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

Center for Medicaid and CHIP Services
Children and Adults Health Programs Group

Valerie Harr, Director
New Jersey Department of Human Services Division
of medical Assistance and Health Services
P.O. Box 712
Trenton, NJ 08625-0712

AUG 13 2012

Dear Valerie:

This letter is in response to your request to continue coverage of parents under your existing title XXI section 1115 demonstration, and to inform you of the associated federal matching rate for the expenditures associated with such coverage.

The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 changed States' authority to cover parents under the Children's Health Insurance Program (CHIP). Specifically, Section 2111(b)(2) of the Social Security Act (the Act) permits a State that had authority in place to cover parents prior to the passage of CHIPRA to continue such coverage through September 30, 2013.

A State which elects to continue parent coverage in federal fiscal year (FY) 2013 may be eligible to receive the REMAP for FY 2013 expenditures, if the State qualified to receive EFMAP for FY 2012 expenditures and meets one of two coverage benchmarks, as follows: 1) ranked among the lowest third of states in terms of percentage of low-income children without health insurance, based on the most recent data from the Bureau of the Census; or 2) qualified for a performance bonus under section 2105(a)(3)(B) in Fiscal Year 2011. For a State meeting these conditions, the REMAP is equal to 50 percent of the sum of the state's enhanced federal medical assistance percentage (FMAP) under CHIP and the state's regular FMAP under Medicaid.

The State of New Jersey's *"State Coverage Initiative"* demonstration, which covers uninsured parents with incomes at or below 200 percent of the Federal poverty level (FPL), and which had been scheduled to expire September 30, 2012, is extended at the State's request through September 30, 2013. Under this extension, New Jersey will continue to be subject to its currently approved expenditure authorities and Special Terms and Conditions (STCs). Furthermore, because New Jersey qualified to receive EFMAP for FY 2012 expenditures and also qualified for a performance bonus under 2105(a)(3)(B) of the Act, the FY 2013 expenditures for parents covered under the demonstration will be at the REMAP rate.

As you are aware, the Affordable Care Act provides eligibility for health coverage to most individuals, including parents, beginning in 2014. In order to avoid a gap in coverage for parents when title XXI authority expires under this demonstration on October 1, 2013, we encourage the

State to continue coverage from October 1, 2013 through December 31, 2013 in Medicaid. We would be happy to work with you to explore options for transitioning this demonstration.

Finally, please note that Federal funds for the expenditures of parents under the Demonstration will come from the State's CHIP allotment, and may not exceed the amount of the "block grant set aside," which is defined in section 2111(b)(2) of the Act. In order to receive Federal funds for FY 2013 for these expenditures, New Jersey must include and separately identify the FY 2013 expenditure projections for the parent population in its submission of the CMS-21B, and include the breakout of such expenditures on the CMS-21B narrative form, by no later than August 31, 2012. These projections are needed to calculate the amount of the block grant set aside. These payments will fund coverage at the existing income level in the currently approved section 1115 demonstration, but the statute provides that these funds cannot be used for any eligibility expansion above this level.

Stacey Green, CHIP Technical Director, can be reached at (410) 786-6102 or by email at mstacey.green@cms.hhs.gov if you have any questions about this extension. We look forward to working with you on the extension of your demonstration.

Sincerely,

/Victoria Wachino/

Victoria Wachino
Director

Enclosure

cc: Michael Melendez, ARA, New York Regional Office

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Office of the Administrator
Washington, DC 20201

JAN 10 2006

Ms. Ann Clemency Kohler, Director
Division of Medical Assistance and Health Services
Department of Human Services
P.O. Box 712
Trenton, NJ 08628-0712

Dear Ms. Kohler:

We are pleased to inform you that your request to renew your title XXI section 1115 demonstration project, No. 21-W-00003/2-01 for title XXI and No. 11-W-00164/2 for title XIX entitled, "Family Coverage Under SCHIP for Families and Pregnant Women," and dated January 13, 2005, with additional information submitted on September 16, 2005, and October 14, 2005, has been approved.

Currently, the demonstration provides health care coverage to uninsured custodial parents and caretaker relatives of Medicaid and State Children's Health Insurance Program (SCRIP) children and uninsured pregnant women with family incomes up to and including 200 percent of the Federal poverty level (FPL). On January 31, 2003, New Jersey's Health Insurance Flexibility and Accountability amendment was approved to standardize the benefit package for parents and to add an additional 12,000 parents and custodial caretakers to the demonstration.

The: Centers for Medicare & Medicaid services (CMS) will extend the demonstration for another 3 years under the authority of section 1115(a) of the Social Security Act (the Act). Both the expenditure authorities granted and the Special Terms and Conditions (STCs) will remain in effect from January 18, 2006, through January 17, 2009.

Enclosed are the STCs that define the nature, character, and extent of anticipated Federal involvement in the project. The award is subject to our receiving your written acceptance of the award, including the STCs, within 30 days of the date of this letter.

All requirements of the Medicaid and SCHIP programs expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in this letter, shall apply to the "Family Coverage Under SCHIP for Families and Pregnant Women," demonstration. Federal funding for this demonstration is limited to, and will be deducted from, New Jersey's available SCHIP allotments under section 2104 of the Act. Parent coverage will be funded with title XIX funds in the event that the title XXI allotment is insufficient to fund such coverage.

Under the authority of section 1115(a)(l) of the Act, a waiver of the following provision of the Act (and its implementing regulations) is granted to enable the State to carry out the demonstration, consistent with the accompanying STCs:

Title XIX

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

To enable the State to modify the Medicaid benefit package to provide a more limited package to the beneficiaries described below as Demonstration Population 1.

Demonstration Population 1: Uninsured custodial parents and caretaker relatives of Medicaid and SCHIP children with family incomes above the previous Medicaid standard up to and including 133 percent of the FPL. Coverage must meet the requirements of section 2103 of the Act, and covered services must be equivalent to the commercial Health Maintenance Organization (HMO) coverage offered in New Jersey with the most non-Medicaid enrollees.

