DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

APR 14 2011

Commissioner Jennifer Velez
Department of Human Services
State of New Jersey
P. O. Box 700
Trenton, NJ 08625-0700

Dear Commissioner Velez:

We are pleased to inform you that New Jersey's request for a new Medicaid section 1115(a) Demonstration entitled "New Jersey Childless Adults" (Project Number 11-W-00274/2) has been approved for the period starting April 15, 2011, through December 31, 2013.

Through this Demonstration, the State is approved to expand health care coverage to individuals who could have been included in the State plan in the optional eligibility category under section 1902(k)(2) of the Social Security Act (the Act) that was added by the Affordable Care Act of 2010. This Demonstration will permit a partial early implementation of the expansion required in 2014. The Demonstration will extend eligibility to low-income adults as defined in the attached New Jersey Childless Adults Demonstration Special Terms and Conditions (STCs).

The enclosed STCs and expenditure authority specify the agreement between the New Jersey Department Human Services Division of Medical Assistance and Health Services (the State) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the term of the Demonstration. This approval is subject to your written acceptance of the award letter within 30 days of the date of this letter.

Your project officer is Ms. Robin Preston, and she is available to answer any questions concerning your section 1115 Demonstration. Ms. Preston's contact information is as follows:

Ms. Robin Preston
Centers for Medicare & Medicaid Services
Center for Medicaid, CHIP and Survey & Certification
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-3420
Facsimile: (410) 786-5882
E-mail: robin.preston@cms.hhs.gov

Official communication regarding program matters should be submitted simultaneously to Ms. Preston and Mr. Michael Melendez, Associate Regional Administrator for the Division of Medicaid and Children's Health Operations in the CMS New York Regional Office. Mr. Melendez's contact information is as follows:

Mr. Michael Melendez
Associate Regional Administrator
Division of Medicaid and Children's Health Operations
26 Federal Plaza, Room 37-100 North
New York, NY 10278
Phone: (212)616-2430
Facsimile: (212)312-8652
Email: Michael.Melendez@cms.hhs.gov

We extend our congratulations to you on this award, and we appreciate your cooperation throughout the review process. If you have additional questions, please contact Ms. Victoria Wachino, Director, Children and Adults Health Programs Group, Center for Medicaid, CHIP and Survey & Certification at (410) 786-5647.

We look forward to continuing to work with you and your staff.

Sincerely,

/Donald M. Berwick, M.D./

Donald M. Berwick, M.D.

Enclosures

cc: Mr. Michael Melendez, Associate Regional Administrator
Ms. Victoria Wachino, Director, Children and Adults Health Programs Group

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

NUMBER: **11-W-00274/2 (Title XIX)**

TITLE: **New Jersey Childless Adults Demonstration**

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

DEMONSTRATION PERIOD: April 15, 2011 – December 31, 2013

I. PREFACE

The following are the Special Terms and Conditions (STCs) for New Jersey's section 1115(a) Medicaid 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 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.

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 December 31, 2013.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Historical Context
III. General Program Requirements
IV. General Reporting Requirements
V. Administrative Requirements
VI. General Financial Requirements Under Title XIX
VII. Monitoring Budget Neutrality for the Demonstration
VIII. Additional attachments have been included to provide supplementary information and guidance for specific STCs.

II. PROGRAM DESCRIPTION AND HISTORICAL CONTEXT

On February 24, 2011 the State of New Jersey submitted a Medicaid section 1115 Demonstration proposal which seeks to provide comprehensive health care benefits for approximately 57,000 individuals enrolled in the New Jersey Work First General Assistance program. The Work First Program is a State run program that provides cash assistance and other community support services to individuals and couples without children.

The "New Jersey Childless Adults" (NJCA) Demonstration is a statewide section 1115 Demonstration to expand health care coverage to individuals who could have been included in the optional eligibility category under section 1902(k)(2) of the Social Security Act (the Act) that was added by the Affordable Care Act of 2010. This Demonstration permits early partial implementation of the expansion required in 2014. The NJCA Demonstration would extend eligibility to adults ages 19 through 64 years old 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 meeting applicable working requirements based on a physical or mental condition and have countable monthly household incomes up to $210 for a childless adult and $289 for a childless couple. Such low-income individuals may enroll in the NJCA Demonstration and receive a comprehensive benefit package of primary and preventative and hospital based services delivered on a fee-for-service basis. The NJCA Demonstration seeks to further serve the objectives of title XIX by requiring New Jersey to seamlessly transition enrolled Demonstration enrollees to a coverage option available under the Patient Protection and Affordable Care Act (Affordable Care Act); and setting system modification milestones that will expedite the State's readiness for compliance with the requirements of the Affordable Care Act and other Federal legislation.

