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

October 6, 2026

Gregory Woods, Assistant Commissioner
Division of Medical Assistance and Health Services
PO Box
Trenton, NJ 08625-0712

Dear Mr. Gregory Woods:

In accordance with 42 CFR 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving New Jersey's submission of a proposal for a state directed payment (SDP) under Medicaid managed care plan contract(s). The proposal was received by CMS on June 29, 2026, and a final revised preprint was received on September 18, 2026. The proposal has a control name of NJ_VBP_Oth_Renewal_20260701-20270630**.**

CMS has completed our review of the following Medicaid managed care SDP(s):

- A perinatal episode of care pilot established by the State for the rating period covering July 1, 2026, through June 30, 2026, incorporated into the capitation rates through a risk-based rate adjustment and separate payment term amount up to $3,500,000.

This letter satisfies the regulatory requirement in 42 CFR 438.6(c)(2) for SDPs described in 42 CFR 438.6(c)(1). This letter pertains only to the actions identified above and does not apply to other actions currently under CMS's review. This letter does not constitute approval of any specific Medicaid financing mechanism used to support the non-federal share of expenditures associated with these actions. All relevant federal laws and regulations apply. CMS reserves its authority to enforce requirements in the Social Security Act and the applicable implementing regulations.

The state is required to submit contract action(s) and related capitation rates that include all SDPs, including those that do not require written prior approval as specified in 42 CFR 438.6(c)(2)(i). Additionally, all SDPs must be addressed in the applicable rate certifications. CMS recommends that states share this letter and the preprint(s) with the certifying actuary. Documentation of all SDPs must be included in the initial rate certification as outlined in Section I, Item 4, Subsection D, of the Medicaid Managed Care Rate Development Guide. The state and its actuary must ensure all documentation outlined in the Medicaid Managed Care Rate Development Guide is included in the initial rate certification. Failure to provide all required documentation in the rate certification will cause delays in CMS review.

Approval of this SDP proposal for the applicable rating period does not preclude CMS from requesting additional materials from the state, revision to the SDP proposal design, or any other modifications to the proposal for this rating period or future rating periods, if CMS determines that such modifications are required for the state to meet relevant federal requirements.

CMS approval of this SDP preprint is conditioned on the state's continued compliance with Medicaid program integrity requirements, including 42 CFR 438 and 42 CFR 455. The state

must ensure that the state and its managed care plans appropriately support program integrity activities, including the prevention, detection, investigation, referral, and resolution of fraud, waste, and abuse through appropriate staffing, oversight, controls, data, analytics, reporting, audits, and other actions. The state is responsible for monitoring all aspects of the managed care program, including the performance of every managed care plan related to program integrity as required in 42 CFR 438.66(b)(9). Any material changes to managed care plans' program integrity responsibilities must be clearly effectuated through the state's managed care contracts submitted to CMS for review and approval in accordance with 42 CFR 438.3(a).

CMS is approving this preprint with a condition that the state provide complete evaluation results for each year of the payment arrangement and the State's assessment of the payment arrangement with the preprint renewal submission for the SFY 2028 rating period. Should the state have any questions, please contact the CMS Division of Quality and Health Outcomes via the ManagedCareQualityTA@cms.hhs.gov for technical assistance.

If you have any questions concerning this letter, please contact StateDirectedPayment@cms.hhs.gov.

Sincerely,

MEAGAN T. KHAU -S

Digitally signed by MEAGAN T. KHAU -S
Date: 2026.10.06 13:42:02 -04'00'

Meagan Khau
Deputy Director, Managed Care Group
Center for Medicaid and CHIP Services

Section 438.6(c) Preprint

42 C.F.R. § 438.6(c) provides States with the flexibility to implement delivery system and provider payment initiatives under MCO, PIHP, or PAHP Medicaid managed care contracts (i.e., state directed payments). 42 C.F.R. § 438.6(c)(1) describes types of payment arrangements that States may use to direct expenditures under the managed care contract. Under 42 C.F.R. § 438.6(c)(2)(ii), contract arrangements that direct an MCO's, PIHP's, or PAHP's expenditures under paragraphs (c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D) must have written approval from CMS prior to implementation and before approval of the corresponding managed care contract(s) and rate certification(s). This preprint implements the prior approval process and must be completed, submitted, and approved by CMS before implementing any of the specific payment arrangements described in 42 C.F.R. § 438.6(c)(1)(i) through (c)(1)(ii) and (c)(1)(iii)(B) through (D). Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).

Submit all state directed payment preprints for prior approval to: StateDirectedPayment@cms.hhs.gov.