SCHlP Costs Not Otherwise Matchable

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

Demonstration Population 1: Expenditures to provide coverage to individuals who are uninsured custodial parents and caretaker relatives of Medicaid and SCHIP children with incomes above the previous Medicaid standard up to and including 133 percent of the FPL. Coverage must meet the requirements of section 2103 of the Act, and covered services must be equivalent to the commercial HMO coverage offered in New Jersey with the most non-Medicaid enrollees.

Demonstration Population 2: Expenditures to provide coverage consistent with section 2103 of the Act for uninsured custodial parents and caretaker relatives of children eligible under the title XXI State plan, when the parents and caretakers have family incomes above 133 percent up to and including 200 percent of the FPL and are not eligible for Medicaid.

Demonstration Population 3: Expenditures to provide coverage consistent with section 2103 of the Act for uninsured pregnant women with family incomes above 185 percent up to and including 200 percent of the FPL, who are not eligible for Medicaid.

SCHIP Requirements Not Applicable to the SCRIP Expenditure Authorities

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

1. **General Requirements, Eligibility and Outreach** **Section 2102**

   For Demonstration Population 1:
   The demonstration population does not have to reflect the State child health plan population, and eligibility standards do not have to be limited by the general principles in section 2102(b)(1)(B). To the extent other requirements in section 2102 duplicate Medicaid or other SCRIP requirements for this or other populations, they do not apply, except that the State must perform eligibility screening to ensure that the demonstration population does not include individuals otherwise eligible for Medicaid under the standards in effect on August 31, 2000.

   For Demonstration Populations 2 and 3:
   The demonstration population does not have to reflect the State child health plan population, and eligibility standards do not have to be limited by the general principles in section 2102(b)(1)(B). The State must perform eligibility screening to ensure that applicants for the demonstration population who are eligible for Medicaid are enrolled in that program and not in the demonstration population.

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

   For Demonstration Populations 1, 2, and 3:
   Coverage and eligibility for the demonstration populations are not restricted to targeted low-income children.

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

   For Demonstration Populations 1, 2, and 3:
   Federal matching payment is available in excess of the 10 percent cap for expenditures related to the demonstration populations and limits on family coverage are not applicable.

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

4. Annual Reporting Requirements **Section 2108**

For Demonstration Populations 1, 2, and 3:
Annual reporting requirements do not apply to the demonstration populations.

Your title XXI project officer is Ms. Kathy Cuneo. She is available to answer questions concerning this renewal and other SCHIP-related issues. Ms. Cuneo's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and State Operations
Mail Stop S2-01-16
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-5913
Facsimile: (410) 786-5943
E-mail: kathleen.cuneo@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Cuneo and to Ms. Sue Kelly, Associate Regional Administrator for the Division of Medicaid and State Operations in the New York City regional office. Ms. Kelly's address is:

Centers for Medicare & Medicaid Services
Division of Medicaid and State Operations
26 Federal Plaza, Room 3811
New York, NY 10278-0063

If you have any additional questions, please contact Ms. Jean Sheil, Director, Family and Children's Health Programs Group, Center for Medicaid and State Operations, at (410) 786-5647.

We look forward to working with you and your staff on this initiative.

Sincerely,

/Mark B. McClellan/

Mark B. McClellan, M.D.,PhD.

Enclosure

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850

Center for Medicaid, CHIP and Survey & Certification

Children and Adults Health Programs Group

FEB 18 2011

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

Dear Ms. Harr:

As you are aware, New Jersey's title XXI funded section 1115 demonstration project No. 21-W-00003/2-01, entitled "State Coverage Initiative," is currently operating under 1115(a) of the Social Security Act (the Act), and is scheduled to expire on September 30, 2011. The purpose of this letter is to inform New Jersey that the State's request to continue to cover uninsured parents at or below 200 percent of the Federal poverty level (FPL) under its existing demonstration authority, and in accordance with Section 2111(b)(1) of the Act, has been approved. The demonstration extension period is through September 30, 2012. Under this extension, New Jersey will continue to be subject to the currently approved expenditure authorities and Special Terms and Conditions (STCs).

Section 2111(b)(3)(A) of the Act, as added by section 112 of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), permits a state that had existing authority in place to cover parents prior to the passage of CHIPRA, to continue to do so at the enhanced federal medical assistance percentage (FMAP) in Federal Fiscal Year (FFY) 2012 if it can achieve certain child outreach or child coverage benchmarks. Specifically, a State may continue to cover parents in FFY 2012 at the enhanced FMAP as long as it has "implemented one or more of the enrollment and retention provisions described in Section 2105(a)(4) of the Act" for both Medicaid and CHIP. New Jersey has met at least the following criteria for covering parents in FFY 2012 as described in Section 2105(a)(4): (1) elimination of in-person interview requirement, (2) use of joint application, (3) auto renewal, and (4) presumptive eligibility.

Federal funds for the expenditures of such parents will come from the State's CHIP allotment, and may not exceed the amount of the "block grant set aside," which is defined in section 2111(b)(2) of the Act. In order to receive Federal funds for FFY 2012, New Jersey must include separate FFY 2012 expenditure projections for the parent population in its submission of the CMS-21B, and include a breakout of such expenditures on the CMS-21B narrative form, by no later than August 31, 2011. These separate projections are needed to calculate the amount of the block grant set aside.

The State must submit an additional request for renewal for 2013 to the Centers for Medicare and Medicaid Services (CMS), to receive consideration for coverage for parents during FFY 2013. To enable calculation of a block grant set-aside for FFY 2013, State must also submit separate FFY 2013 expenditure projections for parents in its CMS-21B, in the manner described above. The request and projections must be sent to CMS by no later than August 31, 2012.