The State's goals in implementing the Demonstration are 1) to study trends that will prepare New Jersey for the implementation of provisions in the Affordable Care Act in 2014, and 2) to improve the health status of all New Jersey residents by:

- Increasing care management and coordination of Demonstration enrollees;
- Producing better health outcomes for those with chronic conditions;
- Reducing the number of emergency room visits and hospital admissions by offering primary care services.

III. GENERAL PROGRAM REQUIREMENTS

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

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, or 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), must apply to the Demonstration.

3. **Changes in Medicaid 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 program 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, modified budget neutrality and allotment neutrality agreements for the Demonstration as necessary to comply with such change. The modified agreements 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 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 title XXI State plan amendments for changes affecting any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid State Plan is affected by a change to the Demonstration, a conforming amendment to the appropriate State Plan may be required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process**. Changes related to eligibility, enrollment, benefits, cost sharing, 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.

    a. Amendment requests must include, but are not limited to, the following:

i. An explanation of the public process used by the State, consistent with the requirements of paragraph 6 to reach a decision regarding the requested amendment;

ii. 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;

iii. A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

iv. If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

b. Changes to benefits described in the State plan shall be made by State plan amendment. Changes to benefits not described in the State plan shall be made by amendment to the Demonstration. Changes in benefits shall be implemented in accordance with the process set forth in paragraph 6 of these STCs.

8. **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.

9. **Demonstration Phase Out.** The State may suspend or terminate this Demonstration in whole or in part at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State must submit a phase-out plan to CMS at least 6 months prior to initiating phase-out activities. Nothing herein should be construed as preventing the State from submitting a phase-out plan with an implementation deadline shorter than 6 months when such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval prior to implementation of phase out. If the project is terminated or any relevant waivers suspended by the State, FFP must be limited to normal closeout costs associated with terminating the Demonstration, including services and administrative costs of disenrolling participants.

10. **Enrollment Limitation During Demonstration Phase-Out**. If the State elects to suspend, terminate, or not renew this Demonstration as described in paragraph 9, during the last 6 months of the Demonstration, the State may choose to not enroll individuals into the Demonstration who would not be eligible for Medicaid under the current Medicaid State plan. Enrollment may be suspended if CMS notifies the State in writing that the Demonstration will not be renewed.

11. Finding of Non-Compliance. The State does not relinquish its rights to challenge the 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 and/or XXI. 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 for reconsideration of the 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. Adequacy of Infrastructure. The State must 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.

14. Public Notice, Tribal Consultation, and Consultation with Interested Parties. The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to section 1902(a)(73) of the Act (as added by section 5006(e)(2) of the American Recovery and Reinvestment Act of 2009 (ARRA)), when any program changes to the Demonstration, including (but not limited to) those referenced in paragraph 6 are proposed by the State. 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 waiver proposal, amendment, and / or renewal of this Demonstration. In the event that the State conducts additional consultation activities consistent with these requirements prior to the implementation of the Demonstration, documentation of these activities must be provided to CMS.

15. FFP. No Federal matching funds for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter.

16. Eligibility Criteria. Demonstration eligibles are individuals who are:

a. Non-pregnant (including 60 day post-partum);
b. Childless or non-custodial adults age 19 through 64 years;
c. Not eligible for Medicaid under the State plan, Medicare, CHIP or are otherwise insured;
d. U.S. citizens, nationals/qualified non-citizens and residents of New Jersey; and
e. Either:
    i. 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,
    ii. have a medical deferral from applicable working requirements because of a physical or mental condition, which prevents them from working requirements

and have countable monthly household incomes up to $210 for a childless adult and $289 for a childless couple.

