his/her family shall determine the types and intensity of services. Services should be provided in a manner that respects the member's and family's cultural heritage and appropriately utilizes natural supports in the member's community.

- The State will retain the authority to make any decisions to transition individuals from one MCO to another or disenroll altogether from the managed LTC program. Whenever an individual transitions to another MCO and is receiving LTC services the receiving MCO must maintain all current services for at least 30 days and until the MCO is able to perform a care assessment and develop a POC.
- MCOs may offer HCBS to individuals who do not meet a NF LOC in order to prevent a decline in health status and maintain individuals safely in their homes and communities. A member may request a LOC determination by the MCO at any time. The MCO will use the State's assessment for this purpose.

Case management and support coordination model

All LTC MCOs will be required to establish a LTC case management and support coordination program as directed by the State. The State will establish minimum qualifications for case managers. MCOs must provide integrated case management for LTC, acute care, and BH. Additionally, the State will ensure that each MCO assigns one and only one case manager to every member enrolled in the managed LTC program.

MCOs will be required to have BH staff (including a BH director under the Office of the Medical Director) as defined by the State available for consultation to case managers for the LTC individuals that may need or are receiving BH services.

For those individuals enrolled at the time of the managed LTC implementation, the State will establish timelines for the initial contact, care assessment, POC, individual service agreement, and authorization and implementation of services. The State will ensure that the MCO case managers have information pertaining to the individual from the previous three months, (e.g., case manager care assessments, POC (most recent) and the types and amount of services currently authorized. The MCOs will be provided prompt access to additional member information as needed.

POC: For each individual enrolled in managed LTC, the MCO will develop and implement a person-centered written POC and individual service agreement in compliance with 42 CFR 440.169 and 441.18. It will analyze and describe the medical, social, behavioral and LTC services that the member will receive. In developing the POC and the individual service agreement, the MCO will consider appropriate options for the individual related to his/her medical, BH, psychosocial and case-specific needs at a specific point in time, as well as goals for longer term strategic planning. The MCO will be expected to emphasize services that are provided in members' homes and communities in order to prevent or delay institutionalization whenever possible. An update to the POC must occur at least annually.

Oversight: The MCOs will be required to develop and provide to the State an annual case management plan. The plan must address how the MCO will implement and monitor the case management contract and policy requirements established by the State. The MCOs will also be required to implement a systematic method of monitoring its case management program to include, but not be limited to conducting quarterly case file audits and quarterly reviews of the consistency of care assessments, POC and service authorizations (inter-rater reliability) and the LTC services actually received. The MCO will be required to provide to the State an analysis of the data and a description of quality improvement (QI) strategies to resolve identified issues.

The State will establish a process to regularly oversee and monitor the MCOs' LTC case management program and provision of LTC services. This will include but not be limited to review and approval of the MCOs' annual case management plan, review of the MCO's oversight of case management and provision of LTC services. The State oversight process will be more intensive during the first one to two years of operation so that steps can be taken to resolve issues and program improvement can be rapidly and effectively initiated.

Participant-directed services

The State will define services that eligible members may elect to self-direct. Members determined, as a part of the needs assessment and POC processes, to require such services, will have the opportunity to exercise decision-making authority regarding the providers (participant-employed) who deliver these services.

For those individuals enrolled at the time of managed LTC implementation, the State will require MCOs to continue participation of individuals already receiving cash and counseling services authorized under Section 1915(j) of the State Plan. The MCO will inform new consumers who are approved for PCA services about the self directed option in a coordinated and collaborative effort with DDS. DDS will continue to provide the administrative support and counseling services for individuals electing self-directed PCA services.

- Upon enrollment in the managed LTC program, regardless of placement, and on a periodic basis thereafter, members will receive information regarding consumer direction of HCBS.
- Participation in consumer direction of HCBS is voluntary. Members may choose to participate in or disenroll from consumer direction of HCBS at any time, service by service, without affecting their enrollment in HCBS. Only the State can make the decision to involuntarily disenroll a member from consumer direction of HCBS, with sufficient documented concerns regarding health, safety and welfare or failure to adhere to program requirements or policies.
- A member may designate a representative to assume consumer direction of HCBS on his/her behalf. A member's representative may not receive payment for serving as a representative or being a member's paid worker.
- The State will utilize a FEA to fulfill the financial administrative functions for members participating in consumer direction of HCBS (e.g., paying workers for services

rendered; and withholding, filing and paying applicable Federal, State and local income and employment taxes for workers) and to provide supports broker assistance. The State will secure FEA services through a competitive bid and make the FEA available to MCOs.

- The POC process for members who participate in consumer direction of HCBS will include an individual risk assessment signed by the member and a backup plan detailing alternative available supports (including the option to obtain services through an in-home caregiver agency), contact information and the order in which contact should be made and for which services in the event a member's scheduled worker is unexpectedly unavailable.
- Members will have the flexibility to hire persons close to them, including family members but excluding spouses and minor children, to serve as their workers. All workers must meet the State-specified qualifications.
- Members will have flexibility to establish payment rates that do not exceed the State-specified ceiling for each service.
- Members and/or representatives must receive training prior to participating, and when re-enrolling, in consumer direction of HCBS.
- On-going training is also available at any point in time upon request of the member, representative and/or caregiver. Additional training may also be provided at any time if the care coordinator feels it is warranted.
- Workers must receive training, as a condition of hiring, which may be provided by the member, with assistance from his/her supports broker, as appropriate. Additional training may be provided at the request of a member and/or representative.
- A member's care coordinator will continuously monitor the adequacy and appropriateness of services provided, a member's quality of care and the adequacy of payment rates.

Aging and Disability Resource Centers (ADRC)

New Jersey will explore the opportunity to utilize ADRC functions to support a more effective, streamlined Medicaid system. New Jersey's ADRCs currently perform functions that are necessary for the efficient and effective administration of the Medicaid program, including the following:

ADRC Function	Is a Medicaid Administrative Service:
Outreach	When outreach emphasizes access to Medicaid program
Information, Referral & Intake	When functions discuss Medicaid as potential service or if provided to someone who is Medicaid eligible
Short-term Stabilization	When the individual is Medicaid eligible and the activities are related to connecting individuals to Medicaid funded services. Also provides Targeted Case Management under the Medicaid State Plan.
Case Review	When individual is Medicaid eligible or if part of Medicaid eligibility determination process
LTC Needs & Supporting Resources Assessment	When individual is Medicaid eligible or if part of Medicaid eligibility determination process
Benefits Counseling	When individual is Medicaid eligible or if part of Medicaid eligibility determination process
LTC Options Counseling	When individual is Medicaid eligible or if part of Medicaid eligibility determination process
Linkage to LTC Services	When individual is Medicaid eligible
Interaction with Medicaid Eligibility Approval Process	When attempting to establish Medicaid eligibility
Assistance in continuous improvement projects for the LTC system	When effort impacts Medicaid services and beneficiaries

New Jersey will explore how to leverage these existing ADRC functions to expedite eligibility determinations, utilizing either or both of two vehicles – an administrative contract or direct reimbursement for administrative costs.

Nursing facility collaborations

The State will explore with the NF industry opportunities to implement policies and programs to ease the effects of transition and diversion of individuals from NFs. For example, the State will explore opportunities to provide grants to NFs to close a facility, downsize a NF and/or diversify their business to include HCBS.

Nursing facility diversions and transitions

NF Diversion Plan: The MCOs will be required to develop and implement a NF diversion plan and processes for LTC individuals who receive HCBS and non-LTC individuals who are at risk of a NF placement (including short-stay NF placements) due to changes in their condition. The NF diversion program shall comply with requirements established by the State and be prior approved by the State. The plan will require the MCOs to monitor hospitalizations and short-stay NF admissions for these at risk individuals and to identify issues and implement strategies to improve diversion outcomes. The diversion program will not prohibit or delay an individual's access to NF services when these services are medically necessary and requested by the member.

NF to community transition plan: The MCOs will be required to develop and implement a NF to community transition plan and processes for LTC NF individuals who can be safely transitioned to the community. The NF diversion plan shall comply with requirements as established by the State and be prior approved by the State. The plan will require the MCOs to work with DHSS and DHS. The plan will require that there are processes for identifying LTC individuals who may have the ability and/or desire to transition from a NF to the community. The MCO will also be required to monitor hospitalizations and NF re-admissions for individuals who transition from a NF to the community and to identify issues and implement strategies to improve transition outcomes.

Reporting, program monitoring and quality management

QI strategy for the managed LTC program: The State will submit to CMS an integrated QI strategy which builds on existing managed care quality requirements as defined in 42 CFR 438, Subpart E. The State must identify: 1) measures of process, health outcomes, functional status, quality of life, member choice, autonomy, member and provider satisfaction and performance; 2) the data sources and sampling methodology for such measures; and 3) the frequency of reporting on specific measures.

The MCOs will be required to establish methods for discovery, remediation and systems improvement and, per State prescribed timeframes, regularly report on outcomes associated with continuous QIs. The State will provide oversight of this process and submit its QI strategy to CMS for approval prior to implementation of the managed LTC program.

Annually, the State will provide information to CMS regarding its QI activities, including evidence regarding system performance based on identified objectives and measures. This information will demonstrate efficacy in implementing the quality strategy, including but not limited to external quality review (EQR), discovery, remediation and systems improvement activities.

Data: The State will establish the baseline and ongoing LTC data appropriate for monitoring programmatic trends under the managed LTC program.

Data plan: The State will collect and submit baseline data to CMS, including but not limited to the following data elements:

- Numbers of persons actively receiving HCBS and numbers of persons actively receiving NF services the day prior to implementation
- Unduplicated numbers of persons receiving HCBS and NF services during a 12-month period
- HCBS and NF expenditures on the managed LTC population during a 12-month period
- HCBS and NF expenditures on the elderly and disabled population during a 12-month period as a percentage of total LTC expenditures
- Average per person HCBS and NF expenditures during a 12-month period
- Average length of stay in HCBS during a 12-month period
- Percent of new LTC recipients admitted to NFs during a 12-month period
- Average length of stay in NFs during a 12-month period
- Number of persons transitioned from NFs to HCBS during a 12-month period

Electronic collection of managed LTC data: The systems will be in place to record the requisite data elements 30 days prior to implementation of the managed LTC program.

Submission of data: An electronic copy of the actual baseline data will be submitted to CMS within six months of the last day of the 12-month period prior to managed LTC implementation. Thereafter, an electronic copy of the data for each subsequent demonstration year will be submitted to CMS within six months of the last day of each demonstration year.

Data reporting: The State will report to CMS on data and trends in the designated data elements in its quarterly and annual progress reports.

QM: The MCOs will be required to revise all existing applicable policies and plans to account for the managed LTC program requirements. The QM requirements that will need modifications and the actions that must be taken include:

- Submitting a revised Quality Assessment and Performance Improvement (QAPI) plan to DMAHS for review and approval
- Submitting a revised utilization management (UM) plan, including prior authorization requirements, processes and timeframes, monitoring for under/over utilization and any other UM strategies proposed to DMAHS for review and approval
- Closely monitoring and reporting specific HEDIS metrics and other performance targets against targeted benchmarks

The MCOs will be required to submit QAPI and UM plans to DMAHS for review and approval 45 days prior to implementation of the LTC program and annually thereafter. The MCOs will also be required to establish processes and provide assurances to the State regarding their access standards as required by 42 CFR 438, Subpart D. These

standards include the availability of services, adequate capacity and services, coordination and continuity of care and coverage and authorization of services.

DMAHS will make a preliminary selection of HEDIS and other performance measures with the understanding that the underlying methodology may require adjustment. Measures may be updated on an annual basis to reflect progress in achieving program goals. The preliminary list of measures includes:

- Reduction in NF placements
- Timely initiation of HCBS
- Reduction in hospital readmissions
- Percent of dollars spent on HCBS

Adult Protective Services: The 1993 New Jersey Adult Protective Services Act. (P.L. 1993, c 249, N.J.S.A. 52:27 D-406 to 426) designates DHSS to administer an intervention program to respond to reports of alleged abuse, neglect or exploitation and to work with the adult about whom the report is made to resolve the situation. To strengthen the Adult Protective Services system each MCO's QM and case management programs and operations will include linkages to DHSS/Adult Protective Services. The State will ensure that these linkages are in place and are being utilized during the readiness review and through the EQR process.

Criminal background checks: The State is considering the opportunity to submit a grant proposal (Funding Opportunity Number: CMS-1A1-12-001) to be considered for inclusion in the National Background Check Program so that it may develop a program for an efficient, effective, and economical process for LTC facilities and providers to conduct background checks on all prospective direct patient access employees.

Readiness reviews

In order to ensure that the MCOs can meet the needs of the managed LTC population, the State will require each MCO to prepare a plan that describes:

- How it will meet specified requirements
- Its experience operating a LTC program in other states
- Its provider network

Upon receipt of an acceptable plan, DMAHS will perform a desk-level (review of policies and procedures) and on-site review (e.g., testing of information systems) of each MCO to determine its readiness to begin enrolling members. The State will not enroll individuals in a MCO until it has successfully passed its readiness review.

The State will develop a readiness review tool to assure uniformity in the determinations made about each MCO's compliance and its ability to perform under the LTC contract provisions. The tool will also identify materials each MCO will be required to submit to describe its operations in detail. Examples of required written materials include:

- Organizational charts
- Organizational and staff qualifications
- Staff training plans regarding managed LTC
- Financial information
- Management information system structure and processes
- Medical and UM policies and procedures
- Provider network development and composition (including geographic mapping)
- Provider credentialing processes
- Provider relations policies and staffing
- Provider compensation arrangements and model contracts
- Access and availability policies
- LTC program policies, procedures and forms/documents
- Linkages with Adult Protective Services
- Case management and coordination of care policies and procedures
- Care planning software description, including data elements tracked, stored and reported
- Local health and community services coordination, including Area Agencies on Aging (AAA)s/ADRCs
- Member services policies and staffing
- Member grievance policies, procedures and data tracking system
- Abuse/neglect reporting policies and procedures
- Marketing plan and policies
- Enrollment and disenrollment procedures
- Examples to illustrate the cost effectiveness of institutional or HCBS services
- QM plan
- Committee structures relevant to LTC program
- Reporting capabilities

Statewide rollout

The State will develop a plan to ensure the safe and effective transition of members to the managed LTC program. Items that will be included in the transition plan include, but are not limited to:

- Preparing and conducting MCO readiness reviews
- Preparing individuals for the transition (e.g., education about managed care and service changes, community forums, other communication plans, enrollment activities, continuity of care plans)
- Preparing providers for the transition (e.g., outreach to HCBS and NF providers about managed care participation, changes to authorization requirements and billing requirements)
- Preparing MCOs for the transition (e.g., continuation of currently authorized services, case management, systems/data sharing, member services, network management specific to LTC providers, provider relations, claims payment, provision of needed technical assistance)
- Preparing State staff for the changes

Managing Behavioral Health

During FY 2010, there were approximately 60,000 Medicaid adult consumers and 40,000 Medicaid child/adolescent consumers who accessed BH care through the FFS system. BH care for adult consumers and children's services under FFS has been fragmented and largely unmanaged, with an over reliance on institutional rather than community-based care. These same individuals receive their medical care through one of four MCOs, with very limited or no formal protocols for coordination between the medical and BH delivery systems. Under this scenario, the risk is greater that BH needs go unidentified and that consumers receive suboptimal BH care in primary care settings. Untreated or suboptimal treatment of BH conditions has long been associated with lower adherence to prescribed medical treatment, higher medical costs, and poorer health outcomes. In particular, adults with mental disorders have a "twofold to fourfold elevated risk of premature mortality", largely due to poorer PH status, not accidents or suicides.¹⁴ There is emerging evidence of the effectiveness of interventions designed to address the need for BH-PH coordination. Given that for Medicaid's highest cost adult beneficiaries, approximately two-thirds have a mental illness and one-fifth have both a mental illness and substance use disorder¹⁵, the opportunity for improved clinical and financial outcomes through improved BH-PH coordination is strong.

The need for improved BH-PH coordination must be balanced with the need to introduce managed care technologies that go beyond basic utilization review of higher levels of care to incorporate care management protocols for the populations with SMI or serious emotional disturbance (SED). In addition, many individuals who are not currently eligible for Medicaid receive critical BH services through State-only funds, Federal block grant dollars or other resources. Some of these become eligible for Medicaid under health care reform in 2014. Under the Comprehensive Waiver, the State plans to braid non-Medicaid funding streams with Medicaid funds to develop a more integrated system of care with an eye toward meeting the BH needs of the Medicaid expansion population in 2014. This will include reviewing rate structures to improve consistency and competitiveness of reimbursement rates across funding streams with the overall goal of adequate access to appropriate services. These initiatives will occur within the context of a recent merger of the Divisions of Mental Health Services (DMHS) and Division of Addiction Services (DAS) to support the integration of care. This merger provides an opportunity to build a combined system that provides best practice treatments for individuals with co-occurring mental illness and substance use disorders. The management of SMI and SED populations, the use of medication to enhance treatment of substance use disorders, integration of mental health and substance use disorder services and braided funding requires specialized expertise, tools and protocols which are not consistently found within most medical plans.

¹⁴ Druss, Benjamin and Reisinger Walker, Elizabeth. *Mental disorder and medical comorbidity*, The Robert Wood Johnson Foundation, The Synthesis Project. February 2011.

¹⁵ Boyd, Cynthia, Leff, Bruce, Weiss, Carols, Wolff, Jennifer, Hamblin, Allison and Martin, Lorie. *Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations*,. Center for Health Care Strategies, Inc., December 2010.

Introducing managed care technologies through contracting with an administrative services organization (ASO) or a Medicaid behavioral health organization (MBHO) has been associated with improved access, better monitoring of quality outcomes, and a better distribution of services across the entire care continuum. Examples include both full risk and non-risk arrangements. In FY2010, over 40,000 child/adolescent consumers with SED and multi-system involvement access BH care through New Jersey's CSOC administered by an ASO contractor with claims payment continuing to be administered through the State's FFS MMIS. In place since 2002, this program has made substantial progress in expanding access and improving outcomes while managing costs. Under the CSOC, utilization has shifted to more community-based settings and allocation of resources has been better matched to level of need. In addition, coordination of care across child serving systems including education, child welfare and juvenile justice has been a priority under the CSOC. Given that over 50 percent of youth with SED are also involved with child welfare services, specialized BH expertise to maintain this connection is vital. The need for specialized BH expertise and management is further supported by recent feedback from the DD community that the BH needs of the DD population would be better met through a separate behavioral program; care is currently carved into the medical plans.

Based on the current managed care landscape in the State and building on the progress made under the CSOC, the design of the State's Medicaid program to manage BH has five key components:

- Requirements for managing BH benefits through an ASO/MBHO contractor with extensive experience in managed care with a Medicaid BH population including individuals dually diagnosed as I/DD and BH
- Requirements for BH-PH integration for both the MCOs and the BH contractor
- Program and financial management structures to support the transition to, and ongoing operation of, the newly designed BH system, including braiding of funds for Non-Medicaid covered individuals and services and revising rate structures to improve consistency and competitiveness of provider reimbursement across funding streams
- For adults, an initial non-risk contract with a MBHO subject to the non-risk UPL at 42 CFR 447.362 that moves incrementally towards full risk to assure alignment of policy objectives with fiscal incentives; the MBHO will function as a prepaid inpatient health plan (PIHP) consistent with the requirements at 42 CFR 438.2
- For children, the State will continue with the current ASO contract with claims payment administered under the FFS Medicaid Management Information System (MMIS)

These components are linked in vision:

- To improve access to appropriate physical and BH care services for individuals with mental illness or substance use disorders

- To better manage total medical costs for individuals with co-occurring BH-PH conditions
- To improve health outcomes and consumer satisfaction

The program design takes a multi-pronged approach to achieve this vision:

- Network enhancements to increase capacity and expand the service array to improve access to community-based services that facilitate recovery for adults and resiliency for children and are grounded in evidence-based practices (EBPs)
- Routine screening of individuals in primary care settings to identify unmet BH needs, with expedited referrals to needed BH services
- Routine screening of individuals in BH settings to identify unmet medical needs, with expedited referrals to appropriate PH services
- Data integration to support predictive modeling to identify high risk/high cost consumers and to facilitate program evaluation across systems
- UM medical management and QM protocols and other administrative services to ensure BH service delivery, and associated financial and clinical outcomes are appropriately managed
- Specialized case management and care coordination protocols to improve consumer engagement, promote self care, and enhance cross system coordination for high risk/high cost consumers, including participation in the health home innovations described earlier in this section
- Specialized case management and care coordination protocols for managing adults dually diagnosed as I/DD and MI as well as providing for behavioral supports in residential, day and home settings
- Comprehensive and ongoing education, training and technical assistance programs for members, BH and PH providers, and MCO and ASO/MBHO staff to facilitate transformation of the system
- A transition plan, with key milestones and timelines for transitioning management of children and adolescents under FFS to the CSOC ASO, selecting the adult MBHO and implementing other key program components

Managed care organization roles and responsibilities

The needs of consumers who present for services, including symptom severity, level of functioning and chronicity will define the relative roles of the Medicaid MCO and the children's ASO/adult MBHO in managing BH conditions. The MCO will continue to arrange or provide, manage and be at risk for any Medicaid covered service that is delivered by its medical plan network. This includes but is not limited to primary care office visits to treat BH conditions and acute detoxification in an inpatient hospital setting for which an MCO authorized provider is the attending. The children's ASO/adult MBHO will arrange or provide and manage services that are delivered by its BH network. A more detailed description of the responsibility for the administration and management of claims for BH services can be found in Table 2 in the Benefits section of this component of the Waiver. Additional responsibilities of the MCO under this design include:

- **Data exchange.** Each MCO will be responsible for regular transmission of data pharmacy claims, medical claims, selected health risk assessment and BH screening results to the ASO/MBHO. The MCO will be required to receive transmission of BH claims and PH risk screening results from the ASO/MBHO. As needed, the MCO also will be required to develop data exchange with other state entities (i.e., DMHAS, DCF) and relevant service providers.
- **Risk screening.** Each MCO will be required to implement a standardized protocol to identify common BH risks in primary care settings, provide necessary education and brief intervention in order to facilitate referrals of individuals who screen positive to an appropriately credentialed and qualified BH provider. This includes but is not limited to selecting appropriate screening tools and establishing provider requirements to follow the established screening and referral protocols, including the Screening, Brief Intervention and Referral to Treatment (SBIRT) protocol. The MCO will collaborate with the ASO/MBHO and DMAHS to establish a list of approved screening tools that are efficient to use and meet generally accepted standards for reliability (consistency of results) and two measures of validity: sensitivity (accuracy in identifying a problem) and specificity (accuracy in identifying individuals who do not have a problem).
- **BH-PH coordination.** The MCO, in collaboration with the ASO/MBHO, will establish a process for identification and management of the top 5% (in terms of medical costs and medical or psychosocial risk factors) of individuals with co-morbid medical and BH conditions. The MCO will participate in necessary co-management of these cases, which may be done through MCO care management staff or through provider initiatives. The MCO will establish a process for dissemination and implementation of EBPs for BH conditions commonly treated in primary care settings, protocols to monitor PCP adherence to these EBPs and financial incentives for BH-PH coordination activities in the primary care setting (i.e., submitting the BH screening tool to the MCO, developing care coordination capacity within a primary care practice for enrollees with chronic diseases and BH co-morbidities, or co-location of BH and PH specialists).
- **Pharmacy management.** The MCO will continue to administer pharmacy benefits for prescriptions written by either MCO or ASO/MBHO contracted providers, with the exception of Methadone maintenance cost and administration. The MCO will seek consultation from the ASO/MBHO regarding policies and procedures governing the utilization and management of drug classifications for the treatment of BH conditions

Children's ASO/ adult MBHO roles and responsibilities

According to goals and objectives established by the State the MBHO for adult consumers will have primary responsibility for developing and managing the adult BH service delivery system while the ASO for child/adolescent consumers will share responsibility with the State for developing and managing the children's BH service delivery system. Core requirements are listed below. Unless otherwise stated, these requirements apply to both the children's ASO and the adult MBHO.

- **Member services.** The ASO/MBHO will develop and disseminate member materials, including a member handbook, educational and other promotional materials specific to accessing BH services, consistent with State and Federal requirements. The

ASO/MBHO will provide access to a 24-hour toll-free line to provide information to members and providers and to provide screening and referral, as necessary. The ASO/MBHO will maintain a website to disseminate information to members, providers and the community, including the toll free member service line, crisis numbers, the member handbook, the network directory, the provider manual, member and provider educational materials and other key initiatives.

- **Network credentialing and contracting.** The State will set reimbursement rates for BH network services until such time that the MBHO assumes full risk. Until that time, beginning with implementation, the ASO/MBHO will provide technical assistance to the State on reimbursement rates as well as appropriate use of financial and nonfinancial incentives for improved outcomes. Contracts initially will be held by the appropriate State agency but will transition to the MBHO at the time the MBHO assumes claims administration. The network will include all currently contracted Medicaid BH service providers. In addition, the demonstration seeks freedom of choice approval to contract with BH service providers that are currently contracted to provide non-Medicaid covered BH services that will become Medicaid covered services, including but not limited to community mental health centers, licensed marriage and family therapists and licensed clinical drug and alcohol counselors. Providers will be required to meet established credentialing standards. In order to maintain service continuity, however, a transition period will be established for new Medicaid providers who were formerly DMHAS contracted providers who fail to meet credentialing standards but have consumers in active treatment on the implementation date. The transition period will allow a limited period after implementation in order to meet educational, supervision or other performance requirements necessary for full credentialing.
- **Network development.** The ASO/MBHO will assist the state with network development, including providing technical assistance to new providers regarding enrollment in Medicaid. At the time the MBHO assumes control of the network from the State, the MBHO will provide access to all covered services through a network of qualified providers that meet state and Federal access to care requirements, including a choice of two or more providers within required access standards. This will include network development to ensure that the network is of sufficient size, scope, type and quality of providers to deliver a more comprehensive array of community-based BH services and reduce reliance on more costly, intrusive levels of care, such as inpatient and residential treatment, as has been accomplished under the CSOC.
- **Crisis response.** The MBHO for adult consumers will coordinate with the PERS system for adult consumers, including providing education and technical assistance to the crisis centers about consumer needs, model programs and best practices. The children's ASO will manage a 24-hour crisis response system, including dispatch of mobile crisis response teams consistent with the currently approved NJ State Plan. Children in crisis will be permitted to access emergency services as necessary including the PERS. The children's ASO will work with all providers to ensure that necessary linkage to the appropriate stabilization services occur and that crisis and stabilization services are available and reimbursed in a comprehensive manner,

including CSOC Mobile Response and Stabilization Services for youth with SED. The State Plan is being revised to include PERS services.

- **Utilization review.** The ASO/MBHO will conduct prior authorization and concurrent review as outlined in Table 1 and consistent with State and Federal requirements. For certain high volume/high cost services that are not subject to prior authorization or routine concurrent review requirements, the ASO/MBHO will implement a data-driven approach to target concurrent review to case and provider outliers based on utilization, cost or quality profiles. The ASO/MBHO will also conduct performance monitoring and provide necessary education and technical assistance to network providers in order to transform practice patterns to align with New Jersey's vision for an efficient, outcomes-oriented system that is grounded in EBPs and promotes recovery for adults and resilience for children and adolescents. The ASO/MBHO will be responsible for eligibility verification as part of the authorization process.
- **Medical management.** The ASO/MBHO will employ a board certified psychiatrist as a full time Medical Director and a panel of qualified licensed clinicians. The medical director will oversee authorizations under the utilization review requirements described above and administration of denials. The adult MBHO will also administer appeals and Level I grievances. The State will maintain Level II grievances/fair hearings for adults. The State also will maintain administration of Fair Hearings for Children. The ASO/MBHO will provide necessary support to the State during the fair hearing process. The medical management program will include development of an annual UM plan and appropriate tracking and trending of utilization, denials, appeals, grievances and clinical outcomes. The UM plan will include protocols to reduce unnecessary or inappropriate utilization and improve denial, appeals and grievance processes.
- **Care management** The children's ASO will continue to use the Child Adolescent Needs and Strengths (CANS) as the assessment tool for children entering the CSOC. As required under the CSOC, the Children's ASO will continue to subcontract to provide care coordination for youth with SED. The adult MBHO will be required to develop and/or implement a uniform assessment of needs. Combining assessment results with claims and other screening data, the adult MBHO will develop a predictive model and a systematic approach to risk stratification to identify high risk BH cases for participation in intensive case management (ICM). The adult MBHO must have the ability and be willing to subcontract to meet the care coordination needs of individuals in the substance abuse initiative (SAI) and behavioral health initiative (BHI). The SAI and BHI are specialty care management programs that go beyond traditional utilization and care management by incorporating return to work goals into consumer treatment plans.
- **QM.** The ASO/MBHO will establish a QM program. At the point in time either contractor assumes responsibility for claims administration and becomes a PIHP, the QM program will be consistent with the State's quality strategy and Federal requirements for quality monitoring. The QM program, including performance metrics, performance improvement projects (PIPs) and clinical outcome measures, is subject to the review and approval of DMHAS for adults. (See later discussion under Reporting, Program Monitoring and QM in this component of the Waiver).

- **Claims administration.** Upon acceptance of responsibility for claims administration, the MBHO will be responsible for adjudication of all BH claims delivered by the specialty BH network, including contracted MBHO providers as well as out-of-network BH providers needed to meet the special needs of enrollees. This will initially be on a non-risk payment basis up to the non-risk upper payment limit of 42 CFR 447.362. As noted earlier in this section, the transition of claims administration from the FFS MMIS to the Children's ASO will not occur at the outset of the waiver. As described later under "Service Delivery", the MBHO may eventually be paid on an at-risk basis. The MBHO will be responsible for eligibility verification as part of the claims administration.
- **Financial management and reporting.** The ASO/MBHO will establish a process for separately tracking service utilization and costs by funding source (i.e., Medicaid, Federal block grants, State only funds) and provide regular financial reports in compliance with State and Federal reporting requirements. The ASO/MBHO will coordinate with the State to establish a process to limit authorization and payment for services which are not entitlement services to only available resources. Upon assumption of responsibility for claims administration, the MBHO will establish a system for monitoring and reporting the completeness and accuracy of encounter data received from providers, processes for coordination of benefits with other third party payers and internal controls to prevent, detect, and reduce fraud, waste and abuse in the BH specialty network.
- **Management information systems (MIS) and electronic data exchange.** The ASO/MBHO will establish and maintain a MIS that allows the MBHO and its subcontractors to collect, analyze, integrate and report data on service utilization, service costs, claim disputes, appeals and clinical and financial outcomes. As relevant, the MIS must also meet Federal block grant reporting requirements. The ASO/MBHO also will establish and maintain electronic interfaces:
 - To send and receive information to and from DMAHS, DMHAS and DCF including, but not limited to, eligibility data and timely, accurate encounter data submissions that meet all State and Federal requirements
 - To receive encounter data and information from subcontractors and providers after assumption of responsibility for claims administration
 - To send BH claims (as relevant) and PH risk screening results to the appropriate MCO
 - To receive pharmacy claims, medical claims and BH risk screening results from each MCO
 - To send and receive data and information to and from other agencies, as required (i.e., other child serving agencies to administer cross system collaboration and measure outcomes under the CSOC)
 - Adoption of the EHR currently in use by the CSOC

All electronic interfaces will adhere to State and Federal guidelines regarding the privacy and security of protected health information (PHI) and confidentiality of client records.
- **Risk screening.** The ASO/MBHO will be required to implement a standardized protocol to identify medical needs and risk factors and refer individuals who screen positive to an appropriate medical plan provider. This will include establishing

- provider requirements to follow the established screening and referral protocols. The ASO/MBHO will collaborate with the MCOs and the State to establish a list of approved screening tools that are efficient to use and meet generally accepted standards for reliability and validity. The ASO/MBHO will also provide a separate toll-free line for MCOs and PH providers for streamlined referral and psychiatric consultation, including a process to react to emergency needs identified during screening and to coordinate with the children's mobile response teams, CSS crisis intervention and the PERS system.
- **BH-PH coordination.** As stated above, the ASO/MBHO, in collaboration with the MCOs will establish a process for identification and management of the top 5% (defined by medical expense and medical or psychosocial risk factors) of individuals with co-morbid medical and BH conditions. The ASO/MBHO will have primary responsibility to implement predictive modeling and risk stratification to identify and manage this population using pharmacy, medical and BH claims and available risk screening data. The ASO/MBHO will participate in necessary co-management of these cases with the MCO which may be done through ASO/MBHO care management staff or through provider initiatives. The adult MBHO will establish a process for dissemination of EBPs for management of chronic medical conditions that are common in SMI and SUD populations, protocols to monitor BH provider adherence to screening, referral and care coordination requirements and financial incentives for coordination activities at the BH provider level (i.e., submitting the PH screening tool, developing care coordination capacity, or co-location of BH and PH specialists).
 - **Pharmacy management.** With the exception of methadone, the MCO has primary responsibility for all pharmacy management. The ASO/MBHO will participate in the MCO's Pharmacy and Therapeutics committee and related activities. At the request of DMAHS and the MCO, the ASO/MBHO will support outreach and education with prescriber outliers specific to the use of psychotropic drugs for the treatment of BH conditions in primary care settings based on real-time pharmacy data exchange. This will include, but not be limited to, protocols to identify clients at risk for prescription drug abuse.
 - **Other administrative duties.** The ASO/MBHO will be required to perform additional administrative duties related to the management of non-Medicaid covered services and enrollees, including but not limited to eligibility, enrollment, prior authorization and concurrent review.

Shared roles and responsibilities

The MCO and the ASO/MBHO will be responsible to collaborate regarding the following:

- The design of screening and referral protocols and annual training of primary care and BH providers on the screening and referral process. Screening will occur at the point of service delivery not less than annually.
- The design of a process to identify and manage the highest risk individuals with one or more BH/medical co-morbidities with the goal of improving treatment engagement, treatment adherence, care coordination, self care and health outcomes. Care coordination protocols initially will occur at the care management level, with the goal

of increasing provider capacity to take increasing responsibility for care coordination. Care coordination may include:

- Extended assessment protocols for individuals who screen positive during BH or PH risk screening
- Assistance in accessing needed BH and PH services, including use of peers to engage and retain patients in the needed behavioral and primary care services
- Assistance in accessing needed community supports (i.e., housing, employment)
- Development and monitoring of integrated care plans for program participants
- Education, follow-up, and adherence monitoring
- Strategies to reduce inappropriate use of ED by individuals with BH conditions
- Initial and ongoing training to educate MCO and ASO/MBHO staff about co-occurring disorders and integrated care management principles to strengthen the knowledge, skill, expertise and coordination efforts within the respective outreach, UM, case management, pharmacy management and provider relations workforce
- Training of PCP and BH providers on screening, referral and co-management and training of PCPs on EBPs for BH conditions commonly treated in primary care settings
- An enrollee consent form to be used by both PH and BH providers for sharing information among primary care/specialty and BH providers.
- Development and implementation of an integrated clinical record necessary to support BH-PH coordination, in accordance with applicable privacy laws
- The design of data-driven protocols to identify and intervene with prescriber outliers specific to the use of psychotropic drugs for the treatment of BH conditions in primary care settings

Transition process and timeline

BH services for children who are currently managed under FFS, including children with addictions, will be managed under the current CSOC ASO contract, through a contract amendment, effective July 1, 2012. This administrative contract will remain through September 2014. During SFY 2012, New Jersey DMHAS will issue a Request for Proposal (RFP) to select a MBHO to manage BH benefits for adults, with an implementation date of January 1, 2013. Because the MBHO will be a PIHP per 42 CFR 438.2, the State of New Jersey is requesting a waiver of section 1902(a)(4) of the Act, which will allow New Jersey to have a single PIHP by waiving requirements at 42 CFR 438.52 for choice and at 42 CFR 438.56 for disenrollment. The state will work with CMS to ensure that the absence of choice of PIHP is not detrimental to beneficiaries' ability to access quality services. The state reserves the right to select two or more MBHOs if it is determined this is necessary to meet geographic or specialty (i.e., child/adult) needs.

As part of the RFP process, a databook will be provided that includes summary level data on penetration, utilization, average unit cost and total cost by category of service (COS). This data will be specific to the populations, services and costs moving to the CSOC ASO or the adult MBHO. In order to ensure strong management of the SMI and SED populations, the data will be aggregated by SMI/non-SMI consumers, consistent with the State's definition of SMI, and by CSOC/non-CSOC consumers. To support

strong BH-PH coordination, the databook will also include penetration, cost and utilization data on the number of adult consumers with chronic medical conditions. This will be provided by diagnosis for the most costly medical conditions for which a co-occurring BH condition is common. The data will be aggregated by individuals with and without a BH claim. The databook will cover the two most recent twelve month periods for which data is available at the time.

New Jersey DCF will conduct a readiness review of the CSOC ASO prior to the implementation date of July 1, 2012 and DMHAS will conduct a readiness review of the adult MBHO prior to the implementation date of January 1, 2013. The timing of the reviews will allow for at least a four month timeframe for implementation prior to the review and a two month timeframe for resolution of issues identified during the review. The reviews will include desk and onsite review components and address readiness in the following areas:

- The documented MIS functionality and processes, including eligibility/enrollment data load and maintenance; the DMAHS provider file data load and maintenance; the automated authorization management system, including the conversion of current authorization data and maintenance; encounter data file transfers; data exchange with the MCO; and claims administration
- Member service functionalities including the telephone call line, website, and enrollee/recipient communications
- The policies, procedures and processes governing member services including complaints, linguistic and other accommodation needs, call responsiveness and enrollee/recipient rights including use and disclosure of PHI and confidentiality of client records; network management including appointment access, network adequacy, credentialing and provider relations; UM including medical necessity criteria, clinical guidelines, prior authorization, concurrent review, outlier management, care management and care coordination; medical management including notice of action, denials, grievances, and administrative hearings; QM; claims processing; financial management, including internal budgeting and third-party liability/coordination of benefits
- An outline of the components of a care plan, how the data is stored, and what data will be transmitted to relevant providers and to the Federal government for purposes of block grant reporting
- Staffing resources, requirements (education, training, experience) and performance monitoring, by department
- Reporting capabilities, including utilization, cost, financial, quality and administrative indicators and performance metrics

Eligibility requirements

With two exceptions, all Medicaid enrollees with a mental illness or substance use disorder who meet the State's definition of medical necessity for one or more covered BH services are eligible to receive the Medicaid covered benefits summarized in the next section of this component of the Waiver. The exceptions are dual eligibles enrolled in a Special Needs Plan (SNP)/MCO and Medicaid eligible members enrolled in one of the

LTC plans described earlier. For dual eligibles, Medicare BH benefits will be carved into the SNP/MCO while Medicaid BH benefits will be carved out to the ASO/MBHO. Also for duals, coinsurance and deductibles associated with these benefits are carved into the SNP. For individuals in a NF LOC or in a home and community-based waiver under managed LTC, administration of BH services will be carved into the LTC plans.

Benefits

The ASO/MBHO shall be responsible for the provision of administrative services as defined earlier in the section ASO/MBHO responsibilities. Different members are eligible for different packages of services that will need to be tracked and provided by the MBHO. All Medicaid BH services, including inpatient and outpatient hospital services with a primary BH diagnosis and community-based services, including clinic services for BH care, are included under this contract for enrolled beneficiaries.

The ASO/MBHO will track the benefit package and funding source of each eligible member and ensure that the member is offered all eligible benefits and that the appropriate funding source reimburses for the covered benefits. Non-Medicaid services to non-Medicaid eligibles will be billed to the participating Departments through a separate invoicing process or invoiced to and paid directly by the participating departments. Payment will be subject to the limit of available funding.

Medicaid covered services will be available statewide and provided by the State or MBHO contracted providers, except that the ASO/MBHO will use the State Medicaid definition of "medically necessary services". For all modalities of care, the duration of treatment will be determined by the member's needs and his or her response to treatment. All services, for which a member is eligible, will, at a minimum, cover:

- The prevention, diagnosis, and treatment of health impairments
- The ability to achieve age-appropriate growth and development
- The ability to attain, maintain or regain functional capacity

Only Medicaid members can receive Medicaid funded BH services. Medicaid BH services only will be provided by DHS and DCF (and later MBHO) licensed and credentialed providers. If access problems are detected, the State (or the MBHO after assumption of network contracting), shall actively recruit, train, and subcontract with additional providers, including independent practitioners, to meet the needs of members.

The delivery of Medicaid, State only, Federal block grant and other funded services will appear seamless to all members, but retain separate fund accountability for audit and encounter data purposes. The MBHO may only use Medicaid funds to purchase Medicaid services for Medicaid enrollees.

During the term of the contract, the MBHO may provide services that are cost-effective alternative treatment services and programs for enrolled members under 42 CFR 438.6(e), including up to 30 days in an IMD for consumers 21 to 64. The MBHO must

perform a cost-benefit analysis for any new services it proposes to provide, as directed by the State, including how the proposed service would be cost-effective compared to the State Plan service(s). The Contractor can implement cost-effective services and programs only after approval by the State. The State will factor the cost of State Plan covered services with an adjustment for managed care efficiency due to cost effective alternative services into the rate calculations with any adjustments for managed care efficiency.

The different Medicaid and non-Medicaid benefit packages are summarized in Table 5.1. Under this waiver, the State is requesting that one service move from State only to Medicaid funding for Medicaid beneficiaries:

- Substance abuse intensive outpatient

Table 5.1 - Covered BH services by covered population ¹⁶							
Services	Plan A FamilyCare and ABD	NJ FamilyCare			Plan G (GA)	Block Grant	State Only
		Plan B	Plan C	Plan D			
Case management (Targeted) – Chronically Ill	Yes	No	No	No	Yes	X	X
Case management behavioral assistance	Plan A <21 in CSOC	<21 in CSOC	<21 in CSOC	<21 in CSOC			<21 in CSOC
Certified Nurse Practitioner	Yes	Yes	Yes	Yes	Yes		
Clinic services – mental health	Yes	Yes	Yes	Yes	Yes	X	X
Community support services	Covered under Medicaid for categorically needy as of 10/1/2011					X	X
EPSDT	Yes	Yes – exams, does not include all services identified through exam	Yes – exams, does not include all services identified through exam	Yes – well child only	NA		
Home health services	Yes	Yes	Yes	Yes	Yes		
Hospital Outpatient	Yes	Yes	Yes	Yes	Charity care		<21 in CSOC
Hospital Rehabilitation	Yes	Yes	Yes	Yes	Charity care		
Intensive in-community and behavioral assistance	Plan A <21 in CSOC	<21 in CSOC	<21 in CSOC	<21 in CSOC			<21 in CSOC
Laboratory and x-ray	Yes	Yes	Yes	Yes	Yes		
Mental health – adult rehabilitation	Yes >21	No	No	No	Yes, eff. 4/15/2011	X	X

¹⁷ When provided by an authorized provider for the diagnosis and treatment of MI or substance use disorder. Copayments and limits may apply – see Exhibit 4.1. *There is no service limit for CHIP beneficiaries under the age of 19 pursuant to the MHPAEA of 2008.*

Table 5.1 - Covered BH services by covered population ¹⁶							
Services	Plan A FamilyCare and ABD	NJ FamilyCare			Plan G (GA)	Block Grant	State Only
		Plan B	Plan C	Plan D			
Mental health inpatient - acute care hospital	Yes	Yes	Yes	Yes	Charity care		X
Mental health outpatient (other licensed practitioners)	Yes	Yes	Yes	Yes	Charity care		< 21 in CSOC
Methadone maintenance	Yes	Yes	Yes	No	Yes	X	X
Mobile response and stabilization	Plan A <21 in CSOC	<21 in CSOC	<21 in CSOC	<21 in CSOC			<21 in CSOC
Physician / PCP Practitioner	Yes	Yes	Yes	Yes	Yes		X
Psychiatric emergency services	Covered under Medicaid for categorically needy with anticipated effective date of 1/1/2012 (State Plan Amendment in development)					X	X
Psychiatric partial hospital	Yes	Yes	Yes	Yes	No	X	X
Partial care	Yes	Yes	Yes	Yes	No	X	X
Personal care assistant – mental health	Yes	No	No	No	No		X
Pharmacy – mental health/substance abuse including atypical antipsychotics, methadone, Suboxone/Subutex	Yes	Yes	Yes	Atypicals and Suboxone only	Yes		X
Psychiatric hospital inpatient – all others including State, county or private facilities	Yes <21 or >65	Yes <21 or >65	Yes <21 or >65	Yes <21 or >65	Charity care		X
Residential treatment	<21	<21	<21	No	No		<21 in CSOC
School-based services	Yes	Yes	Yes	Yes	No		
Substance abuse inpatient	Yes	Yes	Yes	Medical detox only	Through SAI only		
Substance abuse outpatient	Yes	Yes	Yes	Medical detox	Through SAI	X	

Table 5.1 - Covered BH services by covered population ¹⁶							
Services	Plan A FamilyCare and ABD	NJ FamilyCare			Plan G (GA)	Block Grant	State Only
		Plan B	Plan C	Plan D			
services				only	only		
Transportation – all other	Yes	Yes	Yes	No	No		X
Transportation – emergent (ambulance, mobile intensive care unit)	Yes	Yes	Yes	Yes	Yes		
Transportation – non-emergent (ambulance non-emergency medical assistance vehicles, livery, clinic)	Yes	Yes (for ambulance and MAVs, no for livery and clinic)	Yes (for ambulance and MAVs, no for livery and clinic)	No	Yes		
Jail diversion and reentry						X	X
PATH homeless services						X	X
Psychiatric Assertive Community Treatment (PACT)	ABD only	No	No	No	Yes, eff. 4/15/2011	X	X
Residential assisted day treatment						X	X
Sub-acute detoxification							X
Sub-acute enhanced medically managed detoxification							X
Substance abuse Intensive Outpatient					Charity care	X	X
Substance abuse day treatment/partial hospital						X	X
Substance abuse halfway houses						X	X
Substance abuse outpatient						X	X

Table 5.1 - Covered BH services by covered population ¹⁶							
Services	Plan A FamilyCare and ABD	NJ FamilyCare			Plan G (GA)	Block Grant	State Only
		Plan B	Plan C	Plan D			
Substance abuse recovery support							X
Substance abuse short term residential treatment						X	X
Substance abuse long term residential treatment						X	X
Supported employment and education						X	X
Supported housing						X	X

Service delivery (including payment mechanism)

There are four key features of the service delivery system under the BH component of the Waiver:

- The current CSOC contractor will continue to administer BH benefits for SED children and assume responsibility for administering BH benefits for the remaining children and adolescents currently under FFS. The Children's ASO will receive a bundled payment on a monthly basis for fulfilling its administrative duties, including care management of SED children. A MBHO will be selected through a competitive procurement process to manage the BH care of adult enrollees. The adult MBHO will be paid a PMPM administrative fee for the administrative functions described previously. The adult MBHO may earn an additional per participant per month (PPPM) administrative fee based on engagement of participants in the BH-PH coordination program. At any point after implementation, DMAHS may introduce utilization based incentives or transition either contract to full risk capitation. Since utilization and cost patterns are expected to shift under a more managed model, this phased approach to transition to a risk-based contract will allow the State to gather utilization and cost data which becomes the basis for developing rates for a full risk contract.
- Up to 20% of administrative fees may be subject to penalties for nonperformance. The number of performance measures tied to penalties shall not exceed twelve measures per contract (see preliminary measures in next section of this component of the Waiver). Each measure shall be clearly defined, including the measurement methodology, performance target, measurement frequency, risk allocation and reconciliation period. Each contract year, DMAHS in coordination with DMHAS and DCF may at its sole discretion approve, modify or disapprove any or all performance measures or supporting methodology.
- Medicaid claims will be paid on a FFS basis, initially using the rates established for the Medicaid FFS program although during and after implementation the ASO/MBHO will be asked to make recommendations for and prospectively implement adjustments to reimbursement rates for community-based services. Separate encounters and reimbursement rates subject to the prospective payment system (PPS) may be established for BH services delivered through a FQHC.
- Providers must be registered as Medicaid providers and contracted with the State (or MBHO) to provide services within their approved scope of practice. Utilizing the freedom of choice waiver, the State will contract with providers and limit the size of the provider network based on need. Beneficiaries may choose the provider they prefer from a list of contracted providers. Once the MBHO assumes risk, providers must contract with the MBHO.

The anticipated functions of the ASO/MBHO, the performance targets the entity is expected to achieve, and special coordination and management requirements for BH-PH integration are described elsewhere in this component of the Waiver.

Reporting, program monitoring and quality management

Progress updates. During the first year of implementation of the Waiver, the State will submit regular progress updates to CMS regarding the selection and implementation of the adult MBHO and transition of children and adolescents from fee for service to the children's ASO.

Reporting. The ASO/MBHO will be required to submit both financial and program reports to the level of detail required by the State (by funding resource including Federal block grant requirements, person level) in the following areas:

- Quarterly financial statements and reports
- Annual financial statements and reports (audited and unaudited)
- Monthly dashboard reports of BH claims by COS, including penetration, utilization, cost per case and performance targets and an analysis of the data with planned actions as needed
- Quarterly reports of all required measurement elements to assess ASO/MBHO performance and outcomes for the BH population
- An annual QM report that summarizes planned initiatives, associated results and includes a discussion of trends, issues, notable accomplishments and areas of improvement, including findings from performance improvement activities, participant surveys, review of plan grievance process results, State fair hearing information, and other monitoring and evaluation activities
- Quarterly care management reporting by program (ICM, BH-PH coordination) to include the number of at risk consumers identified as well as reach, engagement, and program completion rates
- Annual care management reporting by program on outcomes including, as appropriate, improvements in medication adherence, reductions in ED utilization, reduction in hospital admissions, improved health status and claims savings

Program monitoring. DMHAS will prepare a readiness review tool and a readiness review will be completed prior to implementation (See prior section on readiness review). The adult MBHO must successfully complete all elements of the readiness review before it commences live operations. The children's ASO must successfully complete all elements of the readiness review before it accepts children transitioning from fee for service.

DMHAS and DCF, will also prepare a manual for conducting monitoring on a quarterly and annual basis. This will include quarterly and annual monitoring meetings with the ASO/MBHO to review quarterly and annual reports and completion of a compliance review no less than every three years. A compliance officer will be designated to monitor contract compliance on an ongoing basis.

QM. The ASO/MBHO QM requirements include:

- Developing and submitting a QAPI to DMHAS for review and approval
- Developing and submitting a UM Plan, including prior authorization requirements, processes, and timeframes and any other UM strategy proposed to DMHAS for review and approval
- Achieving URAC or NCQA accreditation as a utilization review organization within 12-24 months
- Closely monitoring and reporting BH specific HEDIS metrics and other performance targets against targeted benchmarks
- Operating a first level complaints and grievances mechanism (See prior separate discussion)

The ASO/MBHO will be required to submit QAPI and UM plans to DMHAS or DCF, as appropriate, for review and approval 45 days prior to implementation and annually thereafter. The MBHO also must implement an automated system that tracks UM actions, generates required notifications to beneficiaries and providers, and includes all relevant records for each case.

DMHAS and DCF will make a preliminary selection of HEDIS and other performance measures with the understanding that the underlying methodology may require adjustment and measures may be updated on an annual basis to reflect progress in achieving program goals. The preliminary list of measures includes:

- BH-PH coordination program referral rates (for MCO)
- BH-PH coordination program engagement rate (for ASO/MBHO)
- ICM program participation rates
- Follow up after hospitalization for mental illness
- Inpatient readmission rates
- Antidepressant medication management
- Increase in community tenure (21 years of age and over)
- Reduction in residential cases (under 21 years of age)
- Percent of dollars spent on community-based services
- Initiation and engagement in community-based services

Psychiatric Emergency Rehabilitation Services

For all Medicaid and CHIP covered populations covered by the Comprehensive Waiver, the State will contract with specific providers of PERS. A Rehabilitation SPA will be submitted to CMS to cover this service. The service will be available on a FFS basis until the MBHO is functional and at that time will be managed by the MBHO..

Service description

The PERS will be provided to a person who is experiencing a BH crisis, designed to interrupt and ameliorate the immediate crisis experience and provide an assessment, immediate crisis resolution and de-escalation; and referral and linkage to appropriate services in an effort to avoid more restrictive levels of treatment. The goals of PERS are symptom reduction, stabilization and restoration to a previous level of functioning. All

activities must occur within the context of a potential or actual BH crisis. The Psychiatric emergency rehabilitation service is a face-to-face intervention and can occur in a variety of locations, including the community locations where the person lives, works, attends school and/or socializes as well as an ED or clinic setting.

Specific services include:

- An assessment of risk and mental status, as well as the need for further evaluation or other mental health services. It includes contact with the client, family members or other collateral sources (e.g. caregiver, school personnel) with pertinent information for the purpose of an assessment and/or referral to other alternative mental health services at an appropriate level
- Short-term PERS including crisis resolution and de-briefing
- Follow-up with the individual, and as necessary, with the individual's caretaker or family member(s)
- Consultation with a physician or other qualified providers to assist with the individual's specific crisis

Certified assessors shall assess, refer and link all Medicaid and CHIP eligible individuals in crisis to appropriate mental health services. This shall include but not be limited to performing any necessary assessments; providing crisis stabilization and de-escalation; development of alternative treatment plans; consultation, training and technical assistance to other staff; consultation with the psychiatrist; monitoring of consumers; and arranging for linkage, transfer, transport or admission as necessary for Medicaid eligible individuals at the conclusion of the PERS.

PERS specialists provide crisis intervention counseling, on and off-site; monitor individuals in crisis; and provide referral and linkage, if indicated. PERS specialists who are nurses may also provide medication monitoring and nursing assessments. Psychiatrists perform psychiatric assessments, evaluation and management as needed; write prescriptions and monitor medication; as well as supervise and consult with program staff.

Children with SED 1915(c) and 1915(i)-like concurrent authority for System of Care Program under the Demonstration

Services for Children with SED

New Jersey recognizes that a number of children have SED diagnoses that place them at risk for hospitalization and out-of-home care. The New Jersey Children's System of Care seeks to target children in a manner that will result in:

- Improved Emotional Stability
- Maintain Children In Communities
- Reduce Residential Lengths Of Stay
- Reduce Acute Hospital Admissions And Re-admissions
- More Stable Living Environments For Children

- Improve Educational And Social Functioning
- Reduced Criminal Activity For Children Involved In Care

NJ will utilize 1915(c) and 1915(i)-like authorities under the 1115 to cover children meeting a SED Level of Need and a hospital LOC in a home and community-based setting.

Level of need and level of care and financial eligibility

All children entering CSOC will be screened using the CANS assessment.

- Children meeting a LON of SED/acute stabilization will be eligible up to 150% of the FPL using institutional eligibility criteria. Parental income will be disregarded and the child will be considered a family of one.
- Children meeting a hospital LOC will be eligible up to 300% of the FBR using institutional eligibility criteria. Parental income will be disregarded and the child will be considered a family of one.

New Jersey uses the federal definition of serious emotional disturbance.

To be functionally eligible for the 1915(i)-like SOC program, one of the two criteria must be met:

1. Acute Stabilization – all of the following criteria are necessary for participation in this LOC.
 - A. The child/youth is between the ages of 5 and 21. Special consideration will be given to children under age five.
 - B. The DCBHS Assessment and other relevant information indicate that the child/youth needs the Mobile Response Stabilization Services LOC.
 - C. The child/youth exhibits risk behaviors.
 - D. The child/youth exhibits behavioral/emotional symptoms.
 - E. The parent/caregiver/guardian capability is limited at this time.
 - F. The child/youth is at risk of being placed out of his/her home or present living arrangement.
 - G. The child/youth requires immediate intervention in order to be maintained in his/her home or present living arrangement.
2. Severe Emotional Disturbance (SED) - The child/youth/young adult must meet A, B, C, D, E, and F:
 - A. Must be between the ages of 5 and their 21st birthday. Special consideration will be given to children under 5.
 - B. Has been currently assessed, or at any time during the past year has been assessed to have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within DSM-IV-TR with the exception of other V codes, substance use, and developmental disorders, unless these disorders co-occur with another diagnosable disturbance. All of these disorders have episodic, recurrent, or persistent

features; however, they vary in terms of severity and disabling effects. The diagnosable disorder identified above has resulted in functional impairment that substantially interferes with or limits the youth's role or functioning in family, school, or community activities. Functional impairment is defined as difficulties that substantially interfere with or limit the youth in achieving or maintaining developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. Functional impairments of episodic, recurrent, and continuous duration are included unless they are temporary and expected responses to stressful events in the environment. Youth who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition.

- C. Be in need of an array of mental health services. Specifically, this youth's clinical needs require more than psychotherapeutic services.
- D. The child/youth and his or her family or caregiver requires face to face assistance in obtaining or coordinating treatment, rehabilitation, financial and/or social services, without which the child/youth could reasonably be expected to require more intensive services.
- E. The DCBHS Assessment and other relevant information indicate that the child/youth requires at least a moderate level of case management.
- F. The person(s) with authority to consent to treatment for the youth voluntarily agrees to participate. The assent of a youth who is not authorized under applicable law to consent to treatment is desirable but not required.

The child/youth/young adult may include any of the following characteristics, but it is not a requirement:

- G. Needs or receives multiple services from state/private agencies, special education, or a combination thereof requiring a care planning team to coordinate services from multiple providers or entities.
- H. Is being discharged from a CCIS, other inpatient psychiatric hospitalization, other institutional or community base treatment facility and is returning to a community setting.
- I. Has not demonstrated successful response to previous community based clinical interventions.
- J. Is potentially at risk for OOH placement or psychiatric hospitalization.
- K. Is awaiting an out of home placement for a group home or higher Intensity of Service on Youth Link.
- L. Is court ordered to receive case management services.

M. Is transitioning from the child service system to the adult service system.

Any of the following criteria is sufficient for exclusion from the SOC 1915(i)-like program.

- N. The person(s) with authority to consent to treatment for the youth refuses to participate.
- O. Current assessment or other relevant information indicate that the child/youth/young adult can be safely maintained and effectively supported at a less intensive LOC.
- P. The Behavioral symptoms are the result of a medical condition that warrants a medical setting for treatment as determined and documented by the child's primary care physician and or the CSA Medical Director.
- Q. The child/youth has a sole diagnosis of Substance Abuse and there are no identified, co-occurring emotional or behavioral disturbances consistent with a DSM IV Axis I Disorder, which would potentially benefit from Youth Case Management services.
- R. The child/youth's sole diagnosis is a Developmental Disability that may include one of the following:
 - a. The child/youth has a sole diagnosis of Autism and there are no co-occurring DSM IV Axis I Diagnoses, or symptoms/behaviors consistent with a DSM IV Axis I Diagnosis.
 - b. The child/youth has a sole diagnosis of Intellectual Disability/Cognitive Impairment and there are no co-occurring DSM IV Axis I Diagnoses, or symptoms/behaviors consistent with a DSM IV Axis I Diagnosis.
 - c. The child/youth has a diagnosis of autism and mental retardation and there are no co-occurring DSM IV Axis I Diagnoses, or symptoms/behaviors consistent with a DSM IV Axis I Diagnosis.
- S. The child, youth, or young adult is not a resident of New Jersey. For minors who are under 18 years of age, the residency of the parent or legal guardian shall determine the residence of the minor.

Any of the following criteria is sufficient for discharge from the SOC 1915(i)-like program.

- T. The current assessment and other relevant information indicate that the child/youth no longer meets criteria for the SOC as listed above.
- U. Youth is lost to contact for 2 month duration or moved out of state.
- V. The child/youth's documented ISP goals and objective have been substantially met.

- W. Consent for treatment is withdrawn by the person(s) with authority to consent to treatment.
- X. The person(s) with authority to consent to treatment has not maintained compliance with the current treatment plan and/or services which have been put in place.

A screener will utilize the CANS algorithm developed by Dr. John Lyons which has been cross-walked to the State's LOC hospital criteria and the State's Level of Need SED and acute stabilization criteria as listed above. The screener will verify that the child meets one of the levels of need outlined under the 1915(c) or 1915(i)-like authorities. The CANS has 7 Domains: Risk, Behavioral/Emotional Needs, Life Domain Functioning, Child Strengths, Caregiver Needs and Caregiver Strengths

Eligibility

- NJ will use the Institutional Medicaid financial eligibility standards.
- Children from age of a SED diagnosis up to age 21 will be eligible for the services.
- All children served under this authority will be otherwise eligible for Medicaid and will receive the full benefit package under Medicaid for which they are eligible.
- The child must meet an hospital LOC up to 300% of FBR or an SED LON up to 150% FPL
- For the purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, step parent, legal guardian, siblings, relatives, grandparents, or foster parents.

Acuity

- Medicaid clients who enroll in the 1915(c)-like hospital waiver or 1915(i)-like SED LON HCBS program will receive services through the NJ System of Care including any services under the SOC HCBS program.
- New Jersey public schools are funded to provide certain autism-related services during school hours. Because this authority is a 1915(c)-like authority at the ICF/MR LOC, this funding may not be utilized for services covered under IDEA and in a child's IEP.

Services

- Each child meeting the functional and financial criteria will be enrolled in the Coordinated System of Care and receive Care Management including POC development through a Child/Family Team through a UCM, a CMO, a Youth Case Management entity (YCM) or a Mobile Response Stabilization Services Agency.
- All children enrolled under the 1915(c)-like and 1915(i)-like benefit will be eligible for all State Plan services.

If a child enrolled under the 1915(c)-like and 1915(i)-like program lives in residential treatment, the Child/Family team will be responsible for ensuring that the residential setting is licensed residential settings and demonstrates a home and community

character. A home and community environment is characterized as an environment like a home, provides full access to typical facilities in a home such as a kitchen with cooking facilities, small dining areas, provides for privacy, visitors at times convenient to the participant and easy access to resources and activities in the community. Group homes are expected to be located in residential neighborhoods in the community. Meals are served family style and participants have access to community activities, employment, schools or day programs. Each facility shall assure to each participant the right to live as normally as possible while receiving care and treatment. Home and Community character will be monitored by each Child/Family Team through ongoing monitoring. Child/Family teams will monitor the community character of the group home during regular monthly monitoring. Results of the monitoring will be reported to each CMO/UCM. Child/Family teams continue to offer participants choice of smaller facilities. The CMS/UCM will monitor facilities over 6 beds to assure the home and community environment. Providers found to be out of compliance will be given a time line in which to come into compliance. All residential treatment facilities for children under this program will not exceed 8 beds.

The State Plan services for enrolled children are eligible include all Medicaid State Plan services including but not limited to the following:

- Mental Health/Behavioral Health Screening, Evaluation & Diagnostic Services
- DCBHS Designated Multi-System Assessments
- Mobile Response and Stabilization Management (MRSS) Services provided by a MRSS entity
- Inpatient Psychiatric Hospital Services provided by Certain Psychiatric Hospitals (Contact the provider. Basically limited to those NJ hospitals which are enrolled as a psychiatric hospital and who are precluded from participating in the state's hospital charity care program)
- Partial Care/Partial Hospitalization
- Intensive In-Community Services
- Mental Health Clinic Services
- Outpatient mental health services, including psychiatric, psychological services or advance practice nurse services, Individual, Group and Family Therapy, provided in either a practitioner's office, a clinic or an outpatient department of a hospital
- Residential treatment
- Medication Management
- Medical transportation

Services covered under the 1915(c)-like and 1915(i)-like benefit will include a variety of supportive services not otherwise covered under the State Plan including:

- Behavioral Assistance Services including services resulting from a co-occurring MR/DD diagnosis
- Independent Living/Skills Building,
- Short term respite in-home or in the community,
- Youth Support and Training,

- Parent Support and Training
- Out-of-home short term Crisis Stabilization Respite in a facility that is not an IMD.
- Monitoring (not including Medication)
- Out of Home Residential Treatment including Treatment Homes, Group Homes, Psychiatric Community Residences meeting the requirements of home and community character.
- Non-medical transportation of children and families for activities on plans of care.

Children in Psychiatric Residential Treatment Facilities (PRTFs) or other IMDs of greater than 16 beds are not eligible for this 1915(c)-like or 1915(i)-like program.

Reimbursement Rates

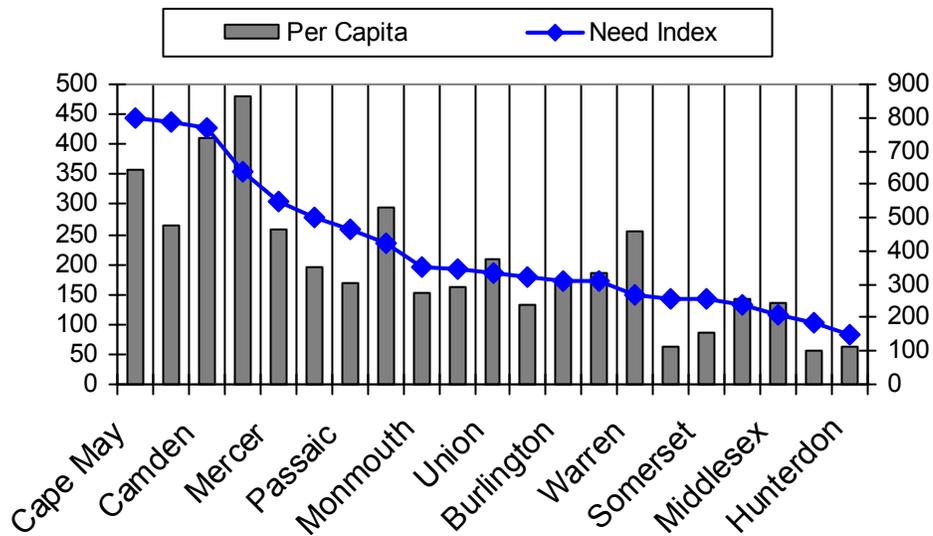
Rates will be established through a fee schedule developed by the State of New Jersey. The State will operate this program with assistance of the children’s ASO contractor where the MMIS pays claims on a FFS basis. Transition to a non-risk or risk MBHO will be explored later as described elsewhere.

Evaluation –

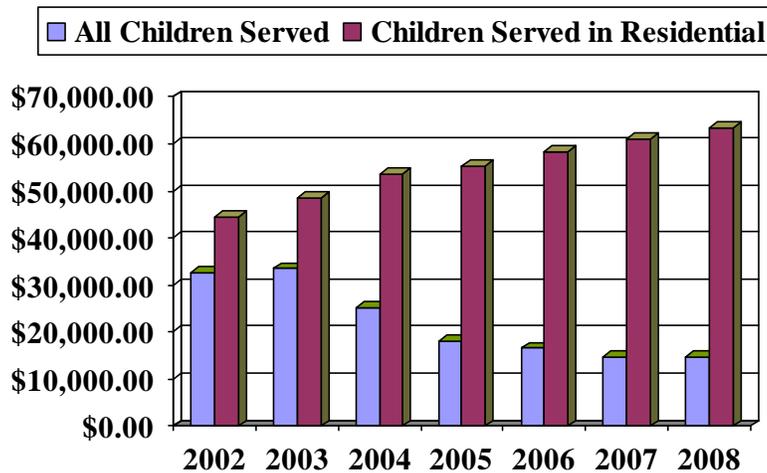
New Jersey will examine the overall number of children placed in residential care with an SED diagnosis compared to children with an SED diagnosis receiving community based services.

New Jersey will examine the average cost per child compared to the need level as measured by the CANS assessment tool. The 2008 baseline is below.

Comparison of FY '08 Consolidated Per Capita Spending to Needs Index by County Shows Improved Fiscal Equity



Average Annual Cost per Child Served Continues to Decrease, Even as Residential Costs Grow



1915(i) Medication Assisted Treatment Initiative

Under a 1915(i) like state plan, the State will implement an expansion to the MATI services for opiate dependent State residents with incomes up to 150% of the FPL and clinical criteria.

Program eligibility

Consumers applying for services under the 1915i waiver will be screened by an independent assessor to determine if they meet the following program eligibility criteria (These are the same as the current MATI criteria):

1. Be a resident of New Jersey and 18 years old
2. Have household income below 150% of FPL
3. Have a history of injectable drug use
4. Test positive for opiates or have a documented one year history of opiate dependence. Individuals who have recently been incarcerated or in residential treatment may not test positive for opiates.
5. Be able to provide proof of identification to prevent dual enrollment in medication-assisted treatment
6. Not currently be enrolled as a client in an OMT program or a client under the care of a physician prescribing Suboxone
7. Not have been enrolled as a client in an OMT program or a client under the care of a physician prescribing Suboxone within the past thirty (30) days

In addition, consumers must be assessed by the independent assessor to establish eligibility based on one or more of the functional impairment criteria:

1. Diagnosed with Psychiatric Disorder at least once in their lifetime by a licensed mental health professional
2. One or more chronic medical conditions (i.e., COPD, diabetes, HIV, Hepatitis C, asthma, etc)
3. Homeless or lacking stable housing for one year or longer
4. Unemployed or lacking stable employment for two years or longer

An estimated 4,839 individuals are expected to qualify.

Services

Services available under the program include opiate medication assisted treatment and psycho social supports delivered through mobile and fixed site services.

1915(i) SMI

The State is evaluating the feasibility of adding certain ambulatory mental health services for individuals with serious mental illness (SMI) through a 1915(i)-like authority under the 1115 demonstration. Upon complete analysis of the financial benefit and exposure the State would like to reserve the right to amend this demonstration accordingly to include those services which may or may not include some or all Medicaid benefits for individuals not otherwise eligible for the full Medicaid benefit package.

Managing supports for intellectual and developmental disabilities

Today, individuals with I/DD residing in the community receive acute/medical services and behavioral care through the four contracted MCOs . This arrangement has been in place since 1995. There will be no change in acute/medical services for individuals with I/DD under the Comprehensive Waiver. They will continue to receive acute/medical care through the MCOs. There will be a change for BH, and at this juncture, New Jersey anticipates that long-term community and institutional supports will remain FFS until the infrastructure for managed care for these long term supports is in place within DDD.

DDD currently serves approximately 42,000 people including those under the HCBS Community Care Waiver, State-funded programs and State Developmental Centers as shown in Table 5.2 below. Medicaid eligible persons with I/DD residing in the community receive acute/medical and BH care services through the four MCOs contracted with DMAHS. LTC supports are provided through DDD within the Department of Human Services. Some of these services are supported by Medicaid through state plan and waiver services and some are not.

Table 5.2 DDD population as of December 31, 2010

Residence Type	Number of Individuals
Community	
Own home	29,704
Group home (This number includes 142 in Parent and Friends Association homes)	4,762
Skill development/FamilyCare	1,089
Supervised apartment	1,264
Supported living/supported housing	707
Boarding home	50
Unsupervised apartment	79
Non DDD funded placements (DCF, Juvenile Justice, Corrections, etc.)	538
Community total	38,193
Developmental Center	
Greenbrook	92
Vineland	395
North Jersey	386
Woodbine	471
New Lisbon	404
Woodbridge	370
Hunterdon	541
Developmental Center total	2,659
Other	
State psychiatric hospital (SPH)	43
Skilled NF	977
Private ICF/MR	58
Other total	1,078
Purchase of Care	
Purchase of Care	796
Purchase of Care total	796
Grand total	42,668

As a preparatory step for the Comprehensive Waiver, DMAHS and DDD conducted an assessment of LTC supports and whether a managed care framework was appropriate. For a number of reasons, both DMAHS and DDD concluded that the basic infrastructure for managed LTC was absent. As a consequence, the five years of the Comprehensive Waiver will focus on preparing DDD for managed care. All DDD Medicaid programs and expenditures will be incorporated into the Comprehensive Waiver.

The rationale for leaving the I/DD population outside of managed care for long term supports (for the present time) includes:

- A significant amount of Medicaid covered services for Medicaid eligibles are provided outside the Medicaid program
- Most I/DD Medicaid claims are paid outside of the MMIS on one of many financial systems in use within the Division
- Providers are paid under purchase of care agreements and receive mainly cost based reimbursement; they are unaccustomed to operating under fee schedules
- The consolidated financial data required for establishing actuarially sound rates is absent
- There is no robust assessment of need that can be used as the basis of eligibility for services through the DDD, LOC for ICF/MR, LOC for HCBS and resource allocation
- There is a waiting list for community based services through the CCW (DDD's only approved waiver)
- Staff currently spend a significant amount of time making children eligible for services that are not available until they are adults
- In 2011, DDD is paying for approximately 779 individuals placed out-of-state for services available in-state (out-of-state placements are declining since 2009 when out-of-state placements totaled 632)
- DDD experiences significant delays in enrollment into the CCW Waiver

Given these infrastructure limitations, DDD will focus on six activities under the Comprehensive Waiver:

- Resolving eligibility and enrollment issues
- Rebalancing facility and community based care
- Pursuing opportunities for enhanced match
- Integrating financial systems within MMIS and its data warehouse
- Developing statewide rate schedules that are not cost based
- Adopting an available off-the-shelf assessment tool or developing a NJ-specific tool

Resolution of eligibility and enrollment issues

While delays in LTC eligibility decisions (particularly for those seeking 1915(c) waiver services) were observed across programs for elderly, physically disabled and I/DD individuals, the delays for the I/DD population were much more significant. While a number of corrective measures were identified, the single most important one is to limit State funded services to individuals with a Medicaid denial for reasons other than failure to comply. Most states have adopted this policy. NJ intends to apply this policy to both new and existing members served beginning October 1, 2011.

The following activities were also identified to improve timeliness:

- Use the PA1C to protect the application date
- Examine the DDD staff's function of collecting application information and its usefulness in expediting eligibility

- Treat each case as potentially financially eligible. DDD has decided to perform the clinical/LOC determination, present choice options required by regulation, confirm the completion and submission of the financial application, develop a POC and initiate waiver services. Once financial eligibility is complete, the State can claim federal financial participation (FFP) back to the application date or when all requirements for enrollment were completed
- Once a comprehensive assessment is adopted, seek SSA approval for the disability determination
- Terminate application processing for children until age 16
- Pursue claiming FMAP for out-of-state placements
- Provide for prior quarter coverage of HCBS under the waiver

Balance facility and community-based care

Consistent with the requirements of the Olmstead decision, a key objective of the Comprehensive Waiver is to reduce the use of institutional placement for people with intellectual and developmental disorders and increase community placement and support for those individuals. Two significant initiatives are aimed at balancing – implementation of a Supports Waiver and development of affordable housing alternatives.

The first initiative directed at balancing is submission, by Fall 2011, of a Supports Waiver designed specifically to support adults in their homes and eventually eliminate waiting lists. In order to ensure that services are available as soon as possible, the State will submit the Supports Waiver as a 1915(c) and incorporate comparable provisions in the Comprehensive Waiver. The State is committed to reinvesting federal funds into services. The Supports Waiver will serve 1,260 adults in Year 1 and increase to 3,780 unduplicated individuals by the third year. The proposed service package includes but not limited to:

- Day habilitation
- Respite
- Behavior supports
- Supported employment
- Support coordination
- Assistive technology
- Environmental and vehicle modification

DDD will also amend the CCW waiver to incorporate behavioral supports which are currently provided with state funds.

The second initiative provides affordable housing to more than 600 individuals with I/DD in renovated homes over the next two years. Under the plan, municipalities can buy three- or four-bedroom ranch-style homes and two-bedroom condominiums in their communities. The homes will be renovated to provide the necessary accommodations. The State will act as the middleman, supplying a list of approximately two dozen

developers and suppliers from whom towns can choose to provide the renovations using tax credit financing and low-interest loans.

Pursue opportunities for enhanced match

In addition to the adoption of programs that provide Medicaid covered services to Medicaid eligible members, DHS/DDD and DMAHS will seek enhanced federal match from the Balancing Incentive Payments provisions under ACA. Initial estimates suggest that NJ will be eligible for a two percent enhancement.

DDD will also seek federal match on out-of-state placements and continue return of New Jersey citizens. Currently the State only claims the FMAP on services provided in Pennsylvania. Two other initiatives for individuals with I/DD and MI and for children with pervasive developmental disorders are described below.

Development of statewide prospective rate schedules that are not cost based

The State is one of two states that continue to reimburse community-based providers based on costs (North Dakota is the other). In order to prepare the provider network for managed care, the network must first have a successful experience operating under a statewide fee schedule. Development of prospective rates is a major task. NJ does have one key element necessary for rate development – cost reports. However, based on rate development activities in other states, often cost reports must be supplemented by a survey to obtain other information, such as wages and productivity.

Cost is not the exclusive source of information in rate development. Rather, independent sources such as the Bureau of Labor Statistics (BLS) are also necessary to determine appropriate wages and employee related expenses for comparable employee categories in the State.

Adopting an off the shelf assessment available and/or developing a New Jersey tool

DDD does not currently have a multi-purpose assessment tool that is independently administered. At a minimum, DDD needs an assessment tool/process that can be used to:

- Determine eligibility for DD services
- Determine LOC for both facility and HCBS
- Serve as the foundation for resource allocation based on assessed need
- Provide input into care planning

DDD will consider adopting an existing tool such as the Supports Intensity Scale, which is currently in use in 20 states. Substantially more effort would be required to develop a State-specific assessment document and process.

Intellectual and development disabilities with dual mental health diagnoses 1915(c)-like pilot program

The State will develop a 200-slot 1915(c)-like program for children with I/DDs and a co-occurring mental illness that meets the state mental hospital LOC. The primary goal of the DD/MI program is to provide a safe, stable, and therapeutically supportive environment in the community for children and young adults with significantly challenging behavior needs.

The objectives of the DD/MI program are to:

- Ensure the safety of the child or young adult and all participating staff by providing individual specific training and on site technical supports
- Decrease elopement risk and safeguard the environment by providing one-time funds to ensure safety
- Keep families united by placing the child or young adult in close proximity to the individual's family or guardian(s) in the least restrictive setting
- Reunite the child or young adult with the family or guardian whenever possible
- Increase infrastructure to serve the children in the State

Children served by the DD/MI waiver

The target population for this waiver includes children with a co-occurring DD and MI. Children are able to enter the waiver program from the age of diagnosis until their 21st birthday. The institutional alternative for the Waiver program is a state mental hospital LOC.

Children will reside at home, in foster care homes or in group homes with four or fewer beds. The group homes will have a home-like environment that includes a kitchen with cooking facilities and small dining areas, and provides for privacy, visitors at times convenient to the participant and easy access to resources/activities in the community. Group homes are expected to be located in residential neighborhoods. Meals are served family style and participants have access to community activities, employment, schools or day programs. Each group home will be required to ensure that each participant has the right to live as normally as possible while receiving care and treatment. The home and community character of each home will be monitored on an ongoing basis by DDD.

Eligibility requirements for services

To be eligible for the DD/MI waiver services, a child must receive a DD diagnosis by a licensed medical doctor or Ph.D. psychologist using an approved screening tool. Once a child has been referred to the Functional Eligibility Specialist (Specialist) for a LOC (functional) determination, the Specialist will complete the assessment within five business days from the date of the initial referral. The child will be assessed for a LOC determination to establish functional eligibility for waiver services.

If a child meets the criteria for the HCBS DD/MI Waiver, the child will receive a letter from the Program Manager informing them they have been placed on the Proposed Waiver Recipient List and his/her numerical position on the list. When a slot in the Waiver program becomes available, the Program Manager will contact the family to offer them the position. Individuals on the waiting list will be served based on highest acuity first rather than on a first-come, first-served basis.

If the child was on a waiting list for longer than six months, and a slot becomes available the Specialist has five business days to schedule a home visit and complete the functional eligibility assessment to verify that the child continues to meet the program's established criteria. If a child is found to be eligible for DD/MI Waiver services, the Specialist will aid the child and the child's family in completing the Medicaid application (if necessary) and gaining access to needed medical, social, educational and other services through the provision of information, referral and related activities. Throughout provision of all information and referral services, the Specialist will promote and ensure participant choice. At this point, the Specialist will refer the child and family to a Service Coordinator

The Service Coordinator has five working days to contact the family and begin to develop the plan of care (service plan).

The Specialist is required to perform an annual assessment utilizing the LOC assessment for each year that the child receives HCBS DD/MI Waiver services. If a child no longer meets a hospital LOC, they will be transitioned off the program.

Services provided through the DD/MI Waiver

Services provided in the HCBS DD/MI Waiver but not limited to include:

- Intensive Behavioral Support (as recommended by the Dual Diagnosis Task Force) is intended to assist the family and paid support staff or other professionals to carry out the IBP/POC that supports the child's functional development and inclusion in the community. This is monitored by a BS who will:
 - Assess the child and family's strengths and needs
 - Develop the IBP/POC
 - Provide training and technical assistance to the family and paid support staff in order to carry out the program
 - Monitor the child's progress within the program and the family's and other providers' implementation of the program
- Intensive In-home and Community Individual Support services assist the child with a DD/MI in acquiring, retaining, improving and generalizing the self-help, socialization and adaptive skills necessary to function successfully in the home and community. Intensive Individual Support workers will provide services directly to the child through evidence-based and data driven methodologies. They will be trained and work under the direction of the BS.
- Respite Services provide temporary direct care and supervision of the child. The primary purpose is to provide relief to families of a child with a DD/MI. This can

include assistance with normal activities of daily living and support in home and community settings.

- Parent Support and Training providers promote engagement and active participation of all family members in all aspects of the treatment process. This involves assisting the family in acquiring the knowledge and skills necessary to understand and address the specific needs of the child. These services will enhance the family's expertise by providing specific problem solving skills, coping mechanisms and help in developing strategies for the child's maladaptive behaviors and behavior management.
- Out of home supports

Children with Pervasive Developmental Disabilities 1915(c)-like pilot program

The State recognizes that a number of individuals with Medicaid coverage have PDD diagnoses and are unable to receive Pervasive Developmental Disabilities-related habilitation services through the Medicaid State Plan that are available to individuals with private health insurance in the State. The State also recognizes that research shows that the most dramatic results in treatment occur during the pre-adolescent years. NJ will utilize 1915(c)-like authorities under the 1115 to cover 200 children meeting a Pervasive Developmental Disability LOC at the ICF/MR LOC.

Level of need

Receive a Pervasive Developmental Disability diagnosis by a licensed Medical Doctor or Ph.D. Psychologist using an approved specific screening tools including:

- ABAS – Adaptive Behavior Assessment System II
- CARS – Childhood Autism Rating Scale
- DDRT – Developmental Disabilities Resource Tool
- GARS – Gilliam Autism Rating Scale
- ADOS – Autism Diagnostic Observation Scale
- ADI – Autism Diagnostic Interview-Revised
- ASDS – Asperger Syndrome Diagnostic Scale

A screener utilizing the State's current DDRT, which has been cross-walked to the State's LOC ICF/MR criteria, will verify that the child meets one of the levels of need outlined under the 1915(c) authority. Completion of the functional assessment tool will result in a score that determines the dollar amount of services that will be available for each child.

The State is projecting that the maximum annual expenditure for a child with the highest need will be equal to \$27,000. Levels below that amount will be capped at three levels of \$9,000; \$18,000; and \$27,000 – a child in the lowest level would be eligible for services up to \$9,000 annually; a child in the next level would be eligible for services up to \$18,000 annually; and a child in the next level would be eligible for services up to \$27,000 annually.

Eligibility

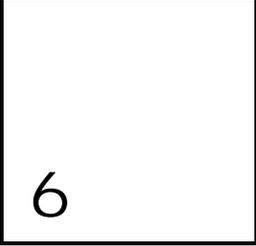
- NJ will use the Community Medicaid and CHIP financial eligibility standards.
- Children from age of a PDD-related diagnosis through age 12 will be eligible for the services.
- All children served under this authority will be otherwise eligible for Medicaid or CHIP and will receive the full benefit package under Medicaid and CHIP for which they are eligible.
- For the purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, step parent, legal guardian, siblings, relatives, grandparents, or foster parents.

Acuity

- Administration of the DDRT tool will result in a score that is used to determine the dollar amount of services available to the child. The intent is to provide a higher dollar amount of services to a child who has more functional needs, but still provide some smaller amount of services to a child with fewer functional needs who also has a PDD diagnosis.
- State private health insurers are mandated to provide up to \$36,000 of autism services annually to each covered individual with PDD. The State will exhaust third party liability first. The State does not anticipate covering more than \$27,000 for any child under the 1915(c)-like authority.
- Medicaid clients who enroll in the 1915(c)-like hospital waiver program will also receive services through the NJ FamilyCare/Medicaid program including any services under the 1915(c) and not available under the 1915(c) for which they are eligible.
- State public schools are funded to provide certain autism-related services during school hours. Because this authority is a 1915(c)-like authority at the ICF/MR LOC, this funding may not be utilized for services covered under Individuals with Disabilities Education Act (IDEA) and in a child's Individual Education Plan (IEP).

Medical necessity and developmental disabilities

The State will ensure that for all covered Medicaid services, the presence of a DD diagnosis, covered under the DSM IV (soon to be DSM V) criteria will not be excluded from the definitions of medical necessity and EPSDT. Services already covered under the Medicaid State Plan such as inpatient and outpatient hospital, physician, clinic, pharmacy, other licensed practitioner, home health, personal care, occupational and speech therapy will not exclude coverage for children with a DSM IV diagnosis, including DD. For example, an individual in crisis accessing ED services will not be determined to not meet medical necessity criteria solely because of the existence of a DD diagnosis. A child who needs a personal care attendant to attend a dental visit will not be excluded from medical necessity due to the presence of a DD diagnosis. For rehabilitation services, medical necessity requires that the service not be habilitative in nature, that the individual is regaining or maintaining a skill that he/she already had, and that the individual has a diagnosis or need in addition to the DD. School-based services are not included in the Comprehensive Waiver. .

6

Rewarding member responsibility and healthy behavior

There is an increased emphasis on the role of preventive health in targeting the underlying causes of chronic disease since the passing of the ACA in March 2010. Keeping people healthy is an important goal of this legislation. One way to reach that goal is to encourage all Americans to make better choices about diet, exercise and smoking to help avoid the future development or progression of conditions such as hypertension, hyperlipidemia, heart disease, diabetes and cancer. The statistics are alarming:

- Life expectancy at birth in the United States is less than life expectancy in most other developed countries
- Tobacco use is responsible for more than 430,000 deaths each year and is the largest cause of preventable morbidity and mortality in the United States
- According to 2009 data, 26.7% of adults in the United States are obese
 - Approximately 300,000 deaths per year may be attributable to obesity
 - The annual health care cost of obesity is estimated to be \$147 billion/year
- More than one-third of adults have two or more major risk factors for heart disease
- Diabetes is the seventh leading cause of death in the United States, accounting for \$116 billion in total United States health care system costs in 2007

In an attempt to improve the overall health of its own Medicaid beneficiaries, the State proposes two opportunities to reward member responsibility and healthy behaviors. These initiatives are described in the following pages.

Managed care organization incentive program

Overview

The State wishes to improve the overall health of its Medicaid members enrolled in managed care by incentivizing members to make healthy behavior and lifestyle choices.

DMAHS will work collaboratively with its Medicaid contracted MCOs to develop and implement an incentive program, *New Jersey Healthy Choices*, to reward healthy behaviors.

To give credit to New Jersey's MCOs, they started rewarding healthy behaviors outside the Comprehensive Waiver. The MCOs report they provide gift cards, ranging from \$10 to \$15 and prepaid phone cards. The following healthy behaviors are targeted:

- Dental screenings
- Prenatal care
- Postpartum follow-up
- Adolescent well child visits
- Well-care services consistent with contractual guidelines

Building on these initiatives, the MCOs will be responsible for program design, marketing, implementation and ongoing program administration to best suit the needs of their membership. While the MCOs will have flexibility in how they design their incentive program, the State will provide the overall program vision. Consideration will be given to leveraging existing MCO efforts, as appropriate. The MCOs will need to consider any ethical, legal and practical constraints in their program design and work collaboratively with the State to ensure that any issues are appropriately identified and addressed. The State will provide ongoing oversight and monitoring and will review/approve all program components and materials prior to implementation.

The program's goal is to encourage/empower members to take responsibility for their health and reward them for adopting healthy behaviors. The ultimate goal of incentive based prevention is to maintain one's short-term success long-term.

Program participation/eligibility requirements

Participation in the *New Jersey Healthy Choices* program will be open (on a voluntary basis) to Medicaid beneficiaries of all ages and categories who are enrolled in a contracted MCO. It will focus on health education and healthy behaviors specific to diet, exercise and smoking cessation. Members on both ends of the health care continuum (i.e., those who are relatively healthy, as well as those with multiple chronic conditions) will be eligible to participate. It is anticipated that program participation levels will be capped per MCO, with the number of participants prorated based on each MCO's New Jersey Medicaid membership. Such discussions/negotiations will take place between the State and each MCO during the program design phase.

Service delivery

Completion of a health risk assessment will serve as the point of entry into the program. This assessment will be used to evaluate current health status, identify at-risk behaviors and increase awareness of health issues, as well as assess the member's readiness to change. The MCO's care management staff (registered nurses) will work collaboratively with each program participant and his/her PCP/health care team to develop an

individualized health improvement and management plan (care plan), which sets reasonable, achievable and age-appropriate personal goals, as well as outlines the member's responsibilities for behavior change. The plan will include evidence-based practices in self management and skill building and will be structured to "meet the member where he/she is at" with respect to readiness to change. Interventions will be predicated upon proven behavior change theories and techniques, such as patient empowerment and motivational interviewing. Members will be provided opportunities to work toward healthy lifestyles within a supportive community environment using numerous resources to support risk reduction.

A model of patient-centered care must compliment the personal responsibility and accountability aspects; therefore, members will be encouraged to choose or be assigned a medical home that will provide the care and enhanced coordination/case management services.

Members will be expected to take their medications as prescribed, keep their appointments (or cancel when necessary) and use the ED only for emergencies. Members with patterns of overuse or inappropriate use of services will receive intensive case management to determine the root causes and modify behavior accordingly.

Rewarding healthy behaviors

As note above, each program participant will have a customized care plan that will include health status, at-risk behaviors, interventions and short- and long-term goals. MCO care managers will be responsible for initial care plan development as well as ongoing reviews and updates. Program participants will be assigned a *New Jersey Healthy Choices* account. The MCO will track member-specific progress made toward the pre-defined goals, which also may include monitoring utilization of services such as annual wellness exams, age and gender appropriate preventive screenings, immunizations and prenatal and post-partum visits. In addition, points will be awarded for adopting healthy lifestyle choices, such as weight management, smoking cessation and regular exercise.

Medicaid beneficiaries will be rewarded on a tiered basis for participation in programs (e.g., engaging in counseling focused on losing weight or smoking cessation), attempts at behavior change (e.g., completing a weight management or smoking cessation program), actual behavior change (e.g., exercising 30 minutes a day or not smoking one week after completing the program) and finally, achievement of health goals (e.g., losing weight or remaining cigarette-free after six months). A tiered incentive approach is key to sustaining behavior changes over the long-term.

As each participant in the program reaches identified milestones with his/her care plan, points will accumulate in the member's *Healthy Choices* account. Points can be converted to cash quarterly for use on health care related service items. It is anticipated that the maximum awarded annually will not exceed \$100. The State is seeking authority to exclude from eligibility determination cash accumulated in *Healthy Choices* accounts.

Reporting, program monitoring and quality management

The success of the programs will be measured by structure, process and individual outcome measures. Structural measures may include beneficiary participation, points/rewards earned and the number/percentage of participants who spend their rewards. Process measures may include participant satisfaction. Outcome measures may include tracking the number of wellness/preventive care visits, improvement in biometric measures (e.g., BMI, cholesterol, blood pressure, etc.), health care utilization (e.g., emergency room visits, inpatient admissions and readmissions) and costs.

DMAHS will work collaboratively with each MCO to develop appropriate outcome measures and reporting parameters based on the design of the program. These will likely include, but not be limited to, program participation, individual goal achievement, preventive measures, medication adherence, improvement in key clinical indicators and utilization measures, such as ED visits and hospital admissions.

Existing QM initiatives and reporting systems (e.g., HEDIS measures and Medicaid State Core Quality Measures) will be leveraged whenever possible to monitor program impact and reduce the administrative burden on the MCOs and contracted providers. The MCOs will provide quarterly and annual reports to the State as agreed upon during the program development phase.

By rewarding healthy behaviors, it is expected that costs will be contained through improved health education and prevention and chronic disease management/control. Additional savings will be generated through reductions in hospitalizations for avoidable complications, as well as reductions in inappropriate use of the ED. A portion of the savings generated from the program will be reinvested to fund future program expansion and management.

Medicaid incentives for prevention of chronic diseases grant opportunity

Overview

On February 23, 2011, CMS announced a competitive grant opportunity for state Medicaid programs to develop, implement and evaluate the use of incentives for the prevention of chronic disease. The ACA authorized \$100 million for states to provide incentives to beneficiaries who participate in the prevention programs and demonstrate changes in health risk and outcomes. Grant applications were due to CMS on May 2, 2011.

In its grant application, DMAHS proposed a partnership among DMAHS, DHSS and NJPCA to pilot an incentive-based model of care related to the management of Medicaid beneficiaries with diabetes, or those who are at-risk for developing diabetes. The projected number of participants was estimated at 9,000.

Program participation/eligibility requirements

The proposed model will be piloted in three FQHCs across the State. Potential participants will be recruited through three entry points – walk-ins, scheduled appointments and data mining using the FQHC’s electronic medical record (EMR). Selection will be based on specific eligibility requirements:

- Eighteen years of age or older and
- Medicaid recipient and
- Primary or secondary diagnosis of diabetes and/or
- Two of the three following criteria:
 - HbA1c greater than or equal to 7.5 for four consecutive quarters
 - Body mass index (BMI) over 25.0
 - Blood pressure greater than 140/90

Walk-ins or individuals with scheduled appointments will be educated about and invited to participate in the program while they are at the FQHC. Those individuals identified through the FQHC’s EMR, who meet the eligibility requirements, will be contacted about the program and invited to participate. Consent will be obtained from individuals who agree to participate in the program. All patients recruited for the study will be tracked using a unique identifier. This unique identifier will include a code to determine location and entry point.

Individuals who will be excluded from the study include those under 18 years of age, pregnant women and those currently undergoing chemotherapy or radiation treatment.

Service delivery

Program participants will participate in programs focused on self management, peer support, behavior change and adoption of healthy lifestyles, with the ultimate goal of mitigating risk and improving overall health status.

Each FQHC will have a diabetes care coordinator (registered nurse with diabetes management experience) on site who will work closely with the physician delivering care to assure all individuals involved in the study are receiving timely, high-quality care. The coordinator will maintain records of care, collect required data and track incentive points earned.

NJPCA, in turn, will also provide a program manager at each of the selected FQHC sites. These individuals will work with the diabetes care coordinators to ensure the program is being implemented as designed, and that all required data is being collected and reported.

As noted above, the State applied for one of the CMS grants, “Medicaid Incentives for the Prevention of Chronic Diseases”. State-specific awards are still pending. The State intends to move forward with this initiative if it is awarded one of these grants.

Member responsibility/promoting self-management

The State intends to use the Chronic Disease Self-Management Program (CDSMP) as the primary intervention for changing participant behaviors and improving self-care. The CDSMP is the best known self-management program for people with chronic conditions. It was developed by Dr. Kate Lorig and her colleagues at Stanford University. The CDSMP has been supported by over 20 years of federally funded research from the Agency for Healthcare Research and Quality, the National Institutes of Health and the Centers for Disease Control and Prevention. (www.patienteducation.stanford.edu).

The CDSMP is a 17-hour course facilitated by trained lay people that focuses on problems common to patients suffering from type 1 or type 2 diabetes, or those at risk for developing diabetes. The classes emphasize individual goal setting and problem solving and are highly interactive. Through facilitated interactions, course participants develop skills aimed at improving their self confidence in managing their illnesses, dealing with symptoms and learning effective strategies such as action planning and feedback, behavior modeling, problem-solving techniques and decision making.

The primary program goal is to reduce risk and improve the management of diabetes for identified individuals who agree to participate in the program. With respect to risk mitigation, this program has identified secondary goals of tobacco cessation, weight control or reduction, lowering blood pressure and greater involvement in self-care through education and application of self-management techniques as noted above. Those seeking assistance in tobacco cessation will be referred to the New Jersey Quit Line, which provides no-cost individualized counseling services.

Rewarding healthy behaviors

Each program participant will have a customized care plan that includes health status, at-risk behaviors, interventions and short- and long-term goals. A tiered incentive point system will be implemented to encourage program participants to fully engage and be successful in attaining goals as outlined in each care plan. The incentives will include gift certificates to local retailers such as the pharmacies or grocery stores. Incentives can be used for healthy foods, diabetic supplies, home blood pressure monitors, pedometers or exercise bands. Participants will have multiple opportunities to obtain points, as described below:

- Tier one points – Registering for the program, keeping all follow-up visits, obtaining appropriate eye and foot examinations, and an annual flu shot
- Tier two points – Reaching the mid level HbA1c weight, exercise and blood pressure goals
- Tier three points – Reaching the final level HbA1c weight, exercise and blood pressure goals
- Tier four points – Maintaining healthy lifestyle goals of weight loss/control, routine exercise and tobacco cessation

As each participant in the program reaches identified milestones within the care plan, incentives will be distributed and will increase in value based on progress towards, and attainment of, the end goal.

Reporting, program monitoring and quality management

Rutgers Center for State Health Policy (CSHP) has a long-standing collaborative relationship with DMAHS and other proposed partners for this project, and is participating in this important initiative. It will provide research, design and implementation consultation services during the first project year. During subsequent project years, the CSHP will collaborate on research design issues, conduct the data analysis and disseminate findings to policy and research audiences.

In addition to using the CSHP to evaluate and analyze the program, the selected pilot sites will also use the Guideline Advantage Program. Formerly the American Heart Association’s Get With The Guidelines® Outpatient program, The Guideline Advantage Program is a jointly directed quality improvement program from the American Cancer Society, American Diabetes Association and American Heart Association. This program works with practices’ existing EMRs, or HIT platforms, to seamlessly extract relevant patient data and provide quarterly reports and benchmarking on adherence to nationally recognized clinical guidelines.

Data collection and analysis

Data collection will be coordinated among the CSHP and the three partner agencies, with DHSS taking the lead to manage the data produced, aggregated and mined at the participating FQHCs. The FQHCs are very accustomed to collecting the type of data that will be needed in conjunction with this study as part of their ongoing state and federal requirements.

Data will be collected via the participants’ EMRs. The Data Manager at each FQHC will work with the Care Coordinator to ensure the appropriate data is collected, monitored and reported to the State in a timely and high-quality fashion.

During year one of this initiative, an evaluation plan (with appropriate tracking mechanisms) will be developed to assess the overall impact of the grant program and monitor progress over time. It will include the specific measures that will be used to evaluate program success, the targeted outcomes for each measure, as well as a detailed plan for data collection, analysis and ongoing monitoring of progress made towards program goals. Collecting pertinent data and creating metric definitions/expectations focus the program on targeted outcome measurements and provide the necessary data to evaluate program success and drive future strategies.

- We understand that CMS plans to use appropriate quality measures from the Core Set of Health Quality Measures for Medicaid Eligible Adults and the Core Set for Children in the evaluation of the grant program. Once such measures are finalized,

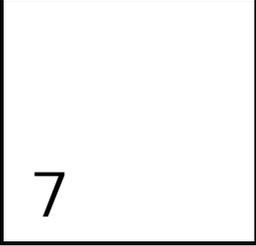
we will work collaboratively with CMS to appropriately align our measures accordingly.

Reporting

DMAHS will lead and coordinate data analysis activities with its respective partners. Semi-annual reports will be developed and submitted to CMS, which will include an evaluation of the program's effectiveness, a description of the processes developed and lessons learned, as well as a summary of preventive services utilized. Specifically, the semi-annual report will include:

- Specific use of grant funds
- An assessment of:
 - Program implementation
 - Processes developed and lessons learned
 - Quality improvements
 - Clinical outcomes
 - Estimate of cost savings

These reports will be a coordinated effort between the agencies participating in this initiative.

7

Evaluation

The Comprehensive Waiver touches every part of the New Jersey Medicaid and Family Care programs. As a result, the evaluation design will be complex. Rather than setting forth a specific evaluation design, the State proposes to convene a Research/Evaluation Committee tasked with development of a comprehensive evaluation plan. The Committee will be charged with developing the initial set of evaluation questions, the data collection strategy, the timing of evaluation components (when to evaluate what), interpreting findings and recommending changes to the program based on those findings. The State wants an evaluation that provides feedback directly on the program's operation under the Comprehensive Waiver. At a minimum the scope of the evaluation will include an assessment of implementation including the process developed and lessons learned, cost savings, quality improvements, and clinical outcomes. One critical component of the evaluation will be to assess the State's success in streamlining NJ FamilyCare/Medicaid from the members' perspective. Because the Comprehensive Waiver has many components, it will be important to develop a common data set to allow evaluation across components.

Participation on the Research/Evaluation Committee will require a significant time commitment by its members. Committee membership will include:

- Health home providers
- DMAHS
- DMHAS
- DCF (DYFS/DCBHS)
- DHSS
- DDD
- DDS
- MCOs
- Medical Directors
- Rutgers University researchers
- Community based providers

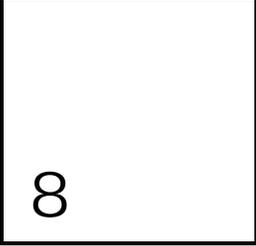
- ACO participants
- Members

The Research/Evaluation Committee would include experts in the following areas:

- Financing
- Quality monitoring and measurement including HEDIS and quality improvement projects
- Health economics
- Large data sets
- Research design
- Data element definition
- Data collection strategies
- Statistics
- Care management
- Predictive modeling and risk adjustment and assessment
- Patterns of care analyses
- Member and provider survey

The Research/Evaluation Committee will be appointed and begin meeting in late fall. DMAHS will prepare materials for the Committee's consideration including sample evaluation plans from other waivers, data collection methods, and potential evaluation questions.

To support the evaluation, DMAHS will solicit outside funding from foundations, CMS, or other federal agencies.

8

Public notice and input process

Public input process

Prior to the submission of the State's Comprehensive Waiver application, we had an extensive process for public input. A website was developed specifically for the Comprehensive Waiver and can be accessed at www.state.nj.us/humanservices. Available on the site is a copy of the Comprehensive Waiver concept paper, a Comprehensive Waiver slide deck and savings estimates for the waiver. Also, there is a link to an email address set-up specifically for stakeholders and interested parties to provide public comment on the proposed waiver concepts.

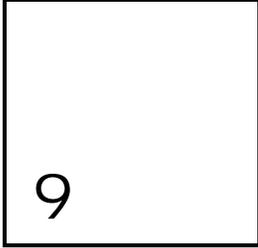
A public notice was also published in newspapers statewide on June 11, 2011 allowing for a 30-day comment period. The notice and a copy of the Comprehensive Waiver concept paper were available for public review on the DHS website and at the 21 CWA and the Medical Assistance Customer Centers. The State received a total of 32 written comments from stakeholders. The public comments have been summarized and are provided in Appendix A.

DHS had extensive public discussions and distributed the waiver widely. We held a special meeting of the DMAHS Medical Assistance Advisory Council (MAAC) on June 13, 2011. We had three meetings with the DHSS Medicaid LTC Funding Advisory Council on March 15, May 18 and July 7, 2011. We have met with interested stakeholder groups and advocates including but not limited to:

- New Jersey Primary Care Association
- New Jersey Hospital Association
- Managed Care Organizations
- Legal Services of New Jersey
- Area Agencies on Aging
- New Jersey Association of Mental Health and Addiction Agencies
- National Alliance on Mental Illness

- ARC of NJ
- Alliance for the Betterment of Citizens with Disabilities
- NJ Association of Community Providers
- American Academy of Pediatrics
- American Association of Retired Persons

We have briefed key legislative staff including the Senate and Assembly Budget Committee on March 24, 2011. A Congressional briefing was held on May 4, 2011 and an Assembly Budget Committee briefing occurred on May 23, 2011. We have also participated in several legislative hearings regarding Medicaid and the Comprehensive Waiver including the Assembly Budget Committee Medicaid Roundtable on April 5, 2011, the Assembly Budget Committee Medicaid hearing on April 5, 2011, the Senate Budget and Appropriations hearing on May 2, 2011, the Assembly Budget Committee hearing on May 24, 2011 and the Senate Health, Human Services and Senior Citizens Committee hearing on June 23, 2011.



Budget neutrality

This section will be submitted under separate cover.

10

Requested Centers for Medicaid & Medicare Services waiver list

Title: New Jersey Section 1115 Comprehensive Waiver Demonstration

Awardee: New Jersey Department of Human Services

All Medicaid and CHIP requirements expressed in law, regulation and policy statement not expressly waived or identified as not applicable in this list, shall apply to the demonstration project beginning October 1, 2011, through September 30, 2016. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STC).

1. Proper and Efficient Administration Section 1902(a)(4) and 42 CFR 438.52, 438.56

To permit the State to limit enrollee's choice of managed care plans to a single PIHP – for the treatment of BH conditions (other than those requiring LTC services at the NF LOC).

To permit the State to automatically reenroll an individual who loses Medicaid eligibility for a period of 90 days or less in the same managed care plan or PIHP in which he or she was previously enrolled. (Applicable only if the State chooses to contract with multiple BH PIHP).

To permit the State to restrict the ability of members to disenroll without cause after an initial 30-day period from a managed care plan and with cause to 90 days.

2. Cost Sharing Section 1902 (a)(14), 1916 and 42 CFR 447.51 and 447.56

To enable the State, under premium support and purchase of premium programs, to authorize coverage of employer-based or private plans that have cost sharing requirements for participants covered under the demonstration in excess of statutory limits.

To enable cost sharing that exceeds the nominal amounts specified in 1916 or approval by the Secretary of such amounts for non-emergency use of hospital EDs under the provisions of 1916 (f).

To permit application of copayments to children.

3. Disproportionate Share Hospital (DSH) Section 1902(a)(13) Requirements

To relieve the State from the obligation to make payments for inpatient disproportionate share of low-income patients for the portion of the State's DSH allotment required for budget neutrality under this agreement and/or required for payment of incentives to hospitals participating in a community Accountable Care Organization.

4. Freedom of Choice Section 1902(a)(23) (42 CFR 431.51)

To enable the State to restrict freedom of choice of providers by furnishing benefits through enrollment of eligible individuals in MCOs and/or Prepaid Inpatient Health Plans.

5. Retroactive Eligibility Section 1902(a) (34)(42 CFR 435.914)

To enable the State to waive the requirement to provide medical assistance for up to three months prior to the date that an application for assistance is made for Medicaid for some eligibility groups, notwithstanding Maintenance of Effort under Section 1902.

6. Amount, Duration, Scope of Services Section 1902(a)(10)(B) and 42 CFR 440.240 and 440.230

To permit MCOs and PIHPs to provide additional or different benefits to enrollees that may not be available to other eligible individuals.

To enable the State to modify the Medicaid benefits package for those in the premium support or purchase of premium programs in order to offer a different benefit package than would otherwise be required under the State plan. This authority is granted only to the extent necessary to allow those with available coverage to receive services through a private or employer-sponsored insurance plan, which may offer a different benefit package than that available through the State plan. Children in such programs are also enrolled in managed care to receive wraparound coverage. Wraparound coverage is not available to adults.

To enable the State to offer CMS approved family planning services only to women of children bearing age with incomes up to 133% of FPL under a new coverage group.

7. Eligibility Based on Institutional Status Section 1902(a)(10)(A)(ii)(V) and 42 CFR 435.217 and 435.236

To the extent that the State would be required to make eligible individuals who are in an acute care hospital for greater than 30 days and who do not meet the LOC standard for LTC services.

8. Federal Medical Assistance Percentage (FMAP) Sections 1903 and 1905

To allow the State to receive an increase FMAP for parents/caretakers eligible for Medicaid with income up to 133% FPL.

9. Medically Needy Eligibility Section (No SSA or CFR Cites?)

To permit incurred cost for the purpose of spend down (share of cost) for medically needy members receiving LTC services in community settings to be defined as a percentage reduction in payments for home and community based services (HCBS) claims or payment of a monthly premium.

10. Grievance and Appeals 42 CFR 438.400

To enable a uniform appeals process for Medicare and Medicaid dual eligibles.

11. PASRR Section 1919 (b) (3) (F) and 42 CFR 483.100 – 483.138

To terminate the Preadmission Screening and Resident Review (PASRR) process under the Comprehensive Waiver and managed LTC because of the financial incentives under the program that ensure appropriate placement.

12. Member Reward Accounts Section 1902 (a)(10)(C)(i)

To enable the State to exclude funds in a member rewards account from the income and resource test established under State and Federal Law for the purposes of determining Medicaid eligibility.

13. Transfer of Assets Section 1917(c)(1)(B)(i)

To enable the State to provide community and facility LTC services to individuals with incomes at or below 100% of FPL while the look behind is occurring.

To enable the State to provide community and facility LTC services to individuals with incomes between 100% of FPL and 300% of the FBR based on their attestation and to recover State and federal funds expended in error.

14.Statewideness Section 1902(a)(1)

To enable the State to offer accountable care organizations in select geographic regions of the State.

Medicaid Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the State for the items identified below (which would not otherwise be included as matchable expenditures under section 1903) shall, for the period of this demonstration, be regarded as matchable expenditures under the State's Medicaid State plan:

1. Expenditures under contracts with managed care entities that do not meet the requirements in section 1903(m)(2)(A) of the Act specified below. Managed care plans participating in the demonstration will have to meet all the requirements of section 1903(m), except the following:
 - a. Section 1903(m)(2)(A)(vi) insofar as it requires compliance with requirements in section 1932(a)(4) and Federal regulations at 42 CFR 438.56(c)(2)(i) that enrollees be permitted an initial period after enrollment to disenroll without cause that would be longer than 30 days.
 - b. Section 1903(m)(2)(H) and Federal regulations at 42 CFR 438.56(g) but only insofar as to allow the State to automatically reenroll an individual who loses Medicaid eligibility for a period of 90 days or less in the same managed care plan from which the individual was previously enrolled.
2. Expenditure authority for shared savings arrangements with MCOs, FFS and PIHPs with accountable care organizations and/or health homes to the extent that some or all of shared savings are reflected in payments
3. Expenditure authority for a uniform Medicare and Medicaid appeals process for MCOs that are also the Medicare Special Needs Plan for the same member
4. Expenditures that would have been disallowed under section 1903(u) of the Act and Federal regulations at 42 CFR 431.865 based on Medicaid Eligibility Quality Control findings.
5. Expenditures for inpatient hospital and LTC facility services, other institutional and non-institutional services (including drugs) provided to FFS beneficiaries, that exceed the amounts allowable under section 1902(a)(30)(A) (Federal regulations at 42 CFR 447.250 through 447.280.
6. Expenditures for inpatient hospital services that take into account the situation of hospitals with a disproportionate share of low-income patients, but are not allowable under sections 1902(a)(13)(A) and 1923 of the Act, but are in accordance with the provisions for DSH payments that are described in the STCs.