New Jersey may apply to receive matching funds for those expenditures at the REMAP rate in FFY 2013 because New Jersey qualifies to receive enhanced FMAP for parents' coverage FFY 2012. (REMAP is a matching percentage that is mid-way between the regular Medicaid FMAP and the enhanced FMAP). New Jersey can qualify for REMAP if it can document meeting one of the two outreach or coverage benchmarks as follows: 1) the State, on the basis of the most timely and accurate published estimate of the Bureau of the Census, ranks in the lowest 1/3 of states in terms of the State's percentage of low-income children without health insurance, or 2) the State qualified for a performance bonus under section 2105(a)(3)(B) for the most recent FFY. If these conditions are not satisfied, the State would receive the regular FMAP from its block grant set aside for parent coverage. We are happy to provide additional technical assistance and encourage you to contact your title XXI Project Officer if you would like to discuss the criteria further.

As specified in section 2111(b)(i)(B) of the Act, states, including New Jersey, are prohibited from receiving payments from the block grant set aside for eligibility expansions to parents that exceed the existing income level in the currently approved section 1115 demonstration.

Your project officer is Rob Nelb. He can be reached at (410) 786-1055 or by email at RobertNelb@cms.hhs.gov if you have any questions about this extension. We look forward to working with you on the extension of your demonstration.

Sincerely,

/Vikki Wachino/

Vikki Wachino
Director

Enclosure
cc: Sue Kelly, ARA, New York Regional Office

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

NUMBER:	**21-W-00003/2-01 (Title XXI – SCHIP funding)**
TITLE:	**New Jersey State Children's Health Insurance Program (SCHIP) Section 1115 Demonstration**
AWARDEE:	**New Jersey Department of Human Services**

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PREFACE

The following are Special Terms and Conditions (STCs)for the award of the New Jersey State Children's Health Insurance Program (SCHIP) section 1115 demonstration (New Jersey Demonstration) renewal request submitted on January 13, 2005. Demonstration Populations 1, 2 and 3 are defined in the award letter that accompanies these STCs.

The STCs have been arranged into the following broad subject areas: General, Eligibility/Benefits, Public Notice, Administrative/Reporting/Other, Special Evaluation Requirements, and Maintenance of Effort. In addition, specific requirements are attached and entitled: General Financial Requirements Under Title XXI (Attachment A), General Financial Requirements Under Title XIX (Attachment B), Monitoring Budget Neutrality (Attachment C), and Program Specifications (Attachment D).

The State agrees that it will comply with all applicable Federal statutes relating to nondiscrimination. These include, but are not limited to: the Americans with Disabilities Act, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

Amendment requests, correspondence, documents, reports, and other materials that are submitted for review or approval shall be directed to the Centers for Medicare & Medicaid Services (CMS) Central Office Project Officer and the Regional Office State Representative at the addresses provided in the award letter.

General

1) All requirements of the Medicaid and SCHIP programs expressed in law, regulation, and policy statement, not expressly waived or identified as not applicable in the award letter of which these STCs are part, shall apply to the New Jersey Demonstration. The State shall, within the time frame specified in law, come into compliance with any relevant changes in Federal law or regulations affecting the Medicaid or SCHIP programs that occur after the demonstration award date. The State may submit to CMS a request for an amendment to the demonstration to request exemption from changes in law occurring after the demonstration award date.

2) The State's title XIX State plan and title XXI State plan, as approved, will continue to operate concurrently with this section 1115 demonstration.

3) Changes related to eligibility, enrollment, benefits, delivery systems, the Premium Support Program, cost sharing, evaluation design, Federal financial participation, budget neutrality, allotment neutrality, sources of non-Federal share of funding, and other comparable program elements must be submitted to CMS as amendments to the demonstration. The State shall not implement changes to these or other comparable program elements without prior approval by CMS. The description of each of these elements in the most recently approved Operational Protocol shall be in effect unless and until CMS has approved an amendment to change the element. The new Attachment D will contain elements of the Demonstration that are subject to the amendment process.

   The State cannot implement a waiver amendment request until the amendment request is first approved by CMS. In addition, to facilitate CMS review of the amendment request, CMS encourages the State to work with the project officer to submit the request in draft form prior to official submission of the request.

   An amendment request should include the following:
   - An explanation of the public process used by the State to reach a decision regarding the requested amendment;
   - A current assessment of the impact the requested amendment will have on allotment neutrality and/or budget neutrality;
   - An explanation of how the amendment is consistent with the overall principles and objectives of the demonstration; and
   - A description of how the evaluation design will be modified to incorporate the amendment request.

4) Demonstration phase-out :
   The State will submit, on a timely basis, a phase-out plan of the demonstration to CMS 6 months prior to initiating normal phase-out activities and, if desired by the State, an extension plan to prevent disenrollment if the demonstration is extended by CMS. Nothing herein shall 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 review and approval.

Eligibility/Benefits

5) All Demonstration Populations will be subject to the same rules, policies, and procedures as the population under the title XXI State plan, unless otherwise specified in this award letter. All Demonstration Populations will be subject to the rules, policies, and procedures governing them specified in the section 1115 demonstration proposal.

6) Demonstration Population 1 and Demonstration Population 2 will receive NJ Family Care Plan D, which is consistent with the most widely used Health Maintenance Organization (HMO) package having the largest commercial non-Medicaid enrollment that is marketed in New Jersey. Demonstration Population 3 will receive the Medicaid benefits package. If changes are made in the benefit package, the State must submit the proposed changes to CMS, which must be reviewed and approved before any modifications can be implemented.

Public Notice

7) The State will continue to comply with the public notice requirements published at 59 FR 49249 (September 27, 1994).

8) The State shall publish adequate and timely notice under the State's administrative procedure law of any program-wide changes made by the State in the benefit package, eligibility standards, procedures for obtaining care, cost sharing, or rights under the program. Whenever such program-wide changes are applied to an individual beneficiary or any action or intended action affecting an individual beneficiary is taken by the State under existing program rules, the State shall give individual, adequate, and timely notice to such beneficiary.