17. **Eligibility Determinations.** Eligibility determinations for the Demonstration eligible populations must be made by individuals who are employed under merit system principles by the State governments. These employees will refer any applicant who may be eligible for either Medicaid or CHIP to the State or local government social services office for an eligibility determination. Any individual eligible for either Medicaid or CHIP is not eligible for enrollment into the Demonstration. Individuals who would only be financially eligible based on a medical deferral from work requirements, and who appear to have a physical or mental condition that would prevent compliance with applicable work requirements, will be promptly referred to a health professional qualified to issue a medical deferral.

18. **Eligibility Redeterminations -** Individuals enrolled in the Demonstration must have an eligibility redetermination at least once every 12 months and must have eligibility redetermination within 1 month after the occurrence of any of the circumstances described in STC 21, or a determination of eligibility for SSI benefits.
    a. Each redetermination must include a reassessment of the individual's eligibility for Medicaid and CHIP. If upon a redetermination, an individual is determined ineligible the individual shall be disenrolled and referred to the State Medicaid Agency.
    b. A Demonstration enrollee may apply for eligibility under Medicaid or CHIP at any time for any reason. The State will determine eligibility for Medicaid and CHIP and enroll individuals in programs for which they are found eligible.

19. **Retroactive Eligibility.** Demonstration enrollees may be enrolled effective the first day of the month in which the application for the Demonstration is made.

20. **Enrollment – Demonstration** eligible individuals
    a. May apply for the Demonstration at any of the 21 County Welfare Agencies or designated municipal welfare offices.
    b. If found eligible, will be simultaneously enrolled into the New Jersey Childless Adults Demonstration, the New Jersey Hospital Care Payment Assistance Program (Charity Care), and the Substance Abuse Initiative (SAI).
    c. Will be issued a NJCA Health Insurance card - that will allow the participant to access services from Medicaid providers, SAI providers and at Charity Care Hospitals. No additional application will be required or enrollee balance billing be permitted.
    d. Will receive a handbook that provides a list of services as well as contact information to obtain a FFS provider in the client's area.
    e. The New Jersey Medical Assistance Customer Assistance Centers (field offices) will assist the Demonstration population in finding a provider, and a Medicaid hotline as well as a website (which includes a provider directory) will be made available to Demonstration enrollees to assist them in locating a Medicaid participating provider.

21. **Disenrollment. -** Demonstration enrollees will be disenrolled in accordance with Medicaid law and policy if they:
    a. No longer reside in the State of New Jersey.

b. Exceed income limits allowed for the program at redetermination;
c. Voluntarily withdraw from the program
d. Become incarcerated or are institutionalized in an IMD;
e. Attain age 65;
f. Are no longer living; or
g. Obtain other health coverage.

22. Seamless Coordination of Benefits. The Demonstration populations will receive a full array of health care benefits through the Demonstration. Benefits are assessable through the following Programs:

a. **Ambulatory Care Benefits** – are made available through the New Jersey Childless Adults Demonstration, formerly known as Plan G, covers medical care received from a non-hospital staff, Medicaid provider and includes:
   i. Physician's services
   ii. Dental care
   iii. Prescription medicines
   iv. Durable medical equipment
   v. EPSDT for Demonstration enrollees 19-21
   vi. Family Planning
   vii. Hearing aid services
   viii. Medically-related transportation
   ix. Chiropractic for spinal manipulation
   x. Laboratory and radiological services
   xi. Ambulatory surgery (independent facility)
   xii. Vision and eye glasses
   xiii. Podiatry services (not routine care)
   xiv. Prosthetics and orthotics
   xv. Independent clinic services
   xvi. Speech, occupational, and physical therapies
   xvii. Inpatient psychiatric services at Mt. Carmel Guild (Newark)

b. **Hospital Benefits** – are made available through The New Jersey Hospital Care Payment Assistance Program (Charity Care Assistance) which is not part of the NJCA Demonstration, but provides benefits coordinated with the NJCA Demonstration. . Demonstration enrollees will receive free care which is provided to patients who receive inpatient and outpatient services at acute care hospitals throughout the State of New Jersey.

c. **Behavioral Health Benefits** - are made available through The New Jersey Substance Abuse Initiative (SAI), which is not part of the NCJA Demonstration, but provides benefits coordinated with the NJCA Demonstration. The SAI combines public health and managed care principles to provide substance abuse services for eligible Temporary Assistance to Needy Families (TANF) and General Assistance (GA)

clients. Consistent with the goals of NJCA, the SAI uses an employment-directed approach to address substance abuse as a barrier to work activities.