7. Expenditure authority to limit expenditures for HCBS for members with intellectual and developmental disorders to appropriate home or out of home placement consistent with their assessment needs.
8. Expenditure authority for reimbursement to the State for payments made by the State to providers for Medicare covered services in Special Disability Workload (SDW) cases in the amount of \$107.3 million.
9. Expenditures associated with provision of HCBS to individuals under managed care with income levels up to 100% of the FPL whose assessed needs meet the State's LOC determination and to those whose assessed needs are not yet up to the LOC.
10. Expenditures associated with the provision of HCBS to disabled individuals under the age of 18 with income levels up to 300% of the SSI income level without considering parental income as otherwise required by section 1902(a)(10)(C)(i) and 42 CFR 435.602.
11. Expenditure authority to provide coverage of parents/caretakers not otherwise eligible for Medicaid with incomes up to 200% of the FPL who are eligible for the program effective October 1, 2011 notwithstanding Maintenance of Effort under Section 1902.
12. Expenditure authority for streamlining of LTC eligibility determinations for HCBS placements
 - a. Medical assistance furnished to Medically Needy eligible individuals where incurred medical expenses were determined through a premium collection or reduction of the amount paid for a HCBS.
 - b. Medical assistance furnished to LTC eligibles who are eligible only as a result of the disregard from eligibility of income currently excluded under section 1612(b) of the Act, and medical assistance that would not be allowable for some of those enrollees but for the disregard of such income from post-eligibility calculations.
 - c. Medical assistance furnished to enrollees who are financially eligible with income equal to or less than 300% of the FBR or Medically Needy and who meet the criteria in the preadmission screening instrument (PAS) regardless of whether or how long they actually have been in an institutional setting; that is, notwithstanding the requirements of 42 CFR 435.540 (regarding disability determination in accordance with SSI standards). Medical assistance furnished to some dependent children or spouses who qualify for LTC based on a disregard of income and resources of legally responsible relatives or spouses during the month of separation from those relatives or spouses.
 - d. Medical assistance furnished to individuals who are eligible as Qualified Medicare Beneficiary, Special Low Income Beneficiary, Qualified Individuals, or Supplemental Security Income Medical Assistance Only (SSI MAO) beneficiaries based only on a disregard of in-kind support and maintenance (ISM).
 - e. Medical assistance furnished to individuals who are eligible based only on an alternate budget calculation for LTC and SSI-MAO income eligibility

- determinations when spousal impoverishment requirements of section 1924 of the Act do not apply or when the applicant/recipient is living with a minor dependent child.
- f. Medical assistance furnished to individuals who are eligible in SSI-MAO groups based only on a disregard of resources in the form of insurance and burial funds, household goods, mineral rights, oil rights, timber rights and personal effects.
 - g. Medical assistance furnished to individuals who are eligible only based on the disregard of interest and dividend from resources, and are in the following eligibility groups:
 - a. The Pickle Amendment Group under 42 CFR 435.135
 - b. The Disabled Adult Child under section 1634(c)
 - c. Disabled Children under section 1902(a)(10)(A)(i)(II)
 - d. The Disabled Widow/Widower group under section 1634(d)
 - h. Medical assistance furnished to LTC recipients under the eligibility group described in section 1902(a)(10)(A)(ii)(V) of the Act that exceeds the amount that would be allowable except for a disregard of interest and dividend from the post-eligibility calculations.
 - i. Medical assistance provided to individuals who would be eligible but for excess resources under the "Pickle Amendment," section 503 of Public Law Number 94-566, section 1634(c) of the Act (disabled adult children), or section 1634(b) of the Act (disabled widows and widowers).
 - j. Medical assistance that would not be allowable but for the disregard of quarterly income totaling less than \$20 from the post-eligibility determination.
15. Expenditures to provide coverage through premium support and purchase of premium programs that would not otherwise be allowable because they were determined cost effective using an alternative methodology
 16. Expenditures to provide coverage to parents of Medicaid or CHIP children with adjusted net countable income from the Temporary Assistance for Needy Families (TANF) standard up to and including 200% of the FPL who are not otherwise eligible for Medicare, Medicaid, or CHIP and for whom the State may claim title XIX funding when title XXI funding is exhausted.
 17. Expenditures to provide coverage to childless adults ages 19 – 64 for health care related costs (other than costs incurred through the Charity Care and Substance Abuse Initiative Programs) who are not otherwise eligible under the Medicaid State Plan, do not have other health insurance coverage, are residents of the State, are citizens or eligible aliens, have limited assets and either: 1) cooperate with applicable work requirements and have countable monthly household incomes up to \$140 for a childless adult and \$193 for a childless adult couple, or 2) have a medical deferral from work requirements based on a physical or mental condition, which prevents them from work requirements and have countable monthly household incomes up to \$210 for a childless adult and \$289 for a childless couple.
 18. Expenditures to provide coverage to uninsured individuals over age 18 with family income below 100% of FPL, who are childless adults and who are not otherwise

eligible for Medicare, Medicaid, or have other creditable health insurance coverage who were covered by New Jersey Family Care prior to enactment of the phase out under Section 2111 of the Social Security Act and to freeze further enrollment into the program.

19. Expenditures not to exceed \$42 million total computable for payments to Federally Qualified Health Centers for uninsured populations.
20. Expenditures for coverage of Medicaid/Medicare dual eligibles who are auto-assigned to the aligned plan for receipt of both Medicare and Medicaid services.
21. Expenditures in the amount that reflects what the State would received under a Balancing Incentive Payment award under the ACA.
22. Expenditures that reflect the enhanced matching share for health home services under Section 2703 of the ACA for qualified health home models.
23. Expenditures for a 1915 (i) like program for opiate dependent adults with incomes below 150% of FPL.
24. Expenditures for 1915 (c) like programs for the children with I/DD and co-occurring mental illness.
25. Expenditures for out-state-payments for individuals with I/DD in similar settings to those authorized under 1915(c) programs.

CHIP Waiver Authority

1. Cost Sharing Section 1902 (a)(14), 1916 and 42 CFR 447.51 and 447.56

To enable the State to impose cost sharing, to the extent necessary, for parents of Medicaid or SCHIP children with income above the TANF standard in excess of prescribed standards.

2. Amount, Duration, Scope of Services Section 1902(a)(10)(B) and 42 CFR 440.230 and 440.240

To enable the State to modify the Medicaid benefits package for those in the premium support and purchase of premium programs in order to offer a different benefit package than would otherwise be required under the State plan. This authority is granted only to the extent necessary to allow those in these programs to receive coverage through a private or employer-sponsored insurance plan, which may offer a different benefit package than that available through the State plan. Children in such programs are also enrolled in managed care to receive wraparound coverage. Wraparound coverage is not available to adults.

3. Premium support and Purchase of Premium Sections 1906 (a) and 2105 (c) (10)

To enable alternate methodologies for determining cost effectiveness.

To allow alternate employer contributions.

To allow mandatory collection of SSN for non-applicants that is not related to the determination of eligibility.

To allow a three month period for determination of coverage under premium support and purchase of premium programs..

4. Benefit Package Requirements Section 2103

To permit the State to offer a benefit package for the employer-sponsored insurance program that does not meet the requirements of section 2103 and Federal regulations at 42 CFR 457.410(b)(1) for adults.

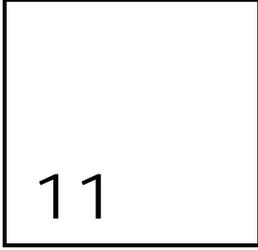
CHIP Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Act as incorporated into title XXI by section 2107(e)(2)(A), State expenditures described below, shall, for the period of this project and to the extent of the State's available allotment under section 2104 of the Act, be regarded as matchable expenditures under the State's title XXI plan. All requirements of title XXI will be applicable to such expenditures for the demonstration populations described below, except those specified below as not applicable to these expenditure authorities.

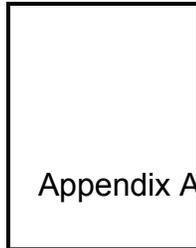
1. **Parents.** Expenditures to provide health care coverage consistent with the requirements of section 2103 to uninsured individuals whose adjusted net countable family income is above the TANF standard up to 200% of the FPL, who are parents of children enrolled in the Medicaid or title XXI program and who are not otherwise eligible for Medicare, Medicaid, or have other creditable health insurance coverage.
2. **Premium Support and Purchase of Premium.** Expenditures to provide coverage through employer-sponsored insurance and private plans for covered individuals with family income below 200% of the FPL and who are not eligible for Medicare or Medicaid.
3. **Annual Reporting Requirements Section 2108 and 42 CFR 457.700 through 457.750.** The State does not have to meet the annual reporting requirements (the submission of an annual report into the State Annual Report Template System of section 457.750 for the demonstration populations). The State will report on issues related to the demonstration populations in quarterly and annual reports and enrollment data through the Statistical Enrollment Data System. Coverage and

eligibility for the demonstration populations are not restricted to targeted low-income children.

4. **SSN.** Expenditures for medical assistance for children when the State required the non-applicant's Social Security Number not for the purpose of eligibility determination.



Appendices



Public input

Summary of public comments

To garner input for our Comprehensive Waiver, the State set up an e-mail address specifically to capture public comments. This e-mail address was included in the public notice that was published statewide and available at all County Welfare Agencies. We received 32 written comments from stakeholders representing hospitals, FQHCs, mental health providers and Offices on Aging and Disability advocates. Below is a summary of the comments we received. Many of the comments are industry-specific, but we have identified areas of support and concern and the common themes shared by the respondents.

The majority of the respondents expressed their appreciation for the opportunity to provide comment. The main topics for comment were the enrollment freeze for parents, ED copayments, managing BH and LTC and the impact on people with developmental disabilities.

The two proposals which received the majority of the comments included:

- Most respondents across all industry groups oppose the proposal to freeze enrollment of adult parents. Some reasons provided were:
 - It would be a strain on FQHCs and hospitals
 - It is a violation of the ACA maintenance of eligibility provision
 - It would not be cost-effective and would increase the number of uninsured and potentially have a negative effect on child enrollment
-
- Most respondents across all industry groups also opposed the \$25 copayment for inappropriate use of the ED. Reasons given for the opposition included reduced payments to the hospitals, difficulty defining and enforcing “inappropriate use” and imposing copayments have no impact on behavior.

We had many comments from the mental health stakeholder groups regarding the different approaches proposed for managing BH services. We received positive feedback from most industry respondents regarding our efforts to integrate physical and BH and support for incorporating BH homes. However, they did express concern with the proposal in the concept paper to have two different delivery systems for adult BH. They opposed using a bifurcated approach that utilized a MCO model and an ASO model, based on level of acuity. Concern was raised on how we would categorize the severity of health needs and what would happen if the person's needs changed and would have to transition from one model to another. Most respondents recommended a single system for adult BH services, with the majority recommending using an ASO model. There were also recommendations that we use one ASO contractor for both children and adult services.

We received comments on the proposal to amend our existing MCO contracts to manage LTC services. There was overall agreement and support among the stakeholders to rebalance from reliance on institutional and acute emergency services to preventive and HCBS. Concern was raised by an organization representing health care workers about the MCOs' network adequacy and their capacity to conduct quality or workforce initiatives. Since there are only four Medicaid plans, concern was raised that nursing homes would have no leverage over rates.

Many of the comments regarding managing LTC came from our Area Agencies on Aging who expressed concerns with MCOs providing case management and support coordination, citing MCO readiness and the potential effect on the current level of quality care offered.

The majority of the disability advocates support the proposed changes to the developmental disabilities system. We received positive feedback on the proposal to close a developmental center and were encouraged to look at closing several more as we shift to community placement and supports for people with I/DD. It was also stated that the waiver provides opportunities to incorporate efficiencies and retooling of administrative, service delivery, IT and fiscal systems to improve access for community based services and supports. The disability advocates did raise concern about the potential impact managed LTC could have with people with I/DD, as well as the \$25 ED copayment in the context of Danielle's law.

We received positive feedback from various respondents on our proposal to potentially increase rates to PCPs prior to 2014. We received support for rewarding member responsibility and healthy behaviors, fairness in payments to in-state and out-of-state providers, and for pursuing opportunities under the ACA including Integrated Care Around a Hospitalization and Medicaid Global Payment System. The majority of respondents were also in support of our proposal to pilot accountable care organizations and health homes. Lastly, we receive a comment regarding Autism and the importance of covering Applied Behavior Analysis (ABA) therapy in Medicaid.

DHS also held a special meeting of the MAAC to obtain input on the Comprehensive Waiver, which was attended by approximately 190 people. A total of 20 individuals provided public comment; many of those that provided public comment also submitted comments in writing. Concern was expressed regarding the freeze of enrollment for adult parents as well as the \$25 ED copayment. There was support for rewarding member responsibility and healthy behavior and for the commitment to close a developmental center. The closing of additional centers was encouraged.

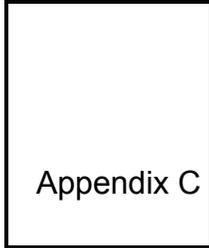
Appendix B

Glossary

Acronym	Term
AAA	Area Agencies on Aging
ABA	Applied Behavior Analysis
ABD	Aged, Blind or Disabled
ACA	Affordable Care Act
ACCAP	AIDS Community Care Alternatives Program
ADDP	Association of Developmental Disabilities Providers
ADRC	Aging and Disability Resource Centers
AFDC	Aid to Families with Dependent Children
ASO	Administrative Services Organization
BH	Behavioral Health
BHI	Behavioral Health Initiative
BS	Behavioral Specialist
CCW	Community Care Waiver
CDPS	Chronic Disability Payment System
CDSMP	Chronic Disease Self-Management Program
CHIP	Children’s Health Insurance Program
CI	Crisis Intervention
CRPD	Community Resources for People with Disabilities
CSHP	Center for State Health Policy
CSOC	Children’s System of Care
CWA	County Welfare Agencies
DACS	Division of Aging and Community Services
DCF	Department of Children and Families
DD	Developmentally Disabled

Acronym	Term
DDD	Division of Developmental Disabilities
DDRT	Developmental Disabilities Resource Tool
DHS	Department of Human Services
DHSS	Department of Health and Senior Services
DMAHS	Division of Medical Assistance and Health Services
DSH	Disproportionate Share Hospital
EBP	Evidence-Based Practices
ED	Emergency Department
EQR	External Quality Review
ESI	Employer-Sponsored Health Insurance
FBR	Federal Benefit Rate
FEA	Fiscal Employer Agency
FFP	Federal Financial Participation
FFS	Fee for Service
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
GA	General Assistance
GO	Global Options for Long-term Care
HCBS	Home and Community Based Services
HEDIS	Healthcare Effectiveness Data and Information Set
HIPP	Health Insurance Premium Payment
MCO	Managed Care Organization
I/DD	Intellectual and Developmental Disabilities
ICF/MR	Intermediate Care Facility for Persons with Mental Retardation
ICM	Intensive Case Management
IMD	Institute for Mental Disease
LANE	Low Acuity Non-Emergent
LOC	Level of Care
LTC	Long-term Care
MAAC	Medical Assistance Advisory Council
MAC	Medicaid Advisory Council
MBHO	Managed Behavioral Health Organization
MCI	Master Client Index
MDC	Medical Day Care
MFP	Money Follows the Person
MMIS	Medicaid Management Information System
MOU	Memorandum of Understanding
NF	Nursing Facility

Acronym	Term
NJPCA	New Jersey Primary Care Association
P4P	Pay for Performance
PACE	Program for All-Inclusive Care for the Elderly
PASRR	Preadmission Screening and Resident Review
PBS	Positive Behavior System
PCP	Primary Care Provider
PH	Physical Health
PHI	Protected Health Information
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Projects
POC	Plan of Care
POP	Payment of Premium
PPPM	Per Participant Per Month
PSP	Premium Support Programs
QA	Quality Assurance
QAPI	Quality Assessment and Performance Improvement
QM	Quality Management
RAI	Request for Additional Information
RFP	Request for Proposal
RN	Registered Nurse
SAI	Substance Abuse Initiative
SBIRT	Screening, Brief Intervention and Referral to Treatment
SED	Serious Emotional Disturbance
SFY	State Fiscal Year
SMI	Serious Mental Illness
SPA	State Plan Amendment
SPH	State Psychiatric Hospital
SSI	Supplemental Security Income
TBI	Traumatic Brain Injury
UM	Utilization Management
VFC	Vaccines for Children
WFNJ/GA	Work First New Jersey/General Assistance



Budget neutrality tables

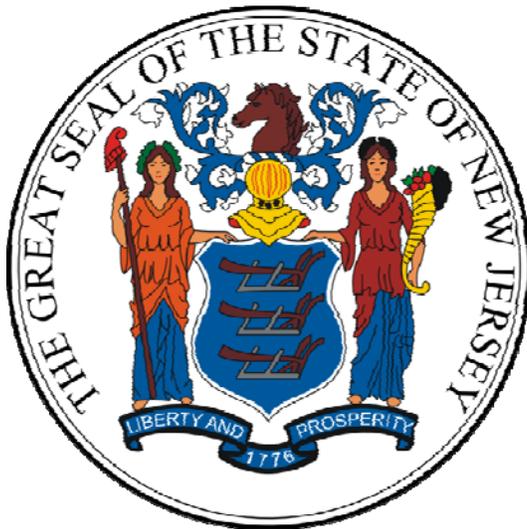
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September 9, 2011

Section 1115 Demonstration Comprehensive Waiver

State of New Jersey

Department of Human Services, in
Cooperation with the
Department of Health and Senior Services
and the Department of Children and
Families



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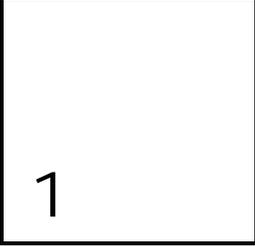
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1

Overview

Over the past decade, the State of New Jersey's (State) NJ FamilyCare/Medicaid program has made tremendous progress in establishing a well-managed, efficient delivery system of care for acute/medical services. The State's managed care program has been recognized nationally for its early use of innovative approaches, such as health-based risk adjustments, health plan efficiency adjustments and overall use of health plan encounter data within the capitation rate-setting process.

Today, however, much of the State Medicaid program remains outside of this efficient delivery system of care and is instead an unmanaged fee-for-service (FFS) delivery system. There are some features of managed care under FFS programs that include utilization and care management without the financial incentives of at risk managed care. Given the reality of the State's budget, the current program is not sustainable and does not best meet the needs of the individuals it serves. Successful expansion of delivery system care innovations to the services and populations that are presently covered under FFS will pave the way for better care, additional savings and management opportunities.

The State's current NJ FamilyCare/Medicaid program, eligibility and enrollment policies, benefit packages and provider payment rates are also in need of rebalancing. While the current program has generous eligibility levels and enrollment policies as well as relatively generous benefits, it nonetheless pays rates to some providers that may serve as a disincentive to participation in the program and limit accessibility to primary care and preventive services and community service options for both long-term care (LTC) and behavioral health (BH).

The State of New Jersey, Department of Human Services (DHS), in cooperation with the Department of Health and Senior Services (DHSS) and the Department of Children and Families (DCF), is seeking a five-year Medicaid and Children's Health Insurance Program (CHIP) Section 1115 research and demonstration waiver that encompasses nearly all services and eligible populations served under a single authority, which provides broad flexibility to manage the State's programs more efficiently. The waiver will

allow the State the flexibility to define who is eligible for services, the benefits they receive and the most cost-effective service delivery and purchasing strategies. The Comprehensive Waiver will:

- Consolidate New Jersey Medicaid and CHIP under a single waiver authority with a streamlined Centers for Medicare & Medicaid Services (CMS) approval process
- Commit the State to making key improvements to the Medicaid eligibility system (both processes and technology) going forward
- Promote increased utilization of home and community-based services (HCBS) for individuals in need of LTC
- Integrate primary, acute and LTC as well as behavioral health (BH) for some populations
- Enhance access to community-based mental health and addiction services
- Promote efficient and value-added health care through health homes and accountable care organizations (ACOs)
- Provide flexibility to promote primary and preventive care access by balancing eligibility and enrollment for services, the benefits received and the rate of payment for services
- Provide flexibility in administration of the program to implement management efficiencies and purchasing strategies
- Promote healthy behaviors and member responsibility for their health care

Beginning in State fiscal year (SFY) 2012, the NJ FamilyCare/Medicaid participating MCOs began taking responsibility for additional populations and services. As SFY 2012 continues, and under the Comprehensive Waiver, these MCOs will be responsible for additional NJ FamilyCare/Medicaid membership and additional costly services that were previously provided by the State through the FFS program. Key waiver components and proposed timeframes appear to the right.

Examples of the innovative changes to the programs' financing, delivery and design on the horizon for the State, include the following:

- Re-thinking the delivery system for LTC. As the influx of baby boomers reach retirement age and beyond, the corresponding demand for LTC services will increase

Timeline for Key Components of the Comprehensive Waiver

July 1, 2011

New managed care membership for acute/medical care (aged, blind and disabled (ABD)) and additional services (pharmacy, personal care, and medical day care)

August 1, 2011

Mandatory managed care for non-dual ABDs

October 1, 2011

New managed care membership for acute/medical care including Medicare/Medicaid dual eligibles and waiver participants

Coverage under Medicaid of treatment and support services for more adults with addiction disorders and adults with serious mental illness

January 1, 2012

Medicare special needs plans offered by NJ FamilyCare/Medicaid MCOs implemented to integrate Medicare and NJ FamilyCare/Medicaid services

Expanded support services for people with intellectual and developmental disabilities

July 1, 2012

Managed LTC through the contracted MCOs implemented including HCBS and nursing facility services and streamlined eligibility for LTC support

CSOC expanded to include community based mental health and addiction services now paid directly by DMAHS

January 1, 2013

Managed BH organization implemented for adults expanding community-based mental health and addiction services

- significantly. Further, most individuals want to receive LTC supports in their homes or in the community rather than in a nursing facility (NF).
- Addressing a growing body of evidence that unmet mental health and addiction service needs have a substantial impact on the high cost of acute/medical care.
 - Evolving the role and structure of contracted managed care plans through medical homes and ACO models.
 - Managing members with dual eligibility using creative approaches, such as a capitated special needs program (SNP).

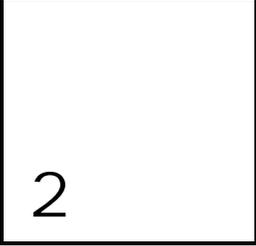
What the Comprehensive Waiver means to:

Our members

- ‘No wrong door’ access per the Affordable Care Act (ACA) and less complexity in accessing services because of integrated health and LTC care services
- Increased primary care provider participation in the program
- Expanded community supports for LTC and mental health and addiction services
- A citizens web portal which allows individuals to conduct self-service screenings to determine eligibility for any Medicaid program and complete an application online
- Stabilized eligibility for NJ FamilyCare/Medicaid by automating many of the processes required annually to maintain eligibility
- Access to a health home for managing all care needs
- Integration of Medicare and Medicaid benefits in the same plan
- Expanded in-home community supports for people with intellectual and developmental disabilities
- Expanded behavioral supports for children with developmental disabilities and mental health issues
- Promotion of member responsibility in using health care resources and rewarding healthy behaviors

Taxpayers

- Achieve significant program savings during the five years of the waiver
- Design a NJ FamilyCare/Medicaid program that is sustainable into the future with the flexibility to respond quickly to changing circumstances
- Consolidate State funding sources under Medicaid to efficiently share the cost with the federal government
- Improve the operational efficiency of NJ FamilyCare/Medicaid and reduce program administration costs
- Bend the health care cost curve and achieve savings through ACOs and health homes
- Position New Jersey for health care reform

2

Streamlined and efficient operations

Consolidation of New Jersey Medicaid under a single waiver with administrative flexibility

Currently, the State Division of Medical Assistance and Health Services (DMAHS) and its sister agencies, including divisions within DHS, DHSS and DCF, administer Title XIX and XXI programs under multiple authorities including:

- A Medicaid State Plan
- A Title XXI Children's Health Insurance Program (CHIP) State Plan
- Two Section 1115 demonstration waivers (one that covers parents and a second recently approved waiver that offers the formerly State-funded general assistance (GA) population an ambulatory benefit package under Title XIX)
- A Section 1915(b) waiver that allows mandatory managed care for certain populations
- Five Section 1915(c) Home and Community-Based Services (HCBS) waivers
- A 1915(j) State Plan authority for participant-directed personal care assistant services (formerly cash and counseling)
- Multiple contracts with managed care organizations (MCO)
- Multiple Program All-Inclusive Care for the Elderly (PACE) contracts
- A 1932 (a) State Plan authority for managed care for the aged, blind and disabled (ABD)
- A new Section 1915(b) waiver for mandatory managed care for duals

This section describes the current waivers, populations and services that will be consolidated under the proposed Comprehensive Waiver, as well as what will remain outside it (See Table 2.1).

Table 2.1 Consolidation of populations/programs under the Comprehensive Waiver

Population/Program	Consolidated in Comprehensive Waiver	Mandatory managed care	Effective date for managed care/managed LTC	Authority prior to Comprehensive Waiver
Aid to Families with Dependent Children (AFDC), including Pregnant Women	Yes	Yes	Current	State Plan Amendment (SPA)
NJ FamilyCare for Parents with Dependent Children	Yes	Yes	Current	1115 Waiver
NJ FamilyCare Pregnant Women	Yes	Yes	Current	SPA
NJ FamilyCare for Children	Yes	Yes	Current	SPA
Medicaid Special	Yes	Yes	Current	SPA
Work First New Jersey/General Assistance (WFNJ/GA)	Yes	No for acute/medical care Managed behavioral health organization (MBHO) for \BH		1115 Waiver
Medically Needy Children and Pregnant Women	Yes	Yes	August 1, 2011	1915(b)
Supplemental Security Income (SSI) Recipients Without Medicare	Yes	Yes	Current	Voluntary under SPA, currently mandatory under 1915(b)
SSI Recipients With Medicare	Yes	Yes	Mandatory October 1, 2011	1915(b)
New Jersey Care Special Medicaid Programs (Aged, Blind and Disabled to 100% of Federal Poverty Level (FPL))	Yes	Yes	Mandatory July 1, 2011	Voluntary under SPA, currently mandatory under 1915(b)
Medically Needy Aged, Blind, or Disabled (ABD)	Yes	Yes	Mandatory July 1, 2011	Voluntary under SPA, currently mandatory under 1915(b)

Population/Program	Consolidated in Comprehensive Waiver	Mandatory managed care	Effective date for managed care/managed LTC	Authority prior to Comprehensive Waiver
New Jersey WorkAbility	Yes	Yes	Current	SPA
Breast and Cervical Cancer (CEED)	Yes	Yes	August 1, 2011	SPA
Medical Emergency Payment Program for Aliens	No	No fee-for-service (FFS)		SPA
PACE	Discontinued	Existing programs can become part of network, receiving 100% of SFY12 capitation through June 30, 2013, receiving 75% of SFY12 capitation through June 30, 2014, and receiving capitation negotiated with MCOs beginning July 1, 2014	July 1, 2012	SPA
1915(j) Personal Care Assistant Services	Yes	Yes (Administrative and Consulting Components will remain with the Division of Disability Services (DSS) and MCOs will refer to DDS)	July 1, 2012	SPA
Institutional Medicaid	Yes	Yes	July 1, 2012	SPA
Traumatic Brain Injury (TBI) Waiver	Yes	Yes	October 1, 2011 for acute/ medical care and July 1, 2012 for managed LTC	1915(c)

Population/Program	Consolidated in Comprehensive Waiver	Mandatory managed care	Effective date for managed care/managed LTC	Authority prior to Comprehensive Waiver
AIDS Community Care Alternatives Program (ACCAP)	Yes	Yes	October 1, 2011 for acute/medical care and July 1, 2012 for managed LTC	1915(c)
Community Resources for People with Disabilities (CRPD)	Yes	Yes	October 1, 2011 for acute/medical care and July 1, 2012 for managed LTC	1915(c)
Global Options for LTC (GO)	Yes	Yes	October 1, 2011 for acute/medical care and July 1, 2012 for managed LTC	1915(c)
Community Care Waiver (CCW)	Yes	Yes for acute/medical care No for LTC/FFS	Current for acute/medical care	1915(c)
Supports Waiver	Yes	Yes for acute/medical care/FFS No for LTC/FFS	October 1, 2011	Supports Waiver will be submitted as a 1915(c) in the Fall 2011
Adult Mental Health and Substance Abuse Services (Division of Mental Health and Addition Services)	Yes	No FFS initially	MBHO January 1, 2013	SPA
Children's System of Care (CSOC) Initiative (DCF)	Yes	Administrative services only (ASO) since 2002	Current ASO accepts additional FFS children July 1, 2012	SPA

Under this proposal, the only populations and services that will remain outside the Comprehensive Waiver are:

- Emergency services only populations and services.
- Services for individuals who are eligible for Medicare but do not receive a "full" Medicaid benefit because their income is too high. These groups include Qualified

Medicare Beneficiaries, Supplemental Low Income Beneficiaries and Qualified Individuals.

- Medicaid administrative or any other expenditure claimed by schools (currently or in the future).

Roles and responsibilities

Under the current multiple authority framework, coordination of traditional SPAs, 1915(j), new State Plan options for offering HCBS waivers (e.g., 1915(i)), 1915(c), 1915(b), and 1115) present a significant challenge to the Department of Human Services designated single state agency, the Division of Medical Assistance and Health Services. While DMAHS retains its statutory authority over all SPAs and waivers involving Medicaid and CHIP funds, including any programs that are administered by other divisions or departments, this process is cumbersome and involves multiple hand-offs from one agency to another.

Consider for example the hand-offs required for each of the State’s five HCBS (soon to be six or more) waivers administered by three different agencies, as shown in Table 2.2.

Table 2.2 1915(c) Waiver hand-offs

	Sister agency	DMAHS	Centers for Medicare & Medicaid Services
Waiver development under consideration	Notifies Medicaid Director	Returns to sister agency designating required members of waiver development group	
Waiver development group convenes and determines waiver content and policies	Notifies Medicaid Director	Returns to sister agency	
Waiver application developed	Transmits to Medicaid Director 45 days prior to submittal to the Centers for Medicaid & Medicare Services (CMS)	Returns to sister agency with questions/issues	
Waiver application revised	Transmits to DMAHS	Transmits to CMS	CMS reviews and sends request for additional information (RAI) to DMAHS
Request for Additional Information (RAI)		DMAHS Legal/Regulatory office coordinates/schedules CMS calls and returns RAI to sister agency	

	Sister agency	DMAHS	Centers for Medicare & Medicaid Services
Response to RAI	Transmits to DMAHS 10 days prior to the 90 th day since waiver submittal	Reviews and submits to CMS	CMS accepts or returns to DMAHS
Waiver renewals and amendments	Notifies Medicaid Director six months prior to waiver expiration or 135 days (if renewal due to CMS 90 days prior to the end of the waiver), including rationale for amendments	Develops timeline based on complexity of amendments and discussions with CMS and returns to sister agency	
Waiver renewal/amendment prepared	Transmits to DMAHS 45 days prior to submittal to CMS	Reviews and resolves questions and transmits to CMS	CMS reviews and sends RAI to DMAHS
RAI		DMAHS Legal/Regulatory office coordinates/schedules CMS calls, and returns RAI to sister agency	
Response to RAI	Transmits to DMAHS 10 days prior to the 90 th day since waiver submittal	Reviews and submits to CMS	CMS accepts or returns to DMAHS
372 Report	Prepares and transmits to DMAHS	Reviews and transmits to CMS	CMS reviews and submits queries to DMAHS
Other 1915(c) reports, Interim Procedural Guidance and Plans of Corrections	Transmits to Medicaid Director for signature two weeks in advance	Transmits to CMS	CMS reviews and approves or requests additional explanation, a corrective action plan, etc.
Audits	Transmits to Medicaid Director for signature two weeks in advance	Transmits to CMS if CMS audit	CMS reviews and includes response in audit findings

Multiply these hand-offs times five for each HCBS waiver, all occurring at different times, and this offers insight into the State’s rationale for consolidation. The FFS structure of current HCBS waivers and the movement of DMAHS increasingly to managed care also argues for consolidation. Once implementation of managed care for LTC services occurs on July 1, 2012, four 1915(c) waivers will be discontinued under the Comprehensive Waiver and fall under the managed care contracts held by DMAHS.

Because the Comprehensive Waiver has components that are implemented at different times, the roles and responsibilities of DMAHS and sister agencies must be transitioned

as well. The reorganization of roles and responsibilities must balance the programmatic expertise of sister agencies needed particularly in the design and development phase, and DMAHS' role as the designated single state agency and its expertise in managed care.

As the departments and divisions implement program changes required by Comprehensive Waiver design and implementation, decisions will be made regarding:

- Timing of reorganization phases
- Identification of budget, staffing and mechanisms of reorganization
- Creating clear lines of accountability
- Impact on staffing roles and responsibilities
- Deciding the placement and structure of regulatory functions
- Deciding the placement and structure of non-regulatory programs
- Deciding who is responsible for policy

Not all of these decisions have been made at this time. The activities related to development, design and implementation will occur over at least two years. The roles and responsibilities will be documented in a Memorandum of Understanding (MOU), which may include the following, as well as any other appropriate terms:

- Milestones, deliverables and performance measures
- DMAHS' lead role in policy and rate-setting and communication with CMS
- Requirements related to procurement involving Medicaid clients/funding, including the involvement of DMAHS as lead or as a participant on Request for Proposal (RFP) committees and a co-signer of contracts
- Medicaid payments to providers must go through the DMAHS fiscal agent
- DMAHS quality oversight responsibility
- Internal audit/assessment procedures
- Procedures/protocol for working with CMS
- Evaluation requirements and data
- Organizational structure of the sister agency and the qualifications/responsibilities of key personnel
- Authority to update/modify timing of updates/modifications
- Duration
- Sister agency responsibilities
- Joint responsibilities

While not all of the changes in roles and responsibilities have been determined, as noted above, the State can provide two very specific examples. First, when the adult and pediatric medical day care (MDC) program transitioned from DHSS to managed care July 1, 2011, the managed care plans assumed the prior authorization and billing/claims processing functions previously conducted by Division of Aging and Community Services (DACS) nursing staff, and billing/claims processing performed by DACS clerical and administrative staff.

A second example is consolidation of HCBS quality assurance (QA) functions. Currently two divisions within DHS, the Division of Disability Services (DDS) and the Division of Developmental Disabilities (DDD) and one division within DHSS, the Division on Aging and Community Supports (DACs), have staff dedicated to QA functions. Providers participating in multiple waivers have different requirements. Under managed care, oversight of QA activities will be unified for maximum efficiency and cost effective operations.

Streamlining

The State intends to streamline its internal program operations to further support consolidation under this Comprehensive Waiver. This streamlining includes enhanced use of information technology (IT) tools, eliminating unnecessary or duplicative activities and improving the service provided to our members. These initiatives are described in detail throughout the remaining sections but include:

- Moving to a competitive bid process for managed care contracts effective with implementation of the Health Insurance Exchange, either by the State or federal government
- Working with the NJ Division of Purchase and Property to develop a streamlined, effective and timely procurement process that supports innovations under the waiver
- Allowing members to conduct a self service screening through a citizens web portal for eligibility to all DHS programs as well as complete an application
- Automate all or most of the eligibility determination and redetermination process
- Using the Master Client Index (MCI) to identify and apply child support enforcement orders for health care.
- Eliminating inconsistencies in operations statewide, particularly in the area of eligibility determinations
- Simultaneously processing clinical and financial eligibility to expedite enrollment in LTC
- Developing a single unified quality monitoring approach for LTC
- Allow exceptions for annual level of care (LOC) reviews and incentivizing MCOs under capitation to promote the least restrictive setting

Each of these initiatives is designed to accomplish specific objectives as detailed throughout this document. For example, the competitive procurement for MCOs aims to accomplish the following:

- Streamline the contract from the 'doorstop' version to one that incorporates the operational details by reference to statutes, regulations and operational manuals, and eliminates existing redundancies/inconsistencies that occurred over years of revision
- Promote cost-effective, participatory care in the most appropriate setting
- Introduce pay-for-performance (P4P)
- Update provider network access standards consistent with the needs of members and community standards
- Update the Early Periodic Screening, Diagnosis and Treatment (EPSDT) performance and sanction provisions (may be part of P4P)

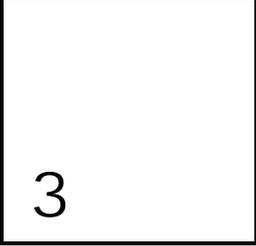
- Introduce managed care operational best practices
- Apply scientifically proven best practice treatment standards
- Apply quality criteria

Approval process

The Comprehensive Waiver seeks a single, unified federal authority that specifies the types of changes that the State can make with streamlined CMS approval and limits the changes that require more extensive and lengthy CMS review. The State seeks CMS' partnership in responding to changes quickly, which may be necessary to administer the most efficient Medicaid and CHIP program possible in a time of limited budget resources. The State requests the following CMS approval process:

- Level 1 changes – CMS approval will not be required. Level 1 changes would be reported by DMAHS in quarterly demonstration reporting. Examples of Level 1 changes include:
 - Administrative changes such as contract requirements for MCOs or ASO organizations (e.g., new performance measures, network requirements, care coordination requirements, quality indicators and/or reporting requirements)
 - Rate (FFS and capitation) increases or decreases less than five percent provided that in the case of FFS, the access study previously submitted demonstrated robust access to services (applicable to Intellectual Disability and Developmental Disabilities (I/DD), the Children's ASO and the managed behavioral health organization (MBHO))
 - New or revisions to existing assessment instruments for LTC (without impact on program eligibility)
 - Changes to professional standards and/or licensure
 - Change in home and community-based number of slots
 - Development or revisions of policies and procedures and operations
 - Revisions in evaluation of network adequacy and the network per se
 - Approval of health home pilots
 - Adding community-based services consistent with CMS guidance
 - Revisions to the disproportionate share hospital (DSH) methodology within the allotment subject to audit
 - Reductions in premiums or copayments
 - Tiered decisions
- Level 2 changes – CMS review and approval comparable to the review process for SPA changes is required. Similar to SPA changes, if CMS does not submit a RAI within 60 days, the change is deemed approved within 90 days. Level 2 does not include changes otherwise approved through the waiver and amendments to budget neutrality terms and conditions.
 - Addition or deletion of SPA, 1915(i), or 2703 defined services (consistent with benchmark flexibility in the Deficit Reduction Act (DRA))
 - Changes in rate methodology and rate increases or decreases greater than five percent for either FFS rates or capitation

- 1915(c) waiver amendments and new submittals for the I/DD population not under managed care
- Increases in premiums or copayments
- Changes to enrollment practices impacting member choice timeframes (e.g., change to the 90-day disenrollment without cause)
- Level 3 changes – CMS review and approval comparable to that for an amendment to a Section 1115 waiver would be required. The State would seek public input, submit these changes 120 days prior to the implementation date and *CMS would have 30 days to raise concerns and begin negotiations comparable to the current process*. Examples include:
 - All eligibility changes
 - Amendments to budget neutrality terms and conditions
 - Benefit changes outside of DRA flexibility

3

Eligibility and enrollment

The State requests broad flexibility for managing eligibility, enrollment, benefits and payment rates. Section 3 addresses eligibility and enrollment and is organized into five subsections:

- Enhanced Federal Medical Assistance Percentage
- New populations
- Reduce FFS periods
- Incorporate operational improvements and streamlining
- Ensure that Medicaid is the payer of last resort
 - Retroactive Medicare Part B
 - Health Insurance Premium Payment (HIPP) program

Enhanced Federal Medical Assistance Percentage

The State is committed to continuing to serve individuals who presently receive benefits under the State's Medicaid and CHIP programs. The State's initial proposal, outlined in the concept paper, was to freeze enrollment for NJ FamilyCare parents with income below 133% FPL. The program was previously closed to parents with income above 134% FPL effective March 1, 2010. After the public input process, this issue received many comments and the most negative feedback; therefore, we are proposing to maintain eligibility for this population given the necessary funds to sustain eligibility.

New Jersey has been in the forefront on expansion of parent coverage and we believe states that were early adopters are being penalized by the Affordable Care Act (ACA). We currently receive a 65% FMAP for our parent population enrolled through our NJ FamilyCare 1115 waiver. Because we began enrolling this population prior to the enactment of the ACA, beginning January 2014 this population will revert back to a 50% match – disenfranchising New Jersey for covering this population. Due to budget constraints it is difficult now to maintain this coverage and will be even more difficult in 2014 when we are slated to receive even less federal matching funds. States that did not

choose to cover parents prior to ACA will be eligible for 100% federal matching funds. Therefore, New Jersey is asking that upon approval of this waiver that we retain enhanced matching funds and are requesting an increase in FMAP from 65% to 75% until December 31, 2013 and then an increase to 85% on January 1, 2014. This amount of FMAP is still below the 90% floor that expansion states will be receiving.

Table 3.1 Eligibility and cost sharing proposed

Population	Non-financial eligibility	Financial eligibility	Service package	Eligible for retroactive Medicaid	Redetermination process	Cost share
AFDC including Pregnant Women	Low income families	The monthly income limit for a family of four is \$507. No resource limit	Plan A services	No	12 months	
NJ FamilyCare for Parents with Dependent Children	Low income parents with dependent children under the age of 19 who are not eligible for Medicaid at the 1996 AFDC income standard	Income is less than or equal to 200% FPL Closed to new applicants 3/1/2010 for applicants with incomes above 133% All resources are disregarded Those who satisfy the following financial eligibility are still eligible: the difference between the 1996 AFDC income standard and 133% FPL is disregarded from the remaining earned income	Plan D services	No	12 months	Yes – copayments and premiums at some income categories currently

Population	Non-financial eligibility	Financial eligibility	Service package	Eligible for retroactive Medicaid	Redetermination process	Cost share
NJ FamilyCare for Pregnant Women	Pregnant women	Income is less than or equal to 200% FPL. No resource limit	Plan A services	No	NA	
NJ FamilyCare for Children	Uninsured children up to the age of 19	Family income is equal to or less than 350% FPL. No resource limit	Income ≤ 133%: Plan A services; Income ≤ 150%: Plan B services; Income ≤ 200%: Plan C services; Income ≤ 350%: Plan D services	No	12 months	Yes – copayments and premiums at some income categories
Foster care	Children under 19	Based on AFDC related Medicaid	Plan A	Yes	12 months	No
Chafee kids	Children 19-21 who were in foster care at the age of 18	On their 18 th birthday must be in DYFS out of home placement supported in whole or in part by public funds.	Plan A	N/A	12 months	No
Subsidized Adoption services	Must be considered to have special needs	NA	Plan A	Yes	NA	No

Population	Non-financial eligibility	Financial eligibility	Service package	Eligible for retroactive Medicaid	Redetermination process	Cost share
Medicaid Special	Single adults age 19 through the end of the month that they turn 21	The difference between the 1996 AFDC income standard and 133% FPL is disregarded from the remaining earned income (this disregard is used instead of the normal AFDC earned income disregard). Countable unearned income must be ≤ the 1996 AFDC income standard. Countable income after all disregards must be ≤ the 1996 AFDC standard. No resource limit	Plan A services	No	12 months	Yes – copayments and premiums at some income categories
WFNJ/GA	Low income adults who may or may not be qualified to work	Monthly income is less than or equal to \$140 for an individual, \$210 for a couple for those able to work and \$193 for an individual and \$290 for a couple medically certified as unemployable	Plan G services	No	12 months	

Population	Non-financial eligibility	Financial eligibility	Service package	Eligible for retroactive Medicaid	Redetermination process	Cost share
Medically Needy Children and Pregnant Women	Children under the age of 21 and pregnant women who do not qualify for another Medicaid program	Income after spend down is equal to or less than \$367 for an individual, \$434 for a couple, two person household or pregnant woman, etc. Up to \$4,000 in resources allowed for an individual, \$6,000 for a couple	Limited Plan A services	No	6 months	Yes spend down
SSI Recipients	Individual or couple is eligible through the Social Security Administration (SSA) with or without Medicare	Financial eligibility through SSA	Plan A services	Yes	12 months	
New Jersey Care Special Medicaid Programs (ABD)	Aged, blind or disabled individuals	Income must be less than or equal to 100% FPL. Resources up to \$4,000/individual, \$6,000 couple	Plan A services	Yes for institutions No for community	12 months	
Medically Needy Aged, Blind, or Disabled	Aged, blind or disabled individuals who do not qualify for other Medicaid programs	Income after spend down is equal to or less than \$367 for an individual, \$434 for a couple, etc. Up to \$4,000 in resources allowed for an individual, \$6,000 for a couple	Plan A services	No	6 months	Yes spend down

Population	Non-financial eligibility	Financial eligibility	Service package	Eligible for retroactive Medicaid	Redetermination process	Cost share
New Jersey WorkAbility	Individual must be between the ages of 16 and 65, have a permanent disability, as determined by the SSA or DMAHS and be employed	Countable unearned income (after disregards) up to 100% FPL, countable income with earnings up to 250% FPL; resources up to \$20,000 for an individual, \$30,000 for a couple	Plan A services	Yes	12 months	
Breast and Cervical Cancer	Uninsured low income women under the age of 65 who have been screened at a NJ cancer education and early detection site	Income less than or equal to 250% FPL. No resource limit	Plan A services	No	12 months	
Medical Emergency Payment Program for Aliens	Individuals who would qualify for Medicaid but for their citizenship status	Individual who would qualify for Medicaid but for their citizenship status	Emergency services only	No	NA	N/A
Institutional Medicaid	Individuals must meet institutional LOC requirements	Income less than or equal to \$2,022 per month. Resources less than or equal to \$2,000	Plan A services	Yes	12 months	Yes
TBI Waiver	Individuals between ages 21 and 64 who have suffered trauma to the brain	Income less than or equal to \$2,022 per month. Resources less than or equal to \$2,000	Plan A services	Yes	12 months	Yes

Population	Non-financial eligibility	Financial eligibility	Service package	Eligible for retroactive Medicaid	Redetermination process	Cost share
ACCAP	Individuals of any age with AIDS	Financially eligible for: (1) SSI, (2) Income below 100% of FPL or (3) Medicaid Institutional criteria - Income less than or equal to \$2,022 per month. Resources less than or equal to \$2,000	Plan A services	Yes	12 months	Yes
CRPD	Individuals determined disabled who can remain in the community	Financially eligible for: (1) SSI, (2) Income below 100% of FPL or (3) Medicaid Institutional criteria - Income less than or equal to \$2,022 per month. Resources less than or equal to \$2,000	Plan A services	Yes	12 months	Yes
GO	Individuals who would qualify for placement in a NF but can use community services	Financially eligible for: (1) SSI, (2) Income below 100% of FPL or (3) Medicaid Institutional criteria - Income less than or equal to \$2,022 per month. Resources less than or equal to \$2,000	Plan A services	Yes	12 months	Yes
CCW	Individuals who are living in the community and are determined clinically eligible by DDD	Financially eligible for: (1) SSI, (2) Income below 100% of FPL or (3) Medicaid Institutional criteria - Income less than or equal to \$2,022 per month. Resources less than or equal to \$2,000	Plan A services	Yes	12 months	Yes

Population	Non-financial eligibility	Financial eligibility	Service package	Eligible for retroactive Medicaid	Redetermination process	Cost share
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All populations must meet the required citizenship status requirements, Social Security Number (SSN) requirements and residency requirements unless otherwise noted. Citizenship status requirements means that the individual is a US citizen or other qualified alien who has either met or is exempt from meeting a five-year US residency period. SSN requirements means that the individual must provide a valid SSN or proof of application for a SSN unless otherwise noted. Residency requirements means that the individual must be a resident of the State of New Jersey or intend to reside in the State of New Jersey.

New populations

The State will add two populations under the Comprehensive Waiver:

- Approximately 1,200 childless adults eligible for state funded services as of October 1, 2011
- Medication Assisted Treatment Initiative (MATI) services for opiate dependent State residents with incomes up to 150% under 1915(i)-like authority (this population is described in detail in Section 5 below)

Reduction of fee-for-service periods

The State also proposes two changes to reduce its FFS exposure for members during the time which they must navigate the health care system unguided. The first is to eliminate the requirement that the State provide coverage prior to the date of a Medicaid application for certain groups of new applicants. The State will continue to provide prior-quarter coverage for individuals who are retroactively determined eligible for SSI and certain individuals at the institutional LOC, including HCBS waivers. The State believes this request is consistent with similar requests that CMS has granted in other states under 1115 demonstration authority. It preserves retroactive eligibility for those most in need and is consistent with DMAHS' belief that care should be managed at the earliest point possible. Exhibit 3.1 identifies those populations that would continue to have prior quarter coverage under the Comprehensive Waiver. In addition to the populations identified on Exhibit 3.1, prior-quarter coverage would continue to be available for adults discharged from Institutes for Mental Disease (IMDs).

It should be noted that the State has a process in place to protect the application date in circumstances when a complete application is not feasible. The effective date of eligibility is the date of application or the date the Form PA1C is completed, whichever is earlier. The PA1C protects the filing date for those individuals admitted to a hospital. (Also, an application may be taken by the out-stationed worker at a hospital or other providers to protect the filing date.) As a component of the PA1C, the hospital or other provider must screen the individual to determine if he/she is already on Medicaid or whether the patient's income and/or resources meet the applicable public assistance standard.

The second change is to require new managed care enrollees to choose a Medicaid MCO upon eligibility application (or within 10 days of the eligibility determination) or be auto-assigned. Members will be allowed a 90-day period to change MCOs without cause. After the 90-day period, plan changes for cause will be allowed, and MCO disenrollment will be possible thereafter once a year during an open enrollment period. New populations added to managed care beginning July 1, 2011 or July 1, 2012 will not be eligible for open enrollment until fall 2012 or fall 2013 respectively.

Based on available statistics, the State has a very low rate of auto-assignment. Individuals processed through county welfare agencies (CWAs) have a 15.0% auto-assignment rate and NJ FamilyCare members have an auto-assignment rate of 0.3%. The State attributes its low auto-assignment rates to outreach. Formal outreach

consists of an introduction letter, enrollment kit and reminder cards. The Health Benefits Coordinator which serves as the choice counselor for the NJ FamilyCare/Medicaid programs also makes managed care program presentations in the community, emphasizing services, benefits, access, care management and the navigation of managed care. A question and answer period follows and individuals are provided an opportunity to enroll. A frequently asked question guide is also available on the DMAHS website, which provides individuals more specific information. And, the enrollment kit mentioned above includes information on what questions to ask of a potential plan (e.g., list the providers you use now so that you can ask each MCO if those providers are in the plan's network). The purpose of the current HBC contract is to screen and process applications, make determinations of NJ FamilyCare/Medicaid program eligibility, assess and collect premiums, provide outreach, marketing and education, and conduct and maintain enrollment with contracting MCOs in accordance with program requirements of the DMAHS programs. Additionally, the contractor shall provide and operate a system capable of performing tasks required of both an Eligibility Processing and Management System and a Managed Care Enrollment System.

The pricing of the contract is based upon actual per member per month enrollments at separate rates for NJ FamilyCare and Medicaid. The case mix will change based on the change in members moved to managed care.

A member will be automatically assigned to a MCO if they have not selected a plan after extensive and repeated outreach attempts. The automatic assignment process randomly assigns an entire NJ FamilyCare/Medicaid case to one of the MCOs operating in their county of residence. The algorithm alternates among each of the available plans, unless/until capacity has been reached. The State is currently discussing alternative algorithms with CMS that would include Medicaid and/or Medicare data to identify commonly used providers and auto-assign the member into a plan that includes his/her most commonly used providers.

It should also be noted that by the time managed LTC is implemented on July 1, 2012, every individual (including duals) receiving LTC care in a facility or in the community will be associated with a MCO for receipt of acute/medical care. Further, the transition plan for LTC (see Section 5) provides a time period during which an individual can receive services from his/her current provider even if that provider does not contract with the MCO.

The State also plans to begin the transition to LTC at least three months prior to July 1, 2012. During this period, DMAHS will provide claim level information to each MCO for its members. Provision of claim level detail allows the MCOs to use predictive modeling and risk assessment tools to design the appropriate care coordination strategy for each member before assuming financial risk on July 1, 2012.

The State continues to move its NJ FamilyCare/Medicaid program towards coordinated care provided in comprehensive managed care delivery systems. Each of the provisions above is consistent with this philosophy. A person's care should be managed from the

earliest point in time possible to ensure quality outcomes and the most effective utilization of resources.

Operational improvements and streamlining

In return for the requested NJ FamilyCare/Medicaid eligibility and enrollment flexibility, the State is committed to improving its performance throughout the NJ FamilyCare/Medicaid eligibility determination process. To this end, the State has or will initiate operational improvements and streamlining in the following areas:

- Reduce processing time for LTC applications
- Spend down options for the medically needy requiring HCBS
- Use IT tools available to automate processes
- Improve overall processing time for eligibility determinations through performance incentives for County Welfare Agencies (CWAs) and CASS implementation – the State's new eligibility determination system.

Reduce processing time for long-term care applications

As a component of the Comprehensive Waiver, the State initiated a review of processing times for financial and clinical eligibility determinations for individuals seeking LTC in Nursing Facilities (NFs) and, more importantly, in the community since prior quarter coverage is not available under 1915(c) waivers. The LTC Medicaid Advisory Council (MAC) brought to DMAHS' attention the potential delays in processing institutional and HCBS Medicaid applications. Upon investigation many reasons were identified for the delays including operational processes, incomplete information provided by the applicant and requirements of the DRA and the five-year look back.

This review produced a series of initiatives to minimize processing time. These initiatives will ensure that delays in receipt of HCBS do not result in institutionalization and include the following:

- Standardized processing statewide based on documented operational protocols
- Protecting the application date as the date of eligibility for receipt of HCBS, which is ninety days prior to date of application
- Simultaneous processing of clinical and financial eligibility for the elderly and physically disabled
- Streamlining the robust assessments conducted under FFS for the elderly and physically disabled under managed LTC where the MCO is responsible for care planning and coordination
- Obtaining authority to use preadmission screening instruments and historical case information and eligibility determinations for the elderly, physically disabled, those with Intellectual and Developmental Disabilities (I/DD), and those with mental illness as the disability determination for SSI from the Social Security Administration (SSA). This will allow the individual to be eligible for LTC services under 42 CFR 435.210 (would be eligible for SSI if they applied) well before the regular SSI eligibility determination is completed. Based on initial review, the assessment for the elderly

and physically disabled used by New Jersey meets the SSI disability criteria and discussions can begin.

- Allow prior quarter coverage for home and community based services under the Comprehensive Waiver provided that clinical eligibility is completed, there is a written plan of care (POC) and require placement choice options to be presented and documented
- Waive the look back for individuals already eligible for the program – those with income below 100% of FPL
- Allow those with income above 100% to receive HCBS based on their attestation regarding transfer of assets with repayment of the State and federal government if the attestation was incorrect

Spend down options for the medically needy seeking long-term care

The State has a medically needy program for LTC. Spend down for residents of NFs is relatively straightforward. However, for community residents spend down is problematic because beneficiaries often use several different HCBS providers, and because beneficiaries must pay shelter or room and board costs to remain in the community. In an effort to rebalance long term care expenditures and make community placements feasible for the LTC medically needy population, the State seeks to develop a new Medically Needy spend down process in a managed LTC environment.

HCBS eligible individuals, who meet nursing home level of care and who have exhausted their assets below the Medicaid eligibility resource level for long term care, may spend down their income by paying their share of the PMPM capitation to the MCO. The beneficiary’s share of the PMPM capitation amount will be equal to the difference between their total gross monthly income and the income standard (Medicaid “cap”) for long term care.

Medically Needy nursing home patients will utilize their monthly income (minus the Medicaid personal needs allowance) to pay their share of the PMPM capitation.

Use information technology tools available to automate processes

The State proposes two innovative initiatives that utilize existing IT tools to streamline eligibility and reduce Medicaid expenditures:

- Automation of all or most of the eligibility determination and redetermination process
- Using the MCI to identify and apply child support enforcement orders for health care

The State, under this Comprehensive Waiver, will automate most (if not all) of the financial eligibility determination and redetermination process using IRS, State tax, Child Support and all other sources of income; residency and eligibility information. In order for the State to accomplish this task the Social Security Number (SSN) of beneficiaries

(which NJ has required) and the SSN or acceptable alternative identifiers of the parents for children covered under Title XIX and XXI will be mandatory and maintained electronically for all programs

In addition, DMAHS is in the process of implementing a MCI to better integrate its data, serve county eligibility offices, and ultimately permit physicians and hospitals with a high proportion of Medicaid patients to view key, accurate information at the point of care. The MCI was funded using CMS Transformation Grant funding. The MCI provides an opportunity to match child support enforcement orders for health care and apply those amounts to reduce both State and federal Medicaid spending.

Improve overall processing time performance for eligibility determination

The Medicaid system currently used by the 21 CWAs does not track pending cases. However, the State is in the process of developing a new eligibility system known as CASS that is designed to determine eligibility for **all** of the State's Medicaid and social services programs. This system will be able to produce various reports so that DMAHS can track the processing of cases by the CWAs.

DMAHS has taken several steps to address this issue. In November 2010, a Medicaid Communication was issued to all eligibility determination agencies reiterating the importance of the timely processing of applications and what notices were needed. In addition, training sessions were held to educate providers on what information is needed to complete an application. Also, DMAHS entered into a MOU with all 21 CWAs agreeing to improve backlogs by 3% quarterly for all Medicaid applications. CWAs will receive an incentive for meeting this benchmark and for providing the requested reports within established timeframes. All the agreements were signed by the end of March 2011 and DMAHS is in the process of evaluating the first quarter reports.

CASS will enable CWAs to provide more effective and efficient service to clients through:

- Automated eligibility determinations based on documented rules
- Common front end edits
- Real-time processing
- Integrated cases and evidence sharing across multiple programs
- Automatic routing of tasks and approvals
- Reduced paper processing and automation of many current manual tasks
- Improved management and tracking reports
- Citizen and provider portals

CASS in cooperation with the Document Imaging Management System (DIMS) resolves many of the major problems of a paper-intensive system including:

- Lost or misplaced files and documents
- Difficulty sharing information among workers

- Inconvenience for clients who must supply the same information multiple times
- High costs of copying, locating and storing information

The State has designed CASS to be its eligibility rules engine for the Health Care Exchange. CASS will process all applications to Medicaid and the Exchange beginning January 1, 2014 and determine program eligibility and handle the expected churning between programs. As a result, the State does expect CASS will qualify for 90% federal Medical Assistance percentage (FMAP) for development for the entire cost of the system based on the Tri-Agency letter of August 10, 2011. Operational costs will continue to receive 75% FMAP for Medicaid's allocated share on an ongoing basis.

The State understands that these performance improvement steps will require a significant investment of time and resources on its part, but believes that the benefits to members and potential cost savings to the State are significant. These proposals reflect the State's commitment to a Medicaid program that operates more efficiently under a cohesive vision of eligibility and coverage.

Medicaid as payer of last resort

Under Title XIX of the Social Security Act, Medicaid is intended to be the payer of last resort with few exceptions, such as Title V and IHS funding. Medicaid continues to be available, however, to individuals who are insured through commercial and employer-based insurance and/or Medicare. On the other hand, Title XXI which authorizes the State CHIP is explicitly available only to the uninsured. Both Medicare and private insurers have avoided payment of millions of dollars in claims they should have rightfully paid, as explained below.

Retroactive Medicare Part B

For well over 30 years, state Medicaid programs provided health care services to individuals who were eligible for Medicare, but because of an error in eligibility determination by the SSA, were categorized as eligible for SSI rather than Social Security Disability Insurance. The error is reflected in the eligibility category known by states as SSI without Medicare. States observed that the SSI without Medicare population was growing at a rate far in excess of the elderly and disabled with Medicare. This error is acknowledged by CMS and the SSA.

The total amount paid by states was originally estimated at \$4.8 billion (state funds only), but this figure is expected to increase. At present, the State's share is estimated at \$107.3 million. In response to the error, CMS originally stated that it could not pay the states because the Medicare program only pays providers. States were asked to recoup payments from providers and then ask providers to bill Medicare. This would be a problem for two reasons. Most of the Medicare claims submitted by providers would no longer be considered timely filed and would be denied. This practice would also place a significant administrative burden on providers and the states.

As an alternative, many states have proposed that CMS allow states to pursue a solution through an 1115 waiver, and to use the amount owed (using the Medicare 222(b) authority) as the non-federal share of expenditures in their current programs. The State has incorporated this proposal into its comprehensive waiver, understanding the final disposition will be negotiated on behalf of a number of states.

At the same time, this Medicare Part B error points to the difficulty states have in ensuring that the Medicaid agency is the payer of last resort.

Health Insurance Premium Payment

The HIPP program has two components:

- POP – The New Jersey Medicaid program pays the entire medical benefit premium for fragile children and adults when such payment is determined to be cost effective.
- PSP – New Jersey Medicaid reimburses the employee portion of the employer-sponsored health insurance (ESI) premium for NJ FamilyCare persons when the payment is determined to be cost-effective.

Currently, POP eligibility is based on manual evaluations of recipient diagnoses, Medicaid expenditures and TPL payments. PSP eligibility is based on ESI premium costs versus Medicaid MC costs. Under the waiver, the State is seeking to streamline the eligibility determination process, including the use of information already being developed through the risk adjustment process. Premium payments under both programs will include available COBRA coverage and LTC insurance, in addition to employer based insurance.

Risk adjustment

Payments to MCOs under the State’s Medicaid Managed Care program are risk adjusted based on the diagnoses, demographic characteristics (i.e., age, gender and geographic area), and pharmacy drug utilization of the covered members. The information used is aggregated from the following sources:

- Encounter records for medical and pharmacy treatment provided through the MCO in which the recipient is currently enrolled
- Encounter records, if any, for medical and pharmacy treatment provided through any other MCOs in which the recipient was previously enrolled
- Claim records for the time period in which the recipient was covered under FFS Medicaid before being enrolled in the Medicaid MCO

Generally, risk adjustment scores are calculated for all recipients who have at least six months of eligibility (through the combination of FFS and MCO coverage) during a 12-month base period. This assures a reasonable opportunity for persons with disease conditions to have a professional or facility visit in which a diagnosis is recorded. In addition, risk adjustment scores are calculated for newborns, even if they have fewer

than six months of coverage during the base period, since they invariably have encounters at birth and during the first several months of life.

The State uses the Chronic Disability Payment System (CDPS)/Rx risk adjustment system. This system is calibrated from State-specific Medicaid and NJ FamilyCare encounter data. There are four separate scales of risk adjustment – for seniors, Temporary Assistance for Needy Families (TANF) and related adults, TANF and related children, and the blind and disabled. The output of the risk adjustment system is a relative risk score compared to a 1.000 for an average adult, child, or disabled person. Adults, children and disabled persons are in separate rate categories in NJ FamilyCare/Medicaid Managed Care.

In the determination of cost-effectiveness for POP or PSP, the risk adjustment score will be utilized for those persons for whom a score is available.

When no such risk adjustment score is available, an assumed risk score would be developed from information on the health status questionnaire that applicants will be required to complete, along with questions about potential sources of ESI. This self-reported health information will be used to develop a proxy risk adjustment score.

Payment of Premium Program

Through the waiver, the State is requesting an expansion of the eligibility group for the POP program. In addition to the current fragile children and adults, the following individuals would be eligible for POP:

- Pregnant women
- Persons in LTC, both in NFs and in community waivers
- Persons whose risk adjustment score (actual or proxy) exceeds a predetermined cost-effective threshold

LTC insurance (LTCI) is typically purchased as an individual insurance policy with no financial contribution by employers. Some persons who become eligible for Medicaid may have been paying LTCI premiums for years, but they will be unable to continue paying the premiums due to their financial circumstances. Having the POP program take over the payment of the LTCI premium may prove cost effective, especially if the person is currently receiving any LTCI benefits (including in-home services) or is currently in the elimination period (90 days is common) after having a qualifying condition

Premium Support Program

Through this waiver, the State is requesting that adults and children eligible for PSP be enrolled in both the ESI coverage and the NJ FamilyCare/Medicaid programs. The MCO will treat the ESI as primary, with the MCO being responsible only for those services that are permissible under these programs but not covered by the ESI. This is a change from the current practice, in which PSP enrollees are enrolled in the ESI with Medicaid FFS providing wraparound services for those costs not covered by the ESI.

The State currently operates under Section 2105(c)(3) of CHIPRA and is requesting a waiver from the current requirement that an employer contribute at least 50% of the total premium. The State is requesting a waiver to allow enrollment of eligible individuals in their ESI as long as it is cost effective to do so.

The State would also like to implement a concurrent eligibility review process when persons first apply to NJ FamilyCare. This method would permit concurrent processing of PSP and NJ FamilyCare applications, thereby preventing PSP applicants from being covered first by NJ FamilyCare for a few months and then being moved to PSP. If they are eligible for NJ FamilyCare and their ESI is cost-effective, they would enroll directly into both NJ FamilyCare and PSP.

In addition, the ESI must meet more requirements to be considered “qualified employer-sponsored coverage.” This includes qualification as creditable coverage under §2701(c) (1) of the Public Health Service Act. ESI that meets the definition of a high deductible health plan under §223(c) (2) of the Internal Revenue Code does not meet the requirements of “qualified employer-sponsored coverage.”

The minimum actuarial value of ESI that qualifies as “qualified employer-sponsored coverage” will need to be determined. Once ESI plans are given the metallic labels (bronze, silver, gold, or platinum) that will be used under Health Reform beginning in 2014, a minimum based on the metallic labels will be determined.

Employee contributions for benefit plans depend on which family members are to be covered. Typically, employees are (if they enroll any child) required to enroll all eligible children. The chart below provides a description of the various rate tier structures that are in common use. Note that the same label name can have different meanings, depending on the tier structure. The 4-tier structure is the most common structure being used currently.

Table 3.2

	Rating tier definitions			
Covered persons	5-tier structure	4-tier structure	3-tier structure	2-tier structure
Employee (Ee)	Ee only	Ee only	1 person	Single
Ee + Spouse (Sp)	Ee + Sp	Ee + Sp	2 person	Family
Ee + 1 Child	Ee + 1 Child	Ee + Child(ren)	2 person	Family
Ee + Children	Ee + Children	Ee + Child(ren)	3 or more	Family
Ee+Sp+Child(ren)	Family	Family	3 or more	Family

Determinations on whether to enroll persons in ESI in addition to their NJ FamilyCare Managed Care will be based on evaluating the scope of services that persons on NJ FamilyCare are eligible for as compared to the scope of services that their employers’ plan provides. Some rate tier structures will result in a parent being enrolled along with

the child or children, as long as it is cost effective to do so. Cost effectiveness will be evaluated in the aggregate.

The MCO capitation payment reflects the average cost of the rate group and the average MCO risk assessment of the rate group.

The value of the NJ FamilyCare/Medicaid coverage being shifted is specific to the covered person, as measured by his/her most recent risk adjustment score (or proxy score based on self-reported health status for those not yet scored). This could result in seemingly disparate determinations due to individuals having different risk adjustment scores. The following example shows how the difference in the risk adjustment information could alter the decision on reimbursement of the employee's portion of the ESI premium. With lower than average risk scores, the ESI premium component is cost effective for covering two (or more) children (Situation 3), but not for covering just one lower risk child (Situation 2). However, with a higher risk score for one child (Situation 1), the ESI coverage is cost-effective.

Table 3.3

	Situation 1	Situation 2	Situation 3
Person(s) being considered	One FamilyCare D child	One FamilyCare D child	Two FamilyCare D children
SFY 2012 monthly MCO premium (1.000 risk score)	\$150.00	\$150.00	\$300.00 (\$150.00 per child)
Risk score of person(s)	1.400	0.860	Average (0.900,0.820) = 0.860
Risk-adjusted SFY 2012 monthly premium	\$210.00	\$129.00	\$258.00
* Actuarial value of ESI (Plan D =1.000)	0.800	0.800	0.800
Risk-adjusted ESI value	\$168.00	\$103.20	\$206.40
ESI rate tier (4-tier structure)	Ee+Child(ren)	Ee+Child(ren)	Ee+Child(ren)
Employee portion of cost to move from current coverage tier to tier covering these persons	\$160.00	\$160.00	\$160.00
Potential monthly savings	\$8.00	(\$56.80)	\$46.40
Decision	Cost effective	Not cost effective	Cost effective

* This value is a comparison between the commercial plan benefit package and the State's Medicaid benefit package. The algorithm is developed in accordance with actuarial standards.

4

Benefits and provider payments

The State is requesting flexibility to define covered services; adopt limits on the amount, duration and scope of services; and impose copayments and other cost sharing under the Comprehensive Waiver as necessary. This section also describes provider payment initiatives under the Comprehensive Waiver.

Benefits

Tables 4.1 and 4.2 describe the current benefits for each of the Plan types tied to the eligible populations described in the previous section and the service delivery system under which the benefits are received. These exhibits also highlight the movement to managed care of certain benefits (under the Comprehensive Waiver) that are currently provided FFS (and 1915(b) waiver authority sought for changes applicable July/October 1, 2011 and January 1, 2012).

- *July 2011 Summary.* Previously carved-out services including ABD Pharmacy, Adult and Pediatric Medical Day Care, ABD Home Health Care, Physical Therapy/Occupational Therapy/Speech Therapy, and Personal Care Assistant services moved to MCOs
- *August 2011 Summary.* Mandatory managed care for non-dual ABDs
- *October 2011 Summary.* Mandatory managed care for dual eligibles
- *January 1, 2012 Summary.* Medicare Special Needs Plan (SNP) services provided through MCOs
- *July 1, 2012 Summary.* NF and HCBS (waivers), except for the Community Care Waiver, moved to MCOs and children's BH services paid by DMAHS moved to the CSOC ASO
- *January 1, 2013 Summary.* Adult mental health and addiction services moved to MBHO

As shown in these exhibits, the State has few limitations on the amount, duration and scope of services, but is seeking the flexibility to adopt such limitations under the

Comprehensive Waiver following the protocol for CMS review and approval described in Section 2 Streamlining and efficient operations.

New community-based services are contemplated under managed LTC, BH and DD programs as described in the applicable subsection of Section 5.

Table 4.1 – Benefits and copayments

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C ^{1, 2}	NJ FamilyCare Plan D ^{1, 2, 3}	Plan G GA
Abortions	Federal law covers only if mother's life is endangered if pregnancy goes to term, or in cases of rape or incest	Yes – FFS for therapeutic/induced abortions; MCO for spontaneous abortions/ miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes – FFS for therapeutic/induced abortions; MCO for spontaneous abortions/ miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes – FFS for therapeutic/induced abortions; MCO for spontaneous abortions/ miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes – FFS for therapeutic/induced abortions; MCO for spontaneous abortions/ miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes
Abortions – Induced/therapeutic	Mandatory - Federal law covers only if mother's life is endangered if pregnancy goes to term, or in cases of rape or incest	Yes – FFS for therapeutic/induced abortions; (dx: 623, 634.0-634.99, 635.9, 637.0-637.99)	Yes – FFS for therapeutic/induced abortions; (dx: 623, 634.0-634.99, 635.9, 637.0-637.99)	Yes – FFS for therapeutic/induced abortions; (dx: 623, 634.0-634.99, 635.9, 637.0-637.99)	Yes – FFS for therapeutic/induced abortions; (dx: 623, 634.0-634.99, 635.9, 637.0-637.99)	Yes
Abortions - Spontaneous	Mandatory - Federal law covers only if mother's life is endangered if pregnancy goes to term, or in cases of rape or incest	Yes – MCO for spontaneous abortions/ miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes – MCO for spontaneous abortions/ miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes – MCO for spontaneous abortions/ miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes – MCO for spontaneous abortions/ miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes
Biofeedback	Optional	No	No	No	No	No

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
Blood and Blood Plasma	Mandatory when needed for inpatient hospital and other mandatory services (e.g., home health, NF and outpatient hospital)	Yes	Yes	Yes	No	Yes
Blood Processing Administrative Cost	Mandatory when needed for inpatient hospital and other mandatory services (e.g., home health, NF and outpatient hospital); otherwise optional	Yes	Yes	Yes	Yes	Yes
Case Management (Targeted) - Chronically Ill	Optional	Yes	No	No	No	No
Case Management - Chronic mental illness	Optional	No	No	No	No	Yes

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
Certified Nurse Practitioner/Clinical Nurse Specialist	Mandatory when covered by State under physician, EPSDT, home health or certified nurse midwife; otherwise optional (e.g., if covered under Other Licensed Practitioner)	Yes	Yes	Yes - \$5 copayment except for preventive care services	Yes - \$5 copayment except for preventive services. \$10 copayment for non-office hours and home visits if indicated on the ID card	Yes
Chiropractor	Optional	Yes – spinal manipulation only	Yes – spinal manipulation only	Yes – spinal manipulation only – \$5 copayment	No	Yes
Clinic Services (free standing) - Ambulatory	Optional, other than Federally Qualified Health Centers (FQHC), RHCs and outpatient hospital which are mandatory	Yes	Yes	Yes – \$5 copayment except for preventive services	Yes – \$5 copayment except for preventive services	Yes
Clinic Services (free standing) - End Stage Renal Disease	Optional, other than FQHCs, RHCs and outpatient hospital which are mandatory	Yes	Yes	Yes	Yes	Yes

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
Clinic Services (free standing) - Family Planning	Mandatory	Yes - Family planning services and supplies from either the MCO's family planning provider network or from any other qualified Medicaid family planning provider for plans A, B and C - not available outside the MCO's provider network for Plan D (except for PSC 380)	Yes - Family planning services and supplies from either the MCO's family planning provider network or from any other qualified Medicaid family planning provider for plans A, B and C - not available outside the MCO's provider network for Plan D (except for PSC 380)	Yes - \$5 copayment except for PAP smear - family planning services and supplies from either the MCO's family planning provider network or from any other qualified Medicaid family planning provider for plans A, B and C - not available outside the MCO's provider network for Plan D (except for PSC 380)	Yes - \$5 copayment except for PAP smear - family planning services and supplies from either the MCO's family planning provider network or from any other qualified Medicaid family planning provider for plans A, B and C - not available outside the MCO's provider network for Plan D (except for PSC 380)	Yes
Clinic Services (free standing) - Mental Health	Optional, other than FQHCs, RHCs and outpatient hospital which are mandatory	Yes - MCO for DDD clients	Yes - FFS	Yes - FFS - \$5 copayment	Yes - FFS - \$5 copayment - 35 days inpatient and 20 visits outpatient per year; \$25 copayment for outpatient hospital mental health; \$5 copayment for psychologist services	Yes

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
Cosmetic Services	Optional	No – except cosmetic surgery when medically necessary and approved	No – except cosmetic surgery when medically necessary and approved	No – except cosmetic surgery when medically necessary and approved	No – except cosmetic surgery when medically necessary and approved	No – except cosmetic surgery when medically necessary and approved
Dental - Medical/Surgical Services of Dentist	Mandatory	Yes	Yes	Yes	Yes	Yes
Dental Services	Optional	Yes – MCO; FFS for specified codes when initiated by a Medicaid non-managed care provider prior to first time managed care enrollment (exemption only if initially received services during 60-120 day period immediately prior to initial managed care enrollment)	Yes – MCO; FFS for specified codes when initiated by a Medicaid non-managed care provider prior to first time managed care enrollment (exemption only if initially received services during 60-120 day period immediately prior to initial managed care enrollment)	Yes – \$5 copayment unless preventive care – MCO; FFS for specified codes when initiated by a Medicaid non-managed care provider prior to first time managed care enrollment (exemption only if initially received services during 60-120 day period immediately prior to initial managed care enrollment)	Yes – same level of dental services as provided to Plan A-C for children under the age of 19	NA

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
Dental Services - Orthodontia	Optional	Yes – limited to children with medical necessity to improve the craniofacial dysfunction and/or dentofacial deformity or orthodontia services initiated prior to July 1, 2010	Yes – limited to children with medical necessity to improve the craniofacial dysfunction and/or dentofacial deformity or orthodontia services initiated prior to July 1, 2010	Yes – limited to children with medical necessity to improve the craniofacial dysfunction and/or dentofacial deformity or orthodontia services initiated prior to July 1, 2010	Yes – limited to children with medical necessity to improve the craniofacial dysfunction and/or dentofacial deformity or orthodontia services initiated prior to July 1, 2010 (for children whose orthodontia services were initiated while enrolled in NJ FamilyCare)	NA
Diabetic Supplies and Equipment	Optional	Yes	Yes	Yes	Yes	Yes
Durable Medical Equipment (DME) for Vision Impairment	Optional	Yes	Yes	Yes	No	Yes
DME	Optional	Yes	Yes	Yes	Yes – limited to certain DME services that could prevent costly future inpatient admissions	Yes

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
Early Intervention	Optional	Yes - FFS	Yes - FFS	Yes - FFS	Yes - FFS	NA
Educational Services	Optional	No	No	No	No	NA
Emergency Services	Mandatory	Yes	Yes	Yes – \$10 copayment	Yes – \$35 copayment per visit; no copayment if results in an admission or if referred to ER by primary care provider (PCP)	Charity Care
EPSDT	Mandatory	Yes	Yes – EPSDT exams, dental, vision and hearing services are covered. Does not include all services identified through an EPSDT exam	Yes – EPSDT exams, dental, vision and hearing services are covered. Does not include all services identified through an EPSDT exam	Yes - Well child care only	Yes – under 21
Experimental Services	Optional	No	No	No	No	No
Family Planning Services	Mandatory	Yes – FFS when furnished by a non-participating provider and MCO when furnished by a participating provider	Yes – FFS when furnished by a non-participating provider and MCO when furnished by a participating provider	Yes – FFS when furnished by a non-participating provider and MCO when furnished by a participating provider	Yes – MCO provider only except for PSC 380	Yes

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
Family Planning Services - Infertility Services	Optional	No	No	No	No	No
FQHC	Mandatory	Yes	Yes	Yes – \$5 copayment for non-preventive care visits	Yes – \$5 copayment for non-preventive care visits	Yes
HealthStart	Mandatory	Yes	Yes	Yes	Yes	NA
Hearing Aid Services	Optional	Yes	Yes	Yes	Yes – only covered for children age 15 or younger in NJ FamilyCare D	Yes
Home Health	Mandatory for over age 21	Yes	Yes	Yes	Yes – limited to skilled nursing care for the home bound	Yes
Home Health - Rehabilitation Services	Optional	Yes	Yes – 60 consecutive business days per incident/injury per year	Yes – 60 consecutive business days per incident/injury per year	Yes – \$5 copayment – 60 consecutive business days per incident/injury per year	Yes
Hospice Services	Optional	Yes	Yes	Yes	Yes	Yes

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
Hospital – Inpatient	Mandatory	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Charity Care
Hospital - Inpatient - Religious Non-Medical Services - Mt. Carmel Guild Hospital and Christian Science Sanitaria Care	Optional	Yes - FFS	No	No	No	No
Hospital – Outpatient	Mandatory	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – \$5 copayment except for preventive services; institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – \$5 copayment except for preventive services; institutions owned or operated by federal government, such as VA hospitals, are excluded	Charity Care

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
Hospital – Rehabilitation	Mandatory	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Charity Care
Intermediate Care Facility for Persons with Mental Retardation (ICF/MR)	Optional	Yes – FFS	No	No	No	No
Laboratory	Mandatory	Yes	Yes	Yes	Yes – \$5 copayment	Yes
Maternity	Mandatory	Yes	Yes	Yes – \$5 copayment for first prenatal care visit only	Yes – \$5 copayment for first prenatal care visit only	No
Maternity - Midwifery Services (non-maternity)	Mandatory	Yes	Yes	Yes - \$5 copayment except for preventive care services	Yes - \$5 copayment except for preventive care services	Yes

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
Maternity - Midwifery Services (maternity)	Mandatory	Yes	Yes	Yes - \$5 copayment except for prenatal care visit	Yes - \$5 copayment except for prenatal care visit; \$10 copayment for non-office hours and home visits	No
Medical Day Care - Adult	Optional	Yes	No	No	No	No
Medical Day Care - pediatric	Optional	Yes	No	No	No	No
Medical Supplies	Optional	Yes	Yes	Yes	Yes – limited	Yes
Mental Health - Adult Rehabilitation	Optional	Yes – FFS; MCO for DDD clients	No	No	No	No
Mental Health – Inpatient	Optional	Yes – FFS; MCO for DDD clients	Yes – FFS	Yes – FFS	Yes – FFS; limited to 35 days per year.	Charity Care
Mental Health - Outpatient	Optional	Yes – FFS; MCO for DDD clients	Yes – FFS	Yes – FFS	Yes – FFS - \$25 copayment per visit	Charity Care
Methadone Maintenance	Optional	Yes - FFS	Yes - FFS	Yes - FFS	No	Yes
NF (or custodial care)	Mandatory for over age 21	Yes – MCO first 30 days and FFS after 30 days (moves to Managed Care July 1, 2012)	No	No	No	No

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
Ophthalmology Services	Mandatory	Yes	Yes	Yes	Yes	Yes
Optical Appliances	Optional	Yes	Yes	Yes	Yes – limited to one pair of glasses or contact lenses per 24 month period or as medically necessary	Yes
Optometrist	Optional	Yes	Yes	Yes – \$5 copayment per visit	Yes – \$5 copayment per visit; one routine eye exam per year	Yes
Organ Transplants	Optional	Yes – experimental organ transplants not covered	Yes – experimental organ transplants not covered			
Orthotics	Optional	Yes	Yes	Yes	No	Yes
Other Therapies	Optional	Yes	Yes	Yes - \$5 copayment	Yes	Yes
Partial Care	Optional	Yes – FFS	Yes – FFS	Yes – FFS	Yes – FFS – limitations apply – 20 outpatient visits per year	Yes

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
Partial Hospital	Optional	Yes – FFS	Yes – FFS	Yes – FFS	Yes – FFS – limitations apply – 35 inpatient visits per year	Yes – charity care
Personal Care Assistant	Optional	Yes	No	No	No	Yes
Personal Care Assistant - Mental Health	Optional	Yes – FFS with limit on hours	No	No	No	Yes
Pharmacy – (ADDP) Covered Anti-Retroviral Drugs	Optional - Pharmaceuticals on the Master Rebate List are mandatory	Yes	Yes	Yes	Yes	Yes
Pharmacy – Erectile Dysfunction Drugs	Optional	No	No	No	No	No
Pharmacy - Mental Health/Substance Abuse	Optional, other than FQHCs, RHCs and outpatient hospitals which are mandatory	Yes	Yes	Yes	No	Yes
Pharmacy - Atypical anti-psych	Optional	Yes	Yes	Yes	Yes	Yes

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
Pharmacy - High Cost Drugs	Optional - Pharmaceuticals on the Master Rebate List are mandatory	Yes	Yes	Yes	Yes	Yes
Pharmacy - Infertility	Optional - Pharmaceuticals on the Master Rebate List are mandatory	No	No	No	No	No
Pharmacy - Suboxone	Optional - Pharmaceuticals on the Master Rebate List are mandatory	Yes	Yes	Yes	Yes	Yes
Pharmacy – Over the Counter (OTC) Drugs and All Other OTC Products	Optional	Yes - for children (EPSDT service)	Yes - for children (EPSDT service)	Yes - for children (EPSDT service)	No	Yes – under 21 (EPSDT services)
Pharmacy – Over the Counter Drugs – Cough, Cold and Cosmetic Products	Optional	Yes - for children (EPSDT service)	Yes - for children (EPSDT service)	Yes - for children (EPSDT service)	No	Yes – under 21 (EPSDT services)
Pharmacy - Physician Administered Drugs	Optional	Yes	Yes	Yes	Yes	Yes

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
Pharmacy – Prescription Drugs Not Reimbursable	Optional	Yes - copayments for adults age 21 or older excluding NJCPW; FFS for ABD and all duals	Yes	Yes – \$1 copayment for generic/\$5 brand – includes insulin, needles and syringes	Yes – \$5 copayment/\$10 copayment>34 day supply for adults age 21 or older	Yes
Pharmacy – Prescription Drugs Reimbursable	Optional	Yes – copayments for adults age 21 or older excluding NJCPW; FFS for ABD and all duals	Yes	Yes – \$1 copayment for generic/\$5 brand – includes insulin, needles and syringes	Yes – \$5 copayment/\$10 copayment>34 day supply for adults age 21 or older	Yes
Pharmacy - Reimbursable Blood Factor	Optional - Pharmaceuticals on the Master Rebate List are mandatory	Yes	Yes	Yes	No	No
Physician/PCP Practitioner	Mandatory	Yes	Yes	Yes – \$5 copayment for non- preventive visits	Yes – \$5 copayment for non-preventive visits; \$10 copayment for after hours and home visits	Yes
Podiatrist	Optional	Yes – no routine care	Yes – no routine care	Yes – no routine care; \$5 copayment	Yes – no routine care; \$5 copayment	Yes - no routine care
Private Duty Nursing	Optional	Yes – when authorized; up to 21 years of age	Yes – when authorized	Yes – when authorized	Yes – when authorized	No

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
Prosthetics	Optional	Yes	Yes	Yes	Yes – limited to the initial provision of a prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease, injury or congenital defect	Yes
Psychiatric Hospital – Inpatient	Optional if covered by the SPA	Yes – FFS for under 21 and over 65 years of age	Yes – FFS for under 21 and over 65 years of age	Yes – FFS for under 21 and over 65 years of age	Yes – FFS for under 21 and over 65 years of age; limited to 35 days per year	Charity Care
Radial Keratotomy	Optional	No	No	No	No	No
Radiology	Mandatory	Yes	Yes	Yes	Yes – \$5 copayment	Yes
Recreational Therapy	Optional	No	No	No	No	No
Rehabilitation – Outpatient Physical, Occupational, Speech	Optional	Yes	Yes – 60 consecutive business days per incident/injury per year	Yes – 60 consecutive business days per incident/injury per year	Yes – \$5 copayment – 60 consecutive business days per incident/injury per year	Yes

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
RTC Services	Optional	Yes – FFS	Yes – FFS	Yes – FFS	No	No
Respite Care	Optional	Yes (moves to Managed LTC July 1, 2012)	Yes	Yes	Yes	Yes
School Based Services	Optional	Yes - FFS	Yes - FFS	Yes - FFS	Yes - FFS	No
Sex Abuse Exams	Mandatory	Yes – FFS	Yes – FFS	Yes – FFS	Yes – FFS	Yes
Skilled Nursing Facility	Mandatory	Yes – MCO first 30 days and FFS after 30 days (moves to Managed LTC July 1, 2012)	Yes	Yes	Yes	Yes
Sleep Therapy	Optional	No – excludes rest cures	No – excludes rest cures	No – excludes rest cures	No – excludes rest cures	No
Substance Abuse – Inpatient (SAI)*	Optional	Yes – FFS; MCO for DDD clients	Yes – FFS	Yes – FFS	Yes – FFS (detox only)	Only through the SAI
Substance Abuse – Outpatient*	Optional	Yes – FFS; MCO for DDD clients	Yes – FFS	Yes – FFS	Yes – FFS - \$5 copayment per visit (detox only)	Only through the SAI
Temporomandibular Joint Disorder Treatment	Optional	Yes	Yes	Yes	No	Yes
Thermograms and Thermography	Optional	Yes	Yes	Yes	No	Yes

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
Transportation – Emergent (Ambulance, Mobile Intensive Care Unit)	Mandatory	Yes	Yes	Yes	Yes	Yes
Transportation – Non-Emergent (Ambulance Non-Emergency, Medical Assistance Vehicles (MAV), Livery, Clinic)	Optional	Yes	Yes	Yes	No	Yes
Vaccines	Mandatory for EPSDT	Yes – While the vaccine administration costs remain the responsibility of the MCOs, the vaccination cost for Title XIX children (NJ FamilyCare A) are not the responsibility of the MCOs. These vaccine costs are covered under the Vaccines for Children (VFC) program.	Yes	Yes	Yes	NA

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA
Vaccines - Administration	Mandatory for EPSDT	Yes – While the vaccine administration costs remain the responsibility of the MCOs, the vaccination cost for children (NJ FamilyCare A) are not the responsibility of the MCOs. These vaccine costs are covered under the VFC program.	Yes	Yes	Yes	
Vaccines - Vaccination	Mandatory for EPSDT	Yes – While the vaccine administration costs remain the responsibility of the MCOs, the vaccination cost for children (NJ FamilyCare A) are not the responsibility of the MCOs. These vaccine costs are covered under the VFC program.	Yes	Yes	Yes	

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C ^{1, 2}	NJ FamilyCare Plan D ^{1, 2, 3}	Plan G GA
1 - Both Eskimos and Native American Indian children under the age of 19, identified by Race Code 3, are not required to pay copayments.						
2 - The total family (regardless of family size) limit on all cost-sharing may not exceed 5% of the annual family income.						
3 - Plan D copayments limited only to adult enrollees with incomes greater than 150% FPL. All Plan D children have copayments.						
4 - Sources Covered Services - Article 4.1 of Volume I of Medicaid/NJ FamilyCare Managed Care Contract; and Section B.4.1 of Appendices (Volume II) of Medicaid/NJ FamilyCare Managed Care Contract.						
Copayments - Section B.5.2 of Appendices (Volume II) of Medicaid/NJ FamilyCare Managed Care Contract.						
Federal Medicaid Law - 42 CFR Part 440						

Table 4.2 Home and community based services under the Comprehensive Waiver

	GO	TBI	CRPD	ACCAP	CCW
1915(c) Waivers responsible for provision and payment until July 1, 2012 when MCOs become responsible Excluding CCW and Supports Waiver once submitted which remain FFS	Case Management	Case Management	Case Management	Case Management	Case Management
	Assisted Living		Private-Duty Nursing	Private-Duty Nursing	Support Coordination for People who Self-Direct
		Behavioral Program	Environmental/Residential Modification	Personal Care Assistant Services (beyond the 40 hour limit available through the MCO or Personal Preference program)	Assistive Technology Devices
		Environmental/Vehicular Modifications	Vehicular Modification		Day Habilitation
	Adult Family Care	Community Residential Services	Personal Emergency Response Systems		Environmental and Vehicle Adaptations
	ALP/Subsidized Housing	Counseling	Community Transitional Services		Individual Supports for Activities of Daily Living
	Caregiver/Participant Training	Cognitive Rehabilitative Therapy			Personal Emergency Response Systems

	GO	TBI	CRPD	ACCAP	CCW
	Chore Services	Structured Day Program			Respite Care
	Community Transition Services	Supported Day Program			Supported Employment Services
	Environmental Accessibility Adaptations	Physical Therapy			Transition Services
	Home Based Supportive Care	Occupational Therapy			Transportation Services to Waiver Services
	Home Delivered Meal Service	Speech, Language and Hearing Therapy			
	Personal Emergency Response Systems	Respite Care			
	PERS Medication Dispensing System				
	Respite Care				
	Special Medical Equipment and Supplies				
	Social Adult Day Care				
	Transitional Care Management- Up to 90 days in NFs to ensure transition back to HCBS				
	Transportation to Waiver and Non-State Plan Services				

Cost sharing

The Comprehensive Waiver also seeks authority to engage the population the State serves in using health care services appropriately. To this end, the State seeks the flexibility to implement enhanced cost sharing, including premiums and copayments. As shown in Exhibit 4.1, the State currently imposes copayments under Plans C and D. In the concept paper, the state was proposing a \$25 copayment for non-emergent emergency department (ED) use for Plans A, B and C (Plan D has a current \$35 copayment; Plan G does not have ED coverage). The stakeholder feedback was mixed regarding charging a \$25 copy for non-emergent use of the ED.

New Jersey Medicaid is not unique from other states in its challenge to reduce non-emergent use of the ED. An article in the Washington Post, 'Hospitals seek more ER patients even as Medicaid tries to lessen demand'¹, references the struggles of other states and some of the strategies states are implementing to combat this issue.

DHS will be establishing a task force, which will be comprised of representatives from hospitals, MCOs, providers groups and FQHCs. The task force will be asked to come up with recommendations on the best way to reduce non-emergent use of the ED in the Medicaid population. Their report will be due to the Commission of Human Services by January 1, 2012. Recommendations could include: co-payments, re-examining the current New Jersey statute 26:2H-12.8, which is more expansive than the federal Emergency Medical Treatment and Labor Act (EMTALA) law, tiered reimbursement and ED diversion programs.

Our MCOs have showed success in reducing ED use among NJ FamilyCare/Medicaid members, our most recent data show that 62% of visits to hospital EDs are still for Low Acuity Non-Emergent (LANE) conditions (SFY 2010 LANE Report). As a result, DMAHS has been and continues to be very aggressive in establishing MCO capitation rates and application of cost efficiency adjustments that reflect the State's expectation that MCOs will continue to reduce LANE ED utilization. Capitation rates set for July 1, 2011 include efficiency adjustments based on the SFY 2010 LANE data.

DMAHS has also taken into consideration the lessons learned from the partnership with the New Jersey Hospital Association's Health Research and Education Trust (HRET) and the New Jersey Primary Care Association to pilot test a model for providing alternate non-emergency services to patients who present with primary care needs in hospital EDs. This pilot included an express care process, connectivity to a community PCP, and expanded capacity of those providers. Of particular importance, the community care provider filled a health home role. (See Section 5 regarding adoption of health home pilots by MCOs.)

¹ Washington Post

http://www.washingtonpost.com/national/health-science/hospitals-seek-more-er-patients-even-as-medicaid-tries-to-lessen-demand/2011/07/01/gIQADoB7WJ_story.html

The 13 most frequent reasons for an ED visit (adults and children combined) based on the State Fiscal Year 2010 report are:

- Acute upper respiratory infection unspecified
- Otitis media (ear infection)
- Unspecified viral infection
- Fever
- Ankle Sprain
- Pharyngitis
- Headache
- Rash (including diaper rash)
- Abdominal Pain
- Urinary tract infection
- Vomiting
- Asthma
- Cough

For children, the top 35 diagnosis codes associated with ED visits appear below.

Rank	Dx	Description	Frequency
1	465.9	ACUTE URIS OF UNSPECIFIED	20,979
2	382.9	UNSPECIFIED OTITIS MEDIA	17,464
3	780.60	FEVER, UNSPECIFIED	13,292
4	079.99	UNSPEC VIRAL INF CCE & UN	11,900
5	462	ACUTE PHARYNGITIS	8,143
6	558.9	UNS NONINF GASTROENTERIT&	7,103
7	787.03	VOMITING ALONE	5,201
8	493.90	UNS ASTHMA W/O ASTHMATICU	3,815
9	599.0	UTI SITE NOT SPECIFIED	3,728
10	920	CONTUS FACE SCALP&NECK EX	3,715
11	789.00	ABDOMINAL PAIN, UNSPECIFI	3,260
12	845.00	UNSPEC SITE ANKLE SPRAIN&	3,045
13	486	PNEUMONIA, ORGANISM UNSPE	2,831
14	782.1	RASH&OTH NONSPECIFIC SKIN	2,601
15	564.00	UNSPECIFIED CONSTIPATION	2,464

16	692.9	CONTACT DERMATIT&OTH ECZEM	2,047
17	372.30	UNSPECIFIED CONJUNCTIVITI	2,007
18	786.2	COUGH	1,896
19	466.19	ACUT BRONCHIOLITIS-OTH IN	1,888
20	034.0	STREPTOCOCCAL SORE THROAT	1,831
21	784.0	HEADACHE	1,819
22	463	ACUTE TONSILLITIS	1,783
23	995.3	ALLERGY UNSPECIFIED NEC	1,659
24	490	BRONCHITIS NOT SPEC AS AC	1,625
25	787.91	DIARRHEA	1,528
26	708.9	UNSPECIFIED URTICARIA	1,148
27	V58.32	ENCOUNTER FOR REMOVAL OF	1,057
28	844.9	SPRAIN&STRAIN UNSPEC SITE	1,028
29	784.7	EPISTAXIS	939
30	729.5	PAIN IN SOFT TISSUES OF L	742
31	842.00	SPRAIN&STRAIN UNSPEC SITE	638
32	787.01	NAUSEA WITH VOMITING	636
33	842.10	SPRAIN&STRAIN UNSPECIFIED	623
34	311	DEPRESSIVE DISORDER NEC	590
35	380.4	IMPACTED CERUMEN	217
Total of Top 35 Adjusted LANE Diagnosis Codes			135,242

It is important to note that more ED visits occur on Monday when office/clinics are available and not during weekend hours when office/clinic hours are more limited.

Provider payments

The Comprehensive Waiver includes components that revise payment rates to providers to achieve four objectives:

- Rebalance the service delivery system toward community based primary and specialty care
- Provide equity in payments to in-state and out-of-state hospitals
- Incentivize payment reforms between MCOs and hospitals
- Participate in the Affordable Care Act (ACA) provider payment reform demonstrations testing global and bundled payments

Rebalancing. While the current program has relatively generous eligibility policies and benefit packages, the program pays rates to some providers that serve as a disincentive to program participation and limit members' access to primary care. The New Jersey Medicaid program is in need of rebalancing with regard to the rates paid to PCPs and specialists. Physician FFS rates are approximately 41% of Medicare rates and are estimated to be less than 25% of usual and customary charges. MCOs are encouraged to delink themselves from the FFS rates and, in the case of primary care, the MCOs appear to have done so. Based on encounter data, payments for primary care CPT codes affected by ACA provisions exceed 53%. Through this waiver, New Jersey anticipates increasing reimbursement for certain specialists and psychiatrists.

Fairness in payments to in-state and out-of-state providers.

In addition to rebalancing, the State will also seek changes in payment rates that are designed to achieve fairness when making payments to out-of-state providers. Most states limit payments to out-of-state hospitals to the lesser of the average rate paid to in-state hospitals or the rates paid the hospital by the Medicaid program in their resident state. The State will adopt a similar policy as follows:

- Pay out-of-state providers the lesser of the New Jersey Medicaid rate or the servicing state's Medicaid rate or the provider's charge for the service.

Pennsylvania and New York have comparable policies for payment of out-of-state hospitals.

Incentivize payment reform between MCOs and hospitals

While DMAHS continues to encourage MCOs to delink themselves from the FFS rates, it is clear that FFS rates continue to influence MCO and hospital behavior. As the State moves more of its population to managed care, FFS rates will no longer be maintained. For this reason, the State is proposing to:

- Require that non-contracted hospitals providing emergency services to NJ FamilyCare/Medicaid members enrolled in the managed care program accept, as payment in full, 95% of the amount that the non-contracted hospital would receive from DMAHS for the emergency services and/or any related hospitalization if the beneficiary were enrolled in Medicaid FFS. (Until such time that DMAHS no longer maintains a fee schedule the rate would be a % of Medicare rate that is an equivalent fee schedule.) This is a modification to the New Jersey Appropriations Act.
- Continue setting Medicaid managed care capitation rates that reflect costs associated with an efficient/effective MCO as compared to rate development at a cost-plus calculation. Specifically, capitation rates will continue to include a LANE analysis, which is a clinical-supported approach that targets inefficient/unnecessary ED utilization, as discussed above. New Jersey Medicaid managed care data shows that about 62% of all ED services were deemed LANE visits in SFY 2010 with 24% determined to be preventable, accounting for 9.6% of the SFY 2010 ED expenditures. Prospectively, Medicaid managed care capitation rates will be reduced

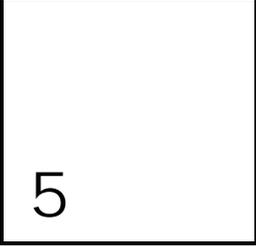
to reflect the expectation that MCOs must further reduce unnecessary ED utilization of its members.

- Under certain circumstances, require non-contracting hospitals and MCOs to enter into mediation.

Participate in provider payment reforms under ACA to pursue episodic pricing and linkages to outcomes. There are two payment reform opportunities under ACA in which the State will seek participation with its MCOs and hospitals if available to Medicaid and not just Medicare:

- Integrated Care Around Hospitalization – Section 2704 establishes a demonstration project, in up to eight states, to study the use of bundled payments for hospital and physician services under Medicaid. The demonstration is effective on January 1, 2012 and ends December 31, 2016.
- Medicaid Global Payment System – Section 2705 establishes a demonstration project, in coordination with the CMS Innovation Center, in up to five states that would allow participating states to adjust their current payment structure for safety net hospitals from a FFS model to a global-capitated payment structure. The demonstration will operate through 2012. The ACA authorizes this program but does not appropriate any funding.

The State is awaiting guidance from CMS on these issues.



5

Delivery system innovations

In April 2011, about 75% of all NJ FamilyCare/Medicaid clients were enrolled in a managed care plan, including over 100,000 individuals with complex medical needs. The SFY 2012 managed care enrollment initiative will result in nearly 92% of Medicaid enrollees being served through managed care.

August 1, 2011 Group – Approximately 45,000 individuals in the Aged, Blind or Disabled categories were enrolled in managed care.

October 1, 2011 Group – Approximately 110,000 individuals who receive both Medicare and Medicaid will be enrolled in managed care.

In addition to these expansions, the Comprehensive Waiver includes a series of delivery system innovations. These innovations include:

- Expansion and innovations through the State's MCOs
 - Duals Medicare SNPs
 - Additional managed care improvements/pilots
 - Health homes
 - Accountable Care Organizations
 - Pharmacy pilots
- Managed LTC
- Managing BH
 - BH for Adults/Children
 - 1915(i) MATI services
- Managing supports for intellectual and DD
 - Community and ICF MR supports
 - I/DD with dual mental health diagnosis 1915(c) like pilot program
 - Children with pervasive developmental disorders 1915(c) like pilot program
 - Medical necessity and developmental disabilities

Expansion and innovations using the State's MCOs

Medicare special needs plans

The integration of care for dual eligibles is part of the State's broader effort to transform its health care system. Beginning July 1, 2011, and into the fall, the State is transitioning from a FFS system to a managed care system for its dual eligibles. The dual eligibles use a wide array of services and the incidence of duplicative services and contraindicated therapies and drugs is heightened in a FFS system that lacks sufficient care coordination. This adversely impacts the quality of care and health outcomes of the dual eligibles, as well as contributes to inefficient and unsustainable health care spending for the State, Medicaid and Medicare. As a result, the primary and acute care needs of most Medicaid populations, including dual eligibles and the aged, blind and disabled, will be met through amendments to the current Medicaid MCOs. In so doing, the State will also include services such as pharmacy for the aged, blind and disabled, that have historically been carved out of managed care. Additionally, effective January 1, 2012, the State will contract with Medicare SNPs that are also Medicaid MCOs.

In addition to primary and acute care services, dual eligibles use LTC services. The care for these services is disconnected in the State's current FFS delivery system. For HCBS or Medicare Advantage plan management of acute Medicare services, there is concentrated case management on that particular service. However, comprehensive care management that addresses all aspects of care is limited. Therefore, effective July 1, 2012, the State will further amend its existing MCO contracts to manage all LTC services including HCBS and NFs for the elderly and physically disabled. Those dual eligibles in LTC or at risk of LTC will have integrated primary, LTC, HCBS, BH and acute care services in a coordinated managed care environment.

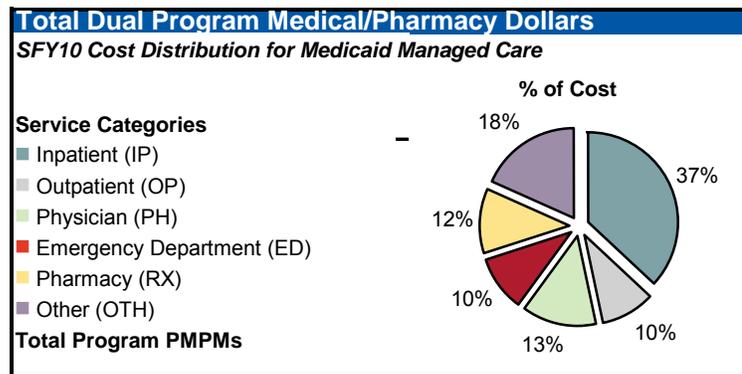
Further, the integration of BH and medical care is an important challenge in any health care system, but it is especially problematic for dual eligible individuals who need to navigate across different payers. BH services provided by New Jersey's current FFS system and Medicare lack the infrastructure to coordinate BH care services for dual eligibles. Beginning July 1, 2012 for children and January 1, 2013 for adult duals with BH needs will be managed by the SNPs for Medicare benefits including deductibles and coinsurance. The care coordination will support more effective care.

Eligibility requirements

The State will target for enrollment in the new integrated care model the Medicaid beneficiaries who receive full Medicaid benefits and who are also eligible for Medicare. There are currently 23,000 duals voluntarily enrolled in a MCO and another 117,000 in FFS and transitioning to Medicaid managed care effective October 1, 2011. Approximately 6,000 dual eligibles are enrolled in existing dual SNP health plans. About 500 of these SNP members are with MCOs other than those under contract with the State for its Medicaid managed care program. Through the comprehensive waiver, the State will require that dual eligibles enroll in a single Medicaid MCO/Medicare Advantage SNP for receipt of both Medicaid and Medicare benefits.

The State will be requesting Medicare data sets to further evaluate the dual eligible population using linked Medicare/Medicaid data. The Medicaid data currently available for this population indicates there are a wide array of care needs, health conditions and spending profiles.

Due to programmatic restrictions, limited provider access, and minimal financial resources, dual eligibles face some of the highest hurdles to getting the specialty care they need. At the same time, though, this group is the most expensive segment of the State's Medicaid population.



Many of the dual eligibles are chronically ill, seriously disabled, or both. Complex health care needs require access to an integrated system where the delivery of care is approached from a health home that promotes care management. Effective July 1, 2011, MCOs in the State are required to participate in health homes. The State will continue to conduct more in depth analyses on the dual eligible population to develop strategies, such as health homes, to more efficiently care for the duals. The State will also review LTC services that would be most effective for the duals. Integrating care has the potential to greatly contribute to quality improvements and potential savings which could be reallocated to better meet the needs of the dual eligibles.

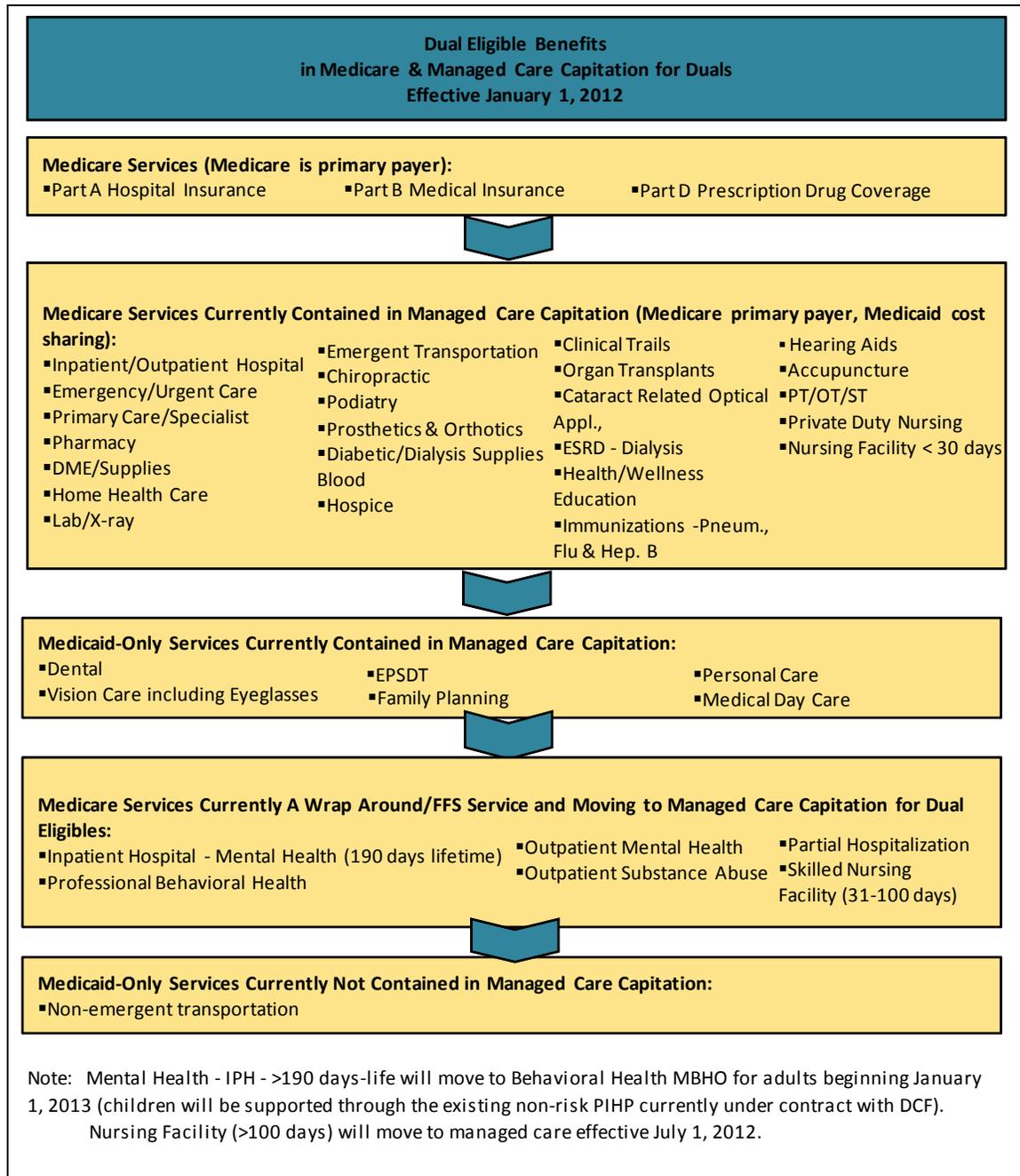
The State intends to design its integrated care model to ensure that a large enough number of dual eligible individuals participate to ensure the feasibility of the program. Enrollment by dual eligible individuals will be mandatory in Medicaid managed care effective October 1, 2011. Enrollment in Medicare SNP is voluntary. Sufficient levels of enrollment in this new model will be critical to expanding access to services and care coordination and improving quality of care and health outcomes. In addition, the savings potential is dependent on adequate enrollment in the integrated care entities. However, it appears that CMS does not have the authority to waive freedom of choice under Medicare. In the absence of such authority, the State requests the ability to auto-assign a member to the same Medicare and Medicaid plan with an opt out for Medicare and the authority to limit Medicaid payment of Medicare cost-sharing to only those Medicare providers that are within the Medicaid MCOs' network. This enhances the goal of encouraging dual eligibles to enroll in the same plan for their Medicaid and Medicare benefits. The State believes this is consistent with the requirements of seamless

conversion enrollment for newly Medicare Advantage (MA) eligibles available option for MA-eligible individuals currently enrolled in other health plans offered by an MA organization (i.e., commercial or Medicaid plan) at the time of their conversion to Medicare. Per the Medicare Managed Care Manual, CMS reviews an organization's proposal and must approve it before use.

Benefits

Dual eligibles participating in the program will have access to the full range of primary, acute, specialty, BH, pharmacy, HCBS and institutional services as currently covered and provided by Medicare and Medicaid. The State currently provides HCBS services to dual eligibles through the Medicaid State Plan and through a broad menu of services covered under Section 1915(c) waivers.