Administration/Reporting/Other

9) The State must fully cooperate with Federal evaluators and their contractors' efforts to conduct an independent federally funded evaluation of the demonstration program.

10) CMS may suspend or terminate any project, in whole or in part, at any time before the date of expiration whenever it determines 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. The State waives none of its rights to challenge CMS' finding that the State materially failed to comply. CMS reserves the right to withdraw waivers at any time if it determines that continuing the demonstration would no longer be in the public interest. If a demonstration is terminated, CMS will only be liable for normal close out costs.

11) The State may suspend or terminate this demonstration in whole or in part at any time before the date of expiration. The State will promptly notify CMS in writing of the reasons for the

suspension or termination, together with the effective date. If the demonstration is terminated, CMS will only be liable for normal close out costs.

12) The State will provide CMS with copies of the following quarterly enrollment reports:

- Each quarter, the State will provide CMS with an enrollment report by demonstration population showing end of quarter actual and unduplicated ever enrolled figures. These enrollment data will be entered into the Statistical Enrollment Data System within 30 days after the end of each quarter. In addition, the State will provide monthly enrollment data as specified by CMS.
- Number of adults whose eligibility for the demonstration was up for redetermination;
- Number of adults who were redetermined to be eligible for the demonstration;
- Number of adults who applied for the demonstration but were denied for, at a minimum, the following reasons: income; failure to complete the application process; enrollment in other government programs; coverage by private insurance; or residence in another State;
- Number of adults who were disenrolled from the demonstration for, at a minimum, the following reasons: increase or decrease in income; failure to complete the renewal process; failure to pay premiums; enrollment in other government programs; purchase of private coverage; or residence in another State; and
- Actual number of eligible member/months for Demonstration Population 1, should the State access title XIX funds for this population.

13) Through at least the first 6 months after implementation, CMS and the State will hold monthly calls to discuss progress.

14) The State will submit quarterly progress reports, which are due 60 days after the end of each Federal fiscal year (FFY) quarter. The reports should include, as appropriate, a discussion of events relating to the demonstration populations that occurred during the quarter that affect the following: health care delivery; the enrollment process for newly eligible adults and pregnant women; enrollment and outreach activities; access; complaints and appeals to the State; the benefit package; and other operational and policy issues. The report should also include proposals for addressing any problems identified in the report. The State will also include a separate section to report on progress toward agreed upon goals for reducing the rate of uninsurance and reducing the number of uninsured.

15) The State will submit a draft annual report no later than January 1, following the end of each FFY. The annual report should include documentation of accomplishments; project status, including a budget update; any quantitative and case study findings; policy and administrative difficulties; and progress on conducting the demonstration evaluation, including results of data collection and analysis of data to test the research hypotheses. Within 30 days of receipt of comments from CMS, a final annual report will be submitted.

16) One year after the implementation of the renewal period, the State will provide CMS with a breakdown of all actual expenditures for the three demonstration populations. CMS will review these expenditures in relation to allotment neutrality and budget neutrality.

17) No later than 3 months after the end of the demonstration, a draft final report must be submitted to CMS for comments. CMS' comments shall be taken into consideration by the State for incorporation into the final report. The final version of the final report is due no later than 90 days after the receipt of CMS comments on the draft version of the report.

18) The State must monitor changes in employer contribution levels or the degree of substitution of coverage and be prepared to make changes to its premium assistance program in response to substantial decreases in contribution levels or data showing significant substitution of coverage in the Premium Support Program.

19) The State must monitor the impact of the demonstration on the group market with respect to health insurance issuer's participation requirements for employers.

Special Evaluation Requirements

20) The State will submit a formal research plan for review and approval by CMS within 60 days of approval. At a minimum, the research plan will include plans for analysis of:
    - How the State will monitor changes in employer contribution levels in the Premium Support Program or the degree of substitution of coverage. This will encompass the following: changes in the uninsured rate for the population groups listed above; changes in the insured rates for the population groups listed above; the degree of substitution of public coverage for employer coverage; the lengths of time enrollees have been uninsured prior to enrolling in the demonstration; the extent to which employers reduce their contributions for employer sponsored insurance; the extent to which employers discontinue employer sponsored insurance for their employees; and the extent to which individuals appear to be dropping employer coverage in order to enroll in the demonstration.
    - How the State will monitor the impact of the demonstration on the group market with respect to health insurance issuer's participation requirements for employers.
    - How the State will study the goals, objectives, and hypotheses that have been proposed as part of this demonstration project. The research plan will discuss the measures that will be used in evaluating the impact of the demonstration during the extension period. It will discuss the data sources and sampling methodology for assessing these outcomes. The plan must include a detailed analysis plan that describes how the effects of the demonstration will be isolated from those other initiatives occurring in the State. The plan will identify whether the State will implement the evaluation or select an outside contractor.

Maintenance of Coverage and Enrollment Standards for Children

21) The State shall not close enrollment, institute waiting lists, or decrease eligibility standards with respect to the children covered under its title XXI State plan while the demonstration is in effect. If the State closes enrollment, institutes waiting lists, or decreases eligibility standards with respect to SCHIP children, then the demonstration is terminated.

22) The State shall, throughout the course of the demonstration, include a review of enrollment data to provide evidence that children are not being denied enrollment, and demonstrate that it has implemented procedures to enroll and retain eligible children for SCHIP, such as those listed below:

- Use of a joint, mail-in application and common application procedures
- Procedures that simplify the redetermination/coverage renewal process by allowing families to establish their child's continuing eligibility by mail and, in the State's separate SCHIP programs, by establishing effective procedures that allow children to be transferred between Medicaid and the separate program
- Elimination of assets test
- Twelve-month continuous eligibility
- Presumptive eligibility

23) The State will continue the monitoring process to ensure that expenditures for the demonstration do not exceed available title XXI funding (i.e., the title XXI allotment or reallocated funds) and the appropriate State match. The State will use title XXI funds to cover services for the SCHIP and Health Insurance Flexibility and Accountability (HIFA) populations in the following priority order:

1) Children eligible under the title XXI State plan.
2) Demonstration Populations 1, 2 and 3.