The SAI is operational statewide. It has two key components: (1) a managed care model of Assessment and Case Management services, and (2) prior authorization fee-for-service treatment offered by providers in the SAI Provider Network.

d. Changes to any of the benefits in the programs described in paragraphs a, b, and c above directly impacting the Demonstration population will require an amendment to the Demonstration.

23. Cost Sharing. All cost-sharing must be in compliance with Medicaid requirements for State plan populations that are set forth in statute, regulation and policies and all Demonstration enrollees must be limited to a 5% aggregate cost sharing limit per family.

24. Delivery System. The State will provide all coverage for services to enrollees in the Demonstration on a fee for service (FFS) basis. Services may be obtained from any participating Medicaid qualified provider. Providers will be paid consistent with the rates under the approved State plan.

25. Network Adequacy and Access Requirements for the Demonstration Population. 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 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.

26. Managed Care Delivery Systems for the Demonstration Population. If the State chooses to use a managed care delivery system to provide benefits to the Demonstration population, any managed care delivery system which uses managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), prepaid ambulatory health plans (PAHPs) or primary care case management systems (PCCMs) [collectively referred to as managed care entities] is

subject to all applicable Medicaid laws and regulations. Prior to any change in delivery system the State must amend the Demonstration as specified in paragraph 7.

IV GENERAL REPORTING REQUIREMENTS

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

28. 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**
Demonstration Population 1			
Demonstration Population 2			
Totals			

29. 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, 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.

30. Quarterly Progress Reports. The State must submit quarterly progress reports in accordance with the guidelines in Attachment A no later than 30 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, grievances, quality of care, and access that is relevant to the Demonstration, pertinent legislative or litigation activity, and other operational issues;
c. Action plans for addressing any policy, administrative, or budget issues identified;
d. Quarterly enrollment reports for Demonstration enrollees, 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; and
e. Medicaid Hotline Reporting – Complaints, Grievances and Appeals
f. Evaluation activities and interim findings.

31. Annual Report.

a. The State must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, and policy and administrative difficulties and solutions in the operation of the Demonstration.
b. The State must submit the draft annual report no later than 120 days after the close of the Demonstration year (DY).
c. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

32. Transition Plan. As this Demonstration will not be extended by CMS beyond December 31, 2013, the State is required to prepare, and incrementally revise, a Transition Plan. By October 1, 2012, the State must submit to CMS for review and approval an initial Transition Plan, consistent with the provisions of the Affordable Care Act for all individuals enrolled in the Demonstration. The plan must contain the required elements and milestones described in subsections a-f outline below. In addition, the Plan will include a schedule of implementation activities that the State will use to operationalize the Transition Plan.

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

    i. Determine eligibility under all January 1, 2014 eligibility groups for which the State is required or has opted to provide medical assistance, including the group described in §1902(a)(10)(A)(i)(VIII) for individuals under age 65 and regardless of disability status with income at or below 133 percent of the FPL.

    ii. Identify Demonstration populations not eligible for coverage under the Affordable Care Act and explain what coverage options and benefits these individuals will have effective January 1, 2014.

iii. Implement a process for considering, reviewing, and making preliminarily determinations under all January 1, 2014 eligibility groups for new applicants for Medicaid eligibility.

iv. Develop a modified adjusted gross income (MAGI) calculation for program eligibility. The State may implement prior to January 1, 2014.

b. **Access to Care and Provider Payments**.

i. **Provider Participation**. The State must identify the criteria that will be used for reviewing provider participation in (e.g., demonstrated data collection and reporting capacity) and means of securing provider agreements for the transition.