Effective January 1, 2012, DMAHS will contract with MCOs to deliver all Medicaid state plan services and Medicare covered services. The MCOs will administer Medicaid and Medicare benefits jointly so that enrollees will experience their coverage as a single, integrated care program. The MCOs offer enhanced benefits to SNP members to encourage enrollment instead of enrollment in the standard Medicaid MCO membership. For example, the State eliminated coverage of the Medicare Part D copayment for duals on July 1, 2011 and SNPs could cover this pharmacy copayment as an incentive for duals to enroll.



Medicare Advantage SNPs include all covered services – physical and behavioral. Further, Medicare does not allow simultaneous enrollment for BH services in FFS and acute medical capitated managed care. The ability to capture Medicare payments for BH is severely limited under a carve out. Therefore, Medicare BH benefits are in the dual eligible SNPs capitation.

Service delivery (including payment mechanism)

The State will build upon its extensive knowledge and experience with managed care programs for dual eligibles and Medicaid-only beneficiaries. Currently, DMAHS contracts with four Medicaid MCOs to manage the health services for 92% of its enrollees. In every area of the State, members have a choice of at least two MCOs. HealthFirst, who entered the New Jersey Medicaid managed care market in the fall of 2009, is expected to be statewide during 2012. All four MCOs have signed contracts with DMAHS to provide comprehensive care management for the Dual-SNP program with enrollment to begin January 1, 2012. The State's integrated care model for dual eligibles will be implemented statewide January 1, 2013.

The MCOs will deliver care that ensures that all of the health needs of dual eligibles are met and coordinated across the health care delivery system. MCOs have demonstrated their experience to deliver care to their current 23,000 voluntary dual eligibles. The State will significantly improve the alignment of services by providing a single capitated rate to the MCOs. Additionally, prior to the alignment of Medicaid and Medicare to begin on January 1, 2012, out of network claims are paid FFS subject to the Medicaid maximum allowable by the State. Following the implementation of the dual eligible SNP program, there will not be any out of network claims. The key design principles of the managed care model are:

- Comprehensive care coordination
- Accountability of a single entity for delivery of covered services
- Administrative Simplicity
- Financial integration

The State has an established infrastructure for actuarially sound capitation rate setting. DMAHS will provide an at-risk capitated payment to MCOs that reflects the full set of covered services, as well as administration and care management costs. The compensation of the contractors will consist of monthly premium payments. The financing model also assumes the MCOs will be building in new payment reform concepts, such as health homes. The State has extensive experience using both FFS claims data and MCO encounter data to support rate development and risk adjustment.

The State will use the experience gained with this integrated care model to make ongoing improvements to the service delivery of dual eligibles.

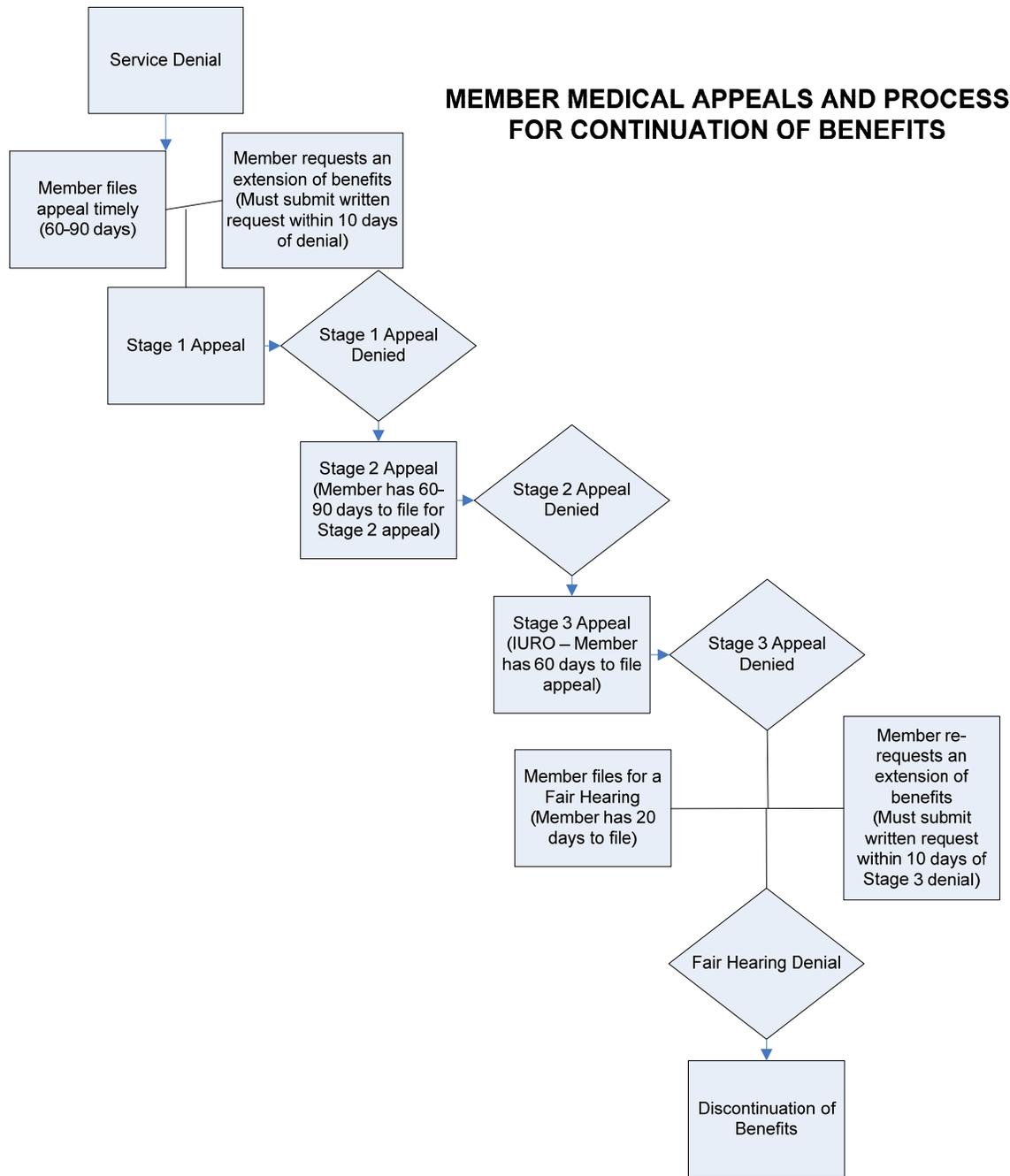
Reporting, program monitoring and quality management

The State has a long history of supporting the administration of services also covered under Medicare Parts A, B and D in both FFS and managed care. The State has an established infrastructure for program monitoring, quality improvement efforts, and capturing utilization through encounter and financial data. The State is well positioned to apply its knowledge and expertise to contract with MCOs.

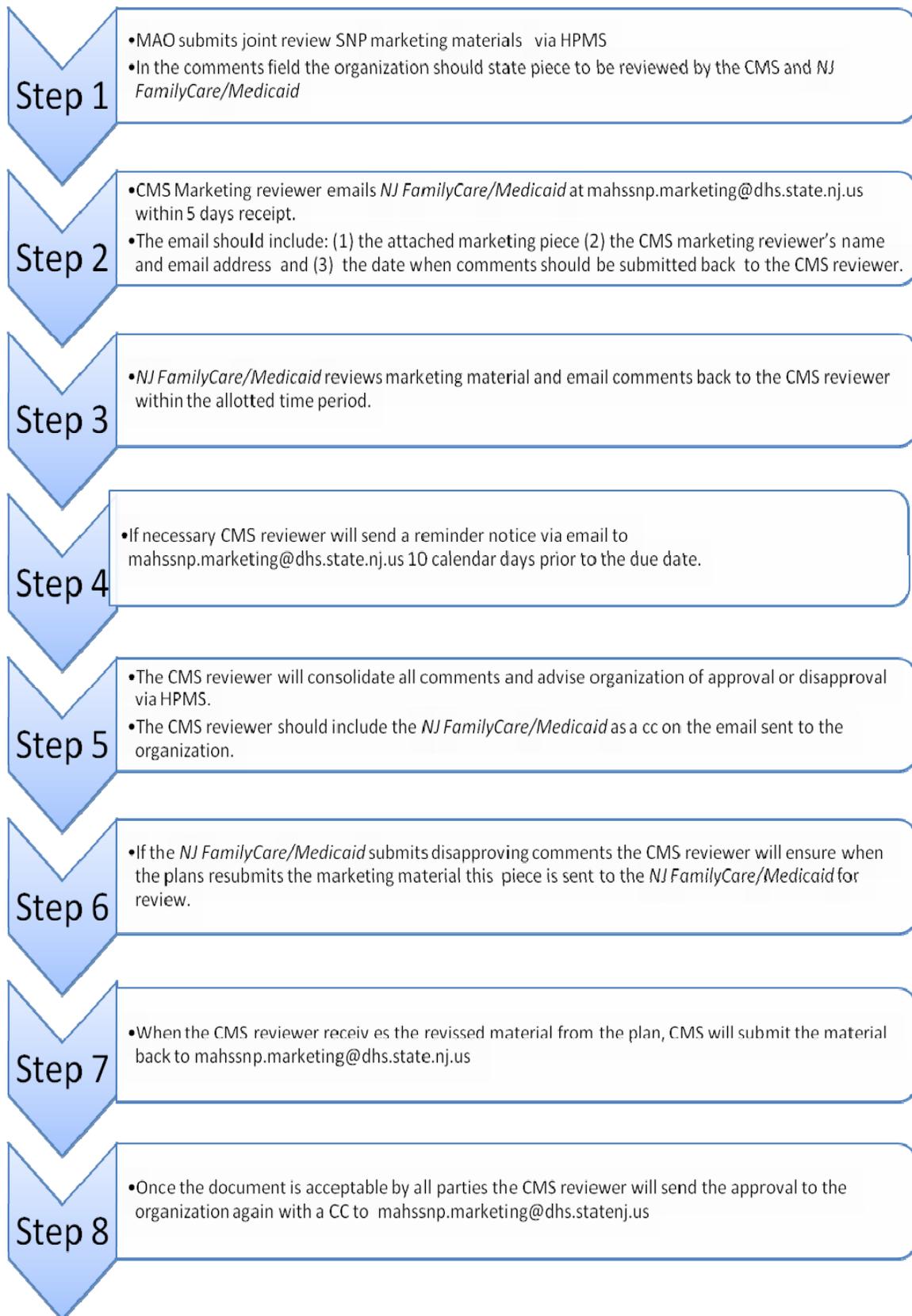
The contractors will be required to collect, analyze and report data to implement effective QA, utilization review and peer review programs. In addition to requiring MCOs to submit financial reports semi-annually and requesting Medicaid MCO encounter data for dual eligibles, the State intends to request the MCOs submit their Medicare SNP data. Given that the State does not currently have access to the full Medicare FFS data files, the State will pursue the attainment of the full Medicare data files through a data use agreement with CMS. The State has a data warehouse that allows for easy and timely access to all eligibility, Medicaid FFS and encounter claims data. This data will be integrated into the State's data warehouse to allow for ease of analyses. The State plans to build on the studies previously undertaken to better understand the unique characteristics of the dual populations, identify potential areas to target for performance improvement, review the adequacy of the Medicare Advantage financing payments and assess various risk adjustment approaches for Medicaid. Performance measurement is a critical component of the demonstration and will be used to guide continuous improvements in service delivery and program effectiveness.

Quality management (QM) entails measuring health outcomes, adhering to evidence-based best practices and promoting continual quality improvements. SNP quality improvement must consider the specialized needs of the population served and conduct quality improvements activities tailored to dual eligibles. Pursuant to 42 CFR 422.152(c)-(d), SNPs shall conduct both a chronic condition improvement program (CCIP) and quality improvement program (QIP). Quality improvement activities shall be shared with the Division of Medical Assistance's External Quality Review Organization. This builds off of DMAHS experience with the managed care program and will be administered by DMAHS.

Finally, the State seeks to streamline oversight requirements, and as such, will seek a single appeals process rather than the two processes – one under Medicare and one under Medicaid. Below is the Medicaid managed care appeals process flowchart.



Additionally, the State has prepared procedures to conduct reviews of dual SNP marketing materials. This is a concurrent review process with CMS. Below is a flowchart outlining the procedures.



Additional managed care improvements/pilots

Health homes

According to the 2008 Actuary Report issued by the Office of the Actuary, Center for Medicare and Medicaid Services, the Medicaid outlay for benefits is expected to grow at an annual average rate of 7.9% and enrollment is expected to increase at an annual rate of 1.2% over the next 10 years.² These figures cement the role of Medicaid becoming the single largest purchaser of health care at a time when the nation's health care system is considered, by most, to be inefficient and difficult to navigate; lacking the necessary infrastructure to drive significant changes in value and quality. These issues are even more significant for Medicaid recipients who often have fewer choices of physicians, longer wait times and greater disparities in health outcomes when compared to their commercial counterparts. In order to address these issues, given the complex nature of our health care system and the growing demand for services, Medicaid programs must develop innovative solutions to ensure both the sustainability of the program through streamlining program administration and by demanding greater value which can be measured through improved health outcomes and access to coordinated and integrated service delivery. The health care reform legislation passed in 2010 provides the necessary authority for states to explore new avenues of service delivery and provides the State with unique opportunities to develop greater synergies with many efforts currently underway within their Medicaid managed care delivery model.

In 2010, the Governor signed Public Law 2012, Chapter 74, which required DMAHS to establish a three year Medicaid Medical Home demonstration program with its managed care providers. The legislation mandated the following principles:

- Must be developed in consultation with the MCOs
- Restructure the payment system to support PCPs in adopting a medical home model
- Develop a system to support PCPs in developing the necessary infrastructure to provide a medical home
- Include Medicaid enrollees with chronic diseases and the frail elderly in the demonstration
- Employ health information technology (HIT) and chronic disease registries
- Develop a standard set of performance measures to assess cost savings, rates of health screenings and outcomes of care.

To provide additional context, the State's acute care program accounted for over 45% of Medicaid expenditures in 2009.³ For this reason, transformation of the primary care network is an integral component in DMAHS' Medicaid reform package. Through partnership with their MCOs, DMAHS can leverage their purchasing power to help drive

² 2008 Actuarial Report, Office of the Actuary, Center for Medicare and Medicaid Services.
<http://www.centerforself-determination.com/docs/MedicaidReport2008.pdf>

³ The Kaiser Foundation, State Health Facts, 2009:
<http://www.statehealthfacts.org/profileind.jsp?cat=4&sub=47&rgn=32>

the necessary delivery system reform. In short, primary care is viewed as the frontline of all service delivery; thus, transformation at this level will help to drive other delivery system innovations such as Accountable Care Organizations, which use medical homes as their building blocks. It is DMAHS’ intent to continue to develop the current Medical Home demonstration pilot as legislated through S-665 into a Health Home program that comports with the requirements of Section 2703 of the ACA.

DMAHS has since signed Memoranda of Agreement (MOA) with each of the four MCOs operating within the program and included it in the managed care contract to develop medical home pilots within each of their networks that meet the components defined under the State’s law. The MOA delineates additional requirements such as:

- Assuring that medical homes attain NCQA Level I accreditation by the end of the first year and Level II accreditation by the end of the 2nd year of the demonstration pilot; Level III is optional, at this point.
- Encourage medical home development aimed at persons that are chronically ill, DD and the frail elderly
- Assure the provision, at a minimum, of the following services:
 - Patient centered care using a multidisciplinary team of health care professionals that coordinate care through use of HIT and chronic disease registries across all domains of the health care system and the patient’s community, including active participation by patient and family in decision-making and care planning
 - Individual customized care plans that promote self-management behaviors
 - Patient and family education for patients with chronic diseases
 - Home-based services
 - Telephonic communication
 - Group care
 - Oral health examination
 - Culturally and linguistically appropriate care
- Each medical home will collect and report data on:
 - A minimum of two quality measures
 - One patient perception of care survey
 - Efficiency measures

The current managed care pilots include various types of practices from individual group practices, a large hospital based IPA and several FQHCs. The initial medical home pilot is expected to target approximately 25,000 enrollees. FQHCs play a pivotal role in many of the State’s delivery system innovations from health homes and ACOs to the pharmacy medication therapy management pilot and the Medicaid incentive program for the chronically ill. The New Jersey Primary Care Association, a non-profit corporation that represents the organizational providers and affiliates of community-based ambulatory health care statewide, has several members actively engaged with DMAHS and the MCOs to promote the patient centered medical home model of primary care delivery both as standalone centers and as part of an ACO.

Concurrent with implementing health home pilots under managed care, the State has developed two BH home pilots funded through Substance Abuse and Mental Health Services Administration (SAMHSA) grants. The pilots operate under two different clinical models. One is a fully integrated health home that is licensed to deliver both BH and primary care services. The other model is a partnership between a FQHC and four BH providers. The FQHC provides medical supervision and staff to deliver medical services at the four BH provider locations. Additional pilots are expected and may choose from the two current clinical models under the SAMHSA grant or offer a new model. Clinical models must be aligned with DMAHS health home goals, deliver the required services, meet all health home standards and be approved by DMAHS.

Based on the same principles of enhanced access, population health management and the use of HIT, enrollees engaged in a BH home will experience comprehensive care management to support building and maintaining self-care habits and engaging community supports. In addition to the services of a Health Home outlined above, the BH Home pilots provide wellness and recovery activities, peer supports to enhance engagement in services, prevention services, coordination of ancillary supports and a specific focus on the medical, emotional and social issues that commonly occur with individuals with SMI and substance use disorders. The success of this program highlights how delivery system innovations can improve the overall health and wellness of vulnerable populations residing within the State.

Under section 2703 of the ACA, States implementing a health home program are entitled to receive enhanced match for the basket of six (6) health home services; this enhanced funding is available for up to eight (8) quarters per target population to be included under the program. Thus, DMAHS anticipates ongoing discussion and collaboration with the MCOs, the MBHO and CMS to ensure that the populations, services and QM, reporting and monitoring requirements comport with those under section 2703 of the ACA.

Patient eligibility requirements

The MCOs have targeted both the adult and pediatric populations that include the chronically ill, special needs, DD and those with BH needs for participation in their individual pilot programs. The BH home will initially target adults, 18 years of age or older and who have a SMI, a co-occurring mental illness and substance use disorder and/or a substance use disorder who experience, or are at high risk for, other chronic health conditions. It is DMAHS' expectation that over time whether the health home targets BH or physical health (PH) as the primary issue – the whole person concept, which is the foundation of the health home, will be embraced by all health home providers and members experiencing co-occurring physical and BH issues will be treated in an integrated environment.

Benefits

The basket of six (6) health homes services outlined in the State Medicaid Director (SMD) letter dated November 16, 2010 are consistent with those required under the State's legislation S-665 and further defined under the MOA between DMAHS and the

MCOs. Service definitions related to the BH home will need to be more fully developed and provider qualifications defined so that the administrative oversight by DMAHS can reach certain economies of scale for ongoing monitoring and reporting. This may include but not be limited to service and provider qualification requirements that are comparable to those for health homes under managed care such as the timeline for Level I, II and III NCQA accreditation. DMAHS will continue to work with the MCOs and CMS to develop service definitions that comport with the health home services required under the ACA.

Service delivery (including payment mechanism)

Implementation of the health home under a managed care delivery system will require additional considerations to ensure a cohesive statewide strategy and to encompass an actuarial rate setting process that is inclusive of managed care strategies that incent the delivery of health home services. Given the various provider types currently engaged in the medical home demonstration pilot, DMAHS has not limited the types of health home provider arrangements but is preferential to those options that afford the greatest flexibility in meeting the overall Medicaid reform package goals. Development of ongoing capitation rates will take into account the various reimbursement methodologies of each of the MCOs in developing their medical home programs. Currently, DMAHS will provide initial start up funding to the MCOs to assist in building the health home framework within their individual networks and encouraging practices to attain NCQA accreditation for medical home Level I and II; Level III is currently optional. Under the current pilot program each of the MCOs require their medical home provider sites to be NCQA recognized prior to participating in pay-for-performance or other provider recognition programs. DMAHS will continue to work with its MCOs and CMS to ensure the evolution from the current State mandated Medical Home demonstration to a more encompassing Health Home program that comports with the ACA requirements.

BH homes are currently funded through a SAMHSA grant. The MCOs will be required to collaborate with DMAHS, DMHAS and the MBHO to develop an integrated financial and provider contracting strategy that addresses the following for the BH home providers:

- Submission of claims for PH services to the MCO
- Submission of claims for BH services to the MBHO
- Per member per month (PMPM) fees to cover BH home care coordination costs that are billed to the MBHO
- Expansion beyond the current SAMHSA grant to include the financial strategy for funding care coordination and financial incentives to support program goals; funding considerations will take into account the savings or other cost impact of the program

Reporting, monitoring and quality management

The MCOs will be responsible for implementing the required reporting and monitoring of health home services through their established health home provider network. Their requirements will be codified in contractual arrangements between the managed care entity and the individual health home practice. DMAHS will be responsible for tracking, calculating and monitoring the overall health home pilot outcomes. Through the use of

MOAs and contract amendments, DMAHS will ensure each managed care entity is in compliance with overall Health Home requirements. The use of EHR and/or patient care registries is required to meet NCQA recognition of a Patient Centered Medical Home. Additional use of HIT through the use of Health Information Exchanges and linked provider networks is also underway within the State. More detail can be found in the ACO section below. The MBHO will be required to assist DMAHS and DMHAS with administration of the BH homes, including but not limited to the two pilots under the SAMHSA grant. Responsibilities will include reporting and monitoring, provider contract and performance requirements and coordination with the MCOs regarding service delivery and financing.

Although many of the quality and efficiency measures under the State mandated Medical Home demonstration are congruent with those required under Section 2703 of the ACA, further alignment will be required to meet the full requirements of the Health Home program. DMAHS will continue to work with CMS to ensure the quality, monitoring and reporting program meets the requirements outlined under the ACA.

It is DMAHS' intent to convene a Health Home Transformation Steering Committee to help guide, direct and build synergies between multiple delivery system innovations currently under consideration as part of the Medicaid reform package. Additionally, DMAHS will convene a Statewide Health Home Transformation Collaborative aimed at providing assistance and technical support to those practices that wish to transform their current delivery model to meet the requirements established for a Health Home.

Accountable Care Organizations

Accountable Care Organizations (ACOs) take the health home concept from the individual primary practice setting and further organize it into a collective group of PCPs, specialists, hospitals and other health care delivery settings such as laboratory, radiology, home health and other community venues. ACOs can take on various shapes and forms but at the heart of each are shared principles aimed at improving the quality of care delivered to patients through implementation of patient focused care planning activities that are coordinated by providers who are held accountable for the cost and outcomes of care. Ultimately, ACOs provide for greater alignment of provider incentives throughout the health delivery system by implementing a transparent process to measure performance of the participating providers and to incent efficient service delivery through a model of shared savings. Shared savings can then be disseminated amongst the ACOs delivery network to those providers who have helped to drive improved health outcomes and greater system efficiency and to invest in and enhance the system infrastructure to create a more sustainable health care system.

On August 19, 2011, Governor Christie signed Public Law 2011, Chapter 114 requiring DMAHS to establish a Medicaid Accountable Care Organization Demonstration project. It is the intent of the project to increase access to primary and BH care, pharmaceuticals and dental care, improve health outcomes and quality and reduce unnecessary and

inefficient care without interfering with patients' access to their health care providers.⁴ The bill requires that ACOs develop networks that include primary care, BH, dental, pharmacy and other health care providers. The aims of the Medicaid ACO are as follows:

- Engage Medicaid recipients in treatment
- Promote medication adherence and use of medication therapy management and promote healthy lifestyles
- Develop skills in help-seeking behaviors including self-management and illness management
- Improve access to services for primary care and BH care through home-based services and telephonic and web-based communications
- Improve service coordination to ensure integrated care for primary, behavioral, dental and other health care needs.

Patient eligibility requirements

All Medicaid enrollees within the ACO's defined geographic service area are eligible to receive services. Each managed care entity that has contracted with a qualified Medicaid ACO will work with the ACO to determine the population by which outcome and performance measures will be collected. There is nothing to preclude a Medicaid recipient from seeking care outside of the ACO or from excluding individuals who live outside of the service area from seeking services from a participating ACO provider.

Benefits

Within the context of the State's managed care delivery model, ACOs will provide access to all the services currently available under the SPA; no additional services outside of the defined benefit package will be available at this time. However, it is the State's expectation that ACOs be integrated into their respective communities and to assist in the coordination of community based services that can close the gap between individual recipient need and available services under the SPA.

Service Delivery (including payment mechanisms)

Under the current state statute ACOs participating in the Medicaid demonstration shall be nonprofit corporations with governing boards that include representation including, but not limited to hospitals, clinics, private practices, physicians, BH care providers, dentists, patients and other social service agencies or organizations located in the designated service area with voting representation from at least two consumer organizations capable of advocating on behalf of patients residing within the designated service area.⁵

The service area is defined by a geographic area and the ACO must include all general hospitals and at a minimum 75% of qualified PCPs and four qualified BH care providers operating within the service area. ACO providers are entitled to continue to receive

⁴ State of New Jersey Public Law 2011, Chapter 114

⁵ State of New Jersey, Public Law 2011, Chapter 114

standard FFS reimbursement from managed care entities which contract with them and must establish a plan for gain sharing.

In the context of a managed care delivery model and under FFS, as these innovations begin to affect the Medicaid cost curve, New Jersey and other states will require the expenditure authority to share savings and redistribute dollars back into the system.

Reporting, monitoring and quality management

Each contract between the managed care entity and the ACO will define the scope of reporting and monitoring requirements. Timeframes for measurement, population identification, performance measures (i.e.: cost and quality) are further described and agreed to within these contract documents.

DMAHS will work with CMS to develop the appropriate evaluation criteria to comport with the requirements of section 2703 of ACA which will include measures including but not limited to: rates of health screening, outcomes of hospitalization rates for persons with chronic illnesses and the hospitalization and readmission rates for patients residing within the ACO service area. The State plans to compare the performance of the ACO service area for LANE use rates for ACO and non-ACO service areas.

Pharmacy pilot

The burden of chronic disease on our healthcare system is staggering, in fact the total healthcare expenditure for the treatment of chronic disease accounts for the majority of healthcare spending.⁶ It is estimated that 66% of total healthcare dollars are expended towards 27% of Americans with multiple chronic illnesses.⁷ An integrated approach directed toward this patient population would greatly reduce the current financial healthcare burden. The success of any intervention requires coordination across all health professionals, including pharmacists. The role of the pharmacist has changed drastically over the past decade.⁸ Today’s clinical pharmacists are specially trained, having comprehensive clinical expertise garnered through intensive patient-centered experiences throughout their education.

Pharmacists are uniquely qualified to *enhance healthcare* by⁹:

- Helping patients optimize medication use
 - Reducing medication errors
 - Minimizing drug-drug and drug-food interactions
 - Encouraging early reporting of adverse drug reactions

⁶ Medco: Drug Trend Report 2010. Accessed online July 9, 2011 at www.drugtrend.com/art/drug_trend/pdf/DT_Report_2010.pdf

⁷ Anderson G. Chronic Care: Making the Case for Ongoing Care. Princeton, NJ: Robert Wood Johnson Foundation; 2010

⁸ American College of Clinical Pharmacy. A vision of pharmacy’s future roles, responsibilities, and manpower needs in the United States. *Pharmacotherapy* 2000;20:991–1020.

⁹ Molloy C. Dean of Rutgers’ Ernest Mario School of Pharmacy. Letter to the commissioner of the Department of Human Services. dated 5/24/2011

- Providing direct patient care services, including:
 - Medication therapy management, especially for chronic diseases
 - Health promotion and education
 - Disease prevention recommendations

Pharmacists are uniquely qualified to *reduce healthcare costs* by¹⁰:

- Recommending cost savings in medication expenditures
- Reducing duplication in medication use and recommending alternative effective treatment regimens in collaboration with the prescriber
- Enhancing patient adherence with appropriate medications that:
 - Reduce hospital readmissions
 - Reduce lengths of stay in the hospital
 - Reduce ED visits.

Pharmacists are able to meet the demands of patients with chronic conditions to help them better understand their disease, their medications and, most importantly, their lifestyle modifications. A collaborative effort between pharmacists and physicians will ultimately benefit all three parties; the patient, the physician and the pharmacist. Pharmacists will triage patients and reduce the burden of follow-up visits on the PCPs.

One primary goal of this pharmacy pilot is to decrease the burden of chronic illness on a healthcare system through medication education, adherence and preventative intervention. The pharmacist plays an invaluable role in this regard. A clinical pharmacist would be placed in three of the currently operating FQHC in the State. The sites will be chosen based on demand and patient demographic data. A concerted effort should also be made to align this pilot with FQHCs operating in conjunction with an Accountable Care Organization (ACO) as this type of front-line practice redesign is a strategy discussed in current ACO legislation. It is estimated that this intervention model will reach approximately 110,000 Medicaid recipients throughout the State.

Patient eligibility requirements

A clinical pharmacist would be located in each of the three pilot FQHC practice sites. This pharmacist, student pharmacists and residents supervised by him/her would be available to all physicians and patients; however, this pilot would primarily be focused towards patients with chronic disease. This patient stratification based on chronic disease and preventative efforts could parallel with a similar stratification in the health home (2703) model should the FQHC choose to participate.

¹⁰ Molloy C. Dean of Rutgers' Ernest Mario School of Pharmacy. Letter to the commissioner of the Department of Human Services. dated 5/24/2011

Service delivery (including payment mechanism)

The entry point to this service is two-fold. Certain disease states will be targeted for pharmacist intervention such as; diabetes, cardiovascular disease, asthma, hemophilia, multiple sclerosis, depression, smoking cessation and DVT/PE prophylactic anticoagulation. Services will also be available to patients stratified by a protocol which would be based on indicators such as; number of disease states, number of medications, drug costs, total healthcare costs. Through collaborative efforts with the FQHC, Rutgers Ernest Mario School of Pharmacy and the MCOs, a predetermined program-wide treatment protocol should be established based on nationally recognized treatment guidelines and agreed upon by all parties participating in this pilot. Follow-up patient visits for these chronic diseases will be triaged to a pharmacist or pharmacy intern, where a complete and comprehensive medication reconciliation and disease assessment would take place. Triaging patients would allow non-emergent maintenance visits to flow through the pharmacist where any monitoring, education, counseling, or medication adjustments within the previously agreed upon guidelines can take place without the recurrent time burden to the physician. From a payer perspective (FFS or MCO), this should manifest cost savings through the shift to a less costly provider without decrease in value to the patient.

Upon reviewing charts and through patient interviews the pharmacist would perform tasks, such as:

- Assessing changes since the last visit, including medication use and transitions in care (care coordination in the health home model).
- Making subjective assessments of medication adherence, self-monitoring, disease control/progression and disease understanding.
- Monitoring drug therapy effectiveness and potential adverse events.
- Addressing any unresolved issues.
- Discussing the goals of prescribed and non-prescribed therapies, including lifestyle modifications.
- Providing an individualized written or printed "take-away," such as an action-plan or personal medication list, to the beneficiary.
- Creating a pharmaceutical treatment plan including any modifications to the patient's drug regimen and schedule a follow-up appointment, as deemed clinically appropriate. The frequency of visits throughout the year will be determined based on patient acuity and disease complexity.

In addition to obtaining a subjective assessment, the pharmacist can also be responsible for ordering or recommending examinations and follow-up lab work, within the permissibility of current law, as it relates to the progression of the disease state (e.g., diabetic monofilament foot assessment for neuropathy, A1C for long-term glycemic control, or FEV1 spirometry to track asthma severity). After the comprehensive review, should any subjective or objective assessment measure fall outside the parameters set forth in the collaborative practice agreement, the pharmacist would reach out to the supervising physician and/or healthcare team for further intervention. Each patient will have a thorough history of past goals, current metrics and future goals which can be

used as means of monitoring the patient through collaborative efforts of the entire clinical team. Patients would also have the opportunity to participate in programs aimed to incentivize healthy behavior, including gift cards for health related expenses. This program would offer incentives, such as gift cards, which could be used for health related expenses for recipients who habitually meet objective goals for their disease state.

Pharmacists will be required to seek additional certification in areas such as diabetes, asthma, hyperlipidemia, cardiovascular disease and smoking cessation. Basic professional requirements for a clinical pharmacist would include:

- Certification (BCPS, CGP) or ASHP Residency including two years clinical experience or
- PharmD degree with three years experience, plus completion of one NCCPC or ACPE Certificate Program or
- BS degree with five years experience, plus completion of two certificate programs.

The pharmacy team will also stay current on treatment guidelines as they pertain to new products, as well as products in the drug pipeline so as to encourage the use of the most cost effective therapies. Pharmacy best practices and medication use for each chronic disease targeted should be documented, updated and disseminated to the entire practitioner group on a regular basis. These best practices would also serve to update the FQHC's practice guidelines under the supervision of each physician specialty group.

In addition to meeting the clinical demands of patients, pharmacists are also uniquely qualified to maximize the healthcare through other mechanisms as well. The pharmacist will be available for consultation regarding polypharmacy as it relates to the overuse of narcotic analgesics, other drugs of abuse and general drug seeking behavior. The pharmacist will also work with pharmacy staff to ensure the FQHC achieves best-price on branded drugs by assuring the health system is adequately maximizing 340b pricing. For efficiency purposes, the FQHC can also defer vaccinations, a low-cost and high-utilization service to the pharmacist.

The State will continue to assess various payment structures for the pilot and will reach consensus on the most appropriate methodology with approval of all participating entities (Rutgers, FQHCs, MCOs).

Each pharmacist may be assisted by up to 3 pharmacy interns with the oversight of Rutgers Ernest Mario School of Pharmacy and no additional cost to the FQHC. These interns have the capacity to fulfill portions of the pharmacist role under the direct supervision of the pharmacist. These student pharmacists can play an important role in patient intake and outcome monitoring throughout the pilot. The opportunity for interns to rotate through the facility offers additional staff for the pilot while also allowing the College to directly participate in this collaboration. The internship program also allows future graduates to become immersed in this setting to pave the way for future PharmDs in expansion sites.

There are two foreseeable barriers to this model which would need to be addressed prior to full implementation. The first barrier is the acceptance of a pharmacist practitioner by the FQHC, physician group and medical directors. The intent of this model should not be misconstrued as a removal of the primary role of the physician, but rather a collaborative practice agreement orchestrated by the physician and implemented by the pharmacist. All exams, lab work and medication changes would be ordered on behalf of the physician within the practice guidelines set forth in the collaborative practice agreement. The adoption of this concept is paramount in the success of the program. The second barrier is the recognition of a pharmacist as a practitioner by the NJ State Board of Pharmacy and other regulatory boards which oversee the practice of medicine in the State.

Reporting, program monitoring and quality management

Assessing the success of an effective medication management intervention can be difficult in that the savings projections are often realized as estimated cost avoidance. There are several surrogate outcomes which can be tracked to monitor quality of care including, but not limited to; HbA1c control, frequency of eye exams in diabetic patients, LDL screening metrics, medication compliance and frequency/results of cardiovascular-related lab work. Most of these can be benchmarked against the regional and national NCQA reported benchmarks and thresholds for Healthcare Effectiveness Data and Information Set (HEDIS) measures. In addition, patient surveys will be created to analyze the success of the program as it relates to patient education and satisfaction. Encounters would need to be tracked for every patient receiving pharmacist services in order to assess outcomes on the backend. In parallel with a billing scenario, pharmacists could track/bill one of the three nationally recognized CPT codes for a pharmacy encounter. A fee schedule suitable for these codes would be agreed upon by the State and participating MCOs.

CPT Code	Service Description
99605	Medication therapy management service(s) provided by a pharmacist, individual, face-to-face, with patient, initial 15 minutes, with assessment, and intervention if provided; initial 15 minutes, new patient.
99606	Initial 15 minutes, established patient visit.
99607 *	Each additional 15 minutes. List separately in addition to code for the primary service.
*Use 99607 in conjunction with 99605, 99606	

Rutgers Ernest Mario School of Pharmacy will work in concert with the three clinical pharmacists to track outcomes. All research efforts will be constructed in collaboration with the MCOs and implemented under the direction of the Dean of the School.

There are a few small studies in the literature which discuss the potential shift in drug utilization trends. A study conducted by the University of Wisconsin-Madison suggests that pharmacist intervention can substantially decrease the medication cost with a

Return on Investment (ROI) of 3.55:1 to the PBM.¹¹ A smaller study completed by the University of North Carolina School of Pharmacy discusses the small fluctuations in drug costs as a result of pharmacist intervention.¹² University of North Carolina researchers found that drug costs can decrease for certain disease states as a result of the combining of drugs to a once-daily regimen for better compliance. They also found that this is offset by other disease states through the addition of new therapies and improved adherence. The savings associated with a pharmacist intervention model will be attributed to the overall improvement in the quality of care as it relates to the treatment of chronic disease. Prevention of disease progression as it pertains to the pharmacist intervention model will realize savings through a decrease in utilization of acute and emergent healthcare services. A recent study published in the *Journal of Managed Care Pharmacy* touts the success of a physician-pharmacist collaborative practice arrangement. This compared the proportion of patients meeting the criteria for metabolic syndrome in a "usual care" setting versus a collaborative arrangement. Researchers found that a higher proportion of patients no longer met the clinical criteria for metabolic syndrome when having pharmacist-provided recommendations and pharmaceutical care.¹³ A similar study also found a clinically important decrease in blood pressure with a commensurate increase in patients reaching goal through an enhanced care model given by a pharmacist and nurse team.¹⁴ Patients were given additional education and counseling in the treatment arm and were referred to the PCP when further assessment was needed. By integrating a clinical pharmacist in the coordination of care on the front end, this care delivery model should realize additional value in the proactive management of chronic disease.

Managed long-term care

In 2010, the State spent more than \$3.5 billion on LTC services for seniors and individuals with physical disabilities under the existing FFS delivery system. Most of the State's spending is for NFs not less costly home and community based care. The experience of other states suggests that managed LTC in a capitated framework can significantly impact cost and shift care to home and community based settings.

Managed care is a tool that the State has been employing to contain costs for well over a decade, although managed care has primarily been used to control the costs of Medicaid primary and acute care rather than LTC. Effective July 1, 2012, the State will further amend its existing MCO contracts to require management of all LTC services including HCBS and NF services for seniors and individuals with physical disabilities. This move to

11 Look KA, Mott DA, Kreling DH, et. al. Economic impact of pharmacist-reimbursed drug therapy modification. *J Am Pharm Assoc* (2003). 2011 Jan-Feb;51(1):58-64.

12 Branham A., Moose J., Ferreri S., et. al. Retrospective Analysis of Medication Adherence and Cost Following Medication Therapy Management. *Innovations in Pharmacy*. 2010, Vol. 1, No. 1, Article 12

13 Hammad EA., Yasein N., Tahaineh L. et. al. A Randomized Controlled Trial to Assess Pharmacist-Physician Collaborative Practice in the Management of Metabolic Syndrome in a University Medical Clinic in Jordan. *J Manag Care Pharm*. 2011;17(4):295-303

14 McLean DL., McAlister FA., Johnson JA., et. al. A Randomized Trial of the Effect of Community Pharmacist and Nurse Care on Improving Blood Pressure Management in Patients With Diabetes Mellitus. *ARCH INTERN MED/VOL 168 (NO. 21), NOV 24, 2008*

managed care for the State's LTC populations is being motivated by a desire to contain costs and reduce inefficiencies in the LTC system, such as cost-shifting among programs, which has resulted in higher overall costs for the system. The goal of the State's managed LTC program is to assist beneficiaries with LTC needs navigate a complex network of health and social support providers, reduce duplication and cost-shifting in the LTC system, and assist the State in better controlling and predicting LTC expenditures.

In order to ensure that the MCOs can meet the needs of these populations, the State will ask each MCO, among other things, to describe:

- How they will operationally satisfy specified requirements
- Their experience managing this population in other states
- Their provider network that is tailored to this population

A MCO will not be allowed to enroll LTC individuals until it has successfully passed a readiness review. MCOs must also submit plans for how they will delay or prevent their aged, blind and disabled (ABD) members, who do not currently meet at risk-of-institutionalization criteria, from reaching that LOC.

Managed LTC will include:

- Those at risk of LTC or meet the LOC criteria established by the State will have integrated NFs, HCBS (including alternative residential services), BH services, primary care and acute care services.
- The continuum of home-and-community based services will be expanded beyond the current 1915(c) and 1915(j) authority.
- Personal care attendant participant directed services now authorized under Section 1915(j) of the State Plan will be included under managed LTC (For a transition period, MCOs will be required to continue services that members are already receiving. At a later date yet to be determined these members will be transitioned to participant-directed services). The administrative and counseling functions, however, will remain with DDS.
- Participant-directed services will be offered through the MCO along with fiscal employer agency (FEA) services to allow members to manage their independent providers (the State will secure FEA services through a competitive bid and make the FEA available to MCOs to provide members with the most cost-effective services).
- PACE will be discontinued; existing PACE programs can become part of network, providing PACE-like services and receiving 100% of SFY12 capitation through June 30, 2013, receiving 75% of SFY12 capitation through June 30, 2014, and receiving capitation negotiated with MCOs beginning July 1, 2014 for delivery of PACE-like services in the context of a health home.
- MCOs will provide integrated case management and support coordination directly or through agreements with current care management agencies for PH, LTC and BH.
- MCOs will be required to implement information systems to automate care planning, tracking functions and predictive modeling.
- MCOs will be required to establish linkages and reporting to Adult Protective Services.

- MCOs have the authority to mandate the cost effective placement of a member in HCBS program or NF.

Termination and transition of the 1915(c) and 1915(j) State Plan Amendment

With the approval of this 1115 demonstration amendment, the State will terminate its 1915(j) SPA (the administrative and counseling components will remain with DDS) and its 1915(c) waivers for the TBI, ACCAP, CRPD and GO programs. Waivers will terminate but services will continue as they do today during the transition period from FFS to managed care. The State requests permission to cease operating these HCBS Waivers under Section 1915(c) and 1915(j) authorities upon approval of the Section 1115 demonstration waiver, but to continue these same programs under transitional 1115 authority until the MCOs implement these programs/services. Once the MCOs are determined ready, the State will cease operating these waivers under the demonstration.

The State is committed to a seamless process for transitioning the 1915(c) and 1915(j) Waiver programs into the Section 1115 demonstration and managed care. The State will submit to CMS and to waiver participants the notices required under section 1915(c). Comparable notices will be sent to 1915(j) SPA participants. The State is also preparing a transition plan for the termination of the Waiver authorities. As the transition between authorities should be seamless to Waiver and SPA participants, the notices will emphasize that there will be no loss of services. Waiver participants will be able to continue seeing their current providers when authority shifts from Section 1915(c) to Section 1115 demonstration authority. A transition period will also be provided when managed LTC is implemented.

Eligibility requirements

Medicaid enrollees (as defined in Exhibit 3.1) requiring health care services at a NF LOC are eligible to receive the Medicaid covered benefits summarized in Section 4 of this component of the waiver.

Financial eligibility: The ABD population must be financially eligible for managed LTC:

- Income below the SSI standard (72% of FPL) and meet the disability criteria established by the Social Security Administration (SSA)
- Income below 100% of FPL
- Income at the institutional level with income equal to or less than 300% of the Federal benefit rate (FBR), as used by the SSA to determine eligibility for SSI
- Spend down to the Medically Needy Income Level

The first two income categories may already be eligible for Medicaid and receive acute/medical care through a MCO. Other financial eligibility criteria include:

- The resource (cash, bank accounts, stocks, bonds, etc.) limit is \$2,000 for a single individual. Resources, such as a person's home, vehicle and irrevocable burial plan are not counted toward the resource limit.
- When the applicant has a spouse who resides in the community, the spouse can retain one-half of the couple's resources, up to the Federal maximum as specified in Section 1924(f)(2) of the Act. Resources, such as a person's home, vehicle and irrevocable burial plan are not counted toward the resource limit.
- The total gross income for a married couple is combined and divided by two. The resulting income may not exceed 300% of the single FBR. If the resulting income exceeds 300% of the single FBR, the income of the applicant only (name on check) is compared to 300% of the single FBR/SSI standard.
- Five year look back for transfer of assets
- Estate recovery

Functional eligibility: The approach to the functional eligibility determination differs for those ABD who are already eligible and enrolled for acute/medical care in a MCO and those who become eligible as result of needing LTC typically at the higher income level.

- *Those already eligible and enrolled in managed care.* MCOs will perform the LOC assessment for those at less than 100% of the FPL using the DHSS NJ Choice tool that will be modified to screen for LOC. Assessment components specific to care planning will be eliminated because the MCOs will assume this responsibility under managed LTC. The criteria for meeting a NF LOC are the same regardless of where the individual resides. The MCO will be allowed to determine which of these individuals have a need for LTC services including institutional services. The rationale for this approach aligns with the State's intent to allow the MCOs to provide HCBS to individuals to prevent a decline in health status and maintain individuals safely in their homes and communities. The State will not allow the MCO to establish functional criteria (to meet a NF LOC) that is stricter than what is established by the State.
- *Those who become eligible for Medicaid once they meet the LOC.* DHSS or its designee will be responsible for performing a clinical/functional LOC assessment for those at greater than 100% of the FPL to determine whether an individual meets a NF LOC for the purpose of the initial eligibility determination. LOC assessments will be performed at least annually or when there has been a significant change in the member's condition/circumstances. Through State-designed criteria, annual LOC assessments will be waived if a LOC assessment indicates an individual's condition will not improve absent a NF LOC.

Upon implementation of managed LTC, individuals currently enrolled will not need to undergo a new assessment to determine their ongoing financial and functional eligibility.

Waiver of preadmission screening and resident review for Medicaid

On an annual basis the State has approximately 100,000 discharges from hospitals to NFs. All of these individuals plus those moving from their home to a NF require a Preadmission Screening and Resident Review (PASRR) Level 1 screening for severe mental illness and/or I/DD. Those who screen positive for mental illness or I/DD require a Level 2 screen. With the implementation of managed LTC, the PASRR process becomes duplicative with inherent controls in the system. MCOs are not responsible for the care of those with severe mental illness or I/DD and capitation payments will not reflect such care. As a result, appropriate referrals to the MBHO and to DDD will occur in the absence of the PASRR process. As part of this application, the State will also seek a waiver of the PASRR requirements for the following reasons:

- MCOs will be incentivized through capitation to make appropriate and cost-effective placements of individuals enrolled in their plan and referrals to appropriate agencies.
- Individuals with a MI who do not meet a NF LOC will be enrolled with an ASO/MBHO as described later in Section 5. The ASO/MBHO will be responsible for ensuring the appropriate placement of members.
- Individuals with an I/DD diagnosis will be referred to the DHS/DDD to determine and authorize the most appropriate placement for the individual.
- *Non-Medicaid* admissions to a Medicare/Medicaid participating NF will be referred to the Level 2 authority if the Level 1 PASRR indicates the individual needs a referral for a Level 2 screening and he/she will have resided in a NF for 90 days.

Access to long-term care services

The State is in the process of transitioning Medicaid enrollees into capitated managed care for most services. Beginning July 1, 2011, and into the fall, the primary and acute care needs of the Medicaid populations, including dual eligibles and the aged, blind and disabled, will be met through amendments to the current Medicaid MCOs.

For the July 1, 2012 managed LTC program implementation the State will utilize its existing MCOs to manage all the Medicaid services, including HCBS, NF and BH services.

Prior to the implementation of managed LTC on July 1, 2012 all Medicaid enrollees currently receiving HCBS under a Section 1915(c) waiver (TBI, ACCAP, CRPD and GO), 1915(j) waiver or meet the NF LOC criteria and reside in a NF will be offered the opportunity to select a new MCO or remain with their current MCO.

The LTC services provided must be sufficient to meet the needs identified by the MCO's case manager's care assessment, taking into account the functional, medical, nursing and psychosocial needs of the individual as well as family and other supports available to the individual. To support the shift away from reliance on institutional services, the State will develop comprehensive contract and policies requirements.

The State will require the following of the MCOs:

- If, at the time of implementation, an individual is currently receiving HCBS under a Section 1915(c) waiver or 1915(j) SPA and meets a NF LOC, the individual must continue to receive HCBS from his/her current provider(s) for at least 90 days or longer if a care assessment has been completed by a MCO case manager. Based upon the services in place at the time of managed LTC implementation, the services need not be identical to the ones previously received under the Section 1915(c) or 1915(j) Waiver, but any change(s) must be based upon the care assessment.
- For all beneficiaries participating in HCBS, expenditures for individuals are limited to the most cost effective placement and in no case greater than the NF cost. Exceptions may be permitted if additional services are related to a transition from the facility or a change in condition that is not expected to last more than six months. If the estimated costs of providing necessary HCBS to the individual are less than the estimated costs of providing necessary care in an institution, the MCO can require the HCBS placement, provided the individual can be safely maintained at home.
- MCOs will have the authority to mandate the cost-effective placement of members in the HCBS program or a NF (HCBS can be more expensive for a short-term transition period post discharge from a NF).
- MCOs will be required to document good faith efforts to establish a cost-effective, person-centered POC in the community using industry best practices and guidelines. If the estimated cost of providing necessary HCBS to the individual exceeds the estimated cost of providing necessary care in an institution, a MCO may refuse to offer HCBS. If an individual in this situation chooses to remain in the community, the MCO will be required to complete with this individual a managed risk agreement detailing the risks to the member regarding his/her choice to remain in the community.
- MCOs will be required to establish an HCBS caregiver back-up system to provide caregivers in situations when an individual's regular caregiver is not available to provide services as scheduled.
- The State will establish specific criteria for the provision and coordination of BH services. Providing and coordinating the BH services of this population is critical to maintaining these individuals in the least restrictive and most integrated setting appropriate to their needs.
- MCOs will be required to have mechanisms in place to collaborate with State agencies that administer state-only funded HCBS programs with the intent for the MCOs to provide medically necessary HCBS rather than utilizing limited state-only HCBS funds.
- MCOs will be required to establish a LTC BH administrator position. This individual will be responsible for developing BH services and settings that can meet the needs of LTC individuals with BH needs, develop processes to coordinate BH care between PCPs and BH providers, coordinate behavioral care needs of LTC individuals with LTC service providers and coordinate behavioral care in collaboration with LTC case managers.
- For all LTC individuals the need for BH services shall be assessed and provided in collaboration with the member, the member's family and all others involved in the

member's care, including other agencies or systems. Services shall be accessible and provided by competent individuals who are adequately trained and supervised. The strengths and needs of the member and his/her family shall determine the types and intensity of services. Services should be provided in a manner that respects the member's and family's cultural heritage and appropriately utilizes natural supports in the member's community.

- The State will retain the authority to make any decisions to transition individuals from one MCO to another or disenroll altogether from the managed LTC program. Whenever an individual transitions to another MCO and is receiving LTC services the receiving MCO must maintain all current services for at least 30 days and until the MCO is able to perform a care assessment and develop a POC.
- MCOs may offer HCBS to individuals who do not meet a NF LOC in order to prevent a decline in health status and maintain individuals safely in their homes and communities. A member may request a LOC determination by the MCO at any time. The MCO will use the State's assessment for this purpose.

Case management and support coordination model

All LTC MCOs will be required to establish a LTC case management and support coordination program as directed by the State. The State will establish minimum qualifications for case managers. MCOs must provide integrated case management for LTC, acute care, and BH. Additionally, the State will ensure that each MCO assigns one and only one case manager to every member enrolled in the managed LTC program.

MCOs will be required to have BH staff (including a BH director under the Office of the Medical Director) as defined by the State available for consultation to case managers for the LTC individuals that may need or are receiving BH services.

For those individuals enrolled at the time of the managed LTC implementation, the State will establish timelines for the initial contact, care assessment, POC, individual service agreement, and authorization and implementation of services. The State will ensure that the MCO case managers have information pertaining to the individual from the previous three months, (e.g., case manager care assessments, POC (most recent) and the types and amount of services currently authorized. The MCOs will be provided prompt access to additional member information as needed.

POC: For each individual enrolled in managed LTC, the MCO will develop and implement a person-centered written POC and individual service agreement in compliance with 42 CFR 440.169 and 441.18. It will analyze and describe the medical, social, behavioral and LTC services that the member will receive. In developing the POC and the individual service agreement, the MCO will consider appropriate options for the individual related to his/her medical, BH, psychosocial and case-specific needs at a specific point in time, as well as goals for longer term strategic planning. The MCO will be expected to emphasize services that are provided in members' homes and communities in order to prevent or delay institutionalization whenever possible. An update to the POC must occur at least annually.

Oversight: The MCOs will be required to develop and provide to the State an annual case management plan. The plan must address how the MCO will implement and monitor the case management contract and policy requirements established by the State. The MCOs will also be required to implement a systematic method of monitoring its case management program to include, but not be limited to conducting quarterly case file audits and quarterly reviews of the consistency of care assessments, POC and service authorizations (inter-rater reliability) and the LTC services actually received. The MCO will be required to provide to the State an analysis of the data and a description of quality improvement (QI) strategies to resolve identified issues.

The State will establish a process to regularly oversee and monitor the MCOs' LTC case management program and provision of LTC services. This will include but not be limited to review and approval of the MCOs' annual case management plan, review of the MCO's oversight of case management and provision of LTC services. The State oversight process will be more intensive during the first one to two years of operation so that steps can be taken to resolve issues and program improvement can be rapidly and effectively initiated.

Participant-directed services

The State will define services that eligible members may elect to self-direct. Members determined, as a part of the needs assessment and POC processes, to require such services, will have the opportunity to exercise decision-making authority regarding the providers (participant-employed) who deliver these services.

For those individuals enrolled at the time of managed LTC implementation, the State will require MCOs to continue participation of individuals already receiving cash and counseling services authorized under Section 1915(j) of the State Plan. The MCO will inform new consumers who are approved for PCA services about the self directed option in a coordinated and collaborative effort with DDS. DDS will continue to provide the administrative support and counseling services for individuals electing self-directed PCA services.

- Upon enrollment in the managed LTC program, regardless of placement, and on a periodic basis thereafter, members will receive information regarding consumer direction of HCBS.
- Participation in consumer direction of HCBS is voluntary. Members may choose to participate in or disenroll from consumer direction of HCBS at any time, service by service, without affecting their enrollment in HCBS. Only the State can make the decision to involuntarily disenroll a member from consumer direction of HCBS, with sufficient documented concerns regarding health, safety and welfare or failure to adhere to program requirements or policies.
- A member may designate a representative to assume consumer direction of HCBS on his/her behalf. A member's representative may not receive payment for serving as a representative or being a member's paid worker.
- The State will utilize a FEA to fulfill the financial administrative functions for members participating in consumer direction of HCBS (e.g., paying workers for services

rendered; and withholding, filing and paying applicable Federal, State and local income and employment taxes for workers) and to provide supports broker assistance. The State will secure FEA services through a competitive bid and make the FEA available to MCOs.

- The POC process for members who participate in consumer direction of HCBS will include an individual risk assessment signed by the member and a backup plan detailing alternative available supports (including the option to obtain services through an in-home caregiver agency), contact information and the order in which contact should be made and for which services in the event a member's scheduled worker is unexpectedly unavailable.
- Members will have the flexibility to hire persons close to them, including family members but excluding spouses and minor children, to serve as their workers. All workers must meet the State-specified qualifications.
- Members will have flexibility to establish payment rates that do not exceed the State-specified ceiling for each service.
- Members and/or representatives must receive training prior to participating, and when re-enrolling, in consumer direction of HCBS.
- On-going training is also available at any point in time upon request of the member, representative and/or caregiver. Additional training may also be provided at any time if the care coordinator feels it is warranted.
- Workers must receive training, as a condition of hiring, which may be provided by the member, with assistance from his/her supports broker, as appropriate. Additional training may be provided at the request of a member and/or representative.
- A member's care coordinator will continuously monitor the adequacy and appropriateness of services provided, a member's quality of care and the adequacy of payment rates.

Aging and Disability Resource Centers (ADRC)

New Jersey will explore the opportunity to utilize ADRC functions to support a more effective, streamlined Medicaid system. New Jersey's ADRCs currently perform functions that are necessary for the efficient and effective administration of the Medicaid program, including the following:

ADRC Function	Is a Medicaid Administrative Service:
Outreach	When outreach emphasizes access to Medicaid program
Information, Referral & Intake	When functions discuss Medicaid as potential service or if provided to someone who is Medicaid eligible
Short-term Stabilization	When the individual is Medicaid eligible and the activities are related to connecting individuals to Medicaid funded services. Also provides Targeted Case Management under the Medicaid State Plan.
Case Review	When individual is Medicaid eligible or if part of Medicaid eligibility determination process
LTC Needs & Supporting Resources Assessment	When individual is Medicaid eligible or if part of Medicaid eligibility determination process
Benefits Counseling	When individual is Medicaid eligible or if part of Medicaid eligibility determination process
LTC Options Counseling	When individual is Medicaid eligible or if part of Medicaid eligibility determination process
Linkage to LTC Services	When individual is Medicaid eligible
Interaction with Medicaid Eligibility Approval Process	When attempting to establish Medicaid eligibility
Assistance in continuous improvement projects for the LTC system	When effort impacts Medicaid services and beneficiaries

New Jersey will explore how to leverage these existing ADRC functions to expedite eligibility determinations, utilizing either or both of two vehicles – an administrative contract or direct reimbursement for administrative costs.

Nursing facility collaborations

The State will explore with the NF industry opportunities to implement policies and programs to ease the effects of transition and diversion of individuals from NFs. For example, the State will explore opportunities to provide grants to NFs to close a facility, downsize a NF and/or diversify their business to include HCBS.

Nursing facility diversions and transitions

NF Diversion Plan: The MCOs will be required to develop and implement a NF diversion plan and processes for LTC individuals who receive HCBS and non-LTC individuals who are at risk of a NF placement (including short-stay NF placements) due to changes in their condition. The NF diversion program shall comply with requirements established by the State and be prior approved by the State. The plan will require the MCOs to monitor hospitalizations and short-stay NF admissions for these at risk individuals and to identify issues and implement strategies to improve diversion outcomes. The diversion program will not prohibit or delay an individual's access to NF services when these services are medically necessary and requested by the member.

NF to community transition plan: The MCOs will be required to develop and implement a NF to community transition plan and processes for LTC NF individuals who can be safely transitioned to the community. The NF diversion plan shall comply with requirements as established by the State and be prior approved by the State. The plan will require the MCOs to work with DHSS and DHS. The plan will require that there are processes for identifying LTC individuals who may have the ability and/or desire to transition from a NF to the community. The MCO will also be required to monitor hospitalizations and NF re-admissions for individuals who transition from a NF to the community and to identify issues and implement strategies to improve transition outcomes.

Reporting, program monitoring and quality management

QI strategy for the managed LTC program: The State will submit to CMS an integrated QI strategy which builds on existing managed care quality requirements as defined in 42 CFR 438, Subpart E. The State must identify: 1) measures of process, health outcomes, functional status, quality of life, member choice, autonomy, member and provider satisfaction and performance; 2) the data sources and sampling methodology for such measures; and 3) the frequency of reporting on specific measures.

The MCOs will be required to establish methods for discovery, remediation and systems improvement and, per State prescribed timeframes, regularly report on outcomes associated with continuous QIs. The State will provide oversight of this process and submit its QI strategy to CMS for approval prior to implementation of the managed LTC program.

Annually, the State will provide information to CMS regarding its QI activities, including evidence regarding system performance based on identified objectives and measures. This information will demonstrate efficacy in implementing the quality strategy, including but not limited to external quality review (EQR), discovery, remediation and systems improvement activities.

Data: The State will establish the baseline and ongoing LTC data appropriate for monitoring programmatic trends under the managed LTC program.

Data plan: The State will collect and submit baseline data to CMS, including but not limited to the following data elements:

- Numbers of persons actively receiving HCBS and numbers of persons actively receiving NF services the day prior to implementation
- Unduplicated numbers of persons receiving HCBS and NF services during a 12-month period
- HCBS and NF expenditures on the managed LTC population during a 12-month period
- HCBS and NF expenditures on the elderly and disabled population during a 12-month period as a percentage of total LTC expenditures
- Average per person HCBS and NF expenditures during a 12-month period
- Average length of stay in HCBS during a 12-month period
- Percent of new LTC recipients admitted to NFs during a 12-month period
- Average length of stay in NFs during a 12-month period
- Number of persons transitioned from NFs to HCBS during a 12-month period

Electronic collection of managed LTC data: The systems will be in place to record the requisite data elements 30 days prior to implementation of the managed LTC program.

Submission of data: An electronic copy of the actual baseline data will be submitted to CMS within six months of the last day of the 12-month period prior to managed LTC implementation. Thereafter, an electronic copy of the data for each subsequent demonstration year will be submitted to CMS within six months of the last day of each demonstration year.

Data reporting: The State will report to CMS on data and trends in the designated data elements in its quarterly and annual progress reports.

QM: The MCOs will be required to revise all existing applicable policies and plans to account for the managed LTC program requirements. The QM requirements that will need modifications and the actions that must be taken include:

- Submitting a revised Quality Assessment and Performance Improvement (QAPI) plan to DMAHS for review and approval
- Submitting a revised utilization management (UM) plan, including prior authorization requirements, processes and timeframes, monitoring for under/over utilization and any other UM strategies proposed to DMAHS for review and approval
- Closely monitoring and reporting specific HEDIS metrics and other performance targets against targeted benchmarks

The MCOs will be required to submit QAPI and UM plans to DMAHS for review and approval 45 days prior to implementation of the LTC program and annually thereafter. The MCOs will also be required to establish processes and provide assurances to the State regarding their access standards as required by 42 CFR 438, Subpart D. These

standards include the availability of services, adequate capacity and services, coordination and continuity of care and coverage and authorization of services.

DMAHS will make a preliminary selection of HEDIS and other performance measures with the understanding that the underlying methodology may require adjustment. Measures may be updated on an annual basis to reflect progress in achieving program goals. The preliminary list of measures includes:

- Reduction in NF placements
- Timely initiation of HCBS
- Reduction in hospital readmissions
- Percent of dollars spent on HCBS

Adult Protective Services: The 1993 New Jersey Adult Protective Services Act. (P.L. 1993, c 249, N.J.S.A. 52:27 D-406 to 426) designates DHSS to administer an intervention program to respond to reports of alleged abuse, neglect or exploitation and to work with the adult about whom the report is made to resolve the situation. To strengthen the Adult Protective Services system each MCO's QM and case management programs and operations will include linkages to DHSS/Adult Protective Services. The State will ensure that these linkages are in place and are being utilized during the readiness review and through the EQR process.

Criminal background checks: The State is considering the opportunity to submit a grant proposal (Funding Opportunity Number: CMS-1A1-12-001) to be considered for inclusion in the National Background Check Program so that it may develop a program for an efficient, effective, and economical process for LTC facilities and providers to conduct background checks on all prospective direct patient access employees.

Readiness reviews

In order to ensure that the MCOs can meet the needs of the managed LTC population, the State will require each MCO to prepare a plan that describes:

- How it will meet specified requirements
- Its experience operating a LTC program in other states
- Its provider network

Upon receipt of an acceptable plan, DMAHS will perform a desk-level (review of policies and procedures) and on-site review (e.g., testing of information systems) of each MCO to determine its readiness to begin enrolling members. The State will not enroll individuals in a MCO until it has successfully passed its readiness review.

The State will develop a readiness review tool to assure uniformity in the determinations made about each MCO's compliance and its ability to perform under the LTC contract provisions. The tool will also identify materials each MCO will be required to submit to describe its operations in detail. Examples of required written materials include:

- Organizational charts
- Organizational and staff qualifications
- Staff training plans regarding managed LTC
- Financial information
- Management information system structure and processes
- Medical and UM policies and procedures
- Provider network development and composition (including geographic mapping)
- Provider credentialing processes
- Provider relations policies and staffing
- Provider compensation arrangements and model contracts
- Access and availability policies
- LTC program policies, procedures and forms/documents
- Linkages with Adult Protective Services
- Case management and coordination of care policies and procedures
- Care planning software description, including data elements tracked, stored and reported
- Local health and community services coordination, including Area Agencies on Aging (AAA)s/ADRCs
- Member services policies and staffing
- Member grievance policies, procedures and data tracking system
- Abuse/neglect reporting policies and procedures
- Marketing plan and policies
- Enrollment and disenrollment procedures
- Examples to illustrate the cost effectiveness of institutional or HCBS services
- QM plan
- Committee structures relevant to LTC program
- Reporting capabilities

Statewide rollout

The State will develop a plan to ensure the safe and effective transition of members to the managed LTC program. Items that will be included in the transition plan include, but are not limited to:

- Preparing and conducting MCO readiness reviews
- Preparing individuals for the transition (e.g., education about managed care and service changes, community forums, other communication plans, enrollment activities, continuity of care plans)
- Preparing providers for the transition (e.g., outreach to HCBS and NF providers about managed care participation, changes to authorization requirements and billing requirements)
- Preparing MCOs for the transition (e.g., continuation of currently authorized services, case management, systems/data sharing, member services, network management specific to LTC providers, provider relations, claims payment, provision of needed technical assistance)
- Preparing State staff for the changes

Managing Behavioral Health

During FY 2010, there were approximately 60,000 Medicaid adult consumers and 40,000 Medicaid child/adolescent consumers who accessed BH care through the FFS system. BH care for adult consumers and children's services under FFS has been fragmented and largely unmanaged, with an over reliance on institutional rather than community-based care. These same individuals receive their medical care through one of four MCOs, with very limited or no formal protocols for coordination between the medical and BH delivery systems. Under this scenario, the risk is greater that BH needs go unidentified and that consumers receive suboptimal BH care in primary care settings. Untreated or suboptimal treatment of BH conditions has long been associated with lower adherence to prescribed medical treatment, higher medical costs, and poorer health outcomes. In particular, adults with mental disorders have a "twofold to fourfold elevated risk of premature mortality", largely due to poorer PH status, not accidents or suicides.¹⁵ There is emerging evidence of the effectiveness of interventions designed to address the need for BH-PH coordination. Given that for Medicaid's highest cost adult beneficiaries, approximately two-thirds have a mental illness and one-fifth have both a mental illness and substance use disorder¹⁶, the opportunity for improved clinical and financial outcomes through improved BH-PH coordination is strong.

The need for improved BH-PH coordination must be balanced with the need to introduce managed care technologies that go beyond basic utilization review of higher levels of care to incorporate care management protocols for the populations with SMI or serious emotional disturbance (SED). In addition, many individuals who are not currently eligible for Medicaid receive critical BH services through State-only funds, Federal block grant dollars or other resources. Some of these become eligible for Medicaid under health care reform in 2014. Under the Comprehensive Waiver, the State plans to braid non-Medicaid funding streams with Medicaid funds to develop a more integrated system of care with an eye toward meeting the BH needs of the Medicaid expansion population in 2014. This will include reviewing rate structures to improve consistency and competitiveness of reimbursement rates across funding streams with the overall goal of adequate access to appropriate services. These initiatives will occur within the context of a recent merger of the Divisions of Mental Health Services (DMHS) and Division of Addiction Services (DAS) to support the integration of care. This merger provides an opportunity to build a combined system that provides best practice treatments for individuals with co-occurring mental illness and substance use disorders. The management of SMI and SED populations, the use of medication to enhance treatment of substance use disorders, integration of mental health and substance use disorder services and braided funding requires specialized expertise, tools and protocols which are not consistently found within most medical plans.

¹⁵ Druss, Benjamin and Reisinger Walker, Elizabeth. *Mental disorder and medical comorbidity*, The Robert Wood Johnson Foundation, The Synthesis Project. February 2011.

¹⁶ Boyd, Cynthia, Leff, Bruce, Weiss, Carols, Wolff, Jennifer, Hamblin, Allison and Martin, Lorie. *Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations*,. Center for Health Care Strategies, Inc., December 2010.

Introducing managed care technologies through contracting with an administrative services organization (ASO) or a Medicaid behavioral health organization (MBHO) has been associated with improved access, better monitoring of quality outcomes, and a better distribution of services across the entire care continuum. Examples include both full risk and non-risk arrangements. In FY2010, over 40,000 child/adolescent consumers with SED and multi-system involvement access BH care through New Jersey's CSOC administered by an ASO contractor with claims payment continuing to be administered through the State's FFS MMIS. In place since 2002, this program has made substantial progress in expanding access and improving outcomes while managing costs. Under the CSOC, utilization has shifted to more community-based settings and allocation of resources has been better matched to level of need. In addition, coordination of care across child serving systems including education, child welfare and juvenile justice has been a priority under the CSOC. Given that over 50 percent of youth with SED are also involved with child welfare services, specialized BH expertise to maintain this connection is vital. The need for specialized BH expertise and management is further supported by recent feedback from the DD community that the BH needs of the DD population would be better met through a separate behavioral program; care is currently carved into the medical plans.

Based on the current managed care landscape in the State and building on the progress made under the CSOC, the design of the State's Medicaid program to manage BH has five key components:

- Requirements for managing BH benefits through an ASO/MBHO contractor with extensive experience in managed care with a Medicaid BH population including individuals dually diagnosed as I/DD and BH
- Requirements for BH-PH integration for both the MCOs and the BH contractor
- Program and financial management structures to support the transition to, and ongoing operation of, the newly designed BH system, including braiding of funds for Non-Medicaid covered individuals and services and revising rate structures to improve consistency and competitiveness of provider reimbursement across funding streams
- For adults, an initial non-risk contract with a MBHO subject to the non-risk UPL at 42 CFR 447.362 that moves incrementally towards full risk to assure alignment of policy objectives with fiscal incentives; the MBHO will function as a prepaid inpatient health plan (PIHP) consistent with the requirements at 42 CFR 438.2
- For children, the State will continue with the current ASO contract with claims payment administered under the FFS Medicaid Management Information System (MMIS)

These components are linked in vision:

- To improve access to appropriate physical and BH care services for individuals with mental illness or substance use disorders

- To better manage total medical costs for individuals with co-occurring BH-PH conditions
- To improve health outcomes and consumer satisfaction

The program design takes a multi-pronged approach to achieve this vision:

- Network enhancements to increase capacity and expand the service array to improve access to community-based services that facilitate recovery for adults and resiliency for children and are grounded in evidence-based practices (EBPs)
- Routine screening of individuals in primary care settings to identify unmet BH needs, with expedited referrals to needed BH services
- Routine screening of individuals in BH settings to identify unmet medical needs, with expedited referrals to appropriate PH services
- Data integration to support predictive modeling to identify high risk/high cost consumers and to facilitate program evaluation across systems
- UM medical management and QM protocols and other administrative services to ensure BH service delivery, and associated financial and clinical outcomes are appropriately managed
- Specialized case management and care coordination protocols to improve consumer engagement, promote self care, and enhance cross system coordination for high risk/high cost consumers, including participation in the health home innovations described earlier in this section
- Specialized case management and care coordination protocols for managing adults dually diagnosed as I/DD and MI as well as providing for behavioral supports in residential, day and home settings
- Comprehensive and ongoing education, training and technical assistance programs for members, BH and PH providers, and MCO and ASO/MBHO staff to facilitate transformation of the system
- A transition plan, with key milestones and timelines for transitioning management of children and adolescents under FFS to the CSOC ASO, selecting the adult MBHO and implementing other key program components

Managed care organization roles and responsibilities

The needs of consumers who present for services, including symptom severity, level of functioning and chronicity will define the relative roles of the Medicaid MCO and the children’s ASO/adult MBHO in managing BH conditions. The MCO will continue to arrange or provide, manage and be at risk for any Medicaid covered service that is delivered by its medical plan network. This includes but is not limited to primary care office visits to treat BH conditions and acute detoxification in an inpatient hospital setting for which an MCO authorized provider is the attending. The children’s ASO/adult MBHO will arrange or provide and manage services that are delivered by its BH network. A more detailed description of the responsibility for the administration and management of claims for BH services can be found in Table 2 in the Benefits section of this component of the Waiver. Additional responsibilities of the MCO under this design include:

- **Data exchange.** Each MCO will be responsible for regular transmission of data pharmacy claims, medical claims, selected health risk assessment and BH screening results to the ASO/MBHO. The MCO will be required to receive transmission of BH claims and PH risk screening results from the ASO/MBHO. As needed, the MCO also will be required to develop data exchange with other state entities (i.e., DMHAS, DCF) and relevant service providers.
- **Risk screening.** Each MCO will be required to implement a standardized protocol to identify common BH risks in primary care settings, provide necessary education and brief intervention in order to facilitate referrals of individuals who screen positive to an appropriately credentialed and qualified BH provider. This includes but is not limited to selecting appropriate screening tools and establishing provider requirements to follow the established screening and referral protocols, including the Screening, Brief Intervention and Referral to Treatment (SBIRT) protocol. The MCO will collaborate with the ASO/MBHO and DMAHS to establish a list of approved screening tools that are efficient to use and meet generally accepted standards for reliability (consistency of results) and two measures of validity: sensitivity (accuracy in identifying a problem) and specificity (accuracy in identifying individuals who do not have a problem).
- **BH-PH coordination.** The MCO, in collaboration with the ASO/MBHO, will establish a process for identification and management of the top 5% (in terms of medical costs and medical or psychosocial risk factors) of individuals with co-morbid medical and BH conditions. The MCO will participate in necessary co-management of these cases, which may be done through MCO care management staff or through provider initiatives. The MCO will establish a process for dissemination and implementation of EBPs for BH conditions commonly treated in primary care settings, protocols to monitor PCP adherence to these EBPs and financial incentives for BH-PH coordination activities in the primary care setting (i.e., submitting the BH screening tool to the MCO, developing care coordination capacity within a primary care practice for enrollees with chronic diseases and BH co-morbidities, or co-location of BH and PH specialists).
- **Pharmacy management.** The MCO will continue to administer pharmacy benefits for prescriptions written by either MCO or ASO/MBHO contracted providers, with the exception of Methadone maintenance cost and administration. The MCO will seek consultation from the ASO/MBHO regarding policies and procedures governing the utilization and management of drug classifications for the treatment of BH conditions

Children's ASO/ adult MBHO roles and responsibilities

According to goals and objectives established by the State the MBHO for adult consumers will have primary responsibility for developing and managing the adult BH service delivery system while the ASO for child/adolescent consumers will share responsibility with the State for developing and managing the children's BH service delivery system. Core requirements are listed below. Unless otherwise stated, these requirements apply to both the children's ASO and the adult MBHO.

- **Member services.** The ASO/MBHO will develop and disseminate member materials, including a member handbook, educational and other promotional materials specific to accessing BH services, consistent with State and Federal requirements. The

ASO/MBHO will provide access to a 24-hour toll-free line to provide information to members and providers and to provide screening and referral, as necessary. The ASO/MBHO will maintain a website to disseminate information to members, providers and the community, including the toll free member service line, crisis numbers, the member handbook, the network directory, the provider manual, member and provider educational materials and other key initiatives.

- **Network credentialing and contracting.** The State will set reimbursement rates for BH network services until such time that the MBHO assumes full risk. Until that time, beginning with implementation, the ASO/MBHO will provide technical assistance to the State on reimbursement rates as well as appropriate use of financial and nonfinancial incentives for improved outcomes. Contracts initially will be held by the appropriate State agency but will transition to the MBHO at the time the MBHO assumes claims administration. The network will include all currently contracted Medicaid BH service providers. In addition, the demonstration seeks freedom of choice approval to contract with BH service providers that are currently contracted to provide non-Medicaid covered BH services that will become Medicaid covered services, including but not limited to community mental health centers, licensed marriage and family therapists and licensed clinical drug and alcohol counselors. Providers will be required to meet established credentialing standards. In order to maintain service continuity, however, a transition period will be established for new Medicaid providers who were formerly DMHAS contracted providers who fail to meet credentialing standards but have consumers in active treatment on the implementation date. The transition period will allow a limited period after implementation in order to meet educational, supervision or other performance requirements necessary for full credentialing.
- **Network development.** The ASO/MBHO will assist the state with network development, including providing technical assistance to new providers regarding enrollment in Medicaid. At the time the MBHO assumes control of the network from the State, the MBHO will provide access to all covered services through a network of qualified providers that meet state and Federal access to care requirements, including a choice of two or more providers within required access standards. This will include network development to ensure that the network is of sufficient size, scope, type and quality of providers to deliver a more comprehensive array of community-based BH services and reduce reliance on more costly, intrusive levels of care, such as inpatient and residential treatment, as has been accomplished under the CSOC.
- **Crisis response.** The MBHO for adult consumers will coordinate with the PERS system for adult consumers, including providing education and technical assistance to the crisis centers about consumer needs, model programs and best practices. The children's ASO will manage a 24-hour crisis response system, including dispatch of mobile crisis response teams consistent with the currently approved NJ State Plan. Children in crisis will be permitted to access emergency services as necessary including the PERS. The children's ASO will work with all providers to ensure that necessary linkage to the appropriate stabilization services occur and that crisis and stabilization services are available and reimbursed in a comprehensive manner,

including CSOC Mobile Response and Stabilization Services for youth with SED. The State Plan is being revised to include PERS services.

- **Utilization review.** The ASO/MBHO will conduct prior authorization and concurrent review as outlined in Table 1 and consistent with State and Federal requirements. For certain high volume/high cost services that are not subject to prior authorization or routine concurrent review requirements, the ASO/MBHO will implement a data-driven approach to target concurrent review to case and provider outliers based on utilization, cost or quality profiles. The ASO/MBHO will also conduct performance monitoring and provide necessary education and technical assistance to network providers in order to transform practice patterns to align with New Jersey's vision for an efficient, outcomes-oriented system that is grounded in EBPs and promotes recovery for adults and resilience for children and adolescents. The ASO/MBHO will be responsible for eligibility verification as part of the authorization process.
- **Medical management.** The ASO/MBHO will employ a board certified psychiatrist as a full time Medical Director and a panel of qualified licensed clinicians. The medical director will oversee authorizations under the utilization review requirements described above and administration of denials. The adult MBHO will also administer appeals and Level I grievances. The State will maintain Level II grievances/fair hearings for adults. The State also will maintain administration of Fair Hearings for Children. The ASO/MBHO will provide necessary support to the State during the fair hearing process. The medical management program will include development of an annual UM plan and appropriate tracking and trending of utilization, denials, appeals, grievances and clinical outcomes. The UM plan will include protocols to reduce unnecessary or inappropriate utilization and improve denial, appeals and grievance processes.
- **Care management** The children's ASO will continue to use the Child Adolescent Needs and Strengths (CANS) as the assessment tool for children entering the CSOC. As required under the CSOC, the Children's ASO will continue to subcontract to provide care coordination for youth with SED. The adult MBHO will be required to develop and/or implement a uniform assessment of needs. Combining assessment results with claims and other screening data, the adult MBHO will develop a predictive model and a systematic approach to risk stratification to identify high risk BH cases for participation in intensive case management (ICM). The adult MBHO must have the ability and be willing to subcontract to meet the care coordination needs of individuals in the substance abuse initiative (SAI) and behavioral health initiative (BHI).The SAI and BHI are specialty care management programs that go beyond traditional utilization and care management by incorporating return to work goals into consumer treatment plans.
- **QM.** The ASO/MBHO will establish a QM program. At the point in time either contractor assumes responsibility for claims administration and becomes a PIHP, the QM program will be consistent with the State's quality strategy and Federal requirements for quality monitoring. The QM program, including performance metrics, performance improvement projects (PIPs)and clinical outcome measures, is subject to the review and approval of DMHAS for adults. (See later discussion under Reporting, Program Monitoring and QM in this component of the Waiver).

- **Claims administration.** Upon acceptance of responsibility for claims administration, the MBHO will be responsible for adjudication of all BH claims delivered by the specialty BH network, including contracted MBHO providers as well as out-of-network BH providers needed to meet the special needs of enrollees. This will initially be on a non-risk payment basis up to the non-risk upper payment limit of 42 CFR 447.362. As noted earlier in this section, the transition of claims administration from the FFS MMIS to the Children's ASO will not occur at the outset of the waiver. As described later under "Service Delivery", the MBHO may eventually be paid on an at-risk basis. The MBHO will be responsible for eligibility verification as part of the claims administration.
- **Financial management and reporting.** The ASO/MBHO will establish a process for separately tracking service utilization and costs by funding source (i.e., Medicaid, Federal block grants, State only funds) and provide regular financial reports in compliance with State and Federal reporting requirements. The ASO/MBHO will coordinate with the State to establish a process to limit authorization and payment for services which are not entitlement services to only available resources. Upon assumption of responsibility for claims administration, the MBHO will establish a system for monitoring and reporting the completeness and accuracy of encounter data received from providers, processes for coordination of benefits with other third party payers and internal controls to prevent, detect, and reduce fraud, waste and abuse in the BH specialty network.
- **Management information systems (MIS) and electronic data exchange.** The ASO/MBHO will establish and maintain a MIS that allows the MBHO and its subcontractors to collect, analyze, integrate and report data on service utilization, service costs, claim disputes, appeals and clinical and financial outcomes. As relevant, the MIS must also meet Federal block grant reporting requirements. The ASO/MBHO also will establish and maintain electronic interfaces:
 - To send and receive information to and from DMAHS, DMHAS and DCF including, but not limited to, eligibility data and timely, accurate encounter data submissions that meet all State and Federal requirements
 - To receive encounter data and information from subcontractors and providers after assumption of responsibility for claims administration
 - To send BH claims (as relevant) and PH risk screening results to the appropriate MCO
 - To receive pharmacy claims, medical claims and BH risk screening results from each MCO
 - To send and receive data and information to and from other agencies, as required (i.e., other child serving agencies to administer cross system collaboration and measure outcomes under the CSOC)
 - Adoption of the EHR currently in use by the CSOC

All electronic interfaces will adhere to State and Federal guidelines regarding the privacy and security of protected health information (PHI) and confidentiality of client records.
- **Risk screening.** The ASO/MBHO will be required to implement a standardized protocol to identify medical needs and risk factors and refer individuals who screen positive to an appropriate medical plan provider. This will include establishing

- provider requirements to follow the established screening and referral protocols. The ASO/MBHO will collaborate with the MCOs and the State to establish a list of approved screening tools that are efficient to use and meet generally accepted standards for reliability and validity. The ASO/MBHO will also provide a separate toll-free line for MCOs and PH providers for streamlined referral and psychiatric consultation, including a process to react to emergency needs identified during screening and to coordinate with the children's mobile response teams, CSS crisis intervention and the PERS system.
- **BH-PH coordination.** As stated above, the ASO/MBHO, in collaboration with the MCOs will establish a process for identification and management of the top 5% (defined by medical expense and medical or psychosocial risk factors) of individuals with co-morbid medical and BH conditions. The ASO/MBHO will have primary responsibility to implement predictive modeling and risk stratification to identify and manage this population using pharmacy, medical and BH claims and available risk screening data. The ASO/MBHO will participate in necessary co-management of these cases with the MCO which may be done through ASO/MBHO care management staff or through provider initiatives. The adult MBHO will establish a process for dissemination of EBPs for management of chronic medical conditions that are common in SMI and SUD populations, protocols to monitor BH provider adherence to screening, referral and care coordination requirements and financial incentives for coordination activities at the BH provider level (i.e., submitting the PH screening tool, developing care coordination capacity, or co-location of BH and PH specialists).
 - **Pharmacy management.** With the exception of methadone, the MCO has primary responsibility for all pharmacy management. The ASO/MBHO will participate in the MCO's Pharmacy and Therapeutics committee and related activities. At the request of DMAHS and the MCO, the ASO/MBHO will support outreach and education with prescriber outliers specific to the use of psychotropic drugs for the treatment of BH conditions in primary care settings based on real-time pharmacy data exchange. This will include, but not be limited to, protocols to identify clients at risk for prescription drug abuse.
 - **Other administrative duties.** The ASO/MBHO will be required to perform additional administrative duties related to the management of non-Medicaid covered services and enrollees, including but not limited to eligibility, enrollment, prior authorization and concurrent review.

Shared roles and responsibilities

The MCO and the ASO/MBHO will be responsible to collaborate regarding the following:

- The design of screening and referral protocols and annual training of primary care and BH providers on the screening and referral process. Screening will occur at the point of service delivery not less than annually.
- The design of a process to identify and manage the highest risk individuals with one or more BH/medical co-morbidities with the goal of improving treatment engagement, treatment adherence, care coordination, self care and health outcomes. Care coordination protocols initially will occur at the care management level, with the goal

of increasing provider capacity to take increasing responsibility for care coordination. Care coordination may include:

- Extended assessment protocols for individuals who screen positive during BH or PH risk screening
- Assistance in accessing needed BH and PH services, including use of peers to engage and retain patients in the needed behavioral and primary care services
- Assistance in accessing needed community supports (i.e., housing, employment)
- Development and monitoring of integrated care plans for program participants
- Education, follow-up, and adherence monitoring
- Strategies to reduce inappropriate use of ED by individuals with BH conditions
- Initial and ongoing training to educate MCO and ASO/MBHO staff about co-occurring disorders and integrated care management principles to strengthen the knowledge, skill, expertise and coordination efforts within the respective outreach, UM, case management, pharmacy management and provider relations workforce
- Training of PCP and BH providers on screening, referral and co-management and training of PCPs on EBPs for BH conditions commonly treated in primary care settings
- An enrollee consent form to be used by both PH and BH providers for sharing information among primary care/specialty and BH providers.
- Development and implementation of an integrated clinical record necessary to support BH-PH coordination, in accordance with applicable privacy laws
- The design of data-driven protocols to identify and intervene with prescriber outliers specific to the use of psychotropic drugs for the treatment of BH conditions in primary care settings

Transition process and timeline

BH services for children who are currently managed under FFS, including children with addictions, will be managed under the current CSOC ASO contract, through a contract amendment, effective July 1, 2012. This administrative contract will remain through September 2014. During SFY 2012, New Jersey DMHAS will issue a Request for Proposal (RFP) to select a MBHO to manage BH benefits for adults, with an implementation date of January 1, 2013. Because the MBHO will be a PIHP per 42 CFR 438.2, the State of New Jersey is requesting a waiver of section 1902(a)(4) of the Act, which will allow New Jersey to have a single PIHP by waiving requirements at 42 CFR 438.52 for choice and at 42 CFR 438.56 for disenrollment. The state will work with CMS to ensure that the absence of choice of PIHP is not detrimental to beneficiaries' ability to access quality services. The state reserves the right to select two or more MBHOs if it is determined this is necessary to meet geographic or specialty (i.e., child/adult) needs.

As part of the RFP process, a databook will be provided that includes summary level data on penetration, utilization, average unit cost and total cost by category of service (COS). This data will be specific to the populations, services and costs moving to the CSOC ASO or the adult MBHO. In order to ensure strong management of the SMI and SED populations, the data will be aggregated by SMI/non-SMI consumers, consistent with the State's definition of SMI, and by CSOC/non-CSOC consumers. To support

strong BH-PH coordination, the databook will also include penetration, cost and utilization data on the number of adult consumers with chronic medical conditions. This will be provided by diagnosis for the most costly medical conditions for which a co-occurring BH condition is common. The data will be aggregated by individuals with and without a BH claim. The databook will cover the two most recent twelve month periods for which data is available at the time.

New Jersey DCF will conduct a readiness review of the CSOC ASO prior to the implementation date of July 1, 2012 and DMHAS will conduct a readiness review of the adult MBHO prior to the implementation date of January 1, 2013. The timing of the reviews will allow for at least a four month timeframe for implementation prior to the review and a two month timeframe for resolution of issues identified during the review. The reviews will include desk and onsite review components and address readiness in the following areas:

- The documented MIS functionality and processes, including eligibility/enrollment data load and maintenance; the DMAHS provider file data load and maintenance; the automated authorization management system, including the conversion of current authorization data and maintenance; encounter data file transfers; data exchange with the MCO; and claims administration
- Member service functionalities including the telephone call line, website, and enrollee/recipient communications
- The policies, procedures and processes governing member services including complaints, linguistic and other accommodation needs, call responsiveness and enrollee/recipient rights including use and disclosure of PHI and confidentiality of client records; network management including appointment access, network adequacy, credentialing and provider relations; UM including medical necessity criteria, clinical guidelines, prior authorization, concurrent review, outlier management, care management and care coordination; medical management including notice of action, denials, grievances, and administrative hearings; QM; claims processing; financial management, including internal budgeting and third-party liability/coordination of benefits
- An outline of the components of a care plan, how the data is stored, and what data will be transmitted to relevant providers and to the Federal government for purposes of block grant reporting
- Staffing resources, requirements (education, training, experience) and performance monitoring, by department
- Reporting capabilities, including utilization, cost, financial, quality and administrative indicators and performance metrics

Eligibility requirements

With two exceptions, all Medicaid enrollees with a mental illness or substance use disorder who meet the State's definition of medical necessity for one or more covered BH services are eligible to receive the Medicaid covered benefits summarized in the next section of this component of the Waiver. The exceptions are dual eligibles enrolled in a Special Needs Plan (SNP)/MCO and Medicaid eligible members enrolled in one of the

LTC plans described earlier. For dual eligibles, Medicare BH benefits will be carved into the SNP/MCO while Medicaid BH benefits will be carved out to the ASO/MBHO. Also for duals, coinsurance and deductibles associated with these benefits are carved into the SNP. For individuals in a NF LOC or in a home and community-based waiver under managed LTC, administration of BH services will be carved into the LTC plans.

Benefits

The ASO/MBHO shall be responsible for the provision of administrative services as defined earlier in the section ASO/MBHO responsibilities. Different members are eligible for different packages of services that will need to be tracked and provided by the MBHO. All Medicaid BH services, including inpatient and outpatient hospital services with a primary BH diagnosis and community-based services, including clinic services for BH care, are included under this contract for enrolled beneficiaries.

The ASO/MBHO will track the benefit package and funding source of each eligible member and ensure that the member is offered all eligible benefits and that the appropriate funding source reimburses for the covered benefits. Non-Medicaid services to non-Medicaid eligibles will be billed to the participating Departments through a separate invoicing process or invoiced to and paid directly by the participating departments. Payment will be subject to the limit of available funding.

Medicaid covered services will be available statewide and provided by the State or MBHO contracted providers, except that the ASO/MBHO will use the State Medicaid definition of "medically necessary services". For all modalities of care, the duration of treatment will be determined by the member's needs and his or her response to treatment. All services, for which a member is eligible, will, at a minimum, cover:

- The prevention, diagnosis, and treatment of health impairments
- The ability to achieve age-appropriate growth and development
- The ability to attain, maintain or regain functional capacity

Only Medicaid members can receive Medicaid funded BH services. Medicaid BH services only will be provided by DHS and DCF (and later MBHO) licensed and credentialed providers. If access problems are detected, the State (or the MBHO after assumption of network contracting), shall actively recruit, train, and subcontract with additional providers, including independent practitioners, to meet the needs of members.

The delivery of Medicaid, State only, Federal block grant and other funded services will appear seamless to all members, but retain separate fund accountability for audit and encounter data purposes. The MBHO may only use Medicaid funds to purchase Medicaid services for Medicaid enrollees.

During the term of the contract, the MBHO may provide services that are cost-effective alternative treatment services and programs for enrolled members under 42 CFR 438.6(e), including up to 30 days in an IMD for consumers 21 to 64. The MBHO must

perform a cost-benefit analysis for any new services it proposes to provide, as directed by the State, including how the proposed service would be cost-effective compared to the State Plan service(s). The Contractor can implement cost-effective services and programs only after approval by the State. The State will factor the cost of State Plan covered services with an adjustment for managed care efficiency due to cost effective alternative services into the rate calculations with any adjustments for managed care efficiency.

The different Medicaid and non-Medicaid benefit packages are summarized in Table 5.1. Under this waiver, the State is requesting that one service move from State only to Medicaid funding for Medicaid beneficiaries:

- Substance abuse intensive outpatient

Table 5.1 - Covered BH services by covered population							
Services	Plan A FamilyCare and ABD	NJ FamilyCare			Plan G (GA)	Block Grant	State Only
		Plan B	Plan C	Plan D			
Case management (Targeted) – Chronically Ill	Yes	No	No	No	Yes	X	X
Case management behavioral assistance	Plan A <21 in CSOC	<21 in CSOC	<21 in CSOC	<21 in CSOC			<21 in CSOC
Certified Nurse Practitioner	Yes	Yes	Yes	Yes	Yes		
Clinic services – mental health	Yes	Yes	Yes	Yes	Yes	X	X
Community support services	Covered under Medicaid for categorically needy as of 10/1/2011					X	X
EPSDT	Yes	Yes – exams, does not include all services identified through exam	Yes – exams, does not include all services identified through exam	Yes – well child only	NA		
Home health services	Yes	Yes	Yes	Yes	Yes		
Hospital Outpatient	Yes	Yes	Yes	Yes	Charity care		<21 in CSOC
Hospital Rehabilitation	Yes	Yes	Yes	Yes	Charity care		
Intensive in-community and behavioral assistance	Plan A <21 in CSOC	<21 in CSOC	<21 in CSOC	<21 in CSOC			<21 in CSOC
Laboratory and x-ray	Yes	Yes	Yes	Yes	Yes		
Mental health – adult rehabilitation	Yes >21	No	No	No	Yes, eff. 4/15/2011	X	X
Mental health inpatient - acute	Yes	Yes	Yes	Yes	Charity care		X

¹⁷ When provided by an authorized provider for the diagnosis and treatment of MI or substance use disorder. Copayments and limits may apply – see Exhibit 4.1. There is no service limit for CHIP beneficiaries under the age of 19 pursuant to the MHPAEA of 2008.

Table 5.1 - Covered BH services by covered population							
Services	Plan A FamilyCare and ABD	NJ FamilyCare			Plan G (GA)	Block Grant	State Only
		Plan B	Plan C	Plan D			
care hospital							
Mental health outpatient (other licensed practitioners)	Yes	Yes	Yes	Yes	Charity care		< 21 in CSOC
Methadone maintenance	Yes	Yes	Yes	No	Yes	X	X
Mobile response and stabilization	Plan A <21 in CSOC	<21 in CSOC	<21 in CSOC	<21 in CSOC			<21 in CSOC
Physician / PCP Practitioner	Yes	Yes	Yes	Yes	Yes		X
Psychiatric emergency services	Covered under Medicaid for categorically needy with anticipated effective date of 1/1/2012 (State Plan Amendment in development)					X	X
Psychiatric partial hospital	Yes	Yes	Yes	Yes	No	X	X
Partial care	Yes	Yes	Yes	Yes	No	X	X
Personal care assistant – mental health	Yes	No	No	No	No		X
Pharmacy – mental health/substance abuse including atypical antipsychotics, methadone, Suboxone/Subutex	Yes	Yes	Yes	Atypicals and Suboxone only	Yes		X
Psychiatric hospital inpatient – all others including State, county or private facilities	Yes <21 or >65	Yes <21 or >65	Yes <21 or >65	Yes <21 or >65	Charity care		X
Residential treatment	<21	<21	<21	No	No		<21 in CSOC
School-based services	Yes	Yes	Yes	Yes	No		
Substance abuse inpatient	Yes	Yes	Yes	Medical detox only	Through SAI only		
Substance abuse outpatient services	Yes	Yes	Yes	Medical detox only	Through SAI only	X	

Table 5.1 - Covered BH services by covered population							
Services	Plan A FamilyCare and ABD	NJ FamilyCare			Plan G (GA)	Block Grant	State Only
		Plan B	Plan C	Plan D			
Transportation – all other	Yes	Yes	Yes	No	No		X
Transportation – emergent (ambulance, mobile intensive care unit)	Yes	Yes	Yes	Yes	Yes		
Transportation – non-emergent (ambulance non-emergency medical assistance vehicles, livery, clinic)	Yes	Yes (for ambulance and MAVs, no for livery and clinic)	Yes (for ambulance and MAVs, no for livery and clinic)	No	Yes		
Jail diversion and reentry						X	X
PATH homeless services						X	X
Psychiatric Assertive Community Treatment (PACT)	ABD only	No	No	No	Yes, eff. 4/15/2011	X	X
Residential assisted day treatment						X	X
Sub-acute detoxification							X
Sub-acute enhanced medically managed detoxification							X
Substance abuse Intensive Outpatient					Charity care	X	X
Substance abuse day treatment/partial hospital						X	X
Substance abuse halfway houses						X	X
Substance abuse outpatient						X	X
Substance abuse recovery							X

Table 5.1 - Covered BH services by covered population							
Services	Plan A FamilyCare and ABD	NJ FamilyCare			Plan G (GA)	Block Grant	State Only
		Plan B	Plan C	Plan D			
support							
Substance abuse short term residential treatment						X	X
Substance abuse long term residential treatment						X	X
Supported employment and education						X	X
Supported housing						X	X

Service delivery (including payment mechanism)

There are four key features of the service delivery system under the BH component of the Waiver:

- The current CSOC contractor will continue to administer BH benefits for SED children and assume responsibility for administering BH benefits for the remaining children and adolescents currently under FFS. The Children's ASO will receive a bundled payment on a monthly basis for fulfilling its administrative duties, including care management of SED children. A MBHO will be selected through a competitive procurement process to manage the BH care of adult enrollees. The adult MBHO will be paid a PMPM administrative fee for the administrative functions described previously. The adult MBHO may earn an additional per participant per month (PPPM) administrative fee based on engagement of participants in the BH-PH coordination program. At any point after implementation, DMAHS may introduce utilization based incentives or transition either contract to full risk capitation. Since utilization and cost patterns are expected to shift under a more managed model, this phased approach to transition to a risk-based contract will allow the State to gather utilization and cost data which becomes the basis for developing rates for a full risk contract.
- Up to 20% of administrative fees may be subject to penalties for nonperformance. The number of performance measures tied to penalties shall not exceed twelve measures per contract (see preliminary measures in next section of this component of the Waiver). Each measure shall be clearly defined, including the measurement methodology, performance target, measurement frequency, risk allocation and reconciliation period. Each contract year, DMAHS in coordination with DMHAS and DCF may at its sole discretion approve, modify or disapprove any or all performance measures or supporting methodology.
- Medicaid claims will be paid on a FFS basis, initially using the rates established for the Medicaid FFS program although during and after implementation the ASO/MBHO will be asked to make recommendations for and prospectively implement adjustments to reimbursement rates for community-based services. Separate encounters and reimbursement rates subject to the prospective payment system (PPS) may be established for BH services delivered through a FQHC.
- Providers must be registered as Medicaid providers and contracted with the State (or MBHO) to provide services within their approved scope of practice. Utilizing the freedom of choice waiver, the State will contract with providers and limit the size of the provider network based on need. Beneficiaries may choose the provider they prefer from a list of contracted providers. Once the MBHO assumes risk, providers must contract with the MBHO.

The anticipated functions of the ASO/MBHO, the performance targets the entity is expected to achieve, and special coordination and management requirements for BH-PH integration are described elsewhere in this component of the Waiver.

Reporting, program monitoring and quality management

Progress updates. During the first year of implementation of the Waiver, the State will submit regular progress updates to CMS regarding the selection and implementation of the adult MBHO and transition of children and adolescents from fee for service to the children's ASO.

Reporting. The ASO/MBHO will be required to submit both financial and program reports to the level of detail required by the State (by funding resource including Federal block grant requirements, person level) in the following areas:

- Quarterly financial statements and reports
- Annual financial statements and reports (audited and unaudited)
- Monthly dashboard reports of BH claims by COS, including penetration, utilization, cost per case and performance targets and an analysis of the data with planned actions as needed
- Quarterly reports of all required measurement elements to assess ASO/MBHO performance and outcomes for the BH population
- An annual QM report that summarizes planned initiatives, associated results and includes a discussion of trends, issues, notable accomplishments and areas of improvement, including findings from performance improvement activities, participant surveys, review of plan grievance process results, State fair hearing information, and other monitoring and evaluation activities
- Quarterly care management reporting by program (ICM, BH-PH coordination) to include the number of at risk consumers identified as well as reach, engagement, and program completion rates
- Annual care management reporting by program on outcomes including, as appropriate, improvements in medication adherence, reductions in ED utilization, reduction in hospital admissions, improved health status and claims savings

Program monitoring. DMHAS will prepare a readiness review tool and a readiness review will be completed prior to implementation (See prior section on readiness review). The adult MBHO must successfully complete all elements of the readiness review before it commences live operations. The children's ASO must successfully complete all elements of the readiness review before it accepts children transitioning from fee for service.

DMHAS and DCF, will also prepare a manual for conducting monitoring on a quarterly and annual basis. This will include quarterly and annual monitoring meetings with the ASO/MBHO to review quarterly and annual reports and completion of a compliance review no less than every three years. A compliance officer will be designated to monitor contract compliance on an ongoing basis.

QM. The ASO/MBHO QM requirements include:

- Developing and submitting a QAPI to DMHAS for review and approval
- Developing and submitting a UM Plan, including prior authorization requirements, processes, and timeframes and any other UM strategy proposed to DMAHS for review and approval
- Achieving URAC or NCQA accreditation as a utilization review organization within 12-24 months
- Closely monitoring and reporting BH specific HEDIS metrics and other performance targets against targeted benchmarks
- Operating a first level complaints and grievances mechanism (See prior separate discussion)

The ASO/MBHO will be required to submit QAPI and UM plans to DMHAS or DCF, as appropriate, for review and approval 45 days prior to implementation and annually thereafter. The MBHO also must implement an automated system that tracks UM actions, generates required notifications to beneficiaries and providers, and includes all relevant records for each case.

DMHAS and DCF will make a preliminary selection of HEDIS and other performance measures with the understanding that the underlying methodology may require adjustment and measures may be updated on an annual basis to reflect progress in achieving program goals. The preliminary list of measures includes:

- BH-PH coordination program referral rates (for MCO)
- BH-PH coordination program engagement rate (for ASO/MBHO)
- ICM program participation rates
- Follow up after hospitalization for mental illness
- Inpatient readmission rates
- Antidepressant medication management
- Increase in community tenure (21 years of age and over)
- Reduction in residential cases (under 21 years of age)
- Percent of dollars spent on community-based services
- Initiation and engagement in community-based services

Psychiatric Emergency Rehabilitation Services

For all Medicaid and CHIP covered populations covered by the Comprehensive Waiver, the State will contract with specific providers of PERS. A Rehabilitation SPA will be submitted to CMS to cover this service. The service will be available on a FFS basis until the MBHO is functional and at that time will be managed by the MBHO..

Service description

The PERS will be provided to a person who is experiencing a BH crisis, designed to interrupt and ameliorate the immediate crisis experience and provide an assessment, immediate crisis resolution and de-escalation; and referral and linkage to appropriate services in an effort to avoid more restrictive levels of treatment. The goals of PERS are symptom reduction, stabilization and restoration to a previous level of functioning. All

activities must occur within the context of a potential or actual BH crisis. The Psychiatric emergency rehabilitation service is a face-to-face intervention and can occur in a variety of locations, including the community locations where the person lives, works, attends school and/or socializes as well as an ED or clinic setting.

Specific services include:

- An assessment of risk and mental status, as well as the need for further evaluation or other mental health services. It includes contact with the client, family members or other collateral sources (e.g. caregiver, school personnel) with pertinent information for the purpose of an assessment and/or referral to other alternative mental health services at an appropriate level
- Short-term PERS including crisis resolution and de-briefing
- Follow-up with the individual, and as necessary, with the individual's caretaker or family member(s)
- Consultation with a physician or other qualified providers to assist with the individual's specific crisis

Certified assessors shall assess, refer and link all Medicaid and CHIP eligible individuals in crisis to appropriate mental health services. This shall include but not be limited to performing any necessary assessments; providing crisis stabilization and de-escalation; development of alternative treatment plans; consultation, training and technical assistance to other staff; consultation with the psychiatrist; monitoring of consumers; and arranging for linkage, transfer, transport or admission as necessary for Medicaid eligible individuals at the conclusion of the PERS.

PERS specialists provide crisis intervention counseling, on and off-site; monitor individuals in crisis; and provide referral and linkage, if indicated. PERS specialists who are nurses may also provide medication monitoring and nursing assessments. Psychiatrists perform psychiatric assessments, evaluation and management as needed; write prescriptions and monitor medication; as well as supervise and consult with program staff.

Children with SED 1915(c) and 1915(i)-like concurrent authority for System of Care Program under the Demonstration

Services for Children with SED

New Jersey recognizes that a number of children have SED diagnoses that place them at risk for hospitalization and out-of-home care. The New Jersey Children's System of Care seeks to target children in a manner that will result in:

- Improved Emotional Stability
- Maintain Children In Communities
- Reduce Residential Lengths Of Stay
- Reduce Acute Hospital Admissions And Re-admissions
- More Stable Living Environments For Children

- Improve Educational And Social Functioning
- Reduced Criminal Activity For Children Involved In Care

NJ will utilize 1915(c) and 1915(i)-like authorities under the 1115 to cover children meeting a SED Level of Need and a hospital LOC in a home and community-based setting.

Level of need and level of care and financial eligibility

All children entering CSOC will be screened using the CANS assessment.

- Children meeting a LON of SED/acute stabilization will be eligible up to 150% of the FPL using institutional eligibility criteria. Parental income will be disregarded and the child will be considered a family of one.
- Children meeting a hospital LOC will be eligible up to 300% of the FBR using institutional eligibility criteria. Parental income will be disregarded and the child will be considered a family of one.

New Jersey uses the federal definition of serious emotional disturbance.

To be functionally eligible for the 1915(i)-like SOC program, one of the two criteria must be met:

1. Acute Stabilization – all of the following criteria are necessary for participation in this LOC.
 - A. The child/youth is between the ages of 5 and 21. Special consideration will be given to children under age five.
 - B. The DCBHS Assessment and other relevant information indicate that the child/youth needs the Mobile Response Stabilization Services LOC.
 - C. The child/youth exhibits risk behaviors.
 - D. The child/youth exhibits behavioral/emotional symptoms.
 - E. The parent/caregiver/guardian capability is limited at this time.
 - F. The child/youth is at risk of being placed out of his/her home or present living arrangement.
 - G. The child/youth requires immediate intervention in order to be maintained in his/her home or present living arrangement.
2. Severe Emotional Disturbance (SED) - The child/youth/young adult must meet A, B, C, D, E, and F:
 - A. Must be between the ages of 5 and their 21st birthday. Special consideration will be given to children under 5.
 - B. Has been currently assessed, or at any time during the past year has been assessed to have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within DSM-IV-TR with the exception of other V codes, substance use, and developmental disorders, unless these disorders co-occur with another diagnosable disturbance. All of these disorders have episodic, recurrent, or persistent

features; however, they vary in terms of severity and disabling effects. The diagnosable disorder identified above has resulted in functional impairment that substantially interferes with or limits the youth's role or functioning in family, school, or community activities. Functional impairment is defined as difficulties that substantially interfere with or limit the youth in achieving or maintaining developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. Functional impairments of episodic, recurrent, and continuous duration are included unless they are temporary and expected responses to stressful events in the environment. Youth who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition.

- C. Be in need of an array of mental health services. Specifically, this youth's clinical needs require more than psychotherapeutic services.
- D. The child/youth and his or her family or caregiver requires face to face assistance in obtaining or coordinating treatment, rehabilitation, financial and/or social services, without which the child/youth could reasonably be expected to require more intensive services.
- E. The DCBHS Assessment and other relevant information indicate that the child/youth requires at least a moderate level of case management.
- F. The person(s) with authority to consent to treatment for the youth voluntarily agrees to participate. The assent of a youth who is not authorized under applicable law to consent to treatment is desirable but not required.

The child/youth/young adult may include any of the following characteristics, but it is not a requirement:

- G. Needs or receives multiple services from state/private agencies, special education, or a combination thereof requiring a care planning team to coordinate services from multiple providers or entities.
- H. Is being discharged from a CCIS, other inpatient psychiatric hospitalization, other institutional or community base treatment facility and is returning to a community setting.
- I. Has not demonstrated successful response to previous community based clinical interventions.
- J. Is potentially at risk for OOH placement or psychiatric hospitalization.
- K. Is awaiting an out of home placement for a group home or higher Intensity of Service on Youth Link.
- L. Is court ordered to receive case management services.

M. Is transitioning from the child service system to the adult service system.

Any of the following criteria is sufficient for exclusion from the SOC 1915(i)-like program.

- N. The person(s) with authority to consent to treatment for the youth refuses to participate.
- O. Current assessment or other relevant information indicate that the child/youth/young adult can be safely maintained and effectively supported at a less intensive LOC.
- P. The Behavioral symptoms are the result of a medical condition that warrants a medical setting for treatment as determined and documented by the child's primary care physician and or the CSA Medical Director.
- Q. The child/youth has a sole diagnosis of Substance Abuse and there are no identified, co-occurring emotional or behavioral disturbances consistent with a DSM IV Axis I Disorder, which would potentially benefit from Youth Case Management services.
- R. The child/youth's sole diagnosis is a Developmental Disability that may include one of the following:
 - a. The child/youth has a sole diagnosis of Autism and there are no co-occurring DSM IV Axis I Diagnoses, or symptoms/behaviors consistent with a DSM IV Axis I Diagnosis.
 - b. The child/youth has a sole diagnosis of Intellectual Disability/Cognitive Impairment and there are no co-occurring DSM IV Axis I Diagnoses, or symptoms/behaviors consistent with a DSM IV Axis I Diagnosis.
 - c. The child/youth has a diagnosis of autism and mental retardation and there are no co-occurring DSM IV Axis I Diagnoses, or symptoms/behaviors consistent with a DSM IV Axis I Diagnosis.
- S. The child, youth, or young adult is not a resident of New Jersey. For minors who are under 18 years of age, the residency of the parent or legal guardian shall determine the residence of the minor.

Any of the following criteria is sufficient for discharge from the SOC 1915(i)-like program.

- T. The current assessment and other relevant information indicate that the child/youth no longer meets criteria for the SOC as listed above.
- U. Youth is lost to contact for 2 month duration or moved out of state.
- V. The child/youth's documented ISP goals and objective have been substantially met.

- W. Consent for treatment is withdrawn by the person(s) with authority to consent to treatment.
- X. The person(s) with authority to consent to treatment has not maintained compliance with the current treatment plan and/or services which have been put in place.

A screener will utilize the CANS algorithm developed by Dr. John Lyons which has been cross-walked to the State's LOC hospital criteria and the State's Level of Need SED and acute stabilization criteria as listed above. The screener will verify that the child meets one of the levels of need outlined under the 1915(c) or 1915(i)-like authorities. The CANS has 7 Domains: Risk, Behavioral/Emotional Needs, Life Domain Functioning, Child Strengths, Caregiver Needs and Caregiver Strengths

Eligibility

- NJ will use the Institutional Medicaid financial eligibility standards.
- Children from age of a SED diagnosis up to age 21 will be eligible for the services.
- All children served under this authority will be otherwise eligible for Medicaid and will receive the full benefit package under Medicaid for which they are eligible.
- The child must meet an hospital LOC up to 300% of FBR or an SED LON up to 150% FPL
- For the purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, step parent, legal guardian, siblings, relatives, grandparents, or foster parents.

Acuity

- Medicaid clients who enroll in the 1915(c)-like hospital waiver or 1915(i)-like SED LON HCBS program will receive services through the NJ System of Care including any services under the SOC HCBS program.
- New Jersey public schools are funded to provide certain autism-related services during school hours. Because this authority is a 1915(c)-like authority at the ICF/MR LOC, this funding may not be utilized for services covered under IDEA and in a child's IEP.