The State may also, for the Demonstration Populations 2 and 3:

- Lower the Federal poverty level (FPL) used to determine eligibility. For Demonstration Population 2 the FPL cannot be lowered below 133 percent, for Demonstration Population 3 the FPL cannot be lowered below 185 percent, and/or
- Suspend eligibility determination and/or intake into the program, or
- Discontinue coverage.

Before taking any of the above actions related to the priority system, New Jersey will provide 60-day notice to CMS.

ATTACHMENT A

GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI

1. The State shall provide quarterly expenditure reports using the Form CMS-21 to report total expenditures for services provided under the approved SCHIP 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.

2. In order to track expenditures under this demonstration, the State will report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-21 reporting instructions outlined in section 2115 of the State Medicaid Manual. Title XXI demonstration expenditures will be reported on separate Form CMS-21 Waiver and/or CMS-21P Waiver, identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services rendered or for which capitation payments were made). All expenditures under this demonstration must be reported on separate Forms CMS-21 Waiver and/or CMS-21P Waiver for each of the Demonstration Populations using the information in the drop-down listing as follows: 1) Demonstration Population 1 under the name NJFAMCAREWAIV-POP 1; 2) Demonstration Population 2 under the name NJFAMCAREWAIV-POP 2 ; and 3) Demonstration Population 3 under the name NJFAMCAREWAIV-POP 3.

   a. 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.

   b. The standard SCHIP funding process will be used during the demonstration. New Jersey must estimate matchable SCHIP expenditures on the quarterly Form CMS-21B. As a footnote to the CMS 21B, the State shall provide updated estimates of expenditures for the demonstration populations. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-21 quarterly SCHIP expenditure report. CMS will reconcile expenditures reported on the Form CMS-21 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

c. The State will certify State/local monies used as matching funds for the demonstration and will further certify that such funds will not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law.

3. 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.

4. Total Federal title XXI funds for the State's SCHIP 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.

5. 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.

6. If the State exhausts the available title XXI Federal funds for the claiming period, the State will continue to provide coverage to the approved title XXI State plan separate child health program population and the Demonstration Populations 2 and 3 with State funds until further title XXI Federal funds become available. Title XIX Federal matching funds will be provided for Demonstration Population 1 (NJFAMCAREWAIV-POP 1) if the title XXI allotment is exhausted, pursuant to the State's budget neutrality monitoring agreement, appended as Attachment C of this document.

7. The State shall provide CMS with 60 days notification before it begins to draw down title XIX matching funds for Demonstration Population 1 in accordance with the terms of the demonstration.

8. All Federal rules shall continue to apply during the period of the demonstration that title XXI Federal funds are not available. The State may close enrollment or institute a waiting list with respect to Demonstration Populations 2 and 3 upon 60 days notice to CMS.

Attachment B

General Financial Requirements under Title XIX

1. The State shall provide quarterly expenditure reports using 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. CMS shall provide Federal financial participation (FFP) for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Attachment C (Monitoring Budget Neutrality for the Demonstration).

   At such time the State determines that it does not have sufficient title XXI funds to cover expenditures for Demonstration Population 1 and begins claiming title XIX funds for this population, the State will complete for each demonstration year a Form CMS-64.9WAIVER and/or 64.9P WAIVER reporting expenditures subject to the budget neutrality cap. All expenditures subject to the budget neutrality ceiling for demonstration eligibles must be reported. The sum of the expenditures, for all demonstration years reported during the quarter, will represent the expenditures subject to the budget neutrality cap (as defined in 2.b.).

2. The following describes the reporting of expenditures subject to the budget neutrality cap:

   a) In order to track expenditures under this demonstration, New Jersey shall report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine Form CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All expenditures subject to the budget neutrality cap shall 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 demonstration year in which services were rendered or for which capitation payments were made). Corrections of any incorrectly reported demonstration expenditures for previous demonstration years must be input within three months of the beginning of the demonstration. For monitoring purposes, cost settlements 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. The term, "expenditures subject to the budget neutrality cap," is defined below in paragraph 2.c.

   b) For each demonstration year, 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 cap. The quarterly expenditures for Demonstration Population 1 (NJFAMCAREWAIV-POP 1) shall represent the expenditures subject to the budget neutrality cap (as defined in paragraph 2.c.).

c) For purposes of this section, the term "expenditures subject to the budget neutrality cap" shall include all Medicaid expenditures on behalf of the individuals who are enrolled in this demonstration (as described in paragraph 3.c. of this attachment) and who are receiving the services subject to the budget neutrality cap. All expenditures that are subject to the budget neutrality cap are considered demonstration expenditures and shall be reported on Forms CMS-64.9 Waiver and/or 64.9P Waiver.

d) Enrollment and similar fees must be reported on the CMS-64 Summary Sheet on Line 9.D. columns A and B. In order to assure that the demonstration is credited with these fees, both Total Computable and Federal Share must also be reported on the CMS-64 Narrative. All other cost sharing should be reported on Line 10.B. in lieu of Lines 9 or 10.C. as previously stated in 2.a. above.

e) Administrative costs shall 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. All administrative costs shall be identified on the Forms CMS-64.10 Waiver and/or 64.10P Waiver.

f) All claims for expenditures subject to the budget neutrality cap (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 CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

3. The following describes the reporting of member months subject to the budget neutrality cap:

a) For the purpose of calculating the budget neutrality expenditure cap described in Attachment C, the State must provide to CMS on a quarterly basis the actual number of eligible member/months for the subpopulations included in the Medicaid Eligibility Group (MEG) defined in paragraph 3.c. These will include only member months for Demonstration Population 1 whose expenditures are matched at the regular Federal Medicaid Assistance Percentages (FMAP) rate. This information should be provided to CMS in conjunction with the quarterly progress report referred to in number 14 of the Special Terms and Conditions. If a quarter overlaps the end of one demonstration year (DY) and the beginning of another, member/months pertaining to the first DY must be distinguished from those pertaining to the second. (Years are defined as the years beginning on the first day of the demonstration, or the anniversary of that day.) To permit full recognition of "in-process" eligibility, reported counts of member months shall be subject to minor revisions for an additional 180 days after the end of each quarter. For example, the counts for the quarter ending December 30, 2005, due to be reported by February 28, 2006 are permitted to be revised until June 30, 2006.