ii. **Adequate Provider Supply**. The State must provide the process that will be used to assure adequate provider supply for the State plan and Demonstration populations affected by the Demonstration on December 31, 2013. The analysis should address delivery system infrastructure/capacity, provider capacity, utilization patterns and requirements (i.e., prior authorization), current levels of system integration, and other information necessary to determine the current state of service delivery. The report must separately address each of the following provider types:
   a. Primary care providers
   b. Specialty providers.
   c. Mental Health services
   d. Substance Use Services.
   e. Dental

iii. **Provider Payments.** The State will establish and implement the necessary processes for ensuring accurate encounter payments to providers entitled to the prospective payment services (PPS) rate (e.g., certain FQHCs and RHCs) or the all inclusive payment rate (e.g., certain Indian Health providers).

c. **Systems Development or Remediation**. The Transition Plan for the Demonstration is expected to expedite the State's readiness for compliance with the requirements of the Affordable Care Act and other Federal legislation. System milestones that must be tested for implementation on or before January 1, 2014 include:

i. Tracking out-of-pocket charges in order to implement a 5 percent aggregate family cost sharing cap for low income population coverage options;

ii. Replacing manual administrative controls with automotive processes to support a smooth interface among coverage and delivery system options that is seamless to beneficiaries;

d. **Pilot Programs.** Progress towards developing and testing, when feasible, pilot programs that support Affordable Care Act-defined "medical homes," "accountable care organizations," and / or "person-centered health homes" to allow for more efficient and effective management of the highest risk individuals.

e. **Progress Updates.** After submitting the initial Transition Plan for CMS approval, the State must include progress updates in each quarterly and annual report. The Transition Plan shall be revised as needed.

f. **Implementation.**

i. By July 1, 2013, the State must begin implementation of 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.

33. Penalty. CMS reserves the right to impose a 2 percent FFP withhold for the Demonstration should the State fail to implement or operationalize the milestones listed in paragraph 32. The penalty amount will result in the loss of some percentage of the expenditures attributable to the Demonstration. If the State continues to fail to meet the Transition Plan requirements or milestones, CMS may impose incrementally larger percentages by which the annual expenditure authority cap will be reduced. The reduction in expenditure authority will be applied to the claims for Federal match of each Federal quarter. Once the requirement or milestone has been met, no further associated penalties will be imposed.

V. ADMINISTRATIVE REQUIREMENTS

34. General Requirements

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

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

i. The State must ensure that new applicants for the New Jersey Childless Adults Demonstration who meet the categorical requirements for Medicaid will be processed and enrolled in the State's Medicaid program. The application packets for the New Jersey Childless Adults program must continue to provide information regarding Medicaid eligibility and application that is subject to CMS review.

VI. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

37. 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. Consistent with section V of these STCs, FFP under the Demonstration will not be provided for hospital inpatient, hospital outpatient (including behavioral and non-behavioral health services), emergency hospital, transplant, and related professional service/charges rendered by hospital staff .

a. 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-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All expenditures subject to the budget neutrality limit will be reported on separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the Demonstration project number assigned by CMS (including the project number extension, which indicates the DY in which services were rendered or for which capitation payments were made). For monitoring purposes, cost settlements must be recorded on Line 10.b, in lieu of Lines 9 or l0.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. The term, "expenditures subject to the budget neutrality limit," is defined below in paragraph 38.

b. The first Demonstration Year (DY1) will be the year beginning April 15, 2011, and ending March 31, 2012, and subsequent DYs will be defined as follows:

Demonstration Year 1 (DY1)	April 15, 2011 to March 31, 2012	11.5 months
Demonstration Year 2 (DY2)	April 1, 2012 to March 31, 2013	12 months
Demonstration Year 3 (DY3)	April 1, 2013 to December 31, 2013	9 months

c. For each DY, separate Forms CMS-64.9 Waiver and/or 64.9P Waiver shall be submitted reporting expenditures for individuals enrolled in the Demonstration,

subject to the budget neutrality limit (section VII of these STCs). The State must complete separate waiver forms for the following eligibility groups/waiver names:

i. NJCA – "Employable"- Individuals complying with work requirements
ii. NJCA – "Unemployable" – Individuals with medical deferral from work requirements.

38. Expenditures Subject to the Budget Agreement. For the purpose of this section, the term "expenditures subject to the budget neutrality limit" will include all Medicaid expenditures on behalf of all Demonstration enrollees (i.e., Demonstration Population), for services listed in paragraph 22(a) of the STCs.

39. 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".

40. 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.