Services

- Each child meeting the functional and financial criteria will be enrolled in the Coordinated System of Care and receive Care Management including POC development through a Child/Family Team through a UCM, a CMO, a Youth Case Management entity (YCM) or a Mobile Response Stabilization Services Agency.
- All children enrolled under the 1915(c)-like and 1915(i)-like benefit will be eligible for all State Plan services.

If a child enrolled under the 1915(c)-like and 1915(i)-like program lives in residential treatment, the Child/Family team will be responsible for ensuring that the residential setting is licensed residential settings and demonstrates a home and community

character. A home and community environment is characterized as an environment like a home, provides full access to typical facilities in a home such as a kitchen with cooking facilities, small dining areas, provides for privacy, visitors at times convenient to the participant and easy access to resources and activities in the community. Group homes are expected to be located in residential neighborhoods in the community. Meals are served family style and participants have access to community activities, employment, schools or day programs. Each facility shall assure to each participant the right to live as normally as possible while receiving care and treatment. Home and Community character will be monitored by each Child/Family Team through ongoing monitoring. Child/Family teams will monitor the community character of the group home during regular monthly monitoring. Results of the monitoring will be reported to each CMO/UCM. Child/Family teams continue to offer participants choice of smaller facilities. The CMS/UCM will monitor facilities over 6 beds to assure the home and community environment. Providers found to be out of compliance will be given a time line in which to come into compliance. All residential treatment facilities for children under this program will not exceed 8 beds.

The State Plan services for enrolled children are eligible include all Medicaid State Plan services including but not limited to the following:

- Mental Health/Behavioral Health Screening, Evaluation & Diagnostic Services
- DCBHS Designated Multi-System Assessments
- Mobile Response and Stabilization Management (MRSS) Services provided by a MRSS entity
- Inpatient Psychiatric Hospital Services provided by Certain Psychiatric Hospitals (Contact the provider. Basically limited to those NJ hospitals which are enrolled as a psychiatric hospital and who are precluded from participating in the state's hospital charity care program)
- Partial Care/Partial Hospitalization
- Intensive In-Community Services
- Mental Health Clinic Services
- Outpatient mental health services, including psychiatric, psychological services or advance practice nurse services, Individual, Group and Family Therapy, provided in either a practitioner's office, a clinic or an outpatient department of a hospital
- Residential treatment
- Medication Management
- Medical transportation

Services covered under the 1915(c)-like and 1915(i)-like benefit will include a variety of supportive services not otherwise covered under the State Plan including:

- Behavioral Assistance Services including services resulting from a co-occurring MR/DD diagnosis
- Independent Living/Skills Building,
- Short term respite in-home or in the community,
- Youth Support and Training,

- Parent Support and Training
- Out-of-home short term Crisis Stabilization Respite in a facility that is not an IMD.
- Monitoring (not including Medication)
- Out of Home Residential Treatment including Treatment Homes, Group Homes, Psychiatric Community Residences meeting the requirements of home and community character.
- Non-medical transportation of children and families for activities on plans of care.

Children in Psychiatric Residential Treatment Facilities (PRTFs) or other IMDs of greater than 16 beds are not eligible for this 1915(c)-like or 1915(i)-like program.

Reimbursement Rates

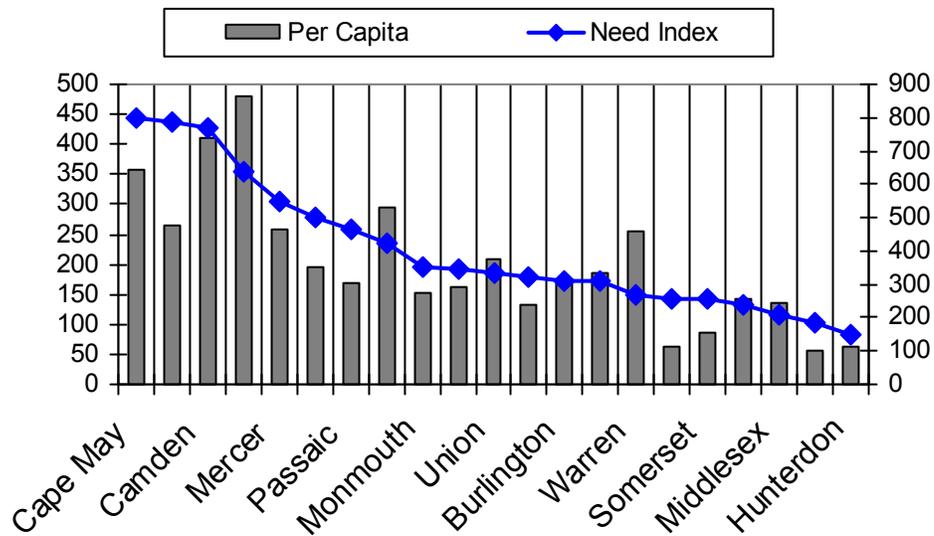
Rates will be established through a fee schedule developed by the State of New Jersey. The State will operate this program with assistance of the children’s ASO contractor where the MMIS pays claims on a FFS basis. Transition to a non-risk or risk MBHO will be explored later as described elsewhere.

Evaluation –

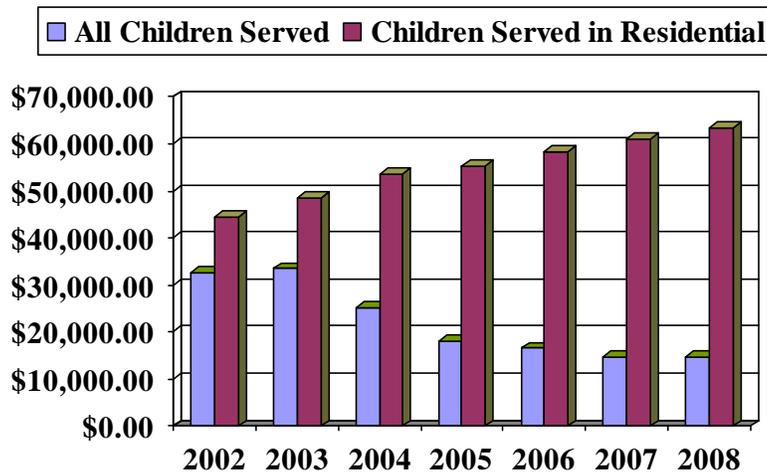
New Jersey will examine the overall number of children placed in residential care with an SED diagnosis compared to children with an SED diagnosis receiving community based services.

New Jersey will examine the average cost per child compared to the need level as measured by the CANS assessment tool. The 2008 baseline is below.

Comparison of FY '08 Consolidated Per Capita Spending to Needs Index by County Shows Improved Fiscal Equity



Average Annual Cost per Child Served Continues to Decrease, Even as Residential Costs Grow



1915(i) Medication Assisted Treatment Initiative

Under a 1915(i) like state plan, the State will implement an expansion to the MATI services for opiate dependent State residents with incomes up to 150% of the FPL and clinical criteria.

Program eligibility

Consumers applying for services under the 1915i waiver will be screened by an independent assessor to determine if they meet the following program eligibility criteria (These are the same as the current MATI criteria):

1. Be a resident of New Jersey and 18 years old
2. Have household income below 150% of FPL
3. Have a history of injectable drug use
4. Test positive for opiates or have a documented one year history of opiate dependence. Individuals who have recently been incarcerated or in residential treatment may not test positive for opiates.
5. Be able to provide proof of identification to prevent dual enrollment in medication-assisted treatment
6. Not currently be enrolled as a client in an OMT program or a client under the care of a physician prescribing Suboxone
7. Not have been enrolled as a client in an OMT program or a client under the care of a physician prescribing Suboxone within the past thirty (30) days

In addition, consumers must be assessed by the independent assessor to establish eligibility based on one or more of the functional impairment criteria:

1. Diagnosed with Psychiatric Disorder at least once in their lifetime by a licensed mental health professional
2. One or more chronic medical conditions (i.e., COPD, diabetes, HIV, Hepatitis C, asthma, etc)
3. Homeless or lacking stable housing for one year or longer
4. Unemployed or lacking stable employment for two years or longer

An estimated 4,839 individuals are expected to qualify.

Services

Services available under the program include opiate medication assisted treatment and psycho social supports delivered through mobile and fixed site services.

1915(i) SMI

The State is evaluating the feasibility of adding certain ambulatory mental health services for individuals with serious mental illness (SMI) through a 1915(i)-like authority under the 1115 demonstration. Upon complete analysis of the financial benefit and exposure the State would like to reserve the right to amend this demonstration accordingly to include those services which may or may not include some or all Medicaid benefits for individuals not otherwise eligible for the full Medicaid benefit package.

Managing supports for intellectual and developmental disabilities

Today, individuals with I/DD residing in the community receive acute/medical services and behavioral care through the four contracted MCOs . This arrangement has been in place since 1995. There will be no change in acute/medical services for individuals with I/DD under the Comprehensive Waiver. They will continue to receive acute/medical care through the MCOs. There will be a change for BH, and at this juncture, New Jersey anticipates that long-term community and institutional supports will remain FFS until the infrastructure for managed care for these long term supports is in place within DDD.

DDD currently serves approximately 42,000 people including those under the HCBS Community Care Waiver, State-funded programs and State Developmental Centers as shown in Table 5.2 below. Medicaid eligible persons with I/DD residing in the community receive acute/medical and BH care services through the four MCOs contracted with DMAHS. LTC supports are provided through DDD within the Department of Human Services. Some of these services are supported by Medicaid through state plan and waiver services and some are not.

Table 5.2 DDD population as of December 31, 2010

Residence Type	Number of Individuals
Community	
Own home	29,704
Group home (This number includes 142 in Parent and Friends Association homes)	4,762
Skill development/FamilyCare	1,089
Supervised apartment	1,264
Supported living/supported housing	707
Boarding home	50
Unsupervised apartment	79
Non DDD funded placements (DCF, Juvenile Justice, Corrections, etc.)	538
Community total	38,193
Developmental Center	
Greenbrook	92
Vineland	395
North Jersey	386
Woodbine	471
New Lisbon	404
Woodbridge	370
Hunterdon	541
Developmental Center total	2,659
Other	
State psychiatric hospital (SPH)	43
Skilled NF	977
Private ICF/MR	58
Other total	1,078
Purchase of Care	
Purchase of Care	796
Purchase of Care total	796
Grand total	42,668

As a preparatory step for the Comprehensive Waiver, DMAHS and DDD conducted an assessment of LTC supports and whether a managed care framework was appropriate. For a number of reasons, both DMAHS and DDD concluded that the basic infrastructure for managed LTC was absent. As a consequence, the five years of the Comprehensive Waiver will focus on preparing DDD for managed care. All DDD Medicaid programs and expenditures will be incorporated into the Comprehensive Waiver.

The rationale for leaving the I/DD population outside of managed care for long term supports (for the present time) includes:

- A significant amount of Medicaid covered services for Medicaid eligibles are provided outside the Medicaid program
- Most I/DD Medicaid claims are paid outside of the MMIS on one of many financial systems in use within the Division
- Providers are paid under purchase of care agreements and receive mainly cost based reimbursement; they are unaccustomed to operating under fee schedules
- The consolidated financial data required for establishing actuarially sound rates is absent
- There is no robust assessment of need that can be used as the basis of eligibility for services through the DDD, LOC for ICF/MR, LOC for HCBS and resource allocation
- There is a waiting list for community based services through the CCW (DDD's only approved waiver)
- Staff currently spend a significant amount of time making children eligible for services that are not available until they are adults
- In 2011, DDD is paying for approximately 779 individuals placed out-of-state for services available in-state (out-of-state placements are declining since 2009 when out-of-state placements totaled 632)
- DDD experiences significant delays in enrollment into the CCW Waiver

Given these infrastructure limitations, DDD will focus on six activities under the Comprehensive Waiver:

- Resolving eligibility and enrollment issues
- Rebalancing facility and community based care
- Pursuing opportunities for enhanced match
- Integrating financial systems within MMIS and its data warehouse
- Developing statewide rate schedules that are not cost based
- Adopting an available off-the-shelf assessment tool or developing a NJ-specific tool

Resolution of eligibility and enrollment issues

While delays in LTC eligibility decisions (particularly for those seeking 1915(c) waiver services) were observed across programs for elderly, physically disabled and I/DD individuals, the delays for the I/DD population were much more significant. While a number of corrective measures were identified, the single most important one is to limit State funded services to individuals with a Medicaid denial for reasons other than failure to comply. Most states have adopted this policy. NJ intends to apply this policy to both new and existing members served beginning October 1, 2011.

The following activities were also identified to improve timeliness:

- Use the PA1C to protect the application date
- Examine the DDD staff's function of collecting application information and its usefulness in expediting eligibility

- Treat each case as potentially financially eligible. DDD has decided to perform the clinical/LOC determination, present choice options required by regulation, confirm the completion and submission of the financial application, develop a POC and initiate waiver services. Once financial eligibility is complete, the State can claim federal financial participation (FFP) back to the application date or when all requirements for enrollment were completed
- Once a comprehensive assessment is adopted, seek SSA approval for the disability determination
- Terminate application processing for children until age 16
- Pursue claiming FMAP for out-of-state placements
- Provide for prior quarter coverage of HCBS under the waiver

Balance facility and community-based care

Consistent with the requirements of the Olmstead decision, a key objective of the Comprehensive Waiver is to reduce the use of institutional placement for people with intellectual and developmental disorders and increase community placement and support for those individuals. Two significant initiatives are aimed at balancing – implementation of a Supports Waiver and development of affordable housing alternatives.

The first initiative directed at balancing is submission, by Fall 2011, of a Supports Waiver designed specifically to support adults in their homes and eventually eliminate waiting lists. In order to ensure that services are available as soon as possible, the State will submit the Supports Waiver as a 1915(c) and incorporate comparable provisions in the Comprehensive Waiver. The State is committed to reinvesting federal funds into services. The Supports Waiver will serve 1,260 adults in Year 1 and increase to 3,780 unduplicated individuals by the third year. The proposed service package includes but not limited to:

- Day habilitation
- Respite
- Behavior supports
- Supported employment
- Support coordination
- Assistive technology
- Environmental and vehicle modification

DDD will also amend the CCW waiver to incorporate behavioral supports which are currently provided with state funds.

The second initiative provides affordable housing to more than 600 individuals with I/DD in renovated homes over the next two years. Under the plan, municipalities can buy three- or four-bedroom ranch-style homes and two-bedroom condominiums in their communities. The homes will be renovated to provide the necessary accommodations. The State will act as the middleman, supplying a list of approximately two dozen

developers and suppliers from whom towns can choose to provide the renovations using tax credit financing and low-interest loans.

Pursue opportunities for enhanced match

In addition to the adoption of programs that provide Medicaid covered services to Medicaid eligible members, DHS/DDD and DMAHS will seek enhanced federal match from the Balancing Incentive Payments provisions under ACA. Initial estimates suggest that NJ will be eligible for a two percent enhancement.

DDD will also seek federal match on out-of-state placements and continue return of New Jersey citizens. Currently the State only claims the FMAP on services provided in Pennsylvania. Two other initiatives for individuals with I/DD and MI and for children with pervasive developmental disorders are described below.

Development of statewide prospective rate schedules that are not cost based

The State is one of two states that continue to reimburse community-based providers based on costs (North Dakota is the other). In order to prepare the provider network for managed care, the network must first have a successful experience operating under a statewide fee schedule. Development of prospective rates is a major task. NJ does have one key element necessary for rate development – cost reports. However, based on rate development activities in other states, often cost reports must be supplemented by a survey to obtain other information, such as wages and productivity.

Cost is not the exclusive source of information in rate development. Rather, independent sources such as the Bureau of Labor Statistics (BLS) are also necessary to determine appropriate wages and employee related expenses for comparable employee categories in the State.

Adopting an off the shelf assessment available and/or developing a New Jersey tool

DDD does not currently have a multi-purpose assessment tool that is independently administered. At a minimum, DDD needs an assessment tool/process that can be used to:

- Determine eligibility for DD services
- Determine LOC for both facility and HCBS
- Serve as the foundation for resource allocation based on assessed need
- Provide input into care planning

DDD will consider adopting an existing tool such as the Supports Intensity Scale, which is currently in use in 20 states. Substantially more effort would be required to develop a State-specific assessment document and process.

Intellectual and development disabilities with dual mental health diagnoses 1915(c)-like pilot program

The State will develop a 200-slot 1915(c)-like program for children with I/DDs and a co-occurring mental illness that meets the state mental hospital LOC. The primary goal of the DD/MI program is to provide a safe, stable, and therapeutically supportive environment in the community for children and young adults with significantly challenging behavior needs.

The objectives of the DD/MI program are to:

- Ensure the safety of the child or young adult and all participating staff by providing individual specific training and on site technical supports
- Decrease elopement risk and safeguard the environment by providing one-time funds to ensure safety
- Keep families united by placing the child or young adult in close proximity to the individual's family or guardian(s) in the least restrictive setting
- Reunite the child or young adult with the family or guardian whenever possible
- Increase infrastructure to serve the children in the State

Children served by the DD/MI waiver

The target population for this waiver includes children with a co-occurring DD and MI. Children are able to enter the waiver program from the age of diagnosis until their 21st birthday. The institutional alternative for the Waiver program is a state mental hospital LOC.

Children will reside at home, in foster care homes or in group homes with four or fewer beds. The group homes will have a home-like environment that includes a kitchen with cooking facilities and small dining areas, and provides for privacy, visitors at times convenient to the participant and easy access to resources/activities in the community. Group homes are expected to be located in residential neighborhoods. Meals are served family style and participants have access to community activities, employment, schools or day programs. Each group home will be required to ensure that each participant has the right to live as normally as possible while receiving care and treatment. The home and community character of each home will be monitored on an ongoing basis by DDD.

Eligibility requirements for services

To be eligible for the DD/MI waiver services, a child must receive a DD diagnosis by a licensed medical doctor or Ph.D. psychologist using an approved screening tool. Once a child has been referred to the Functional Eligibility Specialist (Specialist) for a LOC (functional) determination, the Specialist will complete the assessment within five business days from the date of the initial referral. The child will be assessed for a LOC determination to establish functional eligibility for waiver services.

If a child meets the criteria for the HCBS DD/MI Waiver, the child will receive a letter from the Program Manager informing them they have been placed on the Proposed Waiver Recipient List and his/her numerical position on the list. When a slot in the Waiver program becomes available, the Program Manager will contact the family to offer them the position. Individuals on the waiting list will be served based on highest acuity first rather than on a first-come, first-served basis.

If the child was on a waiting list for longer than six months, and a slot becomes available the Specialist has five business days to schedule a home visit and complete the functional eligibility assessment to verify that the child continues to meet the program's established criteria. If a child is found to be eligible for DD/MI Waiver services, the Specialist will aid the child and the child's family in completing the Medicaid application (if necessary) and gaining access to needed medical, social, educational and other services through the provision of information, referral and related activities. Throughout provision of all information and referral services, the Specialist will promote and ensure participant choice. At this point, the Specialist will refer the child and family to a Service Coordinator

The Service Coordinator has five working days to contact the family and begin to develop the plan of care (service plan).

The Specialist is required to perform an annual assessment utilizing the LOC assessment for each year that the child receives HCBS DD/MI Waiver services. If a child no longer meets a hospital LOC, they will be transitioned off the program.

Services provided through the DD/MI Waiver

Services provided in the HCBS DD/MI Waiver but not limited to include:

- Intensive Behavioral Support (as recommended by the Dual Diagnosis Task Force) is intended to assist the family and paid support staff or other professionals to carry out the IBP/POC that supports the child's functional development and inclusion in the community. This is monitored by a BS who will:
 - Assess the child and family's strengths and needs
 - Develop the IBP/POC
 - Provide training and technical assistance to the family and paid support staff in order to carry out the program
 - Monitor the child's progress within the program and the family's and other providers' implementation of the program
- Intensive In-home and Community Individual Support services assist the child with a DD/MI in acquiring, retaining, improving and generalizing the self-help, socialization and adaptive skills necessary to function successfully in the home and community. Intensive Individual Support workers will provide services directly to the child through evidence-based and data driven methodologies. They will be trained and work under the direction of the BS.
- Respite Services provide temporary direct care and supervision of the child. The primary purpose is to provide relief to families of a child with a DD/MI. This can

include assistance with normal activities of daily living and support in home and community settings.

- Parent Support and Training providers promote engagement and active participation of all family members in all aspects of the treatment process. This involves assisting the family in acquiring the knowledge and skills necessary to understand and address the specific needs of the child. These services will enhance the family's expertise by providing specific problem solving skills, coping mechanisms and help in developing strategies for the child's maladaptive behaviors and behavior management.
- Out of home supports

Children with Pervasive Developmental Disabilities 1915(c)-like pilot program

The State recognizes that a number of individuals with Medicaid coverage have PDD diagnoses and are unable to receive Pervasive Developmental Disabilities-related habilitation services through the Medicaid State Plan that are available to individuals with private health insurance in the State. The State also recognizes that research shows that the most dramatic results in treatment occur during the pre-adolescent years. NJ will utilize 1915(c)-like authorities under the 1115 to cover 200 children meeting a Pervasive Developmental Disability LOC at the ICF/MR LOC.

Level of need

Receive a Pervasive Developmental Disability diagnosis by a licensed Medical Doctor or Ph.D. Psychologist using an approved specific screening tools including:

- ABAS – Adaptive Behavior Assessment System II
- CARS – Childhood Autism Rating Scale
- DDRT – Developmental Disabilities Resource Tool
- GARS – Gilliam Autism Rating Scale
- ADOS – Autism Diagnostic Observation Scale
- ADI – Autism Diagnostic Interview-Revised
- ASDS – Asperger Syndrome Diagnostic Scale

A screener utilizing the State's current DDRT, which has been cross-walked to the State's LOC ICF/MR criteria, will verify that the child meets one of the levels of need outlined under the 1915(c) authority. Completion of the functional assessment tool will result in a score that determines the dollar amount of services that will be available for each child.

The State is projecting that the maximum annual expenditure for a child with the highest need will be equal to \$27,000. Levels below that amount will be capped at three levels of \$9,000; \$18,000; and \$27,000 – a child in the lowest level would be eligible for services up to \$9,000 annually; a child in the next level would be eligible for services up to \$18,000 annually; and a child in the next level would be eligible for services up to \$27,000 annually.

Eligibility

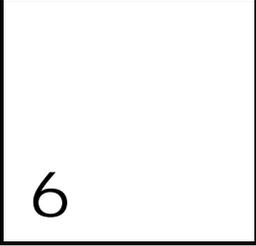
- NJ will use the Community Medicaid and CHIP financial eligibility standards.
- Children from age of a PDD-related diagnosis through age 12 will be eligible for the services.
- All children served under this authority will be otherwise eligible for Medicaid or CHIP and will receive the full benefit package under Medicaid and CHIP for which they are eligible.
- For the purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, step parent, legal guardian, siblings, relatives, grandparents, or foster parents.

Acuity

- Administration of the DDRT tool will result in a score that is used to determine the dollar amount of services available to the child. The intent is to provide a higher dollar amount of services to a child who has more functional needs, but still provide some smaller amount of services to a child with fewer functional needs who also has a PDD diagnosis.
- State private health insurers are mandated to provide up to \$36,000 of autism services annually to each covered individual with PDD. The State will exhaust third party liability first. The State does not anticipate covering more than \$27,000 for any child under the 1915(c)-like authority.
- Medicaid clients who enroll in the 1915(c)-like hospital waiver program will also receive services through the NJ FamilyCare/Medicaid program including any services under the 1915(c) and not available under the 1915(c) for which they are eligible.
- State public schools are funded to provide certain autism-related services during school hours. Because this authority is a 1915(c)-like authority at the ICF/MR LOC, this funding may not be utilized for services covered under Individuals with Disabilities Education Act (IDEA) and in a child's Individual Education Plan (IEP).

Medical necessity and developmental disabilities

The State will ensure that for all covered Medicaid services, the presence of a DD diagnosis, covered under the DSM IV (soon to be DSM V) criteria will not be excluded from the definitions of medical necessity and EPSDT. Services already covered under the Medicaid State Plan such as inpatient and outpatient hospital, physician, clinic, pharmacy, other licensed practitioner, home health, personal care, occupational and speech therapy will not exclude coverage for children with a DSM IV diagnosis, including DD. For example, an individual in crisis accessing ED services will not be determined to not meet medical necessity criteria solely because of the existence of a DD diagnosis. A child who needs a personal care attendant to attend a dental visit will not be excluded from medical necessity due to the presence of a DD diagnosis. For rehabilitation services, medical necessity requires that the service not be habilitative in nature, that the individual is regaining or maintaining a skill that he/she already had, and that the individual has a diagnosis or need in addition to the DD. School-based services are not included in the Comprehensive Waiver. .

6

Rewarding member responsibility and healthy behavior

There is an increased emphasis on the role of preventive health in targeting the underlying causes of chronic disease since the passing of the ACA in March 2010. Keeping people healthy is an important goal of this legislation. One way to reach that goal is to encourage all Americans to make better choices about diet, exercise and smoking to help avoid the future development or progression of conditions such as hypertension, hyperlipidemia, heart disease, diabetes and cancer. The statistics are alarming:

- Life expectancy at birth in the United States is less than life expectancy in most other developed countries
- Tobacco use is responsible for more than 430,000 deaths each year and is the largest cause of preventable morbidity and mortality in the United States
- According to 2009 data, 26.7% of adults in the United States are obese
 - Approximately 300,000 deaths per year may be attributable to obesity
 - The annual health care cost of obesity is estimated to be \$147 billion/year
- More than one-third of adults have two or more major risk factors for heart disease
- Diabetes is the seventh leading cause of death in the United States, accounting for \$116 billion in total United States health care system costs in 2007

In an attempt to improve the overall health of its own Medicaid beneficiaries, the State proposes two opportunities to reward member responsibility and healthy behaviors. These initiatives are described in the following pages.

Managed care organization incentive program

Overview

The State wishes to improve the overall health of its Medicaid members enrolled in managed care by incentivizing members to make healthy behavior and lifestyle choices.

DMAHS will work collaboratively with its Medicaid contracted MCOs to develop and implement an incentive program, *New Jersey Healthy Choices*, to reward healthy behaviors.

To give credit to New Jersey's MCOs, they started rewarding healthy behaviors outside the Comprehensive Waiver. The MCOs report they provide gift cards, ranging from \$10 to \$15 and prepaid phone cards. The following healthy behaviors are targeted:

- Dental screenings
- Prenatal care
- Postpartum follow-up
- Adolescent well child visits
- Well-care services consistent with contractual guidelines

Building on these initiatives, the MCOs will be responsible for program design, marketing, implementation and ongoing program administration to best suit the needs of their membership. While the MCOs will have flexibility in how they design their incentive program, the State will provide the overall program vision. Consideration will be given to leveraging existing MCO efforts, as appropriate. The MCOs will need to consider any ethical, legal and practical constraints in their program design and work collaboratively with the State to ensure that any issues are appropriately identified and addressed. The State will provide ongoing oversight and monitoring and will review/approve all program components and materials prior to implementation.

The program's goal is to encourage/empower members to take responsibility for their health and reward them for adopting healthy behaviors. The ultimate goal of incentive based prevention is to maintain one's short-term success long-term.

Program participation/eligibility requirements

Participation in the *New Jersey Healthy Choices* program will be open (on a voluntary basis) to Medicaid beneficiaries of all ages and categories who are enrolled in a contracted MCO. It will focus on health education and healthy behaviors specific to diet, exercise and smoking cessation. Members on both ends of the health care continuum (i.e., those who are relatively healthy, as well as those with multiple chronic conditions) will be eligible to participate. It is anticipated that program participation levels will be capped per MCO, with the number of participants prorated based on each MCO's New Jersey Medicaid membership. Such discussions/negotiations will take place between the State and each MCO during the program design phase.

Service delivery

Completion of a health risk assessment will serve as the point of entry into the program. This assessment will be used to evaluate current health status, identify at-risk behaviors and increase awareness of health issues, as well as assess the member's readiness to change. The MCO's care management staff (registered nurses) will work collaboratively with each program participant and his/her PCP/health care team to develop an

individualized health improvement and management plan (care plan), which sets reasonable, achievable and age-appropriate personal goals, as well as outlines the member’s responsibilities for behavior change. The plan will include evidence-based practices in self management and skill building and will be structured to “meet the member where he/she is at” with respect to readiness to change. Interventions will be predicated upon proven behavior change theories and techniques, such as patient empowerment and motivational interviewing. Members will be provided opportunities to work toward healthy lifestyles within a supportive community environment using numerous resources to support risk reduction.

A model of patient-centered care must compliment the personal responsibility and accountability aspects; therefore, members will be encouraged to choose or be assigned a medical home that will provide the care and enhanced coordination/case management services.

Members will be expected to take their medications as prescribed, keep their appointments (or cancel when necessary) and use the ED only for emergencies. Members with patterns of overuse or inappropriate use of services will receive intensive case management to determine the root causes and modify behavior accordingly.

Rewarding healthy behaviors

As note above, each program participant will have a customized care plan that will include health status, at-risk behaviors, interventions and short- and long-term goals. MCO care managers will be responsible for initial care plan development as well as ongoing reviews and updates. Program participants will be assigned a *New Jersey Healthy Choices* account. The MCO will track member-specific progress made toward the pre-defined goals, which also may include monitoring utilization of services such as annual wellness exams, age and gender appropriate preventive screenings, immunizations and prenatal and post-partum visits. In addition, points will be awarded for adopting healthy lifestyle choices, such as weight management, smoking cessation and regular exercise.

Medicaid beneficiaries will be rewarded on a tiered basis for participation in programs (e.g., engaging in counseling focused on losing weight or smoking cessation), attempts at behavior change (e.g., completing a weight management or smoking cessation program), actual behavior change (e.g., exercising 30 minutes a day or not smoking one week after completing the program) and finally, achievement of health goals (e.g., losing weight or remaining cigarette-free after six months). A tiered incentive approach is key to sustaining behavior changes over the long-term.

As each participant in the program reaches identified milestones with his/her care plan, points will accumulate in the member’s *Healthy Choices* account. Points can be converted to cash quarterly for use on health care related service items. It is anticipated that the maximum awarded annually will not exceed \$100. The State is seeking authority to exclude from eligibility determination cash accumulated in *Healthy Choices* accounts.

Reporting, program monitoring and quality management

The success of the programs will be measured by structure, process and individual outcome measures. Structural measures may include beneficiary participation, points/rewards earned and the number/percentage of participants who spend their rewards. Process measures may include participant satisfaction. Outcome measures may include tracking the number of wellness/preventive care visits, improvement in biometric measures (e.g., BMI, cholesterol, blood pressure, etc.), health care utilization (e.g., emergency room visits, inpatient admissions and readmissions) and costs.

DMAHS will work collaboratively with each MCO to develop appropriate outcome measures and reporting parameters based on the design of the program. These will likely include, but not be limited to, program participation, individual goal achievement, preventive measures, medication adherence, improvement in key clinical indicators and utilization measures, such as ED visits and hospital admissions.

Existing QM initiatives and reporting systems (e.g., HEDIS measures and Medicaid State Core Quality Measures) will be leveraged whenever possible to monitor program impact and reduce the administrative burden on the MCOs and contracted providers. The MCOs will provide quarterly and annual reports to the State as agreed upon during the program development phase.

By rewarding healthy behaviors, it is expected that costs will be contained through improved health education and prevention and chronic disease management/control. Additional savings will be generated through reductions in hospitalizations for avoidable complications, as well as reductions in inappropriate use of the ED. A portion of the savings generated from the program will be reinvested to fund future program expansion and management.

Medicaid incentives for prevention of chronic diseases grant opportunity

Overview

On February 23, 2011, CMS announced a competitive grant opportunity for state Medicaid programs to develop, implement and evaluate the use of incentives for the prevention of chronic disease. The ACA authorized \$100 million for states to provide incentives to beneficiaries who participate in the prevention programs and demonstrate changes in health risk and outcomes. Grant applications were due to CMS on May 2, 2011.

In its grant application, DMAHS proposed a partnership among DMAHS, DHSS and NJPCA to pilot an incentive-based model of care related to the management of Medicaid beneficiaries with diabetes, or those who are at-risk for developing diabetes. The projected number of participants was estimated at 9,000.

Program participation/eligibility requirements

The proposed model will be piloted in three FQHCs across the State. Potential participants will be recruited through three entry points – walk-ins, scheduled appointments and data mining using the FQHC’s electronic medical record (EMR). Selection will be based on specific eligibility requirements:

- Eighteen years of age or older and
- Medicaid recipient and
- Primary or secondary diagnosis of diabetes and/or
- Two of the three following criteria:
 - HbA1c greater than or equal to 7.5 for four consecutive quarters
 - Body mass index (BMI) over 25.0
 - Blood pressure greater than 140/90

Walk-ins or individuals with scheduled appointments will be educated about and invited to participate in the program while they are at the FQHC. Those individuals identified through the FQHC’s EMR, who meet the eligibility requirements, will be contacted about the program and invited to participate. Consent will be obtained from individuals who agree to participate in the program. All patients recruited for the study will be tracked using a unique identifier. This unique identifier will include a code to determine location and entry point.

Individuals who will be excluded from the study include those under 18 years of age, pregnant women and those currently undergoing chemotherapy or radiation treatment.

Service delivery

Program participants will participate in programs focused on self management, peer support, behavior change and adoption of healthy lifestyles, with the ultimate goal of mitigating risk and improving overall health status.

Each FQHC will have a diabetes care coordinator (registered nurse with diabetes management experience) on site who will work closely with the physician delivering care to assure all individuals involved in the study are receiving timely, high-quality care. The coordinator will maintain records of care, collect required data and track incentive points earned.

NJPCA, in turn, will also provide a program manager at each of the selected FQHC sites. These individuals will work with the diabetes care coordinators to ensure the program is being implemented as designed, and that all required data is being collected and reported.

As noted above, the State applied for one of the CMS grants, “Medicaid Incentives for the Prevention of Chronic Diseases”. State-specific awards are still pending. The State intends to move forward with this initiative if it is awarded one of these grants.

Member responsibility/promoting self-management

The State intends to use the Chronic Disease Self-Management Program (CDSMP) as the primary intervention for changing participant behaviors and improving self-care. The CDSMP is the best known self-management program for people with chronic conditions. It was developed by Dr. Kate Lorig and her colleagues at Stanford University. The CDSMP has been supported by over 20 years of federally funded research from the Agency for Healthcare Research and Quality, the National Institutes of Health and the Centers for Disease Control and Prevention. (www.patienteducation.stanford.edu).

The CDSMP is a 17-hour course facilitated by trained lay people that focuses on problems common to patients suffering from type 1 or type 2 diabetes, or those at risk for developing diabetes. The classes emphasize individual goal setting and problem solving and are highly interactive. Through facilitated interactions, course participants develop skills aimed at improving their self confidence in managing their illnesses, dealing with symptoms and learning effective strategies such as action planning and feedback, behavior modeling, problem-solving techniques and decision making.

The primary program goal is to reduce risk and improve the management of diabetes for identified individuals who agree to participate in the program. With respect to risk mitigation, this program has identified secondary goals of tobacco cessation, weight control or reduction, lowering blood pressure and greater involvement in self-care through education and application of self-management techniques as noted above. Those seeking assistance in tobacco cessation will be referred to the New Jersey Quit Line, which provides no-cost individualized counseling services.

Rewarding healthy behaviors

Each program participant will have a customized care plan that includes health status, at-risk behaviors, interventions and short- and long-term goals. A tiered incentive point system will be implemented to encourage program participants to fully engage and be successful in attaining goals as outlined in each care plan. The incentives will include gift certificates to local retailers such as the pharmacies or grocery stores. Incentives can be used for healthy foods, diabetic supplies, home blood pressure monitors, pedometers or exercise bands. Participants will have multiple opportunities to obtain points, as described below:

- Tier one points – Registering for the program, keeping all follow-up visits, obtaining appropriate eye and foot examinations, and an annual flu shot
- Tier two points – Reaching the mid level HbA1c weight, exercise and blood pressure goals
- Tier three points – Reaching the final level HbA1c weight, exercise and blood pressure goals
- Tier four points – Maintaining healthy lifestyle goals of weight loss/control, routine exercise and tobacco cessation

As each participant in the program reaches identified milestones within the care plan, incentives will be distributed and will increase in value based on progress towards, and attainment of, the end goal.

Reporting, program monitoring and quality management

Rutgers Center for State Health Policy (CSHP) has a long-standing collaborative relationship with DMAHS and other proposed partners for this project, and is participating in this important initiative. It will provide research, design and implementation consultation services during the first project year. During subsequent project years, the CSHP will collaborate on research design issues, conduct the data analysis and disseminate findings to policy and research audiences.

In addition to using the CSHP to evaluate and analyze the program, the selected pilot sites will also use the Guideline Advantage Program. Formerly the American Heart Association’s Get With The Guidelines® Outpatient program, The Guideline Advantage Program is a jointly directed quality improvement program from the American Cancer Society, American Diabetes Association and American Heart Association. This program works with practices’ existing EMRs, or HIT platforms, to seamlessly extract relevant patient data and provide quarterly reports and benchmarking on adherence to nationally recognized clinical guidelines.

Data collection and analysis

Data collection will be coordinated among the CSHP and the three partner agencies, with DHSS taking the lead to manage the data produced, aggregated and mined at the participating FQHCs. The FQHCs are very accustomed to collecting the type of data that will be needed in conjunction with this study as part of their ongoing state and federal requirements.

Data will be collected via the participants’ EMRs. The Data Manager at each FQHC will work with the Care Coordinator to ensure the appropriate data is collected, monitored and reported to the State in a timely and high-quality fashion.

During year one of this initiative, an evaluation plan (with appropriate tracking mechanisms) will be developed to assess the overall impact of the grant program and monitor progress over time. It will include the specific measures that will be used to evaluate program success, the targeted outcomes for each measure, as well as a detailed plan for data collection, analysis and ongoing monitoring of progress made towards program goals. Collecting pertinent data and creating metric definitions/expectations focus the program on targeted outcome measurements and provide the necessary data to evaluate program success and drive future strategies.

- We understand that CMS plans to use appropriate quality measures from the Core Set of Health Quality Measures for Medicaid Eligible Adults and the Core Set for Children in the evaluation of the grant program. Once such measures are finalized,

we will work collaboratively with CMS to appropriately align our measures accordingly.

Reporting

DMAHS will lead and coordinate data analysis activities with its respective partners. Semi-annual reports will be developed and submitted to CMS, which will include an evaluation of the program's effectiveness, a description of the processes developed and lessons learned, as well as a summary of preventive services utilized. Specifically, the semi-annual report will include:

- Specific use of grant funds
- An assessment of:
 - Program implementation
 - Processes developed and lessons learned
 - Quality improvements
 - Clinical outcomes
 - Estimate of cost savings

These reports will be a coordinated effort between the agencies participating in this initiative.

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Evaluation

The Comprehensive Waiver touches every part of the New Jersey Medicaid and Family Care programs. As a result, the evaluation design will be complex. Rather than setting forth a specific evaluation design, the State proposes to convene a Research/Evaluation Committee tasked with development of a comprehensive evaluation plan. The Committee will be charged with developing the initial set of evaluation questions, the data collection strategy, the timing of evaluation components (when to evaluate what), interpreting findings and recommending changes to the program based on those findings. The State wants an evaluation that provides feedback directly on the program's operation under the Comprehensive Waiver. At a minimum the scope of the evaluation will include an assessment of implementation including the process developed and lessons learned, cost savings, quality improvements, and clinical outcomes. One critical component of the evaluation will be to assess the State's success in streamlining NJ FamilyCare/Medicaid from the members' perspective. Because the Comprehensive Waiver has many components, it will be important to develop a common data set to allow evaluation across components.

Participation on the Research/Evaluation Committee will require a significant time commitment by its members. Committee membership will include:

- Health home providers
- DMAHS
- DMHAS
- DCF (DYFS/DCBHS)
- DHSS
- DDD
- DDS
- MCOs
- Medical Directors
- Rutgers University researchers
- Community based providers

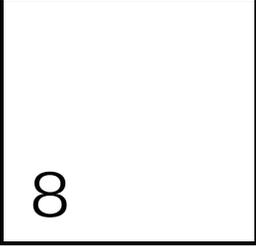
- ACO participants
- Members

The Research/Evaluation Committee would include experts in the following areas:

- Financing
- Quality monitoring and measurement including HEDIS and quality improvement projects
- Health economics
- Large data sets
- Research design
- Data element definition
- Data collection strategies
- Statistics
- Care management
- Predictive modeling and risk adjustment and assessment
- Patterns of care analyses
- Member and provider survey

The Research/Evaluation Committee will be appointed and begin meeting in late fall. DMAHS will prepare materials for the Committee's consideration including sample evaluation plans from other waivers, data collection methods, and potential evaluation questions.

To support the evaluation, DMAHS will solicit outside funding from foundations, CMS, or other federal agencies.

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Public notice and input process

Public input process

Prior to the submission of the State's Comprehensive Waiver application, we had an extensive process for public input. A website was developed specifically for the Comprehensive Waiver and can be accessed at www.state.nj.us/humanservices. Available on the site is a copy of the Comprehensive Waiver concept paper, a Comprehensive Waiver slide deck and savings estimates for the waiver. Also, there is a link to an email address set-up specifically for stakeholders and interested parties to provide public comment on the proposed waiver concepts.

A public notice was also published in newspapers statewide on June 11, 2011 allowing for a 30-day comment period. The notice and a copy of the Comprehensive Waiver concept paper were available for public review on the DHS website and at the 21 CWA and the Medical Assistance Customer Centers. The State received a total of 32 written comments from stakeholders. The public comments have been summarized and are provided in Appendix A.

DHS had extensive public discussions and distributed the waiver widely. We held a special meeting of the DMAHS Medical Assistance Advisory Council (MAAC) on June 13, 2011. We had three meetings with the DHSS Medicaid LTC Funding Advisory Council on March 15, May 18 and July 7, 2011. We have met with interested stakeholder groups and advocates including but not limited to:

- New Jersey Primary Care Association
- New Jersey Hospital Association
- Managed Care Organizations
- Legal Services of New Jersey
- Area Agencies on Aging
- New Jersey Association of Mental Health and Addiction Agencies
- National Alliance on Mental Illness

- ARC of NJ
- Alliance for the Betterment of Citizens with Disabilities
- NJ Association of Community Providers
- American Academy of Pediatrics
- American Association of Retired Persons

We have briefed key legislative staff including the Senate and Assembly Budget Committee on March 24, 2011. A Congressional briefing was held on May 4, 2011 and an Assembly Budget Committee briefing occurred on May 23, 2011. We have also participated in several legislative hearings regarding Medicaid and the Comprehensive Waiver including the Assembly Budget Committee Medicaid Roundtable on April 5, 2011, the Assembly Budget Committee Medicaid hearing on April 5, 2011, the Senate Budget and Appropriations hearing on May 2, 2011, the Assembly Budget Committee hearing on May 24, 2011 and the Senate Health, Human Services and Senior Citizens Committee hearing on June 23, 2011.

9

Budget neutrality

This section presents the State's approach for showing budget neutrality and the data and assumptions used in the development of the cost and caseload estimates supporting this 1115 Waiver request. The ability to show budget neutrality is a significant concern to the State. In today's economic climate, the State realizes that programs must be evaluated carefully to ensure that they could be sustained long term. The State is proposing a demonstration that encompasses most services and eligible populations under a single authority to provide broad flexibility to more effectively manage its programs while pursuing innovations to enhance access to quality care in Medicaid and CHIP.

Overview

The proposed waiver program would begin on October 1, 2011, subject to CMS approval, with the five-year demonstration going through September 30, 2016. The five-year term of the Demonstration project, thus, covers federal fiscal years 2012 through 2016 (FFY12 through FFY16). The time periods for the five-year demonstration period are detailed in the table below:

Table 9.1 Demonstration Year (DY) time periods

Demonstration Year	DY1	DY2	DY3	DY4	DY5
Time period	10/1/2011 – 9/30/2012	10/1/2012 – 9/30/2013	10/1/2013 – 9/30/2014	10/1/2014 – 9/30/2015	10/1/2015 – 9/30/2016

Data was available from State Fiscal Year 2006 (SFY2006) through SFY2010 to support the development of cost and caseload projections. More recent data from SFY2011 was incomplete and was thus, used for limited trending purposes only. SFY10 was chosen as the base year throughout the cost and caseload projections. The tables below present

historical program funding and caseload for SFY2006-2010. Note: growth in SFY2006-2007 is affected by drug coverage for dual eligibles shifting to Medicare.

Table 9.2a Total Spend

	SFY06 (7/1/05-6/30/06)	SFY07 (7/1/06-6/30/07)	SFY08 (7/1/07-6/30/08)	SFY09 (7/1/08-6/30/09)	SFY10 (7/1/09-6/30/10)	5-YEARS
Title XIX						
TOTAL EXPENDITURES						
Eligible Member Months	5,971,385	6,123,197	6,204,095	6,414,982	6,830,273	
Total Cost per Eligible	\$ 237.38	\$ 263.72	\$ 274.64	\$ 275.22	\$ 277.25	
Total Expenditure	\$ 1,417,516,967	\$ 1,614,812,695	\$ 1,703,864,445	\$ 1,765,561,525	\$ 1,893,718,838	\$ 8,395,474,470
						<u>5 YEAR</u>
						<u>AVERAGE</u>
TREND RATES						
						<u>ANNUAL CHANGE</u>
Eligible Member Months		2.5%	1.3%	3.4%	6.5%	3.4%
Total Cost per Eligible		11.1%	4.1%	0.2%	0.7%	4.0%
Total Expenditure		13.9%	5.5%	3.6%	7.3%	7.5%
ABD						
TOTAL EXPENDITURES						
Eligible Member Months	2,428,242	2,468,046	2,506,003	2,584,377	2,649,687	
Total Cost per Eligible	\$ 892.23	\$ 832.83	\$ 846.96	\$ 867.12	\$ 874.95	
Total Expenditure	\$ 2,166,548,881	\$ 2,055,458,605	\$ 2,122,476,811	\$ 2,240,963,223	\$ 2,318,337,274	\$ 10,903,784,794
						<u>5 YEAR</u>
						<u>AVERAGE</u>
TREND RATES						
						<u>ANNUAL CHANGE</u>
Eligible Member Months		1.6%	1.5%	3.1%	2.5%	2.2%
Total Cost per Eligible		-6.7%	1.7%	2.4%	0.9%	-0.5%
Total Expenditure		-5.1%	3.3%	5.6%	3.5%	1.7%
LTC						
TOTAL EXPENDITURES						
Eligible Member Months	411,322	407,890	402,348	398,826	394,805	
Total Cost per Eligible	\$ 6,576.70	\$ 6,633.84	\$ 7,007.91	\$ 7,291.14	\$ 7,188.65	
Total Expenditure	\$ 2,705,143,095	\$ 2,705,876,907	\$ 2,819,617,102	\$ 2,907,895,578	\$ 2,838,113,657	\$ 13,976,646,339
						<u>5 YEAR</u>
						<u>AVERAGE</u>
TREND RATES						
						<u>ANNUAL CHANGE</u>
Eligible Member Months		-0.8%	-1.4%	-0.9%	-1.0%	-1.0%
Total Cost per Eligible		0.9%	5.6%	4.0%	-1.4%	2.2%
Total Expenditure		0.0%	4.2%	3.1%	-2.4%	1.2%
Community Care Waivers						
TOTAL EXPENDITURES						
Eligible Member Months	116,835	121,080	123,923	123,988	123,250	
Total Cost per Eligible	\$ 4,885.90	\$ 5,019.07	\$ 5,054.92	\$ 5,341.44	\$ 5,450.45	
Total Expenditure	\$ 570,843,910	\$ 607,709,431	\$ 626,421,270	\$ 662,275,006	\$ 671,768,188	\$ 3,139,017,803
						<u>5 YEAR</u>
						<u>AVERAGE</u>
TREND RATES						
						<u>ANNUAL CHANGE</u>
Eligible Member Months		3.6%	2.3%	0.1%	-0.6%	1.3%
Total Cost per Eligible		2.7%	0.7%	5.7%	2.0%	2.8%
Total Expenditure		6.5%	3.1%	5.7%	1.4%	4.2%
TOTAL EXPENDITURES						
Eligible Member Months	97,275	99,615	102,986	111,462	125,867	
Total Cost per Eligible	\$ 1,897.04	\$ 1,808.97	\$ 1,899.32	\$ 1,983.84	\$ 2,023.27	
Total Expenditure	\$ 184,534,841	\$ 180,201,033	\$ 195,603,836	\$ 221,122,553	\$ 254,662,315	\$ 1,036,124,579
						<u>5 YEAR</u>
						<u>AVERAGE</u>
TREND RATES						
						<u>ANNUAL CHANGE</u>
Eligible Member Months		2.4%	3.4%	8.2%	12.9%	6.7%
Total Cost per Eligible		-4.6%	5.0%	4.4%	2.0%	1.6%
Total Expenditure		-2.3%	8.5%	13.0%	15.2%	8.4%

Table 9.2b Federal Share

	SFY06 (7/1/05-6/30/06)	SFY07 (7/1/06-6/30/07)	SFY08 (7/1/07-6/30/08)	SFY09 (7/1/08-6/30/09)	SFY10 (7/1/09-6/30/10)	5-YEARS
Title XIX						
TOTAL EXPENDITURES						
Eligible Member Months	5,971,385	6,123,197	6,204,095	6,414,982	6,830,273	
Total Cost per Eligible	\$ 118.69	\$ 131.86	\$ 137.32	\$ 157.67	\$ 170.76	
Total Expenditure	\$ 708,758,483	\$ 807,406,348	\$ 851,932,222	\$ 1,011,446,059	\$ 1,166,341,433	\$ 4,545,884,545
						<u>5 YEAR</u> <u>AVERAGE</u>
TREND RATES						
						<u>ANNUAL CHANGE</u>
Eligible Member Months		2.5%	1.3%	3.4%	6.5%	3.4%
Total Cost per Eligible		11.1%	4.1%	0.2%	0.7%	4.0%
Total Expenditure		13.9%	5.5%	3.6%	7.3%	7.5%
ABD						
TOTAL EXPENDITURES						
Eligible Member Months	2,428,242	2,468,046	2,506,003	2,584,377	2,649,687	
Total Cost per Eligible	\$ 446.11	\$ 416.41	\$ 423.48	\$ 496.75	\$ 538.88	
Total Expenditure	\$ 1,083,274,440	\$ 1,027,729,302	\$ 1,061,238,406	\$ 1,283,791,807	\$ 1,427,863,927	\$ 5,883,897,882
						<u>5 YEAR</u> <u>AVERAGE</u>
TREND RATES						
						<u>ANNUAL CHANGE</u>
Eligible Member Months		1.6%	1.5%	3.1%	2.5%	2.2%
Total Cost per Eligible		-6.7%	1.7%	2.4%	0.9%	-0.5%
Total Expenditure		-5.1%	3.3%	5.6%	3.5%	1.7%
LTC						
TOTAL EXPENDITURES						
Eligible Member Months	411,322	407,890	402,348	398,826	394,805	
Total Cost per Eligible	\$ 3,288.35	\$ 3,316.91	\$ 3,503.95	\$ 4,176.91	\$ 4,427.49	
Total Expenditure	\$ 1,352,571,547	\$ 1,352,938,453	\$ 1,409,808,551	\$ 1,665,860,679	\$ 1,747,994,201	\$ 7,529,173,433
						<u>5 YEAR</u> <u>AVERAGE</u>
TREND RATES						
						<u>ANNUAL CHANGE</u>
Eligible Member Months		-0.8%	-1.4%	-0.9%	-1.0%	-1.0%
Total Cost per Eligible		0.9%	5.6%	4.0%	-1.4%	2.2%
Total Expenditure		0.0%	4.2%	3.1%	-2.4%	1.2%
Community Care Waivers						
TOTAL EXPENDITURES						
Eligible Member Months	116,835	121,080	123,923	123,988	123,250	
Total Cost per Eligible	\$ 2,442.95	\$ 2,509.54	\$ 2,527.46	\$ 3,059.98	\$ 3,356.93	
Total Expenditure	\$ 285,421,955	\$ 303,854,715	\$ 313,210,635	\$ 379,400,794	\$ 413,742,027	\$ 1,695,630,126
						<u>5 YEAR</u> <u>AVERAGE</u>
TREND RATES						
						<u>ANNUAL CHANGE</u>
Eligible Member Months		3.6%	2.3%	0.1%	-0.6%	1.3%
Total Cost per Eligible		2.7%	0.7%	5.7%	-1.4%	2.8%
Total Expenditure		6.5%	3.1%	5.7%	1.4%	4.2%
HCBS Waivers						
TOTAL EXPENDITURES						
Eligible Member Months	97,275	99,615	102,986	111,462	125,867	
Total Cost per Eligible	\$ 948.52	\$ 904.49	\$ 949.66	\$ 1,136.49	\$ 1,246.13	
Total Expenditure	\$ 92,267,421	\$ 90,100,517	\$ 97,801,918	\$ 126,675,583	\$ 156,846,520	\$ 563,691,958
						<u>5 YEAR</u> <u>AVERAGE</u>
TREND RATES						
						<u>ANNUAL CHANGE</u>
Eligible Member Months		2.4%	3.4%	8.2%	12.9%	6.7%
Total Cost per Eligible		-4.6%	5.0%	4.4%	2.0%	1.6%
Total Expenditure		-2.3%	8.5%	13.0%	15.2%	8.4%

All Title XIX and Title XXI medical expenditures, unless specifically identified within this waiver application as being excluded, and the State's disproportionate share hospital

(DSH) allotment are proposed to be subsumed under the demonstration. The State will continue to pay DSH under its state-plan approved methodology unless it needs amounts under the DSH allotment in order to maintain demonstration budget neutrality or to redirect DSH for Medicaid ACO payments.

Budget neutrality approach

This section provides background information about the methods and data sources used to develop the proposed 1115 waiver budget.

The State proposes that the budget neutrality limit for Federal Title XIX funding be determined using a combined per capita cost method and aggregate DSH method with annual budget targets and a cumulative budget limit for the length of the entire demonstration. The risk for the per capita cost would be applicable to the Medicaid eligibles in eligibility groups (EGs) described below, but the State would not be at risk for conditions (economic or other) that may impact caseload levels in each of the groups for the demonstration years. Budget neutrality would not be limited to each individual EG PMPM, but rather across all EG PMPMs for the entire five year demonstration.

The annual budget neutrality expenditure limit for the Demonstration as a whole would be the sum of the DSH allotment plus the annual expenditure caps for each eligibility group. The overall budget neutrality expenditure cap for the 5-year demonstration period would be the sum of the annual budget neutrality expenditure caps for each of the 5 years.

The State expects this demonstration to be budget neutral at the federal level based on various savings initiatives to be applied to the managed care and fee-for-service Medicaid populations. Several groups of individuals' behavior are expected to be modified through this Medicaid waiver. In the Without Waiver population, the State has placed at risk the federal share of Medicaid expenditures for the fee-for-service and managed care Medicaid populations and DSH expenditures. In the With Waiver population, the savings earned from the initiatives will more than compensate for the costs of the expansion population and proposed budget group.

CHIP allotment neutrality

This section presents the State's approach for showing CHIP allotment neutrality as well as the data and assumptions used in the development of the cost and caseload estimates supporting this 1115 waiver request. The State has projected that the CHIP allotment will be neutral using the CMS allotment neutrality spreadsheet. See Table 9.3 below for details.

Base year

In FFY2010 which is the base year for the allotment neutrality, NJ received \$635 million in CHIP allotment. Of that, \$136 million was spent on its Medicaid Expansion CHIP program for children while \$166 million was spent on its separate CHIP program for

children under its 1115 demonstration (noted as Demonstration Population #1 in Table 9.3). An additional \$496 million was spent on the Family Care Adult population (noted as Demonstration Population #2 in Table 9.3). NJ experienced a \$135 million allotment carryover to FFY2011.

CHIP administration

The Allotment Neutrality administrative component was a total of \$66.9 million for FFY2010. It is broken into two pieces:

- Administration allocated to Medicaid Expansion CHIP Children (\$11.4 million)
- Administration allocated to Demonstration Populations both the separate CHIP children and the adult population (\$55.5 million)

Waiver time frame and trend rates

Based on a review of the State's historical eligibility/enrollment data for CHIP populations, we projected the number of people entering CHIP by population. For FFY2011 – FFY2016, the State utilized the President's budget trend rates to trend PMPM expenditures and the State's caseload estimates for the State budget to project member month growth. These growth factors are based on recent growth rates experienced by the program and the State's forecasted enrollment during the demonstration years.

ACA Adult Transition to Medicaid in 2014

After January 1, 2014, the State will transition all adults to Medicaid under the 1115 budget neutrality. The State has reflected this adjustment by backing all adults out of the Allotment Neutrality calculations as of January 1, 2014.

Summary of budget neutrality

For this Demonstration project, the federal share of combined CHIP expenditures for all population groups covered under the CHIP portion of the Demonstration project will not exceed the federal CHIP allotment. The following table summarizes the allotment neutrality estimates for the base year and over the five-year period.

Table 9.3 Title XXI Allotment Neutrality Budget Template for Section 1115 Demonstrations

	Previous Federal Fiscal Year 2010	Previous Federal Fiscal Year 2011	Federal Fiscal Year 2012	Federal Fiscal Year 2013	Federal Fiscal Year 2014	Federal Fiscal Year 2015	Federal Fiscal Year 2016
3 State's Allotment	\$ 634,744,914	\$ 592,187,888	\$ 618,026,013	\$ 618,026,013	\$ 618,026,013	\$ 618,026,013	\$ 618,026,013
4 Funds Carried Over From Prior Year(s)	\$ 62,893,769	\$ 135,260,888	\$ 85,016,047	\$ (0)	\$ 40	\$ 97,264,565	\$ 287,009,561
5 SUBTOTAL (Allotment + Funds Carried Over)	\$ 697,638,683	\$ 727,448,776	\$ 703,042,060	\$ 618,026,013	\$ 618,026,053	\$ 715,290,578	\$ 905,035,574
6 Reallocated Funds (Redistributed or Retained that are Currently Available)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
7 TOTAL (Subtotal + Reallocated funds)	\$ 697,638,683	\$ 727,448,776	\$ 703,042,060	\$ 618,026,013	\$ 618,026,053	\$ 715,290,578	\$ 905,035,574
8 State's Enhanced FMAP Rate	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%
9 Enhanced FMAP Rate for 0-133% FPL Family Care Adults			75.00%	75.00%	75.00%		
COST PROJECTIONS OF APPROVED SCHIP PLAN							
Benefit Costs							
12 Insurance payments							
13 Total Managed Care		\$ 151,135,601	\$ 170,715,546	\$ 193,601,017	\$ 217,756,188	\$ 243,064,514	\$ 269,356,254
14 per member/per month rate		\$174	\$182	\$194	\$207	\$219	\$231
15 # of eligibles (MM)		868,526	938,729	995,857	1,052,874	1,109,923	1,166,965
16 Total Fee for Service		\$ 12,765,060	\$ 14,634,622	\$ 16,596,483	\$ 18,667,189	\$ 20,836,750	\$ 23,090,615
17 per member/per month rate		\$134	\$142	\$152	\$162	\$172	\$181
18 # of eligibles (MM)		95,026	102,706	108,957	115,195	121,437	127,678
19 Total Benefit Costs (Managed Care + Fee for Service)	\$ 135,774,135	\$ 163,900,662	\$ 185,350,167	\$ 210,197,499	\$ 236,423,378	\$ 263,901,264	\$ 292,446,868
20 (Offsetting beneficiary cost sharing payments) (negative number)							
21 Net Benefit Costs	\$ 135,774,135	\$ 163,900,662	\$ 185,350,167	\$ 210,197,499	\$ 236,423,378	\$ 263,901,264	\$ 292,446,868
Administration Costs							
24 Personnel							
25 General administration	\$ 11,374,314	\$ 18,211,185	\$ 20,594,463	\$ 23,355,278	\$ 26,269,264	\$ 29,322,363	\$ 32,494,096
26 Contractors/Brokers							
27 Claims Processing							
28 Outreach/marketing costs							
29 Other (specify)							
30 Total Administration Costs	\$ 11,374,314	\$ 18,211,185	\$ 20,594,463	\$ 23,355,278	\$ 26,269,264	\$ 29,322,363	\$ 32,494,096
31 10% Administrative Cap	\$ 15,086,015	\$ 18,211,185	\$ 20,594,463	\$ 23,355,278	\$ 26,269,264	\$ 29,322,363	\$ 32,494,096
32							
33 Federal Title XXI Share	\$ 95,646,492	\$ 118,372,700	\$ 133,864,010	\$ 151,809,305	\$ 170,750,217	\$ 190,595,357	\$ 211,211,627
34 State Share	\$ 51,501,958	\$ 63,739,146	\$ 72,080,620	\$ 81,743,472	\$ 91,942,425	\$ 102,628,270	\$ 113,729,338
35 TOTAL COSTS OF APPROVED SCHIP PLAN	\$ 147,148,450	\$ 182,111,846	\$ 205,944,630	\$ 233,552,777	\$ 262,692,642	\$ 293,223,627	\$ 324,940,965
COST PROJECTIONS FOR DEMONSTRATION PROPOSAL							
Benefit Costs for Demonstration Population #1: Family Care Child 134%-350% FPL							
39 Insurance payments							
40 Total Managed Care		\$ 201,969,357	\$ 227,684,774	\$ 258,207,321	\$ 290,423,278	\$ 324,177,207	\$ 359,242,724
41 per member/per month rate		\$173	\$180	\$193	\$205	\$217	\$229
42 # of eligibles (MM)		1,169,691	1,264,238	1,341,175	1,417,963	1,494,794	1,571,615
43 Total Fee for Service		\$ 3,017,786	\$ 3,459,769	\$ 3,923,573	\$ 4,413,108	\$ 4,926,014	\$ 5,458,849
44 per member/per month rate		\$256	\$271	\$290	\$308	\$326	\$344
45 # of eligibles (MM)		11,809	12,764	13,541	14,316	15,082	15,867
46 Total Benefit Costs (Managed Care + Fee for Service)	\$ 166,105,079	\$ 204,987,143	\$ 231,144,543	\$ 262,130,893	\$ 294,836,386	\$ 329,103,221	\$ 364,701,574
Benefit Costs for Demonstration Population #2: Family Care Adult							
48 Insurance payments							
49 Total Managed Care		\$ 507,717,652	\$ 485,642,181	\$ 327,923,485	\$ 164,941,101	\$ -	\$ -
50 per member/per month rate		\$279	\$294	\$315	\$337		
51 # of eligibles (MM)		1,820,217	1,650,926	1,041,838	490,158		
52 Total Fee for Service		\$ 12,916,784	\$ 13,382,908	\$ 15,319,559	\$ 4,271,048	\$ -	\$ -
53 per member/per month rate		\$120	\$129	\$138	\$147		
54 # of eligibles (MM)		107,556	103,817	111,066	28,963		
55 Total Benefit Costs (Managed Care + Fee for Service)	\$ 496,439,230	\$ 520,634,436	\$ 499,025,090	\$ 343,243,044	\$ 169,212,149	\$ -	\$ -
56							
57 Total Benefit Costs (For All Demonstration Populations)	\$ 662,544,309	\$ 725,621,579	\$ 730,169,632	\$ 605,373,937	\$ 464,048,535	\$ 329,103,221	\$ 364,701,574
58 (Offsetting beneficiary cost sharing payments) (negative number)							
59 Net Benefit Costs	\$ 662,544,309	\$ 725,621,579	\$ 730,169,632	\$ 605,373,937	\$ 464,048,535	\$ 329,103,221	\$ 364,701,574
Administration Costs							
61 Personnel							
62 General administration	\$ 55,503,849	\$ 80,624,620	\$ 81,129,959	\$ 67,263,771	\$ 51,560,948	\$ 36,567,025	\$ 40,522,397
63 Contractors/Brokers							
64 Claims Processing							
65 Outreach/marketing costs							
66 Other (specify)							
67 Total Administration Costs	\$ 55,503,849	\$ 80,624,620	\$ 81,129,959	\$ 67,263,771	\$ 51,560,948	\$ 36,567,025	\$ 40,522,397
68 10% Administrative Cap	\$ 73,616,034	\$ 80,624,620	\$ 81,129,959	\$ 67,263,771	\$ 51,560,948	\$ 36,567,025	\$ 40,522,397
69							
70							
71 Federal Title XXI Share	\$ 466,731,303	\$ 524,060,029	\$ 569,178,050	\$ 466,216,668	\$ 350,011,270	\$ 237,685,660	\$ 263,395,581
72 State Title XXI Share	\$ 251,316,855	\$ 282,186,170	\$ 242,121,541	\$ 206,421,040	\$ 165,598,213	\$ 127,984,585	\$ 141,828,990
73 TOTAL COSTS FOR DEMONSTRATION	\$ 718,048,158	\$ 806,246,199	\$ 811,299,592	\$ 672,637,708	\$ 515,609,483	\$ 365,670,245	\$ 405,223,971
74							
TOTAL TITLE XXI PROGRAM COSTS (State Plan + Demonstration)							
75	\$ 865,196,608	\$ 988,358,045	\$ 1,017,244,222	\$ 906,190,485	\$ 778,302,125	\$ 658,893,872	\$ 730,164,936
76 Federal Title XXI Share	\$ 562,377,795	\$ 642,432,729	\$ 703,042,060	\$ 618,025,973	\$ 520,761,487	\$ 428,281,017	\$ 474,607,208
77 State Title XXI Share	\$ 302,818,813	\$ 345,925,316	\$ 314,202,161	\$ 288,164,512	\$ 257,540,638	\$ 230,612,855	\$ 255,557,728
78							
79 Total Federal Title XXI Funding Currently Available (Allotment + Reallocated Funds)	\$ 697,638,683	\$ 727,448,776	\$ 703,042,060	\$ 618,026,013	\$ 618,026,053	\$ 715,290,578	\$ 905,035,574
80 Total Federal Title XXI Program Costs (State Plan + Demonstration)	\$ 562,377,795	\$ 642,432,729	\$ 703,042,060	\$ 618,025,973	\$ 520,761,487	\$ 428,281,017	\$ 474,607,208
81 Unused Title XXI Funds Expiring (Allotment or Reallocated)							
82 Remaining Title XXI Funds to be Carried Over (Equals Available Funding - Costs - Expiring Funds)	\$ 135,260,888	\$ 85,016,047	\$ (0)	\$ 40	\$ 97,264,565	\$ 287,009,561	\$ 430,428,366
83							
84 Note: A Federal Fiscal Year (FFY) is October 1 through September 30.							
85							

Notes:

To maintain CHIP allotment neutrality, 106,011 Family Care Adult member months in FFY 2012 and 837,775 member months in FFY 2013 were moved out of CHIP Allotment Neutrality and into 1115 budget neutrality. After January 1, 2014, the State will transition all Family Care Adults to Medicaid under the 1115 budget neutrality. NJ has reflected this adjustment by backing out all adults from the allotment neutrality calculations as of January 1, 2014.

Enhanced FMAP of 75% was applied to benefit costs for Family Care Adults (0-133% FPL portion of the population) for FFY12, FFY13 and the first quarter of FFY14. This resulted in an additional \$41.8M, \$29M and \$14.9M Federal Share for these time periods respectively.

Eligibility groups/Program groups

The proposed EGs that would be subject to per capita cost budget neutrality are identified in the Table below. The annual budget neutrality expenditure cap for the Demonstration as a whole is proposed to be the sum of DSH allotment plus the annual expenditure caps for each eligibility group.

Table 9.4 Eligibility groups/Program groups

Eligibility group/Program group	Description	Waiver population type
Title XIX	Medicaid State Plan populations not otherwise described in other Eligibility Groups below.	Medicaid State Plan
ABD	This represents the aged, blind and disabled segment of the population that is Medicaid eligible. This segment of the population is not in need of LTC services and is living in the community. This group includes individuals dually eligible for Medicare and Medicaid.	Medicaid State Plan
LTC/Transitioned HCBS	This represents the segment of the population requiring NF level care (NHC) and who are Medicaid eligible. Since there is a difference in cost between individuals who reside in NF and those served through HCB programs under a 1915(c) waiver, expenditure estimates were developed separately for these two subsets, but have combined them for presentation purposes in the Demonstration project beginning in July 1, 2012. Prior to this time, this represents only the NF institutional population who obtain Medicaid coverage of nursing homes/facilities services through the Medicaid LTC system. The costs to the Medicaid program for people in NFs are substantially higher than for those served in non-institutionalized settings. This group includes individuals dually eligible for Medicare and Medicaid.	Medicaid State Plan and Hypothetical (HCBS 217-like Group)
Community Care Waiver	Individuals who are living in the community and are determined clinically eligible by DDD	Medicaid State Plan and Hypothetical (HCBS 217-like Group)

Eligibility group/Program group	Description	Waiver population type
Pre-Transitioned HCBS	<p>Previously 1915c Medicaid eligible - transitional</p> <p>This group includes all individuals receiving Medicaid funded home- and community-based (HCB) services who would have been eligible under four of the State’s existing section 1915(c) waivers. This group requires an institutional level-of-care, but has elected to receive services in the community and, thus, have substantially lower overall costs. This includes the Global Options (GO) waiver, AIDS Community Care Alternatives Program (ACCAP), Community Resources for People with Disabilities (CRPD) and Traumatic Brain Injury (TBI) HCBS waiver populations.</p>	Medicaid State Plan and Hypothetical (HCBS 217-like Group)
GA-Employable	Individuals who would be eligible for Medicaid within the group defined at section 1902(k) as authorized by the Affordable Care Act and approved in the State’s “Childless Adults” Demonstration Waiver.	Hypothetical population
GA-Unemployable	Individuals who would be eligible for Medicaid within the group defined at section 1902(k) as authorized by the Affordable Care Act and approved in the State’s “Childless Adults” Demonstration Waiver..	Hypothetical population
Supports Waiver	Supports individuals in their family homes and eliminates waiting lists. 1915c-like population	Hypothetical population
MI/DD	Intellectual and development disabilities with dual mental health diagnoses. 1915(c)-like program	Hypothetical population
PDD	Children with Pervasive Developmental Disabilities (PDD) 1915(c)-like program	Hypothetical population
Children with SED	Children with SED. 1915(c) and 1915(i)-like concurrent authority for System of Care Program under the Demonstration	Hypothetical population
Medication Assisted Treatment Initiative (MATI)	Opioid dependent State residents with incomes up to 150% under 1915(i)-like authority	Hypothetical population
Adult Expansion Group	Childless adults with incomes above the limits for the GA-Employable and GA-Unemployable groups up to 100% FPL.	Expansion population
FQHC	Services billed to the State by FQHCs for providing uncompensated care to uninsured single adults and couples under 200% FPL without dependent children and not otherwise eligible for Medicaid or CHIP who receive a FQHC benefit package.	Budget Group
CHIP children – Expansion	Medicaid expansion CHIP program for children	Medicaid expansion CHIP program

Eligibility group/Program group	Description	Waiver population type
CHIP children – Separate	Separate CHIP program for children	Separate CHIP
CHIP adults	FamilyCare adults	CHIP Expansion population
DSH	DSH allotment	Medicaid State Plan

Transitional eligibility groups

Effective July 1, 2012, all populations in the Pre-Transitioned HCBS eligibility group will have their HCBS waiver services carved into managed care where both their acute care services and their waiver services will be managed. This includes the Global Options (GO) waiver, AIDS Community Care Alternatives Program (ACCAP), Community Resources for People with Disabilities (CRPD) and Traumatic Brain Injury (TBI) HCBS waiver populations. For the purposes of budget neutrality, these populations will transition into the LTC/Transitioned HCBS eligibility group on July 1, 2012. The impact of this transition can be seen in the budget neutrality calculation tables at the end of this section. Until July 1, 2012, the State proposes to provide the HCBS waiver services to this population through exact replicas of the current HCBS programs while their acute care services will be managed by the current State MCOs.

Hypothetical populations

The State is proposing to implement a number of new programs under this demonstration authority that could otherwise be implemented through State Plan or non-1115 waiver authority. The State requests to treat the eligibility groups identified above as “hypothetical populations” that do not require the State to demonstrate waiver savings.

Expansion population

The State is requesting expenditure authority, or “costs not otherwise matchable” to cover the following population:

- 1,200 New Jersey Childless Adults 0-100% FPL eligible and enrolled in a state-only benefit as of September 30, 2011.

This population is currently covered using state-only funds. To help cover the health care costs of this expansion population and also reduce current costs within the Medicaid/FamilyCare population, the State is proposing to implement various cost savings initiatives. These proposed savings initiatives are discussed throughout the application.

Budget group

The State is requesting expenditure authority, or "costs not otherwise matchable," to provide uncompensated care via a limited FQHC benefit to uninsured single adults and couples without children under 200% FPL and not otherwise eligible for Medicaid or CHIP. The State is requesting \$42 million in total computable expenditures.

This population is currently covered using state-only funds and, as with the expansion population, NJ will implement various cost-savings initiatives to generate the savings required for the expenditure request.

Cost and caseload

Complete cost and caseload data was available for the five-year historical period from state fiscal year 2006 through 2010 (SFY2006 through SFY2010) for the Medicaid/FamilyCare eligible populations. SFY2010, the most recent complete historical period, was chosen as the base year throughout the cost and caseload estimates. More recent data from SFY2011 was incomplete and was used for limited trending purposes only. Cost and caseload data for the GA eligibility groups, was taken directly from the approved New Jersey Childless Adults waiver (approved for the period starting April 15, 2011 through December 31, 2013) with only an adjustment made for trending the approved PMPMs using the approved trend rates to the end of the demonstration period under this waiver.

The historical trend for each eligibility group and FY2012 President's Budget Medicaid projections were reviewed. The base SFY2010 was projected to support the development of the without waiver cost and caseload. The following table summarizes the annual medical trend rates from the President's Budget for the eligibility groups during the five years constituting the Demonstration project application. FY2014 and later projections did not include the impact of expansion groups under the Affordable Care Act.

Table 9.5a Without and With Waiver Annual Medical Cost Trends

Demonstration Year	1	2	3	4	5
Child Annualized Trend	6.1%	6.9%	6.4%	5.9%	5.4%
ABD Annualized Trend	3.0%	4.5%	5.1%	4.9%	5.6%
Adult Annualized Trend	7.3%	7.0%	6.9%	6.8%	6.7%

Physician FFS rates are approximately 41% of Medicare rates and are estimated to be less than 25% of usual and customary charges. Based on encounter data, payments for primary care CPT codes affected by ACA provisions exceed 53%. The costs were adjusted under without and with waiver to account for raising the primary care rates to 100% of Medicare rates by 2013. This adjustment and other major adjustments impacting some of the eligibility groups are summarized in the following table

Table 9.5b Eligibility groups/Program groups Adjustments

Eligibility group/Program group	Without Waiver	With Waiver
Title XIX	<ul style="list-style-type: none"> Physician fee increase Shift of CHIP adults beginning in DY3 	<ul style="list-style-type: none"> Physician fee increase Shift of CHIP adults beginning in DY3 Savings Initiatives: <ul style="list-style-type: none"> Reduction of FFS period Health Insurance Premium Payments Fairness in payments to in-state and out-of-state providers Incentivize payment reform between MCOs and hospitals Managing behavioral health Promote competition ER diversion
ABD	<ul style="list-style-type: none"> Physician fee increase 	<ul style="list-style-type: none"> Physician fee increase Savings Initiatives: <ul style="list-style-type: none"> Reduction of FFS period Health Insurance Premium Payments Incentivize payment reform between MCOs and hospitals Expansion and innovations using New Jersey's MCOs Managing behavioral health Promote competition ER diversion
LTC/Transitioned HCBS	<ul style="list-style-type: none"> Physician fee increase Transition of HCBS into managed long term care July 1, 2012 	<ul style="list-style-type: none"> Physician fee increase Transition of HCBS into managed long term care July 1, 2012 Savings Initiatives: <ul style="list-style-type: none"> Managed LTC
Community Care Waiver	<ul style="list-style-type: none"> Physician fee increase 	<ul style="list-style-type: none"> Physician fee increase Savings Initiatives: <ul style="list-style-type: none"> Operational improvements and streamlining

The following tables summarize the trend rate and overall cost and caseload for the populations for the five-year Demonstration period:

Table 9.6a Without Waiver Total Spend

ELIGIBILITY GROUP	TREND RATE	MONTHS OF AGING	DEMONSTRATION YEARS (DY)					TOTAL WOW
			DY 01 (10/1/11 - 9/30/12)	DY 02 (10/1/12 - 9/30/13)	DY 03 (10/1/13 - 9/30/14)	DY 04 (10/1/14 - 9/30/15)	DY 05 (10/1/15 - 9/30/16)	
Title XIX								
Eligible Member Months	9.53%	27	7,720,846	8,724,989	9,768,677	10,699,516	11,112,778	
Total Cost Per Eligible	10.23%	27	\$ 314.99	\$ 352.27	\$ 389.11	\$ 425.50	\$ 464.99	
Total Expenditure			\$ 2,431,955,038	\$ 3,073,585,207	\$ 3,801,051,623	\$ 4,552,595,926	\$ 5,167,356,138	\$ 19,026,543,932
ABD								
Eligible Member Months	2.80%	27	2,818,411	2,900,683	2,982,953	3,065,209	3,147,471	
Total Cost Per Eligible	6.46%	27	\$ 934.69	\$ 989.01	\$ 1,055.34	\$ 1,122.52	\$ 1,200.44	
Total Expenditure			\$ 2,634,343,015	\$ 2,868,803,590	\$ 3,148,034,953	\$ 3,440,758,481	\$ 3,778,360,154	\$ 15,870,300,194
LTC/Transitioned HCBS								
Eligible Member Months	8.07%	27	453,415	569,994	586,160	602,323	618,488	
Total Cost Per Eligible	1.69%	27	\$ 7,272.17	\$ 6,641.84	\$ 6,994.47	\$ 7,350.73	\$ 7,775.55	
Total Expenditure			\$ 3,297,312,236	\$ 3,785,803,816	\$ 4,099,878,007	\$ 4,427,516,908	\$ 4,809,083,329	\$ 20,419,594,295
CCW								
Eligible Member Months	2.80%	27	131,098	134,925	138,752	142,578	146,404	
Total Cost Per Eligible	5.14%	27	\$ 5,822.62	\$ 6,090.46	\$ 6,408.63	\$ 6,730.00	\$ 7,114.04	
Total Expenditure			\$ 763,334,936	\$ 821,756,120	\$ 889,208,915	\$ 959,549,918	\$ 1,041,526,399	\$ 4,475,376,288
Pre-Transitioned HCBS								
Eligible Member Months	0.00%	27	100,411	-	-	-	-	
Total Cost Per Eligible	0.00%	27	\$ 2,161.42	\$ -	\$ -	\$ -	\$ -	
Total Expenditure			\$ 217,030,940	\$ -	\$ -	\$ -	\$ -	\$ 217,030,940
GA Employable								
Eligible Member Months	7.90%	27	468,403	505,406	545,333	588,415	634,900	
Total Cost Per Eligible	3.71%	27	\$ 271.91	\$ 282.00	\$ 292.46	\$ 303.31	\$ 314.56	
Total Expenditure			\$ 127,362,269	\$ 142,522,315	\$ 159,486,874	\$ 178,470,740	\$ 199,714,273	\$ 807,556,472
GA Unemployable								
Eligible Member Months	7.90%	27	234,201	252,703	272,667	294,207	317,450	
Total Cost Per Eligible	3.71%	27	\$ 271.91	\$ 282.00	\$ 292.46	\$ 303.31	\$ 314.56	
Total Expenditure			\$ 63,681,135	\$ 71,261,157	\$ 79,743,437	\$ 89,235,370	\$ 99,857,137	\$ 403,778,236
Supports Waiver								
Eligible Member Months	38.03%	27	15,120	26,184	45,360	49,896	54,886	
Total Cost Per Eligible	5.02%	27	\$ 3,223.41	\$ 3,368.46	\$ 3,540.26	\$ 3,713.73	\$ 3,921.70	
Total Expenditure			\$ 48,737,967	\$ 88,199,860	\$ 160,585,995	\$ 185,300,180	\$ 215,244,689	\$ 698,068,691
M/DD								
Eligible Member Months	2.80%	27	2,272	2,338	2,404	2,470	2,537	
Total Cost Per Eligible	5.90%	27	\$ 3,233.84	\$ 3,405.09	\$ 3,612.11	\$ 3,821.57	\$ 4,067.19	
Total Expenditure			\$ 7,761,218	\$ 8,410,776	\$ 9,175,173	\$ 9,974,897	\$ 10,900,916	\$ 153,663,482
Children with PDD								
Eligible Member Months	2.80%	27	2,400	2,470	2,540	2,610	2,680	
Total Cost Per Eligible	5.90%	27	\$ 3,233.84	\$ 3,405.09	\$ 3,612.11	\$ 3,821.57	\$ 4,067.19	
Total Expenditure			\$ 7,761,218	\$ 8,410,776	\$ 9,175,173	\$ 9,974,897	\$ 10,900,916	\$ 46,222,980
Children with SED								
Eligible Member Months	3.40%	27	81,619	84,539	87,455	90,373	93,291	
Total Cost Per Eligible	2.65%	27	\$ 511.68	\$ 528.09	\$ 543.08	\$ 556.47	\$ 568.18	
Total Expenditure			\$ 41,762,639	\$ 44,644,261	\$ 47,495,138	\$ 50,290,242	\$ 53,005,915	\$ 237,198,195
MATI								
Eligible Member Months	3.40%	27	58,025	60,100	62,174	64,248	66,322	
Total Cost Per Eligible	6.14%	27	\$ 421.25	\$ 450.31	\$ 479.07	\$ 507.26	\$ 534.65	
Total Expenditure			\$ 24,442,733	\$ 27,063,913	\$ 29,785,592	\$ 32,590,691	\$ 35,459,531	\$ 149,342,460
DSH								
Total Allotment			1,288,871,240	1,288,871,240	1,288,871,240	1,288,871,240	1,288,871,240	\$ 6,444,356,200
Total Expenditure			\$ 10,972,864,458	\$ 12,249,174,784	\$ 13,743,852,521	\$ 15,248,069,704	\$ 16,735,070,897	\$ 68,949,032,365

Table 9.6b Without Waiver Federal Share

ELIGIBILITY GROUP	TREND RATE	MONTHS OF AGING	DEMONSTRATION YEARS (DY)					TOTAL WOW
			DY 01 (10/1/11 - 9/30/12)	DY 02 (10/1/12 - 9/30/13)	DY 03 (10/1/13 - 9/30/14)	DY 04 (10/1/14 - 9/30/15)	DY 05 (10/1/15 - 9/30/16)	
Title XIX								
Eligible Member Months	9.53%	27	7,720,846	8,724,989	9,768,677	10,699,516	11,112,778	
Total Cost Per Eligible	12.41%	27	\$ 158.50	\$ 184.17	\$ 208.54	\$ 231.71	\$ 253.12	
Total Expenditure			\$ 1,223,773,659	\$ 1,606,853,308	\$ 2,037,185,372	\$ 2,479,181,661	\$ 2,812,884,089	\$ 10,159,878,089
ABD								
Eligible Member Months	2.80%	27	2,818,411	2,900,683	2,982,953	3,065,209	3,147,471	
Total Cost Per Eligible	6.46%	27	\$ 467.35	\$ 494.50	\$ 527.67	\$ 561.26	\$ 600.22	
Total Expenditure			\$ 1,317,171,507	\$ 1,434,401,795	\$ 1,574,017,477	\$ 1,720,379,240	\$ 1,889,180,077	\$ 7,935,150,097
LTC/Transitioned HCBS								
Eligible Member Months	8.07%	27	453,415	569,994	586,160	602,323	618,488	
Total Cost Per Eligible	1.69%	27	\$ 3,636.08	\$ 3,320.92	\$ 3,497.24	\$ 3,675.36	\$ 3,887.77	
Total Expenditure			\$ 1,648,656,118	\$ 1,892,901,908	\$ 2,049,939,004	\$ 2,213,758,454	\$ 2,404,541,664	\$ 10,209,797,148
CCW								
Eligible Member Months	2.80%	27	131,098	134,925	138,752	142,578	146,404	
Total Cost Per Eligible	5.14%	27	\$ 2,911.31	\$ 3,045.23	\$ 3,204.31	\$ 3,365.00	\$ 3,557.02	
Total Expenditure			\$ 381,667,468	\$ 410,878,060	\$ 444,604,457	\$ 479,774,959	\$ 520,763,200	\$ 2,237,688,144
Pre-Transitioned HCBS								
Eligible Member Months	0.00%	27	100,411	-	-	-	-	
Total Cost Per Eligible	0.00%	27	\$ 1,080.71	\$ -	\$ -	\$ -	\$ -	
Total Expenditure			\$ 108,515,470	\$ -	\$ -	\$ -	\$ -	\$ 108,515,470
GA Employable								
Eligible Member Months	7.90%	27	468,403	505,406	545,333	588,415	634,900	
Total Cost Per Eligible	3.71%	27	\$ 135.95	\$ 141.00	\$ 146.23	\$ 151.65	\$ 157.28	
Total Expenditure			\$ 63,681,135	\$ 71,261,157	\$ 79,743,437	\$ 89,235,370	\$ 99,857,137	\$ 403,778,236
GA Unemployable								
Eligible Member Months	7.90%	27	234,201	252,703	272,667	294,207	317,450	
Total Cost Per Eligible	3.71%	27	\$ 135.95	\$ 141.00	\$ 146.23	\$ 151.65	\$ 157.28	
Total Expenditure			\$ 31,840,567	\$ 35,630,579	\$ 39,871,719	\$ 44,617,685	\$ 49,928,568	\$ 201,889,118
Supports Waiver								
Eligible Member Months	38.03%	27	15,120	26,184	45,360	49,896	54,886	
Total Cost Per Eligible	5.02%	27	\$ 1,611.71	\$ 1,684.23	\$ 1,770.13	\$ 1,856.86	\$ 1,960.85	
Total Expenditure			\$ 24,368,983	\$ 44,099,930	\$ 80,292,998	\$ 92,650,090	\$ 107,622,344	\$ 349,034,346
MI/DD								
Eligible Member Months	2.80%	27	2,272	2,338	2,404	2,470	2,537	
Total Cost Per Eligible	5.02%	27	\$ 5,782.25	\$ 6,042.45	\$ 6,350.62	\$ 6,661.80	\$ 7,034.86	
Total Expenditure			\$ 13,134,546	\$ 14,126,264	\$ 15,267,787	\$ 16,457,555	\$ 17,845,588	\$ 76,831,741
Children with PDD								
Eligible Member Months	2.80%	27	2,400	2,470	2,540	2,610	2,680	
Total Cost Per Eligible	5.90%	27	\$ 1,616.92	\$ 1,702.55	\$ 1,806.06	\$ 1,910.78	\$ 2,033.59	
Total Expenditure			\$ 3,880,609	\$ 4,205,388	\$ 4,587,586	\$ 4,987,449	\$ 5,450,458	\$ 23,111,490
Children with SED								
Eligible Member Months	3.40%	27	81,619	84,539	87,455	90,373	93,291	
Total Cost Per Eligible	2.65%	27	\$ 255.84	\$ 264.05	\$ 271.54	\$ 278.24	\$ 284.09	
Total Expenditure			\$ 20,881,319	\$ 22,322,130	\$ 23,747,569	\$ 25,145,121	\$ 26,502,958	\$ 118,599,097
MATI								
Eligible Member Months	3.40%	27	58,025	60,100	62,174	64,248	66,322	
Total Cost Per Eligible	6.14%	27	\$ 210.62	\$ 225.16	\$ 239.53	\$ 253.63	\$ 267.33	
Total Expenditure			\$ 12,221,367	\$ 13,531,956	\$ 14,892,796	\$ 16,295,345	\$ 17,729,766	\$ 74,671,230
DSH								
Total Allotment			644,435,620	644,435,620	644,435,620	644,435,620	644,435,620	\$ 3,222,178,100
Total Expenditure			\$ 5,494,228,369	\$ 6,194,648,096	\$ 7,008,585,821	\$ 7,826,918,550	\$ 8,596,741,469	\$ 35,121,122,306

Table 9.6c With Waiver Total Spend

ELIGIBILITY GROUP	TREND RATE	MONTHS OF AGING	DEMONSTRATION YEARS (DY)					TOTAL WW
			DY 01 (10/1/11 - 9/30/12)	DY 02 (10/1/12 - 9/30/13)	DY 03 (10/1/13 - 9/30/14)	DY 04 (10/1/14 - 9/30/15)	DY 05 (10/1/15 - 9/30/16)	
Title XIX								
Eligible Member Months	9.53%	27	7,720,846	8,724,989	9,768,677	10,699,516	11,112,778	
Total Cost Per Eligible	10.01%	27	\$ 309.23	\$ 343.51	\$ 381.37	\$ 417.45	\$ 455.38	
Total Expenditure			\$ 2,387,543,511	\$ 2,997,111,997	\$ 3,725,509,997	\$ 4,466,526,704	\$ 5,060,552,330	\$ 18,637,244,538
ABD								
Eligible Member Months	2.80%	27	2,818,411	2,900,683	2,982,953	3,065,209	3,147,471	
Total Cost Per Eligible	6.46%	27	\$ 467.35	\$ 494.50	\$ 527.67	\$ 561.26	\$ 600.22	
Total Expenditure			\$ 1,317,171,507	\$ 1,434,401,795	\$ 1,574,017,477	\$ 1,720,379,240	\$ 1,889,180,077	\$ 15,729,819,277
LTC/Transitioned HCBS								
Eligible Member Months	8.07%	27	453,415	569,994	586,160	602,323	618,488	
Total Cost Per Eligible	1.69%	27	\$ 3,636.08	\$ 3,320.92	\$ 3,497.24	\$ 3,675.36	\$ 3,887.77	
Total Expenditure			\$ 1,648,656,118	\$ 1,892,901,908	\$ 2,049,939,004	\$ 2,213,758,454	\$ 2,404,541,664	\$ 19,819,594,295
CCW								
Eligible Member Months	2.80%	27	131,098	134,925	138,752	142,578	146,404	
Total Cost Per Eligible	5.14%	27	\$ 2,911.31	\$ 3,045.23	\$ 3,204.31	\$ 3,365.00	\$ 3,557.02	
Total Expenditure			\$ 381,667,468	\$ 410,878,060	\$ 444,604,457	\$ 479,774,959	\$ 520,763,200	\$ 4,464,784,901
Pre-Transitioned HCBS								
Eligible Member Months	0.00%	27	100,411	-	-	-	-	
Total Cost Per Eligible	0.00%	27	\$ 1,080.71	\$ -	\$ -	\$ -	\$ -	
Total Expenditure			\$ 108,515,470	\$ -	\$ -	\$ -	\$ -	\$ 217,030,940
GA Employable								
Eligible Member Months	7.90%	27	468,403	505,406	545,333	588,415	634,900	
Total Cost Per Eligible	3.71%	27	\$ 135.95	\$ 141.00	\$ 146.23	\$ 151.65	\$ 157.28	
Total Expenditure			\$ 63,681,135	\$ 71,261,157	\$ 79,743,437	\$ 89,235,370	\$ 99,857,137	\$ 807,556,472
GA Unemployable								
Eligible Member Months	7.90%	27	234,201	252,703	272,667	294,207	317,450	
Total Cost Per Eligible	3.71%	27	\$ 135.95	\$ 141.00	\$ 146.23	\$ 151.65	\$ 157.28	
Total Expenditure			\$ 31,840,567	\$ 35,630,579	\$ 39,871,719	\$ 44,617,685	\$ 49,928,568	\$ 403,778,236
Supports Waiver								
Eligible Member Months	38.03%	27	15,120	26,184	45,360	49,896	54,886	
Total Cost Per Eligible	5.02%	27	\$ 1,611.71	\$ 1,684.23	\$ 1,770.13	\$ 1,856.86	\$ 1,960.85	
Total Expenditure			\$ 24,368,983	\$ 44,099,930	\$ 80,292,998	\$ 92,650,090	\$ 107,622,344	\$ 698,068,691
M/DD								
Eligible Member Months	2.80%	27	2,272	2,338	2,404	2,470	2,537	
Total Cost Per Eligible	5.02%	27	\$ 5,782.25	\$ 6,042.45	\$ 6,350.62	\$ 6,661.80	\$ 7,034.86	
Total Expenditure			\$ 13,134,546	\$ 14,126,264	\$ 15,267,787	\$ 16,457,555	\$ 17,845,588	\$ 153,663,482
Children with PDD								
Eligible Member Months	2.80%	27	2,400	2,470	2,540	2,610	2,680	
Total Cost Per Eligible	5.90%	27	\$ 1,616.92	\$ 1,702.55	\$ 1,806.06	\$ 1,910.78	\$ 2,033.59	
Total Expenditure			\$ 3,880,609	\$ 4,205,388	\$ 4,587,586	\$ 4,987,449	\$ 5,450,458	\$ 46,175,160
Children with SED								
Eligible Member Months	3.40%	27	81,619	84,539	87,455	90,373	93,291	
Total Cost Per Eligible	2.65%	27	\$ 255.84	\$ 264.05	\$ 271.54	\$ 278.24	\$ 284.09	
Total Expenditure			\$ 20,881,319	\$ 22,322,130	\$ 23,747,569	\$ 25,145,121	\$ 26,502,958	\$ 237,198,195
MATI								
Eligible Member Months	3.40%	27	58,025	60,100	62,174	64,248	66,322	
Total Cost Per Eligible	6.14%	27	\$ 210.62	\$ 225.16	\$ 239.53	\$ 253.63	\$ 267.33	
Total Expenditure			\$ 12,221,367	\$ 13,531,956	\$ 14,892,796	\$ 16,295,345	\$ 17,729,766	\$ 149,342,460
DSH								
Total Allotment			644,435,620	644,435,620	644,435,620	644,435,620	644,435,620	\$ 3,222,178,100
FQHC								
Total Expenditure			41,800,000	41,800,000	41,800,000	41,800,000	41,800,000	\$ 209,000,000
Adults w/o Dependent Children								
Eligible Member Months	-5.28%	27	14,422	13,124	12,336	11,966	11,607	
Total Cost Per Eligible	12.58%	27	\$ 156.52	\$ 175.50	\$ 199.02	\$ 224.28	\$ 251.41	
Total Expenditure			\$ 2,257,255	\$ 2,303,256	\$ 2,455,164	\$ 2,683,762	\$ 2,918,156	\$ 12,617,592
Total Expenditure			\$ 10,896,492,976	\$ 12,086,718,871	\$ 13,561,201,075	\$ 15,027,631,046	\$ 16,457,186,471	\$ 68,030,230,439

Table 9.6d With Waiver Federal Share

ELIGIBILITY GROUP	TREND RATE	MONTHS OF AGING	DEMONSTRATION YEARS (DY)					TOTAL WW
			DY 01 (10/1/11 - 9/30/12)	DY 02 (10/1/12 - 9/30/13)	DY 03 (10/1/13 - 9/30/14)	DY 04 (10/1/14 - 9/30/15)	DY 05 (10/1/15 - 9/30/16)	
Title XIX								
Eligible Member Months	9.53%	27	7,720,846	8,724,989	9,768,677	10,699,516	11,112,778	
Total Cost Per Eligible	12.24%	27	\$ 155.63	\$ 179.76	\$ 204.64	\$ 227.66	\$ 248.29	
Total Expenditure			\$ 1,201,567,895	\$ 1,568,376,309	\$ 1,999,094,033	\$ 2,435,826,525	\$ 2,759,161,660	\$ 9,964,026,421
ABD								
Eligible Member Months	2.80%	27	2,818,411	2,900,683	2,982,953	3,065,209	3,147,471	
Total Cost Per Eligible	6.87%	27	\$ 459.18	\$ 484.16	\$ 522.60	\$ 559.85	\$ 600.93	
Total Expenditure			\$ 1,294,162,902	\$ 1,404,383,494	\$ 1,558,894,563	\$ 1,716,049,767	\$ 1,891,418,912	\$ 7,864,909,639
LTC/Transitioned HCBS								
Eligible Member Months	8.07%	27	453,415	569,994	586,160	602,323	618,488	
Total Cost Per Eligible	1.69%	27	\$ 3,614.03	\$ 3,259.51	\$ 3,394.87	\$ 3,534.24	\$ 3,709.92	
Total Expenditure			\$ 1,638,656,118	\$ 1,857,901,908	\$ 1,989,939,004	\$ 2,128,758,454	\$ 2,294,541,664	\$ 9,909,797,148
CCW								
Eligible Member Months	2.80%	27	131,098	134,925	138,752	142,578	146,404	
Total Cost Per Eligible	5.13%	27	\$ 2,873.17	\$ 3,045.06	\$ 3,203.92	\$ 3,364.37	\$ 3,556.15	
Total Expenditure			\$ 376,667,468	\$ 410,855,228	\$ 444,549,337	\$ 479,685,100	\$ 520,635,318	\$ 2,232,392,450
Pre-Transitioned HCBS								
Eligible Member Months	0.00%	27	100,411	-	-	-	-	
Total Cost Per Eligible	0.00%	27	\$ 1,080.71	\$ -	\$ -	\$ -	\$ -	
Total Expenditure			\$ 108,515,470	\$ -	\$ -	\$ -	\$ -	\$ 108,515,470
GA Employable								
Eligible Member Months	7.90%	27	468,403	505,406	545,333	588,415	634,900	
Total Cost Per Eligible	3.71%	27	\$ 135.95	\$ 141.00	\$ 146.23	\$ 151.65	\$ 157.28	
Total Expenditure			\$ 63,681,135	\$ 71,261,157	\$ 79,743,437	\$ 89,235,370	\$ 99,857,137	\$ 403,778,236
GA Unemployable								
Eligible Member Months	7.90%	27	234,201	252,703	272,667	294,207	317,450	
Total Cost Per Eligible	3.71%	27	\$ 135.95	\$ 141.00	\$ 146.23	\$ 151.65	\$ 157.28	
Total Expenditure			\$ 31,840,567	\$ 35,630,579	\$ 39,871,719	\$ 44,617,685	\$ 49,928,568	\$ 210,889,118
Supports Waiver								
Eligible Member Months	38.03%	27	15,120	26,184	45,360	49,896	54,886	
Total Cost Per Eligible	5.02%	27	\$ 1,611.71	\$ 1,684.23	\$ 1,770.13	\$ 1,856.86	\$ 1,960.85	
Total Expenditure			\$ 24,368,983	\$ 44,099,930	\$ 80,292,998	\$ 92,650,090	\$ 107,622,344	\$ 349,034,346
MVDD								
Eligible Member Months	2.80%	27	2,272	2,338	2,404	2,470	2,537	
Total Cost Per Eligible	5.02%	27	\$ 5,782.25	\$ 6,042.45	\$ 6,350.62	\$ 6,661.80	\$ 7,034.86	
Total Expenditure			\$ 13,134,546	\$ 14,126,264	\$ 15,267,787	\$ 16,457,555	\$ 17,845,588	\$ 76,831,741
Children with PDD								
Eligible Member Months	2.80%	27	2,400	2,470	2,540	2,610	2,680	
Total Cost Per Eligible	5.90%	27	\$ 1,616.92	\$ 1,702.55	\$ 1,806.06	\$ 1,910.78	\$ 2,033.59	
Total Expenditure			\$ 3,880,609	\$ 4,205,388	\$ 4,587,586	\$ 4,987,449	\$ 5,450,458	\$ 23,087,580
Children with SED								
Eligible Member Months	3.40%	27	81,619	84,539	87,455	90,373	93,291	
Total Cost Per Eligible	2.65%	27	\$ 255.84	\$ 264.05	\$ 271.54	\$ 278.24	\$ 284.09	
Total Expenditure			\$ 20,881,319	\$ 22,322,130	\$ 23,747,569	\$ 25,145,121	\$ 26,502,958	\$ 118,599,097
MATI								
Eligible Member Months	3.40%	27	58,025	60,100	62,174	64,248	66,322	
Total Cost Per Eligible	6.14%	27	\$ 210.62	\$ 225.16	\$ 239.53	\$ 253.63	\$ 267.33	
Total Expenditure			\$ 12,221,367	\$ 13,531,956	\$ 14,892,796	\$ 16,295,345	\$ 17,729,766	\$ 74,671,230
DSH								
Total Allotment			644,435,620	644,435,620	644,435,620	644,435,620	644,435,620	\$ 3,222,178,100
FQHC								
Total Expenditure			20,900,000	20,900,000	20,900,000	20,900,000	20,900,000	\$ 104,500,000
Adults w/o Dependent Children								
Eligible Member Months	-5.28%	27	14,422	13,124	12,336	11,966	11,607	
Total Cost Per Eligible	12.58%	27	\$ 78.26	\$ 87.75	\$ 99.51	\$ 112.14	\$ 125.70	
Total Expenditure			\$ 1,128,627	\$ 1,151,628	\$ 1,227,582	\$ 1,341,881	\$ 1,459,078	\$ 6,308,796
Total Expenditure			\$ 5,456,042,628	\$ 6,113,179,746	\$ 6,917,439,572	\$ 7,716,378,696	\$ 8,457,478,730	\$ 34,660,519,372

Summary of budget neutrality

The federal share of combined Medicaid expenditures for all population groups covered under this demonstration project will not exceed what the federal share of Medicaid expenditures would be without the waiver. The savings attributable to this waiver would be realized by improving the quality of care and controlling the costs for the Medicaid/FamilyCare populations. Of the multiple savings initiatives demonstrated under with waiver, one of the largest drivers of savings includes the implementation of managed LTC. Below is detail supporting the development of the savings estimates for managed LTC.

Managed LTC

New Jersey is designing its managed LTC program by making decisions on all the key issues described in the preceding section on managed LTC, guided by close familiarity with the challenges faced in its own unique population base, provider market, and other stakeholders' interests. While the program structure in different states varies, the cost savings achieved from implementing managed LTC have generally ranged from 0.5 percent to 5 percent in the initial years up to 10 percent to 23 percent^{18,19,20} annually after a few years of existence.

To develop the cost savings, the data was separated by the following population groups:

- dual eligibles in a nursing facility;
- dual eligibles in HCBS programs;
- non-dual eligibles in a nursing facility; and
- non-dual eligibles in HCBS programs.

Services for which data was provided included the following services categories: inpatient hospital, outpatient, pharmacy, nursing home services, waiver services, home health, other practitioner, lab and radiology, transportation, supplies/DME, mental health/substance abuse, physician services, and other miscellaneous services.

The following assumptions were made regarding the overall LTC program:

- The future mix of duals and non-duals will continue to be 88 percent and 12 percent as observed in the historical FFS base data.
- All services covered by Medicaid, including primary care, acute care, behavioral health services and LTC services will be covered by the managed care plans.
- Managed LTC changes will be implemented by an effective date of July 1, 2012.
- If managed LTC is not implemented, then FFS costs will continue to grow at trend levels observed in recent years (without waiver).
- If managed LTC is implemented, health plans contracting with the State will manage and coordinate services with good care management and cost efficiencies.
- Implementation will be made on a statewide basis.

The level of savings was calculated by comparing against what the LTC program would look like if the health care delivery system were to continue as it is today. This "status quo" is represented by without waiver. Within the above assumed framework of the overall LTC program, assumptions made to create the savings primarily revolve around the following:

¹⁸ California Center for Long Term Care Integration, Policy Issue Brief #2 – Cost Savings in Integrated Long Term Care Systems, December 2003.

¹⁹ National PACE Association – Summary of PACE Provider Regulation, 42 CFR Part 460.

²⁰ Close to Home – www.ascp.com/public/pubs/tcp/1996/feb/closetohome.html "States Pursue Innovative Medicaid Cost Containment Strategies."

- cost savings estimates based on Medicaid dollars only, consideration for Medicare dollars have not been incorporated;
- implementation of managed care and an estimate of the expected enrollment over time; and
- diversion of enrollees away from nursing homes and into home- and community-based alternatives.

The savings assumes a statewide mandatory managed LTC program, replacing the FFS program currently in place. With a complete enrollment transition from FFS into an implemented managed LTC initiative, the greatest amount of cost savings can be achieved. For purposes of estimating the savings, a diversion rate was assumed.^{21,22} Within the managed LTC program the placement distribution is estimated to increase to the percentage of HCBS populations throughout the demonstration period. On the contrary, the NF population will decrease over time. It is assumed that a mandatory program can increase HCBS use seen in the baseline as a result of some individuals no longer requiring nursing facility level of care if a support structure was available. Therefore, the initial managed care PMPM reflects a targeted blend of NF and HCBS PMPMs.

The savings incorporates a mandatory managed LTC program generating considerable savings that increase over time. The savings achieved can be significant. For purposes of the waiver, a modest savings range from approximately \$20 million in DY1 to approximately \$220 million in DY5 was assumed. The results exemplify the potential savings that can be achieved through managed care, and offer a point of reference for with waiver savings.

Summary of budget neutrality

The following table summarizes the total federal share Without and With Waiver estimated expenditures over the five-year period.

Table 9.5a Summary of Without Waiver and With Waiver Projected Medicaid Expenditures – Total Share*

Without Waiver	With Waiver	Savings
\$ 68,949,032,365	\$ 68,030,230,439	\$ 918,801,925

**All estimates are based upon the information available at a point in time, and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which is was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use.*

²¹ USC/UCLA Center for Long Term Care Integration, Policy Issue Brief #2 – Cost Savings in Integrated Long Term Care systems, Arizona Long Term Care System (ALTCS), December 2003.

²² Intensive Care how Three States Reduced the Cost, Larry J. Pfannerstill and David F. Ogden, Pg. 24, March/April 2004.

Table 9.5b Summary of Without Waiver and With Waiver Projected Medicaid Expenditures – Federal Share*

Without Waiver	With Waiver	Savings
\$ 35,121,122,306	\$ 34,660,519,372	\$ 460,602,934

**All estimates are based upon the information available at a point in time, and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use.*

These totals do not include any corresponding savings achieved in the Medicare program resulting from the approval of our waiver request that is summarized below.

Medicare budget neutrality

Although the State understands that savings achieved in the Medicare program are not typically allowed in Medicaid budget neutrality, the State is of the opinion that additional benefits could be realized in Medicare should our demonstration project be approved. Given the duals' high proportion of Medicare coverage, much of the care management savings would accrue to Medicare. For example, as Medicare covers about 90 percent or more of inpatient hospital care, we expect significant utilization savings to inpatient hospital as a result of this demonstration project. New Jersey is committed to transforming the health care delivery system for dual eligibles. With the comprehensive waiver, DMAHS fully expects to improve the quality of care and reduce the cost of serving the dual eligibles. Savings will accrue to Medicare, while New Jersey would be responsible for the cost of developing, implementing and monitoring the program. New Jersey will conduct more in-depth analyses on the dual eligible population to develop strategies, such as health homes, to more efficiently care for the duals. The State will also review LTC services that would be most effective for the duals. Integrating care has the potential to greatly contribute to quality improvements and potential savings which could be reallocated to better meet the needs of the dual eligibles. In addition, the saving initiatives are expected to impact other federally-matched populations.

Other budget neutrality positions and assumptions

The State makes the following assumptions with regard to budget neutrality:

- The State understands that it is CMS policy that administrative costs to the state for administration of this waiver both incurred by the state are not subject to budget neutrality.
- The State is assuming a successful Balancing Incentive Payment award as well as the ability to implement the Section 2703 Health Home option within this demonstration proposal.
- Nothing in this demonstration application precludes the state from applying for enhanced Medicaid funding, such as the 90% federal match for improving Medicaid eligibility and 90% federal match for health information technology through Medicaid.

- The State is assuming the budget neutrality agreement is in terms of total computable so that the State is not hindered by future changes to FMAP rate on services.

Affordable Care Act considerations

Most initial section 1115 demonstration waivers are requested for a five-year period, which for the purposes of this demonstration would encompass the time during which the Medicaid expansion under ACA and other ACA-related provisions are scheduled to be implemented under current law. As the necessary details of many of these changes have not yet been released, unless specified, The State has not modeled the impact of ACA implementation in the budget neutrality estimates. As necessary, the State would expect to amend or otherwise revise the demonstration, including the budget neutrality agreement, to reflect new federal requirements. To that end, the budget neutrality calculations presented in the tables at the end of this section include adjustments for known and expected initiatives and impacts through December 31, 2013, but do not include explicit adjustments for ACA or any other initiatives beyond that date. Only the application of trend has been made to cost and caseload estimates beyond December 31, 2013.

10

Requested Centers for Medicaid & Medicare Services waiver list

Title: New Jersey Section 1115 Comprehensive Waiver Demonstration

Awardee: New Jersey Department of Human Services

All Medicaid and CHIP requirements expressed in law, regulation and policy statement not expressly waived or identified as not applicable in this list, shall apply to the demonstration project beginning October 1, 2011, through September 30, 2016. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STC).

1. Proper and Efficient Administration Section 1902(a)(4) and 42 CFR 438.52, 438.56

To permit the State to limit enrollee's choice of managed care plans to a single PIHP – for the treatment of BH conditions (other than those requiring LTC services at the NF LOC).

To permit the State to automatically reenroll an individual who loses Medicaid eligibility for a period of 90 days or less in the same managed care plan or PIHP in which he or she was previously enrolled. (Applicable only if the State chooses to contract with multiple BH PIHP).

To permit the State to restrict the ability of members to disenroll without cause after an initial 30-day period from a managed care plan and with cause to 90 days.

2. Cost Sharing Section 1902 (a)(14), 1916 and 42 CFR 447.51 and 447.56

To enable the State, under premium support and purchase of premium programs, to authorize coverage of employer-based or private plans that have cost sharing requirements for participants covered under the demonstration in excess of statutory limits.

To permit application of copayments to children.

3. Disproportionate Share Hospital (DSH) Section 1902(a)(13) Requirements

To relieve the State from the obligation to make payments for inpatient disproportionate share of low-income patients for the portion of the State's DSH allotment required for budget neutrality under this agreement and/or required for payment of incentives to hospitals participating in a community Accountable Care Organization.

4. Freedom of Choice Section 1902(a)(23) (42 CFR 431.51)

To enable the State to restrict freedom of choice of providers by furnishing benefits through enrollment of eligible individuals in MCOs and/or Prepaid Inpatient Health Plans.

5. Retroactive Eligibility Section 1902(a) (34)(42 CFR 435.914)

To enable the State to waive the requirement to provide medical assistance for up to three months prior to the date that an application for assistance is made for Medicaid for some eligibility groups, notwithstanding Maintenance of Effort under Section 1902.

6. Amount, Duration, Scope of Services Section 1902(a)(10)(B) and 42 CFR 440.240 and 440.230

To permit MCOs and PIHPs to provide additional or different benefits to enrollees that may not be available to other eligible individuals.

To enable the State to modify the Medicaid benefits package for those in the premium support or purchase of premium programs in order to offer a different benefit package than would otherwise be required under the State plan. This authority is granted only to the extent necessary to allow those with available coverage to receive services through a private or employer-sponsored insurance plan, which may offer a different benefit package than that available through the State plan. Children in such programs are also enrolled in managed care to receive wraparound coverage. Wraparound coverage is not available to adults.