b) 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 4 eligible member/months.

c) There will be one Enrolled Population under the demonstration. The Enrolled Population is Demonstration Population 1 from the title XXI demonstration project No. 21-W-00003/2-01 with expenditures being reported under the demonstration name, NJFAMCAREWAIV-POP 1. The Enrolled Population will be comprised of uninsured custodial parents and caretaker relatives of children eligible for Medicaid and SCHIP when the parents and caretaker relatives have family incomes above the previous Medicaid standard up to and including 133 percent of the FPL, broken down into 3 subpopulations: Females aged 45 and younger; Males aged 45 and younger; and Males and Females 46 and older.

4. The standard Medicaid funding process shall be used during the demonstration. New Jersey must estimate matchable Medicaid expenditures on the quarterly Form CMS-37. In addition, the estimate of matchable demonstration expenditures (total computable and Federal share) subject to the budget neutrality cap must be separately reported by quarter for each FFY on the Form CMS-37.12 for both the Medical Assistance Program and Administrative Costs. CMS shall 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. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

5. Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the following, subject to the limits described in Attachment C:

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) Net medical assistance expenditures made with dates of service during the operation of the demonstration.

6. The State shall certify State/local monies used as matching funds for the demonstration and shall further certify that such funds shall not be used as matching funds for any other Federal grant or contract, except as permitted by law. All sources of the non-Federal share of funding and distribution of monies involving Federal match are subject to CMS approval. Upon review of the sources of the non-Federal share of funding and distribution methodologies of funds under the demonstration, all funding sources and distribution methodologies deemed unacceptable by CMS shall be addressed within the time frames set by CMS. 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.

Monitoring Budget Neutrality for the Demonstration

1. New Jersey shall 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 a per capita cost method, and budget targets are set on a yearly basis with a cumulative budget limit for the length of the entire demonstration.

2. New Jersey shall be at risk for the per capita cost (as determined by the method described below) for Medicaid eligibles in the Enrolled Population under this budget neutrality agreement, but not for the number of Medicaid eligibles in the group. By providing FFP for all eligibles in the specified Enrolled Populations, New Jersey shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing New Jersey at risk for the per capita costs for Medicaid eligibles in the Enrolled Population under this agreement, CMS assures that Federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration.

3. The Enrolled Population under this budget neutrality agreement,"Demonstration Population 1" (NJFAMCAREWAIV-POP 1) is comprised of uninsured custodial parents and caretaker relatives of children eligible for Medicaid and SCHIP, when the parents and caretaker relatives have family incomes above the previous Medicaid standard up to and including 133 percent of the FPL. This Enrolled Population is broken down into 3 subpopulations: Females aged 45 and younger; Males aged 45 and younger; and Males and Females 46 and older.

    a) For each year of the budget neutrality agreement an annual limit is calculated for the Enrolled Population, which is the same as the annual limit for the demonstration.

    b) The Enrolled Population estimate shall be calculated as a product of the number of eligible member months reported by the State under paragraph 3.a. of Attachment B for the appropriate subpopulation of the Enrolled Population, times the appropriate estimated per member per month (PMPM) cost from the table in paragraph 3.e. of this Attachment.

    c) The PMPM limits are determined by applying a trend rate of 6.4 percent.

    d) The budget neutrality limit is the sum of the annual estimates for the demonstration period, less the amount of premiums paid by the demonstration eligibles. The Federal share of the budget neutrality limit represents the maximum amount of FFP that the State may receive for expenditures on behalf of Demonstration Population 1 during the demonstration period.

    e) The PMPM cost for the calculation of the budget neutrality expenditure ceiling for Demonstration Population 1 enrollees under this section 1115(a) demonstration (net

of premiums paid by Demonstration Population 1) are based on FFY 2003 (base year) data as follows:

Gender	**Age Group**	**PMPM DY 1 (2/1/2006 – 1/31/2007)**	**PMPM DY2 (2/1/2007 – 1/31/2008)**	**PMPM DY3 (2/1/2008 – 1/31/2009)**
Females	45 or younger	$198.38	$211.08	$224.59
Males	45 or younger	$155.53	$165.48	$176.08
Males and Females	46 or older	$336.28	$357.80	$380.70

4. For the purpose of monitoring budget neutrality, within 60 days after the end of each quarter, the State shall provide a report to CMS, in the format provided by CMS, identifying the State's actual member months for the MEG and corresponding actual expenditures for the MEG, less the amount of premiums paid by Demonstration Population 1 eligibles.

5. The CMS shall enforce budget neutrality over the life of the demonstration rather than on an annual basis. However, if the State exceeds the calculated cumulative target limit by the percentage identified below for any of the demonstration years, the State shall submit a corrective action plan to CMS for approval.

Year	Cumulative Target Definition	Percentage
1	Year 1 budget neutrality cap plus	1 percent
2	Years 1 and 2 combined budget neutrality caps plus	0.5 percent
3	Years 1 through 3 combined budget neutrality caps plus	0 percent
4	Years 1 through 4 combined budget neutrality caps plus	0 percent
5	Years 1 through 5 combined budget neutrality caps plus	0 percent

The State shall subsequently implement the approved corrective action plan.

6. If at the end of this demonstration period the budget neutrality limit has been exceeded, the excess Federal funds shall be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, the budget neutrality test shall be based on the time elapsed through the termination date.

7. After December 31, 2005, no duplication of coverage of the Part D benefits shall be provided under this demonstration.

