

**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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NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
				<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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NJ Program Name	Population Description and Statutory/Regulatory Citations	Standards and Methodologies	Service Package	MEG
		<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 Resources SSI 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> “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 Resources SSI 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> “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

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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

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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