7. Eligibility Based on Institutional Status Section 1902(a)(10)(A)(ii)(V) and 42 CFR 435.217 and 435.236

To the extent that the State would be required to make eligible individuals who are in an acute care hospital for greater than 30 days and who do not meet the LOC standard for LTC services.

8. Federal Medical Assistance Percentage (FMAP) Sections 1903 and 1905

To allow the State to receive an increase FMAP for parents/caretakers eligible for Medicaid with income up to 133% FPL.

9. Medically Needy Eligibility Section (No SSA or CFR Cites?)

To permit incurred cost for the purpose of spend down (share of cost) for medically needy members receiving LTC services in community settings to be defined as a percentage reduction in payments for home and community based services (HCBS) claims or payment of a monthly premium.

10. Grievance and Appeals 42 CFR 438.400

To enable a uniform appeals process for Medicare and Medicaid dual eligibles.

11. PASRR Section 1919 (b) (3) (F) and 42 CFR 483.100 – 483.138

To terminate the Preadmission Screening and Resident Review (PASRR) process under the Comprehensive Waiver and managed LTC because of the financial incentives under the program that ensure appropriate placement.

12. Member Reward Accounts Section 1902 (a)(10)(C)(i)

To enable the State to exclude funds in a member rewards account from the income and resource test established under State and Federal Law for the purposes of determining Medicaid eligibility.

13. Transfer of Assets Section 1917(c)(1)(B)(i)

To enable the State to provide community and facility LTC services to individuals with incomes at or below 100% of FPL while the look behind is occurring.

To enable the State to provide community and facility LTC services to individuals with incomes between 100% of FPL and 300% of the FBR based on their attestation and to recover State and federal funds expended in error.

14. Statewideness Section 1902(a)(1)

To enable the State to offer accountable care organizations in select geographic regions of the State.

Medicaid Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the State for the items identified below (which would not otherwise be included as matchable expenditures under section 1903) shall, for the period of this demonstration, be regarded as matchable expenditures under the State's Medicaid State plan:

1. Expenditures under contracts with managed care entities that do not meet the requirements in section 1903(m)(2)(A) of the Act specified below. Managed care plans participating in the demonstration will have to meet all the requirements of section 1903(m), except the following:
 - a. Section 1903(m)(2)(A)(vi) insofar as it requires compliance with requirements in section 1932(a)(4) and Federal regulations at 42 CFR 438.56(c)(2)(i) that enrollees be permitted an initial period after enrollment to disenroll without cause that would be longer than 30 days.
 - b. Section 1903(m)(2)(H) and Federal regulations at 42 CFR 438.56(g) but only insofar as to allow the State to automatically reenroll an individual who loses Medicaid eligibility for a period of 90 days or less in the same managed care plan from which the individual was previously enrolled.
2. Expenditure authority for shared savings arrangements with MCOs, FFS and PIHPs with accountable care organizations and/or health homes to the extent that some or all of shared savings are reflected in payments
3. Expenditure authority for a uniform Medicare and Medicaid appeals process for MCOs that are also the Medicare Special Needs Plan for the same member
4. Expenditures that would have been disallowed under section 1903(u) of the Act and Federal regulations at 42 CFR 431.865 based on Medicaid Eligibility Quality Control findings.
5. Expenditures for inpatient hospital and LTC facility services, other institutional and non-institutional services (including drugs) provided to FFS beneficiaries, that exceed the amounts allowable under section 1902(a)(30)(A) (Federal regulations at 42 CFR 447.250 through 447.280).
6. Expenditures for inpatient hospital services that take into account the situation of hospitals with a disproportionate share of low-income patients, but are not allowable under sections 1902(a)(13)(A) and 1923 of the Act, but are in accordance with the provisions for DSH payments that are described in the STCs.
7. Expenditure authority to limit expenditures for HCBS for members with intellectual and developmental disorders to appropriate home or out of home placement consistent with their assessment needs.

8. Expenditure authority for reimbursement to the State for payments made by the State to providers for Medicare covered services in Special Disability Workload (SDW) cases in the amount of \$107.3 million.
9. Expenditures associated with provision of HCBS to individuals under managed care with income levels up to 100% of the FPL whose assessed needs meet the State's LOC determination and to those whose assessed needs are not yet up to the LOC.
10. Expenditures associated with the provision of HCBS to disabled individuals under the age of 18 with income levels up to 300% of the SSI income level without considering parental income as otherwise required by section 1902(a)(10)(C)(i) and 42 CFR 435.602.
11. Expenditure authority for streamlining of LTC eligibility determinations for HCBS placements
 - a. Medical assistance furnished to Medically Needy eligible individuals where incurred medical expenses were determined through a premium collection or reduction of the amount paid for a HCBS.
 - b. Medical assistance furnished to LTC eligibles who are eligible only as a result of the disregard from eligibility of income currently excluded under section 1612(b) of the Act, and medical assistance that would not be allowable for some of those enrollees but for the disregard of such income from post-eligibility calculations.
 - c. Medical assistance furnished to enrollees who are financially eligible with income equal to or less than 300% of the FBR or Medically Needy and who meet the criteria in the preadmission screening instrument (PAS) regardless of whether or how long they actually have been in an institutional setting; that is, notwithstanding the requirements of 42 CFR 435.540 (regarding disability determination in accordance with SSI standards). Medical assistance furnished to some dependent children or spouses who qualify for LTC based on a disregard of income and resources of legally responsible relatives or spouses during the month of separation from those relatives or spouses.
 - d. Medical assistance furnished to individuals who are eligible as Qualified Medicare Beneficiary, Special Low Income Beneficiary, Qualified Individuals, or Supplemental Security Income Medical Assistance Only (SSI MAO) beneficiaries based only on a disregard of in-kind support and maintenance (ISM).
 - e. Medical assistance furnished to individuals who are eligible based only on an alternate budget calculation for LTC and SSI-MAO income eligibility determinations when spousal impoverishment requirements of section 1924 of the Act do not apply or when the applicant/recipient is living with a minor dependent child.
 - f. Medical assistance furnished to individuals who are eligible in SSI-MAO groups based only on a disregard of resources in the form of insurance and burial funds, household goods, mineral rights, oil rights, timber rights and personal effects.

- g. Medical assistance furnished to individuals who are eligible only based on the disregard of interest and dividend from resources, and are in the following eligibility groups:
 - a. The Pickle Amendment Group under 42 CFR 435.135
 - b. The Disabled Adult Child under section 1634(c)
 - c. Disabled Children under section 1902(a)(10)(A)(i)(II)
 - d. The Disabled Widow/Widower group under section 1634(d)
 - h. Medical assistance furnished to LTC recipients under the eligibility group described in section 1902(a)(10)(A)(ii)(V) of the Act that exceeds the amount that would be allowable except for a disregard of interest and dividend from the post-eligibility calculations.
 - i. Medical assistance provided to individuals who would be eligible but for excess resources under the "Pickle Amendment," section 503 of Public Law Number 94-566, section 1634(c) of the Act (disabled adult children), or section 1634(b) of the Act (disabled widows and widowers).
 - j. Medical assistance that would not be allowable but for the disregard of quarterly income totaling less than \$20 from the post-eligibility determination.
15. Expenditures to provide coverage through premium support and purchase of premium programs that would not otherwise be allowable because they were determined cost effective using an alternative methodology
16. Expenditures to provide coverage to parents of Medicaid or CHIP children with adjusted net countable income from the Temporary Assistance for Needy Families (TANF) standard up to and including 200% of the FPL who are not otherwise eligible for Medicare, Medicaid, or CHIP and for whom the State may claim title XIX funding when title XXI funding is exhausted.
17. Expenditures to provide coverage to childless adults ages 19 – 64 for health care related costs (other than costs incurred through the Charity Care and Substance Abuse Initiative Programs) who are not otherwise eligible under the Medicaid State Plan, do not have other health insurance coverage, are residents of the State, are citizens or eligible aliens, have limited assets and either: 1) cooperate with applicable work requirements and have countable monthly household incomes up to \$140 for a childless adult and \$193 for a childless adult couple, or 2) have a medical deferral from work requirements based on a physical or mental condition, which prevents them from work requirements and have countable monthly household incomes up to \$210 for a childless adult and \$289 for a childless couple.
18. Expenditures to provide coverage to uninsured individuals over age 18 with family income below 100% of FPL, who are childless adults and who are not otherwise eligible for Medicare, Medicaid, or have other creditable health insurance coverage who were covered by New Jersey Family Care prior to enactment of the phase out under Section 2111 of the Social Security Act and to freeze further enrollment into the program.

19. Expenditures not to exceed \$42 million total computable for payments to Federally Qualified Health Centers for uninsured populations.
20. Expenditures for coverage of Medicaid/Medicare dual eligibles who are auto-assigned to the aligned plan for receipt of both Medicare and Medicaid services.
21. Expenditures in the amount that reflects what the State would received under a Balancing Incentive Payment award under the ACA.
22. Expenditures that reflect the enhanced matching share for health home services under Section 2703 of the ACA for qualified health home models.
23. Expenditures for a 1915 (i) like program for opiate dependent adults with incomes below 150% of FPL.
24. Expenditures for 1915 (c) like programs for the children with I/DD and co-occurring mental illness.
25. Expenditures for out-state-payments for individuals with I/DD in similar settings to those authorized under 1915(c) programs.

CHIP Waiver Authority

1. Cost Sharing Section 1902 (a)(14), 1916 and 42 CFR 447.51 and 447.56

To enable the State to impose cost sharing, to the extent necessary, for parents of Medicaid or SCHIP children with income above the TANF standard in excess of prescribed standards.

2. Amount, Duration, Scope of Services Section 1902(a)(10)(B) and 42 CFR 440.230 and 440.240

To enable the State to modify the Medicaid benefits package for those in the premium support and purchase of premium programs in order to offer a different benefit package than would otherwise be required under the State plan. This authority is granted only to the extent necessary to allow those in these programs to receive coverage through a private or employer-sponsored insurance plan, which may offer a different benefit package than that available through the State plan. Children in such programs are also enrolled in managed care to receive wraparound coverage. Wraparound coverage is not available to adults.

3. Premium support and Purchase of Premium Sections 1906 (a) and 2105 (c) (10)

To enable alternate methodologies for determining cost effectiveness.

To allow alternate employer contributions.

To allow mandatory collection of SSN for non-applicants that is not related to the determination of eligibility.

To allow a three month period for determination of coverage under premium support and purchase of premium programs..

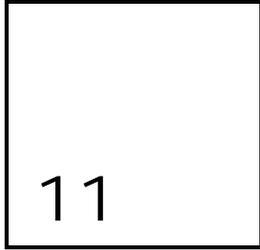
4. Benefit Package Requirements Section 2103

To permit the State to offer a benefit package for the employer-sponsored insurance program that does not meet the requirements of section 2103 and Federal regulations at 42 CFR 457.410(b)(1) for adults.

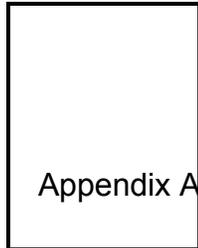
CHIP Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Act as incorporated into title XXI by section 2107(e)(2)(A), State expenditures described below, shall, for the period of this project and to the extent of the State's available allotment under section 2104 of the Act, be regarded as matchable expenditures under the State's title XXI plan. All requirements of title XXI will be applicable to such expenditures for the demonstration populations described below, except those specified below as not applicable to these expenditure authorities.

1. **Parents.** Expenditures to provide health care coverage consistent with the requirements of section 2103 to uninsured individuals whose adjusted net countable family income is above the TANF standard up to 200% of the FPL, who are parents of children enrolled in the Medicaid or title XXI program and who are not otherwise eligible for Medicare, Medicaid, or have other creditable health insurance coverage.
2. **Premium Support and Purchase of Premium.** Expenditures to provide coverage through employer-sponsored insurance and private plans for covered individuals with family income below 200% of the FPL and who are not eligible for Medicare or Medicaid.
3. **Annual Reporting Requirements Section 2108 and 42 CFR 457.700 through 457.750.** The State does not have to meet the annual reporting requirements (the submission of an annual report into the State Annual Report Template System of section 457.750 for the demonstration populations). The State will report on issues related to the demonstration populations in quarterly and annual reports and enrollment data through the Statistical Enrollment Data System. Coverage and eligibility for the demonstration populations are not restricted to targeted low-income children.
4. **SSN.** Expenditures for medical assistance for children when the State required the non-applicant's Social Security Number not for the purpose of eligibility determination.



Appendices



Public input

Summary of public comments

To garner input for our Comprehensive Waiver, the State set up an e-mail address specifically to capture public comments. This e-mail address was included in the public notice that was published statewide and available at all County Welfare Agencies. We received 32 written comments from stakeholders representing hospitals, FQHCs, mental health providers and Offices on Aging and Disability advocates. Below is a summary of the comments we received. Many of the comments are industry-specific, but we have identified areas of support and concern and the common themes shared by the respondents.

The majority of the respondents expressed their appreciation for the opportunity to provide comment. The main topics for comment were the enrollment freeze for parents, ED copayments, managing BH and LTC and the impact on people with developmental disabilities.

The two proposals which received the majority of the comments included:

- Most respondents across all industry groups oppose the proposal to freeze enrollment of adult parents. Some reasons provided were:
 - It would be a strain on FQHCs and hospitals
 - It is a violation of the ACA maintenance of eligibility provision
 - It would not be cost-effective and would increase the number of uninsured and potentially have a negative effect on child enrollment
-
- Most respondents across all industry groups also opposed the \$25 copayment for inappropriate use of the ED. Reasons given for the opposition included reduced payments to the hospitals, difficulty defining and enforcing “inappropriate use” and imposing copayments have no impact on behavior.

We had many comments from the mental health stakeholder groups regarding the different approaches proposed for managing BH services. We received positive feedback from most industry respondents regarding our efforts to integrate physical and BH and support for incorporating BH homes. However, they did express concern with the proposal in the concept paper to have two different delivery systems for adult BH. They opposed using a bifurcated approach that utilized a MCO model and an ASO model, based on level of acuity. Concern was raised on how we would categorize the severity of health needs and what would happen if the person's needs changed and would have to transition from one model to another. Most respondents recommended a single system for adult BH services, with the majority recommending using an ASO model. There were also recommendations that we use one ASO contractor for both children and adult services.

We received comments on the proposal to amend our existing MCO contracts to manage LTC services. There was overall agreement and support among the stakeholders to rebalance from reliance on institutional and acute emergency services to preventive and HCBS. Concern was raised by an organization representing health care workers about the MCOs' network adequacy and their capacity to conduct quality or workforce initiatives. Since there are only four Medicaid plans, concern was raised that nursing homes would have no leverage over rates.

Many of the comments regarding managing LTC came from our Area Agencies on Aging who expressed concerns with MCOs providing case management and support coordination, citing MCO readiness and the potential effect on the current level of quality care offered.

The majority of the disability advocates support the proposed changes to the developmental disabilities system. We received positive feedback on the proposal to close a developmental center and were encouraged to look at closing several more as we shift to community placement and supports for people with I/DD. It was also stated that the waiver provides opportunities to incorporate efficiencies and retooling of administrative, service delivery, IT and fiscal systems to improve access for community based services and supports. The disability advocates did raise concern about the potential impact managed LTC could have with people with I/DD, as well as the \$25 ED copayment in the context of Danielle's law.

We received positive feedback from various respondents on our proposal to potentially increase rates to PCPs prior to 2014. We received support for rewarding member responsibility and healthy behaviors, fairness in payments to in-state and out-of-state providers, and for pursuing opportunities under the ACA including Integrated Care Around a Hospitalization and Medicaid Global Payment System. The majority of respondents were also in support of our proposal to pilot accountable care organizations and health homes. Lastly, we receive a comment regarding Autism and the importance of covering Applied Behavior Analysis (ABA) therapy in Medicaid.

DHS also held a special meeting of the MAAC to obtain input on the Comprehensive Waiver, which was attended by approximately 190 people. A total of 20 individuals provided public comment; many of those that provided public comment also submitted comments in writing. Concern was expressed regarding the freeze of enrollment for adult parents as well as the \$25 ED copayment. There was support for rewarding member responsibility and healthy behavior and for the commitment to close a developmental center. The closing of additional centers was encouraged.

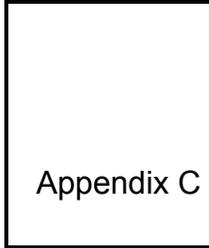
Appendix B

Glossary

Acronym	Term
AAA	Area Agencies on Aging
ABA	Applied Behavior Analysis
ABD	Aged, Blind or Disabled
ACA	Affordable Care Act
ACCAP	AIDS Community Care Alternatives Program
ADDP	Association of Developmental Disabilities Providers
ADRC	Aging and Disability Resource Centers
AFDC	Aid to Families with Dependent Children
ASO	Administrative Services Organization
BH	Behavioral Health
BHI	Behavioral Health Initiative
BS	Behavioral Specialist
CCW	Community Care Waiver
CDPS	Chronic Disability Payment System
CDSMP	Chronic Disease Self-Management Program
CHIP	Children’s Health Insurance Program
CI	Crisis Intervention
CRPD	Community Resources for People with Disabilities
CSHP	Center for State Health Policy
CSOC	Children’s System of Care
CWA	County Welfare Agencies
DACS	Division of Aging and Community Services
DCF	Department of Children and Families
DD	Developmentally Disabled

Acronym	Term
DDD	Division of Developmental Disabilities
DDRT	Developmental Disabilities Resource Tool
DHS	Department of Human Services
DHSS	Department of Health and Senior Services
DMAHS	Division of Medical Assistance and Health Services
DSH	Disproportionate Share Hospital
EBP	Evidence-Based Practices
ED	Emergency Department
EQR	External Quality Review
ESI	Employer-Sponsored Health Insurance
FBR	Federal Benefit Rate
FEA	Fiscal Employer Agency
FFP	Federal Financial Participation
FFS	Fee for Service
FPL	Federal Poverty Level
FQHC	Federally Qualified Health Center
GA	General Assistance
GO	Global Options for Long-term Care
HCBS	Home and Community Based Services
HEDIS	Healthcare Effectiveness Data and Information Set
HIPP	Health Insurance Premium Payment
MCO	Managed Care Organization
I/DD	Intellectual and Developmental Disabilities
ICF/MR	Intermediate Care Facility for Persons with Mental Retardation
ICM	Intensive Case Management
IMD	Institute for Mental Disease
LANE	Low Acuity Non-Emergent
LOC	Level of Care
LTC	Long-term Care
MAAC	Medical Assistance Advisory Council
MAC	Medicaid Advisory Council
MBHO	Managed Behavioral Health Organization
MCI	Master Client Index
MDC	Medical Day Care
MFP	Money Follows the Person
MMIS	Medicaid Management Information System
MOU	Memorandum of Understanding
NF	Nursing Facility

Acronym	Term
NJPCA	New Jersey Primary Care Association
P4P	Pay for Performance
PACE	Program for All-Inclusive Care for the Elderly
PASRR	Preadmission Screening and Resident Review
PBS	Positive Behavior System
PCP	Primary Care Provider
PH	Physical Health
PHI	Protected Health Information
PIHP	Prepaid Inpatient Health Plan
PIP	Performance Improvement Projects
POC	Plan of Care
POP	Payment of Premium
PPPM	Per Participant Per Month
PSP	Premium Support Programs
QA	Quality Assurance
QAPI	Quality Assessment and Performance Improvement
QM	Quality Management
RAI	Request for Additional Information
RFP	Request for Proposal
RN	Registered Nurse
SAI	Substance Abuse Initiative
SBIRT	Screening, Brief Intervention and Referral to Treatment
SED	Serious Emotional Disturbance
SFY	State Fiscal Year
SMI	Serious Mental Illness
SPA	State Plan Amendment
SPH	State Psychiatric Hospital
SSI	Supplemental Security Income
TBI	Traumatic Brain Injury
UM	Utilization Management
VFC	Vaccines for Children
WFNJ/GA	Work First New Jersey/General Assistance



Budget neutrality tables

The following tables summarize the trend rate and overall cost and caseload for the populations for the five-year Demonstration period:

Table 9.6a Without Waiver Total Spend

ELIGIBILITY GROUP	TREND RATE	MONTHS OF AGING	DEMONSTRATION YEARS (DY)					TOTAL WOW
			DY 01 (10/1/11 - 9/30/12)	DY 02 (10/1/12 - 9/30/13)	DY 03 (10/1/13 - 9/30/14)	DY 04 (10/1/14 - 9/30/15)	DY 05 (10/1/15 - 9/30/16)	
Title XIX								
Eligible Member Months	9.53%	27	7,720,846	8,724,989	9,768,677	10,699,516	11,112,778	
Total Cost Per Eligible	10.23%	27	\$ 314.99	\$ 352.27	\$ 389.11	\$ 425.50	\$ 464.99	
Total Expenditure			\$ 2,431,955,038	\$ 3,073,585,207	\$ 3,801,051,623	\$ 4,552,595,926	\$ 5,167,356,138	\$ 19,026,543,932
ABD								
Eligible Member Months	2.80%	27	2,818,411	2,900,683	2,982,953	3,065,209	3,147,471	
Total Cost Per Eligible	6.46%	27	\$ 934.69	\$ 989.01	\$ 1,055.34	\$ 1,122.52	\$ 1,200.44	
Total Expenditure			\$ 2,634,343,015	\$ 2,868,803,590	\$ 3,148,034,953	\$ 3,440,758,481	\$ 3,778,360,154	\$ 15,870,300,194
LTC/Transitioned HCBS								
Eligible Member Months	8.07%	27	453,415	569,994	586,160	602,323	618,488	
Total Cost Per Eligible	1.69%	27	\$ 7,272.17	\$ 6,641.84	\$ 6,994.47	\$ 7,350.73	\$ 7,775.55	
Total Expenditure			\$ 3,297,312,236	\$ 3,785,803,816	\$ 4,099,878,007	\$ 4,427,516,908	\$ 4,809,083,329	\$ 20,419,594,295
CCW								
Eligible Member Months	2.80%	27	131,098	134,925	138,752	142,578	146,404	
Total Cost Per Eligible	5.14%	27	\$ 5,822.62	\$ 6,090.46	\$ 6,408.63	\$ 6,730.00	\$ 7,114.04	
Total Expenditure			\$ 763,334,936	\$ 821,756,120	\$ 889,208,915	\$ 959,549,918	\$ 1,041,526,399	\$ 4,475,376,288
Pre-Transitioned HCBS								
Eligible Member Months	0.00%	27	100,411	-	-	-	-	
Total Cost Per Eligible	0.00%	27	\$ 2,161.42	\$ -	\$ -	\$ -	\$ -	
Total Expenditure			\$ 217,030,940	\$ -	\$ -	\$ -	\$ -	\$ 217,030,940
GA Employable								
Eligible Member Months	7.90%	27	468,403	505,406	545,333	588,415	634,900	
Total Cost Per Eligible	3.71%	27	\$ 271.91	\$ 282.00	\$ 292.46	\$ 303.31	\$ 314.56	
Total Expenditure			\$ 127,362,269	\$ 142,522,315	\$ 159,486,874	\$ 178,470,740	\$ 199,714,273	\$ 807,556,472
GA Unemployable								
Eligible Member Months	7.90%	27	234,201	252,703	272,667	294,207	317,450	
Total Cost Per Eligible	3.71%	27	\$ 271.91	\$ 282.00	\$ 292.46	\$ 303.31	\$ 314.56	
Total Expenditure			\$ 63,681,135	\$ 71,261,157	\$ 79,743,437	\$ 89,235,370	\$ 99,857,137	\$ 403,778,236
Supports Waiver								
Eligible Member Months	38.03%	27	15,120	26,184	45,360	49,896	54,886	
Total Cost Per Eligible	5.02%	27	\$ 3,223.41	\$ 3,368.46	\$ 3,540.26	\$ 3,713.73	\$ 3,921.70	
Total Expenditure			\$ 48,737,967	\$ 88,199,860	\$ 160,585,995	\$ 185,300,180	\$ 215,244,689	\$ 698,068,691
M/DD								
Eligible Member Months	2.80%	27	2,272	2,338	2,404	2,470	2,537	
Total Cost Per Eligible	5.90%	27	\$ 3,233.84	\$ 3,405.09	\$ 3,612.11	\$ 3,821.57	\$ 4,067.19	
Total Expenditure			\$ 7,761,218	\$ 8,410,776	\$ 9,175,173	\$ 9,974,897	\$ 10,900,916	\$ 153,663,482
Children with PDD								
Eligible Member Months	2.80%	27	2,400	2,470	2,540	2,610	2,680	
Total Cost Per Eligible	5.90%	27	\$ 3,233.84	\$ 3,405.09	\$ 3,612.11	\$ 3,821.57	\$ 4,067.19	
Total Expenditure			\$ 7,761,218	\$ 8,410,776	\$ 9,175,173	\$ 9,974,897	\$ 10,900,916	\$ 46,222,980
Children with SED								
Eligible Member Months	3.40%	27	81,619	84,539	87,455	90,373	93,291	
Total Cost Per Eligible	2.65%	27	\$ 511.68	\$ 528.09	\$ 543.08	\$ 556.47	\$ 568.18	
Total Expenditure			\$ 41,762,639	\$ 44,644,261	\$ 47,495,138	\$ 50,290,242	\$ 53,005,915	\$ 237,198,195
MATI								
Eligible Member Months	3.40%	27	58,025	60,100	62,174	64,248	66,322	
Total Cost Per Eligible	6.14%	27	\$ 421.25	\$ 450.31	\$ 479.07	\$ 507.26	\$ 534.65	
Total Expenditure			\$ 24,442,733	\$ 27,063,913	\$ 29,785,592	\$ 32,590,691	\$ 35,459,531	\$ 149,342,460
DSH								
Total Allotment			1,288,871,240	1,288,871,240	1,288,871,240	1,288,871,240	1,288,871,240	\$ 6,444,356,200
Total Expenditure			\$ 10,972,864,458	\$ 12,249,174,784	\$ 13,743,852,521	\$ 15,248,069,704	\$ 16,735,070,897	\$ 68,949,032,365

Table 9.6b Without Waiver Federal Share

ELIGIBILITY GROUP	TREND RATE	MONTHS OF AGING	DEMONSTRATION YEARS (DY)					TOTAL WOW
			DY 01 (10/1/11 - 9/30/12)	DY 02 (10/1/12 - 9/30/13)	DY 03 (10/1/13 - 9/30/14)	DY 04 (10/1/14 - 9/30/15)	DY 05 (10/1/15 - 9/30/16)	
Title XIX								
Eligible Member Months	9.53%	27	7,720,846	8,724,989	9,768,677	10,699,516	11,112,778	
Total Cost Per Eligible	12.41%	27	\$ 158.50	\$ 184.17	\$ 208.54	\$ 231.71	\$ 253.12	
Total Expenditure			\$ 1,223,773,659	\$ 1,606,853,308	\$ 2,037,185,372	\$ 2,479,181,661	\$ 2,812,884,089	\$ 10,159,878,089
ABD								
Eligible Member Months	2.80%	27	2,818,411	2,900,683	2,982,953	3,065,209	3,147,471	
Total Cost Per Eligible	6.46%	27	\$ 467.35	\$ 494.50	\$ 527.67	\$ 561.26	\$ 600.22	
Total Expenditure			\$ 1,317,171,507	\$ 1,434,401,795	\$ 1,574,017,477	\$ 1,720,379,240	\$ 1,889,180,077	\$ 7,935,150,097
LTC/Transitioned HCBS								
Eligible Member Months	8.07%	27	453,415	569,994	586,160	602,323	618,488	
Total Cost Per Eligible	1.69%	27	\$ 3,636.08	\$ 3,320.92	\$ 3,497.24	\$ 3,675.36	\$ 3,887.77	
Total Expenditure			\$ 1,648,656,118	\$ 1,892,901,908	\$ 2,049,939,004	\$ 2,213,758,454	\$ 2,404,541,664	\$ 10,209,797,148
CCW								
Eligible Member Months	2.80%	27	131,098	134,925	138,752	142,578	146,404	
Total Cost Per Eligible	5.14%	27	\$ 2,911.31	\$ 3,045.23	\$ 3,204.31	\$ 3,365.00	\$ 3,557.02	
Total Expenditure			\$ 381,667,468	\$ 410,878,060	\$ 444,604,457	\$ 479,774,959	\$ 520,763,200	\$ 2,237,688,144
Pre-Transitioned HCBS								
Eligible Member Months	0.00%	27	100,411	-	-	-	-	
Total Cost Per Eligible	0.00%	27	\$ 1,080.71	\$ -	\$ -	\$ -	\$ -	
Total Expenditure			\$ 108,515,470	\$ -	\$ -	\$ -	\$ -	\$ 108,515,470
GA Employable								
Eligible Member Months	7.90%	27	468,403	505,406	545,333	588,415	634,900	
Total Cost Per Eligible	3.71%	27	\$ 135.95	\$ 141.00	\$ 146.23	\$ 151.65	\$ 157.28	
Total Expenditure			\$ 63,681,135	\$ 71,261,157	\$ 79,743,437	\$ 89,235,370	\$ 99,857,137	\$ 403,778,236
GA Unemployable								
Eligible Member Months	7.90%	27	234,201	252,703	272,667	294,207	317,450	
Total Cost Per Eligible	3.71%	27	\$ 135.95	\$ 141.00	\$ 146.23	\$ 151.65	\$ 157.28	
Total Expenditure			\$ 31,840,567	\$ 35,630,579	\$ 39,871,719	\$ 44,617,685	\$ 49,928,568	\$ 201,889,118
Supports Waiver								
Eligible Member Months	38.03%	27	15,120	26,184	45,360	49,896	54,886	
Total Cost Per Eligible	5.02%	27	\$ 1,611.71	\$ 1,684.23	\$ 1,770.13	\$ 1,856.86	\$ 1,960.85	
Total Expenditure			\$ 24,368,983	\$ 44,099,930	\$ 80,292,998	\$ 92,650,090	\$ 107,622,344	\$ 349,034,346
MI/DD								
Eligible Member Months	2.80%	27	2,272	2,338	2,404	2,470	2,537	
Total Cost Per Eligible	5.02%	27	\$ 5,782.25	\$ 6,042.45	\$ 6,350.62	\$ 6,661.80	\$ 7,034.86	
Total Expenditure			\$ 13,134,546	\$ 14,126,264	\$ 15,267,787	\$ 16,457,555	\$ 17,845,588	\$ 76,831,741
Children with PDD								
Eligible Member Months	2.80%	27	2,400	2,470	2,540	2,610	2,680	
Total Cost Per Eligible	5.90%	27	\$ 1,616.92	\$ 1,702.55	\$ 1,806.06	\$ 1,910.78	\$ 2,033.59	
Total Expenditure			\$ 3,880,609	\$ 4,205,388	\$ 4,587,586	\$ 4,987,449	\$ 5,450,458	\$ 23,111,490
Children with SED								
Eligible Member Months	3.40%	27	81,619	84,539	87,455	90,373	93,291	
Total Cost Per Eligible	2.65%	27	\$ 255.84	\$ 264.05	\$ 271.54	\$ 278.24	\$ 284.09	
Total Expenditure			\$ 20,881,319	\$ 22,322,130	\$ 23,747,569	\$ 25,145,121	\$ 26,502,958	\$ 118,599,097
MATI								
Eligible Member Months	3.40%	27	58,025	60,100	62,174	64,248	66,322	
Total Cost Per Eligible	6.14%	27	\$ 210.62	\$ 225.16	\$ 239.53	\$ 253.63	\$ 267.33	
Total Expenditure			\$ 12,221,367	\$ 13,531,956	\$ 14,892,796	\$ 16,295,345	\$ 17,729,766	\$ 74,671,230
DSH								
Total Allotment			644,435,620	644,435,620	644,435,620	644,435,620	644,435,620	\$ 3,222,178,100
Total Expenditure			\$ 5,494,228,369	\$ 6,194,648,096	\$ 7,008,585,821	\$ 7,826,918,550	\$ 8,596,741,469	\$ 35,121,122,306

Table 9.6c With Waiver Total Spend

ELIGIBILITY GROUP	TREND RATE	MONTHS OF AGING	DEMONSTRATION YEARS (DY)					TOTAL WW
			DY 01 (10/1/11 - 9/30/12)	DY 02 (10/1/12 - 9/30/13)	DY 03 (10/1/13 - 9/30/14)	DY 04 (10/1/14 - 9/30/15)	DY 05 (10/1/15 - 9/30/16)	
Title XIX								
Eligible Member Months	9.53%	27	7,720,846	8,724,989	9,768,677	10,699,516	11,112,778	
Total Cost Per Eligible	10.01%	27	\$ 309.23	\$ 343.51	\$ 381.37	\$ 417.45	\$ 455.38	
Total Expenditure			\$ 2,387,543,511	\$ 2,997,111,997	\$ 3,725,509,997	\$ 4,466,526,704	\$ 5,060,552,330	\$ 18,637,244,538
ABD								
Eligible Member Months	2.80%	27	2,818,411	2,900,683	2,982,953	3,065,209	3,147,471	
Total Cost Per Eligible	6.46%	27	\$ 467.35	\$ 494.50	\$ 527.67	\$ 561.26	\$ 600.22	
Total Expenditure			\$ 1,317,171,507	\$ 1,434,401,795	\$ 1,574,017,477	\$ 1,720,379,240	\$ 1,889,180,077	\$ 15,729,819,277
LTC/Transitioned HCBS								
Eligible Member Months	8.07%	27	453,415	569,994	586,160	602,323	618,488	
Total Cost Per Eligible	1.69%	27	\$ 3,636.08	\$ 3,320.92	\$ 3,497.24	\$ 3,675.36	\$ 3,887.77	
Total Expenditure			\$ 1,648,656,118	\$ 1,892,901,908	\$ 2,049,939,004	\$ 2,213,758,454	\$ 2,404,541,664	\$ 19,819,594,295
CCW								
Eligible Member Months	2.80%	27	131,098	134,925	138,752	142,578	146,404	
Total Cost Per Eligible	5.14%	27	\$ 2,911.31	\$ 3,045.23	\$ 3,204.31	\$ 3,365.00	\$ 3,557.02	
Total Expenditure			\$ 381,667,468	\$ 410,878,060	\$ 444,604,457	\$ 479,774,959	\$ 520,763,200	\$ 4,464,784,901
Pre-Transitioned HCBS								
Eligible Member Months	0.00%	27	100,411	-	-	-	-	
Total Cost Per Eligible	0.00%	27	\$ 1,080.71	\$ -	\$ -	\$ -	\$ -	
Total Expenditure			\$ 108,515,470	\$ -	\$ -	\$ -	\$ -	\$ 217,030,940
GA Employable								
Eligible Member Months	7.90%	27	468,403	505,406	545,333	588,415	634,900	
Total Cost Per Eligible	3.71%	27	\$ 135.95	\$ 141.00	\$ 146.23	\$ 151.65	\$ 157.28	
Total Expenditure			\$ 63,681,135	\$ 71,261,157	\$ 79,743,437	\$ 89,235,370	\$ 99,857,137	\$ 807,556,472
GA Unemployable								
Eligible Member Months	7.90%	27	234,201	252,703	272,667	294,207	317,450	
Total Cost Per Eligible	3.71%	27	\$ 135.95	\$ 141.00	\$ 146.23	\$ 151.65	\$ 157.28	
Total Expenditure			\$ 31,840,567	\$ 35,630,579	\$ 39,871,719	\$ 44,617,685	\$ 49,928,568	\$ 403,778,236
Supports Waiver								
Eligible Member Months	38.03%	27	15,120	26,184	45,360	49,896	54,886	
Total Cost Per Eligible	5.02%	27	\$ 1,611.71	\$ 1,684.23	\$ 1,770.13	\$ 1,856.86	\$ 1,960.85	
Total Expenditure			\$ 24,368,983	\$ 44,099,930	\$ 80,292,998	\$ 92,650,090	\$ 107,622,344	\$ 698,068,691
MVDD								
Eligible Member Months	2.80%	27	2,272	2,338	2,404	2,470	2,537	
Total Cost Per Eligible	5.02%	27	\$ 5,782.25	\$ 6,042.45	\$ 6,350.62	\$ 6,661.80	\$ 7,034.86	
Total Expenditure			\$ 13,134,546	\$ 14,126,264	\$ 15,267,787	\$ 16,457,555	\$ 17,845,588	\$ 153,663,482
Children with PDD								
Eligible Member Months	2.80%	27	2,400	2,470	2,540	2,610	2,680	
Total Cost Per Eligible	5.90%	27	\$ 1,616.92	\$ 1,702.55	\$ 1,806.06	\$ 1,910.78	\$ 2,033.59	
Total Expenditure			\$ 3,880,609	\$ 4,205,388	\$ 4,587,586	\$ 4,987,449	\$ 5,450,458	\$ 46,175,160
Children with SED								
Eligible Member Months	3.40%	27	81,619	84,539	87,455	90,373	93,291	
Total Cost Per Eligible	2.65%	27	\$ 255.84	\$ 264.05	\$ 271.54	\$ 278.24	\$ 284.09	
Total Expenditure			\$ 20,881,319	\$ 22,322,130	\$ 23,747,569	\$ 25,145,121	\$ 26,502,958	\$ 237,198,195
MATI								
Eligible Member Months	3.40%	27	58,025	60,100	62,174	64,248	66,322	
Total Cost Per Eligible	6.14%	27	\$ 210.62	\$ 225.16	\$ 239.53	\$ 253.63	\$ 267.33	
Total Expenditure			\$ 12,221,367	\$ 13,531,956	\$ 14,892,796	\$ 16,295,345	\$ 17,729,766	\$ 149,342,460
DSH								
Total Allotment			644,435,620	644,435,620	644,435,620	644,435,620	644,435,620	\$ 3,222,178,100
FQHC								
Total Expenditure			41,800,000	41,800,000	41,800,000	41,800,000	41,800,000	\$ 209,000,000
Adults w/o Dependent Children								
Eligible Member Months	-5.28%	27	14,422	13,124	12,336	11,966	11,607	
Total Cost Per Eligible	12.58%	27	\$ 156.52	\$ 175.50	\$ 199.02	\$ 224.28	\$ 251.41	
Total Expenditure			\$ 2,257,255	\$ 2,303,256	\$ 2,455,164	\$ 2,683,762	\$ 2,918,156	\$ 12,617,592
Total Expenditure			\$ 10,896,492,976	\$ 12,086,718,871	\$ 13,561,201,075	\$ 15,027,631,046	\$ 16,457,186,471	\$ 68,030,230,439

Table 9.6d With Waiver Federal Share

ELIGIBILITY GROUP	TREND RATE	MONTHS OF AGING	DEMONSTRATION YEARS (DY)					TOTAL WW
			DY 01 (10/1/11 - 9/30/12)	DY 02 (10/1/12 - 9/30/13)	DY 03 (10/1/13 - 9/30/14)	DY 04 (10/1/14 - 9/30/15)	DY 05 (10/1/15 - 9/30/16)	
Title XIX								
Eligible Member Months	9.53%	27	7,720,846	8,724,989	9,768,677	10,699,516	11,112,778	
Total Cost Per Eligible	12.24%	27	\$ 155.63	\$ 179.76	\$ 204.64	\$ 227.66	\$ 248.29	
Total Expenditure			\$ 1,201,567,895	\$ 1,568,376,309	\$ 1,999,094,033	\$ 2,435,826,525	\$ 2,759,161,660	\$ 9,964,026,421
ABD								
Eligible Member Months	2.80%	27	2,818,411	2,900,683	2,982,953	3,065,209	3,147,471	
Total Cost Per Eligible	6.87%	27	\$ 459.18	\$ 484.16	\$ 522.60	\$ 559.85	\$ 600.93	
Total Expenditure			\$ 1,294,162,902	\$ 1,404,383,494	\$ 1,558,894,563	\$ 1,716,049,767	\$ 1,891,418,912	\$ 7,864,909,639
LTC/Transitioned HCBS								
Eligible Member Months	8.07%	27	453,415	569,994	586,160	602,323	618,488	
Total Cost Per Eligible	1.69%	27	\$ 3,614.03	\$ 3,259.51	\$ 3,394.87	\$ 3,534.24	\$ 3,709.92	
Total Expenditure			\$ 1,638,656,118	\$ 1,857,901,908	\$ 1,989,939,004	\$ 2,128,758,454	\$ 2,294,541,664	\$ 9,909,797,148
CCW								
Eligible Member Months	2.80%	27	131,098	134,925	138,752	142,578	146,404	
Total Cost Per Eligible	5.13%	27	\$ 2,873.17	\$ 3,045.06	\$ 3,203.92	\$ 3,364.37	\$ 3,556.15	
Total Expenditure			\$ 376,667,468	\$ 410,855,228	\$ 444,549,337	\$ 479,685,100	\$ 520,635,318	\$ 2,232,392,450
Pre-Transitioned HCBS								
Eligible Member Months	0.00%	27	100,411	-	-	-	-	
Total Cost Per Eligible	0.00%	27	\$ 1,080.71	\$ -	\$ -	\$ -	\$ -	
Total Expenditure			\$ 108,515,470	\$ -	\$ -	\$ -	\$ -	\$ 108,515,470
GA Employable								
Eligible Member Months	7.90%	27	468,403	505,406	545,333	588,415	634,900	
Total Cost Per Eligible	3.71%	27	\$ 135.95	\$ 141.00	\$ 146.23	\$ 151.65	\$ 157.28	
Total Expenditure			\$ 63,681,135	\$ 71,261,157	\$ 79,743,437	\$ 89,235,370	\$ 99,857,137	\$ 403,778,236
GA Unemployable								
Eligible Member Months	7.90%	27	234,201	252,703	272,667	294,207	317,450	
Total Cost Per Eligible	3.71%	27	\$ 135.95	\$ 141.00	\$ 146.23	\$ 151.65	\$ 157.28	
Total Expenditure			\$ 31,840,567	\$ 35,630,579	\$ 39,871,719	\$ 44,617,685	\$ 49,928,568	\$ 210,889,118
Supports Waiver								
Eligible Member Months	38.03%	27	15,120	26,184	45,360	49,896	54,886	
Total Cost Per Eligible	5.02%	27	\$ 1,611.71	\$ 1,684.23	\$ 1,770.13	\$ 1,856.86	\$ 1,960.85	
Total Expenditure			\$ 24,368,983	\$ 44,099,930	\$ 80,292,998	\$ 92,650,090	\$ 107,622,344	\$ 349,034,346
M/DD								
Eligible Member Months	2.80%	27	2,272	2,338	2,404	2,470	2,537	
Total Cost Per Eligible	5.02%	27	\$ 5,782.25	\$ 6,042.45	\$ 6,350.62	\$ 6,661.80	\$ 7,034.86	
Total Expenditure			\$ 13,134,546	\$ 14,126,264	\$ 15,267,787	\$ 16,457,555	\$ 17,845,588	\$ 76,831,741
Children with PDD								
Eligible Member Months	2.80%	27	2,400	2,470	2,540	2,610	2,680	
Total Cost Per Eligible	5.90%	27	\$ 1,616.92	\$ 1,702.55	\$ 1,806.06	\$ 1,910.78	\$ 2,033.59	
Total Expenditure			\$ 3,880,609	\$ 4,205,388	\$ 4,587,586	\$ 4,987,449	\$ 5,450,458	\$ 23,087,580
Children with SED								
Eligible Member Months	3.40%	27	81,619	84,539	87,455	90,373	93,291	
Total Cost Per Eligible	2.65%	27	\$ 255.84	\$ 264.05	\$ 271.54	\$ 278.24	\$ 284.09	
Total Expenditure			\$ 20,881,319	\$ 22,322,130	\$ 23,747,569	\$ 25,145,121	\$ 26,502,958	\$ 118,599,097
MATI								
Eligible Member Months	3.40%	27	58,025	60,100	62,174	64,248	66,322	
Total Cost Per Eligible	6.14%	27	\$ 210.62	\$ 225.16	\$ 239.53	\$ 253.63	\$ 267.33	
Total Expenditure			\$ 12,221,367	\$ 13,531,956	\$ 14,892,796	\$ 16,295,345	\$ 17,729,766	\$ 74,671,230
DSH								
Total Allotment			644,435,620	644,435,620	644,435,620	644,435,620	644,435,620	\$ 3,222,178,100
FQHC								
Total Expenditure			20,900,000	20,900,000	20,900,000	20,900,000	20,900,000	\$ 104,500,000
Adults w/o Dependent Children								
Eligible Member Months	-5.28%	27	14,422	13,124	12,336	11,966	11,607	
Total Cost Per Eligible	12.58%	27	\$ 78.26	\$ 87.75	\$ 99.51	\$ 112.14	\$ 125.70	
Total Expenditure			\$ 1,128,627	\$ 1,151,628	\$ 1,227,582	\$ 1,341,881	\$ 1,459,078	\$ 6,308,796
Total Expenditure			\$ 5,456,042,628	\$ 6,113,179,746	\$ 6,917,439,572	\$ 7,716,378,696	\$ 8,457,478,730	\$ 34,660,519,372

		State Fiscal Year				
		2012	2013	2014*	2015*	2016*
Section 1 Initial Projection	Enrollment	135,486	148,557	161,613	174,672	187,731
(Based on March 2011 Data)	State \$	\$150,225,639	\$170,328,581	\$233,406,837	\$305,436,661	\$338,954,565
	Fed \$	\$278,990,473	\$316,324,507	\$313,759,896	\$305,436,661	\$338,954,565
	Total \$	\$429,216,112	\$486,653,088	\$547,166,733	\$610,873,321	\$677,909,129

		2012**	2013	2014***	2015	2016
Section 2 Revised FMAP	Enrollment	135,486	148,557	161,613	174,672	187,731
(Included in FY12 Approp)	State \$	\$117,631,304	\$121,663,272	\$108,859,363	\$91,630,998	\$101,686,369
	Fed \$	\$311,584,808	\$364,989,816	\$438,307,370	\$519,242,323	\$576,222,760
	Total \$	\$429,216,112	\$486,653,088	\$547,166,733	\$610,873,321	\$677,909,129
Revised FMAP vs Initial	Enrollment Chg	0	0	0	0	0
	Cumulative Chg	0	0	0	0	0
	State Savings	\$32,594,335	\$48,665,309	\$124,547,474	\$213,805,662	\$237,268,195
	Cumulative Savings	\$32,594,335	\$81,259,644	\$205,807,118	\$419,612,780	\$656,880,975

Enrollments = FY End

Data Based on DMAHS Monthly Public Stat Rpts

Capitation + Other Expenses Only

Section 1 FY12/FY13 current 65/35 (Fed/State) match

* - Beginning Jan 2014 Assume 50/50 (Fed/State) match and continues through FY2016

Section 2 - Assumes No Enrollment Freeze

** - Oct 2011: FMAP chgs from 65/35 (Fed/State) to 75/25 (Fed/State) through Jan 2014

*** - Jan 2014: FMAP chgs from 75/25 (Fed/State) to 85/15 (Fed/State) through 2016

Impact of Jan 2014 Chg from 65/35 match to 50/50 match

Match at 65/35	SFY 2104
State \$	\$191,508,357

Fed \$	\$355,658,377
Total \$	\$547,166,733

Increased State Expense due to Match Chg to 50/50

State \$	\$41,898,480
Fed \$	(\$41,898,480)
Total \$	\$0

	SFY06 (7/1/05-6/30/06)	SFY07 (7/1/06-6/30/07)	SFY08 (7/1/07-6/30/08)	SFY09 (7/1/08-6/30/09)	SFY10 (7/1/09-6/30/10)	5-YEARS
Title XIX						
TOTAL EXPENDITURES						
Eligible Member Months	5,971,385	6,123,197	6,204,095	6,414,982	6,830,273	
Total Cost per Eligible	\$ 237.38	\$ 263.72	\$ 274.64	\$ 275.22	\$ 277.25	
Total Expenditure	\$ 1,417,516,967	\$ 1,614,812,695	\$ 1,703,864,445	\$ 1,765,561,525	\$ 1,893,718,838	\$ 8,395,474,470
						<u>5-YEAR</u>
TREND RATES			<u>ANNUAL CHANGE</u>			<u>AVERAGE</u>
Eligible Member Months		2.5%	1.3%	3.4%	6.5%	3.4%
Total Cost per Eligible		11.1%	4.1%	0.2%	0.7%	4.0%
Total Expenditure		13.9%	5.5%	3.6%	7.3%	7.5%
ABD						
TOTAL EXPENDITURES						
Eligible Member Months	2,428,242	2,468,046	2,506,003	2,584,377	2,649,687	
Total Cost per Eligible	\$ 892.23	\$ 832.83	\$ 846.96	\$ 867.12	\$ 874.95	
Total Expenditure	\$ 2,166,548,881	\$ 2,055,458,605	\$ 2,122,476,811	\$ 2,240,963,223	\$ 2,318,337,274	\$ 10,903,784,794
						<u>5-YEAR</u>
TREND RATES			<u>ANNUAL CHANGE</u>			<u>AVERAGE</u>
Eligible Member Months		1.6%	1.5%	3.1%	2.5%	2.2%
Total Cost per Eligible		-6.7%	1.7%	2.4%	0.9%	-0.5%
Total Expenditure		-5.1%	3.3%	5.6%	3.5%	1.7%
LTC						
TOTAL EXPENDITURES						
Eligible Member Months	411,322	407,890	402,348	398,826	394,805	
Total Cost per Eligible	\$ 6,576.70	\$ 6,633.84	\$ 7,007.91	\$ 7,291.14	\$ 7,188.65	
Total Expenditure	\$ 2,705,143,095	\$ 2,705,876,907	\$ 2,819,617,102	\$ 2,907,895,578	\$ 2,838,113,657	\$ 13,976,646,339
						<u>5-YEAR</u>
TREND RATES			<u>ANNUAL CHANGE</u>			<u>AVERAGE</u>
Eligible Member Months		-0.8%	-1.4%	-0.9%	-1.0%	-1.0%
Total Cost per Eligible		0.9%	5.6%	4.0%	-1.4%	2.2%
Total Expenditure		0.0%	4.2%	3.1%	-2.4%	1.2%
Community Care Waiver						
TOTAL EXPENDITURES						
Eligible Member Months	116,835	121,080	123,923	123,988	123,250	
Total Cost per Eligible	\$ 4,885.90	\$ 5,019.07	\$ 5,054.92	\$ 5,341.44	\$ 5,450.45	
Total Expenditure	\$ 570,843,910	\$ 607,709,431	\$ 626,421,270	\$ 662,275,006	\$ 671,768,188	\$ 3,139,017,803
						<u>5-YEAR</u>
TREND RATES			<u>ANNUAL CHANGE</u>			<u>AVERAGE</u>
Eligible Member Months		3.6%	2.3%	0.1%	-0.6%	1.3%
Total Cost per Eligible		2.7%	0.7%	5.7%	2.0%	2.8%
Total Expenditure		6.5%	3.1%	5.7%	1.4%	4.2%
HCBS Waivers						
TOTAL EXPENDITURES						
Eligible Member Months	97,275	99,615	102,986	111,462	125,867	
Total Cost per Eligible	\$ 1,897.04	\$ 1,808.97	\$ 1,899.32	\$ 1,983.84	\$ 2,023.27	
Total Expenditure	\$ 184,534,841	\$ 180,201,033	\$ 195,603,836	\$ 221,122,553	\$ 254,662,315	\$ 1,036,124,579
						<u>5-YEAR</u>
TREND RATES			<u>ANNUAL CHANGE</u>			<u>AVERAGE</u>
Eligible Member Months		2.4%	3.4%	8.2%	12.9%	6.7%
Total Cost per Eligible		-4.6%	5.0%	4.4%	2.0%	1.6%
Total Expenditure		-2.3%	8.5%	13.0%	15.2%	8.4%

	SFY06 (7/1/05-6/30/06)	SFY07 (7/1/06-6/30/07)	SFY08 (7/1/07-6/30/08)	SFY09 (7/1/08-6/30/09)	SFY10 (7/1/09-6/30/10)	5-YEARS
Title XIX						
TOTAL EXPENDITURES						
Eligible Member Months	5,971,385	6,123,197	6,204,095	6,414,982	6,830,273	
Total Cost per Eligible	\$ 118.69	\$ 131.86	\$ 137.32	\$ 157.67	\$ 170.76	
Total Expenditure	\$ 708,758,483	\$ 807,406,348	\$ 851,932,222	\$ 1,011,446,059	\$ 1,166,341,433	\$ 4,545,884,545
						<u>5-YEAR</u>
TREND RATES			<u>ANNUAL CHANGE</u>			<u>AVERAGE</u>
Eligible Member Months		2.5%	1.3%	3.4%	6.5%	3.4%
Total Cost per Eligible		11.1%	4.1%	0.2%	0.7%	4.0%
Total Expenditure		13.9%	5.5%	3.6%	7.3%	7.5%
ABD						
TOTAL EXPENDITURES						
Eligible Member Months	2,428,242	2,468,046	2,506,003	2,584,377	2,649,687	
Total Cost per Eligible	\$ 446.11	\$ 416.41	\$ 423.48	\$ 496.75	\$ 538.88	
Total Expenditure	\$ 1,083,274,440	\$ 1,027,729,302	\$ 1,061,238,406	\$ 1,283,791,807	\$ 1,427,863,927	\$ 5,883,897,882
						<u>5-YEAR</u>
TREND RATES			<u>ANNUAL CHANGE</u>			<u>AVERAGE</u>
Eligible Member Months		1.6%	1.5%	3.1%	2.5%	2.2%
Total Cost per Eligible		-6.7%	1.7%	2.4%	0.9%	-0.5%
Total Expenditure		-5.1%	3.3%	5.6%	3.5%	1.7%
LTC						
TOTAL EXPENDITURES						
Eligible Member Months	411,322	407,890	402,348	398,826	394,805	
Total Cost per Eligible	\$ 3,288.35	\$ 3,316.92	\$ 3,503.95	\$ 4,176.91	\$ 4,427.49	
Total Expenditure	\$ 1,352,571,547	\$ 1,352,938,453	\$ 1,409,808,551	\$ 1,665,860,679	\$ 1,747,994,201	\$ 7,529,173,433
						<u>5-YEAR</u>
TREND RATES			<u>ANNUAL CHANGE</u>			<u>AVERAGE</u>
Eligible Member Months		-0.8%	-1.4%	-0.9%	-1.0%	-1.0%
Total Cost per Eligible		0.9%	5.6%	4.0%	-1.4%	2.2%
Total Expenditure		0.0%	4.2%	3.1%	-2.4%	1.2%
Community Care Waiver						
TOTAL EXPENDITURES						
Eligible Member Months	116,835	121,080	123,923	123,988	123,250	
Total Cost per Eligible	\$ 2,442.95	\$ 2,509.54	\$ 2,527.46	\$ 3,059.98	\$ 3,356.93	
Total Expenditure	\$ 285,421,955	\$ 303,854,715	\$ 313,210,635	\$ 379,400,794	\$ 413,742,027	\$ 1,695,630,126
						<u>5-YEAR</u>
TREND RATES			<u>ANNUAL CHANGE</u>			<u>AVERAGE</u>
Eligible Member Months		3.6%	2.3%	0.1%	-0.6%	1.3%
Total Cost per Eligible		2.7%	0.7%	5.7%	2.0%	2.8%
Total Expenditure		6.5%	3.1%	5.7%	1.4%	4.2%
HCBS Waivers						
TOTAL EXPENDITURES						
Eligible Member Months	97,275	99,615	102,986	111,462	125,867	
Total Cost per Eligible	\$ 948.52	\$ 904.49	\$ 949.66	\$ 1,136.49	\$ 1,246.13	
Total Expenditure	\$ 92,267,421	\$ 90,100,517	\$ 97,801,918	\$ 126,675,583	\$ 156,846,520	\$ 563,691,958
						<u>5-YEAR</u>
TREND RATES			<u>ANNUAL CHANGE</u>			<u>AVERAGE</u>
Eligible Member Months		2.4%	3.4%	8.2%	12.9%	6.7%
Total Cost per Eligible		-4.6%	5.0%	4.4%	2.0%	1.6%
Total Expenditure		-2.3%	8.5%	13.0%	15.2%	8.4%

	Previous Federal Fiscal Year 2010	Previous Federal Fiscal Year 2011	Federal Fiscal Year 2012	Federal Fiscal Year 2013	Federal Fiscal Year 2014	Federal Fiscal Year 2015	Federal Fiscal Year 2016	
3	State's Allotment	\$ 634,744,914	\$ 592,187,888	\$ 618,026,013	\$ 618,026,013	\$ 618,026,013	\$ 618,026,013	
4	Funds Carried Over From Prior Year(s)	\$ 62,893,769	\$ 135,260,888	\$ 85,016,047	\$ (0)	\$ 40	\$ 97,264,565	
5	SUBTOTAL (Allotment + Funds Carried Over)	\$ 697,638,683	\$ 727,448,776	\$ 703,042,060	\$ 618,026,013	\$ 618,026,053	\$ 715,290,578	
6	Reallocated Funds (Redistributed or Retained that are Currently Available)	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	
7	TOTAL (Subtotal + Reallocated funds)	\$ 697,638,683	\$ 727,448,776	\$ 703,042,060	\$ 618,026,013	\$ 618,026,053	\$ 715,290,578	
8	State's Enhanced FMAP Rate	65.00%	65.00%	65.00%	65.00%	65.00%	65.00%	
9	Enhanced FMAP Rate for 0-133% FPL Family Care Adults			75.00%	75.00%	75.00%		
10	COST PROJECTIONS OF APPROVED SCHIP PLAN							
11	Benefit Costs							
12	Insurance payments							
13	Total Managed Care	##### #	##### #	##### #	##### #	##### #	##### #	
14	per member/per month rate	\$174	\$182	\$194	\$207	\$219	\$231	
15	# of eligibles (MM)	##### #	938,729	995,857	1,052,874	1,109,923	1,166,965	
16	Total Fee for Service	##### #	\$134	\$142	\$152	\$162	\$172	
17	per member/per month rate	##### #	\$134	\$142	\$152	\$162	\$172	
18	# of eligibles (MM)	##### #	95,026	102,706	108,957	115,195	121,437	
19	Total Benefit Costs (Managed Care + Fee for Service)	\$ 135,774,135	\$ 163,900,662	\$ 185,350,167	\$ 210,197,499	\$ 236,423,378	\$ 263,901,264	
20	(Offsetting beneficiary cost sharing payments) (negative number)							
21	Net Benefit Costs	\$ 135,774,135	\$ 163,900,662	\$ 185,350,167	\$ 210,197,499	\$ 236,423,378	\$ 263,901,264	
22								
23	Administration Costs							
24	Personnel							
25	General administration	##### #	##### #	##### #	##### #	##### #	##### #	
26	Contractors/Brokers							
27	Claims Processing							
28	Outreach/marketing costs							
29	Other (specify)							
30	Total Administration Costs	\$ 11,374,314	\$ 18,211,185	\$ 20,594,463	\$ 23,355,278	\$ 26,269,264	\$ 29,322,363	
31	10% Administrative Cap	\$ 15,086,015	\$ 18,211,185	\$ 20,594,463	\$ 23,355,278	\$ 26,269,264	\$ 29,322,363	
32								
33	Federal Title XXI Share	\$ 95,646,492	\$ 118,372,700	\$ 133,864,010	\$ 151,809,305	\$ 170,750,217	\$ 190,595,357	
34	State Share	\$ 51,501,958	\$ 63,739,146	\$ 72,080,620	\$ 81,743,472	\$ 91,942,425	\$ 102,628,270	
35	TOTAL COSTS OF APPROVED SCHIP PLAN	\$ 147,148,450	\$ 182,111,846	\$ 205,944,630	\$ 233,552,777	\$ 262,692,642	\$ 293,223,627	
36								
37	COST PROJECTIONS FOR DEMONSTRATION PROPOSAL							
38	Benefit Costs for Demonstration Population #1: Family Care Child 134%-350% FPL							
39	Insurance payments							
40	Total Managed Care	\$ 201,969,357	\$ 227,684,774	\$ 258,207,321	\$ 290,423,278	\$ 324,177,207	\$ 359,242,724	
41	per member/per month rate	\$173	\$180	\$193	\$205	\$217	\$229	
42	# of eligibles (MM)	##### #	1,264,238	1,341,175	1,417,963	1,494,794	1,571,615	
43	Total Fee for Service	\$ 3,017,786	\$ 3,459,769	\$ 3,923,573	\$ 4,413,108	\$ 4,926,014	\$ 5,458,849	
44	per member/per month rate	\$256	\$271	\$290	\$308	\$326	\$344	
45	# of eligibles (MM)	11,809	12,764	13,541	14,316	15,092	15,867	
46	Total Benefit Costs (Managed Care + Fee for Service)	\$ 166,105,079	\$ 204,987,143	\$ 231,144,543	\$ 262,130,893	\$ 294,836,386	\$ 329,103,221	
47	Benefit Costs for Demonstration Population #2: Family Care Adult							
48	Insurance payments							
49	Total Managed Care	\$ 507,717,652	\$ 485,642,181	\$ 327,923,485	\$ 164,941,101	\$ -	\$ -	
50	per member/per month rate	\$279	\$294	\$315	\$337			
51	# of eligibles (MM)	##### #	1,650,926	1,041,838	490,158			
52	Total Fee for Service	\$ 12,916,784	\$ 13,382,908	\$ 15,319,559	\$ 4,271,048	\$ -	\$ -	
53	per member/per month rate	\$120	\$129	\$138	\$147			
54	# of eligibles (MM)	##### #	103,817	111,066	28,963			
55	Total Benefit Costs (Managed Care + Fee for Service)	\$ 496,439,230	\$ 520,634,436	\$ 499,025,090	\$ 343,243,044	\$ 169,212,148	\$ -	
56								
57	Total Benefit Costs (For All Demonstration Populations)	\$ 662,544,309	\$ 725,621,579	\$ 730,169,632	\$ 605,373,937	\$ 464,048,535	\$ 329,103,221	
58	(Offsetting beneficiary cost sharing payments) (negative number)							
59	Net Benefit Costs	\$ 662,544,309	\$ 725,621,579	\$ 730,169,632	\$ 605,373,937	\$ 464,048,535	\$ 329,103,221	
60								
61	Administration Costs							
62	Personnel							
63	General administration	\$ 55,503,849	\$ 80,624,620	\$ 81,129,959	\$ 67,263,771	\$ 51,560,948	\$ 36,567,025	
64	Contractors/Brokers							
65	Claims Processing							
66	Outreach/marketing costs							
67	Other (specify)							
68	Total Administration Costs	\$ 55,503,849	\$ 80,624,620	\$ 81,129,959	\$ 67,263,771	\$ 51,560,948	\$ 36,567,025	
69	10% Administrative Cap	\$ 73,616,034	\$ 80,624,620	\$ 81,129,959	\$ 67,263,771	\$ 51,560,948	\$ 36,567,025	
70								
71	Federal Title XXI Share	\$ 466,731,303	\$ 524,060,029	\$ 569,178,050	\$ 466,216,668	\$ 350,011,270	\$ 237,685,660	
72	State Title XXI Share	\$ 251,316,855	\$ 282,186,170	\$ 242,121,541	\$ 206,421,040	\$ 165,598,213	\$ 127,984,585	
73	TOTAL COSTS FOR DEMONSTRATION	\$ 718,048,158	\$ 806,246,199	\$ 811,299,592	\$ 672,637,708	\$ 515,609,483	\$ 365,670,245	
74								
75	TOTAL TITLE XXI PROGRAM COSTS (State Plan + Demonstration)	\$ 865,196,608	\$ 988,358,045	\$ 1,017,244,222	\$ 906,190,485	\$ 778,302,125	\$ 658,893,872	
76	Federal Title XXI Share	\$ 562,377,795	\$ 642,432,729	\$ 703,042,060	\$ 618,025,973	\$ 520,761,487	\$ 428,281,017	
77	State Title XXI Share	\$ 302,818,813	\$ 345,925,316	\$ 314,202,161	\$ 288,164,512	\$ 257,540,638	\$ 230,612,855	
78								
79	Total Federal Title XXI Funding Currently Available (Allotment + Reallocated Funds)	\$ 697,638,683	\$ 727,448,776	\$ 703,042,060	\$ 618,026,013	\$ 618,026,053	\$ 715,290,578	
80	Total Federal Title XXI Program Costs (State Plan + Demonstration)	\$ 562,377,795	\$ 642,432,729	\$ 703,042,060	\$ 618,025,973	\$ 520,761,487	\$ 428,281,017	
81	Unused Title XXI Funds Expiring (Allotment or Reallocated)							
82	Remaining Title XXI Funds to be Carried Over (Equals Available Funding - Costs - Expiring Funds)	\$ 135,260,888	\$ 85,016,047	\$ (0)	\$ 40	\$ 97,264,565	\$ 287,009,561	
83								
84	Note: A Federal Fiscal Year (FFY) is October 1 through September 30.							
85								

Notes:

To maintain CHIP allotment neutrality, 106,011 Family Care Adult member months in FFY 2012 and 837,775 member months in FFY 2013 were moved out of CHIP Allotment Neutrality and into 1115 budget neutrality.

After January 1, 2014, the State will transition all Family Care Adults to Medicaid under the 1115 budget neutrality. NJ has reflected this adjustment by backing out all adults from the allotment neutrality calculations as of January 1, 2014.

Enhanced FMAP of 75% was applied to benefit costs for Family Care Adults (0-133% FPL portion of the population) for FFY12, FFY13 and the first quarter of FFY14. This resulted in an additional \$41.8M, \$29M and \$14.9M Federal Share for these time periods respectively.

ELIGIBILITY GROUP	TREND RATE	MONTHS OF AGING	DEMONSTRATION YEARS (DY)					TOTAL WOW
			DY 01 (10/1/11 - 9/30/12)	DY 02 (10/1/12 - 9/30/13)	DY 03 (10/1/13 - 9/30/14)	DY 04 (10/1/14 - 9/30/15)	DY 05 (10/1/15 - 9/30/16)	
Title XIX								
Eligible Member Months	9.53%	27	7,720,846	8,724,989	9,768,677	10,699,516	11,112,778	
Total Cost Per Eligible	10.23%	27	\$ 314.99	\$ 352.27	\$ 389.11	\$ 425.50	\$ 464.99	
Total Expenditure			\$ 2,431,955,038	\$ 3,073,585,207	\$ 3,801,051,623	\$ 4,552,595,926	\$ 5,167,356,138	\$ 19,026,543,932
ABD								
Eligible Member Months	2.80%	27	2,818,411	2,900,683	2,982,953	3,065,209	3,147,471	
Total Cost Per Eligible	6.46%	27	\$ 934.69	\$ 989.01	\$ 1,055.34	\$ 1,122.52	\$ 1,200.44	
Total Expenditure			\$ 2,634,343,015	\$ 2,868,803,590	\$ 3,148,034,953	\$ 3,440,758,481	\$ 3,778,360,154	\$ 15,870,300,194
LTC/Transitioned HCBS								
Eligible Member Months	8.07%	27	453,415	569,994	586,160	602,323	618,488	
Total Cost Per Eligible	1.69%	27	\$ 7,272.17	\$ 6,641.84	\$ 6,994.47	\$ 7,350.73	\$ 7,775.55	
Total Expenditure			\$ 3,297,312,236	\$ 3,785,803,816	\$ 4,099,878,007	\$ 4,427,516,908	\$ 4,809,083,329	\$ 20,419,594,295
CCW								
Eligible Member Months	2.80%	27	131,098	134,925	138,752	142,578	146,404	
Total Cost Per Eligible	5.14%	27	\$ 5,822.62	\$ 6,090.46	\$ 6,408.63	\$ 6,730.00	\$ 7,114.04	
Total Expenditure			\$ 763,334,936	\$ 821,756,120	\$ 889,208,915	\$ 959,549,918	\$ 1,041,526,399	\$ 4,475,376,288
Pre-Transitioned HCBS								
Eligible Member Months	0.00%	27	100,411	-	-	-	-	
Total Cost Per Eligible	0.00%	27	\$ 2,161.42	\$ -	\$ -	\$ -	\$ -	
Total Expenditure			\$ 217,030,940	\$ -	\$ -	\$ -	\$ -	\$ 217,030,940
GA Employable								
Eligible Member Months	7.90%	27	468,403	505,406	545,333	588,415	634,900	
Total Cost Per Eligible	3.71%	27	\$ 271.91	\$ 282.00	\$ 292.46	\$ 303.31	\$ 314.56	
Total Expenditure			\$ 127,362,269	\$ 142,522,315	\$ 159,486,874	\$ 178,470,740	\$ 199,714,273	\$ 807,556,472
GA Unemployable								
Eligible Member Months	7.90%	27	234,201	252,703	272,667	294,207	317,450	
Total Cost Per Eligible	3.71%	27	\$ 271.91	\$ 282.00	\$ 292.46	\$ 303.31	\$ 314.56	
Total Expenditure			\$ 63,681,135	\$ 71,261,157	\$ 79,743,437	\$ 89,235,370	\$ 99,857,137	\$ 403,778,236
Supports Waiver								
Eligible Member Months	38.03%	27	15,120	26,184	45,360	49,896	54,886	
Total Cost Per Eligible	5.02%	27	\$ 3,223.41	\$ 3,368.46	\$ 3,540.26	\$ 3,713.73	\$ 3,921.70	
Total Expenditure			\$ 48,737,967	\$ 88,199,860	\$ 160,585,995	\$ 185,300,180	\$ 215,244,689	\$ 698,068,691
M/DD								
Eligible Member Months	2.80%	27	2,272	2,338	2,404	2,470	2,537	
Total Cost Per Eligible	5.02%	27	\$ 11,564.51	\$ 12,084.91	\$ 12,701.24	\$ 13,323.60	\$ 14,069.72	
Total Expenditure			\$ 26,269,092	\$ 28,252,528	\$ 30,535,574	\$ 32,915,111	\$ 35,691,177	\$ 153,663,482
Children with PDD								
Eligible Member Months	2.80%	27	2,400	2,470	2,540	2,610	2,680	
Total Cost Per Eligible	5.90%	27	\$ 3,233.84	\$ 3,405.09	\$ 3,612.11	\$ 3,821.57	\$ 4,067.19	
Total Expenditure			\$ 7,761,218	\$ 8,410,776	\$ 9,175,173	\$ 9,974,897	\$ 10,900,916	\$ 46,222,980
Children with SED								
Eligible Member Months	3.40%	27	81,619	84,539	87,455	90,373	93,291	
Total Cost Per Eligible	2.65%	27	\$ 511.68	\$ 528.09	\$ 543.08	\$ 556.47	\$ 568.18	
Total Expenditure			\$ 41,762,639	\$ 44,644,261	\$ 47,495,138	\$ 50,290,242	\$ 53,005,915	\$ 237,198,195
MATI								
Eligible Member Months	3.40%	27	58,025	60,100	62,174	64,248	66,322	
Total Cost Per Eligible	6.14%	27	\$ 421.25	\$ 450.31	\$ 479.07	\$ 507.26	\$ 534.65	
Total Expenditure			\$ 24,442,733	\$ 27,063,913	\$ 29,785,592	\$ 32,590,691	\$ 35,459,531	\$ 149,342,460
DSH								
Total Allotment			1,288,871,240	1,288,871,240	1,288,871,240	1,288,871,240	1,288,871,240	\$ 6,444,356,200
Total Expenditure			\$ 10,972,864,458	\$ 12,249,174,784	\$ 13,743,852,521	\$ 15,248,069,704	\$ 16,735,070,897	\$ 68,949,032,365

ELIGIBILITY GROUP	TREND RATE	MONTHS OF AGING	DEMONSTRATION YEARS (DY)					TOTAL WOW
			DY 01 (10/1/11 - 9/30/12)	DY 02 (10/1/12 - 9/30/13)	DY 03 (10/1/13 - 9/30/14)	DY 04 (10/1/14 - 9/30/15)	DY 05 (10/1/15 - 9/30/16)	
Title XIX								
Eligible Member Months	9.53%	27	7,720,846	8,724,989	9,768,677	10,699,516	11,112,778	
Total Cost Per Eligible	12.41%	27	\$ 158.50	\$ 184.17	\$ 208.54	\$ 231.71	\$ 253.12	
Total Expenditure			\$ 1,223,773,659	\$ 1,606,853,308	\$ 2,037,185,372	\$ 2,479,181,661	\$ 2,812,884,089	\$ 10,159,878,089
ABD								
Eligible Member Months	2.80%	27	2,818,411	2,900,683	2,982,953	3,065,209	3,147,471	
Total Cost Per Eligible	6.46%	27	\$ 467.35	\$ 494.50	\$ 527.67	\$ 561.26	\$ 600.22	
Total Expenditure			\$ 1,317,171,507	\$ 1,434,401,795	\$ 1,574,017,477	\$ 1,720,379,240	\$ 1,889,180,077	\$ 7,935,150,097
LTC/Transitioned HCBS								
Eligible Member Months	8.07%	27	453,415	569,994	586,160	602,323	618,488	
Total Cost Per Eligible	1.69%	27	\$ 3,636.08	\$ 3,320.92	\$ 3,497.24	\$ 3,675.36	\$ 3,887.77	
Total Expenditure			\$ 1,648,656,118	\$ 1,892,901,908	\$ 2,049,939,004	\$ 2,213,758,454	\$ 2,404,541,664	\$ 10,209,797,148
CCW								
Eligible Member Months	2.80%	27	131,098	134,925	138,752	142,578	146,404	
Total Cost Per Eligible	5.14%	27	\$ 2,911.31	\$ 3,045.23	\$ 3,204.31	\$ 3,365.00	\$ 3,557.02	
Total Expenditure			\$ 381,667,468	\$ 410,878,060	\$ 444,604,457	\$ 479,774,959	\$ 520,763,200	\$ 2,237,688,144
Pre-Transitioned HCBS								
Eligible Member Months	0.00%	27	100,411	-	-	-	-	
Total Cost Per Eligible	0.00%	27	\$ 1,080.71	\$ -	\$ -	\$ -	\$ -	
Total Expenditure			\$ 108,515,470	\$ -	\$ -	\$ -	\$ -	\$ 108,515,470
GA Employable								
Eligible Member Months	7.90%	27	468,403	505,406	545,333	588,415	634,900	
Total Cost Per Eligible	3.71%	27	\$ 135.95	\$ 141.00	\$ 146.23	\$ 151.65	\$ 157.28	
Total Expenditure			\$ 63,681,135	\$ 71,261,157	\$ 79,743,437	\$ 89,235,370	\$ 99,857,137	\$ 403,778,236
GA Unemployable								
Eligible Member Months	7.90%	27	234,201	252,703	272,667	294,207	317,450	
Total Cost Per Eligible	3.71%	27	\$ 135.95	\$ 141.00	\$ 146.23	\$ 151.65	\$ 157.28	
Total Expenditure			\$ 31,840,567	\$ 35,630,579	\$ 39,871,719	\$ 44,617,685	\$ 49,928,568	\$ 201,889,118
Supports Waiver								
Eligible Member Months	38.03%	27	15,120	26,184	45,360	49,896	54,886	
Total Cost Per Eligible	5.02%	27	\$ 1,611.71	\$ 1,684.23	\$ 1,770.13	\$ 1,856.86	\$ 1,960.85	
Total Expenditure			\$ 24,368,983	\$ 44,099,930	\$ 80,292,998	\$ 92,650,090	\$ 107,622,344	\$ 349,034,346
M/DD								
Eligible Member Months	2.80%	27	2,272	2,338	2,404	2,470	2,537	
Total Cost Per Eligible	5.02%	27	\$ 5,782.25	\$ 6,042.45	\$ 6,350.62	\$ 6,661.80	\$ 7,034.86	
Total Expenditure			\$ 13,134,546	\$ 14,126,264	\$ 15,267,787	\$ 16,457,555	\$ 17,845,588	\$ 76,831,741
Children with PDD								
Eligible Member Months	2.80%	27	2,400	2,470	2,540	2,610	2,680	
Total Cost Per Eligible	5.90%	27	\$ 1,616.92	\$ 1,702.55	\$ 1,806.06	\$ 1,910.78	\$ 2,033.59	
Total Expenditure			\$ 3,880,609	\$ 4,205,388	\$ 4,587,586	\$ 4,987,449	\$ 5,450,458	\$ 23,111,490
Children with SED								
Eligible Member Months	3.40%	27	81,619	84,539	87,455	90,373	93,291	
Total Cost Per Eligible	2.65%	27	\$ 255.84	\$ 264.05	\$ 271.54	\$ 278.24	\$ 284.09	
Total Expenditure			\$ 20,881,319	\$ 22,322,130	\$ 23,747,569	\$ 25,145,121	\$ 26,502,958	\$ 118,599,097
MATI								
Eligible Member Months	3.40%	27	58,025	60,100	62,174	64,248	66,322	
Total Cost Per Eligible	6.14%	27	\$ 210.62	\$ 225.16	\$ 239.53	\$ 253.63	\$ 267.33	
Total Expenditure			\$ 12,221,367	\$ 13,531,956	\$ 14,892,796	\$ 16,295,345	\$ 17,729,766	\$ 74,671,230
DSH								
Total Allotment			644,435,620	644,435,620	644,435,620	644,435,620	644,435,620	\$ 3,222,178,100
Total Expenditure			\$ 5,494,228,369	\$ 6,194,648,096	\$ 7,008,585,821	\$ 7,826,918,550	\$ 8,596,741,469	\$ 35,121,122,306

ELIGIBILITY GROUP	TREND RATE	MONTHS OF AGING	DEMONSTRATION YEARS (DY)					TOTAL WW
			DY 01 (10/1/11 - 9/30/12)	DY 02 (10/1/12 - 9/30/13)	DY 03 (10/1/13 - 9/30/14)	DY 04 (10/1/14 - 9/30/15)	DY 05 (10/1/15 - 9/30/16)	
Title XIX								
Eligible Member Months	9.53%	27	7,720,846	8,724,989	9,768,677	10,699,516	11,112,778	
Total Cost Per Eligible	10.01%	27	\$ 309.23	\$ 343.51	\$ 381.37	\$ 417.45	\$ 455.38	
Total Expenditure			\$ 2,387,543,511	\$ 2,997,111,997	\$ 3,725,509,997	\$ 4,466,526,704	\$ 5,060,552,330	\$ 18,637,244,538
ABD								
Eligible Member Months	2.80%	27	2,818,411	2,900,683	2,982,953	3,065,209	3,147,471	
Total Cost Per Eligible	6.87%	27	\$ 918.36	\$ 968.31	\$ 1,045.20	\$ 1,119.70	\$ 1,201.87	
Total Expenditure			\$ 2,588,325,805	\$ 2,808,766,989	\$ 3,117,789,125	\$ 3,432,099,534	\$ 3,782,837,824	\$ 15,729,819,277
LTC/Transitioned HCBS								
Eligible Member Months	8.07%	27	453,415	569,994	586,160	602,323	618,488	
Total Cost Per Eligible	1.69%	27	\$ 7,228.06	\$ 6,519.03	\$ 6,789.75	\$ 7,068.49	\$ 7,419.84	
Total Expenditure			\$ 3,277,312,236	\$ 3,715,803,816	\$ 3,979,878,007	\$ 4,257,516,908	\$ 4,589,083,329	\$ 19,819,594,295
CCW								
Eligible Member Months	2.80%	27	131,098	134,925	138,752	142,578	146,404	
Total Cost Per Eligible	5.13%	27	\$ 5,746.34	\$ 6,090.12	\$ 6,407.83	\$ 6,728.74	\$ 7,112.29	
Total Expenditure			\$ 753,334,936	\$ 821,710,455	\$ 889,098,673	\$ 959,370,200	\$ 1,041,270,637	\$ 4,464,784,901
Pre-Transitioned HCBS								
Eligible Member Months	0.00%	27	100,411	-	-	-	-	
Total Cost Per Eligible	0.00%	27	\$ 2,161.42	\$ -	\$ -	\$ -	\$ -	
Total Expenditure			\$ 217,030,940	\$ -	\$ -	\$ -	\$ -	\$ 217,030,940
GA Employable								
Eligible Member Months	7.90%	27	468,403	505,406	545,333	588,415	634,900	
Total Cost Per Eligible	3.71%	27	\$ 271.91	\$ 282.00	\$ 292.46	\$ 303.31	\$ 314.56	
Total Expenditure			\$ 127,362,269	\$ 142,522,315	\$ 159,486,874	\$ 178,470,740	\$ 199,714,273	\$ 807,556,472
GA Unemployable								
Eligible Member Months	7.90%	27	234,201	252,703	272,667	294,207	317,450	
Total Cost Per Eligible	3.71%	27	\$ 271.91	\$ 282.00	\$ 292.46	\$ 303.31	\$ 314.56	
Total Expenditure			\$ 63,681,135	\$ 71,261,157	\$ 79,743,437	\$ 89,235,370	\$ 99,857,137	\$ 403,778,236
Supports Waiver								
Eligible Member Months	38.03%	27	15,120	26,184	45,360	49,896	54,886	
Total Cost Per Eligible	5.02%	27	\$ 3,223.41	\$ 3,368.46	\$ 3,540.26	\$ 3,713.73	\$ 3,921.70	
Total Expenditure			\$ 48,737,967	\$ 88,199,860	\$ 160,585,995	\$ 185,300,180	\$ 215,244,689	\$ 698,068,691
MI/DD								
Eligible Member Months	2.80%	27	2,272	2,338	2,404	2,470	2,537	
Total Cost Per Eligible	5.02%	27	\$ 11,564.51	\$ 12,084.91	\$ 12,701.24	\$ 13,323.60	\$ 14,069.72	
Total Expenditure			\$ 26,269,092	\$ 28,252,528	\$ 30,535,574	\$ 32,915,111	\$ 35,691,177	\$ 153,663,482
Children with PDD								
Eligible Member Months	2.80%	27	2,400	2,470	2,540	2,610	2,680	
Total Cost Per Eligible	5.85%	27	\$ 3,233.84	\$ 3,403.60	\$ 3,608.60	\$ 3,816.00	\$ 4,059.47	
Total Expenditure			\$ 7,761,218	\$ 8,407,084	\$ 9,166,258	\$ 9,960,365	\$ 10,880,234	\$ 46,175,160
Children with SED								
Eligible Member Months	3.40%	27	81,619	84,539	87,455	90,373	93,291	
Total Cost Per Eligible	2.65%	27	\$ 511.68	\$ 528.09	\$ 543.08	\$ 556.47	\$ 568.18	
Total Expenditure			\$ 41,762,639	\$ 44,644,261	\$ 47,495,138	\$ 50,290,242	\$ 53,005,915	\$ 237,198,195
MATI								
Eligible Member Months	3.40%	27	58,025	60,100	62,174	64,248	66,322	
Total Cost Per Eligible	6.14%	27	\$ 421.25	\$ 450.31	\$ 479.07	\$ 507.26	\$ 534.65	
Total Expenditure			\$ 24,442,733	\$ 27,063,913	\$ 29,785,592	\$ 32,590,691	\$ 35,459,531	\$ 149,342,460
DSH								
Total Allotment			1,288,871,240	1,288,871,240	1,288,871,240	1,288,871,240	1,288,871,240	\$ 6,444,356,200
FQHC								
Total Expenditure			41,800,000	41,800,000	41,800,000	41,800,000	41,800,000	\$ 209,000,000
Adults w/o Dependent Children								
Eligible Member Months	-5.28%	27	14,422	13,124	12,336	11,966	11,607	
Total Cost Per Eligible	12.58%	27	\$ 156.52	\$ 175.50	\$ 199.02	\$ 224.28	\$ 251.41	
Total Expenditure			\$ 2,257,255	\$ 2,303,256	\$ 2,455,164	\$ 2,683,762	\$ 2,918,156	\$ 12,617,592
Total Expenditure			\$ 10,896,492,976	\$ 12,086,718,871	\$ 13,562,201,075	\$ 15,027,631,046	\$ 16,457,186,471	\$ 68,030,230,439

ELIGIBILITY GROUP	TREND RATE	MONTHS OF AGING	DEMONSTRATION YEARS (DY)					TOTAL WW
			DY 01 (10/1/11 - 9/30/12)	DY 02 (10/1/12 - 9/30/13)	DY 03 (10/1/13 - 9/30/14)	DY 04 (10/1/14 - 9/30/15)	DY 05 (10/1/15 - 9/30/16)	
Title XIX								
Eligible Member Months	9.53%	27	7,720,846	8,724,989	9,768,677	10,699,516	11,112,778	
Total Cost Per Eligible	12.24%	27	\$ 155.63	\$ 179.76	\$ 204.64	\$ 227.66	\$ 248.29	
Total Expenditure			\$ 1,201,567,895	\$ 1,568,376,309	\$ 1,999,094,033	\$ 2,435,826,525	\$ 2,759,161,660	\$ 9,964,026,421
ABD								
Eligible Member Months	2.80%	27	2,818,411	2,900,683	2,982,953	3,065,209	3,147,471	
Total Cost Per Eligible	6.87%	27	\$ 459.18	\$ 484.16	\$ 522.60	\$ 559.85	\$ 600.93	
Total Expenditure			\$ 1,294,162,902	\$ 1,404,383,494	\$ 1,558,894,563	\$ 1,716,049,767	\$ 1,891,418,912	\$ 7,864,909,639
LTC/Transitioned HCBS								
Eligible Member Months	8.07%	27	453,415	569,994	586,160	602,323	618,488	
Total Cost Per Eligible	1.69%	27	\$ 3,614.03	\$ 3,259.51	\$ 3,394.87	\$ 3,534.24	\$ 3,709.92	
Total Expenditure			\$ 1,638,656,118	\$ 1,857,901,908	\$ 1,989,939,004	\$ 2,128,758,454	\$ 2,294,541,664	\$ 9,909,797,148
CCW								
Eligible Member Months	2.80%	27	131,098	134,925	138,752	142,578	146,404	
Total Cost Per Eligible	5.13%	27	\$ 2,873.17	\$ 3,045.06	\$ 3,203.92	\$ 3,364.37	\$ 3,556.15	
Total Expenditure			\$ 376,667,468	\$ 410,855,228	\$ 444,549,337	\$ 479,685,100	\$ 520,635,318	\$ 2,232,392,450
Pre-Transitioned HCBS								
Eligible Member Months	0.00%	27	100,411	-	-	-	-	
Total Cost Per Eligible	0.00%	27	\$ 1,080.71	\$ -	\$ -	\$ -	\$ -	
Total Expenditure			\$ 108,515,470	\$ -	\$ -	\$ -	\$ -	\$ 108,515,470
GA Employable								
Eligible Member Months	7.90%	27	468,403	505,406	545,333	588,415	634,900	
Total Cost Per Eligible	3.71%	27	\$ 135.95	\$ 141.00	\$ 146.23	\$ 151.65	\$ 157.28	
Total Expenditure			\$ 63,681,135	\$ 71,261,157	\$ 79,743,437	\$ 89,235,370	\$ 99,857,137	\$ 403,778,236
GA Unemployable								
Eligible Member Months	7.90%	27	234,201	252,703	272,667	294,207	317,450	
Total Cost Per Eligible	3.71%	27	\$ 135.95	\$ 141.00	\$ 146.23	\$ 151.65	\$ 157.28	
Total Expenditure			\$ 31,840,567	\$ 35,630,579	\$ 39,871,719	\$ 44,617,685	\$ 49,928,568	\$ 201,889,118
Supports Waiver								
Eligible Member Months	38.03%	27	15,120	26,184	45,360	49,896	54,886	
Total Cost Per Eligible	5.02%	27	\$ 1,611.71	\$ 1,684.23	\$ 1,770.13	\$ 1,856.86	\$ 1,960.85	
Total Expenditure			\$ 24,368,983	\$ 44,099,930	\$ 80,292,998	\$ 92,650,090	\$ 107,622,344	\$ 349,034,346
MI/DD								
Eligible Member Months	2.80%	27	2,272	2,338	2,404	2,470	2,537	
Total Cost Per Eligible	5.02%	27	\$ 5,782.25	\$ 6,042.45	\$ 6,350.62	\$ 6,661.80	\$ 7,034.86	
Total Expenditure			\$ 13,134,546	\$ 14,126,264	\$ 15,267,787	\$ 16,457,555	\$ 17,845,588	\$ 76,831,741
Children with PDD								
Eligible Member Months	2.80%	27	2,400	2,470	2,540	2,610	2,680	
Total Cost Per Eligible	5.85%	27	\$ 1,616.92	\$ 1,701.80	\$ 1,804.30	\$ 1,908.00	\$ 2,029.74	
Total Expenditure			\$ 3,880,609	\$ 4,203,542	\$ 4,583,129	\$ 4,980,182	\$ 5,440,117	\$ 23,087,580
Children with SED								
Eligible Member Months	3.40%	27	81,619	84,539	87,455	90,373	93,291	
Total Cost Per Eligible	2.65%	27	\$ 255.84	\$ 264.05	\$ 271.54	\$ 278.24	\$ 284.09	
Total Expenditure			\$ 20,881,319	\$ 22,322,130	\$ 23,747,569	\$ 25,145,121	\$ 26,502,958	\$ 118,599,097
MATI								
Eligible Member Months	3.40%	27	58,025	60,100	62,174	64,248	66,322	
Total Cost Per Eligible	6.14%	27	\$ 210.62	\$ 225.16	\$ 239.53	\$ 253.63	\$ 267.33	
Total Expenditure			\$ 12,221,367	\$ 13,531,956	\$ 14,892,796	\$ 16,295,345	\$ 17,729,766	\$ 74,671,230
DSH								
Total Allotment			644,435,620	644,435,620	644,435,620	644,435,620	644,435,620	\$ 3,222,178,100
FQHC								
Total Expenditure			20,900,000	20,900,000	20,900,000	20,900,000	20,900,000	\$ 104,500,000
Adults w/o Dependent Children								
Eligible Member Months	-5.28%	27	14,422	13,124	12,336	11,966	11,607	
Total Cost Per Eligible	12.58%	27	\$ 78.26	\$ 87.75	\$ 99.51	\$ 112.14	\$ 125.70	
Total Expenditure			\$ 1,128,627	\$ 1,151,628	\$ 1,227,582	\$ 1,341,881	\$ 1,459,078	\$ 6,308,796
Total Expenditure			\$ 5,456,042,628	\$ 6,113,179,746	\$ 6,917,439,572	\$ 7,716,378,696	\$ 8,457,478,730	\$ 34,660,519,372

Table 9.5a - Total Share*

Without Waiver	With Waiver	Savings
\$ 68,949,032,365	\$ 68,030,230,439	\$ 918,801,925

Table 9.5b - Federal Share*

Without Waiver	With Waiver	Savings
\$ 35,121,122,306	\$ 34,660,519,372	\$ 460,602,934

**All estimates are based upon the information available at a point in time, and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party or for any other purpose than for which is was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use.*

**OCT 02 2012**

The Honorable Jennifer Velez
Commissioner
Department of Human Services
State of New Jersey
P. O. Box 700
Trenton, NJ 08625-0700

Dear Commissioner Velez:

This letter is to inform you that New Jersey's request for a new Medicaid section 1115(a) demonstration, entitled "New Jersey Comprehensive Waiver"(NJCW) (Project Number 11-W-00279/2), has been approved by the Centers for Medicare & Medicaid Services (CMS) in accordance with section 1115(a) of the Social Security Act (the Act). This approval is effective from October 1, 2012 through June 30, 2017.

Under this demonstration, New Jersey will operate a statewide health reform effort that will expand existing managed care programs to include managed long term services and supports (MLTSS) and expand home and community based services to some populations. This demonstration builds upon existing managed acute and primary care programs and established provider networks. The 1115 demonstration also combines, under a single demonstration, authority for several existing Medicaid and CHIP waiver and demonstration programs, including two 1915(b) managed care waiver programs; a title XIX Medicaid and a title XXI CHIP section 1115 demonstrations and four 1915(c) programs.

In addition, it establishes a funding pool to promote health delivery system transformation. Below are the primary components of New Jersey's comprehensive demonstration request that we have approved.

Transition of Existing 1915(b) Managed Care Waivers and Four 1915(c) HCBS Waivers

CMS has approved the transition of two existing 1915(b) managed care waiver programs into the comprehensive demonstration effective upon approval. Those existing 1915(b) waiver programs are the Duals Waiver ("NJ 04"), which had previously authorized the state to require Medicare and Medicaid eligible beneficiaries to enroll in a managed care organization (MCO) for Medicaid services, and the NJ FamilyCare Waiver ("NJ 03"), which permits mandatory enrollment of disabled and foster care children in an MCO for care.

The following existing 1915(c) Home and Community Based Services fee-for-service waivers will be transitioned to managed care:

1. Global Options (GO) (which serves Medicaid beneficiaries over the age of 21 who meet the nursing facility level of care for physical disabilities in the community);
2. Community Resources for People with Disabilities (CRPD) (which serves Medicaid beneficiaries of all ages who may require a nursing facility level of care and cannot complete at least 3 activities of daily living (ADL));
3. Traumatic Brain Injury (TBI) (which serves Medicaid beneficiaries ages 21 to 64 with traumatic brain injury who require assistance with at least 3 ADLs in the community);
4. AIDS Community Care Alternatives Program (ACCAP) (which serves Medicaid beneficiaries diagnosed with AIDS, and at risk of nursing home placement in the community).

Effective January 1, 2013, or a date thereafter (depending on readiness), the state will implement MLTSS by allowing the MCOs to manage HCBS and behavioral health services for enrollees in all of these programs. The state is required to submit a transition plan to CMS for approval 90 days in advance of implementation that includes a managed care readiness review. The state must continue to adhere to all HCBS statutory assurances and submit a revised managed care quality strategy that includes these programs.

Additional Home and Community Based Services for Certain Medicaid Eligibles

The new demonstration will also provide additional community support and coordination services for certain low income populations, including individuals eligible under the state plan between the ages of 6 and 21 who meet the ICF/MR institutional level of care; individuals with Pervasive Developmental Disorders including Medicaid children up to age 13; and individuals eligible under the state plan over the age of 21 with intellectual disabilities who have completed their educational entitlement and meet the ICFIMR level of care.

Simplified Eligibility for Long Term Care Services

Under the demonstration the state will streamline eligibility requirements for long term with a goal of simplifying Medicaid eligibility and enrollment process, while assuring program integrity. We have included an evaluation component of these simplifications in the Special Terms and Conditions (STCs) as part of your evaluation activities related to this demonstration.

Transition of Existing section 1115 Childless Adults Medicaid Demonstration and the Family Coverage CHIP Demonstration

The existing New Jersey Childless Adults Medicaid Demonstration and the New Jersey Family Coverage CHIP Demonstration will also be transitioned into the new comprehensive demonstration. The Childless Adults Medicaid Demonstration currently provides coverage for low-income childless adults with household incomes up to 24 percent of the FPL.

The Family Coverage CHIP section 1115 demonstration currently provides coverage for uninsured custodial parents and caretaker relatives of Medicaid and CHIP children, through both direct coverage and premium assistance with title XXI wrap-around benefits and cost sharing protections. Coverage for parents with title XXI funds under this demonstration will expire on September 30, 2013. From October 1, 2013 through December 31, 2013, the state will receive title XIX funds at the regular FMAP for this population.

As part of this approval, New Jersey has modified its formula for calculating whether premium assistance is cost effective for families relative to coverage provided under the CHIP state plan. We will continue to provide technical assistance to the state subsequent to this approval to ensure that their cost effectiveness test meets the new requirements, including requirements related to administrative costs at 2105(c)(3), as added by Section 301(a)(2) of CHIPRA.

Hospital Delivery System Reform

As the demonstration begins, the state will end its existing supplemental payment programs for hospitals. Following a one-year transition period, the demonstration will include a Delivery System Reform Incentive Payment program through which hospitals may receive incentive payments for undertaking health care delivery system reform and quality improvement initiatives.

Additional Demonstration Programs

The new demonstration provides federal financial participation for the following programs that provide:

- o Community support and coordination services including behavioral health and medication assisted treatment to certain low income individuals 18 years and older with income up to and including 150 percent of the Federal Poverty Level (FPL) who have a mental illness and an opioid addiction diagnosis.
- o Coverage to 800 low-income, uninsured individuals with family income between 25 and 100 percent of the FPL including childless adults, which was a state funded program.
- o Select HCBS for individuals who meet an institutional level of care with intellectual disabilities based on the individual's plan of care who reside out of state.
- o Select HCBS for individuals who meet institutional level of care ages 6-21 with intellectual disabilities and mental illness.
- o Select services to children up to age 21 with income up to and including 150 percent of the FPL who have been diagnosed with a serious emotional disturbance (SED). Additionally, individuals within this group who meet an institutional level of care will receive full Medicaid state plan services, if they did not previously.

Requests CMS is Not Approving

As we have discussed, there are also some requests that CMS is not able to approve at this time.

- New Jersey requested to have some future programmatic changes to the demonstration "deemed approved" if CMS did not act upon a state request within a specified time. Although CMS is not approving this request, we have established streamlined approval processes for some changes related to home and community based care.
- New Jersey also requested to use Special Disability Workload funds as the non-federal share for the demonstration. The state was notified in a letter from the Secretary to the nation's Governors dated October 27, 2011 that we do not have legal authority to grant such requests.
- New Jersey requested all five of its 1915(c) waivers and its 1915(j) state plan Personal Directed Personal Assisted Services programs be included in the new demonstration. Because neither the Community Care Waiver (CCW) 1915(c) waiver program nor the 1915(j) programs required any changes requiring section 1115 authority, they have not been included in the demonstration.
- The elimination retroactive eligibility for most populations would constitute a more restrictive eligibility procedure than those in place on March 23, 2010 and thus would violate the Maintenance of Effort (MOE) provisions of the Affordable Care Act. The demonstration does not include this authority.

Demonstration Approval Requirements

The enclosed STCs, waiver authorities, expenditure authorities, and list of requirements that are not applicable to the expenditure authorities specify the agreement between the New Jersey Department Human Services Division of Medical Assistance and Health Services and CMS. The state may deviate from the Medicaid state plan and CHIP state plan requirements only to the extent those requirements have been specifically listed as waived or not applicable to the expenditure authorities. All requirements of the Medicaid and CHIP programs as expressed in law, regulation, and policy statement not expressly waived or identified as not applicable shall apply to the NJCW.

This approval is conditioned upon continued compliance with the enclosed STCs which set forth in detail the nature, character, and extent of Federal involvement in the demonstration and the state's obligations to CMS, including an evaluation of this demonstration, during the term of the demonstration. This award letter is subject to our receipt of your written acceptance of the award within 30 days of the date of this letter.

Your project officer is Lane Terwilliger, and she is available to answer any questions concerning your section 1115 demonstration. Ms. Terwilliger's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid, CHIP and Survey & Certification
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850

Telephone: (410) 786-2059
Facsimile: (410) 786-5882
E-mail: Lane.Terwilliger@cms.hhs.gov

Official communication regarding program matters should be submitted simultaneously to Lane Terwilliger and Mr. Michael Melendez, Associate Regional Administrator for the Division of Medicaid and Children's Health Operations in the CMS New York Regional Office. Mr. Melendez's contact information is as follows:

Mr. Michael Melendez
Associate Regional Administrator
Division of Medicaid and Children's Health Operations
26 Federal Plaza, Room 37-100 North
New York, NY 10278
Phone: (212)616-2430
Facsimile: (212)312-8652
Email: Michael.Melendez@cms.hhs.gov

We extend our congratulations to you on this award, and we appreciate your cooperation throughout the review process. If you have additional questions, please contact Ms. Victoria Wachino, Director, Children and Adults Health Programs Group, Center for Medicaid, CHIP and Survey & Certification at (410) 786-5647.

We look forward to continuing to work with you and your staff.

Sincerely,

/Marilyn Tavenner/

Marilyn Tavenner
Acting Administrator

Enclosures

cc: Ms. Cindy Mann, CMCS
Ms. Victoria Wachino, CMCS
Mr. Michael Melendez, ARA, Region II

**CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY**

NUMBER: 11-W-00279/2 (Titles XIX & XXI)

TITLE: New Jersey Comprehensive Waiver Demonstration

AWARDEE: New Jersey Department of Human Services Division of Medical Assistance and Health Services

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by the State for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act, incurred during the period of this Demonstration, shall be regarded as expenditures under the State's title XIX plan.

The following expenditure authorities shall enable the State to operate its section 1115 Medicaid and CHIP Comprehensive Waiver Demonstration.

Title XIX – Cost Not Otherwise Matchable

1. Expenditures for health care-related costs related to services listed in Attachment E (other than those incurred through Charity Care) under the **Serious Emotional Disturbance Program** for children up to age 21 who meet the institutional or needs based level of care for serious emotional disturbance.
2. Expenditures for health care-related costs related to services listed in Attachment F (other than those incurred through Charity Care) under the **Medical Assistance Treatment Program** for adults with household income up to 150 percent of the Federal poverty level (FPL) who have been diagnosed with mental illness and have a history of opioid use.
3. Expenditures for health care-related costs (other than costs incurred through the Charity Care) under the **Work First Childless Adults** for childless non-pregnant adults ages 19 through 64 years who are not otherwise eligible under the Medicaid State plan, do not have other health insurance coverage, are residents of New Jersey, are citizens or eligible aliens, have limited assets, and either: 1) cooperate with applicable work requirements and have countable monthly household incomes up to \$140 for a childless adult and \$193 for a childless adult couple; or 2) have a medical deferral from work requirements based on a physical or mental condition, which prevents them from work requirements and have countable monthly household incomes up to \$210 for a childless adult and \$289 for a childless couple. (This authority will terminate December 31, 2013)
4. Expenditures to provide coverage under the **NJ FamilyCare Childless Adult Program** to uninsured individuals over age 18 with family income below 100% of FPL, who are childless adults and who are not otherwise eligible for Medicare, Medicaid, or have other creditable health insurance coverage who were covered by New Jersey Family Care prior to enactment of the phase out under Section 2111 of the Social Security Act. (This authority will terminate December 31, 2013)

5. Expenditures for the 217-Like Expansion Populations.

Expenditures for the provision of Medicaid State plan services and HCBS services (as specified in Attachments C-1, C-2, and D) for individuals identified in the Special Terms and Conditions (STCs) who would otherwise be Medicaid-eligible under section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR § 435.217 in conjunction with section 1902(a)(10)(A)(ii)(V) of the Act, if the services they receive under an HCBS waiver granted to the State under section 1915(c) of the Act.

6. HCBS for SSI-Related State Plan Eligibles

Expenditures for the provision of HCBS waiver-like services (as specified in Attachments C-1 and C-2 of the STCs) that are not described in section 1905(a) of the Act, and not otherwise available under the approved State plan, but that could be provided under the authority of section 1915(c) waivers, that are furnished to HCBS/MLTSS Demonstration Participants with qualifying income and resources, and meet an institutional level of care.

7. Expenditures Related to the Transition Payments

Subject to an overall cap on the transition payments, expenditures for transition year payments to hospitals and other providers as outlined in paragraph 92 (of the STCs) for the period of the Demonstration.

8. Expenditure for HCBS Services furnished to Low-Income Individuals who Transferred Assets

Expenditures for HCBS services that would not otherwise be covered based on a transfer of assets by the low-income individual as described in section 1917(c) of the Act

9. Expenditures Related to the Delivery System Reform Incentive Payment (DSRIP) Program

Subject to CMS' timely receipt and approval of all deliverables specified in STC paragraph 93, expenditures for incentive payments from pool funds for the Delivery System Reform Incentive Payment (DSRIP) Program for the period of the Demonstration.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, shall apply to the Demonstration Populations as specified in the individual not applicable beginning from the approval date of the Demonstration through June 30, 2017.

Title XIX Requirements Not Applicable to the:

1. Retroactive Eligibility

Section 1902(a)(34)

To the extent necessary to allow the State to enroll Demonstration participants in the **Work First Childless Adults Population** no earlier than the first day of the month in which the application for the Demonstration was submitted.

2. Reasonable Promptness

Section 1902(a)(8)

To the extent necessary to enable the State to limit enrollment through waiting lists for the **Supports, Pervasive Development Disability, Persons with Intellectual Disabilities and Mental Illness, and the Persons with Intellectual Disabilities Out of State Programs, Medication Assisted Treatment Initiative, and Serious Emotional Disturbance** to receive HCBS services outlined in Attachment C, D, and E.

CHIP – Title XXI Costs Not Otherwise Matchable

Under the authority of section 1115(a)(2) of the Act as incorporated into title XXI by section 2107(e)(2)(A), State expenditures described below (which would not otherwise be included as matchable expenditures under title XXI) shall, for the period of this project and to the extent of the State's available allotment under section 2104 of the Act, be regarded as matchable expenditures under the State's title XXI plan. All requirements of the title XXI statute will be applicable to such expenditures, except those specified below as not applicable to these expenditure authorities. In addition, all requirements in the enclosed STCs will apply to these expenditure authorities.

1. Expenditures to provide coverage to individuals who are uninsured custodial parents and caretaker relatives of Medicaid and CHIP children with incomes above the previous Medicaid standard up to and including 133 percent of the FPL. Coverage must meet the requirements of section 2103 of the Act, and covered services must be actuarially equivalent to the commercial HMO coverage offered in New Jersey with the most non-Medicaid enrollees. For the period October 1, 2013 to December 31, 2013, these individuals will receive title XIX funding.
2. Expenditures to provide coverage consistent with section 2103 of the Act for uninsured custodial parents and caretaker relatives of children eligible under the title XXI State plan, when the parents and caretakers have family incomes at or above 134 percent up to and including 200 percent of the FPL and are not eligible for Medicaid. For the period October 1, 2013 to December 31, 2013, these individuals will receive title XIX funding.

CHIP Requirements Not Applicable to the CHIP Expenditure Authorities

All requirements of the CHIP program expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in this letter shall apply to this demonstration. To further this demonstration, we are identifying the following requirements as inapplicable to the extent indicated:

1. General Requirements, Eligibility and Outreach

Section 2102

For CHIP Parent/Caretakers up to 133 percent of the FPL:

The demonstration population does not have to reflect the state child health plan population, and eligibility standards do not have to be limited by the general principles in

section 2102(b)(1)(B). To the extent other requirements in section 2102 duplicate Medicaid or other CHIP requirements for this or other populations, they do not apply, except that the State must perform eligibility screening to ensure that the demonstration population does not include individuals otherwise eligible for Medicaid under the standards in effect on August 31, 2000.

For CHIP Parent/Caretakers with income between 134 and 200 percent of the FPL:

The demonstration population does not have to reflect the state child health plan population, and eligibility standards do not have to be limited by the general principles in section 2102(b)(1)(B). The State must perform eligibility screening to ensure that applicants for the demonstration population who are eligible for Medicaid are enrolled in that program and not in the demonstration population.

2. Restrictions on Coverage and Eligibility to Targeted Low-Income Children **Sections 2103 and 2110**

Coverage and eligibility for the demonstration populations are not restricted to targeted low-income children.

3. Federal Matching Payment and Family Coverage Limits **Section 2105**

Federal matching payment is available in excess of the 10 percent cap for expenditures related to the demonstration populations and limits on family coverage are not applicable.

Federal matching payments remain limited by the allotment determined under section 2104. Expenditures other than for coverage of the demonstration populations remain limited in accordance with section 2105(c)(2).

4. Annual Reporting Requirements **Section 2108**

Annual reporting requirements do not apply to the demonstration populations.

5. Purchase of Family Coverage Substitution Mechanism **Section 2105(c)(3)(B)**

To permit the State to apply the same waiting period for families opting for premium assistance that it applies for children that receive direct coverage under the Children's Health Insurance State plan.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER AUTHORITY**

NUMBER: 11-W-00279/2 (Title XIX)

TITLE: New Jersey Comprehensive Waiver Demonstration

AWARDEE: New Jersey Department of Human Services Division of Medical Assistance and Health Services

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the Demonstration from the effective date specified through June 30, 2017. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

Under the authority of section 1115(a)(1) of the Social Security Act (the Act), the following waivers of State plan requirements contained in section 1902 of the Act are granted in order to enable New Jersey to carry out the New Jersey Comprehensive Waiver section 1115 Demonstration.

1. Statewideness **Section 1902(a)(1)**

To enable the State to conduct a phased transition of Home and Community Based Services (HCBS) for Medicaid beneficiaries from fee-for-service to a managed care delivery system based on geographic service areas.

2. Amount, Duration, & Scope **Section 1902(a)(10)(B)**

To enable the State to modify the Medicaid benefit package to provide a more limited package to beneficiaries who are eligible as parents or caretaker relatives with incomes above the 1996 AFDC income standard and at or below 133 percent of the Federal poverty level (FPL).

To the extent necessary to enable the State to vary the amount, duration, and scope of services offered to individuals, regardless of eligibility category, by providing additional services to enrollees in certain targeted programs to provide home and community-based services.

3. Transfer of Assets **Section 1902(a)(18)**

To enable the State not to impose penalties on individuals who are enrolled in HCBS benefit programs whose transfer assets but have incomes at or below 100 percent of the FPL.

4. Freedom of Choice **Section 1902(a)(23)(A)**

To the extent necessary, to enable the State to restrict freedom of choice of provider through the use of mandatory enrollment in managed care plans for the receipt of covered services. No waiver of freedom of choice is authorized for family planning providers.

5. Direct Payment to Providers

Section 1902(a)(32)

To the extent necessary to permit the State to have individuals self-direct expenditures for HCBS long-term care and supports.

CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS (STCs)

NUMBER: 11-W-00279/2 (Titles XIX and XXI)

TITLE: New Jersey Comprehensive Waiver (NJCW) Demonstration

AWARDEE: New Jersey Department Human Services
Division of Medical Assistance and Health Services

DEMONSTRATION
PERIOD: October 1, 2012 through June 30, 2017

I. PREFACE

The following are the Special Terms and Conditions (STCs) for New Jersey’s “Comprehensive Waiver” section 1115(a) Medicaid and Children’s Health Insurance Plan (CHIP) demonstration (hereinafter “demonstration”), to enable the New Jersey Department Human Services, Division of Medical Assistance and Health Services (State) to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under section 1902(a) of the Social Security Act (Act), and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth conditions and limitations on those waivers and expenditure authorities, and describe in detail the nature, character, and extent of Federal involvement in the demonstration and the State’s obligations to CMS during the life of the demonstration. These STCs neither grant additional waivers or expenditure authorities, nor expand upon those separately granted.

The STCs related to the programs for those state plan and demonstration populations affected by the demonstration are effective from the date indicated above through June 30, 2017.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description and Historical Context
- III. General Program Requirements
- IV. Eligibility
- V. Benefits
- VI. Cost Sharing
- VII. Delivery System I – Managed Care Requirements
- VIII. Delivery System II – Additional Delivery System Requirements for Home and Community Based Services and Managed Long Term Services and Supports
- IX. Delivery System III - Behavioral Health
- X. Transition Requirements for Managed Long Term Services and Supports
- XI. New Home and Community Based Service Programs
- XII. Premium Assistance

- XIII. Quality
- XIV. Funding Pools
- XV. General Reporting Requirements
- XVI. Administrative Requirements
- XVII. General Financial Requirements Under Title XIX
- XVIII. General Financial Requirements Under Title XXI
- XIX. Monitoring Budget Neutrality for the Demonstration
- XX. Evaluation Plan and Design
- XXI. Scheduled Deliverables

Additional attachments have been included to provide supplementary information and guidance for specific STCs.