ATTACHMENT D

PROGRAM SPECIFICATIONS

Pursuant to Special Term and Condition number 3, Attachment D details the policy and program specifications applicable to the NJ FamilyCare Demonstration.

Attachment D is arranged in sections, as follows:

1.0. Eligibility/Delivery System

1.1 Eligibility for the Demonstration

Income Level	Eligibility Determination Responsibility
Applications for beneficiaries with income **above** the previous Medicaid standard, **up to and including** 133% FPL (Demonstration Population 1)	Processed by either the County Board of Social Services (CBOSS) or the Health Benefits Coordinator (HBC), based on applicant/beneficiary's choice
Applications for beneficiaries with income **above** 133% **up to and including** 200% FPL (Demonstration Population 2)	Processed exclusively by the HBC
Applications for pregnant women with income **above** 185% **up to and including** 200% FPL (Demonstration Population 3)	Processed by the HBC or CBOSS

A. Medicaid expansion population (Demonstration Population 1)

Custodial parents and caretaker relatives in Demonstration Population 1 (family income above the previous Medicaid standard up to and including 133 percent of the FPL can, in addition to applying in person as set out above, apply for coverage through the use of a mail-in application. There are no premiums or other copayments required of Demonstration Population 1, nor is an asset test or "crowd-out" period applied. Parents in Demonstration Population 1 may have other insurance coverage. This population receives Plan D benefits.

Medical services are delivered by managed care organizations that contract with the Department of Human Services. Parents have a choice of at least two competing plans. Parents enroll in the same plan as their children. Medical services are delivered on a fee-for-service basis pending enrollment in a managed care plan. Retroactive eligibility is available for this population. The State will not undertake presumptive eligibility for adults under the demonstration. Throughout the 12 month period of eligibility, parents must submit any changes in income, residency, or household size to NJ FamilyCare.

B. Custodial parents and Caretaker Relatives with income up to and including 200 percent of the FPL not eligible for Medicaid (Demonstration Population 2)

Custodial parents and caretaker relatives in Demonstration Population 2 (family income above 133 percent up to and including 200 percent FPL) can, in addition to applying in person as set out above, apply for coverage through the use of a mail-in application. The parents must be uninsured. New Jersey will utilize a 3-month crowd-out provision for group health insurance coverage, with exceptions for situations such as expiration of Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage. In addition, an applicant may voluntarily terminate coverage under COBRA, or any other health insurance purchased through the individual market, in order to be considered for NJ FamilyCare eligibility. There is no asset test. The State will not undertake presumptive eligibility for adults under the demonstration. Throughout the 12 month period of eligibility, parents must submit any changes in income, residency, or household size to NJ FamilyCare.

Medical services are delivered by managed care organizations that contract with the Department of Human Services. Parents have a choice of at least two competing plans. Parents enroll in the same plan as their children. Medical services are delivered once the parents are enrolled in a managed care plan.

C. Pregnant women with income above 185 percent up to and including 200 percent FPL (Demonstration Population 3)

Pregnant women with income above 185 percent up to and including 200 percent FPL (Demonstration Population 3) can, in addition to applying in person as set out above, apply for coverage through the use of a mail-in application. Applicants must be uninsured. New Jersey will utilize a 3-month crowd-out provision for group health insurance coverage, with exceptions for situations such as expiration of COBRA coverage. In addition, an applicant may voluntarily terminate coverage under COBRA, or any other health insurance purchased through the individual market, in order to be considered for NJ FamilyCare eligibility. There is no asset test. Retroactive eligibility is available for this population. The State will not undertake presumptive eligibility for pregnant women under the demonstration. Throughout the 12 month period of eligibility, parents must submit any changes in income, residency, or household size to NJ FamilyCare.

Medical services are delivered by managed care organizations that contract with the Department of Human Services. Demonstration Population 3 will receive the Medicaid benefits package. Pregnant women have a choice of at least two competing plans. There are no premiums or other cost sharing for Demonstration Population 3.

Medical services are delivered on a fee-for-service basis pending enrollment in a managed care plan. Coverage is provided for 60 days following delivery.

1.2 Process for Determining Adequacy of Delivery System

The State continues to monitor the delivery system under NJ FamilyCare by:

a) Requiring managed care organizations to submit detailed information on the provider network, on a monthly basis.

b) Reviewing the network submissions against pre-established standards.

c) Limiting enrollment in an individual plan based on the network information provided and ongoing monitoring of approved maximum enrollment capacity limits against monthly enrollment levels.

d) Conducting ongoing “spot check” reviews of the provider networks. Reviews include telephone contact to primary care practitioners and specialty providers to assure they have active contracts with HMOs and are accepting new patients.

e) Investigating and resolving any complaints or issues brought to New Jersey's Division of Medical Assistance and Health Services' attention regarding access to care.

1.3 Process for Ensuring Care is not Interrupted

Should the State expend the full amount of available Federal title XXI funds during the demonstration, claiming for Demonstration Population 1 would continue under title XIX. This change would be seamless to the members of Demonstration Population 1. This group would continue to receive the same package of services (NJ FamilyCare Plan D), regardless of the claiming change.

Demonstration Populations 2 and 3 are currently capped populations and have a decreasing enrollment trend through attrition; hence, there is no waiting list for these populations. If the available allotment is exceeded, the State will convert any parents in the demonstration populations to Medicaid, if they are deemed eligible at that time. Expenditures for parents that are found not eligible for Medicaid will be paid with State-only funds.

2.0. Cost Sharing

Description of the Cost Sharing Requirements

Pregnant women will not be charged cost sharing. Parents with incomes above 150 percent of the FPL will be charged cost sharing. The premiums required will be adjusted in accordance with the change in the FPL for a family of 2 at 100 percent of the FPL, as compared to the previous year. In other words, as income increases with the increase in the FPL, premiums will increase by the same percentage. The State will notify CMS when the annual adjustment is made each year. The State will also provide CMS with a copy of the public notification of the premium adjustment.