41. 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 enrollees. Enrollment information should be provided to CMS in conjunction with the quarterly and monthly enrollment reports referred to in section IV of these STCs. If a quarter overlaps the end of one DY and the beginning of another DY, member/months pertaining to the first DY must be distinguished from those pertaining to the second.

a. The term "eligible member/months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes three eligible member/months to the total. Two individuals who are eligible for 2 months each contribute two eligible member months to the total, for a total of four eligible member/months.

b. The Demonstration Population will be reported for the purpose of calculating the without waiver baseline (budget neutrality expenditure limit) using the following waiver names. The group used for calculating the budget neutrality expenditure limit is described below:

i. "Employable Demonstration Population" is a hypothetical group as defined in paragraph 37 who would be eligible for Medicaid within the group defined at section 1902(k) as authorized by the Affordable Care Act.

ii. "Unemployable Demonstration Population" is a hypothetical group as defined in paragraph III of these STCs, who would be eligible for Medicaid within the group defined at section 1902(k), as authorized by the Affordable Care Act.

42. 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.

43. 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 54:

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.

44. 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.

45. 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.

VII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

46. Limit on Title XIX Funding. The State will be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The limit is determined by using the per capita cost method described in paragraph 51, 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.

47. Risk. The State will be at risk for the per capita cost (as determined by the method described below) for both the Employable and Unemployable Demonstration Populations as defined in STC 37, but not at risk for the number of enrollees 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.

48. Calculation of the Budget Neutrality Limit: General. For the purpose of calculating the overall budget neutrality limit for the Demonstration, separate annual budget limits will be calculated for each DY on a total computable basis, as described in paragraph 54 below. The annual limits will then be added together to obtain a budget neutrality limit for the entire Demonstration period. The Federal share of this limit will represent the maximum amount of FFP that the State may receive during the Demonstration period for the types of Demonstration expenditures described below. The Federal share will be calculated by multiplying the total computable budget neutrality limit by the Composite Federal Share, which is defined in paragraph 54 below.

49. 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.

50. "Hypothetical" Eligibility Groups. 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. For this Demonstration, these are the "Demonstration Populations." 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.

51. Demonstration Populations Used to Calculate the Budget Neutrality Limit. For each DY, separate annual budget limits of Demonstration service expenditures will be calculated as the product of the trended monthly per person cost times the actual number of eligible/member months as reported to CMS by the State under the guidelines set forth in paragraph 41 of these STCs. The trend rates and per capita cost estimates for each EG for each year of the Demonstration are listed in the table below.

Demonstration Populations	DY 1 - PMPM	NJCA Trend	DY 2 - PMPM	NJCA Trend	DY 3 - PMPM
Employable	$267	3.71%	$277	3.71%	$288
Unemployable	$267	3.71%	$277	3.71%	$288

52. Composite Federal Share Ratio. 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. 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.

53. Exceeding Budget Neutrality. The budget neutrality limit calculated in paragraph 54 will apply to actual expenditures for Demonstration services as reported by the State under section VI 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.

54. 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	Cumulative budget neutrality cap plus:	0 percent

XII. EVALUATION OF THE DEMONSTRATION

55. Submission of a Draft Evaluation Plan. 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. At a minimum, the draft design shall include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those that focus specifically on the target population for the Demonstration. The draft design shall discuss the outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval, particularly among the target population. It shall discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design shall include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the State. The draft design shall identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

As a component of the draft evaluation plan for the Demonstration, the State will conduct an outcomes analysis of the impact of CMS approved cost sharing changes on enrollment and utilization of services.

Evaluation Topics. In preparation for implementation of the provisions of the Affordable Care Act, the State will:

a. Evaluate key program outcomes to determine the program's effectiveness;

b. Include any limitations, challenges, or opportunities presented by the Demonstration;

c. Include successes or best practices, interpretations or conclusions reached during the Demonstration;

d. Examine and review the objectives and the hypotheses proposed as part of this Demonstration; and

e. Inform CMS of the status of the State's evaluation in the quarterly and annual reports using the timeframes specified herein.