Attachment A	Quarterly Report Template
Attachment B	State Plan Benefits
Attachment C.1	Non-MLTSS HCBS Benefits
Attachment C.2	HCBS Benefits
Attachment D	Serious Emotional Disturbance (SED) Program Benefits
Attachment E	Medication Assisted Treatment Initiative (MATI) Program Benefits
Attachment F	Behavioral Health Organization (BHO) and Administrative Services Organization (ASO)
Attachment G	DSRIP Planning Protocol
Attachment H	DSRIP Plan
Attachment I	Hospitals Eligible for Transition and DSRIP Payments

II. PROGRAM DESCRIPTION AND HISTORICAL CONTEXT

On September 14, 2011 the State of New Jersey submitted a Medicaid section 1115 demonstration proposal which seeks to provide comprehensive health care benefits for approximately 1.3 million individuals, including individuals eligible for benefits under New Jersey’s Medicaid Program and additional populations eligible only under the demonstration. The new demonstration will consolidate the delivery of services under a number of separate State initiatives, including its Medicaid State plan, existing CHIP State plan, its previous Childless Adults section 1115 demonstration, four previous 1915(c) waiver programs and a previous State-funded Childless Adult program. The demonstration will require approximately 98 percent or 1.3 million beneficiaries to enroll in Managed Care Organizations (MCOs), with approximately 75,000 beneficiaries enrolled in Medicaid fee-for-service (FFS).

This five year demonstration will:

- Maintain Medicaid and CHIP State plan benefits without change;
- Continue the expanded eligibility and service delivery system under four existing 1915(c) home and community-based services (HCBS) waivers that:
 - Offer HCBS services and supports through a Traumatic Brain Injury Program (TBI) to certain individuals between the ages of 21 to 64 years of age who have

- acquired, non-degenerative, structural brain damage and who meet the Social Security Administration's (SSA) disability standard.
 - Offer HCBS services through an AIDS Community Care Alternative program (ACCAP) to certain individuals diagnosed with AIDS that support them and their primary caregivers.
 - Offers HCBS services and supports through a Community Resources for People with Disabilities program (CRPD) to certain individuals with physical disabilities who need assistance with at least 3 activities of daily living; and,
 - Offers HCBS services and supports through a Global Options (GO) program for certain individuals 65 years of age and older and physically disabled persons between 21 years of age and 64, who are assessed as needing nursing facility level of care.
- Continue the service delivery system under two previous 1915(b) managed care waiver programs that:
 - Require Medicare and Medicaid eligible beneficiaries to mandatorily enroll in an MCO for Medicaid services only.
 - Require disabled and foster care children to enroll in an MCO for care.
- Streamline eligibility requirements with a projected spend down for individuals who meet the nursing facility level of care
- Eliminate penalties for beneficiaries who transfer assets prior to seeking nursing facility services and have income at or below 100 percent of the Federal Poverty Level (FPL);
- Cover additional home and community-based services to Medicaid and CHIP beneficiaries with serious emotional disturbance, opioid addiction, pervasive developmental disabilities, and intellectual disabilities/developmental disabilities;
- Cover outpatient treatment for opioid addiction or mental illness for an expanded population of adults with household incomes up to 150 percent FPL;
- Expand eligibility to include a population of individuals between 18 and 65 who are not otherwise eligible for Medicaid, have household incomes between 25 and 100 percent of the FPL and are in satisfactory immigration status;
- Transform the State's behavioral health system for adults by delivering behavioral health through behavioral health administrative service organizations.
- Furnish premium assistance options to individuals with access to employer-based coverage.

Demonstration Goals:

Ensure continued coverage for groups of individuals currently under the Medicaid and CHIP State plans, previous waiver programs, and previously state-funded programs. In this demonstration the State seeks to achieve the following goals:

- Create “no wrong door” access and less complexity in accessing services for integrated health and Long-Term Care (LTC) care services;
- Provide community supports for LTC and mental health and addiction services;
- Provide in-home community supports for an expanded population of individuals with intellectual and developmental disabilities;
- Provide needed services and HCBS supports for an expanded population of youth with severe emotional disabilities; and

- Provide need services and HCBS supports for an expanded population of individuals with co-occurring developmental/mental health disabilities.
- Encourage structural improvements in the health care delivery system through DSRIP funding.

Demonstration Hypothesis:

The State will test the following hypotheses in its evaluation of the demonstration:

- Expanding Medicaid managed care to include long-term care services and supports will result in improved access to care and quality of care and reduced costs, and allow more individuals to live in their communities instead of institutions.
- Providing home and community-based services to Medicaid and CHIP beneficiaries and others with serious emotional disturbance, opioid addiction, pervasive developmental disabilities, or intellectual disabilities/developmental disabilities will lead to better care outcomes.
- Utilizing a projected spend-down provision and eliminating the penalty for transfer of assets for long term care and home and community based services will simplify Medicaid eligibility and enrollment processes without compromising program integrity.
- The Delivery System Reform Incentive Payment (DSRIP) Program will result in better care for individuals (including access to care, quality of care, health outcomes), better health for the population, and lower cost through improvement.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
2. **Compliance with Medicaid and Child Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid program, or the Children’s Health Insurance Program (CHIP) for the separate CHIP population, expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.
3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.
4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

- a. To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this demonstration, the State must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph.
 - b. If mandated changes in the Federal law require State legislation, the changes must take effect on the earlier of the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
5. **State Plan Amendments.** The State will not be required to submit title XIX or XXI State plan amendments for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP State plan is affected by a change to the demonstration, a conforming amendment to the appropriate State Plan is required, except as otherwise noted in these STCs.
6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, delivery systems, cost sharing, evaluation design, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in paragraph 7 below.
7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. Amendment requests must include, but are not limited to, the following:
 - a. An explanation of the public process used by the State, consistent with the requirements of paragraph 15 to reach a decision regarding the requested amendment;
 - b. A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
 - c. An up-to-date CHIP allotment worksheet, if necessary.

- d. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and
- e. If applicable, a description of how the evaluation designs will be modified to incorporate the amendment provisions.

8. Extension of the Demonstration.

- a. States that intend to request demonstration extensions under sections 1115(a), 1115(e) or 1115(f) must submit an extension request no later than 12 months prior to the expiration date of the demonstration. The chief executive officer of the State must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9.
- b. Compliance with Transparency Requirements 42 CFR Section 431.412:
Effective April 27, 2012, as part of the demonstration extension requests the State must provide documentation of compliance with the transparency requirements 42 CFR Section 431.412 and the public notice and tribal consultation requirements outlined in paragraph 15, as well as include the following supporting documentation:
 - i. **Historical Narrative Summary of the demonstration Project:** The State must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.
 - ii. **Special Terms and Conditions (STCs):** The State must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.
 - iii. **Waiver and Expenditure Authorities:** The State must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.
 - iv. **Quality:** The State must provide summaries of: External Quality Review Organization (EQRO) reports; managed care organization (MCO) and Coordinated Care Organization (CCO) reports; State quality assurance monitoring; and any other documentation that validates of the quality of care provided or corrective action taken under the demonstration.
 - v. **Financial Data:** The State must provide financial data (as set forth in the current STCs) demonstrating the State's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension as well as

cumulatively over the lifetime of the demonstration. CMS will work with the State to ensure that Federal expenditures under the extension of this project do not exceed the Federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension. In addition, the State must provide up to date responses to the CMS Financial Management standard questions. If title XXI funding is used in the demonstration, a CHIP Allotment Neutrality worksheet must be included.

- vi. **Evaluation Report:** The State must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.
- vii. **Documentation of Public Notice 42 CFR section 431.408:** The State must provide documentation of the State's compliance with public notice process as specified in 42 CFR section 431.408 including the post-award public input process described in 431.420(c) with a report of the issues raised by the public during the comment period and how the State considered the comments when developing the demonstration extension application.

9. **Demonstration Phase-Out.** The State may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements.

- a. **Notification of Suspension or Termination:** The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The State must submit its notification letter and a draft phase-out plan to CMS no less than 5 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the State must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the State must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the State must provide a summary of each public comment received the State's response to the comment and how the State incorporated the received comment into a revised phase-out plan.
- b. The State must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.
- c. **Phase-out Plan Requirements:** The State must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the State will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

- d. **Phase-out Procedures:** The State must comply with all notice requirements found in 42 CFR §431.206, 431.210 and 431.213. In addition, the State must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR §431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the State must maintain benefits as required in 42 CFR §431.230. In addition, the State must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.
 - e. **Federal Financial Participation (FFP):** If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.
 - f. **Post Award Forum:** Within six months of the demonstration’s implementation, and annually thereafter, the State will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the State must publish the date, time and location of the forum in a prominent location on its website. The State can use either its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The State must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly report, as specified in paragraph 102, associated with the quarter in which the forum was held. The State must also include the summary in its annual report as required in paragraph 103.
10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the demonstration in whole or in part at any time before the date of expiration, whenever it determines, following a hearing that the State has materially failed to comply with the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.
11. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge CMS’ finding that the State materially failed to comply.
12. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS’ determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services and administrative costs of disenrolling participants.

13. Submission of State Plan and Demonstration Amendments, and Transition Plan, Related to Implementation of the Affordable Care Act (ACA).

Upon implementation of the Affordable Care Act (ACA) in January 2014, expenditure authority for many demonstration Expansion populations will end. To the extent that the State seeks authority for the eligibility, benefits and cost sharing for these populations under the Medicaid or CHIP State plan, the State will, by April 1, 2013, submit proposed State plan amendments for any such populations. Concurrently, the State will submit proposed amendments to the demonstration to the extent that such populations will be subject to the demonstration. In addition, the State will submit by October 1, 2013, a transition plan consistent with the provisions of the Affordable Care Act for individuals enrolled in the demonstration, including how the State plans to coordinate the transition of these individuals to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. The plan must contain the required elements and milestones described in subparagraphs outlined below. In addition, the Plan will include a schedule of implementation activities that the State will use to operationalize the Transition Plan and meet the requirements of regulations and other CMS guidance related to ACA implementation.

- a. Transition plan must assure seamless transitions: Consistent with the provisions of the Affordable Care Act, the Transition Plan will include details on how the State will obtain and review any additional information needed from each individual to determine eligibility under all eligibility groups, and coordinate the transition of individuals enrolled in the demonstration (by FPL) (or newly applying for Medicaid) to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. Specifically, the State must:
 - i. Determine eligibility under all January 1, 2014, eligibility groups for which the State is required or has opted to provide medical assistance, including the group described in §1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL.
 - ii. Identify demonstration populations not eligible for coverage under the Affordable Care Act and explain what coverage options and benefits these individuals will have effective January 1, 2014.
 - iii. Implement a process for considering, reviewing, and making preliminary determinations under all January 1, 2014 eligibility groups for new applicants for Medicaid eligibility.
 - iv. Conduct an analysis that identifies populations in the demonstration that may not be eligible for or affected by the Affordable Care Act and the authorities the State identifies that may be necessary to continue coverage for these individuals.

- v. Develop a modified adjusted gross income (MAGI) conversion for program eligibility.
- b. Cost-sharing Transition: The Plan must include the State's process to come into compliance with all applicable Federal cost-sharing requirements,
- c. Transition Plan Implementation:
 - i. By October 1, 2013, the State must begin to implement a simplified, streamlined process for transitioning eligible enrollees in the demonstration to Medicaid, the Exchange or other coverage options in 2014. In transitioning these individuals from coverage under the waiver to coverage under the State plan, the State will not require these individuals to submit a new application.
 - ii. On or before December 31, 2013, the State must provide notice to the individual of the eligibility determination using a process that minimizes demands on the enrollees.

14. **Adequacy of Infrastructure.** The State will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

15. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The State must also comply with the tribal consultation requirements in section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act (ARRA) of 2009 and the tribal consultation requirements contained in the State's approved State plan, when any program changes to the demonstration, including (but not limited to) those referenced in paragraph 7, are proposed by the State. In States with Federally recognized Indian tribes, consultation must be conducted in accordance with the consultation process outlined in the July 17, 2001 letter or the consultation process in the State's approved Medicaid State plan if that process is specifically applicable to consulting with tribal governments on waivers (42 C.F.R. §431.408(b)(2)). In States with Federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, and/or renewal of this demonstration (42 C.F.R. §431.408(b)(3)). The State must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting payment rates.

16. **Federal Financial Participation (FFP).** Federal funds are not available for expenditures for this demonstration until the effective date identified in the demonstration approval letter.

IV. ELIGIBILITY

The NJCW maintains Medicaid and CHIP eligibility for populations eligible prior to the demonstration, including eligibility under the prior CHIP and childless adult demonstrations, four 1915(c) waiver programs, and two 1915(b) waiver programs. In addition, this demonstration provides for some expanded eligibility for some additional populations, as indicated below. In addition, populations eligible under the state plan, as identified below, may be affected by the demonstration through requirements to enroll in the Medicaid managed care program under the demonstration to receive state plan benefits. Individuals eligible for both Medicare and Medicaid (duals) are covered under this demonstration for Medicaid services.

17. **Eligibility Groups Affected By the Demonstration.** Benefits and service delivery options for the mandatory and optional State plan groups described in STC 19(a) and (b) below are affected by the demonstration. To the extent indicated in STC 32, these groups receive covered benefits through managed care organizations (MCOs).

18. **Expansion Groups:** Non-Medicaid eligible groups described in STC 19(c) and (d) are eligible under the demonstration, to the extent included in expenditure authorities separately granted to facilitate this demonstration. To the extent indicated in STC 32, these groups receive covered benefits through managed care organizations (MCOs).

19. **Demonstration Population Summary.** The Following Chart Describes the Populations Affected and the Demonstration Expansion Populations.

a. Medicaid State Plan Mandatory Groups

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
AFDC including Pregnant women	<ul style="list-style-type: none"> ▪ Section 1931 low-income families with children- §1902(a)(10)(A)(i)(I) §1931 ▪ Individuals who lose eligibility under §1931 due to increased earned income or working hours - §1902(a)(10)(A)(i)(I) §408(a)(11)(A), §1925, 1931(c)(2), 1902(a)(52), 1902(e)(1)(B) ▪ Individuals who lose eligibility under §1931 because of income from child or spousal support - §1902(a)(10)(A)(i)(I), §1931(c)(1), §408(a)(11)(B) ▪ Qualified pregnant women - §1902(a)(10)(A)(i)(III) §1905(n)(1) ▪ Qualified children - §1902(a)(10)(A)(i)(III) §1905(n)(2) ▪ Newborns deemed eligible for one year - §1902(e)(4) ▪ Pregnant women who lose eligibility receive 60 days coverage for pregnancy- 	<p>AFDC standard and methodologies or more liberal</p> <p>The monthly income limit for a family of four is \$507. No resource limit</p>	Plan A (See Attachment B)	“Title XIX”

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	<p>related and post-partum services - §1902(e)(5)</p> <ul style="list-style-type: none"> ▪ Pregnant women losing eligibility because of a change in income remain eligible 60 days post-partum - §1902(e)(6) 			
Foster Care	<ul style="list-style-type: none"> ▪ Children receiving IV-E foster care payments or with IV-E adoption assistance agreements - §1902(a)(10)(i)(I), §473(b)(3) 	Auto-eligible	Plan A (see Attachment B)	“Title XIX”
SSI recipients	<ul style="list-style-type: none"> ▪ Individuals receiving SSI cash benefits - §1902(a)(10)(A)(i)(I) ▪ Disabled children no longer eligible for SSI benefits because of a change in definition of disability - §1902(a)(10)(A)(i)(II)(aa) ▪ Individuals under age 21 eligible for Medicaid in the month they apply for SSI - §1902(a)(10)(A)(i)(II)(cc) ▪ Disabled individuals whose earnings exceed SSI substantial gainful activity level - §1619(a) ▪ Disabled widows and 	<p>SSI standards and methodologies</p> <p>SSI amount and NJ includes a state supplement</p>	Plan A (see Attachment B)	<p>(1) If enrolled in TBI, ACCAP, CRPD, or GO, then “HCBS (State plan).”</p> <p>(2) If residing in a NF, ICF/MR, or other institutional setting, then “LTC.”</p> <p>(3) If not (1) or (2), then “ABD.”</p>

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	<p>widowers - §1634(b) §1939(a)(2)(C)</p> <ul style="list-style-type: none"> ▪ Disabled adult children - §1634(c) §1939(a)(2)(D) ▪ Early widows/widowers - §1634(d) §1939(a)(2)(E) ▪ Individuals receiving mandatory State supplements - 42 CFR 435.130 ▪ Individuals eligible as essential spouses in December 1973 - 42 CFR 435.131 ▪ Institutionalized individuals who were eligible in December 1973 - 42 CFR 435.132 ▪ Blind and disabled individuals eligible in December 1973 - 42 CFR 435.133 ▪ Individuals who would be eligible except for the increase in OASDI benefits under Public Law 92-336 - 42 CFR 435.134 ▪ Individuals who become 			

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	<p>ineligible for cash assistance as a result of OASDI cost-of-living increases received after April 1977 - 42 CFR 435.135</p> <ul style="list-style-type: none"> ▪ Individuals ineligible for SSI or optional state supplement because of requirements that do not apply for Title XIX – 42 CFR 435.122 			
1619 (b)	<ul style="list-style-type: none"> ▪ Disabled individuals whose earnings are too high to receive SSI cash - §1619(b) 	<p>Earned income is less than the threshold amount as defined by Social Security Unearned income is the SSI amount The resource amount is the SSI limit of 2,000 for an individual and 3000 for a couple.</p>	Plan A (see Attachment B)	<p>(1) If enrolled in TBI, ACCAP, CRPD, or GO, then “HCBS (State plan).”</p> <p>(2) If residing in a NF, ICF/MR, or other institutional setting, then “LTC.”</p> <p>(3) If not (1) or (2), then “ABD.”</p>
New Jersey Care Special Medicaid Programs	<ul style="list-style-type: none"> ▪ Poverty level pregnant women - §1902(a)(10)(A)(i)(IV) §1902(l)(1)(A) ▪ Poverty level infants - §1902(a)(10)(A)(i)(IV) §1902(l)(1)(B) ▪ Poverty level children age 1- 	<p>Pregnant Women and Infants: Income less than or equal to 133% FPL Children age 1-5: Family income less than or equal to 133% FPL Children age 6-18:</p>	Plan A (see Attachment B)	“Title XIX”

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	5 §1902(a)(10)(A)(i)(VI) §1902(l)(1)(C) <ul style="list-style-type: none"> ▪ Poverty level children age 6-18 - §1902(a)(10)(A)(i)(VII) ▪ Poverty level infants and children receiving inpatient services who lose eligibility because of age must be covered through an inpatient stay - §1902(e)(7) 	Family income less than or equal to 100% FPL		

b. Medicaid State Plan Optional Groups

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
AFDC including Pregnant women	<ul style="list-style-type: none"> ▪ Individuals who are eligible for but not receiving IV-A, SSI or State supplement cash assistance - §1902(a)(10)(A)(ii)(I) ▪ Individuals who would have been eligible for IV-A cash assistance, SSI, or State supplement if not in a medical institution - §1902(a)(10)(A)(ii)(IV) 	<ul style="list-style-type: none"> ▪ AFDC methodology <p>The monthly income limit for a family of four is \$507. AFDC resource limit.</p>	Plan A (see Attachment B)	"Title XIX"
Medicaid Special	<ul style="list-style-type: none"> ▪ All individuals under 21 who are not covered as mandatory categorically needy - §1902(a)(10)(A)(ii)(I) and (IV) §1905(a)(i) 	<ul style="list-style-type: none"> ▪ AFDC methodology ▪ The difference between the 1996 AFDC income standard and 133% FPL is disregarded from the remaining earned income. 	Plan A (see Attachment B)	"Title XIX"
SSI recipients	<ul style="list-style-type: none"> ▪ Individuals receiving only an optional state supp. 42 CFR 435.232 ▪ Individuals who meet the SSI requirements but do 	<p>NJ state supplement only – determined annually and based on living arrangement</p> <p>Resources - SSI SSI methodology</p> <p>Income standard – SSI</p>	Plan A (see Attachment B)	<p>(1) If enrolled in TBI, ACCAP, CRPD, or GO, then "HCBS (State plan)."</p> <p>(2) If residing in a NF, ICF/MR, or other</p>

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	<p>not receive cash – 42 CFR 435.210</p> <ul style="list-style-type: none"> ▪ Individuals who would be eligible for cash if not in an institution – 42 CFR 435.211 	<p>and SSI supplement payment Resource: SSI</p>		<p>institutional setting, then “LTC.”</p> <p>(3) If not (1) or (2), then “ABD.”</p>
Institutional Medicaid	<p><i>Special income level group:</i> Individuals who are in a medical institution for at least 30 consecutive days with gross income that does not exceed 300% of the SSI income standard, or state-specified standard - §1902(a)(10)(A)(ii)(V)</p> <p><i>Hospice Group:</i> Individuals who are terminally ill, would be eligible if they were in a medical institution, and will receive hospice care - §1902(a)(10)(A)(ii)(VII)</p> <p><i>Special Home and Community Based Services Group:</i> Individuals who would be eligible in an institution and receiving</p>	<p><i>Special income level group:</i> Income less 300% of SSI/Federal Benefit Rate (FBR) per month; Resources SSI Standard; Individuals must meet institutional LOC requirements</p> <p><i>Hospice Group:</i> Individuals Income less 300% of SSI/Federal Benefit Rate (FBR) per month. Resources SSI Standard</p>	Plan A (see Attachment B)	<p>(1) If enrolled in TBI, ACCAP, CRPD, or GO, then “HCBS (State plan).”</p> <p>(2) If residing in a NF, ICF/MR, or other institutional setting, then “LTC.”</p> <p>(3) If not 1 or 2 then ABD</p>

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	<p>services under the State’s current 1915(c) waivers specifically: (1) Global Options Waiver (GO) # NJ.0032; (2) Community Resources for People with Disabilities (CRPD) Waiver #NJ.4133; (3) AIDS Community Care Alternatives Program (ACCAP) NJ#06-160; (4) and Traumatic Brain Injury (TBI) Program NJ# 4174</p>			
<p>New Jersey Care Special Medicaid Programs Pregnant Women and Children</p>	<ul style="list-style-type: none"> ▪ Poverty level pregnant women not mandatorily eligible - §1902(a)(10)(A)(ii)(IX) §1902(l)(1)(A) ▪ Poverty level infants not mandatorily eligible - §1902(a)(10)(A)(ii)(IX) §1902(l)(1)(B) ▪ Optional targeted low income children age 6-18 – 1902(a)(10)(A)(ii)(XIV) 	<ul style="list-style-type: none"> ▪ Pregnant women: Income less than or equal to 185% FPL ▪ Infants: Family income less than or equal to 185% FPL ▪ Children: Family income more than 100% and less than or equal to 133% FPL 	<p>Attachment B</p>	<p>“Title XIX”</p>
<p>New Jersey Care Special Medicaid</p>	<ul style="list-style-type: none"> ▪ Individuals receiving COBRA continuation 	<p>Income must be less than or equal to 100%</p>	<p>Plan XX (see Attachment B)</p>	<p>(1) If enrolled in TBI, ACCAP, CRPD, or</p>

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
Programs ABD	benefits - §1902(a)(10)(F) 1902(u) <ul style="list-style-type: none"> ▪ Eligibility group only includes aged and disabled individuals - §1902(a)(10)(A)(ii)(X) 	FPL. Resources up to \$4,000 for individual, \$6,000 for couple		GO, then “HCBS (State plan).” (2) If residing in a NF, ICF/MR, or other institutional setting, then “LTC.” (3) If not (1) or (2), then “ABD.”
Chafee Kids	<ul style="list-style-type: none"> ▪ Children under age 21 who were in foster care on their 18th birthday – 1902(a)(10)(A)(ii)(XVII) 	Children 18 up to 21 who were in foster care at the age of 18. On their 18 th birthday must be in DCF out of home placement supported in whole or in part by public funds No income or resource test	Plan A (see Attachment B)	“Title XIX”
Subsidized Adoption Services	<ul style="list-style-type: none"> ▪ Children under 21 who are under State adoption agreements - §1902(a)(10)(A)(ii)(VIII) 	Must be considered to have special needs	Plan A (see Attachment B)	“Title XIX”
Medically Needy Children and Pregnant Women	<ul style="list-style-type: none"> ▪ Individuals under 18 who would be mandatorily categorically eligible except for income and resources - §1902(a)(10)(C)(ii)(I) 	AFDC methodology – including spend down provision outlined in the state plan Income after spend	Limited Plan A Services (see Attachment B)	“Title XIX”

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	<ul style="list-style-type: none"> ▪ Pregnant women who would be categorically eligible except for income and resources - §1902(a)(10)(C)(ii)(II) ▪ Pregnant women who lose eligibility receive 60 days coverage for pregnancy-related and post-partum services - §1902(a)(10)(C) §1905(e)(5) 	<p>down is equal to or less than \$367 for an individual, \$434 for a couple, two person household or pregnant woman, etc. Up to \$4,000 in resources allowed for an individual, \$6,000 for a couple</p>		
Medically Needy Aged, Blind or Disabled	<ul style="list-style-type: none"> ▪ Medically Needy - §1902(a)(10)(C) ▪ Blind and disabled individuals eligible in December 1973 - 42 CFR 435.340 	<p>SSI methodology – including spend down provision outlined in the state plan Income after spend down is equal to or less than \$367 for an individual, \$434 for a couple, two person household or pregnant woman, etc. Up to \$4,000 in resources allowed for an individual, \$6,000 for a couple</p>	Attachment B	<p>(1) If enrolled in TBI, ACCAP, CRPD, or GO, then “HCBS (State plan).”</p> <p>(2) If residing in a NF, ICF/MR, or other institutional setting, then “LTC.”</p> <p>(3) If not (1) or (2), then “ABD.”</p>
New Jersey WorkAbility	<ul style="list-style-type: none"> ▪ §1902(a)(10)(A)(ii)(XV) 	Individual must be between the ages of 16 and 65, have a	Plan A (see Attachment B)	“Title XIX”

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
		<p>permanent disability, as determined by the SSA or DMAHS and be employed</p> <p>Countable unearned income (after disregards) up to 100% FPL, countable income with earnings up to 250% FPL; resources up to \$20,000 for an individual, \$30,000 for a couple</p>		
Breast and Cervical Cancer	<ul style="list-style-type: none"> ▪ §1902(a)(10)(A)(ii)(XVIII) 	<p>Uninsured low income women under the age of 65 who have been screened at a NJ cancer education and early detection site and needs treatment</p> <p>No Medicaid income or resource limit</p>	Plan A (Attachment B)	“ABD”
Title XXI Medicaid Expansion Children		The Medicaid expansion is for children 6 to 18 years of age whose family income is above 100 percent up to and	Plan A (see Attachment B)	“Title XIX”

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
		including 133 percent of the FPL.		
Parents/Caretakers up to 133% FPL		Uninsured custodial parents and caretaker relatives of Medicaid and CHIP children with family incomes from AFCD up to and including 133 percent off the FPL with earned income. (These are the parents that are NOT specified in the currently approved Medicaid State plan).	Plan D (see Attachment B)	In October, November, and December 2013. "XIX CHIP Parents"
Parent Caretakers between 134 & 200% FPL		Parents/Caretakers with income between 134 and 200 % FPL	Plan D (see Attachment B)	In October, November, and December 2013. "XIX CHIP Parents"

c. Expansion Eligibility Groups

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
Work First (Childless Adults)		Childless non-pregnant adults ages 19 through 64 years who are not otherwise eligible under the Medicaid State plan, do not have other health insurance coverage, are residents of New Jersey, are citizens or eligible aliens, have limited assets, and either: 1) cooperate with applicable work requirements and have countable monthly household incomes up to \$140 for a childless adult and \$193 for a childless adult couple; or 2) have a medical deferral from work requirements based on a physical or mental condition, which prevents them from work requirements and have countable monthly household incomes up to \$210 for a childless adult and \$289 for a childless	Plan G (see Attachment B)	(1) If categorized as Employable, then “Employable.” (2) If categorized as Unemployable, then “Unemployable.”

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
		couple.		
Childless Adults		Adults between 25 and 100% FPL who were enrolled in the program as of September 2001.	Plan D (see Attachment B)	“Adults without Dependent Children”
MATI New HCBS program Medication Assisted Treatment Initiative (MATI)	Adults 18 years and older at risk of institutionalization.	Income 150% FPL for adults who do not otherwise qualify for Medicaid Resources SSI Use financial institutional eligibility and post eligibility rules in the community for individuals who would not be eligible in the community because of community deeming rules in the same manner that would be used under a 1915(c) waiver program.	HCBS MATI services only (see Attachment E)	“MATI At Risk”

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
New HCBS program Serious Emotional Disturbance (SED)	SED children under age 21 at risk of hospitalization who have been diagnosed as seriously emotionally disturbed. (1115)	Income 150% FPL Resources SSI. Use financial institutional eligibility and post eligibility rules for individuals who would not be eligible in the community because of community deeming rules in the same manner that would be used under a 1915(c) waiver program.	3 HCBS services plus State Plan Behavioral Health Services (Children otherwise eligible for Medicaid will receive the full Medicaid benefit package + the three HCBS services)	“SED At Risk”

d. Expansion 217 –Like Eligibility Groups

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
217-like Existing .217 under HCBS	<p>Special income level (SIL) group receiving HCBW-like or services.</p> <p>42 CFR 435.217, 435.236 and 435.726 of and section 1924 of the Social Security Act, if the State had 1915(c) waivers</p> <p>(formerly served through the Community Resources for People with Disabilities, AIDS Community Care Alternatives , Traumatic Brain Injury, and Global Options for Long Term Care 1915(c) Waivers)</p> <p>Prior to transition of TBI, ACCAP, CRPD, and GO to MLTSS, this group includes individuals participating in those programs who are eligible for Medicaid under 42 CFR 435.217,</p>	<p>Income up to 300% of SSI/FBR</p> <p>Resources SSI</p> <p>Methodology SSI</p> <p>Use institutional eligibility and post eligibility rules for individuals who would only be eligible in the institution in the same manner as specified as if the State had 1915(c) waiver programs</p>	<p>State plan services with additional waiver services (see Attachment D)</p>	<p>“HCBS (217-Like)”</p>
217-like Existing .217 under HCBS	<p>A subset of the aged and disabled (Aged and Disabled) poverty level group who would only be eligible in the institution and receive HCBW-like services.</p>	<p>Income up to 100% of FPL</p> <p>Resources SSI</p> <p>Methodology SSI</p> <p>Use institutional eligibility and post eligibility rules for individuals who would</p>	<p>State plan services with additional waiver services.</p>	<p>“HCBS (217-Like)”</p>

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	<p>42 CFR 435.217, 435.726, 1902(m) and section 1924 of the Social Security Act</p> <p>(formerly served through the Community Resources for People with Disabilities, AIDS Community Care Alternatives , Traumatic Brain Injury, and Global Options for Long Term Care 1915(c) Waivers)</p> <p>Prior to transition of TBI, ACCAP, CRPD, and GO to MLTSS, this group includes individuals participating in those programs who are eligible for Medicaid under 42 CFR 435.217,</p>	<p>only be eligible in the institution in the same manner as if the State had 1915(c) waiver programs.</p>		
New 217-like Medically Needy	<p>The medically needy with a “hypothetical” spend down receiving HCBW--like services.</p> <p>42 CFR 435.217, 435.726, 1902(a)(10)(C)(i)(III) and section 1924 of the Social Security Act</p> <p>(Medically Needy With A Spenddown under the 435.217 group. These individuals were not previously covered under the</p>	<p>Use institutional eligibility and post eligibility rules for individuals who would only be eligible in the institution in the same manner as specified under, if the State had 1915(c) waiver programs.</p> <p>In order for medically needy individuals with a spenddown to be covered under the 217 like HCBS</p>	State plan services with additional waiver services	“HCBS (217-Like)”

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
	State's 1915(c) Waiver Programs)	<p>group the State must develop as hypothetical spenddown to demonstrate that these individuals would be eligible if in an institution. New Jersey's hypothetical spenddown uses the annual average nursing facility costs which are the statewide average cost of institutional care. This amount will be adjusted annually in accordance with the change in the Consumer Price Index all Urban Consumers, rounded up to the nearest dollar. If the individual's hypothetical cost exceeds the individual's monthly income, individual is Medicaid eligible. However, the individual's is considered categorically needy because he/she is eligible in the 217 like group and has no spenddown. Post eligibility treatment of</p>		

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
		income rules apply in accordance with 435.726 and 1924 of the Act.		
217 like New HCBS program Serious Emotional Disturbance (SED) that is optional under State Plan	SED children under age 21 meeting hospital level of care who have been diagnosed as seriously emotionally disturbed. 42 CFR 435.217, 435.726, 435.236 and 1924 of the Social Security Act	Income 300% of the SSI/FBR Resources SSI. Use institutional eligibility and post eligibility rules for individuals who would only be eligible in the institution in the same manner as specified under, if the State had 1915(c) waiver programs.	3 HCBS services plus State Plan Services	“SED (217-Like)”
Expansion group 217 like New HCBS program Intellectual Disabilities/Developmental Disabilities with Co-occurring Mental Health	IDD/MI children under age 21 meeting state mental hospital level of care 42 CFR 435.217, 435.726, 435.236 and 1924 of the Social Security Act	Income 300% SSI/FBR Resources SSI. Use institutional eligibility and post eligibility rules for individuals who would only be eligible in the institution in the same manner as specified under, if the State had 1915(c) waiver programs.	Medicaid Benefit package +HCBS services	“IDD/MI (217-Like)”

NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
Diagnosis (IDD/MI)				

20. Eligibility/Post-Eligibility Treatment of Income and Resources for Institutionalized Individuals. In determining eligibility (except for short term stays) for institutionalized individuals, the State must use the rules specified in the currently approved Medicaid State plan. All individuals receiving institutional services must be subject to post-eligibility treatment of income rules set forth in section 1924 of the Act and 42 CFR Section 435.725 of the Federal regulations.

a. Individuals Receiving Home and Community Based Services or Managed Long Term Services and Supports

i. 217-Like Group of Individuals Receiving HCBS Services. Institutional eligibility and post eligibility rules apply in the same manner as specified under 42 CFR 435.217, 435.236, 435.726 and 1902(m)(1), and 1924 of the Social Security Act, if the State had 1915(c) waivers. These groups of individuals were previously included under the State’s existing 1915(c) waivers #0032, #0160, #4133 and #4174.

- The State will use the portion of the capitated payment rate that is attributable to HCBS/MLTSS as the “dollar” amount of HCBS/MLTSS services that the individual is liable for since the capitated portion of the rate that is attributable HCBS/MLTSS is the actual amount the State pays to the managed care organization/entity for these services.

ii. 217-like Medically Needy Individuals Eligible for HCBS /MLTSS Programs. Institutional eligibility and post eligibility rules apply in the same manner as specified under 42 CFR 435.217, 435.236, 435.726 and 1902(m)(1), and 1924 of the Social Security Act, if the State had 1915(c) waivers, except that a projected spend down using nursing home costs is applied to determine eligibility And, in the post-eligibility process, a maintenance amount is disregarded . This applies to individuals who could have been included under the State’s existing 1915(c) waivers #0032, #0160, #4133 and 4174 had the State elected to cover these individuals under these 1915(c) waivers and had the waiver programs not been rolled into the 1115 waiver.

- The State will use the portion of the capitated payment rate that is attributable HCBS/MLTSS as the “dollar” amount of HCBS/MLTSS services that the individual is liable for since the capitated portion of the rate that is attributable HCBS/MLTSS is the actual amount the State pays to the managed care organization/entity for these services.

iii. 217 Like Groups of Individuals Receiving HCBS Like Services Under New Medicaid Programs. Institutional eligibility and post eligibility rules apply in the same manner as specified under 42 CFR 435.217, 435.236, 435.726 and 1924 of the Social Security Act, if the State had 1915(c) waivers. The State uses the SSI resource standard.

21. **Transfer of Assets.** New Jersey will not apply any transfer of assets penalty under section 1917 of the Act for long term care beneficiaries with income at or below 100 percent of the FPL.

22. **Excluded Populations.** The following populations are excluded from the demonstration:

- a. QMBs – 1902(a)(10)(E)(i); 1905(p)
- b. SLMBs – 1902(a)(10)(E)(iii); 1905(p)
- c. QIs – 1902(a)(10)(E)(iv); 1905(p)
- d. QDWIs – 1902(a)(10)(E)(iii); 1905(s)
- e. PACE Participants

V. BENEFITS

Individuals affected by, or eligible under, the demonstration will receive benefits as specified in Attachment B, as outlined in the table in paragraph 19 above. For populations eligible under the State plan, these benefits should equal the benefits available under the State plan. Individuals may receive additional benefits as described below to the extent that they are enrolled in the referenced programs that are set forth in sections VIII, IX, X and XI of these STCs.

23. Individuals enrolled in the Managed Long Term Services and Supports Program described in section X of these STCs receive all Medicaid and CHIP State Plan services, including behavioral health, through their Medicaid MCO listed in Attachment B. This population also receives a HCBS package of benefits listed in Attachment C.2.
24. Individuals enrolled in the Supports Program described in STC 78 receive all Medicaid and CHIP State Plan services through their Medicaid MCO listed in Attachment B. This population also receives a HCBS package of benefits listed in Attachment C.1.
25. Individuals enrolled in the Pervasive Developmental Disorders (PDD) Program described in STC 79 receive all Medicaid and CHIP State Plan services through their Medicaid MCO listed in Attachment B and behavioral health demonstration services through the children's Administrative Services Organization listed in Attachment F. This population also receives a HCBS package of benefits listed in Attachment C.1.
26. Individuals enrolled in the Pilot for Individuals with Intellectual Disabilities/ Development Disabilities with Co-Occurring Mental Health Diagnoses (ID-DD/MI) described in STC 80 receive all Medicaid State Plan services through their Medicaid MCO listed in Attachment B and behavioral health demonstration services through the children's Administrative Services Organization listed in Attachment F. This population also receives a HCBS package of benefits listed in Attachment C.1.
27. Individuals enrolled in the Intellectual Developmental Disability Program for Out of State (IDD/OOS) New Jersey Residents described in STC 81 receive all Medicaid State plan services listed in Attachment B. In addition to Medicaid State Plan services in Plan A this population receives HCBS service package of benefits designed to provide the appropriate supports to maintain the participants safely in the community listed in Attachment C.1.
28. Individuals enrolled in the Program for Children diagnosed with Serious Emotional Disturbance (SED) described in STC 82 receive all Medicaid and CHIP State Plan services through their Medicaid MCO listed in Attachment B and SED program services listed in Attachment D.
29. Individuals enrolled in the Medication Assisted Treatment Initiative (MATI) described in STC 83 receive all Medicaid and CHIP State Plan services through their Medicaid MCO listed in Attachment B and MATI services through the adult behavioral health ASO listed in Attachment E.
30. **Short term Nursing Facility Stays.** Short term nursing facility stays are covered for

individuals receiving HCBS or Managed Long Term Services and Supports. Coverage of nursing facility care for up to no more than 180 days is available to a HCBS/MLTSS demonstration participant receiving home and community-based services upon admission who requires temporary placement in a nursing facility when such participant is reasonably expected to be discharged and to resume HCBS participation within no more than 180 days including situations when a participant needs skilled or rehabilitative services for no more than 180 days due either to the temporary illness of the participant or absence of a primary caregiver.

- Such HCBS/MLTSS demonstration participants must meet the nursing facility level of care upon admission, and in such case, while receiving short-term nursing facility care may continue enrollment in the demonstration pending discharge from the nursing facility within no more than 180 days or until such time it is determined that discharge within 180 days from admission is not likely to occur, at which time the person shall be transitioned to an institution, as appropriate.
- The community maintenance needs allowance shall continue to apply during the provision of short-term nursing facility care in order to allow sufficient resources for the member to maintain his or her community residence for transition back to the community.

VI. COST SHARING

31. Costs sharing for the Medicaid and CHIP programs are reflected in Attachment B. Notwithstanding Attachment B, all cost-sharing for State plan populations must be in compliance with Medicaid and CHIP requirements that are set forth in statute, regulation and polices. In addition, aggregate cost sharing imposed on any individual adult demonstration participant on an annual basis must be limited to five percent of the individual's aggregate family income.

VIII. DELIVERY SYSTEMS I -- MANAGED CARE REQUIREMENTS

32. **Applicability of Managed Care Requirements to Populations Affected by and Eligible Under the Demonstration.** All populations affected by, or eligible under the Demonstration that receive State plan benefits (Attachment B) are enrolled in managed care organizations that comply with the managed care regulations published at 42 CFR 438 to receive such benefits, except as expressly waived or specified as not applicable to an expenditure authority. Capitation rates shall be developed and certified as actuarially sound, in accordance with 42 CFR 438.6. The certification shall identify historical utilization of State Plan and HCBS services, as appropriate, which were used in the rate development process. The following populations are excepted from mandatory enrollment in managed care:
- a. Work First (Childless Adults),
 - b. MATI At Risk,
 - c. SED At Risk,

- d. American Indians and Alaska Natives, and
- e. Medicaid eligible not listed in paragraphs 19(a) or 19(b).

33. **Benefits Excepted from Managed Care Delivery System:** Benefits that are excepted from the Managed Care Delivery System are those that are designated as FFS in Attachment B.
34. **Care Coordination and Referral Under Managed Care.** As noted in plan readiness and contract requirements, the State must require that each MCO refer and/or coordinate, as appropriate, enrollees to any needed State plan services that are excluded from the managed care delivery system but available through a fee for service delivery system, and must also assure referral and coordination with services not included in the established benefit package.
35. **Managed Care Contracts.** No FFP is available for activities covered under contracts and/or modifications to existing contracts that are subject to 42 CFR 438 requirements prior to CMS approval of such contracts and/or contract amendments. The State shall submit any supporting documentation deemed necessary by CMS. The State must provide CMS with a minimum of 60 days to review and approve changes. CMS reserves the right, as a corrective action, to withhold FFP (either partial or full) for the demonstration, until the contract compliance requirement is met.
36. **Public Contracts.** Payments under contracts with public agencies, that are not competitively bid in a process involving multiple bidders, shall not exceed the documented costs incurred in furnishing covered services to eligible individuals (or a reasonable estimate with an adjustment factor no greater than the annual change in the consumer price index).
37. **Network Requirements.** The State must ensure the delivery of all covered benefits, including high quality care. Services must be delivered in a culturally competent manner, and the MCO network must be sufficient to provide access to covered services to the low-income population. In addition, the MCO must coordinate health care services for demonstration populations. The following requirements must be included in the State's MCO contracts:
- a. **Special Health Care Needs.** Enrollees with special health care needs must have direct access to a specialist, as appropriate for the individual's health care condition, as specified in 42 C.F.R. 438.208(c)(4).
 - b. **Out of Network Requirements.** Each MCO must provide demonstration populations with all demonstration program benefits described within these STCs and must allow access to non-network providers when services cannot be provided consistent with the timeliness standards required by the State.
38. **Demonstrating Network Adequacy.** Annually, each MCO must provide adequate assurances that it has sufficient capacity to serve the expected enrollment in its service area and offers an adequate range of preventive, primary, pharmacy, and specialty and HCBS services for the anticipated number of enrollees in the service area.

- a. The State must verify these assurances by reviewing demographic, utilization and enrollment data for enrollees in the demonstration as well as:
 - i. The number and types of primary care, pharmacy, and specialty providers available to provide covered services to the demonstration population;
 - ii. The number of network providers accepting the new demonstration population; and
 - iii. The geographic location of providers and demonstration populations, as shown through GeoAccess or similar software.
 - b. The State must submit the documentation required in subparagraphs i – iii above to CMS with initial MCO contract submission as well as with each annual report.
39. **Provider Credentialing.** The provider credentialing criteria described at 42 CFR 438.214 must apply to MLTSS providers. If the MCO’s credentialing policies and procedures do not address non-licensed/non-certified providers, the MCO must create alternative mechanisms to ensure enrollee health and safety.
40. **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Compliance.** The State must ensure that the MCOs are fulfilling the State’s responsibilities for coverage, outreach, and assistance with respect to EPSDT services that are described in the requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements), and 1905(r) (definitions).
41. **Advisory Committee as required in 42 CFR 438.** The State must maintain for the duration of the demonstration a managed care advisory group comprised of individuals and interested parties impacted by the demonstration’s use of managed care, regarding the impact and effective implementation of these changes to seniors and persons with disabilities. Membership on this group should be periodically updated to ensure adequate representation of individuals receiving MLTSS.
42. **Mandatory Enrollment.** The State will require that individuals served through this demonstration enroll in managed care programs to receive benefits only when the plans in the applicable geographic area have been determined by the State to meet certain readiness and network requirements and require plans to ensure sufficient access, quality of care, and care coordination for beneficiaries established by the State, as required by 42 CFR 438 and approved by CMS. The State may not mandatorily enroll individuals into any plan that does not meet network adequacy requirements as defined in 42 CFR 438.206.
43. **Choice of MCO.** The State must ensure that at the time of initial enrollment and on an ongoing basis, the individuals have a minimum of 2 MCOs meeting all readiness requirements from which to choose. If at any time, the State is unable to offer 2 plans, an alternative delivery system must be available within 60 days of loss of plan choice.

44. **MCO Selection.** Demonstration participants who are enrolled in Medicaid and Medicaid Expansion populations are required to enroll in an MCO and must have no less than 10 days to make an active selection of an MCO upon notification that a selection must be made. Any demonstration participant that does not make an active selection will be assigned, by default, to a participating MCO. That assignment shall be based on 42 CFR 438.50. Once the participant is advised of the State's MCO assignment, the participant, consistent with 42 CFR section 438.56, is permitted up to 90 days to disenroll from the assigned MCO and select another. The participant then receives a second 90-day period to disenroll after enrolling in that MCO, if other MCO choices are available. Once the participant remains in an MCO beyond 90 days, disenrollment may only occur for cause (as defined by the State) or at least every 12 months during an open enrollment period.
45. **Required Notice for Change in MCO Network.** The State must provide notice to CMS as soon as it becomes aware of (or at least 90 days prior if possible) a potential change in the number of plans available for choice within an area, or any other changes impacting proposed network adequacy. The State must provide network updates through its regular meetings with CMS and submit regular documentation as requested.

VIII. DELIVERY SYSTEM --II – ADDITIONAL DELIVERY SYSTEM REQUIREMENTS FOR HOME AND COMMUNITY BASED SERVICES (HCBS) AND MANAGED LONG TERM SUPPORT SERVICES (MLTSS) PROGRAM

In addition to the requirements described in Section VII Delivery System I, the following additional delivery system requirements apply to all the HCBS programs and MLTSS programs in this demonstration.

46. **Administrative Authority.** There are multiple State agencies involved in the administration of the HCBS; therefore, the Single State Medicaid Agency (SSMA) must maintain authority over the programs. The SMA must exercise appropriate monitoring and oversight over the State agencies involved, the MCO's, and other contracted entities.
47. **Home and Community-Based Characteristics.** Residential settings located in the community will provide members with the following:
- a. Private or semi-private bedrooms including decisions associated with sharing a bedroom.
 - b. All participants must be given an option to receive home and community based services in more than one residential setting appropriate to their needs.
 - c. Private or semi-private bathrooms that include provisions for privacy.
 - d. Common living areas and shared common space for interaction between participants, their guests, and other residents.
 - e. Enrollees must have access to a food storage or food pantry area at all times.

- f. Enrollees must be provided with an opportunity to make decisions about their day to day activities including visitors, when and what to eat, in their home and in the community.
 - g. Enrollees will be treated with respect, choose to wear their own clothing, have private space for their personal items, have privacy to visit with friends, family, be able to use a telephone with privacy, choose how and when to spend their free time, and have opportunities to participate in community activities of their choosing.
48. **Health and Welfare of Enrollees.** The State, or the MCO for MLTSS enrolled individuals, through an MCO contract, shall be required on a continuous basis to identify, address, and seek to prevent instances of abuse, neglect and exploitation through the Critical Incident Management System referenced in paragraph 50.
49. **Demonstration Participant Protections.** The State will assure that children, youth, and adults in MLTSS and HCBS programs are afforded linkages to protective services (e.g., Ombudsman services, Protection and Advocacy, Division of Child Protection and Permanency) through all service entities, including the MCOs.
- a. The State will ensure that these linkages are in place before, during, and after the transition to MLTSS as applicable.
 - b. The State/MCOs will develop and implement a process for community-based providers to conduct efficient, effective, and economical background checks on all prospective employees/providers with direct physical access to enrollees.
50. **Critical Incident Management System.** The State must operate a critical incident management system according to the State’s established policies, procedures and regulations and as described in section XIII.
51. **Managed Care Grievance/Complaint System.** The MCO must operate a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services.
52. **Fair Hearings.** All enrollees must have access to the State fair hearing process as required by 42 CFR 431 Subpart E. In addition, the requirements governing MCO appeals and grievances in 42 CFR 438 Subpart F shall apply.
53. **Plan of Care (PoC).** A “Plan of Care” is a written plan designed to provide the demonstration enrollee with appropriate services and supports in accordance with his or her individual needs. All individuals receiving HCBS or MLTSS under the demonstration must have a PoC and will be provided services in accordance with their plan. The State must establish minimum guidelines regarding the PoC that will be reflected in contracts and/or provider agreements. These must include at a minimum: 1) a description of qualification for individuals who will develop the PoC; 2) timing of the PoC including how and when it will be updated and including mechanisms to address changing circumstances and needs; 3) types

of assessments; 4) how enrollees are informed of the services available to them; 5) the MCOs' responsibilities for implementing and monitoring the PoC.

- a. Each member's PoC must include team-based Person-Centered Planning, which is a highly individualized and ongoing process to develop care plans that focus on the person's abilities and preferences. Person-Centered Planning includes consideration of the current and unique bio-psycho-social and medical needs and history of the enrollee, as well as the person's functional level, and support systems.
- b. The State or the MCO, for those enrolled in MLTSS will emphasize services provided in home and community-based settings, maximizing health and safety, whenever possible.
- c. Meetings related to the enrollee's PoC will be held at a location, date, and time convenient to the enrollee and his/her invited participants.
- d. A back-up plan must be developed and incorporated into the plan to assure that the needed assistance will be provided in the event that the regular services and supports identified in the PoC are temporarily unavailable. The back-up plan may include other assistance or agency services.
- e. The State (not the MCOs) will be responsible for the PoC developed for each enrollee transitioning from an institutional setting to a community-based setting through the State's Money Follows the Person demonstration.
- f. The State or the MCO for those enrolled in MLTSS must ensure that services are delivered in accordance with the PoC including the type, scope, amount and frequency.
- g. The State or the MCO, for those enrolled in MLTSS must ensure that enrollees have the choice of participating providers within the plan network as well as access to non-participating providers when the appropriate provider type is not on the MCO's network.
- h. Individuals served in ID/DD programs must have the choice of institutional placements and community settings.
- i. Each enrollee's PoC must be reviewed annually at a minimum, or more frequently with individual circumstances as warranted.

54. Option for Participant Direction of certain HCBS and MLTSS. NJCW participants who elect the self-direction opportunity must have the option to self-direct the HCBS or MLTSS, Participant direction affords NJCW participants the opportunity to have choice and control over how services are provided and who provides the service. Member participation in participant direction is voluntary, and members may participate in or withdraw from participant direction at any time.

The services, goods, and supports that a participant self-directs must be included in the calculations of the participant's budget. Participant's budget plans must reflect the plan for purchasing these needed services.

- a. Information and Assistance in Support of Participant Direction. The State/MCO shall have a support system that provides participants with information, training, counseling, and assistance, as needed or desired by each participant, to assist the participant to effectively direct and manage their self-directed services and budgets. Participants shall be informed about self-directed care, including feasible alternatives, before electing the self-direction option. Participants shall also have access to the support system throughout the time that they are self-directing their care. Support activities must include, but is not limited to Support for Participant Direction service which includes two components: Financial Management Services and Support Brokerage. Providers of Support for Participant Direction must carry out activities associated with both components. The Support for Participant Direction service provides assistance to participants who elect to self-direct their personal care services.
- b. Participant Direction by Representative. The participant who self-directs the personal care service may appoint a volunteer designated representative to assist with or perform employer responsibilities to the extent approved by the participant. Waiver services may be directed by a legal representative of the participant. Waiver services may be directed by a non-legal representative freely chosen by an adult participant. A person who serves as a representative of a participant for the purpose of directing personal care services cannot serve as a provider of personal attendant services for that participant.
- c. Independent Advocacy. Each enrollee shall have access to an independent advocate or advocacy system in the State. This function is performed by individuals or entities that do not provide direct services, perform assessments, or have monitoring, oversight or fiscal responsibilities for the demonstration. The plans will provide participants with information regarding independent advocacy such as the Ombudsman for Institutionalized Elderly and State staff who approved LOC determination and did options counseling.
- d. Participant Employer Authority. The participant (or the participant's representative) must have decision-making authority over workers who provide personal care services.
 - i. Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide personal care services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.
 - ii. Decision Making Authorities. The participant exercises the following decision making authorities: Recruit staff, select staff from worker registry, hire staff as common law employer, verify staff qualifications, obtain criminal

history and/or background investigation of staff, specify additional staff qualifications based on participant needs and preferences, evaluate staff performance, verify time worked by staff and approve time sheets, and discharge staff.

- e. Disenrollment from Participant-Direction. A participant may voluntarily disenroll from the self-directed option at any time and return to a traditional service delivery system. To the extent possible, the member shall provide his/her provider ten (10) days advance notice regarding his/her intent to withdraw from participant direction. A participant may also be involuntarily disenrolled from the self-directed option for cause, if continued participation in the participant-directed services option would not permit the participant's health, safety, or welfare needs to be met, or the participant demonstrates the inability to self-direct by consistently demonstrating a lack of ability to carry out the tasks needed to self-direct personal care services, or if there is fraudulent use of funds such as substantial evidence that a participant has falsified documents related to participant directed services. If a participant is terminated voluntarily or involuntarily from the self-directed service delivery option, the MCO must transition the participant to the traditional agency direction option and must have safeguards in place to ensure continuity of services.
- f. Appeals. The following actions shall be considered an adverse action under both 42 CFR 431 Subpart E (state fair hearing) and 42 CFR 438 Subpart F (MCO grievance process):
 - i. A reduction in services;
 - ii. A denial of a requested adjustment to the budget; or
 - iii. A reduction in amount of the budget.

Participants may use either the State fair hearing process or the MCO appeal process to request reconsideration of these adverse actions.

IX. DELIVERY SYSTEM -- III - BEHAVIORAL HEALTH

55. Behavioral Health Organization. Coverage of behavioral health services will vary depending on population and level of care as described in the Benefits section above and in Attachments B and F. In general, behavioral health for demonstration beneficiaries will be excluded from the coverage furnished through the primary managed care organization, but instead will be covered through a behavioral health organization (BHO). The State will contract with BHOs on a non-risk basis as an Administrative Services Organization (ASO). Exceptions to this service delivery system, under which behavioral health will be included in the MCO benefit package include; dual eligibles enrolled in a SNP and individuals enrolled in a MLTSS MCO furnishing long term supports and services/HCBS services.

56. Behavioral Health for Children. Upon the effective date of this demonstration, children who are not in a HCBS/MLTSS/SNP population will have their behavioral health care coordinated by a behavioral health ASO.

a. The ASO shall perform the following functions on behalf of the State:

1. 24/7 Call Center
2. Member services
3. Medical Management
4. Provide and manage MIS/EMR for Children's System of Care
5. Dispatch Mobile Response/Crisis Response
6. Clinical Phone Triage (performed by licensed clinicians)
7. Facilitate Needs Assessments
8. Clinical Reviews of Needs Assessments
9. Care Coordination
10. Intensity of Service Determinations
11. Treatment Plan Reviews
12. Prior Authorizations
13. Quality Monitoring in Coordination with DCF
14. Utilization Management
15. Data Sharing and Reporting
16. Grievance and Intensity of Service Dispute Resolution
17. Behavioral Health and Primary Health Coordination

b. Excluded Children's ASO functions.

1. Provider Network Management
2. Claims payment
3. Rate Setting

c. Should the State decide to implement an at-risk arrangement for the BHO the State will submit an amendment to CMS in accordance with paragraph 7.

57. Behavioral Health for Adults. Behavioral health services will not be included in the benefit package provided by the primary managed care organization. Effective July 1, 2013 or a date thereafter, adults will have their behavioral health care coordinated by a behavioral health ASO. Prior to that date, behavioral health services will be covered on a fee for service basis.

a. Functions of the Adult ASO. The ASO shall perform the following functions:

1. 24/7 Call Center
2. Member services
3. Screening and assessment
4. Prior authorization
5. Network management
6. Utilization management, including level of care determination and continuing care review

7. Care management
8. Medical management
9. Care coordination
10. Quality management
11. Information technology
12. Data submission and reporting requirements
13. Financial management, including claims processing and payment
14. Development of care models and service arrays for consumers with intellectual and developmental disabilities; non-SNP dual eligibles (Medicare and Medicaid), and Medicaid expansion populations
15. Coordination with the MCOs regarding high-utilizing consumers and consumers screened with behavioral health/medical conditions

b. Excluded Adult ASO function.

1. Adult populations currently enrolled in the 1915(c) programs who are moving to MLTSS program will be excluded from the ASO since their behavioral health care will be managed by the MCO.
2. Should the State decide to implement an at-risk arrangement for the BHO the State will submit an amendment to CMS in accordance with paragraph 7.

58. Behavioral Health Home. The State is seeking to implement a behavioral health home through the State Plan Amendment process. Upon implementation of the health home the ASO(s) will coordinate with the provider for comprehensive behavioral health care.

59. Services Provided by the BHO/ASO. The services provided by the BHO/ASO are listed in Attachment F.

60. Duplication of Payment. To avoid duplication of payment for services for demonstration participants who require behavioral health, the Behavioral Health Service and Payer table in Attachment F will determine who the payer for behavioral health care is.

X. MANAGED LONG TERM SERVICES AND SUPPORTS (MLTSS) PROGRAM

61. Transition of Existing section 1915(c) Programs. Prior to the implementation of MLTSS, the State provided HCBS through section 1915(c) waivers using a fee-for-service delivery system for long-term care services and supports. The following 1915(c) waivers that will be transitioned into the demonstration and into a mandated managed care delivery systems upon CMS review and approval of a transition plan, the State completion of managed care readiness reviews, and providing notice of transition to program participants are:

- Traumatic Brain Injury (TBI) Program, NJ4174;
- Community Resources for People with Disabilities (CRPD) Program, NJ 4133;
- Global Options for Long Term Care (GO) Program, NJ 0032; and
- AIDS Community Care Alternatives Program (ACCAP) Program, NJ0160.

- 62. Notice of Transition to Program Participants.** The State will provide notice to participants of current 1915 (c) waiver authority to the demonstration, that no action is required on behalf of the participant, and that there is no disruption of services. Such notice must be provided to said beneficiaries 30 days prior to the transfer of waiver authorities from section 1915(c) to the section 1115 demonstration. (42 CFR 431.210) requires States to notify 1915(c) waiver participants 30 days prior to waiver termination.
- 63. Transition Plan from FFS Programs to Managed Care Delivery System.** To ensure a seamless transition of HCBS waiver participants and those currently in a nursing facility from fee for service delivery systems and section 1915(c) waivers to MLTSS, the State must:
- a. Prepare a MLTSS Transition Plan to be reviewed by CMS.
 - b. Meet regularly with the MCOs during transition process and thereafter. Complete an outreach and communication strategy to HCBS demonstration participants impacted by MLTSS to include multiple contacts and notice with HCBS/MLTSS participants in a staggered manner to commence 90 days prior to the implementation of MLTSS.
 - c. Provide materials for enrollees in languages, formats, and reading levels to meet enrollee needs.
 - d. Make available to the MCOs sufficient data to assist them in developing appropriate care plans for each enrollee.
 - i. The data will include past claims data, providers, including HCBS and the individual's past and current Plan of Care (PoC).
 - ii. The State will ensure participants will receive the same type and level of services they received in section 1915(c) programs until the MCO has completed an assessment.
 - iii. Enrollees transitioning from one plan to another will continue to receive the same services until the new MCO is able to perform its own Assessment, and develop an updated Plan of Care (PoC).
 - e. To facilitate the establishment of a smooth transition process, the State will develop a readiness certification tool to be used to assess the readiness of the MCOs to assume the provision of the MLTSS. The State will submit its MCO readiness certification tool for the provision of the MLTSS to CMS prior to its use.
 - f. The State will submit to CMS for review all informing notices that will be sent to participants outlining their new services, changes in the service delivery system, and due process rights. Informing notices will be sent to beneficiaries no less than 60 days prior to the transition to MLTSS.

- g. To facilitate collaboration with case management functions, the State agencies will require each MCO to have a MLTSS Consumer Advisory Committee including representation of MLTSS stakeholders, including participants, case managers, and others, and will address issues related to MLTSS.
- h. Upon receipt of a plan acceptable by the State Medicaid Agency, it will perform a desk-level review of the MCO's policies and procedures, an on-site review to validate readiness.
- i. The State will develop a readiness certification /review tool to assure uniformity in the determinations made about each MCO's compliance and its ability to perform under the MLTSS contract provisions.

64. Readiness Review Requirements. The State shall begin a readiness review of each MCO at least 90 days prior to program implementation.

- a. Readiness reviews shall address each MCO's capacity to serve the enrollees, including, but not limited to, adequate network capacity, and operational readiness to provide the intensive level of support and care management to this population as well as the ability to implement a self-direction program.
- b. At least 30 days prior to the State's planned implementation date for the expansion, the State must submit the following to CMS review, according to the timelines specified below:
 - i. A list of deliverables and submissions the State will request from health plans to establish their readiness, with a description of the State's approach to analysis and verification;
 - ii. Plans for ongoing monitoring and oversight of MCO contract compliance;
 - iii. A contingency plan for addressing insufficient network issues;
 - iv. A plan for the transition from the section 1915(c) waiver program to the demonstration HCBS programs as described in STC 63;
 - v. Proposed managed care contracts or contract amendments, as needed, to implement the Expansion.
- c. CMS reserves the right to request additional documentation and impose additional milestones on the Expansion in light of findings from the readiness review activities.
- d. The transition plan terminating 1915(c) waiver services for these populations must be submitted to notify CMS as part of the Readiness Review specified in STC 63 and with the "intent to terminate 1915(c) waivers" letter that must be sent to the CMS Regional Office writing at least 30 days prior to waiver termination, per 42 CFR 441.307.

65. **Steering Committee.** For a period of time, DMAHS will authorize a MLTSS Steering Committee that will include adequate representation of stakeholders. Additionally, its Medical Care Advisory Committee per 42 CFR 431.12 will include MLTSS representation.
66. **Transition of Care Period from FFS to Managed Care.** Each enrollee who is receiving HCBS and who continues to meet the appropriate level of care criteria in place at the time of MLTSS implementation must continue to receive services under the enrollee's pre-existing service plan until a care assessment has been completed by the MCO. During this assessment, should the MCO determine that the enrollee's circumstances have changed sufficiently to warrant a complete re-evaluation, such a re-evaluation shall be initiated. Any reduction, suspension, denial or termination of previously authorized services shall trigger the required notice under 42 CFR 438.404.
67. **Money Follows the Person (MFP).** The State will continue to operate its MFP demonstration program outside of the section 1115 demonstration. Under New Jersey's MFP program, the State will continue its responsibilities for developing transitional plans of services for enrollees. With the implementation of MLTSS on January 1, 2013 or at a date thereafter, the State must update the MFP demonstration's Operational Protocols. A draft of the revised Operational Protocol will be due to CMS by 30 days prior to implementation of MLTSS.
- a. The MLTSS plans' responsibilities include:
1. Identifying enrollees who may be appropriate to transition from nursing homes;
 2. Referring enrollees to State staff in the MFP office;
 3. Providing ongoing care, case management and coordination when the enrollee returns to the community;
 4. The delivery of MLTSS, and
 5. Reassessing the MFP participant prior to the 365th day in the MFP program and designating which HCBS services are the most appropriate.
68. **Nursing Facility Diversion.** Each MCO, with assistance from the State, will develop and implement a "NF Diversion Plan" to include processes for enrollees receiving HCBS and enrollees at risk for NF placement, including short-term stays. The diversion plan will comply with requirements established by the State and be prior approved by the State, and CMS. The Plan will include a requirement for the MCOs to monitor hospitalizations and short-stay NF admission for at-risk enrollees, and identify issues and strategies to improve diversion outcomes.
69. **Nursing Facility Transition to Community Plan.** Each MCO, with assistance from the State, will develop and implement a "NF to Community Transition Plan" for each enrollee placed in a NF when the enrollee can be safely transitioned to the community, and has requested transition to the community. The Plan will include a requirement for the MCOs to work with State entities overseeing services to older adults and other special populations utilizing NF services. Each MCO will have a process to identify NF residents with the ability

and desire to transition to a community setting. MCOs will also be required to monitor hospitalizations, re-hospitalizations, and NF admissions to identify issues and implement strategies to improve enrollee outcomes.

70. Level of Care Assessment for MLTSS Enrollees. The following procedures and policies shall be applied to enrollees receiving MLTSS:

- a. An evaluation for LOC must be given to all applicants for whom there is reasonable indication that services may be needed by either the State or the MCO.
 - i. The plans and the State will use the “NJ Choice” tool as the standardized functional assessment for determining a LOC.
 - ii. In addition to the NJ Choice tool, the State and the MCOs may also utilize the "Home and Community-Based Long Term Care Assessment" Form (CP-CM-1).
- b. The State must perform the assessment function for individuals not presently enrolled in managed care. The MCO must complete the LOC assessment as part of its comprehensive needs assessment for its members and will forward to the State for final approval for those individuals determined to meet NF LOC.
- c. The MCOs must not fundamentally alter the nature of the NJ Choice tool when accommodating it to their electronic/database needs.
- d. The MCOs and, or the State must perform functional assessments within 30 days of the time a referral is received.
- e. All enrollees must be reevaluated at least annually or as otherwise specified by the State, as a contractual requirement by the MCO.

71. Demonstration Participant Protections under MLTSS. The State will assure that children, youth, and adults in MLTSS and HCBS programs are afforded linkages to protective services through all service entities, including the MCOs.

- a. The State will ensure that these linkages are in place before, during, and after the transition to MLTSS.
- b. The State/MCO’s will develop and implement a process for community-based providers to conduct efficient, effective, and economical background checks on all prospective employees/providers with direct physical access to enrollees.

72. Institutional and Community-Based MLTSS. The provisions related to institutional and community-based MLTSS are as follows:

- a. Enrollees receiving MLTSS will most often receive a cost-effective placement, which will usually be in a community environment.
- b. Enrollees receiving MLTSS will typically have costs limited/aligned to the annual expenditure associated with their LOC assessment (e.g. Hospital, Nursing Facility).
- c. Exceptions are permitted to the above provisions in situations where a) an enrollee is transitioning from institutional care to community-based placement; b) the enrollee experiences a change in health condition expected to last no more than six months that involve additional significant costs; c) special circumstances where the State determines an exception must be made to accommodate an enrollee's unique needs. The State will establish a review procedure to describe the criteria for exceptional service determinations between the State and the MCOs which shall be approved by CMS.
- d. MCOs may require community-based placements, provided the enrollee's PoC provides for adequate and appropriate protections to assure the enrollee's health and safety.
- e. If the estimated cost of providing the necessary community-based MLTSS to the enrollee exceeds the estimated cost of providing care in an institutional setting, the MCO may refuse to offer the community-based MLTSS. However, as described in (c) above, exceptions may be made in individual special circumstances where the State determines the enrollee's community costs shall be permitted to exceed the institutional costs.
- f. If an enrollee whose community-based costs exceed the costs of institutional care refuses to live in an institutional setting and chooses to remain in a community-based setting, the enrollee and the MCO will complete a special risk assessment detailing the risks of the enrollee in remaining in a community-based setting, and outlining the safeguards that have been put in place. The risk assessment will include a detailed back-up plan to assure the health and safety of the enrollee under the cost cap that has been imposed by the State.
- g. Nothing in these STCs relieves the State of its responsibility to comply with the Supreme Court *Olmstead* decision, and the Americans with Disabilities Act.

73. Care Coordination for MLTSS. Care Coordination is services to assist enrollees in gaining access to needed demonstration and other services, regardless of the funding source. Care Coordinators are responsible for ongoing monitoring of the provision of services included in the PoC and assuring enrollee health and safety. Care Coordinators initiate the process to evaluate or re-evaluate the enrollee's PoC, his or her level of care determination (where appropriate), and other service needs.

- a. Integrated care coordination for physical health and MLTSS will be provided by the MCOs in a manner that is "conflict-free."

- b. The State will establish a process for conflict free care coordination, to be approved by CMS that will include safeguards, such as separation of services and other structural requirements, State/enrollee oversight, and administrative review.
- c. Each MCO shall also assign a Behavioral Health Administrator to develop processes to coordinate behavioral health care with physical health care and MLTSS, in collaboration with the care coordinators.
- d. The State will assure that there are standard, established timelines for initial contact, assessment, development of the PoC, the individual service agreement, and authorization and implementation of services between the state and the MCOs.
- e. Care coordinators must monitor the adequacy and appropriateness of services provided through self-direction, and the adequacy of payment rates for self-directed services.

XI. SPECIAL TARGETED HCBS PROGRAMS

74. New HCBS Programs. HCBS is provided outside of the Managed Long Term Services and Supports (MLTSS) MCO in the following programs: The Supports Program; Persons with Pervasive Developmental Disorders (PDD); Persons with intellectual disabilities and mental illness (IDD/MI); Persons with intellectual developmental disabilities who live out of state (IDD OOS) but in an HCBS setting; Serious emotional disturbance (SED) and Medication Assisted Treatment Initiative (MATI).

75. Network Adequacy and Access Requirements. The State must ensure that the fee-for service network complies with network adequacy and access requirements, including that services are delivered in a culturally competent manner that is sufficient to provide access to covered services to the low-income population. Providers must meet standards for timely access to care and services, considering the urgency of the service needed.

- a. Accessibility to primary health care services will be provided at a location in accordance at least equal to those offered to the Medicaid fee-for-service participants.
- b. Primary care and Urgent Care appointments will be provided at least equal to those offered to the Medicaid fee-for-service participants.
- c. Specialty care access will be provided at least equal to those offered to the Medicaid fee-for-service participants.
- d. FFS providers must offer office hours at least equal to those offered to the Medicaid fee-for-service participants.
- e. The State must establish mechanisms to ensure and monitor provider compliance and must take corrective action when noncompliance occurs.

- f. The State must establish alternative primary and specialty access standards for rural areas in accordance with the Medicaid State Plan.

76. **Provider Credentialing.** The provider credentialing criteria are included for each separate service as outlined in Attachment C. To assure the health and welfare of the demonstration participants, the State verifies that providers initially and continually meet required licensure and/or certification standards and adhere to other standards prior to furnishing services. The State also monitors non-licensed/non-certified providers to assure adherence to other standards prior to their furnishing waiver services.

77. **Non-duplication of Services.** HCBS will not duplicate services included in an enrollee's Individualized Education Program under the Individuals with Disabilities Education Act, or services provided under the Rehabilitation Act of 1973.

78. **Supports Program**

- a. Program Overview: The Supports Program is to provide a basic level of support services to individuals who live with family members or who live in their own homes that are not licensed by the State.
- b. Operations: The administration of the program is through the Division of Developmental Disabilities (DDD).
- c. Eligibility:
 - i. Are Medicaid eligible;
 - ii. Are at least 21 years of age and have completed their educational entitlement;
 - iii. Live in an unlicensed setting, such as on their own or with their family; and
 - iv. Meet all criteria for functional eligibility for DDD services including the following definition of "developmental disability": Developmental disability is defined as: "a severe, chronic disability of an individual which:
 - 1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
 - 2. Is manifest before age 22;
 - 3. Is likely to continue indefinitely;
 - 4. Results in substantial functional limitations in three or more of the following areas of major life activity, that is: self-care, receptive and expressive language, learning, mobility, self-direction capacity for independent living and economic self-sufficiency;

5. Reflects the need for a combination and sequences of special interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and are individually planned and coordinated; and
 6. Includes but is not limited to severe disabilities attributable to intellectual disability, autism, cerebral palsy, epilepsy, spina bifida and other neurological impairments where the above criteria are met.”
- d. POC Referral. When it has been confirmed that a candidate has met all of the requirements for enrollment, DDD will refer the case to the appropriate support coordination provider for development of the Participant's plan of care (PoC) and initiation of services.
- e. Exclusions: Individuals may not enroll in the Supports Program if:
- i. They are enrolled in another HCBS/MLTSS program, the Out-of-State IDD programs, or the Community Care Waiver.
 - ii. They require institutional care and cannot be maintained safely in the community.
- f. Expenditure Cap. Participants in the program will have an individual expenditure cap per person per year that is based on functional assessment. This expenditure cap is reevaluated annually during development of the annual plan of care.
- g. Case Management. Every Participant will have access to Support Coordination (case management) which is outside of the expenditure cap. Every Participant will have access (if they choose) to Financial Management Services (fiscal intermediary) if he/she chooses to self-direct services. This will also be outside of the expenditure cap.
- h. Bump-Up. This program also contains a unique feature whereby Participants who experience a major change in life circumstances which results in a need for additional temporary services may be eligible to receive a short-term “bump up” in their expenditure cap. This “bump up” is capped at \$5,000 per Participant. The bump up will be effective for up to one year. Participants may only seek bump up services once every three years. The services that may be purchased with bump up dollars are any services described in Attachment C-1 under Supports Program, with the exception of the Day Program Related Services described above.
- i. Enrollment: All referrals for the Supports Program are screened by DDD to determine if the individual meets the target population criteria, is Medicaid eligible, meets LOC clinical criteria, is in need of support services, and participant’s needs can be safely met in the community. Individuals who currently receive state-funded day services and/or state-funded support services as of the effective date of the demonstration will be

assessed for Medicaid eligibility and LOC clinical criteria and enrolled into the program in phases. When potential new participants are referred, they will be assessed for eligibility and enrolled based on availability of annual state budget allocations.

- j. Level of Care (LOC) Assessment: The participant has a developmental disability and substantial functional limitations in three or more major life activities.
- k. Assessment tool: DDD is in the process of streamlining their current multiple assessment instruments that will be used to assess clinical LOC and functional level for budget determination(s). A statement will be included certifying that an individual meets the functional criteria for DDD and is eligible for the Supports Program.
- l. LOC Reassessment: Reassessment will occur when there is a noted change in a participant's functional level that warrants less supports.. The initial LOC assessment is based on an individual being diagnosed with a developmental disability and substantial functional limitation in three or more major life activities. This is unlikely to change from year to year.
- m. Transition: If health and safety cannot be maintained for a participant on this program because s/he requires a higher level of services than are available, the IDT will make the recommendation and the participant will voluntarily disenroll from the program. The IDT will commence transition planning to identify service needs and necessary resources. Referrals will be made to all services, as applicable including the Community Care Waiver.
- n. Disenrollment: Participants will disenroll from the program if they lose Medicaid eligibility, choose to decline participation in the program, enroll on the CCW, no longer need support services, or no longer reside in New Jersey.
- o. Benefits/Services, Limitations, and Provider Specifications: In addition to Plan A services in Attachment B, Supports program participants receive the benefits outlined in Attachment C.
- p. Cost Sharing: See Attachment B.
- o. Delivery System: Medicaid State Plan services for this population will be delivered and coordinated through their Medicaid MCO. HCBS services available to this population will be delivered either through providers that are enrolled as Medicaid providers and are approved by DDD or through non-traditional service providers that are approved by DDD and bill for services through a fiscal intermediary. Services can be either provider-managed, self-directed, or a combination thereof, as approved in the participant's Plan of Care.

79. Pervasive Developmental Disorders (PDD) Pilot Program

- a. Program Overview: This program is intended to provide NJ FamilyCare/Medicaid eligible children with needed therapies that they are unable to access via the State plan that are available to other children via private health insurance. The State will provide children up to their 13th birthday who have a diagnosis of Pervasive Developmental Disability (PDD), with habilitation services. Through the assessment process, PDD participants will be screened by DCF to determine eligibility, LOC, and to determine their level of need. Those with the highest need will receive up to \$27,000 in services; those with moderate needs will receive up to \$18,000 in services and the lowest needs participants will receive \$9,000 in PDD services. If the participant's needs change at any time, she/he can be reassessed to determine the current acuity level and the service package would be adjusted accordingly. Services will be coordinated and managed through the participant's Plan of Care, as developed by the Care Managers with the Medicaid MCOs.

- b. Eligibility: Children up to their 13th birthday who are eligible for either the New Jersey Medicaid or CHIP programs and have a PDD diagnosis covered under the *DSM IV* (soon to be *DSM V*) as determined by a medical doctor, doctor of osteopathy, or Ph.D. psychologist using an approved assessment tool referenced below:
 - i. Approved Assessment Tools include:
 1. ABAS – Adaptive Behavior Assessment System II
 2. CARS – Childhood Autism Rating Scale
 3. DDRT – Developmental Disabilities Resource Tool
 4. GARS – Gilliam Autism Rating Scale
 5. ADOS – Autism Diagnostic Observation Scale
 6. ADI – Autism Diagnostic Interview-Revised
 7. ASDS – Asperger's Syndrome Diagnostic Scale

 - ii. Meet the ICF/MR level of care criteria

- c. Exclusions:
 - i. Individuals over the age of 13

 - ii. Individuals without a PDD diagnosis

 - iii. Children with private insurance that offers these types of benefits, whether or not they have exhausted the benefits.

- d. Enrollment: Potential PDD program participants are referred to DCF for screening and assessment. Once a child has been determined to have a PDD and assessed for LOC clinical eligibility and acuity level by DCF, she/he will be referred to DMAHS for enrollment onto the demonstration.

- e. Enrollment Cap: In cases where the State determines, based on advance budget projections that it cannot continue to enroll PDD Program participants without exceeding

the funding available for the program the State can establish an enrollment cap for the PDD Program.

- i. *Notice* - before affirmatively implementing the caps authorized in subparagraph (e), the State must notify CMS at least 60 days in advance. This notice must also include the impact on budget neutrality.
 - ii. *Implementing the Limit* - if the State imposes an enrollment cap, it will implement a waiting list whereby applicants will be added to the demonstration based on date of application starting with the oldest date. Should there be several applicants with the same application date, the State will enroll based on date of birth starting with the oldest applicant
 - iii. *Outreach for those on the Wait Lists* - the State will conduct outreach for those individuals who are on the PDD Program wait list for at least 6 months, to afford those individuals the opportunity to sign up for other programs if they are continuing to seek coverage. Outreach materials will remind individuals they can apply for Medicaid.
 - iv. *Removing the Limit* – the State must notify CMS in writing at least 30 days in advance when removing the limit.
- f. LOC Criteria: The participant has substantial functional limitations in three or more major life activities, one of which is self care, which require care and/or treatment in an ICF/MR or alternatively, in a community setting. The substantial functional limitations shall be evaluated according to the expectations based upon the child’s chronological age. When evaluating very young children, a showing of substantial functional limitations in two or more major life activities can be enough to qualify the child, due to the lack of relevance of some of the major life activities to young children (e.g., economic sufficiency).
- i. *LOC Assessment*: Administration, by a licensed clinical professional approved and/or employed by the State, of the assessment tool to be developed by the State prior to implementation will be used to determine ICF/MR LOC will be performed prior to enrollment into the program and a minimum of annually thereafter.
 - ii. *LOC Reassessment*: A reassessment will be conducted a minimum of annually and will use the same tool.
- g. Transition: The services offered under this program are targeted for young children. When a child in the demonstration reaches 12 years of age, transition planning will be initiated by the Interdisciplinary Team and the Medicaid MCO to identify service needs & available resources, support the participant, and maintain health and safety. Referrals will be made to all services as applicable. Should an individual require continued HCBS services, enrollment will be facilitated to other programs.

- h. Disenrollment: A participant will be disenrolled from the demonstration for the following reasons:
 - i. Age out at age 13
 - ii. Participant is deemed no longer in need of services, as per the reassessment process.
 - iii. Loss of NJ FamilyCare/Medicaid eligibility
 - iv. Participant no longer resides in New Jersey
- i. Benefits/Services, Limitations, and Provider Qualifications: In addition to Medicaid and CHIP State Plan services listed in Attachment B, this demonstration population receives a PDD service package of benefits. The full list of services may be found in Attachment C. Services rendered in a school setting are not included in this program.
- j. Cost sharing: See Attachment B.
- k. Delivery System: All State plan and PDD services for this population will be delivered and coordinated through their Medicaid MCO. Behavioral health services will be delivered and coordinated through the children's ASO. The Plan of Care will be developed and overseen by the Medicaid MCOs care management staff.

80. Intellectual Disabilities/ Development Disabilities with Co-Occurring Mental Health Diagnoses (ID-DD/MI) Pilot

- a. Program Overview: The primary goal of the program is to provide a safe, stable, and therapeutically supportive environment for children with developmental disabilities and co-occurring mental health diagnoses, ages five (5) up to twenty-one (21), with significantly challenging behaviors. This program provides intensive in-home and out-of-home services.
- b. Delivery System and Benefits: All Medicaid State Plan services through their Medicaid MCO; behavioral health and demonstration services through the children's ASO.
- c. Eligibility: Medicaid-eligible children with developmental disabilities and co-occurring mental health diagnoses, age five (5) up to twenty-one (21), who are still in their educational entitlement, have significantly challenging behaviors, and meet the LOC clinical criteria. Developmental disability is defined as: "a severe, chronic disability of an individual which:
 - i. is attributable to a mental or physical impairment or combination of mental and physical impairments;
 - ii. is manifest before age 21;

- iii. is likely to continue indefinitely;
 - iv. results in substantial functional limitations in three or more of the following areas of major life activity, that is: self care, receptive and expressive language, learning, mobility, self-direction capacity for independent living and economic self-sufficiency;
 - v. reflects the need for a combination and sequences of special interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and are individually planned and coordinated;
 - vi. includes but is not limited to severe disabilities attributable to intellectual disability, autism, cerebral palsy, epilepsy, spina bifida and other neurological impairments where the above criteria are met;”
 - vii. the substantial functional limitations shall be evaluated according to the expectations based upon the child’s chronological age; and
 - viii. Mental health diagnosis is defined as: “ a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet the diagnostic criteria specified within DSM-IV-TR with the exception of other V codes, substance use, and developmental disorders, unless these disorders co-occur with another diagnosable disturbance.”
- d. Exclusions:
- i. Individuals who are not residents of New Jersey
 - ii. Services eligible to be provided through their educational entitlement are not covered under this demonstration
 - iii. For in-home services, these cannot be provided if the family/caregiver is unwilling or unable to comply with all program requirements. In these instances, individuals will be provided with out-of-home services if necessary.
- e. LOC Assessment: Co-occurring developmental disability and mental health diagnosis that meets the state mental hospital level of care. The participant will be assessed at least annually, using the New Jersey System of Care Strengths and Needs Assessment tool.
- f. Enrollment: All referrals for the program are screened to determine if the individual meets the target population criteria, is Medicaid eligible, meets LOC clinical criteria, is in need of program services, and participant’s needs can be safely met in the community.
- g. Enrollment Cap: In cases where the State determines, based on advance budget

projections that it cannot continue to enroll ID-DD/MI participants without exceeding the funding available for the program the State can establish an enrollment cap for the ID-DD/MI program.

- i. *Notice:* Before affirmatively implementing the caps authorized in subparagraph (g), the State must notify CMS at least 60 days in advance. This notice must also include the impact on budget neutrality.
 - ii. *Implementing the Limit* - if the State imposes an enrollment cap, it will implement a waiting list whereby applicants will be added to the demonstration based on date of application starting with the oldest date. Should there be several applicants with the same application date, the State will enroll based on date of birth starting with the oldest applicant
 - iii. *Outreach for those on the Wait Lists* - the State will conduct outreach for those individuals who are on the IDD Out-of-State wait list for at least 6 months, to afford those individuals the opportunity to sign up for other programs if they are continuing to seek coverage. Outreach materials will remind individuals they can apply for Medicaid.
 - iv. *Removing the Limit* – the State must notify CMS in writing at least 30 days in advance when removing the limit.
- h. **Disenrollment:** An individual will be disenrolled from the program for the following reasons:
- i. The family/caregiver declines participation or requests to be disenrolled from the program; or
 - ii. The family/caregiver is unable or unwilling to implement the treatment plan or fails to comply with the terms as outlined in the plan. Prior to disenrollment, the team will collaborate and make substantial efforts to ensure the individual’s success in the program, including working to remedy any barriers or issues that have arisen. An individual will only be disenrolled after significant efforts have been made to achieve success. If they will be disenrolled, the team will make recommendations and identify alternative local community and other resources for the individual prior to disenrollment; or
 - iii. The individual’s documented treatment plan goals and objectives have been met.
- i. **Transition:** At least one year in advance of an individual aging out of this program, the Interdisciplinary Team and Medicaid MCO will commence transition planning to identify service needs and necessary resources. Referrals will be made to all services, as

applicable. Should an individual require continued HCBS services, enrollment will be facilitated to the other program.

- j. Benefits/Services, Limitations, and Provider Qualifications: In addition to Medicaid State Plan services, this population receives HCBS service package of benefits designed to provide the appropriate supports to maintain the participants safely in the community. The full list of program services may be found in Attachment C.
- k. Cost Sharing: For out of home services: The family of the individuals receiving ID/DD-MI out of home services will be assessed for their ability to contribute towards the cost of care and maintenance. The amount paid by the family is based both on earned (wages over minimum wage) and unearned income.

81. Intellectual Developmental Disability Program for Out of State (IDD/OOS)New Jersey Residents

- a. Program Overview: This program consists of individuals who receive out-of-state HCBS coordinated by DDD. Services claimed through this program will not duplicate services provided through a participant's educational entitlement or via the Rehabilitation Act. Other than the individuals currently living in an eligible out of state setting who will be enrolled onto the IDD/OOS program. The only additional demonstration participants who will be added to this program are those who DDD has been court-ordered to provide the services in an out-of-state setting.
- b. Eligibility: An individual must be Medicaid eligible and meet all criteria for DDD eligibility for services. Specifically, an individual must be determined functionally eligible, based on a determination that they have a developmental disability and must apply for all other benefits for which he or she may be entitled. Developmental disability is defined as: "a severe, chronic disability of an individual which: (1) is attributable to a mental or physical impairment or combination of mental and physical impairments; (2) is manifest before age 22; (3) is likely to continue indefinitely; (4) results in substantial functional limitations in three or more of the following areas of major life activity, that is: self care, receptive and expressive language, learning, mobility, self-direction capacity for independent living and economic self-sufficiency (e.g.5) reflects the need for a combination and sequences of special interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and are individually planned and coordinated; and (6) includes but is not limited to severe disabilities attributable to intellectual disability, autism, cerebral palsy, epilepsy, spina bifida and other neurological impairments where the above criteria are met."
- c. Exclusionary Criteria:
 - i. Individuals who live in New Jersey;
 - ii. Individuals who are enrolled in another HCBS program;
 - iii. Individuals who have declared residency in another state;

- iv. Individuals who require institutional care and cannot be maintained safely in the community; and
 - v. Individuals who do not meet ICF/MR-DD level of care
- d. Enrollment: New enrollments in the IDD Out-of-State program will only include those demonstration participants who are currently residing in an eligible out of state setting or those individuals who are court ordered after the effective date of this program to receive services outside of New Jersey.
- e. LOC Assessment: The LOC criteria: The participant has substantial functional limitations in three or more major life activities, one of which is self care, which require care and/or treatment in an ICF/MR-DD or alternatively, in a community setting. The LOC tool will be developed prior to the program being implemented.
- f. LOC Reassessment: The reassessment is made as part of the annual Service Plan for each participant. Functional assessment tools are utilized to confirm LOC assessment and to determine service needs. Goals and training in the Service Plan are based on the needs identified at the time of the reassessment.
- g. Transition: New individuals will not transition into this program, except per court order. Individuals will transition out of this program as outlined in Program Overview and Disenrollment. The majority of individuals transitioning out of this program will transition into community-based settings in New Jersey and will then be enrolled on the Community Care Waiver or the Supports Program.
- h. Disenrollment: An individual will be disenrolled from the program for the following reasons:
- i. Acceptable alternative services are identified in state and the individual is returned to New Jersey;
 - ii. Residency in the state in which they are currently receiving services can be established and/or the individual transfers to services funded by that state;
 - iii. An individual declines participation/requests to be disenrolled;
 - iv. The agency serving the individual notifies the individual and DDD (30 days advance notice is required) that they can no longer serve the individual for one of the following reasons:
 - 1) The individual's medical needs have increased and the provider is no longer able to manage their care;
 - 2) The individual's behaviors have escalated and the provider is no longer able to manage their care.
- i. Benefits: In addition to Medicaid State Plan services Plan A in Attachment B, this population receives HCBS service package of benefits designed to provide the appropriate supports to maintain the participants safely in the community.

- j. Delivery System: Medicaid State Plan and HCBS services are delivered through fee-for-service, coordinated by New Jersey's DDD. The State assures CMS that 100 percent of the payment to providers is maintained by the provider. The State shall only claim its federal match rate for any out of State services rendered, based upon the federal match rate of NJ.

82. Program for Children diagnosed with Serious Emotional Disturbance (SED)

- a. Program Overview: The SED Program provides behavioral health services for demonstration enrollees who have been diagnosed as seriously emotionally disturbed which places them at risk for hospitalization and out-of-home placement.
- b. Eligibility: Enrollees in the SED Program must meet the following criteria:
 - i. All children served under this population who are eligible for Medicaid or CHIP State plan populations, or,
 - ii. NJ will use the Institutional Medicaid financial eligibility standards of:
 - 1) Children from age of a SED diagnosis up to age 21 years will be eligible for the services;
 - 2) The child must meet a hospital level of care up to 300% of FBR or at risk of hospitalization up to 150% FPL;
 - 3) Must be a US Citizen or lawfully residing alien;
 - 4) Must be a resident in the State of New Jersey; and
 - 5) For the purposes of this program, "family" is defined as the persons who live with or provide care to a person served in the SED Program, and may include a parent, step parent, legal guardian, siblings, relatives, grandparents, or foster parents.
- c. Functional Eligibility: To be functionally eligible for the SED program, the enrollee must meet one of the two programmatic criteria for participation:
 - i. Acute Stabilization Program– the enrollee must meet the following criteria necessary for participation in this LOC.
 - 1) The enrollee must be between the ages of 5 and up to 21 years. Special consideration will be given to children under age five which include:

- a. The child meets the clinical criteria for the services for which are being sought.
 - b. The child cannot obtain the needed services through the NJ Early Intervention Program through the Department of Health
 - c. The Medical Director at the ASO reviews determines the service is appropriate, and authorizes the service.
 - 2) The DCBHS Assessment and other relevant information must indicate that the enrollee has a need that can be served by the Care Management Organization or the Mobile Response Stabilization Services LOC.
 - 3) The enrollee exhibits at-risk behaviors.
 - 4) The enrollee exhibits behavioral/emotional symptoms based on the NJ System of Care Needs Assessment Tool.
 - 5) The enrollee is at risk of being placed out of his/her home or present living arrangement.
 - 6) The enrollee requires immediate intervention in order to be maintained in his/her home or present living arrangement.
- d. Enrollment: SED Program enrollees are initially referred to the children’s ASO by providers, parents, or schools. The ASO performs a clinical triage performed by an appropriately licensed clinician and screens for insurance including Medicaid and CHIP programs. Any youth that is determined in the initial screening to potentially be SED must receive a complete “in-community” bio-psycho-social assessment that includes the completion of the Child and Adolescent Needs and Strengths (CANS) Assessment. This assessment, reviewed by the ASO, will be used to determine enrollment.
- e. Reassessment: The Care Management Organization must submit an updated Individualized Service Plan (ISP) at least every 90 days and the ASO must make a determination for continued eligibility with each submitted ISP.
- f. Exclusion criteria. Include at least one of the following:
- i. The person(s) with authority to consent to treatment for the youth refuses to participate
 - ii. Current assessment or other relevant information indicates that the enrollee/young adult can be safely maintained and effectively supported at a less intensive LOC.
 - iii. The behavioral symptoms are the result of a medical condition that warrants a medical setting for treatment as determined and documented by the child’s primary care physician and or the ASO Medical Director.

- iv. The enrollee has a sole diagnosis of Substance Abuse and there is no identified, co-occurring emotional or behavioral disturbances consistent with a DSM IV-TR Axis I Disorder.
- v. The enrollee's sole diagnosis is a Developmental Disability that may include one of the following:
 - 1) The enrollee has a sole diagnosis of Autism and there are no co-occurring DSM IV-TR Axis I Diagnoses or symptoms/behaviors consistent with a DSM IV-TR Axis I Diagnosis.
 - 2) The enrollee has a sole diagnosis of Intellectual Disability/Cognitive Impairment and there are no co-occurring DSM IV-TR Axis I Diagnoses or symptoms/behaviors consistent with a DSM IV-TR Axis I Diagnosis.

83. Medication Assisted Treatment Initiative (MATI)

- a. Program Overview. Effective July 1, 2013, or a date thereafter, the treatment program delivers a comprehensive array of medication-assisted treatment and other clinical services through MATI provider mobile and office-based sites. The program goals include:
 - i. The reduction in the spread of blood borne diseases through sharing of syringes;
 - ii. The reduction of opioid and other drug dependence among eligible participants;
 - iii. The stabilization of chronic mental health and physical health conditions; and,
 - iv. Improved housing and employment outcomes among program participants.
- b. Eligibility: Demonstration enrollees applying for services must be screened by the mobile or fixed site service provider using a standardized clinical and functional assessment tool that will be independently reviewed by appropriate qualified clinicians to determine if the applicant meets the following program eligibility criteria:
 - i. Be a resident of New Jersey and at least 18 years old;
 - ii. Have household income at or below 150% of FPL;
 - iii. Have a history of injectable drug use;
 - iv. Test positive for opiates or have a documented one-year history of opiate dependence; this requirement may be waived for individuals who have recently been incarcerated and subsequently released or in residential treatment.
 - v. Provide proof of identification (to prevent dual enrollment in medication assisted treatment)

- vi. Not currently enrolled as a client in an Opioid Treatment Program (OTP) or a client under the care of a Center for Substance Abuse Treatment (CSAT) waived physician providing Office-Based Opioid Treatment Services (OBTS)
- c. Programmatic Eligibility - Applicants must also meet at least two of the following criteria:
- i. Diagnosed with a mental illness or a substance use disorder at least once in their lifetime by a licensed professional in the state of New Jersey qualified to render such a diagnosis within their scope of practice.
 - 1) A mental illness diagnosis may be rendered by: an MD or DO Board Certified or Board eligible in psychiatry; a Certified Nurse Practitioner-Psychiatry and Mental Health (CNP-PMH); an Advanced Practice Nurse-Psychiatry and Mental Health (APN-PMH); a Physician's Assistant (PA) w/Psychiatric and Mental Health certification; a Licensed Clinical Social Worker (LCSW); Licensed Professional Counselor (LPC); Licensed Psychologist; or Licensed Marriage and Family Therapist (LMFT).
 - 2) A substance use disorder diagnosis may be rendered by one of the qualified licensed professionals listed above or a Licensed Clinical Alcohol and Drug Counselor (LCADC).
 - ii. Diagnosed with one or more chronic medical conditions (e.g., Chronic Obstructive Pulmonary Disease (COPD), Diabetes, HIV/AIDS, Hepatitis C, Asthma, etc.).
 - iii. Homeless or lacking stable housing for one year or longer.
 - iv. Unemployed or lacking stable employment for two years or longer.
- d. Enrollment: Enrollees in the MATI program who are not eligible for other demonstration populations and only gain demonstration eligibility for MATI services by enrollment into the MATI program. The MATI population is able to enroll in the program directly at the MATI provider agency mobile medication unit or office-based site. The MATI provider, in collaboration with the ASO, will facilitate Medicaid enrollment.
- e. Level of Care Assessment: The provider must conduct an initial assessment of the program applicant, including documentation of eligibility criteria, on the mobile unit or at the office-based site using an American Society of Addiction Medicine (ASAM)-based standardized clinical assessment tool to determine appropriateness for medication-assisted treatment and level of care placement. If the applicant is deemed clinically appropriate for medication assisted treatment he/she will meet with a qualified physician within 48 hours to determine the specific medication protocol.

- i. Documentation of program eligibility and clinical assessment results will be electronically submitted to the ASO for independent review.
 - ii. Within one business day, a determination of eligibility will be rendered from the ASO to both the provider and applicant.
 - iii. Upon enrollment in the MATI the ASO will provide for continued care management.
- f. **LOC Reassessment:** A reassessment of eligibility requirements will be conducted quarterly for each enrollee by the provider and sent to the ASO for review and approval of continuation in the program. Reassessment for eligibility will include review of the following criteria:
 - i. The enrollee continues to demonstrate need for medication assisted treatment (MAT) services to support recovery; and
 - ii. The enrollee continues to be at or below 150% of FLP; or
 - iii. The enrollee is above 150% FLP with no identified alternative payer.
- g. **Disenrollment:** A consumer will be considered no longer enrolled in the MATI program if they meet one of the following criteria:
 - i. The enrollee is no longer appropriate for MATI services to support recovery; as determined by consultation among the clinician, the physician and the consumer; or
 - ii. The enrollee continues to be appropriate for MATI services and has another identified payer.
- h. **Benefits:** Please refer to attachment F for a comprehensive list of MATI services and benefits.
- i. **Delivery System:** MATI services are reimbursed at fee-for-service through the ASO.

XII. PREMIUM ASSISTANCE PROGRAMS

84. New Jersey Family Care/Premium Support Program (PSP) – Title XXI Funded

- a. **Program Overview:** The PSP is designed to cover individual's eligible for NJ FamilyCare (and under certain conditions, non-eligible family members) who have access to cost effective employer-sponsored health plans. Some uninsured families have access to health insurance coverage through an employer, but have not purchased the

coverage because they cannot afford the premiums. Assistance is provided in the form of a direct reimbursement to the beneficiary for the entire premium deduction or a portion thereof required for participation in the employer-sponsored health insurance plan. Beneficiaries are reimbursed on a regular schedule, to coincide with their employer's payroll deduction, so as to minimize any adverse financial impact on the beneficiary. Note that this program operates under title 2105(c)(3) of the Social Security Act, but has waived certain title XXI provisions for children and families by virtue of this Section 1115 demonstration.

- b. Eligibility Requirements: Parents and/or their children must be determined eligible for NJ FamilyCare in order to participate in the PSP. If the PSP unit determines that the parents have a cost-effective employer-sponsored plan available to them, the parents must enroll in the plan as a condition of participation in the NJ FamilyCare program. The PSP will reimburse the premiums for the non-eligible family members only if it is cost-effective in the aggregate. Children and parents must *not* have had coverage under a group health plan for three months prior to enrollment in the PSP. If proven cost effective, family members are required to enroll in ESI as their primary healthcare plan rather than direct state plan coverage.
- c. Benefit Package: NJ's Plan mirrors the benchmark health plan offered through an HMO with the largest commercial, non-Medicaid enrollment in the state. If the employer's health plan is not equal to Plan D, then the state provides wraparound services for children and adults through its managed care organizations. "Wraparound service" means any service that is not covered by the enrollee's employer plan that is an eligible service covered by NJ FamilyCare for the enrollee's category of eligibility. This process is similar to how NJ currently handles all other beneficiaries who have TPL. Assurances to that effect will also be inserted in the Managed Care contract.

(Process for Benefit Analysis: If an uninsured parent has access to employer-sponsored insurance, the PSP Unit evaluates the employer's health plan and compares the services to NJ FamilyCare services, taking into account any limitations on coverage.)

- d. Cost Sharing: Premiums and co-payments vary under employer-sponsored plans regardless of FPL, but cost sharing is capped at 5 percent of the individual or family's gross income. This protection applies equally to parents enrolled in NJ FamilyCare and to parents enrolled in an employer-sponsored plan through the PSP.
 - i. The PSP will reimburse the beneficiary for the difference between the NJFC/PSP co-payment amount and that of the employer-sponsored plan co-payment amount. For example, if the NJFC/PSP co-payment amount for a physician's office visit is \$5.00 and the employer-sponsored plan co-pay charge is \$15.00 for the same service, the PSP will reimburse the beneficiary the difference in excess of the NJFC/PSP co-payment amount (\$10.00).

- ii. When the 5 percent limit is reached for the year, the parent's NJ FamilyCare identification card is revised to indicate that no cost-sharing can be imposed for the rest of the calendar year.
 - iii. If the PSP participant makes an out-of-pocket payment after the 5 percent limit is reached, any additional charges submitted to the PSP for the remainder of the calendar year are reimbursed at 100 percent as long as the parent submits proof of additional expenses.
 - iv. Parents may also request that the PSP notify medical service providers that a voucher can be submitted to the PSP for any cost sharing charges for the remainder of the year.
- e. Employer Contribution: Each plan must provide an employer contribution amount as required under 2105(c)(3). The amount will not be specified by the State and can vary by plan. The contribution amount may range from 5% to 100%.
- f. Cost Effectiveness Test –
 - i. Cost-effectiveness shall be determined by comparing the cost, including administrative costs, of the beneficiary/employee and all eligible family members' participation in the NJ FamilyCare program against the total cost to the State of reimbursing the beneficiary/employee for the employee share of the cost of family coverage less a monthly premium contribution amount under the CHIP state plan for the family purchasing the employer plan. The amounts used for the calculations shall be derived from actuarial tables used by the NJ FamilyCare program and actual costs reported by the employee/employer during the processing of the Premium Support Program (PSP) application.
 - ii. For the State to provide benefits under NJ FamilyCare, an actuarially valid total cost per family per month will be determined, using current data from NJ FamilyCare (NJFC), Managed Care participant rates and also factoring in risk-adjusted scores.
 - iii. The cost of the employer-sponsored plan shall be determined by totaling the costs to the State to participate in the employer-sponsored plan. The monthly amount of the employee premium plus the actuarial value of all excess cost-sharing expenditures (co-payments, deductible and coinsurance), less the NJ FamilyCare/Premium Support Program monthly premium amount, plus the cost of "wraparound" services, if applicable, will constitute the total cost to the State to purchase the employer plan.
 - iv. As a condition of PSP approval, the result of the cost-effectiveness test shall indicate a cost savings difference of, at a minimum, five percent between what the State would pay for the employee's participation in the employer-

sponsored health plan vs. what the State would pay for the employee's participation in the NJ FamilyCare program alone.

- v. If the employer-sponsored plan is determined by the Division to be cost-effective in accordance with (a) above, the applicant shall participate in the Premium Support Program. If the employer-sponsored plan is determined not cost-effective, in accordance with (a) above, the beneficiary will continue to participate in the NJ FamilyCare program.

XIII. QUALITY

85. **Administrative Authority.** When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency shall maintain authority, accountability, and oversight of the program. The State Medicaid Agency shall exercise oversight of all delegated functions to operating agencies, MCOs and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.
86. **Quality for Managed Care/MLTSS.** The State must develop a comprehensive Quality Strategy with measures related to behavioral health and Managed Care measures to reflect all CHIP, Medicaid, Behavioral Health Programs, (including SED, PDD, and MATI Programs) acute and primary health care, and MLTSS operating under the programs proposed through this demonstration and submit to CMS for approval 90 days prior to implementation. The State must obtain the input of recipients and other stakeholders in the development of its comprehensive Quality Strategy and make the Strategy available for public comment.
87. **Quality for Fee for Service HCBS Programs.** The State must develop Quality Strategies to reflect all Programs operated under this demonstration through the Division of Developmental Disabilities and the Division of Children and Families. The State must obtain the input of recipients and other stakeholders in the development of its comprehensive Quality Strategy and make the Strategy available for public comment.
- a. FFS HCBS Programs under the Division of Developmental Disabilities (Supports, and IDD-OOS) will submit a quality plan to CMS for approval 60 days prior to the implementation of any programs.
 - b. FFS or ASO HCBS Programs - (ID-DD/MI) under the Division of Children and Families will submit a quality plan for CMS approval 60 days prior to the implementation of any programs.
88. **Content of Quality Strategy(ies).** All Managed Care, MLTSS (Comprehensive) and HCBS Quality Strategies for all services must include the application of a continuous quality improvement process, representative sampling methodology, frequency of data collections and analysis, and performance measure in the following areas:

- a. Outcomes related to qualities of life; and,
- b. Health and welfare of participants receiving services including:
 - i. Development and monitoring of each participant’s person-centered service plan to ensure that the State and MCOs are appropriately creating and implementing service plans based on enrollee’s identified needs.
 - ii. Specific eligibility criteria for each identified HCBS program that addresses level of care determinations – to ensure that approved instruments are being used and applied appropriately and as necessary, and to ensure that individuals being served with HCBS or MLTSS have been assessed to meet the required level of care for those services.
 - iii. Adherence to provider qualifications and/or licensure for HCBS programs and MCO credentialing and/or verification policies for managed care and MLTSS are provided by qualified providers. Also need to indicate specifications when the participant self directs. While these providers frequently are not credentialed or licensed, some have alternative provisions for assuring qualifications are in place.
 - iv. Assurance of health and safety and participant safeguards for demonstration participants to ensure that the State or the MCO operates a critical incident management system according to the State’s established policies, procedures and regulations. Specifically, on an ongoing basis the State ensures that all entities, including the MCO identifies, addresses, and seeks to prevent instances of abuse, neglect and exploitation, and ensures participant safeguards concerning seclusion, restraint, risk mitigation, and medication management.
 - v. The State shall incorporate by reference its policies, procedures and regulations for health, safety and participant safeguards into MCO contracts with adherence expectations defined. Any changes to the policies, procedures and regulations must be submitted to CMS for review prior to implementation.
 - vi. Administrative oversight by the State Medicaid Agency of State Operating Agencies, the Managed Care Plans, and any other entities performing delegated administrative functions.

89. Oversight process: Required Monitoring Activities related to the areas above shall be conducted by State and/or External Quality Review Organization (EQRO). As defined and delegated by the State Medicaid Agency, the State’s EQRO process shall meet all the requirements of 42 CFR 438 Subpart E. The State, or its EQRO, shall monitor and annually evaluate the MCOs’ performance on specific requirements under MLTSS. The State shall also include minimum oversight expectations of the Managed Care Organizations’ oversight

of providers in the contracts. These include the areas in the Quality Strategy(ies) as applicable.

90. **Revision of the State Quality Strategy(ies) and Reporting.** The Single State Medicaid Agency shall update its Quality Strategy(ies) whenever significant changes are made, including changes through this demonstration, and submit to CMS for approval. The State must obtain the input of recipients and other stakeholders in the development of revised Quality Strategy(ies) and make the Strategy(ies) available for public comment. In addition, the State must provide CMS with annual reports on the implementation and effectiveness of the updated Quality Strategy(ies) as it impacts the beneficiaries in the demonstration. Specifically, the annual reports shall include summaries of analyzed and aggregated data on measures and quality improvements.
- 91.

XIII. FUNDING POOLS

The terms and conditions in Section IX apply to the State's exercise of the following Expenditure Authorities: (7) Expenditures Related to Transition Payments, and Expenditures Related to the Delivery System Reform Incentive Payment (DSRIP) Pool.

91. Terms and Conditions Applying to Pools Generally.

- a. The non-Federal share of pool payments to providers may be funded by state general revenue funds and transfers from units of local government that are compliant with section 1903(w) of the Act. Any payments funded by intergovernmental transfers from governmental providers must remain with the provider, and may not be transferred back to any unit of government. CMS reserves the right to withhold or reclaim FFP based on a finding that the provisions of this subparagraph have not been followed.
- b. The State must inform CMS of the funding of all payments from the pools to hospitals through a quarterly payment report, in coordination with the quarterly operational report required by paragraph 102, to be submitted to CMS within 60 days after the end of each quarter. This report must identify and fully disclose all the underlying primary and secondary funding sources of the non-Federal share (including health care related taxes, certified public expenditures, intergovernmental transfers, general revenue appropriations, and any other mechanism) for each type of payment received by each provider.
- c. On or before December 31, 2012, the State must submit Medicaid State plan amendments to CMS to remove all supplemental payments for inpatient and outpatient hospital services from its State plan, with an effective date the same as the approval date for this demonstration. Except as discussed in paragraph 92(h), the State may not subsequently amend its Medicaid State plan to authorize supplemental payments for hospitals, so long as the expenditure authorities for pool payments under this demonstration remain in force.

- d. The State will ensure that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope or quality of services available under the State plan or this demonstration. The preceding sentence is not intended to preclude the State from modifying the Medicaid benefit through the State Plan amendment process.
- e. Each quarter the State makes DSRIP Payments or Transition payments (as described below) and claims FFP, appropriate supporting documentation will be made available for CMS to determine the allowability of the payments. Supporting documentation may include, but is not limited to, summary electronic records containing all relevant data fields such as Payee, Program Name, Program ID, Amount, Payment Date, Liability Date, Warrant/Check Number, and Fund Source. Documentation regarding the Funds revenue source for payments will also identify all other funds transferred to such fund making the payment.

92. Transition Payments. During the Transition Period (which is the period between the approval date for this demonstration and June 30, 2013), the State will make Transition Payments to hospitals that received supplemental payments under the Medicaid State plan for SFY 2012 (July 1, 2011 through June 30, 2012). The Transition Period ensures that providers are eligible to secure historical Medicaid funding as the State develops the Delivery System Reform Incentive Payment Pool. Transition Payments may be made only during the Transition Period, and are subject to the following requirements.

- a. The hospitals eligible to receive Transition Payments are listed in Attachment K. These hospitals meet the following criteria:
 - i. Is enrolled as a New Jersey Medicaid provider, and
 - ii. Received a supplemental payment under the Medicaid State plan during SFY 12.
- b. Qualifying hospitals may receive two distinct types of Transition Payments, as described in (i) and (ii) below.
 - i. 2013 HRSF Transition Payments may be paid to hospitals in proportion to the supplemental payments that each hospital received from the Hospital Relief Subsidy Fund in SFY 2012. The total amount of 2013 HRSF Transition Payments for all hospitals combined may not exceed the following amount: \$166,600,000, less any payments that hospitals received in Hospital Relief Subsidy Fund payments under the State plan in SFY 2013.
 - ii. 2013 GME Transition Payments may be paid to hospitals in proportion to the supplemental payments that each hospital received for GME in SFY 2012. The total amount of 2013 GME Transition Payments for all hospitals combined may not exceed the following amount: \$90,000,000 less any payments that hospitals received in Graduate Medical Education payments under the State plan in SFY 2013.