A 5 percent limit on family income for cost sharing will apply. Under NJ FamilyCare, a calculation of the 5 percent limit amount is done at the time of the eligibility determination. Families are told to contact the State when cost sharing payments reach 80 percent of that amount (also calculated for the family), so that a timely determination can be made. Under NJ FamilyCare, families are held harmless for any premium and cost sharing amounts that exceed 5 percent of family income during the coverage year, including amounts charged by the employer-sponsored plan. Families will be held harmless for any premium and cost sharing amounts that exceed 5 percent of their income during the coverage year.

Procedures for Ensuring that Cost Sharing Does Not Exceed the 5 Percent Limit

For those cases in which the family has reached the 5 percent limit, the family is notified by letter, with a copy going to the appropriate HMO, indicating that premiums and co-payments are no longer required. The HMO is then required to ensure that providers participating in the plan do not collect co-payments for the remainder of the benefit year. The HMO issues a new identification card that will indicate co-payment amounts of zero. The State enrollment vendor is also informed to immediately cease collection of the premium amounts for the remainder of the benefit year. The State has developed a voucher program to reimburse providers directly for any cost sharing requirements that exceed those required in the State-contracted, benchmark

plan. A family also has the option to pay the excess co-payments and seek reimbursement directly from the State.

3.0. Substitution of Coverage

The State will contract with a vendor on an ongoing basis to perform file reviews to establish and monitor levels of substitution. Once monitoring begins, if the State finds that, measured over a period of 6 months, more than 10 percent of applicants are voluntarily dropping coverage for SCHIP or are going through the 3 month waiting period to get into SCHIP, the State will increase the waiting period from 3 months to 6 months.

4.0. Premium Support Program

Description of the Premium Support Program (PSP)

The purpose of the PSP is to enable parents to purchase health insurance coverage by paying for enrollment in an available cost-effective employer-sponsored plan. Some uninsured families have access to health insurance coverage through an employer, but have not purchased the coverage because they cannot afford the premiums. The PSP reimburses parents for payment of premiums for cost-effective employer-sponsored health insurance coverage.

Requirements for Participation in the PSP

Parents must be determined eligible for NJ FamilyCare in order to participate in the PSP. If the PSP Unit determines that the parents have a cost-effective employer-sponsored plan available to them, the parents must enroll in the plan as a condition of continuing participation in the NJ FamilyCare program. Furthermore, the parents must not have had coverage under a group health plan for a period of at least 6 months prior to the enrollment in the Premium Support Program.

Process for Determining whether the Benefit Package Meets Benchmark

If an uninsured parent has access to employer-sponsored insurance, the PSP Unit evaluates the application and contacts the parent's employer to obtain information about 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.

The PSP Unit will evaluate the employer's plan based on the following:

1. If the employer is a large business (50 or more employees), whether the employer's plan offers the same or better benefit package than that provided under NJ FamilyCare. If the employer is a large business, parents will not be enrolled in the employer-sponsored coverage unless the specific services and the extent of coverage in the employer-sponsored benefit package are at least equal to the NJ FamilyCare Plan D benefit package. If the services are not equal, the parents will be enrolled in NJ FamilyCare Plan D.

2. If the employer is a small business (fewer than 50 employees), whether the employer's plan offers the same services as the services in the Plan D service package. However, the extent of coverage in the employer-sponsored benefit package need not be the same. If the extent of coverage is not the same, wrap-around services will be provided to match the coverage under Plan D.

Provision of Wrap-Around Services

For parents who are employed by a small business, wrap-around services are provided to the parents on a fee-for-service basis, to match the coverage provided under NJ FamilyCare Plan D.

Policies that Ensure that Cost Sharing Limits Are Not Exceeded

Parents are held harmless for any premium and cost sharing amounts that exceed 5 percent of their income during the coverage year. This protection applies equally to parents enrolled in NJ FamilyCare and to parents enrolled in an employer-sponsored plan through the PSP. The parents submit proof of payment for premium and cost sharing expenses to the HBC. 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.

For PSP participants, once 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 of the charges imposed on the parent by the employer sponsored plan. Parents may submit proof of any additional expenses to the PSP and obtain reimbursement. Additionally, parents may 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 coverage year.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CENTERS for MEDIG4/IE & MEDICAID SEIMCES

Center for Medicaid, CHIP and Survey & Certification

SEP 27 2011

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

Dear Mrs. Harr:

The Centers for Medicare & Medicaid Services (CMS) is pleased to inform you that it has approved your request to amend New Jersey's title XXI funded section 1115 demonstration project No. 21-W-00003/2-01. The amendment provides for additional durable medical equipment benefits for uninsured custodial parents and caretaker relatives of Medicaid and CHIP children in Demonstration Populations 1 and 2, and is effective as of the date of this letter. Under this amendment, New Jersey will continue to be subject to its currently approved expenditure authorities and Special Terms and Conditions (STCs).

Your Title XXI project officer is Mr. Robert Nelb. He is available to answer any questions concerning this Title XXI-funded section 1115 Demonstration. Mr. Nelb's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid, CHIP and Survey & Certification
7500 Security Boulevard
Mailstop S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-1055
E-mail: Robert.nelb@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Mr. Nelb and to Mr. Michael Melendez, Associate Regional Administrator for the Division of Medicaid and Children's Health in our New York Regional Office. Mr. Melendez's contact information is as follows:

Centers for Medicare & Medicaid Services
Division of Medicaid and Children's Health
Jacob K. Javits Federal Building
26 Federal Plaza, Room 37-100 North
New York, NY 10278

If you have questions regarding this approval, please contact Victoria Wachino, Director, Children and Adults Health Program Group, Center for Medicaid, CHIP and Survey & Certification, at (410) 786-5647.

Congratulations on the approval this amendment to your section 1115 Demonstration.

Sincerely,

/Cindy Mann/

Cinday Mann
Director

Enclosure

cc: Michael Melendez, ARA, New York Regional Office