56. Final Evaluation Design and Implementation. CMS shall provide comments on the draft evaluation plan within 60 days of receipt, and the State shall submit a final design within 60 days after receipt of CMS comments. The State shall implement the evaluation plan and submit its progress in each of the quarterly and annual reports. The State shall submit to CMS a draft of the evaluation report within 120 days after expiration of the Demonstration. CMS shall provide comments within 60 days after receipt of the report. The State shall submit the final evaluation report within 60 days after receipt of CMS comments.

57. CMS Independent Evaluation. 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.

XIII. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Date	Deliverable	Paragraph
30 days after approval date	State acceptance of Demonstration Waivers, STCs, and Expenditure Authorities	Approval letter
120 days after approval date	Submit Draft Design for Evaluation Report	Paragraph 55
October 1, 2012	Submit a Transition Plan	Paragraph 32
120 days after expiration of the Demonstration	Submit Draft Final Evaluation Report	Paragraph 56
60 days after receipt of CMS comments	Submit Final Evaluation Report	Paragraph 56
Monthly Deliverables	Monitoring Call	Paragraph 29
	Monthly Enrollment Report	Paragraph 28
Quarterly Deliverables Due 60 days after end of each quarter, except 4th quarter	Quarterly Progress Reports	Paragraph 30 and Attachment A
	Quarterly Expenditure Reports	Paragraph 37
Annual Deliverable – Due July 1 of each year	Annual Review Plan	Paragraph 31
Annual Deliverables - Due 120 days after end of each 4th quarter	Annual Reports	Paragraph 31 and Attachment A

ATTACHMENT A

Pursuant to paragraph 30 *(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 Childless Adults 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: Approval Period XXX 1, 2011 – December 31, 2013

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 participant counts, not member months

Demonstration Populations	Total Number of Demonstration enrollees Quarter Ending – MM/YY	Total Number of Demonstration enrollees Quarter Ending – MM/YY	Total Number of Demonstration enrollees Quarter Ending – MM/YY	Total Number of Demonstration enrollees Quarter Ending – MM/YY
Demonstration Population 1 – Employable				
Demonstration Population 2 - Unemployable				

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 enrollees or potential eligibles.

V. Collection and Verification of Encounter Data and Enrollment Data

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

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

A status update that identifies all other significant program developments/issues/problems that have occurred in the current quarter or are anticipated to occur in the near future that affect health care delivery, including but not limited to program development, quality of care, approval and contracting with new plans, health plan contract compliance and financial performance relevant to the Demonstration, fiscal issues, systems issues, and pertinent legislative or litigation activity.

VII. Action Plans for Addressing Any Issues Identified

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

VIII. Financial/Budget Neutrality Development/Issues

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

IX. Member Month Reporting

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

A. For Use in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Demonstration Population 1				
Demonstration Population 2				

X. Consumer Issues

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

XI. Quality Assurance/Monitoring Activity

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

XII. Demonstration Evaluation

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

XIII. Enclosures/Attachments

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

XIV. State Contact(s)

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

XV. Date Submitted to CMS

CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY

NUMBER: **11-W-00274/2 (Title XIX)**

TITLE: **New Jersey Childless Adults Demonstration**

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

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

The following expenditure authority shall enable the State to operate its section 1115 Medicaid Childless Adults Demonstration.

New Jersey Childless Adults Demonstration Population. Expenditures for health care-related costs (other than costs incurred through the Charity Care and Substance Abuse Initiative programs) for childless non-pregnant adults ages 19 through 64 years who are not otherwise eligible under the Medicaid State plan, do not have other health insurance coverage, are residents of New Jersey, are citizens or eligible aliens, have limited assets, and either: 1) cooperate with applicable work requirements and have countable monthly household incomes up to $140 for a childless adult and $193 for a childless adult couple; or 2) have a medical deferral from work requirements based on a physical or mental condition, which prevents them from work requirements and have countable monthly household incomes up to $210 for a childless adult and $289 for a childless couple.

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly identified as not applicable in the list below, shall apply to the Demonstration Population beginning April 15, 2011, through December 31, 2013.

Title XIX Requirements Not Applicable to the Demonstration Population:

1. **Retroactive Eligibility** **Section 1902(a)(34)**
   To the extent necessary to allow the State to enroll Demonstration participants no earlier than the first day of the month in which the application for the Demonstration is made.