- c. Participating providers are eligible to receive one-fourth of their total Transition Payment amount each quarter in the Transition Period, beginning October 1, 2012, through the quarter ending June 30, 2013.
- d. As part of the first Quarterly Progress Report submitted under this demonstration, the State must provide a table showing the amounts of 2012 State plan supplemental payments received by each hospital listed in Attachment K (by type of payment), the amounts of 2013 State plan supplemental payments received by each hospital, and the total of each type of Transition Payments each hospital can expect to receive in DY 1. The State must identify the source of funding for each Transition Payment as a part of this list. Should the State determine that any of the hospitals listed in Attachment K will not receive Transition Payments, the State must provide an explanation for this in its report.
- e. In the first Annual Report submitted by the State after the end of the Transition Period, the State must provide a list of hospitals that received Transition Payments DY 1, and the amounts actually paid to each hospital, along with an explanation for how the payment amounts were determined.
- f. The State may alter the list of hospitals eligible to receive Transition Payments, or change the formula for determining the amounts to be paid, by submitting a request to amend the demonstration, following the process described in paragraph 7.
- g. Transition Payments received by a hospital provider count as title XIX revenue, and must be included as offsetting revenue in the State's annual DSH audit reports.
- h. During the Transition Period, CMS shall work with the State to get a State Plan Amendment approved by July 1, 2013 that allows the State to pay \$90 million in Graduate Medical Education (GME) payments directly to hospitals per 42 CFR 438.60, starting in DY 2. These payments will not be subject to federal fee-for-service upper payment limit restriction, but will be subject to the budget neutrality test for this demonstration.

93. Delivery System Reform Incentive Payment (DSRIP) Pool. The DSRIP Pool is available in DY 2 through 5 for the development of a program of activity that supports hospitals' efforts to enhance access to health care, the quality of care, and the health of the patients and families they serve. The program of activity funded by the DSRIP will be those activities that are directly responsive to the needs and characteristics of the populations and communities served by each hospital. Each participating hospital will develop a Hospital DSRIP Plan, consistent with the DSRIP Planning Protocol, that is rooted in the intensive learning and sharing that will accelerate meaningful improvement. The Individual Hospital DSRIP Plan will be consistent with the hospital's mission and quality goals, as well as CMS's overarching approach for improving health care through the simultaneous pursuit of three aims: better care for individuals (including access to care, quality of care, and health outcomes), better health for the population, and lower cost through improvement (without

any harm whatsoever to individuals, families or communities). In its Hospital DSRIP Plan, each hospital will describe how it will carry out a *project* that is designed to improve the quality of care provided, the efficiency with which care is provided, or population health. Each project will consist of a series of *activities* drawn from a predetermined menu of activities grouped according to four *Project Stages*. Hospitals may qualify to receive incentive payments (*DSRIP Payments*) for fully meeting performance *metrics* (as specified in the Hospital DSRIP Plan), which represent measurable, incremental steps toward the completion of project activities, or demonstration of their impact on health system performance or quality of care.

- a. **Eligibility.** The program of activity funded by the DSRIP shall take place in the general acute care hospitals listed and shown in Attachment K.
- b. **Project Focus Areas:** Each eligible hospital will select a project from the menu of focus areas listed below. Projects may include those based on regional planning needs as part of its DSRIP plan. Each focus area has an explicit connection to the achievement of the Three Part Aim:
 - Behavioral Health,
 - HIV/AIDS,
 - Chemical Addiction/Substance Abuse,
 - Cardiac Care,
 - Asthma,
 - Diabetes,
 - Obesity,
 - Pneumonia, or
 - Another medical condition that is unique to a specific hospital, if approved by CMS. (The DSRIP Program Funding and Mechanics Protocol must specify a process for the State to obtain CMS approval for hospital-specific Focus Areas.)
- c. **Project Stages.** Hospital projects will consist of activities that can be grouped into four stages.
 - i. *Stage 1: Infrastructure Development* – Activities in this stage lay the foundation for delivery system transformation through investments in technology, tools, and human resources that will strengthen the ability of providers to serve populations and continuously improve services.
 - ii. *Stage 2: Chronic Medical Condition Redesign and Management.* Activities in this stage include the piloting, testing, and replicating of chronic patient care models.
 - iii. *Stage 3: Quality Improvements* – This stage involves the broad dissemination of interventions from a list of activities identified by the State, in which major improvements in care can be achieved within four years. To the extent

possible the interventions will rely on the work of the New Jersey Hospital Engagement Network currently under development. These are hospital-specific initiatives and will be jointly developed by hospitals, the State, and CMS and are unlikely to be uniform across all of the hospitals.

- iv. *Stage 4: Population Focused Improvements* – Activities in this stage include reporting measures across several domains selected by the State based on community readmission rates and hospital acquired infections, which will allow the impact of activities performed under Stages 1 through 3 to be measured, and may include:
 - (A) Patient experience,
 - (B) Care outcomes, and
 - (C) Population health.

d. **DSRIP Performance Indicators.** The State will choose performance indicators that are connected to the achievement of providing better care, better access to care, and enhanced prevention of chronic medical conditions and population improvement. The DSRIP Performance Indicators will comprise the list of reporting measures that hospitals will be required to report under Stage 4: Population Focused Improvements.

e. **DSRIP Planning Protocol.** The State must develop and submit to CMS for approval a DSRIP Planning Protocol, following the timeline specified in paragraph 95(a)(v). Once approved by CMS, this document will be incorporated as Attachment H of these STCs, and once incorporated may be altered only by amending the demonstration through the process described in paragraph 7. The Protocol must:

- i. Outline the global context, goals and outcomes that the State seeks to achieve through the combined implementation of individual projects by hospitals;
- ii. Specify the Project Stages, as shown in subparagraph (c) above, and for each Stage specify a menu of activities, along with their associated population-focused objectives and evaluation metrics, from which each eligible hospital will select to create its own projects;
- iii. Detail the requirements of the Hospital DSRIP Plans, consistent with subparagraph (g); and
- iv. Specify a set of Stage 4 measures that must be collected and reported by all hospitals, regardless of the specific projects that they choose to undertake.

f. **DSRIP Program Funding and Mechanics Protocol.** The State must develop a DSRIP Program Funding and Mechanics Protocol to be submitted to CMS for approval, following the timeline specified in paragraph 95(a)(v). Once approved by CMS, this document will be incorporated as Attachment I of these STCs, and once incorporated may be altered only by amending the demonstration through the process described in paragraph 7. DSRIP payments for each participating hospital are contingent on the

hospital fully meeting project metrics defined in the approved hospital-specific Hospital DSRIP Plan. In order to receive incentive funding relating to any metric, the hospital must submit all required reporting, as outlined in the DSRIP Program Funding and Mechanics Protocol. In addition, the DSRIP Program Funding and Mechanics Protocol must:

- i. Include guidelines requiring hospitals to develop individual Hospital DSRIP Plans, which shall include timelines and deadlines for the meeting of metrics associated with the projects and activities undertaken to ensure timely performance;
- ii. Provide minimum standards for the process by which hospitals seek public input in the development of their Hospital DSRIP Plans, and provide that hospitals must include documentation of public input in their Hospital DSRIP Plans;
- iii. Specify a State review process and criteria to evaluate each hospital's individual DSRIP plan and develop its recommendation for approval or disapproval prior to submission to CMS for final approval;
- iv. Specify a process for obtaining CMS approval for hospital-specific Focus Areas that do not appear on the list in paragraph 93(b);
- v. Allow sufficient time for CMS to conduct its review of the Hospital DSRIP Plans;
- vi. Describe, and specify the role and function, of a standardized, hospital-specific application to be submitted to the State on an annual basis for the utilization of DSRIP funds that outlines the hospital's specific DSRIP plan, as well as any data books or reports that hospitals may be required to submit to report baseline information or substantiate progress;
- vii. Specify that hospitals must submit semi-annual reports to the State using a standardized reporting form to document their progress (as measured by the specific metrics applicable to the projects that the hospitals have chosen), and qualify to receive DSRIP Payments if the specified performance levels were achieved;
- viii. Specify a review process and timeline to evaluate hospital progress on its DSRIP plan metrics in which first the State and then CMS must certify that a hospital has met its approved metrics as a condition for the release of associated DSRIP funds to the hospital;
- ix. Specify an incentive payment formula to determine the total annual amount of DSRIP incentive payments each participating hospital may be eligible to receive in DY 2 through 5, consistent with subparagraphs (i) and (j) below,

and a formula for determining the incentive payment amounts associated with the specific activities and metrics selected by each hospital, such that the amount of incentive payment is commensurate with the value and level of effort required;

- x. Specify that hospital's failure to fully meet a performance metric under its Hospital DSRIP Plan within the time frame specified will result in forfeiture of the associated incentive payment (i.e., no payment for partial fulfillment);
 - xi. Describe a process by which a hospital that fails to meet a performance metric in a timely fashion (and thereby forfeits the associated DSRIP Payment) can reclaim the payment at a later point in time (not to exceed one year after the original performance deadline) by fully achieving the original metric in combination with timely performance on a subsequent related metric, or by which a payment missed by one hospital can be redistributed to other hospitals, including rules governing when missed payments can be reclaimed or must be redistributed;
 - xii. Include a process that allows for potential hospital plan modification (including possible reclamation, or redistribution, pending State and CMS approval) and an identification of circumstances under which a plan modification may be considered, which shall stipulate that CMS may require that a plan be modified if it becomes evident that the previous targeting/estimation is no longer appropriate or that targets were greatly exceeded or underachieved; and
 - xiii. Include a State process of developing an evaluation of DSRIP as a component of the draft evaluation design as required by paragraph 134. When developing the DSRIP Planning Protocol, the State should consider ways to structure the different projects that will facilitate the collection, dissemination, and comparison of valid quantitative data to support the Evaluation Design required in section XVI of the STCs. The State must select a preferred evaluation plan for the applicable evaluation question, and provide a rationale for its selection. To the extent possible, participating hospitals should use similar metrics for similar projects to enhance evaluation and learning experience between hospitals. To facilitate evaluation, the DSRIP Planning Protocol must identify a core set of Category 4 metrics that all participating hospitals must be required to report even if the participating hospital chooses not to undertake that project. The intent of this data set is to enable cross hospital comparison even if the hospital did not elect the intervention.
- g. **Hospital DSRIP Plans.** The hospitals will develop hospital specific Hospital DSRIP Plans in good faith, to leverage hospital and other community resources to best achieve delivery system transformation goals of the State consistent with the demonstration's requirements.

- i. Each hospital's DSRIP plan must identify the project, population-focused objectives, and specific activities and metrics, which must be chosen from the approved DSRIP Planning Protocol, and meet all the requirements pursuant to this waiver.
- ii. Each project must feature activities from all four Stages, and require the hospital to report at least two metrics in each reporting cycle and report metrics for all four Stages in each DY 3 through 5.
- iii. For each stated goal or objective of a project, there must be an associated outcome (Stage 4) metric that must be reported in all years. The initially submitted Hospital DSRIP Plan must include baseline data on all Stage 4 measures.
- iv. Hospital DSRIP Plans shall include estimated funding available by year to support DSRIP payments, and specific allocation of funding to DSRIP activities proposed within the Hospital DSRIP Plan, with greater weight of payment on Stage 1 and 2 metrics in the early years, and on Stage 3 and 4 metrics in the later years.
- v. Payment of funds allocated in a Hospital DSRIP Plan to Stage 4 may be contingent on the hospital reporting DSRIP Performance Indicators to the State and CMS, on the hospital meeting a target level of improvement in the DSRIP Performance Indicator relative to baseline, or both. At least some of the funds so allocated in DY 3 and DY 4, and all such funds allocated in DY 5, must be contingent on meeting a target level of improvement.
- vi. Hospitals shall provide opportunities for public input to the development of Hospital DSRIP Plans, and shall provide opportunities for discussion and review of proposed Hospital DSRIP Plans prior to plan submission to the State.
- vii. Participating hospitals must implement new, or significantly enhance existing health care initiatives; to this end, hospitals must identify the CMS and HHS funded initiatives in which they participate, and explain how their proposed DSRIP activities are not duplicative of activities that are already funded.
- viii. Each individual Hospital DSRIP Plan must report on progress to receive DSRIP funding. Eligibility for DSRIP Payments will be based on successfully meeting metrics associated with approved activities as outlined in the Hospital DSRIP Plans. Hospitals may not receive credit for metrics achieved prior to CMS approval of their Hospital DSRIP Plans.

- h. **Status of DSRIP Payments.** DSRIP payments are not direct reimbursement for expenditures or payments for services. Payments from the DSRIP pool are intended to support and reward hospital systems and other providers for improvements in their delivery systems that support the simultaneous pursuit of improving the experience of care, improving the health of populations, and reducing per capita costs of health care. Payments from the DSRIP Pool are not considered patient care revenue, and shall not be offset against disproportionate share hospital expenditures or other Medicaid expenditures that are related to the cost of patient care (including stepped down costs of administration of such care) as defined under these Special Terms and Conditions, and/or under the State Plan.
- i. **Demonstration Year 2 DSRIP Payments.** Each hospital's DSRIP Payments for DY 2 will at a maximum equal the total amount of the 2013 HRSF Transition Payments it received in DY 1, contingent on the hospital's submission of a Hospital DSRIP Plan, and its acceptance by the State and CMS.
- i. Upon receiving each Hospital DSRIP Plan, the State will conduct a review to determine whether the plan meets the requirements outlined in the DSRIP Planning Protocol, DSRIP Program Funding and Mechanics Protocol, and these STCs.
 - ii. If a hospital's Hospital DSRIP Plan is not accepted by the State and not approved by CMS by September 30, 2013, the State may not claim FFP for DSRIP Payments made to that hospital for DY 2 or any subsequent DY, except under the circumstances described in subparagraph (iv).
 - iii. A hospital may receive no more than one-half of its maximum of DY 2 DSRIP Payments upon CMS approval of its Hospital DSRIP Plan, and may receive the remainder based on its performance on metrics included in its approved Hospital DSRIP Plan.
 - iv. If either (A) or (B) applies, the State may submit a Hospital DSRIP Plan to CMS no later than September 30, 2014 for a hospital that did not receive approval of a plan under subparagraph (ii), which would allow the hospital to qualify for DSRIP Payments in DY 3 through 5 if approved by CMS. The State must notify CMS at least 30 days in advance of its intention to submit a Hospital DSRIP Plan under this provision.
 - (A) If a hospital failed to submit a DSRIP plan in DY 1 because of a significant adverse unforeseen circumstance and the hospital's prior year HRSF payment was not less than 0.5% of the hospital's annual Net Patient Service Revenues as shown on the most recent year audited Financial Statements, the Hospital may submit a DSRIP plan. A significant adverse unforeseen circumstance is one not commonly experienced by hospitals.

(B) If a Hospital did not receive approval of its Hospital DSRIP Plan or failed to submit a plan and the hospital received certificate of need approval of a merger, acquisition, or other business combination of a hospital within the State of New Jersey, the hospital may submit a Hospital DSRIP Plan in the year the merger, acquisition, or business combination is completed, provided the successor hospital is a participating provider contracted with all Managed Care Insurers licensed and operating in the State of New Jersey.

- j. **Demonstration Years 3 through 5 Payments.** Each hospital with a State and CMS approved Hospital DSRIP Plan may receive DSRIP Payments in DY 3, DY 4, and DY 5. The total amount of DSRIP Payments available to each hospital in DY 3, 4, and 5 will be determined based on the parameters listed below. The determination of weighting factors to be used will be based on discussions with hospital industry as to what will best accelerate meaningful improvement.
- i. Percentage of Medicaid, NJ FamilyCare and Charity Care admissions, patient days, and revenues;
 - ii. Trends in absolute percentage changes in the Medicaid, NJ FamilyCare and Charity Care admissions, patient days, and revenues;
 - iii. Trends in absolute percentage changes in the Medicaid, NJ FamilyCare and Charity Care admissions, patient days, and revenues from the base period of budget neutrality measurement; and
 - iv. Geographic location: urban vs. suburban.

94. **Federal Financial Participation (FFP) For DSRIP.** The following terms govern the State's eligibility to claim FFP for DSRIP.

- a. The State may not claim FFP for DSRIP until after CMS has approved the DSRIP Planning Protocol and DSRIP Funding and Mechanics Protocol.
- b. The State may claim FFP for payments to hospitals for submission of their Hospital DSRIP Plans in DY 2 upon approval of those plans by CMS. The State may claim FFP for the remaining DY 2 incentive payments to hospitals on the same conditions applicable to DY 3 through 5 DSRIP Payments as presented in subparagraph (c) below.
- c. The State may not claim FFP for DSRIP Payments in DY 3 through 5 until both the State and CMS have concluded that the hospitals have met the performance indicated for each payment. Hospitals' reports must contain sufficient data and documentation to allow the State and CMS to determine if the hospital has fully met the specified metric, and hospitals must have available for review by the State or CMS, upon request, all supporting data and back-up documentation. FFP will be available only for payments related to activities listed in an approved Hospital DSRIP Plan.

- d. In addition to the documentation discussed in paragraph 91(e), the State must use the documentation discussed in paragraph 93(f)(vii) to support claims made for FFP for DSRIP Payments that are made on the CMS-64.9 Waiver forms.

95. Life Cycle of Five-Year Demonstration. This is a synopsis of anticipated funding pool activities planned for this demonstration.

a. *Demonstration Year 1 – Planning and Design*

- i Payment Type: Transition Payments, in the amounts discussed in paragraph 92(b)
- ii The State will work with the hospital industry to establish priorities for the DSRIP program.
- iii The program application, status reports and data books will be developed. These will be submitted to the State annually as part of the hospitals' formal DSRIP application process.
- iv Starting no later than January 1, 2013, the State must submit to CMS its initial drafts of the DSRIP Planning Protocol and DSRIP Funding and Mechanics Protocol, and CMS, the State, and hospitals will begin a collaborative process to develop and finalize these documents. The State and CMS agree to a target date of February 28, 2013 for CMS to issue its final approval of these protocols.
- v Hospitals will begin drafting their Hospital DSRIP Plans after the DSRIP Planning Protocol and DSRIP Funding and Mechanics Protocol are approved by CMS.

b. *Demonstration Year 2 – Infrastructure Development*

- i Payment Type: DSRIP Payments totaling \$166.6 million. A hospital's payments will equal the total amount of its 2013 HRSF Payments it received in DY 1, provided that its Hospital DSRIP Plan and application are completed, submitted and accepted by the State. If a hospital does not submit a Hospital DSRIP Plan and application, all of its DY 2 DSRIP payment must be withheld, consistent with paragraph 93(i).
- ii On or before May 1, 2013, Hospitals will submit their initial DSRIP applications, data books and DSRIP plans that will include:
 - a. Infrastructure investments that will be made;

- b. How it specifically sees these investments leading to efficient and more effective care in accordance with the State’s DSRIP vision;
 - c. Baseline performance metrics.
 - iii By July 1, 2013, the State must submit all accepted Hospital DSRIP Plans to CMS, as well as a list of eligible hospitals that will be excluded from DSRIP for failure to submit an acceptable Hospital DSRIP Plan.
 - iv CMS and the State will work diligently to review the Hospital DSRIP Plans, with a goal of making final decisions by September 30, 2013.
 - v Note that hospitals can begin to make infrastructure improvements in this year.
- c. *Demonstration Year 3 – Chronic Medical Condition Redesign and Management Begins*
- i Payment Type: DSRIP totaling \$166.6 million.
 - ii Hospitals are fully engaged in infrastructure investments as specified in their DSRIP plans.
 - iii Hospitals will begin utilizing them to improve upon the baseline performance data submitted with the DSRIP plan.
 - iv Hospitals will submit to the State the semi-annual status of their DSRIP progress and infrastructure developments. A hospital’s progress, or lack of progress, will be the determining factor for their receipt of DSRIP Payments over the course of the year.
 - v By the end of this year, hospitals will submit a status report on the infrastructure developments and its plan to begin utilizing them. As part of the status report, the hospital will submit updates to performance metrics identified in the DSRIP plan.
- d. *Demonstration Year 4 – Quality Improvement and Measurements*
- i. Payment Type: DSRIP totaling \$166.6 million.
 - ii. Hospitals’ infrastructure improvements are complete or nearly complete.
 - iii. Hospitals will update the State on a quarterly basis to demonstrate progress towards the desired outcome measures. A hospital’s progress, or lack of progress, will be the determining factor for their receipt of DSRIP Payments over the course of the year.

- iv. Hospitals will submit a status report outlining progress as part of its application for the next demonstration year.

e. *Demonstration Year 5 – Quality Improvement and Measurements*

- i. Payment Type: DSRIP totaling \$166.6 million
- ii. The State reviews the progress hospitals have made on their desired outcomes.
- iii. Initial DSRIP payments for this year will be based on hospitals’ overall performances in DY 4 along with any other projects they may want to undertake.
- iv. Hospitals will update the State on a semi-annual basis to demonstrate progress towards the desired outcome measures. A hospital’s progress, or lack of progress, will be the determining factor for their receipt of DSRIP payment over the course of the year
- v. Hospitals will submit a status report on the project five-year DSRIP plan outcome.

96. Limits on Pool Payments. The State can claim FFP for Transition Payments and DSRIP Payments in each DY up to the limits on total computable payments shown in the table below. The \$256.6 million that the State had budgeted to provide to hospitals in the forms of Hospital Relief Subsidy Fund and Graduate Medical Education supplemental payments in SFY 2012 (less amounts paid to hospitals in State plan supplemental payments in SFY 2013) establish the limit on the Transition Payments in DY 1. The \$166.6 million that the State provided to hospitals in SFY 2012 in the form of Hospital Relief Subsidy Fund supplemental payments equals the limit on the DSRIP pool payments in DY 2 through DY 5. GME payments made in DY 2 or later under a State plan amendment are not subject to the limits shown below. If the state wishes to change any provision of the DSRIP program, it must submit a waiver amendment to CMS. The waiver amendment must be approved by CMS before any changes are made to the program. Except as permitted under paragraph 93(f)(xii) above, the State may not carry over DSRIP funds from one Demonstration Year to the next.

Pool Allocations According to Demonstration Year (All figures are total computable dollars.)

Type of Pool	Transition Period: Approval to 6/30/13	DY 2 7/1/13 to 6/30/14	DY 3 7/1/14 to 6/30/15	DY 4 7/1/15 to 6/30/16	DY 5 7/1/16 to 6/30/17	Totals
DSRIP	n/a	\$166.6 Million	\$166.6 Million	\$166.6 Million	\$166.6 Million	\$666.4 Million
Transition Payments	\$256.6 Million minus	n/a	n/a	n/a	n/a	\$256.6 Million minus State

	State plan supplemental payments in SFY 2013					plan supplemental payments in SFY 2013
Total/DY	\$256.6 Million minus State plan supplemental payments in SFY 2013	\$166.6 Million	\$166.6 Million	\$166.6 Million	\$166.6 Million	\$923 Million less SFY 2013 state supplemental payments

97. **Transition Plan for Funding Pools** No later than June 30, 2016, the State shall submit a transition plan to CMS based on the experience with the DSRIP pool, actual uncompensated care trends in the State, and investment in value based purchasing or other payment reform options.

XIV. GENERAL REPORTING REQUIREMENTS

98. **General Financial Requirements.** The State must comply with all general financial requirements, including reporting requirements related to monitoring budget neutrality, set forth in section 0 of these STCs. The State must submit any corrected budget and/or allotment neutrality data upon request.

99. **MLTSS Data Plan for Quality.** The State will collect and submit MLTSS data as follows:

- a. Reporting on:
 - i. Numbers of beneficiaries receiving HCBS and NF services just prior to implementation;
 - ii. Numbers of enrollees receiving HCBS and NF services during each twelve month period;
 - iii. HCBS and NF expenditures for MLTSS during a twelve month period as percentages of total long-term services and supports expenditures;
 - iv. Average HCBS and NF expenditures per enrollee during a twelve month period;
 - v. Average length of stay in HCBS and NFs during a twelve month period
 - vi. Percent of new MLTSS enrollees admitted to NFs during a twelve month period
 - vii. Number of transitioning individuals from NFs to the community, and the community to NFs, during a twelve month period;

- viii. Other data relevant to system rebalancing;
- ix. The State will assure that appropriate electronic collection of MLTSS data systems will be in place to record identified data elements prior to the implementation of MLTSS.
- x. Baseline data will be submitted to CMS within 18 months of the last day of the twelve month period prior to MLTSS implementation. Thereafter, an electronic copy of the MLTSS data for each demonstration year will be submitted to CMS within a year of the last day of each demonstration year.
- xi. The State will require the MCOs to revise all existing applicable policies and plans for quality to account for MLTSS requirements. Quality measures that need revising and submission at least 45 days prior to implementation of MLTSS by each MCO.
- xii. The State will also require the MCOs to establish processes and provide assurances to the State regarding access standards described in 42 CFR.438, Subpart D including availability of services, adequate capacity and services, coordination and continuity of care, and coverage and authorization of services.
- xiii. The State Medicaid Agency will make a preliminary selection of HEDIS, OASIS, Medicaid Adult and Child Quality Measures and other performance measures as appropriate, and may adjust the underlying methodology to account for the unique features of the MLTSS. These may include: reductions in NF placements, timely initiation of MLTSS, reduction in hospital readmissions, and percent of Medicaid funding spent on HCBS including MLTSS. The measures will take into consideration particular programs, groups, geographic areas, and characteristics of the MCO.

100. **Monthly Enrollment Report.** Within 20 days following the first day of each month, the State must report via e-mail the demonstration enrollment figures for the month just completed to the CMS Project Officer, the Regional Office contact, and the CMS CAHPG Enrollment mailbox, using the table below.

The data requested under this subparagraph is similar to the data requested for the Quarterly Report in Attachment A, except that they are compiled on a monthly basis.

Demonstration Populations (as hard coded in the CMS 64)	Point In Time Enrollment (last day of month)	Newly Enrolled Last Month	Disenrolled Last Month
MEG			

MEG			
Totals			

101. **Monthly Monitoring Calls.** CMS will convene monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to: transition and implementation activities, health care delivery, enrollment, cost sharing, quality of care, access, the benefit package, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, legislative developments, and any demonstration amendments the State is considering submitting. CMS will provide updates on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the demonstration. The State and CMS will jointly develop the agenda for the calls.

102. **Quarterly Progress Reports.** The State must submit quarterly progress reports in accordance with the guidelines in Attachment A no later than 60 days following the end of each quarter. The intent of these reports is to present the State’s analysis and the status of the various operational areas. These quarterly reports must include the following, but are not limited to:

- a. An updated budget neutrality monitoring spreadsheet;
- b. A discussion of events occurring during the quarter or anticipated to occur in the near future that affect health care delivery, including, but not limited to: benefits, enrollment and disenrollment, provider enrollment and transition from FFS to managed care complaints and grievances, quality of care, and access that is relevant to the demonstration, pertinent legislative or litigation activity, and other operational issues;
- c. HCBS/MLTSS activities including reporting for each program operating under the demonstration including the PDD pilot program;
- d. Adverse incidents including abuse, neglect, exploitation, morality reviews and critical incidents that result in death;
- e. Action plans for addressing any policy, administrative, or budget issues identified;
- f. Medical Loss Ratio (MLR) reports for each participating MCO;
- g. A description of any actions or sanctions taken by the State against any MCO, SNP, PACE organization, or ASO;
- h. Quarterly enrollment reports for demonstration participants, that include the member months and end of quarter, point-in-time enrollment for each demonstration population, and other statistical reports listed in Attachment A;

- i. Number of participants who chose an MCO and the number of participants who change plans after being auto-assigned;
- j. Hotline Reporting (from MCOs) – Complaints, Grievances and Appeals by type including access to urgent, routine, specialty and MLTSS; and,
- k. Evaluation activities and interim findings.

103. **Annual Report.**

- a. The State must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the demonstration.
- b. The State must submit the draft annual report no later than 120 days after the close of the demonstration year (DY).
- c. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.
- d. Elements of the Annual report should include:
 - i. A report of service use by program including each HCBS program (encounter data);
 - ii. a summary of the use of self-directed service delivery options in the State;
 - iii. a general update on the collection, analysis and reporting of data by the plans at the aggregate level;
 - iv. monitoring of the quality and accuracy of screening and assessment of participants who qualify for HCBS/MLTSS;
 - v. GEO access reports from each participating MCO;
 - vi. waiting list(s) information by program including number of people on the list and the amount of time it takes to reach the top of the list where applicable;
 - vii. the various service modalities employed by the State, including updated service models, opportunities for self-direction in additional program, etc.;
 - viii. specific examples of how HCBS have been used to assist participants;

- ix. a description of the intersection between demonstration MLTSS and any other State programs or services aimed at assisting high-needs populations and rebalancing institutional expenditures (e.g. New Jersey's Money Follows the Person demonstration, other Federal grants, optional Medicaid Health Home benefit, behavioral health programs, etc.);
- x. A summary of the outcomes of the State's Quality Strategy for HCBS as outlined above;
- xi. Efforts and outcomes regarding the establishment of cost-effective MLTSS in community settings using industry best practices and guidelines;
- xii. policies for any waiting lists where applicable;
- xiii. Other topics of mutual interest between CMS and the State related to the HCBS included in the demonstration;
- xiv. The State may also provide CMS with any other information it believes pertinent to the provision of the HCBS and their inclusion in the demonstration, including innovative practices, certification activity, provider enrollment and transition to managed care special populations, workforce development, access to services, the intersection between the provision of HCBS and Medicaid behavioral health services, rebalancing goals, cost-effectiveness, and short and long-term outcomes.
- xv. A report of the results of the State's monitoring activities of critical incident reports
- xvi. An updated budget neutrality analysis, incorporating the most recent actual data on expenditures and member months, with updated projections of expenditures and member months through the end of the demonstration, and proposals for corrective action should the projections show that the demonstration will not be budget neutral on its scheduled end date.

XVI. ADMINISTRATIVE REQUIREMENTS

104. General Requirements

- a. **Medicaid Administrative Requirements.** Unless otherwise specified in these STCs, all processes (e.g., eligibility, enrollment, redeterminations, terminations, appeals) must comply with Federal law and regulations governing Medicaid program.
- b. **Facilitating Medicaid Enrollment.** The State must screen new applicants for Medicaid eligibility, and if determined eligible, enroll the individual in Medicaid, and must screen

current the General Assistance participants at least annually upon recertification / renewal of enrollment.

- i. The State must ensure that new applicants for the New Jersey Childless Adults demonstration who meet the categorical requirements for Medicaid will be processed and enrolled in the State's Medicaid program. The application packets for the New Jersey Childless Adults program must continue to provide information regarding Medicaid eligibility and application that is subject to CMS review.

XVII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

105. **Reporting Expenditures under the Demonstration.** The State will provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. The CMS will provide FFP for allowable demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs. FFP will be provided for expenditures net of collections in the form of pharmacy rebates, cost sharing, or third party liability.
- a. **Use of Waiver Forms.** In order to track expenditures under this demonstration, the State must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All demonstration expenditures claimed under authority of title XIX and section 1115 and subject to the budget neutrality expenditure limit (as defined in Section XVIII below) must be reported on separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration Project Number assigned by CMS.
 - b. **Reporting by Demonstration Year (DY) by Date of Service.** In each quarter, demonstration expenditures (including prior period adjustments) must be reported separately by DY (as defined in subparagraph (h) below). Separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted for each DY for which expenditures are reported. The DY is identified using the Project Number Extension, which is a 2-digit number appended to the Demonstration Project Number. Capitation and premium payments must be reported in the DY that includes the month for which the payment was principally made. Pool payments are subject to annual limits by DY, and must be reported in DY corresponding to the limit under which the payment was made. All other expenditures must be assigned to DYs according to date of service,
 - c. **Use of Waiver Names.** In each quarter, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver must be submitted for the following categories of expenditures, identified using the Waiver Names shown in "quotes." Waiver Names (i) through (xiii) are to be used to report all expenditures for individuals identified with those names in the MEG columns in the tables in paragraph 22, except as noted. For the other Waiver Names, a description

of the expenditures to be reported is included in each subparagraph.

- i. "Title XIX"
- ii. "ABD"
- iii. "LTC"
- iv. "HCBS (State plan)": Excludes expenditures described in subparagraphs (xiv) through (xvii)
- v. "HCBS (217-like)": Excludes expenditures described in subparagraphs (xviii) through (xxi)
- vi. "SED (217-like)"
- vii. "IDD/MI (217-like)"
- viii. "Employable"
- ix. "Unemployable"
- x. "XIX CHIP Parents"
- xi. "AwDC"
- xii. "SED At Risk"
- xiii. "MATI At Risk"
- xiv. "TBI 1915(c) SP": Expenditures for HCBS services provided to non-435.217 eligibles under TBI 1915(c) waiver with dates of service from October 1, 2012 through transition to MLTSS are to be reported here.
- xv. "ACCAP 1915(c)": Expenditures for HCBS services provided to non-435.217 eligibles under ACCAP 1915(c) waiver with dates of service from October 1, 2012 through transition to MLTSS are to be reported here.
- xvi. "CRPD 1915(c)": Expenditures for HCBS services provided to non-435.217 eligibles under CRPD 1915(c) waiver with dates of service from October 1, 2012 through transition to MLTSS are to be reported here.
- xvii. "GO 1915(c)": Expenditures for HCBS services provided to non-435.217 eligibles under GO 1915(c) waiver with dates of service from October 1, 2012 through transition to MLTSS are to be reported here.

- xviii. “TBI 1915(c) 217”: Expenditures for HCBS services provided to 435.217 eligibles under TBI 1915(c) waiver with dates of service from October 1, 2012 through transition to MLTSS are to be reported here
 - xix. “ACCAP 1915(c) 217”: Expenditures for HCBS services provided to 435.217 eligibles under ACCAP 1915(c) waiver with dates of service from October 1, 2012 through transition to MLTSS are to be reported here
 - xx. “CRPD 1915(c) 217”: Expenditures for HCBS services provided to 435.217 eligibles under CRPD 1915(c) waiver with dates of service from October 1, 2012 through transition to MLTSS are to be reported here
 - xxi. “GO 1915(c) 217”: Expenditures for HCBS services provided to 435.217 eligibles under GO 1915(c) waiver with dates of service from October 1, 2012 through transition to MLTSS are to be reported here.
 - xxii. “Transition HRSF”: 2013 HRSF Transition Payments are to be reported here.
 - xxiii. “Transition GME”: 2013 GME Transition Payments are to be reported here.
 - xxiv. “State Plan GME”: GME payments made under a State plan amendment described in paragraph 92(h) are to be reported here.
 - xxv. “DSRIP”: All DSRIP Payments are to be reported here.
- d. For monitoring purposes, cost settlements related to demonstration expenditures must be recorded on Line 10.b, in lieu of Lines 9 or 10.c. For any other cost settlements (i.e., those not attributable to this demonstration), the adjustments should be reported on lines 9 or 10.c, as instructed in the State Medicaid Manual.
- e. **Pharmacy Rebates.** By November 30, 2012, the State must propose a methodology to CMS for assigning a portion of pharmacy rebates to the demonstration, in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which reasonably identifies pharmacy rebate amounts with DYs and with MEGs. Pharmacy rebates cannot be reported on Waiver forms for budget neutrality purposes until an assignment methodology is approved by the CMS Regional Office. Changes to the methodology must also be approved in advance by the Regional Office. The portion of pharmacy rebates assigned to the demonstration using the approved methodology will be reported on the appropriate Forms CMS-64.9 Waiver for the demonstration and not on any other CMS 64.9 form to avoid double-counting.
- f. **Premium and Cost Sharing Adjustments.** Premiums and other applicable cost-sharing contributions that are collected by the State from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet Line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, premium and cost-sharing collections (both total computable and Federal share) should

also be reported separately by demonstration Year on the Form CMS-64 Narrative. In the calculation of expenditures subject to the budget neutrality expenditure limit, premium collections applicable to demonstration populations will be offset against expenditures. These section 1115 premium collections will be included as a manual adjustment (decrease) to the demonstration’s actual expenditures on a quarterly basis.

g. Mandated Increase in Physician Payment Rates in 2013 and 2014. Section 1202 of the Health Care and Education Reconciliation Act of 2010 (Pub. Law 110-152) requires State Medicaid programs to reimburse physicians for primary care services at rates that are no less than what Medicare pays, for services furnished in 2013 and 2014, with the Federal Government paying 100 percent of the increase. The entire amount of this increase will be excluded from the budget neutrality test for this demonstration. The specifics of separate reporting of these expenditures will be described in guidance to be issued by CMS at a later date,

h. Demonstration Years. The first Demonstration Year (DY1) will be the year effective date of the approval letter through June 30, 2017, and subsequent DYs will be defined as follows:

Demonstration Year 1 (DY1)	October 1, 2012 to June 30, 2013	9 months
Demonstration Year 2 (DY2)	July 1, 2013 to June 30, 2014	12 months
Demonstration Year 3 (DY3)	July 1, 2014 to June 30, 2015	12 months
Demonstration Year 4 (DY4)	July 1, 2015 to June 30, 2016	12 months
Demonstration Year 5 (DY5)	July 1, 2016 to June 30, 2017	12 months

106. **Expenditures Subject to the Budget Agreement.** For the purpose of this section, the term “expenditures subject to the budget neutrality limit” will include the following:

- a. All medical assistance expenditures (including those authorized in the Medicaid State plan, through section 1915(c) waivers, and through section 1115 waivers and expenditure authorities, but excluding the increased expenditures resulting from the mandated increase in payments to physicians) made on behalf of all demonstration participants listed in the table in paragraph 22, with dates of service within the demonstration’s approval period;
- b. GME payments made under a State plan amendment described in paragraph 92(h) and
- c. All Transition Payments and DSRIP Payments.

107. **Administrative Costs.** Administrative costs will not be included in the budget neutrality limit, but the State must separately track and report additional administrative costs that are directly attributable to the demonstration, using separate CMS-64.10 waiver and 64.10 waiver forms, with waiver name “ADM”.

108. **Claiming Period.** All claims for expenditures subject to the budget neutrality limit (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the Form CMS-64 in order to properly account for these expenditures in determining budget neutrality.

109. **Reporting Member Months.** For the purpose of calculating the budget neutrality expenditure limit and other purposes, the State must provide to CMS on a quarterly basis the actual number of eligible member/months for demonstration participants. Enrollment information should be provided to CMS in conjunction with the quarterly and monthly enrollment reports referred to in section XV of these STCs. If a quarter overlaps the end of one DY and the beginning of another DY, member/months pertaining to the first DY must be distinguished from those pertaining to the second.

- a. The term “eligible member/months” refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member/months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member/months.
- b. The demonstration populations will be reported for the purpose of calculating the without waiver baseline (budget neutrality expenditure limit) using the following Waiver Names, following the cross-walk shown in paragraph 22:
 - i. Title XIX,
 - ii. ABD,
 - iii. LTC,
 - iv. HCBS (State plan),
 - v. Employable (July-March only),
 - vi. Employable (April-June only),
 - vii. Unemployable (July-March only),
 - viii. Unemployable (April-June only),
 - ix. HCBS (217-like),
 - x. SED (217-like),

- xi. IDD/MI (217-like), and
- xii. XIX CHIP Parents (October-December 2013 only).

110. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used during the demonstration. The State must estimate matchable Medicaid expenditures on the quarterly Form CMS-37. As a supplement to the Form CMS-37, the State will provide updated estimates of expenditures subject to the budget neutrality limit. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. The CMS will reconcile expenditures reported on the Form CMS-64 quarterly with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

111. **Extent of FFP for the Demonstration.** The CMS will provide FFP at the applicable Federal matching rate for the following, subject to the limits described in paragraph 133:Section XVIII:

- a. Administrative costs, including those associated with the administration of the demonstration.
- b. Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved State plan.
- c. Medical Assistance expenditures made under section 1115 demonstration authority, including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third party liability.

112. **Sources of Non-Federal Share.** The State certifies that the matching non-Federal share of funds for the demonstration is State/local monies. The State further certifies that such funds shall not be used as the match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

- a. CMS may review the sources of the non-Federal share of funding for the demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
- b. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

113. **State Certification of Funding Conditions.** Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the State as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the State government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes—including health care provider-related taxes—fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

XVIII GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI

114. The State shall provide quarterly expenditure reports using the Form CMS-21 to report total expenditures for services provided under the approved CHIP plan and those provided through the New Jersey demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS will provide Federal financial participation (FFP) only for allowable New Jersey demonstration expenditures that do not exceed the State's available title XXI funding.

115. In order to track expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-21 reporting instructions outlined in section 2115 of the State Medicaid Manual. Title XXI demonstration expenditures will be reported on separate Form CMS-21 Waiver and/or CMS-21P Waiver, identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services rendered or for which capitation payments were made). All expenditures under this demonstration must be reported on separate Forms CMS-21 Waiver and/or CMS-21P Waiver for each of the demonstration populations using the information in the drop-down listing as follows:

- a. CHIP Expansion Children up to 133 percent of the FPL
- b. CHIP Parents/Caretakers above AFDC limit up to and including 133 percent of the FPL
- c. CHIP Parents/Caretakers 134 up to and including 200 percent of the FPL
- d. CHIP Pregnant Women
- e. Premium Support Program

116. All claims for expenditures related to the demonstration (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within 2 years after the conclusion or termination

of the demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the Form CMS-21.

117. The standard CHIP funding process will be used during the demonstration. New Jersey must estimate matchable CHIP expenditures on the quarterly Form CMS-21B. As a footnote to the CMS 21B, the State shall provide updated estimates of expenditures for the demonstration populations. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-21 quarterly CHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-21 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.
118. The State will certify State/local monies used as matching funds for the demonstration and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.
119. New Jersey will be subject to a limit on the amount of Federal title XXI funding that the State may receive on demonstration expenditures during the demonstration period. Federal title XXI funding available for demonstration expenditures is limited to the State's available allotment, including currently available reallocated funds. Should the State expend its available title XXI Federal funds for the claiming period, no further enhanced Federal matching funds will be available for costs of the approved title XXI child health program or demonstration until the next allotment becomes available.
120. Total Federal title XXI funds for the State's CHIP program (i.e., the approved title XXI State plan and this demonstration) are restricted to the State's available allotment and reallocated funds. Title XXI funds (i.e., the allotment or reallocated funds) must first be used to fully fund costs associated with the State plan population. Demonstration expenditures are limited to remaining funds.
121. Total expenditures for outreach and other reasonable costs to administer the title XXI State plan and the demonstration that are applied against the State's title XXI allotment may not exceed 10 percent of total title XXI expenditures.
122. If the State exhausts the available title XXI Federal funds for the claiming period, the State will continue to provide coverage to the approved title XXI State plan separate child health program population and the Demonstration Populations 22 and 23 with State funds until further title XXI Federal funds become available. Title XIX Federal matching funds will be provided for Demonstration Population 21 if the title XXI allotment is exhausted, pursuant to the State's budget neutrality monitoring agreement, appended as Attachment C of this document.

123. The State shall provide CMS with 60 days notification before it begins to draw down title XIX matching funds for Demonstration Population 1 in accordance with the terms of the demonstration.
124. All Federal rules shall continue to apply during the period of the demonstration that title XXI Federal funds are not available. The State may close enrollment or institute a waiting list with respect to Demonstration Populations 2 and 3 upon 60 days notice to CMS.

XIX. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

125. **Limit on Title XIX Funding.** The State will be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using the per capita cost method described in paragraph 128, and budget neutrality expenditure limits are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the State to CMS to set the annual caps is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the State's compliance with these annual limits will be done using the Schedule C report from the CMS-64.
126. **Risk.** The State will be at risk for the per capita cost (as determined by the method described below) for both the Employable and Unemployable Demonstration Populations as defined in STC 105, demonstration eligibles, but not at risk for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration populations, CMS will not place the State at risk for changing economic conditions. However, by placing the State at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration.
127. **Calculation of the Budget Neutrality Limit and How It Is Applied.** For the purpose of calculating the overall budget neutrality limit for the demonstration, separate annual budget limits will be calculated for each DY on a total computable basis, as described in paragraph 133 below. The annual limits will then be added together to obtain a budget neutrality limit for the entire demonstration period. The Federal share of this limit will represent the maximum amount of FFP that the State may receive during the demonstration period for the types of demonstration expenditures described below. The Federal share will be calculated by multiplying the total computable budget neutrality limit by the Composite Federal Share, which is defined in paragraph 133 below. Composite Federal Share 1, which is defined in paragraph 0 below. The demonstration expenditures subject to the budget neutrality limit are those reported under the following Waiver Names (Title XIX, ABD, LTC, HCBS (State plan), AwDC, SED At Risk, MATI At Risk, TBI 1915(c) SP, ACCAP 1915(c) SP, CRPD 1915(c) SP, GO 1915(c) SP, Transition HRSF, Transition GME, State Plan GME, DSRIP), plus any excess spending from the Hypotheticals Test described in paragraph 130.
128. **Impermissible DSH, Taxes, or Donations.** CMS reserves the right to adjust the budget neutrality ceiling to be consistent with enforcement of laws and policy statements, including

regulations and letters regarding impermissible provider payments, health care related taxes, or other payments (if necessary adjustments must be made). CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of section 1903(w) of the Social Security Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

129. The trend rates and per capita cost estimates for each EG for each year of the demonstration are listed in the table below. The PMPM cost estimates are based on actual Medicaid PMPM costs in SFY 2012, trended forward using trends based on the lower of state historical trends from SFY 2006 to 2008 and the FFY 2012 President’s Budget trends. Year-to-year changes in the ABD MEG differ from the stated percentage in the early years of the demonstration due to the effect of adjustments made to the PMPMs after trending.

MEG	TREND	DY 1 - PMPM	DY 2 – PMPM	DY3 – PMPM	DY4 – PMPM	–DY5 – PMPM
Title XIX	5.8%	\$327.03	\$346.00	\$366.07	\$387.30	\$409.76
ABD	3.6%	\$1,045.04	\$1,123.36	\$1,163.80	\$1,205.69	\$1,249.10
LTC	3.9%	\$8,636.81	\$8,973.64	\$9,323.62	\$9,687.24	\$10,065.04
HCBS (State Plan)	3.7%	\$2,256.69	\$2,340.19	\$2,426.78	\$2,516.57	\$2,609.68

130. **Hypothetical Eligibility Groups and the Hypotheticals Test.** Budget neutrality agreements may include optional Medicaid populations that could be added under the State plan but have not been and are not included in current expenditures. However, the agreement will not permit accumulate or access to budget neutrality "savings." A prospective per capita cap on Federal financial risk is established for these groups based on the costs that the population is expected to incur under the demonstration.

- a. The MEGs listed in the table below are the hypothetical groups.

MEG	TREND	DY 1 – PMPM	DY 2 – PMPM	DY3 – PMPM	DY4 – PMPM	–DY5 – PMPM
HCBS (217-like)	3.7%	\$2,256.69	\$2,340.19	\$2,426.78	\$2,516.57	\$2,609.68
SED (217-like)	6.0%	\$2,246.37	\$2,381.15	\$2,524.02	\$2,675.46	\$2,835.99
IDD/MI (217-like)	6.0%	\$9,839.39	\$10,429.75	\$11,055.53	\$11,718.87	\$12,422.00
Employable AND Unemployable	3.7%	\$277.00 (October 2012-March 2013)	\$288.00 (July-December 2013)			
Employable	3.7%	\$288.00				

AND Unemployable		(April-June 2013)				
XIX CHIP Parents			\$307.24 (October-December 2013)			

- b. The Hypotheticals Cap is calculated by taking the PMPM cost projection for each group and in each DY times the number of eligible member months for that group in that DY, and adding the products together across groups and DYs. The Federal share of the Hypotheticals Cap is obtained by multiplying the Hypotheticals Cap by the Composite Federal Share 2.
- c. The Hypotheticals Test is a comparison between the Federal share of the Hypotheticals Cap and total FFP reported by the State for hypothetical groups under the following Waiver Names (HCBS (217-like), SED (217-like), IDD/MI (217-like), Employable, Unemployable, XIX CHIP Parents, TBI 1915(c) 217, ACCAP 1915(c) 217, CRPD 1915(c) 217, GO 1915(c) 217).
- d. If total FFP for hypothetical groups should exceed the Federal share of the Hypotheticals Cap, the difference must be reported as a cost against the budget neutrality limit described in paragraph 109 of these STCs.¹²⁷.

131. **Composite Federal Share Ratios.** The Composite Federal Share is the ratio calculated by dividing the sum total of Federal financial participation (FFP) received by the State on actual demonstration expenditures during the approval period, as reported through the MBES/CBES and summarized on Schedule C (with consideration of additional allowable demonstration offsets such as, but not limited to, premium collections) by total computable demonstration expenditures for the same period as reported on the same forms. There are two Composite Federal Share Ratios for this demonstration: Composite Federal Share 1, based on the expenditures reported under the Waiver Names listed in paragraph 127, and Composite Federal Share 2, based on paragraph 130(c). For the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed upon method.

132. **Exceeding Budget Neutrality.** The budget neutrality limits calculated in paragraph 128 paragraphs 127 and 130 will apply to actual expenditures for demonstration services as reported by the State under section XV of these STCs. If at the end of the demonstration period the budget neutrality limit has been exceeded, the excess Federal funds will be returned to CMS. If the demonstration is terminated prior to the end of the demonstration period, the budget neutrality test will be based on the time period through the termination date.

133. **Enforcement of Budget Neutrality.** If the State exceeds the calculated cumulative target limit by the percentage identified below for any of the DYs, the State shall submit a

corrective action plan to CMS for approval. .

Year	Cumulative target definition	Percentage
DY 1	Cumulative budget neutrality cap plus:	0.25 percent
DY 2	Cumulative budget neutrality cap plus:	0.25 percent
DY 3, 4, & 5	Cumulative budget neutrality cap plus:	0 percent

XX. EVALUATION OF THE DEMONSTRATION

134. **Submission of a Draft Evaluation Design.** The State shall submit to CMS for approval a draft Evaluation Design for an overall evaluation of the demonstration no later than no later than 120 days after CMS approval of the demonstration. The draft Evaluation Design must include a discussion of the goals, objectives, and specific hypotheses that are being tested, and identify outcome measures that shall be used to evaluate the demonstration’s impact. It shall discuss the data sources, including the use of Medicaid encounter data, and sampling methodology for assessing these outcomes. The draft Evaluation Design must describe how the effects of the demonstration will be isolated from other initiatives occurring in the State. The draft Evaluation Design shall identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

- a. Domains of Focus. The Evaluation Design must, at a minimum, address the research questions listed below. For questions that cover broad subject areas, the State may propose a more narrow focus for the evaluation.
 - i What is the impact of the managed care expansion on access to care, the quality, efficiency, and coordination of care, and the cost of care?
 - ii What is the impact of including long-term care services in the capitated managed care benefit on access to care, quality of care, and mix of care settings employed?
 - iii What is the impact of the hypothetical spend-down provision on the Medicaid eligibility and enrollment process? What economies or efficiencies were achieved, and if so, what were they? Was there a change in the number of individuals or on the mix of individuals qualifying for Medicaid due to this provision?
 - iv What is the impact of eliminating the Transfer of assets look-back period for long term care and home and community based services for individuals who are at or below 100 percent of the FPL. Was there a change in the number of individuals or on the mix of individuals qualifying for Medicaid due to this provision?

- v What is the impact of providing additional home and community-based services to Medicaid and CHIP beneficiaries with serious emotional disturbance, opioid addiction, pervasive developmental disabilities, or intellectual disabilities/developmental disabilities?
 - vi What is the impact of the program to provide a safe, stable, and therapeutically supportive environment for children from age 5 up to age 21 with serious emotional disturbance who have, or who would otherwise be at risk for, institutionalization?
 - vii What is the impact of providing adults who do not qualify for Medicaid or the Work First Childless Adults population with outpatient treatment for their opioid addiction or mental illness?
 - viii Was the DSRIP program effective in achieving the goals of better care for individuals (including access to care, quality of care, health outcomes), better health for the population, or lower cost through improvement? To what degree can improvements be attributed to the activities undertaken under DSRIP?
 - ix What is the impact of the transition from supplemental payments to DSRIP on hospitals' finances and the distribution of payments across hospitals?
 - iv. What do key stakeholders (covered individuals and families, advocacy groups, providers, health plans) perceive to be the strengths and weaknesses, successes and challenges of the expanded managed care program, and of the DSRIP pool? What changes would these stakeholders recommend to improve program operations and outcomes?
- b. Evaluation Design Process: Addressing the research questions listed above will require a mix of quantitative and qualitative research methodologies. When developing the DSRIP Planning Protocol, the State should consider ways to structure the different projects that will facilitate the collection, dissemination, and comparison of valid quantitative data to support the Evaluation Design. From these, the State must select a preferred research plan for the applicable research question, and provide a rationale for its selection.

To the extent applicable, the following items must be specified for each design option that is proposed:

- i. Quantitative or qualitative outcome measures;
- ii. Baseline and/or control comparisons;
- iii. Process and improvement outcome measures and specifications;
- iv. Data sources and collection frequency;

- v. Robust sampling designs (e.g., controlled before-and-after studies, interrupted time series design, and comparison group analyses);
 - vi. Cost estimates;
 - vii. Timelines for deliverables.
- c. Levels of Analysis: The evaluation designs proposed for each question may include analysis at the beneficiary, provider, and aggregate program level, as appropriate, and include population stratifications to the extent feasible, for further depth and to glean potential non-equivalent effects on different sub-groups. In its review of the draft evaluation plan, CMS reserves the right to request additional levels of analysis.

135. **Final Evaluation Design and Implementation.** CMS shall provide comments on the draft Evaluation Design within 60 days of receipt, and the State shall submit a final Evaluation Design within 60 days after receipt of CMS comments. The State shall implement the Evaluation Design and submit its progress in each of the quarterly and annual reports.

136. **Evaluation Reports.**

- a. **Interim Evaluation Report.** The State must submit a Draft Interim Evaluation Report by July 1, 2016, or in conjunction with the State’s application for renewal of the demonstration, whichever is earlier. The purpose of the Interim Evaluation Report is to present preliminary evaluation findings, and plans for completing the evaluation design and submitting a Final Evaluation Report according to the schedule outlined in (b). The State shall submit the final Interim Evaluation Report within 60 days after receipt of CMS comments.
- b. **Final Evaluation Report.** The State shall submit to CMS a draft of the Final Evaluation Report by July 1, 2017. The State shall submit the final evaluation report within 60 days after receipt of CMS comments.

137. **Cooperation with Federal Evaluators.** Should CMS undertake an independent evaluation of any component of the demonstration, the State shall cooperate fully with CMS or the independent evaluator selected by CMS. The State shall submit the required data to CMS or the contractor.

XXI. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Date	Deliverable	Paragraph
Administrative		

30 days after approval date	State acceptance of demonstration Waivers, STCs, and Expenditure Authorities	Approval letter
December 30 days prior to implementation	Termination notice regarding the 1915(c) waivers	Paragraph 63
3030 days after approval date	Termination notice regarding the 1915(b) waivers	
3030 days after approval date	Termination notice regarding the existing section 1115 demonstrations	
120 days after approval date	Submit Draft Design for Evaluation Report	Paragraph 134
See quality section STC	A revised Quality Strategy	Paragraph 85
July 1, 2013	ACA Transition Plan	Paragraph
July 1, 2016, or with renewal application	Submit Draft Interim Evaluation Report	Paragraph 136(a)
60 days after receipt of CMS comments	Submit Final Interim Evaluation Report	Paragraph 136(a)
July 1, 2017	Submit Draft Final Evaluation Report	Paragraph 136(b)
60 days after receipt of CMS comments	Submit Final Evaluation Report	Paragraph 135 136(b)
DSRIP Pool		
	Medicaid State plan amendment to remove supplemental payments from the State Plan	Paragraph 91
	DSRIP Planning Protocol	Paragraph 93
	Submit a Transition Plan for DSRIP Pool	Paragraph 93
	DSRIP Plan	Paragraph 93
HCBS/MLTSS		
9090 days prior to implementation	MLTSS Transition Plan	Paragraph 63
3030 days prior the implementation of MLTSS	Readiness Review Plan for the MLTSS	Paragraph 64

Monthly Deliverables	Monitoring Call	Paragraph 101
	Monthly Enrollment Report	Paragraph 100
Quarterly Deliverables Due 60 days after end of each quarter, except 4 th quarter	Quarterly Progress Reports	Paragraph 102 and Attachment A
	Quarterly Expenditure Reports	Paragraph 105
Annual Deliverables - Due 120 days after end of each 4 th quarter	Annual Reports	Paragraph 103 and Attachment A

ATTACHMENT A

Pursuant to paragraph 102 (*Quarterly Progress Report*) of these STCs, the State is required to submit quarterly progress reports to CMS. The purpose of the quarterly report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include an updated budget neutrality monitoring workbook. An electronic copy of the report narrative, as well as the Microsoft Excel workbook must be provided.

NARRATIVE REPORT FORMAT:

Title Line One –New Jersey Comprehensive Waiver Demonstration

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example: Demonstration Year: 1 (4/1/2011 – 3/31/2012)

Federal Fiscal Quarter: 3/2011 (4/11 - 7/11)

Footer: Date on the approval letter through June 30, 2017

I. Introduction

Present information describing the goal of the demonstration, what it does, and the status of key dates of approval/operation.

II. Enrollment and Benefits Information

Discuss the following:

- Trends and any issues related to eligibility, enrollment, disenrollment, access, and delivery network.
- Any changes or anticipated changes in populations served and benefits. Progress on implementing any demonstration amendments related to eligibility or benefits.

Please complete the following table that outlines all enrollment activity under the demonstration. The State should indicate “N/A” where appropriate. If there was no activity under a particular enrollment category, the State should indicate that by “0”.

III. Enrollment Counts for Quarter

Note: Enrollment counts should be unique enrollee counts, not member months

Demonstration Populations	Total Number of Demonstration participants Quarter Ending – MM/YY	Total Number of Demonstration participants Quarter Ending – MM/YY	Total Number of Demonstration participants Quarter Ending – MM/YY	Total Number of Demonstration participants Quarter Ending – MM/YY
Demonstration Population 1				
Demonstration Population 2				

IV. Outreach/Innovative Activities to Assure Access

Summarize marketing, outreach, or advocacy activities to potential eligibles and/or promising practices for the current quarter to assure access for demonstration participants or potential eligibles.

V. Collection and Verification of Encounter Data and Enrollment Data

Summarize any issues, activities, or findings related to the collection and verification of encounter data and enrollment data.

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

A status update that identifies all other significant program developments/issues/problems that have occurred in the current quarter or are anticipated to occur in the near future that affect health care delivery, including but not limited to program development, quality of care, approval and contracting with new plans, health plan contract compliance and financial performance relevant to the demonstration, fiscal issues, systems issues, and pertinent legislative or litigation activity.

VII. Action Plans for Addressing Any Issues Identified

Summarize the development, implementation, and administration of any action plans for addressing issues related to the demonstration. Include a discussion of the status of action plans implemented in previous periods until resolved.

VIII. Financial/Budget Neutrality Development/Issues

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and CMS 64 and budget neutrality reporting for the current quarter. Identify the State's actions to address these issues.

IX. Member Month Reporting

Enter the member months for each of the EGs for the quarter.

A. For Use in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Demonstration Population 1				
Demonstration Population 2				
Demonstration Population 3				
Demonstration Population 4				
Demonstration Population 5				
Demonstration Population 6				
Demonstration Population 7				
Demonstration Population 8				
Demonstration Population 9				
Demonstration Population 10				
Demonstration Population 11				
Demonstration Population 12				
Demonstration Population 13				
Demonstration Population 14				

X. Consumer Issues

A summary of the types of complaints or problems consumers identified about the program or grievances in the current quarter. Include any trends discovered, the resolution of complaints or grievances, and any actions taken or to be taken to prevent other occurrences.

XI. Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity or any other quality of care findings and issues in current quarter.

XII. Demonstration Evaluation

Discuss progress of evaluation plan and planning, evaluation activities, and interim findings.

XIII. Enclosures/Attachments

Identify by title the budget neutrality monitoring tables and any other attachments along with a brief description of what information the document contains.

XIV. State Contact(s)

Identify the individual(s) by name, title, phone, fax, and address that CMS may contact should any questions arise.

XV. Date Submitted to CMS.

Attachment B – Demonstration Benefits

New Jersey Comprehensive Waiver Benefit Table

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C ^{1, 2}	NJ FamilyCare Plan D ^{1, 2, 3}	Plan G GA – FFS Only
Abortions, if mother's life is endangered if pregnancy goes to term, or in cases of rape or incest	Mandatory	Yes – FFS for therapeutic/induced abortions; MCO for spontaneous abortions/miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes – FFS for therapeutic/induced abortions; MCO for spontaneous abortions/miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes – FFS for therapeutic/induced abortions; MCO for spontaneous abortions/miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes – FFS for therapeutic/induced abortions; MCO for spontaneous abortions/miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes
Abortions – Induced/therapeutic, if mother's life is endangered if pregnancy goes to term, or in cases of rape or incest	Mandatory	Yes – FFS for therapeutic/induced abortions; (dx: 623, 634.0-634.99, 635.9, 637.0-637.99)	Yes – FFS for therapeutic/induced abortions; (dx: 623, 634.0-634.99, 635.9, 637.0-637.99)	Yes – FFS for therapeutic/induced abortions; (dx: 623, 634.0-634.99, 635.9, 637.0-637.99)	Yes – FFS for therapeutic/induced abortions; (dx: 623, 634.0-634.99, 635.9, 637.0-637.99)	Yes
Abortions – Spontaneous, if mother's life is endangered if pregnancy goes to term, or in cases of rape or incest	Mandatory	Yes – MCO for spontaneous abortions/miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes – MCO for spontaneous abortions/miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes – MCO for spontaneous abortions/miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes – MCO for spontaneous abortions/miscarriages (dx: 623, 634.0-634.99, 637.0-637.99)	Yes
Biofeedback	Optional	No	No	No	No	No
Blood and Blood Plasma	Mandatory when needed for inpatient hospital and other mandatory services (e.g., home health, NF and outpatient hospital)	Yes	Yes	Yes	No	Yes

Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA – FFS Only
Blood Processing Administrative Cost	Mandatory when needed for inpatient hospital and other mandatory services (e.g., home health, NF and outpatient hospital); otherwise optional	Yes	Yes	Yes	Yes	Yes
Case Management (Targeted) - Chronically Ill	Optional	Yes	Yes	Yes	No	No
Case Management - Chronic mental illness	Optional	No	No	No	No	Yes
Certified Nurse Practitioner/Clinical Nurse Specialist	Mandatory when covered by State under physician, EPSDT, home health or certified nurse midwife; otherwise optional (e.g., if covered under Other Licensed Practitioner)	Yes	Yes	Yes - \$5 copayment except for preventive care services	Yes - \$5 copayment except for preventive services. \$10 copayment for non-office hours and home visits if indicated on the ID card	Yes
Chiropractor	Optional	Yes – spinal manipulation only	Yes – spinal manipulation only	Yes – spinal manipulation only – \$5 copayment	No	Yes

Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA – FFS Only
Clinic Services (free standing) - Ambulatory	Optional, other than Federally Qualified Health Centers (FQHC), RHCs and outpatient hospital which are mandatory	Yes	Yes	Yes – \$5 copayment except for preventive services	Yes – \$5 copayment except for preventive services	Yes
Clinic Services (free standing) - End Stage Renal Disease	Optional, other than FQHCs, RHCs and outpatient hospital which are mandatory	Yes	Yes	Yes	Yes	Yes
Clinic Services (free standing) - Family Planning	Mandatory	Yes - Family planning services and supplies from either the MCO's family planning provider network or from any other qualified Medicaid family planning provider for plans A, B and C - not available outside the MCO's provider network for Plan D (except for PSC 380)	Yes - Family planning services and supplies from either the MCO's family planning provider network or from any other qualified Medicaid family planning provider for plans A, B and C - not available outside the MCO's provider network for Plan D (except for PSC 380)	Yes - \$5 copayment except for PAP smear - family planning services and supplies from either the MCO's family planning provider network or from any other qualified Medicaid family planning provider for plans A, B and C - not available outside the MCO's provider network for Plan D (except for PSC 380)	Yes - \$5 copayment except for PAP smear - family planning services and supplies from either the MCO's family planning provider network or from any other qualified Medicaid family planning provider for plans A, B and C - not available outside the MCO's provider network for Plan D (except for PSC 380)	Yes

Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA – FFS Only
Clinic Services (free standing) - Mental Health	Optional, other than FQHCs, RHCs and outpatient hospital which are mandatory	Yes - MCO for DDD clients until ASO is operational	Yes - FFS	Yes - FFS - \$5 copayment	Yes - FFS - \$5 copayment - 35 days inpatient and 20 visits outpatient per year; \$25 copayment for outpatient hospital mental health; \$5 copayment for psychologist services	Yes
Cosmetic Services	Optional	No – except cosmetic surgery when medically necessary and approved	No – except cosmetic surgery when medically necessary and approved	No – except cosmetic surgery when medically necessary and approved	No – except cosmetic surgery when medically necessary and approved	No – except cosmetic surgery when medically necessary and approved
Dental - Medical/Surgical Services of Dentist	Mandatory	Yes	Yes	Yes	Yes	Yes

Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA – FFS Only
Dental Services	Optional	Yes – MCO; FFS for specified codes when initiated by a Medicaid non-managed care provider prior to first time managed care enrollment (exemption only if initially received services during 60-120 day period immediately prior to initial managed care enrollment)	Yes – MCO; FFS for specified codes when initiated by a Medicaid non-managed care provider prior to first time managed care enrollment (exemption only if initially received services during 60-120 day period immediately prior to initial managed care enrollment)	Yes – \$5 copayment unless preventive care – MCO; FFS for specified codes when initiated by a Medicaid non-managed care provider prior to first time managed care enrollment (exemption only if initially received services during 60-120 day period immediately prior to initial managed care enrollment)	Yes – same level of dental services as provided to Plan A-C for children under the age of 19	NA

Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA – FFS Only
Dental Services - Orthodontia	Optional	Yes – limited to children with medical necessity demonstrated by severe functional difficulties, developmental anomalies of facial bones and/or oral structures, facial trauma resulting in severe functional difficulties and/or demonstration that long term psychological health requires correction.	Yes – limited to children with medical necessity demonstrated by severe functional difficulties, developmental anomalies of facial bones and/or oral structures, facial trauma resulting in severe functional difficulties and/or demonstration that long term psychological health requires correction.	Yes – limited to children with medical necessity demonstrated by severe functional difficulties, developmental anomalies of facial bones and/or oral structures, facial trauma resulting in severe functional difficulties and/or demonstration that long term psychological health requires correction.	Yes – limited to children with medical necessity demonstrated by severe functional difficulties, developmental anomalies of facial bones and/or oral structures, facial trauma resulting in severe functional difficulties and/or demonstration that long term psychological health requires correction.	NA
Diabetic Supplies and Equipment	Optional	Yes	Yes	Yes	Yes	Yes
Durable Medical Equipment (DME) for Vision Impairment	Optional	Yes	Yes	Yes	No	Yes
DME	Optional	Yes	Yes	Yes	Yes – limited to certain DME services that could prevent costly future inpatient admissions	Yes
Early Intervention	Optional	Yes - FFS	Yes - FFS	Yes - FFS	Yes - FFS	NA

Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA – FFS Only
Emergency Services	Mandatory	Yes	Yes	Yes – \$10 copayment	Yes – \$35 copayment per visit; no copayment if results in an admission or if referred to ER by primary care provider (PCP)	Charity Care
EPSDT	Mandatory	Yes	Yes – EPSDT exams, dental, vision and hearing services are covered.	Yes – EPSDT exams, dental, vision and hearing services are covered.	Yes - Well child care only	Yes – under 21
Experimental Services	Optional	No	No	No	No	No
Family Planning Services	Mandatory	Yes – FFS when furnished by a non-participating provider and MCO when furnished by a participating provider	Yes – FFS when furnished by a non-participating provider and MCO when furnished by a participating provider	Yes – FFS when furnished by a non-participating provider and MCO when furnished by a participating provider	Yes – MCO provider only except for PSC 380	Yes
Family Planning Services - Infertility Services	Optional	No	No	No	No	No
FQHC	Mandatory	Yes	Yes	Yes – \$5 copayment for non-preventive care visits	Yes – \$5 copayment for non-preventive care visits	Yes
HealthStart	Mandatory	Yes	Yes	Yes	Yes	NA

Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA – FFS Only
Hearing Aid Services	Optional	Yes	Yes	Yes	Yes – only covered for children age 15 or younger in NJ FamilyCare D	Yes
Home Health	Mandatory	Yes	Yes	Yes	Yes	Yes
Home Health - Rehabilitation Services	Optional	Yes	Yes – 60 consecutive business days per incident/injury per year	Yes – 60 consecutive business days per incident/injury per year	Yes – \$5 copayment – 60 consecutive business days per incident/injury per year	Yes
Hospice Services	Optional	Yes	Yes	Yes	Yes	Yes
Hospital – Inpatient	Mandatory	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Charity Care
Hospital - Inpatient - Religious Non-Medical Services - Mt. Carmel Guild Hospital and Christian Science Sanitaria Care	Optional	Yes - FFS	No	No	No	No

Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA – FFS Only
Hospital – Outpatient	Mandatory	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – \$5 copayment except for preventive services; institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – \$5 copayment except for preventive services; institutions owned or operated by federal government, such as VA hospitals, are excluded	Charity Care
Hospital – Rehabilitation	Mandatory	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Yes – institutions owned or operated by federal government, such as VA hospitals, are excluded	Charity Care
Intermediate Care Facility for Persons with Mental Retardation (ICF/MR)	Optional	Yes – FFS	No	No	No	No
Laboratory	Mandatory	Yes	Yes	Yes	Yes – \$5 copayment	Yes
Maternity	Mandatory	Yes	Yes	Yes – \$5 copayment for first prenatal care visit only	Yes – \$5 copayment for first prenatal care visit only	No
Maternity - Midwifery Services (non-maternity)	Mandatory	Yes	Yes	Yes - \$5 copayment except for preventive care services	Yes - \$5 copayment except for preventive care services	Yes

Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA – FFS Only
Maternity - Midwifery Services (maternity)	Mandatory	Yes	Yes	Yes - \$5 copayment except for prenatal care visit	Yes - \$5 copayment except for prenatal care visit; \$10 copayment for non-office hours and home visits	No
Medical Day Care - Adult	Optional	Yes	No	No	No	No
Medical Day Care - pediatric	Optional	Yes	No	No	No	No
Medical Supplies	Optional	Yes	Yes	Yes	Yes – limited	Yes
Mental Health - Adult Rehabilitation	Optional	Yes – FFS; MCO for DDD clients	No	No	No	No
Mental Health – Inpatient	Optional	Yes – FFS; MCO for DDD clients until ASO is operational	Yes – FFS	Yes – FFS	Yes – FFS; limited to 35 days per year.	Charity Care
Mental Health - Outpatient	Optional	Yes – FFS; MCO for DDD clients until ASO is operational	Yes – FFS	Yes – FFS	Yes – FFS - \$25 copayment per visit	Charity Care
Methadone Maintenance	Optional	Yes - FFS	No	No	No	Yes
NF	Mandatory for over age 21	Yes – MCO first 30 days and FFS after 30 days (moves to Managed Care July 1, 2012)	No	No	No	No

Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA – FFS Only
Ophthalmology Services	Mandatory	Yes	Yes	Yes	Yes	Yes
Optical Appliances	Optional	Yes	Yes	Yes	Yes – limited to one pair of glasses or contact lenses per 24 month period or as medically necessary	Yes
Optometrist	Optional	Yes	Yes	Yes – \$5 copayment per visit	Yes – \$5 copayment per visit; one routine eye exam per year	Yes
Organ Transplants	Optional	Yes – experimental organ transplants not covered	Yes – experimental organ transplants not covered			
Orthotics	Optional	Yes	Yes	Yes	No	Yes
Other Therapies	Optional	Yes	Yes	Yes - \$5 copayment	Yes	Yes
Partial Care	Optional	Yes – FFS	Yes – FFS	Yes – FFS	Yes – FFS – limitations apply – 20 outpatient visits per year	Yes
Partial Hospital	Optional	Yes – FFS	Yes – FFS	Yes – FFS	Yes – FFS – limitations apply – 35 inpatient visits per year	Yes – charity care
Personal Care Assistant	Optional	Yes	No	No	No	Yes

Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA – FFS Only
Personal Care Assistant - Mental Health	Optional	Yes – FFS, No PA, 25 hour per week limit	No	No	No	Yes
Pharmacy – (ADDP) Covered Anti-Retroviral Drugs	Optional - Pharmaceuticals on the Master Rebate List are mandatory	Yes	Yes	Yes	Yes	Yes
Pharmacy – Erectile Dysfunction Drugs	Optional	No	No	No	No	No
Pharmacy - Mental Health/Substance Abuse	Optional, other than FQHCs, RHCs and outpatient hospitals which are mandatory	Yes	Yes	Yes	Yes	Yes
Pharmacy - Atypical anti-psych	Optional	Yes	Yes	Yes	Yes	Yes
Pharmacy - High Cost Drugs	Optional - Pharmaceuticals on the Master Rebate List are mandatory	Yes	Yes	Yes	Yes	Yes
Pharmacy - Infertility	Optional - Pharmaceuticals on the Master Rebate List are mandatory	No	No	No	No	No

Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA – FFS Only
Pharmacy - Suboxone	Optional - Pharmaceuticals on the Master Rebate List are mandatory	Yes	Yes	Yes	Yes	Yes
Pharmacy – Over the Counter (OTC) Drugs and All Other OTC Products	Optional	Yes	Yes	Yes	No	Yes
Pharmacy – Over the Counter Drugs – Cough, Cold and Cosmetic Products	Optional	Yes - for children (EPSDT service)	Yes - for children (EPSDT service)	Yes - for children (EPSDT service)	No	Yes – under 21 (EPSDT services)
Pharmacy - Physician Administered Drugs	Optional	Yes	Yes	Yes	Yes	Yes
Pharmacy – Prescription Drugs Not Reimbursable	Optional	Yes	Yes	Yes – \$1 copayment for generic/\$5 brand – includes insulin, needles and syringes	Yes – \$5 copayment/\$10 copayment>34 day supply	Yes
Pharmacy – Prescription Drugs Reimbursable	Optional	Yes	Yes	Yes – \$1 copayment for generic/\$5 brand – includes insulin, needles and syringes	Yes – \$5 copayment/\$10 copayment>34 day supply	Yes

Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA – FFS Only
Pharmacy - Reimbursable Blood Factor	Optional - Pharmaceuticals on the Master Rebate List are mandatory	Yes	Yes	Yes	No	No
Physician/PCP Practitioner	Mandatory	Yes	Yes	Yes – \$5 copayment for non- preventive visits	Yes – \$5 copayment for non-preventive visits; \$10 copayment for after hours and home visits	Yes
Podiatrist	Optional	Yes – no routine care	Yes – no routine care	Yes – no routine care; \$5 copayment	Yes – no routine care; \$5 copayment	Yes - no routine care
Private Duty Nursing	Optional	Yes – when authorized; up to 21 years of age	Yes – when authorized	Yes – when authorized	Yes – when authorized	No
Prosthetics	Optional	Yes	Yes	Yes	Yes – limited to the initial provision of a prosthetic device that temporarily or permanently replaces all or part of an external body part lost or impaired as a result of disease, injury or congenital defect	Yes

Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA – FFS Only
Psychiatric Hospital – Inpatient	Optional if covered by the SPA	Yes – FFS for under 21 and over 65 years of age	Yes – FFS for under 21 and over 65 years of age	Yes – FFS for under 21 and over 65 years of age	Yes – FFS for under 21 and over 65 years of age; limited to 35 days per year	Charity Care
Radial Keratotomy	Optional	No	No	No	No	No
Radiology	Mandatory	Yes	Yes	Yes	Yes – \$5 copayment	Yes
Recreational Therapy	Optional	No	No	No	No	No
Rehabilitation – Outpatient Physical, Occupational, Speech	Optional	Yes	Yes – 60 consecutive business days per incident/injury per year	Yes – 60 consecutive business days per incident/injury per year	Yes – \$5 copayment – 60 consecutive business days per incident/injury per year	Yes
RTC Services	Optional	Yes – FFS	Yes – FFS	Yes – FFS	No	No
Respite Care	Optional	No – (will be covered by Managed LTC July 1, 2012)	No	No	No	No
School Based Services	Optional	Yes - FFS	No	No	No	No
Sex Abuse Exams	Mandatory	Yes – FFS	Yes – FFS	Yes – FFS	Yes – FFS	Yes
Skilled Nursing Facility	Mandatory	Yes – MCO first 30 days and FFS after 30 days (moves to Managed LTC July 1, 2012)	Yes	Yes	No	No
Substance Abuse – Inpatient (SAI)*	Optional	Yes – FFS; MCO for DDD clients	Yes – FFS	Yes – FFS	Yes – FFS (detox only)	Only through the SAI

Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA – FFS Only
Substance Abuse – Outpatient*	Optional	Yes – FFS; MCO for DDD clients	Yes – FFS	Yes – FFS	Yes – FFS - \$5 copayment per visit (detox only)	Only through the SAI
Temporomandibular Joint Disorder Treatment	Optional	Yes	Yes	Yes	No	Yes
Thermograms and Thermography	Optional	Yes	Yes	Yes	No	Yes
Transportation – Emergent (Ambulance, Mobile Intensive Care Unit)	Mandatory	Yes	Yes	Yes	Yes	Yes
Transportation – Non-Emergent (Ambulance Non-Emergency, Medical Assistance Vehicles (MAV), Livery, Clinic)	Optional	Yes	Yes, no livery	Yes, no livery	No	Yes

Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C 1, 2	NJ FamilyCare Plan D 1, 2, 3	Plan G GA – FFS Only
Vaccines	Mandatory for EPSDT	Yes – While the vaccine administration costs remain the responsibility of the MCOs, the vaccination cost for Title XIX children (NJ FamilyCare A) are not the responsibility of the MCOs. These vaccine costs are covered under the Vaccines for Children (VFC) program.	Yes	Yes	Yes	NA
Vaccines - Administration	Mandatory for EPSDT	Yes – While the vaccine administration costs remain the responsibility of the MCOs, the vaccination cost for children (NJ FamilyCare A) are not the responsibility of the MCOs. These vaccine costs are covered under the VFC program.	Yes	Yes	Yes	

Attachment B – Demonstration Benefits

Service type	Federal Medicaid law	Plan A FamilyCare and ABD	NJ FamilyCare Plan B	NJ FamilyCare Plan C ^{1, 2}	NJ FamilyCare Plan D ^{1, 2, 3}	Plan G GA – FFS Only
Vaccines - Vaccination	Mandatory for EPSDT	Yes – While the vaccine administration costs remain the responsibility of the MCOs, the vaccination cost for children (NJ FamilyCare A) are not the responsibility of the MCOs. These vaccine costs are covered under the VFC program.	Yes	Yes	Yes	

1 - Both Eskimos and Native American Indian children under the age of 19, identified by Race Code 3, are not required to pay copayments.

2 - The total family (regardless of family size) limit on all cost-sharing may not exceed 5% of the annual family income.

3 - Plan D copayments limited only to adult enrollees with incomes greater than 150% FPL. All Plan D children have copayments.

4 - Sources Covered Services - Article 4.1 of Volume I of Medicaid/NJ FamilyCare Managed Care Contract; and Section B.4.1 of Appendices (Volume II) of Medicaid/NJ FamilyCare Managed Care Contract.

Copayments - Section B.5.2 of Appendices (Volume II) of Medicaid/NJ FamilyCare Managed Care Contract.

Federal Medicaid Law - 42 CFR Part 440

Attachment C.1
New Jersey’s Comprehensive Waiver Demonstration
Home and Community Based Services – Fee for Service Program
Service Definitions

The Supports Program:

Program Overview: The Supports Program is to provide a basic level of support services to Demonstration participants who live with family members or who live in their own homes that are not licensed by the State. Each individual served will receive a smaller package of program services than what is available to individuals served in New Jersey’s Community Care Waiver (CCW), primarily because individuals have access to nonpaid supports available to them. In effect, federal financial participation is available for New Jersey’s current Family Support Program plus adds some new services centered on independent living including employment and day services.

The goal of this program is to support each Demonstration participant in the least restrictive setting in the community and ensure the Demonstration participant’s health and safety while respecting the rights of the individual. Language from the New Jersey Family Support Act of 1993 expresses well the primary goal of this program: “[Supports] ...must be easily accessible, flexible, culturally sensitive and individualized. They must be designed to promote interdependence, independence, productivity and integration of people with disabilities into the community. Supports must also be built on existing social networks and naturally occurring supports including extended families, neighbors and community associations. ...Failure to provide needed supports can result in premature placement of the [Demonstration participant] in a setting outside the home.”

The following services are available through the Supports Program:

1. **Service Name:** Support Coordination

- a. **Description:** Services that assist Demonstration participants in gaining access to needed program and State plan services, as well as needed medical, social, educational and other services. Support Coordination is managed by one individual (the Support Coordinator) for each Demonstration participant. The Support Coordinator is responsible for developing and maintaining the Individualized Service Plan with the Demonstration participant, their family, and other team members designated by the Demonstration participant. The Support Coordinator is responsible for the ongoing monitoring of the provision of services included in the Individualized Service Plan.
- b. **Service Limits:** All Supports Program Demonstration participants receive monthly contact with their Support Coordinator.
- c. **Provider Specification(s):**
 - i. Approved Medicaid provider;
 - ii. Has met the qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
- d. Participant Direction Option
- e. Provider Directed Participant Directed

2. **Service Name:** Community Inclusion Services

- a. **Description:** Services provided outside of a Demonstration participant's home that support and assist Demonstration participants in educational, enrichment or recreational activities as outlined in his/her Service Plan that are intended to enhance inclusion in the community. Community Inclusion Services are delivered in a group setting not to exceed six (6) individuals.
- b. **Service Limits:** Community Inclusion Services are limited to 30 hours per week. . Transportation to or from a Community Inclusion Service site is not included in the service.
- c. **Provider Specification(s):**
 - i. Approved Medicaid provider
 - ii. Has met the qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

3. **Service Name:** Community Based Supports

- a. **Description:** Services that provide direct support and assistance for Demonstration participants, with or without the caregiver present , in or out of the Demonstration participant's residence, to achieve and/or maintain the outcomes of increased independence, productivity, enhanced family functioning, and inclusion in the community, as outlined in his/her Service Plan. Community-Based Supports are delivered one-on-one with a Demonstration participant and may include but are not limited to: assistance with community-based activities and assistance to, as well as training and supervision of, individuals as they learn and perform the various tasks that are included in basic self-care, social skills, and activities of daily living. .
- b. **Service Limits:** Providers of Community-Based Support Services may be members of the Demonstration participant's family except for spouse or parent of a minor child, provided that the family member has met the same standards as providers who are unrelated to the individual.
- c. **Provider Specification(s):**
 - i. Approved Medicaid provider
 - ii. Has met the qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
 - iii. Individual Supports Assistant (for Demonstration participants that self-direct) who has met all eligibility requirements established by the DHS/DDD to be hired by a Demonstration participant who serves as the Employer of Record.
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

4. **Service Name:** Day Habilitation

- a. **Description:** Services that provide education and training to acquire the skills and experience needed to participate in the community, consistent with the Demonstration participant's Service Plan. This may include activities to support Demonstration participants with building problem-solving skills, self-help, social skills, adaptive skills, daily living skills, and leisure skills. Activities and environments are designed to foster the acquisition of skills, building positive social behavior and interpersonal

competence, greater independence and personal choice. Services are provided during daytime hours and do not include employment-related training. Day Habilitation may be offered in a center-based or community-based setting.

- b. **Service Limits:** Day Habilitation does not include services, activities or training which the Demonstration participant may be entitled to under federal or state programs of public elementary or secondary education, State Plan services, or federally funded vocational rehabilitation. Day Habilitation is limited to 30 hours per week. Transportation to or from a Day Habilitation site is not included in the service.
- c. **Provider Specification(s):**
 - i. Approved Medicaid provider
 - ii. Has met the qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

5. **Service Name:** Prevocational Training

- a. **Description:** Services that provide learning and work experiences, including volunteer work, where the individual can develop general, non-job-task-specific strengths and skills that contribute to employability in paid employment in integrated community settings. Services may include training in effective communication with supervisors, co-workers and customers; generally accepted community workplace conduct and dress; ability to follow directions; ability to attend to tasks; workplace problem solving skills and strategies; and general workplace safety and mobility training. Prevocational Training is intended to be a service that Demonstration participants receive over a defined period of time and with specific outcomes to be achieved in preparation for securing competitive, integrated employment in the community for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. Prevocational Training services cannot be delivered within a sheltered workshop. Supports are delivered in a face-to-face setting, either one-on-one with the Demonstration participant or in a group of two to eight Demonstration participants.
- b. **Service Limits:** This service is available to Demonstration participants in accordance with the DHS/DDD Employment Services and Supports Policy Manual, and as authorized in their Service Plan. Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.) or P.L. 94-142. Prevocational Training is limited to 30 hours per week. Transportation to or from a Prevocational Training site is not included in the service.
- c. **Provider Specification(s):**
 - i. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
 - ii. Provider approved by DHS/DDD
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

6. **Service Name:** Supported Employment– Individual Employment Support

- a. **Description:** Activities needed to help a Demonstration participant obtain and maintain an individual job in competitive or customized employment, or self-employment, in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities. The service may be delivered for an intensive period upon the Demonstration participant’s initial employment to support the Demonstration participant who, because of their disability, would not be able to sustain employment without supports. Supports in the intensive period are delivered in a face-to-face setting, one-on-one. The service may also be delivered to a Demonstration participant on a less intensive, ongoing basis (“follow along”) where supports are delivered either face-to-face or by phone with the Demonstration participant and/or his or her employer. Services are individualized and may include but are not limited to: training and systematic instruction, job coaching, benefit support, travel training, and other workplace support services including services not specifically related to job-skill training that enable the Demonstration participant to be successful in integrating into the job setting.
- b. **Service Limits:** This service is available to Demonstration participants in accordance with the DHS/DDD Employment Services and Supports Policy Manual, and as authorized in their Service Plan. Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.) or P.L. 94-142. Supported Employment – Individual Employment Support is limited to 30 hours per week. Transportation to or from a Supported Employment site is not included in the service. When Supported Employment is provided at a work site in which people without disabilities are employed, payment will be made only for the adaptations, supervision and training required for Demonstration participants as a result of their disabilities and will not include payment for the supervisory activities rendered as a normal part of the business setting or for incentive payments, subsidies or unrelated training expenses.
- c. **Provider Specification(s):**
 - i. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD);
 - ii. Provider approved by DHS/DDD;
 - iii. Division of Vocational Rehabilitation Services (DVRS) approved supported employment vendor;
 - iv. Employment specialist/job coach that has met all qualifications as specified by DHS/DDD
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

7. **Service Name:** Supported Employment – Small Group Employment Support

- a. **Description:** Services and training activities provided to Demonstration participants in regular business, industry and community settings for groups of two to eight workers with disabilities. Services may include mobile crews and other business-

based workgroups employing small groups of workers with disabilities in employment in the community. Services must be provided in a manner that promotes integration into the workplace and interaction between Demonstration participants and people without disabilities. Services may include but are not limited to: job placement, job development, negotiation with prospective employers, job analysis, training and systematic instruction, job coaching, benefit support, travel training and planning.

- b. **Service Limits:** This service is available to Demonstration participants in accordance with the DHS/DDD Employment Services and Supports Policy Manual, and as authorized in their Service Plan. Documentation is maintained in the file of each individual receiving this service that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973, the IDEA (20 U.S.C. 1401 et seq.) or P.L. 94-142. Supported Employment – Small Group Employment Support is limited to 30 hours per week. Transportation to or from a Supported Employment site is not included in the service. When Supported Employment is provided at a work site in which people without disabilities are employed, payment will be made only for the adaptations, supervision and training required for Demonstration participants as a result of their disabilities and will not include payment for the supervisory activities rendered as a normal part of the business setting or for incentive payments, subsidies or unrelated training expenses.
- c. **Provider Specification(s):**
 - i. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD);
 - ii. Provider approved by DHS/DDD;
 - iii. Division of Vocational Rehabilitation Services (DVRS) approved supported employment vendor;
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

8. **Service Name:** Career Planning

- a. **Description:** Career planning is a person-centered, comprehensive employment planning and support service that provides assistance for program Demonstration participants to obtain, maintain or advance in competitive employment or self-employment. It is a focused, time-limited service engaging a Demonstration participant in identifying a career direction and developing a plan for achieving competitive, integrated employment at or above the state’s minimum wage. The outcome of this service is documentation of the Demonstration participant’s stated career objective and a career plan used to guide individual employment support. If a Demonstration participant is employed and receiving supported employment services, career planning maybe used to find other competitive employment more consistent with the person’s skills and interests or to explore advancement opportunities in his or her chosen career.
- b. **Service Limits:** This service is available to Demonstration participants in accordance with the DHS/DDD Employment Services and Supports Policy Manual, and as authorized in their Service Plan. This service is available to Demonstration participants at a maximum of 80 hours per Service Plan year. If the Demonstration

participant is eligible for services from the State's Division of Vocational Rehabilitation Services, these services must be exhausted before Career Planning can be offered to the Demonstration participant.

c. **Provider Specification(s):**

- i. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD);
- ii. Provider approved by DHS/DDD;
- iii. Division of Vocational Rehabilitation Services (DVRS) approved time-limited job coaching or supported employment vendor;
- iv. Employment specialist/job developer that has met all qualifications as specified by DHS/DDD
- v.

d. Participant Direction Option

- i. Provider Directed Participant Directed

9. **Service Name:** Respite

a. **Description:** Services provided to Demonstration participants unable to care for them that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the Demonstration participant. Respite may be delivered in multiple periods of duration such as partial hour, hourly, daily without overnight, or daily with overnight. Respite may be provided in the Demonstration participant's home, a DHS licensed group home, , or another community-based setting approved by DHS. Some settings, such as a hotel, may be approved by the State for use when options using other settings have been exhausted.

b. **Service Limits:** Room and board costs will not be paid when services are provided in the Demonstration participant's home. Hotel Respite shall not exceed two consecutive weeks and 30 days per year. **Provider Specification(s):**

- i. Provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
- ii. Provider approved by DHS/DDD
- iii. A homemaker agency approved as a Medicaid provider
- iv. A licensed, certified home health agency approved as a Medicaid provider
- v. Individual Supports Assistant (for Demonstration participants that self-direct) who has met all eligibility requirements established by the DHS/DDD to be hired by a Demonstration participant and paid through the fiscal intermediary.

c. Participant Direction Option

- i. Provider Directed Participant Directed

10. **Service Name:** Transportation

a. **Description:** Service offered in order to enable Demonstration participants to gain access to services, activities and resources, as specified by the Service Plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State Plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Whenever possible, family,

- neighbors, friends, or community agencies which can provide this service without charge are utilized.
- b. **Service Limits:** Reimbursement for transportation is limited to distances not to exceed 150 miles one way and only within the States of New Jersey, New York, Pennsylvania and Delaware.
 - c. **Provider Specification(s):**
 - i. Approved Medicaid provider that has met the qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD);
 - ii. Provider approved by DHS/DDD;
 - iii. Valid driver's license;
 - iv. Valid vehicle registration;
 - v. Valid insurance
 - vi. A homemaker agency approved as a Medicaid provider.
 - vii. A licensed, certified home health agency approved as a Medicaid provider.
 - viii. Individual Supports Assistant (for Demonstration participants that self-direct) who has met all eligibility requirements established by the DHS/DDD to be hired by a Demonstration participant who serves as the Employer of Record.
 - d. Participant Direction Option
 - i. Provider Directed Participant Directed

11. Service Name: Natural Supports Training

- a. **Description:** Training and counseling services for individuals who provide unpaid support, training, companionship or supervision to Demonstration participants. For purposes of this service, individual is defined as: "any person, family member, neighbor, friend, companion, or co-worker who provides uncompensated care, training, guidance, companionship or support to a Demonstration participant." Training includes instruction about treatment regimens and other services included in the Service Plan, use of equipment specified in the Service Plan, and includes updates as necessary to safely maintain the Demonstration participant at home. Counseling must be aimed at assisting the unpaid caregiver in meeting the needs of the Demonstration participant. All training for individuals who provide unpaid support to the Demonstration participant must be included in the Demonstration participant's Service Plan. Natural Supports Training may be delivered to one individual or may be shared with one other individual.
- b. **Service Limits:** This service may not be provided in order to train paid caregivers. When delivered by a Direct Service Professional (DSP), the DSP must have a minimum of two years' experience working with individuals with developmental disabilities. When delivered by professional staff, the professional must have a license in psychiatry, physical therapy, occupational therapy, speech language pathology, social work, or must be a registered nurse or a degreed psychologist.
- c. **Provider Specification(s):**
 - i. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD) Office of Quality Improvement
 - ii. A homemaker agency approved as a Medicaid provider

- iii. A social work agency approved as a Medicaid provider
- iv. A licensed, certified home health agency approved as a Medicaid provider
- v. A board-certified and board-eligible psychiatrist approved as a Medicaid provider
- vi. A clinical psychologist approved as a Medicaid provider
- vii. A licensed registered nurse approved as a Medicaid provider
- viii. A licensed social worker approved as a Medicaid provider
- ix. A licensed physical therapist approved as a Medicaid provider
- x. A licensed occupational therapist approved as a Medicaid provider
- xi. A licensed speech language pathologist approved as a Medicaid provider
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

12. **Service Name:** Behavioral Management

- a. **Description:** Individual and/or group counseling, behavioral interventions, diagnostic evaluations or consultations related to the individual's developmental disability and necessary for the individual to acquire or maintain appropriate interactions with others. Intervention modalities must relate to an identified challenging behavioral need of the individual. Specific criteria for remediation of the behavior shall be established. The provider(s) shall be identified in the Service Plan and shall have the minimum qualification level necessary to achieve the specific criteria for remediation. Behavioral management includes a complete assessment of the challenging behavior(s), development of a structured behavioral modification plan, implementation of the plan, ongoing training and supervision of caregivers and behavioral aides, and periodic reassessment of the plan.
- b. **Service Limits:** Behavioral management services are offered in addition to and do not replace treatment services for behavioral health conditions that can be accessed through the State Plan/MBHO and mental health service system. Individuals with co-occurring diagnoses of developmental disabilities and mental health conditions shall have identified needs met by each of the appropriate systems without duplication but with coordination to obtain the best outcome for the individual. .
- c. **Provider Specification(s):**
 - i. Provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
 - ii. Provider approved by DHS/DDD
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

13. **Service Name:** Cognitive Rehabilitative Therapy (CRT)

- a. **Description:** As defined by Harley, et al, a systematic, functionally-oriented service of therapeutic cognitive activities, based on an assessment and understanding of the person's brain behavior deficits. Services are directed to achieve functional changes: by (1) reinforcing, strengthening or re-establishing previously learned patterns of behavior, or (2) establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems. Therapeutic interventions include but are not limited to direct retraining, use of compensatory strategies, use of cognitive

- orthotics and prostheses. Activity type and frequency are determined by assessment of the Demonstration participant, the development of a treatment plan based on recognized deficits, and periodic reassessments. Cognitive therapy can be provided in the individual's home or community settings
- b. **Service Limits:** Daily limits as delineated by the Demonstration participant's Service Plan. Frequency and duration of service must be supported by assessment and included in the Demonstration participant's Service Plan. CRT may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five Demonstration participants. Both group and individual sessions may not exceed 60 minutes in length. The therapist must record the time the therapy session started and when it ended in the Demonstration participant's clinical record. This service must be coordinated and overseen by a CRT provider holding at least a master's degree. All individuals who provide or supervise the CRT service must complete six hours of relevant ongoing training in CRT and or brain injury rehabilitation. Training may include, but is not limited to, participation in seminars, workshops, conferences, and in-services.
 - c. **Provider Specification(s):**
 - i. A board-certified and board-eligible psychiatrist approved as a Medicaid provider
 - ii. A clinical psychologist approved as a Medicaid provider
 - iii. Mental Health Agency
 - iv. Post-acute non-residential rehabilitative services provider agency
 - v. An outpatient program of a rehabilitation hospital
 - vi. Certified Occupational Therapy Assistants (COTAs) and Physical Therapy Assistants (PTAs) may provide CRT but only under the guidelines described in the New Jersey practice acts for occupational and physical therapists.
 - vii. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
 - viii. Staff members working for any of the agencies above who meet the above-mentioned degree requirements, but are not licensed or certified, may practice under the supervision of a rehabilitation practitioner who is licensed and/or meets the criteria for certification by the Society for Cognitive Rehabilitation (actual certification is not necessary so long as criteria is met).
 - d. Participant Direction Option
 - i. Provider Directed Participant Directed

14. Service Name: Interpreter Services

- a. **Description:** Service delivered to a Demonstration participant face-to-face to support them in integrating more fully with community-based activities or employment. Interpreter services may be delivered in a Demonstration participant's home or in a community setting. For language interpretation, the interpreter service must be delivered by an individual proficient in reading and speaking in the language that the Demonstration participant speaks in.
- b. **Service Limits:** Interpreter services may be used when the State Plan service for language line interpretation is not available or not feasible or when natural interpretive supports are not available.

- c. **Provider Specification(s):**
 - i. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
 - ii. Individual Supports Assistant (for Demonstration participants that self-direct) who has met all eligibility requirements established by the DHS/DDD to be hired by a Demonstration participant who serves as the Employer of Record
 - iii. For language interpreter: 18 yrs of age, cleared criminal background check, proficient in reading & speaking both languages
- d. Participant Direction Option
 - i. Provider Directed X Participant Directed X

15. **Service Name:** Physical Therapy

- a. **Description:** The scope and nature of these services do not otherwise differ from the Physical Therapy services described in the State Plan. They may be either rehabilitative or habilitative in nature. Services that are rehabilitative in nature are only provided when the limits of physical therapy services under the approved State Plan are exhausted. The provider qualifications specified in the State plan apply. Physical Therapy may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five Demonstration participants.
- b. **Service Limits:** These services are only available as specified in Demonstration participant's Service Plan and when prescribed by an appropriate health care professional. These services can be delivered on an individual basis or in groups. A group session is limited to 1 therapist with 5 participants and may not exceed 60 minutes in length. The therapist must record the time the therapy session started and when it ended in the Demonstration participant's clinical record.
- c. **Provider Specification(s):**
 - i. A licensed physical therapist or physical therapy assistant approved as a Medicaid provider
 - ii. Licensed, certified home health agency
 - iii. Post-acute non-residential rehabilitative services provider agency
 - iv. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD)
 - v. Staff members working for any of the agencies above shall meet the New Jersey licensure standards and requirements for practice (N.J.A.C. 13:39A).
- d. Participant Direction Option
 - i. Provider Directed X Participant Directed

16. **Service Name:** Occupational Therapy

- a. **Description:** The scope and nature of these services do not otherwise differ from the Occupational Therapy services described in the State Plan. They may be either rehabilitative or habilitative in nature. Services that are rehabilitative in nature are only provided when the limits of occupational therapy services under the approved State Plan are exhausted. The provider qualifications specified in the State plan apply. Occupational Therapy may be provided on an individual basis or in groups. A

- group session is limited to one therapist with maximum of five Demonstration participants.
- b. **Service Limits:** These services are only available as specified in Demonstration participant's Service Plan and when prescribed by an appropriate health care professional. These services can be delivered on an individual basis or in groups. A group session is limited to one therapist with a maximum of five participants and may not exceed 60 minutes in length. The therapist must record the time the therapy session started and when it ended in the Demonstration participant's clinical record.
 - c. **Provider Specification(s):**
 - i. A licensed occupational therapist or occupational therapy assistant approved as a Medicaid provider
 - ii. Licensed, certified home health agency
 - iii. Post-acute non-residential rehabilitative services provider agency
 - iv. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD) Office of Quality Improvement
 - v. Staff members working for any of the agencies above shall be registered as an occupational therapist (OTR) with the American Occupational Therapy Association (AOTA). A certified occupational therapy assistant (COTA) shall be registered with the AOTA and work under the direction of the OTR.
 - d. Participant Direction Option
 - i. Provider Directed Participant Directed

17. **Service Name:** Speech, Language, and Hearing Therapy (ST)

- a. **Description:** The scope and nature of these services do not otherwise differ from the Speech Therapy services described in the State Plan. They may be either rehabilitative or habilitative in nature. Services that are rehabilitative in nature are only provided when the limits of speech therapy services under the approved State Plan are exhausted. The provider qualifications specified in the State plan apply. Speech, Language or Hearing Therapy may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five Demonstration participants.
- b. **Service Limits:** These services are only available as specified in Demonstration participant's Service Plan and when prescribed by an appropriate health care professional. These services can be delivered on an individual basis or in groups. Group sessions are limited to one therapist with five participants and may not exceed 60 minutes in length. The therapist must record the time the therapy session started and when it ended in the Demonstration participant's clinical record.
- c. **Provider Specification(s):**
 - i. A licensed speech therapist approved as a Medicaid provider
 - ii. Licensed, certified home health agency
 - iii. Post-acute non-residential rehabilitative services provider agency
 - iv. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD) Office of Quality Improvement

- v. Staff members working for any of the agencies above shall meet the New Jersey licensure standards and requirements for practice (N.J.A.C. 13:44C).
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

18. **Service Name:** Demonstration participant-Directed Goods and Services

- a. **Description:** Demonstration participant-Directed Goods and Services are services, equipment or supplies, not otherwise provided through generic resources, this program, or through the State Plan, which address an identified need (including improving and maintaining the Demonstration participant’s opportunities for full membership in the community) and meet the following requirements: the item or service would decrease the need for other Medicaid services; AND/OR promote inclusion in the community; AND/OR increase the Demonstration participant’s safety in the home environment; AND, the Demonstration participant does not have the funds to purchase the item or service or the item or service is not available through another source. Demonstration participant-Directed Goods and Services are purchased from the Demonstration participant-directed budget and paid and documented by the fiscal intermediary.
- b. **Service Limits:** Experimental or prohibited treatments are excluded. Demonstration participant-Directed Goods and Services must be based on assessed need and specifically documented in the Service Plan.
- c. **Provider Specification(s):**
 - i. Fiscal intermediary provider that has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
 - ii. Individual Supports Assistant (for Demonstration participants that self-direct) who has met all eligibility requirements established by the DHS/DDD to be hired by a Demonstration participant who serves as the Employer of Record
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

19. **Service Name:** Supports Brokerage

- a. **Description:** Service/function that assists the Demonstration participant (or the Demonstration participant’s family or representative, as appropriate) in arranging for, directing and managing services. Serving as the agent of the Demonstration participant or family, the service is available to assist in identifying immediate and long-term needs, developing options to meet those needs and accessing identified supports and services. Practical skills training is offered to enable families and Demonstration participants to independently direct and manage program services. Examples of skills training include providing information on recruiting and hiring personal care workers, managing workers and providing information on effective communication and problem-solving. The service/function includes providing information to ensure that Demonstration participants understand the responsibilities involved with directing their services.
- b. **Service Limits:** This service is available only to Demonstration participants who self-direct some or all of the services in their Service Plan and is intended to supplement, but not duplicate, the Support Coordination service. The extent of the

assistance furnished to the Demonstration participant or family is specified in the Service Plan. The Supports Brokerage services cannot be paid to New Jersey DDD provider agencies or employees of these agencies, legal guardians of the Demonstration participant, or other individuals who reside with the Demonstration participant. Legal guardians or other natural supports can provide the service at no cost to the State.

- c. **Provider Specification(s):**
 - i. Provider that has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD).
 - ii. Individual Supports Assistant (for Demonstration participants that self-direct) who has met all eligibility requirements established by the DHS/DDD to be hired by a Demonstration participant who serves as the Employer of Record
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

20. **Service Name:** Financial Management Services

- a. **Description:** Service/function that assists the Demonstration participant (or the Demonstration participant's family or representative, as appropriate) to: (a) manage and direct the disbursement of funds contained in the Demonstration participant-directed budget; (b) facilitate the employment of staff by the family or Demonstration participant, by performing (as the Demonstration participant's agent) such employer responsibilities as processing payroll, withholding Federal, state, and local tax and making tax payments to appropriate tax authorities; and, (c) performing fiscal accounting and making expenditure reports to the Demonstration participant or family and state authorities.
- b. **Service Limits:** This service is available only to Demonstration participants who self-direct some or all of the services in their Service Plan.
- c. **Provider Specification(s):**
 - i. Fiscal intermediary provider that has met the provider qualifications as specified by the Department of Human Services (DHS), Division of Developmental Disabilities (DDD) Office of Quality Improvement.
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

21. **Service Name:** Environmental Modifications

- a. **Description:** Those physical adaptations to the private residence of the Demonstration participant or the Demonstration participant's family, based on assessment and as required by the Demonstration participant's Service Plan, that are necessary to ensure the health, welfare and safety of the Demonstration participant or that enable the Demonstration participant to function with greater independence in the home. Such adaptations include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the Demonstration participant.

- b. **Service Limits:** All services shall be provided in accordance with applicable State or local building codes and are subject to prior approval on an individual basis by DDD. Excluded items are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the Demonstration participant. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).
- c. **Provider Specification(s):**
 - i. Provider approved by the DHS/DDD.
 - ii. New Jersey licensed contractor and proof of liability insurance.
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

22. **Service Name:** Vehicle Modifications

- a. **Description:** Assessments, Adaptations, or alterations to an automobile or van that is the Demonstration participant's primary means of transportation in order to accommodate the special needs of the Demonstration participant. Vehicle adaptations are specified by the Service Plan, are necessary to enable the Demonstration participant to integrate more fully into the community and to ensure the health, welfare and safety of the Demonstration participant.
- b. **Service Limits:** All Vehicle Modifications are subject to prior approval on an individual basis by DDD. The following are specifically excluded: (1) Adaptations or improvements to the vehicle that are of general utility, and are not of direct medical or remedial benefit to the individual; (2) Purchase or lease of a vehicle; and (3) Regularly scheduled upkeep and maintenance of a vehicle except upkeep and maintenance of the modifications.
- c. **Provider Specification(s):**
 - i. Provider approved by the DHS/DDD.
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

23. **Service Name:** Assistive Technology

- a. **Description:** Assistive technology device means an item, piece of equipment, or product system, whether acquired commercially, modified, or customized, that is used to increase, maintain, or improve functional capabilities of Demonstration participants. Assistive technology service means a service that directly assists a Demonstration participant in the selection, acquisition, or use of an assistive technology device. Assistive technology includes: (A) the evaluation of the assistive technology needs of a Demonstration participant, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the Demonstration participant in the customary environment of the Demonstration participant; (B) services consisting of purchasing, leasing, or otherwise providing for the acquisition of assistive technology devices for Demonstration participants; (C) services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices; (D) ongoing maintenance fees to utilize the assistive technology

- (e.g., remote monitoring devices); (E) coordination and use of necessary therapies, interventions, or services with assistive technology devices, such as therapies, interventions, or services associated with other services in the Service Plan; (F) training or technical assistance for the Demonstration participant, or, where appropriate, the family members, guardians, advocates, or authorized representatives of the Demonstration participant; and (G) training or technical assistance for professionals or other individuals who provide services.
- b. **Service Limits:** All Assistive Technology services and devices shall meet applicable standards of manufacture, design and installation and are subject to prior approval on an individual basis by DDD. Prior approval will be based on the functional evaluation as described above. Items covered by the Medicaid State Plan cannot be purchased through this service.
 - c. **Provider Specification(s):**
 - i. Provider approved by the DHS/DDD.
 - d. Participant Direction Option
 - i. Provider Directed Participant Directed

24. Service Name: Personal Emergency Response System (PERS)

- a. **Description:** PERS is an electronic device that enables program Demonstration participants to secure help in an emergency. The Demonstration participant may also wear a portable "help" button to allow for mobility. The system is connected to the Demonstration participant's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals, as specified herein. The service may include the purchase, the installation, a monthly service fee, or all of the above.
- b. **Service Limits:** All PERS shall meet applicable standards of manufacture, design and installation and are subject to prior approval on an individual basis by DDD.
- c. **Provider Specification(s):**
 - i. Provider approved by the DHS/DDD.
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

Children with Pervasive Developmental Disabilities Program

Program Overview: Habilitation services will be provided to children with a diagnosis of Pervasive Developmental Disability (PDD) according to the American Psychological Association's most recent version of the Diagnostic and Statistical Manual of Mental Disorders, up to their 13th birthday. Evidence-based habilitation services will support the child's functional development, and enhance his/her inclusion in the community with improved adaptive behavior, language, and cognitive outcomes. Highest need children will receive up to \$27,000 in services; those with moderate needs will receive up to \$18,000 in services and the lowest needs participants will receive \$9,000 in services. If the participant's needs change at any time, s/he can be reassessed to determine the current acuity level and the service package would be adjusted accordingly. Services will be coordinated and managed through the participant's Service Plan, as developed by the MCO care coordinators. PDD Habilitation services are available to the extent that they are not available under a program funded by the Individuals with Disabilities Education Act and the Rehabilitation Services Act of 1973.

1. Service Name: Behavior Consultative Supports (BCS)

- a. Service Description - Assessing a child, designing a Behavior Plan that is part of the larger Plan of Care developed by the Case Manager / with interventions for the child, and providing on-going consultation to the family. Consultative Supports are intended to address the behavioral symptoms often related to the diagnosis of PDD through the teaching of adaptive skills provided by the Consultative Supports staff. BCS are also intended to assist the family and paid support staff or other professionals with carrying out the Behavioral Plan (BP) that supports the child's functional development and inclusion in the community.

Behavior Consultative Supports consist of:

- i. Completion of a comprehensive assessment
- ii. Identification, with family's input, of which therapies and/or interventions will be utilized. Therapies and interventions will be based on reliable evidence, and may be: drawn from the principles of applied behavior analysis (ABA), social skills interventions, play or interaction focused interventions, play/interaction focused interventions, and cognitive behavioral therapy.
- iii. Development of the Behavior Plan based on the identified needs of the child with the family's input and guidance.
- iv. Basic training and technical assistance to the family and paid support staff regarding the particular child's needs, in order to carry out the BP.
- v. Development of the teaching protocol by which the Behavior Supports Individual Support person implements the evidence-based treatment.
- vi. Monitor the child's progress within the program.
- vii. Utilizes data-based decision making to monitor progress, track gains, and make program modifications.
- viii. Assists families to participate in the development, training, and implementation of the evidence-based therapy being utilized.

b. Service Limits:

- No more than one Consultative Supports person may be paid for services at any given time.
- Travel time is not reimbursable.

c. Provider Specifications:

- Medicaid MCO Network provider
- Master's degree, preferably in human services-related fields or education and documentation of 2,000 hours of experience working with a child with PDD OR Board Certified Behavior Analysts (BCBA) OR Board Certified Assistant Behavior Analyst (BCBA)
- Training in the intervention/therapy identified in the BP
- Must successfully pass criminal background checks

d. Participant Direction Option

- Provider Directed Participant Directed

2. Service Name: Individual Behavior Supports

- a. Service Description- services, as identified in the BP, provided to a child with PDD to assist in acquiring, retaining, improving, and generalizing the self-help, socialization, and adaptive skills necessary to reside and function successfully in home and community settings. Therapies and interventions will be based on reliable evidence, and may be: drawn from the principles of applied behavior analysis (ABA), social skills interventions, play or interaction focused interventions, play/interaction focused interventions, and cognitive behavioral therapy. Services are provided through evidence-based and data-driven methodologies.
- b. Supports are provided by the Individual Supports person who is trained on the particular needs of the child, and works under the direction of the Consultative Supports person and provides one-one services with the child, and documents services provided.

Individual Supports include assisting with the development of skills such as:

- i. (including imitation, social initiations and response to adults and peers, parallel and interactive play with peers and siblings)
 - ii. Expressive verbal language, receptive language, and nonverbal communications skills which may be enhanced through the use of a functional symbolic communication system.
 - iii. Increased engagement and flexibility in developmentally appropriate tasks and play, including the ability to attend to the environment and respond to an appropriate motivational system, based on positive behavioral supports.
 - iv. Fine and gross motor skills used for age-appropriate functional activities, as needed
 - v. Cognitive skills, including symbolic play and basic concepts, as well as academic skills
 - vi. Positive behavioral skills, in place of negative behavior patterns
 - vii. Independent organizational skills and other socially appropriate behaviors that facilitate successful community integration (such as completing a task independently, following instruction in a group, or asking for help)
- b. Service Limits: The majority of these contacts must occur in community locations where the child lives, has child care, and/or socializes, etc.
 - c. Provider Specifications:
 - i. Medicaid MCO Network provider
 - ii. Training in the intervention/therapy identified in the BP/POC.
 - iii. Bachelor's degree, preferably in education or human services-related fields OR 60 college credit hours
 - iv. Documentation of 1,000 hours of experience working with a child with a PDD Disorder OR Board Certified Assistant Behavior Analyst (BCBA)
 - v. Must work under the direction of the Consultative Supports person
 - vi. Must successfully pass criminal background checks
 - d. Participant Direction Option
 - i. Provider Directed Participant Directed

3. Service Name: Occupational Therapy

- a. **Description:** Services that are provided when the limits of occupational therapy services under the approved State plan are exhausted. The scope and nature of these services do not otherwise differ from the physical therapy service furnished under the State plan. The provider qualifications specified in the State plan apply. Physical Therapy may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five participants.
- b. **Service Limits:** These services are only available when prescribed by an appropriate health care professional. These services are available to the extent that they are not available under a program funded by the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).
- c. **Provider Specification(s):**
 - i. A licensed occupational therapist or occupational therapy assistant approved as a Medicaid provider
 - ii. Licensed, certified home health agency
 - iii. Post-acute non-residential rehabilitative services provider agency
 - iv. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Children & Families
 - v. Staff members working for any of the agencies above shall be registered as an occupational therapist (OTR) with the American Occupational Therapy Association (AOTA). A certified occupational therapy assistant (COTA) shall be registered with the AOTA and work under the direction of the OTR.
- d.
 - a. Participant Direction Option
 - i. Provider Directed Participant Directed

4. Service Name: Physical Therapy

- a. **Service Description:** Services that are provided when the limits of physical therapy services under the approved State Plan are exhausted. The scope and nature of these services do not otherwise differ from the physical therapy service furnished under the State plan. The provider qualifications specified in the State Plan apply. Physical Therapy may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five participants.
- b. **Service Limits:** These services are only available when prescribed by an appropriate health care professional. These services are available to the extent that they are not available under a program funded by the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).
- c. **Provider Specification(s):**
 - b.A licensed physical therapist or physical therapy assistant approved as a Medicaid provider
 - c.Licensed, certified home health agency
 - d.Post-acute non-residential rehabilitative services provider agency
 - e.Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Children & Families

f. Staff members working for any of the agencies above shall meet the New Jersey licensure standards and requirements for practice (N.J.A.C. 13:39A).

a.

b. Participant Direction Option

a. Provider Directed Participant Directed

5. Service Name: Speech and Language Therapy (ST)

a. **Service Description:** Services that are provided when the limits of speech and language therapy services under the approved State Plan are exhausted. The scope and nature of these services do not otherwise differ from the speech and language therapy service furnished under the State plan. The provider qualifications specified in the State Plan apply. Speech and Language Therapy may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five participants.

b. **Service Limits:** These services are only available when prescribed by an appropriate health care professional. These services are available to the extent that they are not available under a program funded by the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

c. **Provider Specification(s):**

- i. A licensed speech therapist approved as a Medicaid provider
- ii. Licensed, certified home health agency
- iii. Post-acute non-residential rehabilitative services provider agency
- iv. Agency provider that is an approved Medicaid provider and has met the provider qualifications as specified by the Department of Children & Families
- v. Staff members working for any of the agencies above shall meet the New Jersey licensure standards and requirements for practice (N.J.A.C. 13:44C).

d.

e. Participant Direction Option

i. Provider Directed Participant Directed

ID/DD-MI Dually Diagnosed Children Service Program

Program Overview: The primary goal of the program is to provide a safe, stable, and therapeutically supportive environment for children with developmental disabilities and co-occurring mental health diagnoses, ages five (5) up to twenty-one (21), with significantly challenging behaviors (Demonstration participants). This program provides both in-home intensive and out-of-home services.

It is the purpose of this program to serve and stabilize the child with ID-DD/MI in the least restrictive environment. The optimum goal is for the child to remain, or return, home with their natural supports. It may not always be possible for a child to remain or return to their natural home. In these cases, the program will provide out of home services for the child. The in-home services provided to a child remaining in their own home are intended to develop a safe, structured home environment while increasing the ability of the family/caregiver to provide the needed supports. This program is intended to assist families/caregivers by working with qualified agencies and consultants skilled in positive behavior supports to develop appropriate and safe ways to redirect the child to a more productive, safe and involved lifestyle. As the

family/caregiver gains knowledge and becomes more skilled in working with their child, the level of supports will be decreased to match the level of intensive behavioral need. The ultimate goal is to return the family home to an environment requiring minimal, if any, outside intervention.

The following services are available through this Program.

1. **Service Name:** Case/Care Management

a. Service Description: Services which will assist individuals who receive program services, in gaining access to needed program and specific State Plan services, as well as needed medical, social, behavioral, educational and other services. The Case/Care Manager is responsible for convening team meetings, developing and implementing the treatment plan, community resource development, information management, quality assessment and improvement, coordination of care with all providers and agencies with whom the family is involved, and routine coordination (including regular contact, sharing of treatment plan documents, and regular team meetings) with the MCO to assist the individual in accessing physical health care.

b. Service Limits: None

c. Provider Specifications:

- 1. Agency that has met the qualifications as specified by the Department of Human Services (DHS) or the Department of Children & Families (DCF);
- 2. Must pass criminal background check.
- 3. Must have a Bachelor's degree.

e. Participant Direction Option

- i. Provider Directed Participant Directed

2. **Service Name:** Individual Supports

a. Service Description: Individual Support services assist the child with acquiring, retaining, improving and generalizing the behavioral, self-help, socialization and adaptive skills necessary to function successfully in the home and community. Individual Support workers will provide services directly to the child through evidence-based and data driven methodologies. Individual support services are behavioral, self-care and habilitative related tasks performed and/or supervised by service provider staff in a Demonstration participant's family home, the home of a relative or in other community-based settings, in accordance with approved treatment plans.

These supports include behavioral supports & training, adaptive skill development, assistance with activities of daily living and community inclusion that assist the Demonstration participant to reside in the most integrated setting appropriate to his/her needs. Services may be furnished in the following living arrangements: Demonstration participant's own home, the home of a relative or other community based living arrangement.

- b. **Service Limits:** Supports in own home cannot exceed 16 hours per day; payment is not made for the cost of room and board, including the cost of building maintenance, upkeep and improvement. Services are prior authorized, by the State or its designee, based on needs assessment and as delineated in the treatment plan.
- c. **Provider Specifications:** Staff must meet the minimum levels of education, experience and training as described in the DHS/DCF Contract Reimbursement Manual or as required for Medicaid participation.
 - Agency that has met the qualifications as specified by the Department of Human Services (DHS) or the Department of Children & Families (DCF);
 - DDD Contracted Agency; NJAC 10:44 A and/or NJAC 10:44B and/or NJAC 10:44C; or DCF Contracted Agency;
 - Medicaid enrolled provider.
- Participant Direction Option
 - Provider Directed Participant Directed

3. **Service Name:** Natural Supports Training

- a. **Service Description:** Training and counseling services for individuals who provide unpaid support, training, companionship, or supervision to Demonstration participants. For purposes of this service, individual is defined as any person, family member, neighbor, friend, companion, or co-worker who provides uncompensated care, training, guidance, companionship or support to a Demonstration participant. Training includes instruction about treatment regimens and other services included in the treatment plan, use of equipment specified in the treatment plan, as well as updates as necessary to safely maintain the Demonstration participant at home. Counseling must be aimed at assisting the unpaid caregiver in meeting the needs of the Demonstration participant. All training for individuals who provide unpaid support to the Demonstration participant must be included in the Demonstration participant's treatment plan.
- b. **Service Limits:** Prior authorization required by the State or its designee, based on needs assessment and as delineated in the treatment plan. This service may not be provided in order to train paid caregivers.
- c. **Provider Specifications:** Provider must meet the minimum levels of education, experience and training as determined by DCF and as required for Medicaid participation. Provider must be an approved provider and meet all applicable licensing and credentialing standards in psychiatry, physical therapy, occupational therapy, speech language pathology, social work, or must be registered nurse or a degreed psychologist or hold a degree in other related areas.
 - Agency that has met the qualifications as specified by the Department of Human Services (DHS) or the Department of Children & Families (DCF);
 - DDD Contracted Agency; NJAC 10:44 A and/or NJAC 10:44B and/or NJAC 10:44C; or DCF Contracted Agency

- Medicaid enrolled provider
- Participant Direction Option
 - Provider Directed Participant Directed

4. **Service Name:** Intensive In-Community Services - Habilitation

a. Service Description: Clinical and therapeutic services that are not covered by the State Plan and assist unpaid caregivers and/or paid support staff in carrying out individual treatment/support plans, and are necessary to improve the individual’s independence and inclusion in their community. These services are flexible, multi-purpose, in-home/community clinical support for Demonstration participants and their parents/caregivers/guardians. These services are flexible both as to where and when they are provided based on the family’s needs. This Demonstration participant-driven treatment is based on targeted needs as identified in the treatment plan. The treatment plan includes specific intervention(s) with target dates for accomplishment of goals that focus on the restorative functioning of the Demonstration participant with the intention of:

- Stabilizing the Demonstration participant’s behavior(s) that led to the crisis,
- Preventing/reducing the need for inpatient hospitalization,
- Preventing the movement of the Demonstration participant’s residence,
- Preventing the need for out-of-home living arrangements.

The services provided will also facilitate a Demonstration participant’s transition from an intensive treatment setting back to his/her home. Interventions will be delivered with the goal of diminishing the intensity of treatment over time.

These services encompass a broad array of interventions ranging from clinical therapy to behavioral assistance. Behavioral assistance (BA) services are medically necessary, objective, behavior changing through measurable goals intervention. These services are provided to a “moderate” or “high needs” youth and his/her family. BA services occur in the youth’s natural environment (school, home, neighborhood), are not office-based, and work to improve youth’s functioning in his/her natural environment. BA services are provided to make change through the diminution of maladaptive behaviors and/or the development of adaptive behaviors. Behaviors of focus for BA services are fully described in terms of intensity, frequency, antecedents, and desired outcome. Consequently, BA services are the most easily evaluated for effectiveness and change. Services include a comprehensive integrated program of clinical rehabilitation services to support improved behavioral, social, educational and vocational functioning. In general, this program will provide children/youth and their families with services such as psychoeducation, negotiation and conflict resolution skill training, effective coping skills, healthy limit-setting, stress management, self-care, budgeting, symptom/medication management, and developing or building on skills that would enhance self-fulfillment, education and potential employability.

b. Service Limits: Use of this service requires the preparation of a formal comprehensive assessment and submission of any behavioral support program, Level III, to the provider agency’s internal Behavior Management Committee & Human Rights Committee or the State’s Behavior Management Committee & Human Rights Committee for assurance of compliance to Division Circulars 19 & 34 for approval prior to implementation. Contacts

cannot be office-based and must occur in community locations where the child lives, has child care, and/or socializes, etc. Treatment modalities must be based in best practices.

- c. **Provider Specification:** Staff qualifications: Psychologists, Masters Level or Board Certified Behavior Specialist, Bachelor Level Behaviorist with oversight by a Masters Level or Board Certified Behavior Analyst; Licensed Clinical Social Workers, Professional Counselor;
 - Agency that has met the qualifications as specified by the Department of Human Services (DHS) or the Department of Children & Families (DCF);
 - DDD Contracted Agency; NJAC 10:44 A and/or NJAC 10:44B and/or NJAC 10:44C; or DCF Contracted Agency
 - Medicaid enrolled provider
- o Participant Direction Option
 - Provider Directed Participant Directed

5. **Service Name:** Respite

a. **Service Description:** Services provided to Demonstration participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of those persons who normally provide care for the Demonstration participant. Respite may be provided in the Demonstration participant's home, a program group home, a licensed respite care facility, or a State-approved camp. Respite will not be provided in hospital settings.

b. **Service Limits:** Must comply with all requirements of DCF respite policy. The State does not pay for room and board except for licensed, non-private residence facilities that are approved by the State. Camp may not be delivered simultaneously with Day Habilitation, Community-Based Supports or during the extended school year. Transportation to or from camp services is not included in the service.

c. **Provider Specifications:**

- Agency that has met the qualifications as specified by the Department of Human Services (DHS) or the Department of Children & Families (DCF);
 - DDD Contracted Agency; NJAC 10:44 A and/or NJAC 10:44B and/or NJAC 10:44C or DCF Contracted Agency;
 - Authorized Camps: N.J.A.C. 8:25; or
 - Authorized Medicaid provider
- o Participant Direction Option
 - Provider Directed Participant Directed

6. **Service Name:** Non-Medical Transportation

- a. **Service Description:** Service offered in order to enable Demonstration participant to gain access to program and other community services, activities and resources, as specified by the Service Plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the State Plan, defined at 42 CFR §440.170(a) (if applicable), and does not replace them. Transportation services are offered in accordance with the Demonstration participant’s Service Plan. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge are utilized.
- b. **Service Limits:** Outside of medical transportation, transportation provided through the educational entitlement, transportation available through the Medicaid State Plan, or transportation available at no charge or as part of an administrative expenditure. Reimbursement for transportation is limited to distances not to exceed 150 miles one way and only within the States of New Jersey, New York, Pennsylvania and Delaware. Reimbursement for mileage will not exceed the rate established by the State.
- c. **Provider Specifications:** Valid Driver’s license, registration and insurance.
 - Agency that has met the qualifications as specified by the Department of Human Services (DHS) or the Department of Children & Families (DCF); or
 - DDD Contracted Agency; NJAC 10:44 A and/or NJAC 10:44B and/or NJAC 10:44C or DCF Contracted Agency; or
 - Authorized Medicaid provider.
- Participant Direction Option
 - Provider Directed Participant Directed

7. **Service Name:** Interpreter Services

- a. **Service Description:** Service delivered to a Demonstration participant or uncompensated caregiver face-to-face to support them in carrying out Demonstration participants’ treatment/support plans, and that are not covered by the Medicaid State Plan. For language interpretation, the interpreter service must be delivered by an individual proficient in reading and speaking in the language in which the Demonstration participant speaks.
- b. **Service Limits:** Prior authorization required by the State or its designee. Interpreter services may be used when the State Plan service for language line interpretation is not available or not feasible or when natural interpretive supports – i.e. an adult family member who can provide the interpretation - are not available.
- c. **Provider Specification:**
 - Agency that has met the qualifications as specified by the Department of Human Services (DHS) or the Department of Children & Families (DCF);

- Sign language interpreter: Screened by the NJ Division of the Deaf and Hard of Hearing and/or possess certification offered by the National Registry of Interpreters for the Deaf.

Language interpreter:

- 18 yrs of age;
- Cleared Criminal background check; and
- Proficient in reading & speaking both languages.

f. Participant Direction Option

- i. Provider Directed Participant Directed

IDD/OOS Service Definitions

Program Overview: This program consists of individuals who receive out-of-state services funded by DDD. At this time, individuals are only being added to this program in extremely limited cases (only when DDD has been court-ordered to provide the services in an out-of-state setting), so this program is not expected to grow. Historically, individuals in this program were referred out of state for a variety of reasons. Some were placed in an out-of-state program by their local school district as part of their educational entitlement. In those cases, DDD may have been partially funding the placement prior to the individual aging out of their educational entitlement, as part of a shared agreement with the school or by court order. In other cases, DDD may not have had any involvement with - or knowledge of - the out of state placement until the educational entitlement was ending, at which time the individual/family requested that DDD pick up the funding to allow the individual to remain in their out of state placement. Additionally, some adults were referred for out of state services by DDD staff historically, when an acceptable alternative could not be accessed in the state. The available services vary from setting to setting.

Notably, DDD is making great efforts to minimize the use of out-of-state services for people with intellectual and developmental disabilities. To that end, DDD is no longer approving out-of-state services for new individuals, except where court ordered to do so. DDD is also working to return the out-of-state individuals to New Jersey to receive services, or alternatively, to assist them in becoming residents of, and receiving services from, the state in which they are currently located. Also, as individuals who were placed out-of-state as part of their educational entitlement approach the end of that entitlement, DDD is identifying them, notifying them that DDD will not fund the out-of-state services once they age out of school, and beginning the process of locating appropriate in-state services.

The following services will be available through this Program.

1. **Service Name:** Case Management

- a. **Description:** Services which will assist Demonstration participants in planning and gaining access to needed services. DDD Case managers are responsible for participating in Team meetings to develop the Demonstration participant's Plan of care and reviewing and authorizing Service Plans. Provider Case Managers are responsible for coordinating and leading the Plan of

care meetings and development process, and assisting the Demonstration participants in locating and coordinating access to medical and other needed services. Provider Case Managers are responsible for the ongoing monitoring of the service plan.

b. **Service Limits:** None.

c. **Provider Specifications:**

i. For DDD Case Managers:

1. Must meet the qualifications for a QMRP.
2. Must have a Bachelor's degree.
3. Must pass criminal background check.
4. Must qualify for and pass a NJ Civil Service Test.
5. Must be employed in position.

ii. For Provider Case Managers:

1. Must have a Bachelor's degree in a Human Services field
2. Must have 2 years of previous experience
3. Must pass criminal background check.

d. Participant Direction Option

i. Provider Directed Participant Directed

2. **Service Name:** Individual Supports

a. **Description:** Services provided to assist, train, and supervise a Demonstration participant as they learn and perform various tasks that are included in basic self-care, social skills and activities of daily living. This also includes but is not limited to: personal care, companion services, chore services, day and night supervision, transportation and travel training.

b. **Service Limits:** These services are only available as specified in the Demonstration participant's Service Plan.

c. **Provider Specifications:**

- i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
- ii. Must pass criminal background check.

d. Participant Direction Option

i. Provider Directed Participant Directed

3. **Service Name:** Habilitation

a. **Description:** Services which are designed to develop, maintain and/or maximize the individual's independent functioning in self-care, physical and emotional growth, socialization, communication and prevocational training.

b. **Service Limits:** These services are only available as specified in Demonstration participant's Service Plan.

c. **Provider Specifications:**

- i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
- ii. Must pass criminal background check.

d. Participant Direction Option

i. Provider Directed Participant Directed

4. **Service Name:** Supported Employment

- a. **Description:** Supported employment includes job development, pre-job placement and job coaching activities that can assist an individual to secure a job that will result in paid employment and/or to maintain that employment.
- b. **Service Limits:** These services are only available as specified in Demonstration participant's Service Plan.
- c. Documentation is maintained in the file of each Demonstration participant that the service is not available under a program funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) as applicable.
- d. **Provider Specifications:**
 - i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
 - ii. Must pass criminal background check.
- e. Participant Direction Option
 - i. Provider Directed Participant Directed

5. **Service Name:** Occupational Therapy

- a. **Description:** Services that are provided to the Demonstration participant when they are unable to access needed occupational therapy from the State Plan because of the geographic location of their out of state placement. The scope and nature of these services do not otherwise differ from the Occupational Therapy services described in the State Plan. They may be either rehabilitative or habilitative in nature. Services that are rehabilitative in nature are only provided when the limits of occupational therapy services under the approved State Plan are exhausted.
- b. **Service Limits:**
 - i. These services are only available as specified in Demonstration participant's Plan of care and when prescribed by an appropriate health care professional. These services can be delivered on an individual basis or in groups.
 - ii. Services available through the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.), as applicable, must be utilized before program services are made available.
- c. **Provider Specifications:**
 - i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
 - ii. Must pass criminal background check.
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

6. **Service Name:** Physical Therapy

- a. **Description:** Services that are provided to the Demonstration participant when they are unable to access needed physical therapy from the State Plan because of the geographic location of their out of state placement. The scope and nature of these services do not otherwise differ from the Physical Therapy services described in the State Plan. They may be either rehabilitative or habilitative in nature. Services that are rehabilitative in nature are only provided when the limits of physical therapy services under the approved State Plan are exhausted.
- b. **Service Limits:**
 - i. These services are only available as specified in Demonstration participant's Plan of care and when prescribed by an appropriate health care professional. These services can be delivered on an individual basis or in groups.

- ii. Services available through the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.), as applicable, must be utilized before program services are made available.
- c. **Provider Specifications:**
 - i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
 - ii. Must pass criminal background check.
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

7. **Service Name:** Speech and Language Therapy

- a. **Description:** Services that are provided to the Demonstration participant when they are unable to access needed speech therapy from the State Plan because of the geographic location of their out of state placement. The scope and nature of these services do not otherwise differ from the Speech Therapy services described in the State Plan. They may be either rehabilitative or habilitative in nature. Services that are rehabilitative in nature are only provided when the limits of speech therapy services under the approved State Plan are exhausted.
- b. **Service Limits:**
 - i. These services are only available as specified in Demonstration participant’s Plan of care and when prescribed by an appropriate health care professional. These services can be delivered on an individual basis or in groups.
 - ii. Services available through the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.), as applicable, must be utilized before program services are made available.
- c. **Provider Specifications:**
 - i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
 - ii. Must pass criminal background check.
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

8. **Service Name:** Transportation

- a. **Description:** Services which allow the individual to access services, activities, and resources, as specified by the Service Plan, and to participate in their communities.
- b. **Service Limits:** This service may include provider-run transportation services, drivers, taxi fares, train and bus tickets, or other public transportation services or private contractors. The selected service chosen must be the most cost effective means of transportation that the individual is reasonably able to access. Reimbursement for mileage will not exceed the established rate.
- c. **Provider Specifications:**
 - i. Valid driver’s license
 - ii. Valid vehicle registration
 - iii. Valid insurance
 - iv. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

9. **Service Name:** Counseling & Psychological Supports

Description: Services designed to provide counseling and psychological supports and services to Demonstration participants when they are unable to access those services from the State plan because of the geographic location of their out-of-state residential placement.

- a. **Service Limits:** Services available through the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.), as applicable, must be utilized before program services are made available.
- b. **Provider Specifications:**
 - i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
 - ii. Must pass criminal background check.
- c. **Participant Direction Option**
 - i. Provider Directed Participant Directed

10. **Service Name:** Behavioral Assessment & Management

- a. **Description:** Services designed to assist an individual with functional behavioral issues. These services may include a functional behavioral assessment, development of a behavioral support plan, implementation of behavioral interventions as specified in the plan, and ongoing monitoring of the behavioral support plan. Behavioral interventions are geared toward developing positive behaviors needed for the individual to remain safe and healthy and function in community environments.
- b. **Service Limits:** These services are only available as specified in Demonstration participant's Service Plan.
- c. Services available through the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.), as applicable, must be utilized before program services are made available.
- d. **Provider Specifications:**
 - i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
 - ii. Must pass a criminal background check.
- e. **Participant Direction Option**
 - i. Provider Directed Participant Directed

11. **Service Name:** Community Integration

- a. **Description:** Services provided outside of a residential setting that support and assist Demonstration participants in educational or enrichment activities, as outlined in the Service Plan, that are intended to enhance inclusion in the community.
- b. **Service Limits:** These services can be delivered in an individual or group setting. These services may not be delivered simultaneously with Habilitation, Therapeutic Recreation, or Supported Employment.
- c. **Provider Specifications:**
 - i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
 - ii. Must pass criminal background check.
- d. **Participant Direction Option**
 - i. Provider Directed Participant Directed

12. **Service Name:** Routine Health Care & Medication

- a. **Description:** Routine health care services that are provided to the Demonstration participant when they are unable to access those services from the State plan because of the geographic location of their out-of-state residential placement. These services include primary health care, nursing, medication, medication management, and other routine medical assistance.
- b. **Service Limits:** None.
- c. **Provider Specifications:**
 - i. Must meet all applicable licensing and credentialing standards in the state in which the service is rendered.
- d. Participant Direction Option
 - i. Provider Directed Participant Directed

Attachment C.2

New Jersey's Comprehensive Waiver Demonstration

Home and Community Based Services – Current 1915(c) Programs that Will be Transitioned to Managed Care Service Definitions

Global Options Waiver (Formerly NJ.0032)

1. Service Name: Care Management

a. Description: Care Management is a service that will assist individuals who receive Waiver services in gaining access to needed Waiver and other State Plan services (as identified in the Waiver), as well as medical, social, educational and other services, regardless of the funding source. Care Managers are responsible for ongoing monitoring of the provision of services included in the individual's Plan of Care.

Care Managers initiate and oversee the process of re-evaluation of the individual's level of care and the review of plans of care every 12 months at a minimum.

b. Service Limits: Care Managers are required to contact each participant at specific intervals, on an as needed basis, and visit each participant quarterly. Examples of circumstances that would be considered an "as needed basis" contact by the Care Manager could include: if the participant requested a change in service provider or frequency of services, if the participant prompted a contact to the Care Manager, if the participant had a recent hospitalization, or if the participant needed assistance of some sort and a change in the Plan of Care were necessary.

c. Provider Specification(s):

i. Adult Family Care Sponsor Agency

ii. Accredited Registered Homemaker Agency

iii. Licensed Medicare Certified Home Health Agency

iv. Proprietary or Not-for-Profit Care Management Entity

v. Area Agency on Aging

vi. County Welfare Agency

2. Service Name: Respite

a. Description: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence or need for relief of an unpaid, informal caregiver (those persons who normally provide unpaid care) for the participant. Federal financial participation is not claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

Respite Care may be provided in the following location(s): 1) the Individual's home or place of residence; 2) a Medicaid certified Nursing Facility that has a separate Medicaid provider number to bill for Respite; 3) An other community care residence approved by the State that is not a private residence including only: an Assisted Living Residence (AL), a Comprehensive Personal Care Home (CPCH), or an Adult Family Care (AFC) Home

b. Service Limits: Respite is limited to 30 days per participant per Waiver year. Room and Board charges are included in Institutional Respite rate. The Medicaid Waiver Year starts October 1st. If 30 days of nursing facility Respite is reached, but the participant needs to remain in the facility longer, the individual must be referred to the Regional Office of Community Choice Options for a short-term Pre Admission Screen (PAS).

Respite will not be reimbursed for individuals who reside permanently in an Assisted Living Residence or Comprehensive Personal Care Home or for GO participants that are admitted to the Nursing Facility.

Respite care shall not be reimbursed as a separate service during the hours the participant is participating in either Adult Day Health Services or Social Adult Day Care. Services excluded from additional billing while simultaneously receiving Respite care include: Chore, Home-Based Supportive Care, Home-delivered meals, and Personal Care Assistant.

Sitter, live-in, or companion services are not considered Respite Services and cannot be authorized as such.

Respite services are not provided for formal, paid caregivers (i.e. Home Health or Certified Nurse Aides). Respite services are not to be authorized due to the absence of those persons who would normally provide paid care for the participant.

Respite care in a nursing facility requires a negative Pre Admission Screening Resident Review (PASRR) Level I screen prior to service authorization.

- c. Provider Specification(s)
- i. Adult Family Care Sponsor Agencies
 - ii. Licensed Employment Agency and Temporary Help Agency (In-home respite)
 - iii. Licensed Health Care Service Firm (In-home respite)
 - iv. Licensed, Certified Home Health Agency (In-home respite)
 - v. Licensed Assisted Living Residence (ALR) or Comprehensive Personal Care Home (CPCH)
 - vi. Accredited, Registered Home Care Agency (In-home respite)
 - vii. Licensed Adult Family Care (AFC) Caregiver (Individual)
 - viii. Licensed Nursing Facility

3. Service Name: Adult Family Care

a. Description: Adult Family Care (AFC) enables up to three unrelated individuals to live in the community in the primary residence of a trained caregiver who provides support and health services for the resident. Adult Family Care may provide personal care, meal preparation, transportation, laundry, errands, housekeeping, socialization and recreational activities, monitoring of participant's funds when requested by the participant, up to 24 hours a day of supervision, and medication administration.

The individual remains responsible for the cost of Room and Board and cost share, if applicable.

b. Service Limits: Individuals that opt for Adult Family Care do not receive Personal Care Assistant, Chore Service, Home-Delivered Meals, Home-Based Supportive Care, Caregiver/Participant Training, Assisted Living, or Assisted Living Program. Those services would duplicate services integral to and inherent in the provision of Adult Family Care services.

c. Provider Specification(s)

i. Licensed Adult Family Care (AFC) Caregiver (Individual)

ii. Licensed Adult Family Care (AFC) Sponsor Agency (Agency)

4. Service Name: Assisted Living (ALR or CPCH)

a. Description: Assisted Living means a coordinated array of supportive personal and health services, chore, medication administration, intermittent skilled nursing services, available 24 hours per day, to residents who have been assessed to need these services including persons who require nursing home level of care. A planned, diversified program of resident activities shall be offered daily for residents, including individual and/or group activities, on-site or off-site, to meet the individual needs of residents. Assisted Living facilities also either arrange or provide for transportation that is specified in the Plan of Care and periodic nursing evaluations. Assisted Living promotes resident self-direction and participation in decisions that emphasize independence, individuality, privacy, dignity, and homelike surroundings.

ALR "Assisted Living Residence" means a facility which is licensed by the Department of Health to provide apartment-style housing and congregate dining and to assure that assisted living services are available when needed, for four or more adult persons unrelated to the proprietor. Apartment units offer, at a minimum, one unfurnished room, a private bathroom, a kitchenette, and a lockable door on the unit entrance. CPCH "Comprehensive Personal Care Home" means a facility which is licensed by the Department of Health to provide room and board and to assure that assisted living services are available when needed, to four or more adults unrelated to the proprietor. Residential units in comprehensive personal care homes house no more than two residents and have a lockable door on the unit entrance.

Individuals in Assisted Living are responsible to pay their Room and Board costs at a rate established by the Department and any applicable cost share.

Residents in Assisted Living Facilities have access to both their own living unit's kitchen 24/7 and to a facility pantry with food and beverages 24/7.

Residents in Comprehensive Personal Care Homes have access to their own living unit's kitchen 24/7. In some situations, these kitchens may be modified to eliminate the cooking appliance. However their refrigerator and dry food storage is available.

b. Service Limits: Individuals that opt for Assisted Living do not receive Personal Care Assistant, Adult Family Care, Assisted Living Program, Environmental Accessibility Adaptations, Chore Services, Personal Emergency Response Services, Home-Delivered Meals, Caregiver/Participant Training, Adult Day Health Services, Social Adult Day Care, Attendant Care, Home-Based Supportive Care, or Respite as they would duplicate services integral to and inherent in the provision of Assisted Living services.

c. Provider Specification(s)

i. Comprehensive Personal Care Home (CPCH)

ii. Assisted Living Residence (ALR)

5. Service Name: Assisted Living Program (ALP) in Subsidized Housing

a. Description: Assisted Living Program means the provision of or arrangement for meals and assisted living services to the tenants/residents of publicly subsidized housing. Assisted Living Services include personal care, homemaker, chore, and medication oversight and administration throughout the day.

Individuals reside in their own independent apartments. The individual is responsible for his or her own rent and utility payments as defined in a lease with the landlord. Individuals are also responsible for the cost of meals and other household expenses.

Again, Assisted Living Program means the provision of or arrangement for meals and assisted living services to the tenants/residents of publicly subsidized housing. Assisted Living Program services are provided to individuals who reside in their own independent apartments. The ALP individual is responsible for his or her own rent and utility payments as defined in a lease with the landlord.

Having an ALP provider offers the subsidized housing tenants the opportunity to remain in their own apartments with the support of others, while maintaining their independence dignity.

Participation in the services of an Assisted Living Program (ALP) are voluntary on the part of any tenant of any ALP contracted publicly subsidized housing building.

The ALP is to make available dining services and/or meal preparation assistance to meet the daily nutritional needs of residents.

ALP providers work with participants to ensure a strong sense of connectedness in each apartment community as well as with the larger communities in which they are located. Individuals may participate in tenant/resident meetings, attend community-based civic

association meetings and plan recreational activities. Sometimes, ALP providers host community health screening events to encourage wellness for the tenant population at large.

By state regulation, ALP providers are required to have procedures for arranging resident transportation to and from health care services provided outside of the program site, and shall provide reasonable plans for security and accountability for the resident and his or her personal possessions.

Additionally, a planned, diversified program of activities is to be posted and offered daily for residents, including individual and/or group activities, on-site or off-site to meet the service needs of residents.

Because ALPs are located in independent subsidized housing, tenants are free to be as actively involved in their communities as they desire to be. ALP buildings often have relationships with community partners and local strategic alliances that create conditions to promote increased access, inclusiveness, and tenant engagement in local happenings as well as, better health and wellness services and opportunities for tenants.

b. Service Limits: Individuals that opt for Assisted Living Program do not receive Personal Care Assistant, Adult Day Health Services, Chore Service, Attendant Care, Home-Based Supportive Care, Caregiver/Participant Training, Assisted Living, or Adult Family Care as they would duplicate services integral to and inherent in the provision of Assisted Living Program services. The subsidized housing provider is responsible for Environmental Accessibility Adaptations.

c. Provider Specification(s)

i. Assisted Living Program in Subsidized Housing

6. Service Name: Attendant Care

a. Description: Hands-on care (needs physical assistance to accomplish task), of both a supportive and health-related nature, specific to the needs of a medically stable physically disabled individual, who is capable of self directing his or her own health care. Supportive services are those that substitute for the absence, loss, diminution, or impairment of a physical function.

This service is intended to assist individuals in accessing care of a more health related nature, beyond basic Activities of Daily Living/Instrumental Activities of Daily Living (ADL/IADL). This service may include skilled or nursing care to the extent permitted by State law. Supervision must be furnished directly by the participant when the person has been trained to perform this function and when the safety and efficacy of participant-provided supervision has been certified in writing by a Registered Nurse or otherwise as provided in State law. This certification must be based on direct observation of the participant and the specific attendant care provider by the Registered Nurse evaluator, during the actual provision of care.

Housekeeping activities that are incidental to the performance of care may also be furnished as part of this activity.

Attendant Care may ONLY be provided by a Participant-Employed Provider. Attendant Care is not available in Assisted Living, Adult Family Care or Assisted Living Program as it would duplicate services furnished through the Assisted Living, Adult Family Care and Assisted Living Program service packages.

b. Service Limits: Attendant Care is limited to a total of 40 hours per week.

c. Provider Specification(s)

i. Participant Employed Provider (PEP)

7. Service Name: Caregiver Participant Training

a. Description: Instruction provided to a client or caregiver in either a one-to-one or group situation to teach a variety of skills necessary for independent living, including: use of specialized or adaptive equipment, completion of medically related procedures required to maintain the participant in a home or community setting; activities of daily living; adjustment to mobility impairment; management of personal care needs; skills to deal with care providers and attendants. Training needs must be identified through the comprehensive evaluation, re-evaluation, or in a professional evaluation and must be identified in the approved Plan of Care as a required service.

Caregiver/Participant Training is not available to participants that have chosen Assisted Living, Adult Family Care, or the Assisted Living Program as it would duplicate services furnished through Assisted Living, Adult Family Care or Assisted Living Program.

b. Service Limits: Caregiver Participant Training is not considered a service that can be received monthly by GO participants.

c. Provider Specification(s)

i. Individual with appropriate expertise (i.e. RN, OT) to train the recipient/caregiver as required by the Plan of Care (Individual Provider)

ii. Homemaker Agency with Health Care Service Firm

iii. Centers for Independent Living (CIL)

iv. Health Care Service Firm

v. Licensed Medicare Certified Home Health Agency

vi. Adult Family Care Sponsor Agency

vii. Proprietary or Not-for-Profit Business entity

8. Service Name: Chore Services

a. Description: Services needed to maintain the home in a clean, sanitary and safe environment. The chores are non-continuous, non-routine heavy household maintenance tasks intended to increase the safety of the individual. Chore services include cleaning appliances, cleaning and securing rugs and carpets, washing walls, windows, and scrubbing floors, cleaning attics and basements to remove fire and health hazards, clearing walkways of ice, snow, leaves, trimming overhanging tree branches, replacing fuses, light bulbs, electric plugs, frayed cords, replacing door locks, window catches, replacing faucet washers, installing safety equipment, seasonal changes of screens and storm windows, weather stripping around doors, and caulking windows.

Chore Services do not include normal everyday housekeeping tasks such as dusting, vacuuming, changing bed linens, washing dishes, cleaning the bathroom, etc.

Chore is not a service that would be received monthly by a GO participant.

b. Service Limits: Chore service is not available to those who opt for Assisted Living, Adult Family Care, or Assisted Living Program as it is included in the Assisted Living, Adult Family Care and Assisted Living Program service packages.

Chore services are appropriate only when neither the participant, nor anyone else in the household, is capable of performing the chore; there is no one else in the household capable of financially paying for the chore service; and there is no relative, caregiver, landlord, community agency, volunteer, or 3rd party payer capable or responsible to complete this chore.

c. Provider Specification(s)

i. Participant-Employed Provider (PEP) (Individual provider)

ii. Congregate Housing Services Program

iii. Private Contractor (Individual Provider)

iv. Subsidized Independent Housing for Seniors

9. Service Name: Community Transition Services

a. Description: Community Transitions Services (CTS) are non-recurring set-up expenses for individuals who are transitioning from an institutional or another provider-operated living arrangement to an Assisted Living Facility, Adult Family Care home or a living arrangement in a private residence where the person is directly responsible for his or her own living expenses. Allowable expenses are those necessary to enable a person to establish a basic household that do not constitute room and board and may include: (a) security deposits that are required to obtain a lease on an apartment or home; (b) essential household furnishings and moving expense required to occupy and use a community domicile, including furniture, window coverings, food preparation items, and bed/bath linens; (c) set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; (d) services necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy; (e) moving expenses; (f) necessary accessibility adaptations; and (g) activities to assess need, arrange for and procure need resources. Community Transition Services are furnished only to the extent that

they are reasonable and necessary as determined through the service plan development process, clearly identified in the service plan, and the person is unable to meet such expense or when the services cannot be obtained from other sources.

Community Transition Services may be furnished as a Waiver service to individuals to facilitate the transition from an institution to a more independent/less restrictive living arrangement.

Community Transition Services do not include monthly rental or mortgage expense; food, regular utility charges; and/or household appliances or items that are intended for purely diversional/recreational purposes.

b. Service Limits: Community Transition Services are non-recurring and available one time only per person. If a participant returns to the Nursing Home, remains there for any period of time, and wishes to return again to the community, he or she may do so and participate in the Waiver, but Community Transition Services will not be a Waiver service the person may utilize again.

Community Transition Services may not be used to pay for furnishing living arrangements that are owned or leased by a waiver provider where the provision of these items and services are inherent to the service they are already providing.

All Community Transition Services are prior authorized by the Division of Aging and Community Services' Central Office and not considered in the monthly spending cap.

c. Provider Specification(s)

i. Private Contractor/Business (Individual provider)

10. Service Name: Environmental Accessibility Adaptations (EAA)

a. Description: Those physical adaptations to the private residence of the participant or the participant's family, required by the participant's Plan of Care which are necessary to ensure the health, safety and welfare of the participant and enable the participant to function with greater independence in the home, without which the participant would require institutionalization.

Adaptations may include the installation of ramps and grab bars, widening of doorways, modification of bathroom facilities, or the installation of specialized electrical and plumbing systems necessary to accommodate the medical equipment and supplies essential for the participant's welfare. Excluded are those adaptations or improvements to the home which are of general utility and are not of direct medical or remedial benefit to the participant, including but not limited to items such as carpeting, roof repairs and central air conditioning. Adaptation to vehicles (vehicle modifications) are excluded and not a covered service. Adaptations which add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g. in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a participant's wheelchair. All services shall be provided in accordance with applicable State, Local and Americans with Disability Act (ADA) and/or ADA Accessibility Guidelines (ADAAG) and Specifications.

Per Olmstead Letter #3, assessments for the accessibility and need for modifications to a participant's home may be included as an expense in the EAA Waiver Service as a relevant service by another provider such as a home health agency or occupational therapist.

Evidence of permits, approvals or authorizations must be made available if required.

Participants living in licensed residences (ALR, CPCH, ALP, and Class B Boarding Homes) are not eligible to receive EAAs. Modifications to public apartment buildings and/or rental properties are the responsibility of the owner/landlord and excluded from this benefit.

Environmental accessibility adaptations may not be furnished to adapt living arrangements that are owned or leased by providers of waiver services, except for approved Adult Family Care (AFC) Caregivers' homes as assessed to be needed by GO program participants.

EAAs are not comparable or equivalent to Vehicle Modifications. Vehicle modifications are not a covered waiver service for GO participants.

EAAs are not considered a waiver service that a participant can receive on a monthly basis.

A minimum of two estimates are required by approved Waiver providers reflecting the EAA's total cost. Total cost includes all materials, labor, and equipment, shipping fees, permits or any other expenditure to be incurred from the initiation phase to the completion phase of the EAA modification. Authorized EAA costs do not include potential removal fees of the modification.

All home modifications are limited based on the participant's assessed need for an EAA. The adaptation will represent the most cost effective means to meet the needs of the participant. The adaptation will be specific to, but not in excess of, the participant's needs. If another service, such as a State Plan Service or other Waiver service (i.e. Specialized Medical Equipment and Supplies) will meet the same need for which an EAA is being proposed, the SME will be the authorized service.

b. Service Limits: Environmental Accessibility Adaptations that cost \$500 or more must be prior authorized by the Division of Aging and Community Services. The cost of the Environmental Accessibility Adaptation is outside the participant's individual spending cap.

If the EAA cost is over \$500, a minimum of two independent cost estimates must be submitted to the Division of Aging and Community Services (DACs). If the estimates are far apart in cost, a revision or third estimate may be necessary. Estimates must include the approved provider's contact information. A description of work to be done to include pictures/schematics if appropriate and will also detail materials and labor costs. The estimate is to include a Physicians Order if appropriate indicating the service needed and the medical rationale for the service. Also, a letter from the owner of the property approving the modification to the property and acknowledging that the State is not responsible for the removal of the modification from the property is required.

Environmental Accessibility Adaptations are limited to \$5,000 per participant per Waiver year. Additional modification costs exceeding those limits may be requested if a participant's health and safety require special consideration, however, the service of EAA is subject to a \$10,000 lifetime cost cap for each participant assessed to require such adaptation(s).

For those individuals who are in need of Environmental Accessibility Adaptations to transition from a nursing facility to the community, the State may initiate the adaptations up to 180 days prior to actual discharge but authorization of the EAA and reimbursement of the service will not be reimbursed until program enrollment has occurred.

- c. Provider Specification(s)
- i. Private Contractor/Business (Individual Provider)

11. Service Name: Home-Based Supportive Care

a. Description: Services designed to reduce or prevent inappropriate institutionalization by maintaining, strengthening, or restoring an individual's functioning. Needs must be identified through the validated InterRAI comprehensive level of care evaluation tool or re-evaluation, and must be itemized in the approved Plan of Care as a required service. All services include the provision of non-medical transportation necessary for the implementation of the Plan of Care.

Home-Based Supportive Care is not a duplication of the State Plan of Personal Care Assistant. According to N.J.A.C. 10:60-1.2, Personal care assistant services means "health related tasks performed by a qualified individual in a beneficiary's home, under the supervision of a Registered Nurse, as certified by a physician in accordance with a beneficiary's written plan of care." PCA services are prior authorized by the Division of Disability Services in the Department of Human Services. In Home-Based Supportive Care, the services listed in the next paragraph are authorized by the Care Manager based on the needs identified in the initial Level of Care Evaluation and include services beyond "health-related."

Home-Based Supportive Care includes providing assistance with Activities of Daily Living: bathing, dressing, toileting, transferring, eating, bed mobility, and locomotion, either hands-on (needs physical assistance to accomplish the task) or through supervision and cueing. Home-Based Supportive Care also includes assistance with Instrumental Activities of Daily Living (IADL): preparing meals, shopping, managing money, housework, laundry, medication administration, transportation, and mobility outside the home.

Home-Based Supportive Care may be provided by an approved Agency or a Participant-Employed Provider (PEP) selected and hired by the participant.

Individuals will receive Options Counseling from the Office of Community Choice Options Community Choice Counselors and/or County Assessors to assure that the individual has the choice between Home-Based Supportive Care and the State Plan Personal Care Assistant Service.

Home-Based Supportive Care is not available in an Assisted Living Facility, Adult Family Care Home, or Assisted Living Program as it would duplicate services required in Assisted Living, Adult Family Care, or Assisted Living Program.

b. Service Limits: Home-Based Supportive Care is limited to 40 hours a week. If a participant selects Home-Based Supportive Care, he or she is then excluded from receiving Personal Care Assistant.

Home-Based Supportive Care is not reimbursed when the participant is hospitalized or institutionalized.

c. Provider Specification(s)

- i. Subsidized Independent Housing for Seniors
- ii. Licensed Medicare Certified Home Health Agency
- iii. Homemaker Agency that has Health Care Service Firm license
- iv. Licensed Health Care Service Firm
- v. Participant Employed Provider (PEP) (Individual Provider)
- vi. Licensed Employment Agency or Temporary Help Agency
- vii. Congregate Housing Services Program

12. Service Name: Home-Delivered Meals

a. Description: Nutritionally balanced meals delivered to the participant's home when this meal provision is more cost effective than having a personal care provider prepare the meal. These meals do not constitute a full nutritional regimen, but each meal shall provide at least 1/3 of the current Recommended Dietary Allowance established by the Food & Nutrition Board of the National Academy of Sciences, and National Research Council.

When the participant's needs cannot be met by a Title III (Area Plan Contract) provider due to: geographic inaccessibility, special dietary needs, the time of day or week the meal is needed, or existing Title III provider waiting lists precluding service delivery, a meal may be provided by restaurants, cafeterias, or caterers who comply with the New Jersey State Department of Health and local Board of Health regulations for food service establishments. The need for this service must be specified in the participant's Plan of Care, and the unavailability of other resources to satisfy this need must be documented in the case record.

Home-Delivered Meals are not provided in an Assisted Living Facility or Adult Family Care as meal provision is included in the Assisted Living Facility or Adult Family Care service package. A Home-Delivered Meal is not to be used to replace the regular form of "board" associated with routine living in an Assisted Living Facility or Adult Family Care Home. Waiver participants eligible for non-Waiver nutritional services would access those services first.

b. Service Limits: A unit of service equals one meal.

Home-delivered meals are provided to an individual at home, and included in the Plan of Care only when the participant is unable to leave the home independently, unable to prepare the meal, and there is no other person, paid or unpaid, to prepare the meal.

No more than one meal per day will be reimbursed under the GO Waiver.

c. Provider Specification(s)

i. Title III Approved Provider of Meal Service

ii. Restaurant or Food Service Vendor (Individual Provider)

13. Service Name: Personal Emergency Response System (PERS)

a. Description: Personal Emergency Response System is an electronic device, which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable “help” button to allow for mobility. The system is connected to the person’s phone and programmed to signal a response center once a “help” button is activated. Personal Emergency Response System. Trained professionals staff the response center.

A Personal Emergency Response System unit may also include an electronic medication-dispensing device that allows for a set amount of medications to be dispensed as per the dosage instructions. If the medication is not removed from the unit in a timely manner the unit will “lock” that dosage, not allowing the participant access to the missed medication. Before locking, the unit will use a series of verbal and/or auditory reminders that the participant is to take his or her medication. If there is no response, a telephone call will be made to the participant, participant’s contact person, and care management site in that order until a “live” person is reached.

Installation, upkeep and maintenance of device/systems is provided.

Personal Emergency Response System is not available to individuals residing in Assisted Living Facilities (ALF) as it would duplicate services intrinsic to Assisted Living Facilities.

b. Service Limits: Personal Emergency Response System services are limited to those individuals who live alone, or who are alone for significant parts of the day, and have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

c. Provider Specification(s)

i. Electronic communication equipment vendor & monitoring staff (Individual Provider)

14. Service Name: Social Adult Day Care

a. Description: Social Adult Day Care (SADC) is a community-based group program designed to meet the needs of adults with functional impairments through an individualized Plan of Care. Social Adult Day Care is a structured comprehensive program that provides a variety of health, social and related support services in a protective setting during any part of a day but less than 24-hour care.

Individuals who participate in Social Adult Day Care attend on a planned basis during specified hours. Social Adult Day Care assists its participants to remain in the community, enabling families and other caregivers to continue caring at home for a family member with impairment.

Social Adult Day Care services shall be provided for at least five consecutive hours daily, exclusive of any transportation time, up to five days a week.

b. Service Limits: Social Adult Day Care services shall be provided for at least five consecutive hours daily, exclusive of any transportation time, up to five days a week.

Social Adult Day Care is not available to those residing in an Assisted Living Facility as it would duplicate services required by the Assisted Living Licensing Regulations.

Social Adult Day Care cannot be combined with Adult Day Health Services.

The individual has no specific medical diagnosis requiring the oversight of an RN while in attendance at the Social Adult Day Care.

Assisted Living Program (ALP) participants, not ALR or CPCH participants may attend Social Adult Day Care 2 (two) days a week, and (3) three days with prior authorization by the Division of Aging and Community Services' County Liaison/Quality Assurance Specialist.

Adult Family Care (AFC) participants may attend Social Adult Day Care 2 (two) days a week, and (3) three days with prior authorization by the Division of Aging and Community Services' County Liaison/Quality Assurance Specialist.

c. Provider Specification(s)

i. Social Adult Day Care

15. Service Name: Specialized Medical Equipment and Supplies

a. Description: Specialized medical equipment and supplies is also a State Plan Service, but the scope of the Waiver coverage is materially different from the State plan service and the providers of the Waiver service may be different from the providers of the State plan service.

Specialized medical equipment (SME) and supplies as a Waiver service include (a) devices, controls, or appliances, specified in the Plan of Care, which enable individuals to increase their abilities to perform activities of daily living; (b) devices, controls, or appliances that enable the participant to perceive, control, or communicate with the environment in which they live; (c) items necessary for life support or to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items; (d) such other durable and non-durable medical equipment not available under the State plan that is necessary to address participant functional limitations; and, (e) necessary medical supplies not available under the State plan. Items reimbursed with Waiver funds are in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items, which are not of direct medical or remedial benefit to the participant. All items shall meet applicable standards of manufacture, design and installation.

SME items reimbursed with Waiver funds are in addition to any medical equipment and supplies furnished under the State plan and shall exclude those items, which are not of direct medical or remedial benefit to the participant.

For verification of SME items covered in the State Plan, the Care Manager must contact the Medical Assistance Customer Center (MACC) in the applicable county.

b. Service Limits: Specialized medical equipment and supplies that cost \$250 or more (such as a lift chair) require prior authorization by the Division of Aging and Community Services' Central Office Staff and are not included in the spending cap.

SME, as a GO Waiver service, do not include supplies that are already included in the per diem reimbursement for the Assisted Living Program in Subsidized Housing, the Assisted Living (ALR/CPCH) service package, or the Adult Family Care option

c. Provider Specification(s)

i. Licensed Medicare Certified Home Health Agency

ii. Medical Supplier (Individual Provider)

iii. Various Approved Vendors (Individual Provider)

16. Service Name: Transitional Care Management

a. Description: Services which will assist individuals who are in a nursing facility or sub-acute unit of a hospital or nursing facility to gain access to Waiver services. Transitional Care Management services foster the transition from an institution to a community-based living arrangement.

Transitional Care Management involves the planning, arranging, and authorization of services necessary for the individual to transfer back to the community. Community Transition Services is the actual implementation of a set-up service identified as a need by the Transitional Care Manager and applicant during the planning stage of the relocation.

b. Service Limits: Transitional Care Management may be provided up to six months before the individual leaves the institutional setting. However, Medicaid cannot pay for transitional care management services until after the applicant moves into the community and enrolls in the GO waiver.

Transitional care management (TCM) services are not considered services that a GO participant will receive on a monthly basis. TCM may only be provided in certain circumstances with the purpose of facilitating the transition of a consumer from an institutional setting to the community.

Approved care management agencies may bill for one unit of the waiver service Transitional Care Management, at the designated price, i.e. \$200 for the initial transition/first month of GO enrollment when the Care Manager has participated in the Interdisciplinary Team meeting. When a GO participant has been admitted to a nursing facility and returns back to the community, the care management agency may bill up to \$285 (3 months x \$95 a month) for up to three months if

the Care Manager helped facilitate the transition back to the community, contacted the participant, and worked with the nursing facility staff for interdisciplinary team planning.

The initial fee for Transitional Care Management is billable only if the individual is discharged from the nursing facility/sub-acute unit and enrolled in GO as a new participant.

The Care Manager bills for Transitional Care Management in place of Initial Care Management for the first month of GO enrollment when the Care Manager participated in an IDT.

It is not permissible to bill for both Transitional Care Management and Initial Care Management for the same person.

The fee for Transitional Care Management for the GO participant who is readmitted to the NF is billable for up to three months only if the Care Manager makes the required contacts each month and the person is discharged back to the community.

- c. Provider Specification(s)
 - i. Accredited Registered Homemaker Agency
 - ii. Proprietary or Not-for-profit Care Management entity
 - iii. Adult Family Care Sponsor Agency
 - iv. Area Agency on Aging
 - v. County Welfare Agency
 - vi. Licensed Medicare Certified Home Health Agency

17. Service Name: Transportation

a. Description: Service offered in order to enable individuals served on the Waiver to gain access to Waiver and other community services, activities and resources specified in the Plan of Care. This service is offered in addition to medical transportation required under 42 Code of Federal Regulations 431.53 and transportation services under the State plan, defined at 42 Code of Federal Regulations 440.170(a) (if applicable), and shall not replace them. Transportation services under the Waiver shall be offered in accordance with the individual's Plan of Care. Whenever possible, family, neighbors, friends, or community agencies, which can provide this service without charge, will be utilized. Transportation as a Waiver service is one that enhances the individual's quality of life. An approved provider may transport the participant to shopping, to the beauty salon, the bank, or to the religious services of his or her choice.

b. Service Limits: Services are limited to those that are required for implementation of the Plan of Care.

Transportation incidental to the provision of another service is not reimbursable.

Reimbursement for private vehicles will be set at the State rate of mileage reimbursement.

When available, appropriate to the participant's need and capabilities, and cost-effective, transportation shall also mean the use of public transit, tickets, etc.

- c. Provider Specification(s)
 - i. Adult Family Care Caregiver or substitute caregiver
 - ii. Participant Employed Provider (PEP) (Individual Provider)
 - iii. Transportation Provider Registered as a Business in NJ

Community Resources for People with Disabilities (CRPD) (Formerly HCBS Waiver Base #NJ4133)

1. Service Name: Case Management

a. Description: Case Management services are those which assist waiver participants in gaining access to needed waiver and specific State Plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Case managers shall be responsible for the assessment and re-assessment, at specified intervals, of the need for waiver services; development and review of the service plan; ongoing monitoring of the provision of services included in the participants plan of care; coordinating among multiple providers and/or multiple waiver services; and monitoring the service plan and participant's health and welfare. The case manager shall initiate process of re-evaluation of the participant's level of care at the specified intervals and address any problems in service provision.

b. Service Limits: N/A

c. Provider Specification(s):

- i. New Jersey Department of Health, Special Child Health Services, Case Management Services
- ii. County Welfare Agency
- iii. Licensed Certified Home Health Agency
- iv. A Proprietary or Not-for-Profit Case Management Agency that has met requirements pursuant to NJSA 45:11-26 and NJSA 45:15BB and is a Medicaid approved provider.
- v. Non-Profit Freestanding Community Health Center
- vi. Non-Profit, Registered, Accredited Homemaker Agency

2. Service Name: Community Transitional Services

a. Description: CTS are those services provided to a participant that may aid in the transitioning from institutional settings to his/her own home in the community through coverage of one-time transitional expenses. Examples of those expenses include the cost of furnishing an apartment (basic living items such as bed, table, chairs, window blinds, eating utensils, and food preparation items); moving expenses required to occupy and use a community domicile; the expense of security deposits; utility connection fees (e.g. telephone, electricity, gas, etc.); health and safety assurances such as pest eradication, allergen control, or one-time cleaning prior to occupancy. These services may not constitute payment for housing or for rent. The concept of essential furnishings does not include diversional or recreational items (TV, VCR, cable access, etc.). Reasonable costs are necessary expenses in the judgment of the State for an individual to establish his or her basic living arrangement. The addition of the fiscal intermediary is the modification to the provider specifications. Previously the provider of the specific service was required to execute a purchase agreement with the case manager; now that agreement is between the fiscal intermediary and the service provider.

b. Service Limits: As noted, these are one-time expenses and delivered on an as-needed basis.

c. Provider Specification(s)

i. Fiscal Intermediary

3. Service Name: Environmental/Residential Modification

a. Description: Those physical modifications/adaptations to a participant's home required by his/her plan of care which are necessary to ensure the health, welfare and safety of the individual, or which enable him/her to function with greater independence in the home or community and without which the individual would require institutionalization. Such adaptations may include the installation of ramps and grab bars, widening of doorways, modifications of bathrooms, or installation of specialized electrical or plumbing systems that are necessary to accommodate the medical equipment and supplies which are needed for the welfare of the individual. The addition of the fiscal intermediary is the modification to the provider specifications. Previously the provider of the specific service was required to execute a purchase agreement with the case management agency; now that agreement is between the fiscal intermediary and the service provider.

b. Service Limits: Excluded from this service are those modifications to the home that are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which increase the square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State/local building codes. This is not a stand-alone service. The participant must need other home and community-based services supporting the return to the community (de-institutionalization) or to remain in the community (at risk of nursing facility placement).

c. Provider Specification(s)

i. Fiscal Intermediary

4. Service Name: Personal Emergency Response Service (PERS)

a. Description: PERS is an electronic device which enables participants at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and is programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. The service consists of two components both of which are managed by the PERS contractor; first is the initial installation of the equipment and the second is the monitoring of the service by staff at the response center. The addition of the fiscal intermediary is the modification to the provider specifications. Previously the provider of the specific service was required to execute a purchase agreement with the case management agency; now that agreement is between the fiscal intermediary and the service provider.

b. Service Limits: PERS services are limited to those individuals who live alone or who are alone for significant portions of the day and who have no regular caregiver for extended portions of time and who would otherwise require extensive routine supervision. PERS is not available to individuals who live in congregate settings.

c. Provider Specification(s)

i. Fiscal Intermediary

5. Service Name: Private Duty Nursing

a. Description: Individual and continuous care (in contrast to part-time or intermittent care) provided by licensed nurses within the scope of the State law. These services are provided to an individual at home.

b. Service Limits: To receive private duty nursing, a participant must be assessed by the DDS to require individual and continuous care provided by a licensed nurse. Private duty nursing will be provided only when there is a live-in primary caregiver (adult relative or significant other adult) who accepts 24-hour responsibility for the health and welfare of the participant. Private duty nursing shall be limited per person to a maximum of 16 hours in a 24-hour period.

c. Provider Specification(s)

i. Licensed Certified Home Health Agency

ii. Registered, Accredited Private Duty Nursing Agency

6. Service Name: Vehicular Modification

a. Description: The service includes needed vehicle modification (such as electronic monitoring systems to enhance beneficiary safety, mechanical lifts to make access possible) to a

participant or family vehicle as defined in an approved plan of care. Modifications must be needed to ensure the health, welfare and safety of a participant or which enable the individual to function more independently in the home or community. All services shall be provided in accordance with applicable State motor vehicle codes. The addition of the fiscal intermediary is the modification to the provider specifications. Previously the provider of the specific service was required to execute a purchase agreement with the case management agency; now that agreement is between the fiscal intermediary and the service provider.

b. Service Limits: Excluded are those adaptations/modifications to the vehicle which are of general utility, and are not of direct medical or remedial benefit to the participant. Maintenance of the normal vehicle systems is not permitted as a part of this service; neither is the purchase/leasing of a vehicle. This is not a stand-alone service and the participant requesting this service must also require ongoing waiver services supporting the return to the community (de-institutionalization) or to remain in the community (at risk of placement).

c. Provider Specification(s)

i. Fiscal Intermediary

AIDS Community Care Alternatives Program (ACCAP)

1. Service Name: Case Management

a. Description: Case Management services are those which assist waiver participants in gaining access to needed waiver and specific State Plan services as well as needed medical, social, educational and other services regardless of the funding source for the service to which access is gained. Case Managers shall be responsible for the assessment and re-assessment of the need for waiver services, development and review of the service plan; ongoing monitoring of the provision of services included in the participant's plan of care; coordinating among multiple providers and/or multiple services; and monitoring the service plan and participant's health and welfare. The case manager shall initiate the process of re-evaluation of the participant's level of care at the specific intervals and address any problems in service provision.

b. Service Limits: N/A

c. Provider Specification(s):

i. Licensed, Certified Home Health Agency

ii. Non-Profit, Freestanding Community Health Centers

iii. Hospital

iv. Private, Incorporated Case Management Firm

v. Non-Profit, Accredited, Registered Homemaker Agency

vi. New Jersey Department of Health, Special Child Health Services, Case Management Services

vii. A Proprietary or Not-for-Profit Case Management Agency that has met requirements pursuant to NJSA 45:11-26 and NJSA 45:15BB, and is a Medicaid approved provider.

2. Service Name: Personal Care Assistant

a. Description: Personal Care Assistant Services (PCA) are those services rendered by a certified homemaker-home health aide to assist a waiver participant with his/her activities of daily living (ADL). ADL are the functions or tasks for self-care which are performed either independently or with supervision or assistance. Activities of daily living include at least mobility, transferring, walking, grooming, bathing, dressing and undressing, eating, and toileting. Services can be provided up to 24 hours a day, based on medical need and available CAP dollars. The State Plan PCA service is a maximum of 40-hours per week.

b. Service Limits: N/A

c. Provider Specification(s)

i. Licensed, Certified Home Health Agency

ii. Registered, Accredited Homemaker Agency

3. Service Name: Private Duty Nursing

a. Description: Individual and continuous care (in contrast to part-time or intermittent care) provided by licensed nurses within the scope of the State law. These services are provided to an individual at home.

b. Service Limits: To receive private duty nursing, a participant must be assessed by the DDS to require individual and continuous care provided by a licensed nurse. Private duty nursing will be provided only when there is a live-in primary caregiver (adult relative or significant other adult) who accepts 24-hour responsibility for the health and welfare of the participant and provides a minimum of 8-hours of care.

Private duty nursing shall be limited per person to a maximum of 16 hours in a 24-hour period.

c. Provider Specification(s)

i. Licensed Certified Home Health Agency

ii. Registered, Accredited Homemaker Agency

Traumatic Brain Injury (TBI) Program

1. **Service Name:** Case Management
 - a. **Description:** Services which will assist individuals who receive waiver services in gaining access to needed waiver and specific State Plan services, as well as needed medical, social, education, and other services regardless of the funding source for the services to which access is gained. Case Managers are responsible for planning, locating, coordinating, authorizing, and monitoring a group of services designed to meet the needs of the participant. As well as developing the plan of care with the waiver participant and for monitoring the cost of the service package.
 - b. **Service Limits:** All TBI program participants receive monthly (face-to-face visits) services from their case manager.
 - c. **Provider Specification(s):**
 - i. Agency provider that is a privately incorporated case management firm.
 - ii. Agency provider that is a proprietary or non-for-profit Case Management Agency that has met requirements pursuant to NJSA 45:11-26 and NJSA 45:15BB, and is a approved Medicaid provider.
 - iii. A private incorporated case management consulting firm.
 - iv. A licensed certified home health agency.
2. **Service Name:** Respite
 - a. **Description:** Services provided to participants unable to care for themselves, furnished on a short-term basis because of the absence or need for relief of those persons normally providing the care. Respite services are provided in the participant's home (place of residence) or a Community Residential Services (CRS) provider.
 - b. **Service Limits:** This service is only available to participants who are NOT receiving services in a Community Residential Services (CRS) setting and living at home.
 - c. **Provider Specification(s):**
 - i. A non-profit accredited, registered homemaker agency
 - ii. Community Residential Services (CRS) provider
 - iii. Licensed, certified home health agency
3. **Service Name:** Occupational Therapy
 - a. **Description:** This therapy service is extended beyond the parameters of the State Plan service definition. The expansion of therapy services allows TBI participants who are primarily ambulatory young adults with cognitive, behavioral, and physical defects to continue to receive this service even though they may no longer require intensive rehabilitation and have exhausted all Medicare or State Plan benefits for this service. Therapy shall continue to be offered alone or in combination with other TBI waiver services to enhance or maintain participant functioning as required by the plan of care. An occupational therapy provider shall be registered as an occupational therapist (OTR) with the American Occupational Therapy Association

(AOTA). A certified occupational therapy assistant (COTA) shall be registered with the AOTA and work under the direction of an OTR.

- i. An OTR and COTA shall be under contract to, or on the staff of, a licensed community residential services provider, rehabilitation hospital or agency, or home health agency which shall be reimbursed for the OT services.
- ii. OT may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five participants. The addition of OT group session is a modification of the service definition.
- iii. All therapy services are a part of the approved waiver care plan prepared by the TBI waiver case manager with input from the participant, involved parties, and providers. Case managers are required to send a confirmation of services letter to providers of services delineating exactly what services and from what payment source they are to be provided. Therapy services under the waiver are fee-for-service with billing codes exclusive to services provided to TBI participants. Should a participant still qualify for therapy services under Medicare or State Plan, those payment sources and the duration of that source are identified on the participant care plan. DDS monitors care plans at the case management sites on an ongoing basis and compares services on the approved care plan to paid claims reports which are provided monthly to DDS by Medicaid information systems.

b. **Service Limits:** Both group and individual session are 30 minutes in length. The therapist must record the time the therapy session started and when it ended in the participant's clinical record.

c. **Provider Specification(s):**

- i. A rehabilitation hospital
- ii. Community Residential Services (CRS) provider
- iii. Licensed, certified home health agency
- iv. Post-acute non-residential rehabilitative services provider agency

4. **Service Name:** Physical Therapy

a. **Description:** This therapy service is extended beyond the parameters of the State Plan service definition. The expansion of therapy services allows TBI participants who are primarily ambulatory young adults with cognitive, behavioral, and physical defects to continue to receive this service even though they may no longer require intensive rehabilitation and have exhausted all Medicare or State Plan benefits for this service. Therapy shall continue to be offered alone or in combination with other TBI waiver services to enhance or maintain participant functioning as required by the plan of care. Physical therapists (PT) and physical therapy assistants (PTA) shall meet the New Jersey licensure standards and requirements for practice (see

N.J.A.C. 13:39A). PT and PTA shall be under contract to, or on the staff of, a licensed community residential services provider, rehabilitation hospital or agency, or home health agency which shall be reimbursed for the PT services.

- i. PT may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five participants. The addition of PT group session is a modification of the service definition.
 - ii. All therapy services are a part of the approved waiver care plan prepared by the TBI waiver case manager with input from the participant, involved parties, and providers. Case managers are required to send a confirmation of services letter to providers of services delineating exactly what services and from what payment source they are to be provided. Therapy services under the waiver are fee-for-service with billing codes exclusive to services provided to TBI participants. Should a participant still qualify for therapy services under Medicare or State Plan, those payment sources and the duration of that source are identified on the participant care plan. DDS monitors care plans at the case management sites on an ongoing basis and compares services on the approved care plan to paid claims reports which are provided monthly to DDS by Medicaid information systems.
 - b. **Service Limits:** Both group and individual session are 30 minutes in length. The therapist must record the time the therapy session started and when it ended in the participant's clinical record.
 - c. **Provider Specification(s):**
 - i. A rehabilitation hospital
 - ii. Community Residential Services (CRS) provider
 - iii. Licensed, certified home health agency
 - iv. Post-acute non-residential rehabilitative services provider agency
5. **Service Name:** Speech, Language, and Hearing Therapy (ST)
 - a. **Description:** This therapy service is extended beyond the parameters of the State Plan service definition. The expansion of therapy services allows TBI participants who are primarily ambulatory young adults with cognitive, behavioral, and physical defects to continue to receive this service even though they may no longer require intensive rehabilitation and have exhausted all Medicare or State Plan benefits for this service. Therapy shall continue to be offered alone or in combination with other TBI waiver services to enhance or maintain participant functioning as required by the plan of care. A speech-language pathologist provider shall be licensed by the State of New Jersey (see N.J.A.C. 13:44C). A speech-language pathologist shall be under contract to a community residential services provider,

rehabilitation hospital or agency, or home health agency, which shall be reimbursed for the speech-language therapy services.

- i. ST may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five participants. The addition of ST group session is a modification of the service definition.
 - ii. All therapy services are a part of the approved waiver care plan prepared by the TBI waiver case manager with input from the participant, involved parties, and providers. Case managers are required to send a confirmation of services letter to providers of services delineating exactly what services and from what payment source they are to be provided. Therapy services under the waiver are fee-for-service with billing codes exclusive to services provided to TBI participants. Should a participant still qualify for therapy services under Medicare or State Plan, those payment sources and the duration of that source are identified on the participant care plan. DDS monitors care plans at the case management sites on an ongoing basis and compares services on the approved care plan to paid claims reports which are provided monthly to DDS by Medicaid information systems.
- b. **Service Limits:** Both group and individual session are 30 minutes in length. The therapist must record the time the therapy session started and when it ended in the participant's clinical record.
- c. **Provider Specification(s):**
- i. A rehabilitation hospital
 - ii. Community Residential Services (CRS) provider
 - iii. Licensed, certified home health agency
 - iv. Post-acute non-residential rehabilitative services provider agency

6. **Service Name:** Behavioral Management

- a. **Description:** A daily program provided by, and under the supervision of, a licensed psychologist or board-certified/board-eligible psychiatrist and by trained behavioral aides designed to service recipients who display severe maladaptive or aggressive behavior which is potentially destructive to self or others. The program, provided in the home or out of the home, is time-limited and designed to treat the individual and caregivers, if appropriate, on a short-term basis. Behavioral programming includes a complete assessment of the maladaptive behavior(s); development of a structured behavioral modification plan, implementation of the plan, ongoing training and supervision of caregivers and behavioral aides, and periodic reassessment of the plan. The goal of the program is to return the individual to the prior level of functioning which is safe for him/her and others. The average timeframe needed to provide this service is usually four to six months.

- i. Program enrollment requires prior evaluation and recommendation of a board-certified and eligible psychiatrist, a licensed neuropsychologist or neuro-psychiatrist with subsequent consultation by same on an as-needed basis. The case manager shall also prior authorize the service.
 - b. **Service Limits:** Both group and individual session are 30 minutes in length. The therapist must record the time the therapy session started and when it ended in the participant's clinical record.
 - c. **Provider Specification(s):**
 - i. A board-certified and board-eligible psychiatrist
 - ii. Clinical psychologist
 - iii. Mental Health Agency
 - iv. A rehabilitation hospital
 - v. Community Residential Services (CRS) provider
 - vi. Post-acute non-residential rehabilitative services provider agency
- 7. **Service Name:** Cognitive Rehabilitative Therapy
 - a. **Description:** "systematic, functionally-oriented service of therapeutic cognitive activities, based on an assessment and understanding of the person's brain-behavior deficits." "Services are directed to achieve functional changes by (1) reinforcing, strengthening, or reestablishing previously learned patterns of behavior, or (2) establishing new patterns of cognitive activity or compensatory mechanisms for impaired neurological systems " (Harley, et al., 1992, p.63).
 - i. As defined by the Brain Injury Interdisciplinary Special Interest Group (BI-ISIG) of the American Congress of Rehabilitation Medicine, and is quoted by the Society for Cognitive Rehabilitation. Therapeutic interventions include but are not limited to direct retraining, use of compensatory strategies, use of cognitive orthotics and prostheses, etc. Activity type and frequency are determined by assessment of the participant, the development of a treatment plan based on recognized deficits, and periodic reassessments.
 - ii. Cognitive rehabilitation therapy can be provided in various settings, including but not limited to the individual's own home and community, outpatient rehabilitation facilities, or residential programs. This service may be provided by rehabilitation professionals with the following credentials, training, experience, and supervision:
 - iii. Training
 - 1. Minimum of a master's or degree in an allied health field from an accredited institution or holds licensure and or certification or
 - 2. Minimum of bachelor's degree from an accredited institution in allied health fields where the degree is sufficient for licensure, certification or registration or in

fields where licensure, certification or registration are not available (i.e. special education) or

3. Applicable degree programs including but not limited to communication disorders (speech), counseling, education, psychology, physical therapy, occupational therapy, recreation therapy, social work, and special education.
4. Certified Occupational Therapy Assistants (COTA'S) and Physical Therapy Assistants (PTA'S) may provide CRT only under the guidelines described in the New Jersey practice acts for occupational and physical therapists.
5. Staff members who meet the above-mentioned degree requirements, but are not licensed or certified, may practice under the supervision of a rehabilitation practitioner who is licensed and/or meets the criteria for certification by the Society for Cognitive Rehabilitation (actual certification is not necessary so long as criteria is met).

iv. Supervision

1. This service must be coordinated and overseen by a CRT provider holding at least a master's degree. Provided by a rehabilitation professional that is licensed or certified. The master's level CRT provider must ensure that bachelor's level CRT providers receive the appropriate level of supervision, as delineated below.
2. Supervision for CRT providers who are not licensed or certified is based on number of years of experience
 - a. 1) For staff with less than 1 year of experience: 4 hours of individual supervision per month.
 - b. 2) 1 to 5 years experience: 2 hours individual supervision per month
 - c. 3) More than 5 years experience: 1 hour per month

- v. All individuals who provide or supervise the CRT service must complete 6 hours of relevant ongoing training in CRT and or brain injury rehabilitation. Training may include, but is not limited to, participation in seminars, workshops, conferences, and in-services.

- b. **Service Limits:** Daily limits as delineated by the participants plan of care. Frequency and duration of service must be supported by assessment and included in participant care plan.
 - i. CRT may be provided on an individual basis or in groups. A group session is limited to one therapist with maximum of five participants. The addition of CRT group session and the

provider qualifications and service is a modification of the service.

- ii. Both group and individual session are 30 minutes in length. The therapist must record the time the therapy session started and when it ended in the participant's clinical record.

c. **Provider Specification(s):**

- i. A rehabilitation hospital
- ii. Community Residential Services (CRS) provider
- iii. Post-acute non-residential rehabilitative services provider agency

8. **Service Name:** Community Residential Services (CRS)

- a. **Description:** A package of services provided to a participant living in the community, residence-owned, rented, or supervised by a CRS provider. The services include personal care, companion services, chore services, transportation, night supervision, and recreational activities. The service does not include room and board and personal needs which will be paid by the participant. A CRS is a participant's "home." The bundling of these services distinguishes supervision/residential services from the unique day program services provided under the waiver at the CRS as well.

- i. The CRS provider is responsible for coordinating the service to ensure the participant's safety and access to services as determined by the participant and TBI waiver case manager. Waiver participants are assigned one of three levels of supervision. These levels are determined by the dependency of the participant. The case manager, in conjunction with CRS staff, evaluate participant, using the "TBI WAIVER LEVEL OF CARE GUIDELINES FOR CRS" form. This form, on file at DDS and available to CMS upon request, lists categories of dependency. Level I is indicative of a high level of independence; Level II is indicative of a moderate level of dependence; and Level III representing the highest level of dependency or the need for the 2-person lift.

- ii. The State will make retainer payments for providers of Community Residential Services (CRS) when the waiver participant is hospitalized or absent from his/her home for a period of no more than 30 consecutive days. For hospital absences and related absences (e.g., rehabilitation time in a rehabilitation unit) the service plan does not need to reflect the absence. For all other absences, the service plan shall reflect the need for absence from the home.

- b. **Service Limits:** The level of assessment is assessed minimally on an annual basis, more frequently if there is a change in participants care. Service is not rendered in conjunction with service provider retainer. Only one level of service can be billed per 24-hour period (12:00 a.m. to 11:59 p.m.)

- c. **Provider Specification(s):**
 - i. Community Residential Services (CRS) provider
- 9. **Service Name:** Counseling
 - a. **Description:** Counseling of an intensive or long-term nature to resolve interpsychic or interpersonal conflicts resulting from the head injury may be provided to participant and family, if necessary. Counseling as an adjunct to a behavioral program may be provided in severe cases. Counseling for a substance abuse problem should be provided by a Certified Alcohol and Drug Counselor familiar with head injury or a local alcohol/drug treatment program. Due to the high correlation between TBI and substance abuse, detailed drug/alcohol abuse history should be obtained by the case manager for each participant to monitor a potential for substance abuse. Waiver services should be utilized only if state plan counseling services for mental health or drug treatment are either unavailable or inappropriate to meet participant needs.
 - i. Under the TBI waiver, the service of counseling can be billed by mental health agencies, family service agencies, or clinical psychologists. Registered nurses (45:11-26) or licensed clinical social workers (45:1-15) may provide this service as an employee of one of the agencies listed in the provider categories under Appendix C:3-1. Additionally, a licensed clinical social worker may provide this service under the supervision of a clinical psychologist as listed in Appendix C:3-1 under the “Individual” provider specification.
 - b. **Service Limits:** n/a
 - c. **Provider Specification(s):**
 - i. Clinical psychologist
 - ii. Family Services Agency
 - iii. Mental Health Agency
- 10. **Service Name:** Environmental/Vehicular Modifications
 - a. **Description:**
 - i. Those physical modifications/adaptations to a participant's home required by his/her plan of care which are necessary to ensure the health, welfare and safety of the individual, or which enable him/her to function with greater independence in the home or community and without which the individual would require institutionalization. Such adaptations may include the installation of ramps and grab bars, widening of doorways, modifications of bathrooms, or installation of specialized electrical or plumbing systems that are necessary to accommodate the medical equipment and supplies which are needed for the welfare of the participant.
 - ii. Vehicle modification; such as, electronic monitoring systems to enhance beneficiary safety, mechanical lifts to make access possible to a participant's or family's vehicle as defined in an

approved plan of care are acceptable services. Modification must be needed to ensure the health, welfare and safety of a participant or which enable the individual to function more independently in the home or community. All services shall be provided in accordance with applicable State motor vehicle codes.

- b. **Service Limits:** Excluded from this service are those modifications to the home that are of general utility and are not of direct medical or remedial benefit to the individual, such as carpeting, roof repair, central air conditioning, etc. Adaptations which increase the square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable State/local building codes. This is not a stand-alone service. The participant must need other home and community-based services supporting the return to the community (de-institutionalizations) or to remain in the community (at risk of nursing facility placement).
 - i. Excluded are those adaptations/modifications to the vehicle which are of general utility, and are not of direct medical or remedial benefit to the participant. Maintenance of the normal vehicle systems is not permitted as a part of this service; neither is the purchase/leasing of a vehicle. This is not a stand-alone service and the participant requesting this service must also require ongoing waiver services supporting the return to the community (de-institutionalization) or to remain in the community (at risk of placement).
 - ii. This service is not available to participants living in Community Residential Services (CRS) settings. Residence modifications are the responsibility of the CRS provider.
 - iii. The case manager must project what impact the cost of the environmental/vehicular modification will have on the participant's monthly service caps.
- c. **Provider Specification(s):**
 - i. Fiscal intermediary

11. Service Name: Structured Day Program

- a. **Description:** A program of productive supervised activities, directed at the development and maintenance of independent and community living skills.
 - i. Services will be provided in a setting separate from the home in which the participant lives. Services may include group or individualized life skills training that will prepare the participant for community reintegration, including but not limited to attention skills, task completion, problem solving, money management, and safety. This service will include nutritional supervision, health monitoring, and recreation as appropriate to the individualized care plan. The service is provided in half day (3 hours) or full day (6 hours or more,

including lunch) segments. The program will not cover services paid for by other agencies. The program excludes medical day care, which may be provided as a State Plan Service.

- b. **Service Limits:** If the participant is in a full structured day program, the combined total number of additional therapy (OT, PT, ST, CRT) sessions (30 minute intervals) cannot exceed six.
- c. **Provider Specification(s):**
 - i. Post-acute, non-residential rehabilitation services provider agency
 - ii. Comprehensive Outpatient Rehabilitation Facility; Post-acute Day Program
 - iii. Community Residential Services (CRS) provider
 - iv. Rehabilitation Hospital (outpatient)

12. **Service Name:** Supported Day Services

- a. **Description:** A program of individual activities directed at the development of productive activity patterns, requiring initial and periodic oversight, at least monthly, from a professional holding at least a Master's degree in a rehabilitation related discipline (including but not limited to; Psychology, Social Work, PT, OT, SLP, Nursing, CRC, etc.) to sustain the program. This service may be provided by rehabilitation staff at the paraprofessional level (minimum of 48 college credits) or higher, and the program and service providers will receive ongoing supervision from a licensed or certified professional at a minimum, in addition to the clinical oversight provided by the aforementioned Master's level rehabilitation professional.
 - i. This service is provided in the home or community, not within a Structured Day Program or CRS setting. Activities that support this service include but are not limited to therapeutic recreation, volunteer activities, household management, shopping for food, household goods, clothing, etc., negotiating various components of activities in the community, building social supports in the community etc.
 - ii. The professional support will be reimbursed on an hourly basis, depending on the amount of support required. Supported Day Services are provided as an alternative to Structure Day Program when the participant does not require continual supervision.
 - iii. Registered nurses (NJSA 45:11-26) and licensed clinical social workers (NJSA 45:1-15) may provide this service when employed by an approved provider agency such as a mental health agency or family service agency. Licensed, clinical social worker may provide this service if under the supervision of a psychologist who is listed as an individual provider under specifications for this waiver service.

- b. **Service Limits:** Services are not to be provided in a setting where the setting itself is already paid to supervise the participant. Limits in service should be delineated by assessment of the person receiving the service, as directed by the Master's level Rehabilitation professional as noted above.
 - i. The amount, frequency, and duration of this service are determined by the recommendation made by the qualified professional identified above to the TBI waiver case manager. The case manager develops the plan of care, taking the professional's recommendations into account when developing the total service package necessary to maintain the participant in the home/community environment within the confines of the monthly service cap.
- c. **Provider Specification(s):**
 - i. Psychologist
 - ii. Family Services Agency
 - iii. Post-acute, non-residential rehabilitation services provider agency
 - iv. Community Residential Services (CRS) provider
 - v. Mental Health Agency

Attachment D
SED Program
Service Definitions

SED Program Overview

The SED Program provides behavioral health services for children up to age 21 who have been diagnosed as seriously emotionally disturbed which places them at risk for hospitalization and out-of-home placement. The program serves two primary purposes. First, it allows for Medicaid eligibility based on SED determination irrespective of parental income to extend SED services to more youth. Secondly, three new services that have been found to be critical for the success of youth we are serving are being created. The goals of the program are to:

- i. improve participants emotional stability;
- ii. maintain children in the community and increase community integration;
- iii. support youth with SED that are transitioning into adulthood;
- iv. improve participants success in a wide range of life domains;
- v. reduce residential lengths of stay by providing a less restrictive but medically appropriate treatment option;
- vi. reduce acute hospitalization lengths of stay and recidivism; and,
- vii. improve social and educational functioning and reduce incidents of criminal activity for those children eligible for the program.

1. Service Name: Transitioning Youth Life Skill Building

- a. Service Description: Services that will assist youth ages 16 to 21 that have an SED and are transitioning out of child behavioral health services into adult life and possibly adult mental health services. The service is aimed at building the core communication and self-organizational skills needed for a Demonstration participant to manage his or her own life's affairs as they transition into adulthood. The self-empowerment enhancing service will provide education and guidance in the areas of continuing education, professional skill building/training, finances, personal health, relationships, parenthood, transportation, community connections and resources, and many other areas that will focus on the basic skills needed to successfully integrate into a community and avoid incarceration, homelessness, and hospitalization. The provider of these services is responsible for developing a structured curriculum that utilizes individual and/or small group sessions. DCF will develop a policy explaining the core components of an acceptable curriculum and all curriculums will be required to adhere to this policy. The curriculum must be approved by the NJ Department of Children and Families and will be consistent with services provided to youth who are aging out of the child welfare system.
- b. Service Limits: This service must be a part of a comprehensive individualized service plan developed by a Care Management Organization (CMO) and prior authorized by the ASO. The youth must be currently authorized and receiving care management services from a CMO. Frequency and duration of service must be supported by the NJ System of Care Strength and Needs Assessment Tool and included in the Demonstration participant's individualized service plan. This service must be provided in a community setting and is not to be used in a residential or hospital setting.
- c. Provider Specification:

- i. A licensed community mental health provider
- ii. A state-certified Intensive In-Community and Behavioral Assistance provider

2. Service Name: Youth Support and Training

- a. Service Description: Services that will assist youth ages 5 to 16 to provide guidance, training, and support, to include positive role modeling, to help the youth be successful with basic activities of life such as peer and family relationships, social interactions, responding to authority, personal health, school functioning, internet/social media safety, spirituality, and many other areas that will focus on the basic skills needed to successfully function at home, in school and in their community.

Service Limits: This service must be a part of a comprehensive individualized service plan developed by a Care Management Organization (CMO) and prior authorized by the ASO.

These services are to be provided on an individual basis, not a group setting. The youth must be currently authorized and receiving care management services from a CMO. Frequency and duration of service must be supported by the NJ System of Care Strength and Needs

Assessment Tool and included in the Demonstration participant's individualized service plan.

This service must be provide in a community setting and is not to be used in a residential or hospital setting. This service is limited to no more than 5 hours per week and a total of 120 hours in any 12 month period.

- b. Provider Specification:

- i. These services are provided by individuals that are employed by an approved agency, successfully complete a criminal background check, and are trained in the basics of child safety and development. The providers of these services are not expected to be licensed mental health professionals. Providers may include:

1. A licensed community mental health provider
2. A state-certified Intensive In-Community and Behavioral Assistance provider

3. Non-medical transportation

- a. Service Description: This transportation service will be provided to children from ages 5 to 21 and/or their primary caregiver that are determined by the Care Management Organization to be in need of short-term transportation to and/or from a non-medical activity that is an integral part of the youth's individualized service plan where there are no other feasible transportation options. These non-medical services could include, but are not limited to, recreational activities, youth training sessions, transitioning youth services, after-school programs not associated with a youth's Individual Education Plan (IEP), and parent support services.

- b. Service Limits: This service must be a part of a comprehensive individualized service plan developed by a Care Management Organization (CMO) and prior authorized by the ASO. The youth must be currently authorized and receiving care management services from a CMO. Frequency and duration of service must be supported by the NJ System of Care Strength and Needs Assessment Tool and included in the Demonstration participant's individualized service plan. This service must be provided in a community setting and is not to be used in a residential or hospital setting. This service is limited to 3 roundtrip transports a week and a total of 36 roundtrip transports per year.

- c. Provider Specification:

- i. Agency that has met the qualifications as specified by the Department of Human Services (DHS) or the Department of Children and Families (DCF): or
- ii. Authorized Medicaid provider.

MATI - Medically Assisted Treatment Initiative

MATI Methadone, Suboxone, and Substance Abuse (SA) Clinical Services

Effective July 1, 2013, or a date thereafter, the treatment program delivers a comprehensive array of medication-assisted treatment and other clinical services through MATI provider mobile and office-based sites. The program goals include:

- the reduction in the spread of blood borne diseases through sharing of syringes;
- the reduction of opioid and other drug dependence among eligible participants;
- the stabilization of chronic mental health and physical health conditions; and,
- improved housing and employment outcomes among program participants.

Eligibility: Demonstration enrollees receiving these services must be screened by the mobile or fixed site service provider using a standardized clinical and functional assessment tool that will be independently reviewed by appropriate qualified clinicians to determine if the applicants meets the following criteria:

- be a resident of New Jersey and at least 18 years old;
- have household income at or below 150% of the FPL;
- have a history of injectable drug use;
- test positive for opiates or have a documented one-year history of opiate dependence.

Service Name	Description	Comment	Unit Value
Methodone medication and dispensing in a licensed opioid treatment facility*	The MATI program will follow the Medicaid state plan with no variance.	N/A	4.25 dose
Suboxone medication and dispensing in a licensed opioid treatment facility*	The MATI program will exceed the State plan limit for this service; however, all other components to the Medicaid state plan will apply.	The Medicaid state plan includes suboxone in the Rx formulary but does not include dispensing in an opioid treatment facility.	7.25-11.38 depending on dose
Medication Monitoring - MAT*	The MATI program will exceed the State plan limit for this service; however, all other components to the Medicaid state plan will apply.	MATI participants will receive up to 2 units of medication monitoring a day and no more than 2 units a month.	42
Comprehensive Assessment in a SA treatment facility	The state plan does not include this MATI service.	MATI participants will receive up to 4 units of comprehensive assessment annually.	26.00 thirty minutes
Outpatient substance abuse counseling individual*	The MATI program will follow the Medicaid state plan with no variance.	N/A	24.50 thirty minutes
Outpatient substance abuse counseling group*	The MATI program will follow the Medicaid state plan with no variance.	N/A	23.00 hour

MATI - Medically Assisted Treatment Initiative

Cognitive Behavioral Motivational Therapy - Group	The state plan does not include this MATI service.	MATI participants will receive up to 16 units of CBT group a month and no more than 1 in a single day.	25.00 hour
Intensive Outpatient Treatment in a SA treatment facility	The state plan does not include this MATI service.	MATI participants will receive up to 18 units of IOP a month and no more than 1 in a single day.	71.00 day
Outpatient - Family Counseling/ Education in a SA treatment facility	The state plan does not include this MATI service.	MATI participants will receive up to 2 units of family counseling/education a month.	49.00 hour
Case Management -Recovery Support	The state plan does not include this MATI service.	MATI participants will receive up to 8 units of CBT group a month.	12.00 fifteen minutes
Urine Drug Screen - Collection **	The state plan does not include this MATI service.	MATI participants are eligible for collection of up to 8 specimens a month and no more than 1 in a single day.	8.00 per collection
Oral Swab Drug Screen - Collection**	The state plan does not include this MATI service.	MATI participants are eligible for collection of up to 8 specimens a month and no more than 1 in a single day.	8.00 per collection
TB test*	The MATI program will follow the Medicaid state plan with no variance.	N/A	10.00 per test
Continuing Care Review - LOCI	The state plan does not include this MATI service.	MATI participants will receive up to 1 continuing care review a month.	25.00 twenty minutes

MATI - Medically Assisted Treatment Initiative

MATI Co-Occurring Mental Health and Substance Use Disorder Services¹			
Service Name	Description	Comment	
Case Management - co-occurring disorder in a SA treatment facility	The state plan does not include this MATI service.	MATI participants will receive up to 8 units of case management a month.	12.00 fifteen minutes
Comprehensive Evaluation - co-occurring disorder in a SA treatment facility	The state plan does not include this MATI service.	MATI participants are eligible for up to 6 units of comprehensive intake evaluation in a month.	26.00 thirty minutes
Crisis Intervention - co-occurring disorder in a SA treatment facility	The state plan does not include this MATI service.	MATI participants will receive up to 8 units of crisis intervention a month and no more than 8 units in a single day.	13.00 fifteen minutes
Family Therapy (with patient)*	The MATI program will follow the Medicaid state plan with no variance.	N/A	24.50 thirty minutes
Family Therapy (without patient)	The state plan does not include this MATI service.	MATI participants are eligible for up to 10 units of family therapy a month and no more than 2 units in a single day.	24.50 thirty minutes
Individual Therapy *	The MATI program will follow the Medicaid state plan with no variance.	N/A	24.50 thirty minutes
Clinical Consultation - co-occurring disorder in a SA treatment facility	The state plan does not include this MATI service.	MATI participants will receive up to 6 units of clinical consultation a month and no more than 4 units in a single day.	25.00 thirty minutes
Medication Monitoring -Co-Occuring*	The MATI program will follow the Medicaid state plan with no variance.	N/A	42.00 fifteen minutes
Psychiatric Evaluation*	The MATI program will follow the Medicaid state plan with no variance.	N/A	32.00 fifteen minutes

MATI - Medically Assisted Treatment Initiative

MATI Residential Community-Based SA Treatemnt Services ²			
Service Name	Description	Comment	
Short Term Residential	N/A	N/A	147.00 day
Long Term Residential	N/A	N/A	68.00 day
Halfway House	N/A	N/A	57.00 day
Detoxification Level III.7	N/A	N/A	204.00 day
Medically Enhanced Detoxification Level III.7 D Enhanced	N/A	N/A	416.00 day

* MATI rates for these services are higher than State Plan service rates.

** Does not include single or multiuse device lab testing.

¹Co-Occurring services were not included in original budget projection; however, anticipated costs for these services will not exceed projected costs for the program. The independent assessment component in the original budget is no longer required.

²These services are subject to IMD exclusion and not proposed for state plan inclusion; however, MATI participants will be able to access these services through state funds based on clinical need.

ATTACHMENT F – BHO/ASO BENEFIT AND PAYMENT TABLE

Services	Payment Methodology/ Responsibility
Ambulatory care	
Assessment and treatment of a BH condition when provided by a BHO authorized provider	FFS/ASO/BHO
Assessment and treatment of a BH condition when provided by a MCO authorized provider (i.e., PCP office visit for depression)	MCO
Services utilizing methadone treatment for maintenance, Cyclazocine, or their equivalents	FFS/ASO/BHO
24-hour care	
Admission to an acute care hospital, psychiatric facility or other specialty facility when ordered by a BHO authorized provider for the treatment of a BH condition, excluding detoxification	FFS/ASO/BHO
Admission by a BHO authorized provider for subacute medically managed detoxification or subacute enhanced detoxification	FFS/ASO/BHO
Detoxification in a medical bed for acute withdrawal, seizures, Delirium Tremens or medical instability when ordered by a MCO authorized provider	MCO
Stabilization in a medical bed or in ICU for treatment of eating disorders or following attempted suicide or self-induced trauma poisoning	MCO
Emergency department (ED)	
Facility and professional fees for primary BH diagnoses (codes 291 to 319 except as noted under “Miscellaneous” at the end of this table)	FFS/ASO/BHO

Services	Payment Methodology/ Responsibility
Facility charges and professional fees for primary PH diagnosis, including medical stabilization for attempted suicide or self-induced trauma poisoning	MCO
Consults	
BH consult on medical surgical unit, nursing home or assisted living facility, with the exception of individuals in MLTSS who will have their BH services provided by the MCO.	Determinant is treating provider type
Medical/surgical consult on a BH unit	MCO
Prescription Drugs	
Prescription drugs – outpatient cost of drug including atypical antipsychotic drugs and medications for addictions treatment (ie, buprenorphine) except methadone for addiction treatment	MCO
In office administration (i.e., medication assisted therapies, injectable drugs)	Determinant is treating provider type
Methadone maintenance programs	FFS/ASO/BHO
Ambulance	
Transport to the hospital when primary diagnosis is medical, including medical stabilization for suicide attempt, and transfers from psychiatric or substance use disorder treatment bed to a medical bed	MCO
Outpatient diagnostic procedures	
When ordered by a BHO network provider (i.e., x-rays, EKG, laboratory work such as therapeutic drug levels, complete drug count (CBC), urinalysis, etc.)	Determinant is treating provider type

Services	Payment Methodology/ Responsibility
When ordered by a MCO network provider (i.e., tests ordered prior to having a patient medically cleared or for the evaluation of medical problems such as CT scans, thyroid studies, EKG, etc.)	MCO
Psychological testing	
Psychological or neuropsychological testing when approved by the BHO	FFS/ASO/BHO
Neuropsychological testing when ordered by a MCO authorized provider as part of a comprehensive neurological evaluation or treatment program	MCO
Miscellaneous	
Any BH service delivered through an FQHC	Determinant is treating provider type
Electroconvulsive therapy, including anesthesiology services	FFS/ASO/BHO
Assessment and treatment of chronic pain	Determinant is treating provider type
TBI – out patient psycho-therapy, psychiatric consultation	Determinant is treating provider type
TBI – medical or medical rehabilitation programs	MCO
Treatment for caffeine related disorders	MCO
Treatment for nicotine related disorders (including smoking cessation programs)	Determinant is treating provider type

Services	Payment Methodology/ Responsibility
Treatment for disorders which are primarily neurologically or organically based, including delirium, dementia, amnesia and other cognitive disorders	MCO
Treatment for Korsakoff's disease/Wernicke's	MCO
Treatment for fetal alcohol syndrome or other symptoms exhibited by newborns whose mothers abused drugs	MCO
Treatment for primary sleep disorders	Excluded

Attachment G

DSRIP Planning Protocol

[PLACEHOLDER: TO BE WRITTEN LATER]

Attachment H

DSRIP Plan

[PLACEHOLDER: TO BE WRITTEN LATER]

Attachment I

Hospitals Eligible For Transition And DSRIP Payments

Medicaid No.	Medicare No.	Hospital Name
3674100	310001	HACKENSACK UNIVERSITY MEDICAL CENTER
4135008	310002	NEWARK BETH ISRAEL MEDICAL CENTER
4135105	310003	PALISADES GENERAL HOSPITAL
4135202	310005	HUNTERDON MEDICAL CENTER
4135300	310006	ST. MARY'S HOSPITAL (PASSAIC)
4135407	310008	HOLY NAME HOSPITAL
4135504	310009	CLARA MAASS MEDICAL CENTER
4135601	310010	UNIVERSITY MED CTR PRINCETON
4135709	310011	CAPE REGIONAL MEDICAL CENTER
4135806	310012	VALLEY HOSPITAL
4136004	310014	COOPER HOSPITAL/UNIVERSITY MEDICAL CTR
4136101	310015	MORRISTOWN MEMORIAL HOSPITAL
3674207	310016	CHRIST HOSPITAL
4136209	310017	CHILTON MEMORIAL HOSPITAL
4136403	310019	ST. JOSEPH'S HOSPITAL MEDICAL CENTER
4136403	310019	ST. JOSEPH'S HOSPITAL - Wayne
4136608	310021	ST. FRANCIS MEDICAL CENTER (TRENTON)
3674304	310022	VIRTUA - WEST JERSEY HOSPITAL Voorhees
3674304	310022	VIRTUA - WEST JERSEY HOSPITAL Berlin
3674304	310022	VIRTUA - WEST JERSEY HOSPITAL Marlton
3674401	310024	ROBERT WOOD JOHNSON AT RAHWAY HOSPITAL
4136705/0167011	310025	BAYONNE HOSPITAL
4136900	310027	TRINITAS - ELIZABETH GENERAL
4137001	310028	NEWTON MEMORIAL HOSPITAL
4137108	310029	OUR LADY OF LOURDES MEDICAL CENTER
4137205	310031	DEBORAH HEART & LUNG CENTER
3674509	310032	SOUTH JERSEY HEALTH SYSTEM
4137400	310034	RIVERVIEW MEDICAL CENTER
4137701	310038	R. W. JOHNSON UNIVERSITY HOSPITAL
4137809	310039	RARITAN BAY MED CTR - Perth Amboy Div.
4137809	310039	RARITAN BAY MED CTR - Old Bridge Div.
4137906/0249297	310040	HOBOKEN UNIV MED CTR
3674606	310041	COMMUNITY MEDICAL CENTER
4138201	310044	CAPITAL HEALTH SYSTEM - MERCER CAMPUS
4138309	310045	ENGLEWOOD HOSPITAL ASSOCIATION
3674703	310047	SHORE MEMORIAL HOSPITAL
4138406	310048	SOMERSET MEDICAL CENTER
4138601	310050	ST. CLARE'S-RIVERSIDE MEDICAL CTR DENVL
4138601	310050	ST. CLARE'S - Dover
3674801	310051	OVERLOOK HOSPITAL
3674908	310052	MEDICAL CENTER OF OCEAN COUNTY
4138708/0139564	310054	MOUNTAINSIDE HOSPITAL
4138902	310057	MEMORIAL HOSP OF BURLINGTON CTY (Virtua)

Attachment I

Hospitals Eligible For Transition And DSRIP Payments

Medicaid No.	Medicare No.	Hospital Name
4139003	310058	BERGEN PINES COUNTY (Bergen Reg'l) HOSPITAL
4139208	310060	ST. LUKE'S HOSPITAL (formerly Warren Hospital)
3675203	310061	LOURDES MED CTR OF BURLINGTON CNTY
4139402	310064	ATLANTICARE REG'L MED CTR - Mainland Div.
4139402	310064	ATLANTICARE REG'L MED CTR - City Div.
3675602	310069	SOUTH JERSEY HEALTH SYSTEM - ELMER
4139500	310070	ST. PETER'S MEDICAL CENTER
3675700	310073	JERSEY SHORE MEDICAL CENTER
4139801	310074	JERSEY CITY MEDICAL CENTER
3675807	310075	MONMOUTH MEDICAL CENTER
3675904	310076	ST. BARNABAS MEDICAL CENTER
3676102	310081	UNDERWOOD MEMORIAL HOSPITAL
4140001	310083	EAST ORANGE GENERAL HOSPITAL
3676200	310084	KIMBALL MEDICAL CENTER
4140206	310086	KENNEDY MEMORIAL HOSPITALS - Stratford
4140206	310086	KENNEDY MEMORIAL HOSPITALS - Cherry Hill
4140206	310086	KENNEDY MEMORIAL HOSPITALS - Washington Twp.
9031308	310091	MEMORIAL HOSPITAL OF SALEM COUNTY
3676609	310092	CAPITAL HEALTH SYSTEM - FULD CAMPUS
4140508	310096	ST. MICHAEL'S MEDICAL CENTER
3676803	310108	JFK MEDICAL CENTER {EDISON} / Anthony M. Yelencics
3676901	310110	RWJ UNIVERSITY MEDICAL CTR AT HAMILTON
4141008	310111	CENTRASTATE MEDICAL CENTER
4141105	310112	BAYSHORE COMMUNITY HOSPITAL
4141202	310113	SOUTHERN OCEAN COUNTY HOSPITAL
4141300	310115	HACKETTSTOWN COMMUNITY HOSPITAL
4141504/0249297	310118	MEADOWLANDS HOSPITAL MEDICAL CENTER
3677001	310119	UNIVERSITY HOSPITAL (UMDNJ)
4141601	310120	ST. CLARE'S HOSP SUSSEX (WALLKILL VALLEY)



State of New Jersey
DEPARTMENT OF HUMAN SERVICES
PO Box 700
TRENTON NJ 08625-0700

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

JENNIFER VULLAZ
Commissioner

November 9, 2012

Lane Terwilliger
Centers for Medicare and
Medicaid Services
Center for Medicaid, CHIP and
Survey and Certification
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Ms. Terwilliger:

I am writing to accept the Special Terms and Conditions (STCs) and award letter, dated October 2, 2012, for the New Jersey Comprehensive Waiver Demonstration (Demonstration).

The approval of the Demonstration will assist New Jersey in attaining our goal of preserving and sustaining our Medicaid program for decades to come through delivery system reform. It allows us to use savings to improve services for populations that are currently underserved, such as those with developmental disabilities and those with significant behavioral health care needs, as well as rebalancing our long-term care expenditures.

We appreciate the opportunity afforded us to review the STCs and are requesting some technical corrections prior to finalizing the agreement. The enclosed document outlines our proposed technical corrections which do not impact budget neutrality.

Please forward official communications regarding program matters to:

Valerie Harr, Director
Division of Medical Assistance and Health Services
NJ Department of Human Services
P.O. Box 712
Trenton, NJ 08625-0712
Telephone: 609-588-2600
Facsimile: 609-588-3583
E-mail: valerie.j.harr@dhs.state.nj.us

Lane Terwilliger
November 9, 2012
Page 2

I would like to thank you and your team for the dedicated time and effort, resources, and collaborative engagement throughout the review process. New Jersey looks forward to operationalizing a successful Demonstration for our Medicaid beneficiaries.

Sincerely,

/Jennifer Velez/

Jennifer Velez
Commissioner

JV:2:jc

Enclosure

c: Valerie Harr
Cindy Mann
Victoria Wachino
Michael Melendez

New Jersey Department of Human Services
Technical Corrections to the
Comprehensive Waiver Special Terms and Conditions

Below is New Jersey's request for technical correction to the Comprehensive Waiver Special Terms and Conditions, Waiver Authority and Expenditure Authority. New Jersey is requesting five technical corrections. Please note that these requested technical corrections do not impact budget neutrality.

1. Transfer of Assets

The transfer of assets 5 year look back period STC and Waiver Authority change the State's intended process concerning the transfer of assets eligibility process. The intended process was to have all applicants with income up to 100% FPL self-attest and if the individual attested that no assets were transferred the state would *not* perform required asset research. If the individual attested that he or she did transfer assets the required research would be done. The way the approval documents describe it now is an elimination of a penalty. The proposed language change is outline below:

Approved Waiver Authority

Transfer of Assets Section 1902(a)(18)

Current language in final approval documents:

"To enable the State not to impose penalties on individuals who are enrolled in HCBS benefit programs whose transfer assets but have incomes at or below 100 percent of the FPL."

Proposed change:

"Eliminate the five year look back at time of application for applicants or beneficiaries seeking long term services and supports who have income at or below 100 percent of the Federal Poverty Level (FPL);"

Special Terms and Conditions (STCs)

Page 3 - PROGRAM DESCRIPTION AND HISTORICAL CONTEXT

This five year demonstration will:

Current language in final approval documents:

"Eliminate penalties for beneficiaries who transfer assets prior to seeking nursing facility services and have income at or below 100 percent of the Federal Poverty Level (FPL);"

Proposed change:

"Eliminate the five year look back at time of application for applicants or beneficiaries seeking long term services and supports who have income at or below 100 percent of the Federal Poverty Level (FPL);"

Page 4 - Demonstration Hypothesis

The State will test the following hypotheses in its evaluation of the demonstration:

Current language in final approval documents:

"Utilizing a projected spend-down provision and eliminating the penalty for transfer of assets for long term care and home and community based services will simplify Medicaid eligibility and enrollment processes without compromising program integrity."

Proposed change:

"Utilizing a projected spend-down provision and eliminating the look back period at time of application for transfer of assets for applicants or beneficiaries seeking long term services and supports whose income is at or below 100% of the FPL will simplify Medicaid eligibility and enrollment processes without compromising program integrity."

STC21 – Transfer of Assets

Current language in final approval documents:

Transfer of Assets. New Jersey will not apply any transfer of assets penalty under section 1917 of the Act for long term care beneficiaries with income at or below 100 percent of the FPL.

Proposed change:

Transfer of Assets. At the time of application for long term care and home and community based services, based on self-attestation, New Jersey will not review assets pursuant to section 1917 of the Act for applicants or beneficiaries seeking long term services and supports with income at or below 100 percent of the FPL."

STC 134 (iv) - EVALUATION OF THE DEMONSTRATION

Current language in final approval documents:

"iv. What is the impact of eliminating the Transfer of assets look-back period for long term care and home and community based services for individuals who are at or below 100 percent of the FPL. Was there a change in the number of individuals or on the mix of individuals qualifying for Medicaid due to this provision?"

Proposed change:

"iv. What is the impact of using self-attestation on the Transfer of assets look-back period for long term care and home and community based services for individuals who are at or below 100 percent of the FPL. Was there a change in the number of individuals or on the mix of individuals qualifying for Medicaid due to this provision?"

2. Expenditure Authority:

Current language in final approval documents:

Expenditure for HCBS Services furnished to Low-Income Individuals who Transferred Assets - Expenditures for HCBS services that would not otherwise be covered based on a transfer of assets by the low-income individual as described in section 1917(c) of the Act."

Proposed change:

Expenditure for HCBS/ML TSS furnished to Low-Income Individuals who Transferred Assets – Expenditures for the provision of long term care and home and community based services that could be provided under the authority of section 1915(c) waivers, that would not otherwise be covered due to a transfer of assets penalty when the low-income individual has attested that no transfers were made during the look back period.

3. Federal reporting requirements:

STC #115

- Item a) The STCs indicate the Medicaid Expansion up to 133 percent of the FPL should be reported on the CMS 21. We believe this should be changed to the CMS64.21 U form on the CMS 64 instead.
- Item d) The STCs indicate that CHIP Pregnant Women are part of the demonstration. We believe they are part of the CHIP State Plan and should not be included in the demonstration reporting.

STC #117

- The STC indicates CMS will make federal funds available based on the State estimate on the CMS 21B. The CHIP allotment is based on the previous year expenditures and/or budget and not related to the CMS 21B estimate. The language in this STC is appropriate for the Title XIX funding process, but not for Title XXL

STC #122

- The STC should describe Populations 21, 22, and 23.

STC #123

- The STC states the State shall provide CMS with 60 days' notice before drawing down funds for Population 1. This condition is unclear and maybe unnecessary.

STC #124

- The STC should describe Populations 2 and 3.
-

4. Premium Support Program:

New Jersey is requesting a technical correction to the cost-effectiveness language under STC #84(f) - see language below:

- i. Cost-effectiveness shall be determined in the aggregate by comparing the cost, including administrative costs, of all eligible members' participation in the NJ FamilyCare program against the total cost to the State of reimbursing eligible members for their employer-sponsored insurance. The amounts used for the calculations (including risk-adjusted capitation rates) shall be derived from actuarial tables used by the NJ FamilyCare program and actual costs reported by the employer during the processing of the NJFC/PSP application.
- ii. The cost of the employer-sponsored plans shall be determined by totaling the amount of the employees' premiums plus the actuarial value of all "wraparound" services, if applicable, minus any NJFC premium contributions owed to the State under the CHIP state plan.
- iii. As a condition of PSP approval, the result of the cost-effectiveness test in the aggregate shall indicate a cost savings difference of, at a minimum, five percent between what the State would pay for the beneficiaries' participation in their employer-sponsored plans and NJFC vs. what the State would pay for their participation in the NJFC program alone.
- iv. If the employer-sponsored plans are determined by the Division to be cost-effective in the aggregate in accordance with (i) above, the applicants shall participate in the Premium Support Program. If the employer-sponsored plans are determined not to be cost-effective, in accordance with (i) above, the applicants will continue to participate solely in the NJ FamilyCare program.

5. Transition plan from FFS Programs to Managed Care Delivery System:

- New Jersey is requesting to technically correct STC #63(f).
- The STC currently states that the state send informing notices to the beneficiaries no less than 60 days prior to implementation of MLTSS. We are requesting to change this to no less than 45 days, due to our eligibility system programming. Please note that beneficiaries will be receiving at least four notices prior to the implementation of MLTSS beginning 90 days prior to implementation.