SECTION I: DATE AND TIMING INFORMATION

1. Identify the State's managed care contract rating period(s) for which this payment arrangement will apply (for example, July 1, 2020 through June 30, 2021):
   July 1, 2026 - June 30, 2027
2. Identify the State's requested start date for this payment arrangement (for example, January 1, 2021). *Note, this should be the start of the contract rating period unless this payment arrangement will begin during the rating period.* July 1, 2026
3. Identify the managed care program(s) to which this payment arrangement will apply:
   NJ FamilyCare
4. Identify the estimated **total dollar amount** (federal and non-federal dollars) of this state directed payment: $3.5 million per contract rating period
   a. Identify the estimated federal share of this state directed payment: $1.75 million
   b. Identify the estimated non-federal share of this state directed payment: $1.75 million

   Please note, the estimated total dollar amount and the estimated federal share should be described for the rating period in Question 1. If the State is seeking a multi-year approval (which is only an option for VBP/DSR payment arrangements (42 C.F.R. § 438.6(c)(1)(i)-(ii))), States should provide the estimates per rating period. For amendments, states should include the change from the total and federal share estimated in the previously approved preprint.

5. Is this the initial submission the State is seeking approval under 42 C.F.R. § 438.6(c) for this state directed payment arrangement? ☐ Yes ☒ No

6. If this is not the initial submission for this state directed payment, please indicate if:

a. ☐ The State is seeking approval of an amendment to an already approved state directed payment.

b. ☒ The State is seeking approval for a renewal of a state directed payment for a new rating period.

i. If the State is seeking approval of a renewal, please indicate the rating periods for which previous approvals have been granted:

Previous approvals were for 4/1/22-6/30/23, 7/1/23-6/30/24, 7/1/24-6/30/25, 7/1/25-6/30/26

c. Please identify the types of changes in this state directed payment that differ from what was previously approved.

☐ Payment Type Change
☐ Provider Type Change
☐ Quality Metric(s) / Benchmark(s) Change
☐ Other; please describe:

☒ No changes from previously approved preprint other than rating period(s).

7. ☒ Please use the checkbox to provide an assurance that, in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(F), the payment arrangement is not renewed automatically.

SECTION II: TYPE OF STATE DIRECTED PAYMENT

8. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(A), describe in detail how the payment arrangement is based on the utilization and delivery of services for enrollees covered under the contract. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., utilization of services by managed care enrollees, meet or exceed a performance benchmark on provider quality metrics).

The State's perinatal episode of care holds obstetrical providers to the quality and cost of care associated with their attributed, valid episodes within managed care.

To identify a provider's attributed, valid episodes: 1) An episode is triggered by a professional claim for a labor and delivery service that has been reimbursed by managed care, 2) The episode is attributed to the obstetrical provider of prenatal and/or labor and delivery care, 3) Valid episodes must not be subject to business or clinical exclusions, and must be attributable to a participating obstetrical provider. Thus, both the episode trigger and attribution is based on services that are covered by managed care and included in NJ's managed care contract.

To evaluate the provider on utilization and delivery of services, performance is determined for all of a provider's attributed, valid episodes: 1) An episode includes the enrollee's pregnancy-related care from 280 days prior to and 60 days after the birth event, 2) Performance Period 5 includes all episodes ending between 7/1/26-6/30/27, 3) Performance is judged based on five quality metrics and on the calculation of risk-adjusted, average episode cost (a provider's quality thresholds and spend benchmarks are the same state-wide, regardless of the managed care payer). Most pregnancy-related care is covered by managed care and included in NJ's managed care contract.

To receive a payment, a participating provider must have at least 15 attributed, valid episodes, and meet the following requirements for the three, independently determined incentives of Performance Period 1: 1) Shared savings: providers must meet quality thresholds and spend benchmarks, 2) High Performer Bonus: providers must meet peer-based quality thresholds and spend benchmarks, 3) SUD Participation Incentive: providers must serve a high proportion of SUD patients (defined as when the provider ranks in the top 20% when all statewide providers are ranked by the percentage of their attributed, valid episodes that involve a SUD diagnosis). The purpose of the SUD Participation Incentive is to encourage participation in our voluntary program by those providers who have patient panels that are more clinically complex and are often associated with increased spend. Performance Period will be upside only.

a. ☒ Please use the checkbox to provide an assurance that CMS has approved the federal authority for the Medicaid services linked to the services associated with the SDP (i.e., Medicaid State plan, 1115(a) demonstration, 1915(c) waiver, etc.).

b. Please also provide a link to, or submit a copy of, the authority document(s) with initial submissions and at any time the authority document(s) has been renewed/revised/updated.

https://www.state.nj.us/humanservices/dmahs/home/waiver.html

https://www.nj.gov/humanservices/dmahs/info/state_plan.html

9. Please select the general type of state directed payment arrangement the State is seeking prior approval to implement. (Check all that apply and address the underlying questions for each category selected.)

a. ☒ **VALUE-BASED PAYMENTS / DELIVERY SYSTEM REFORM:** In accordance with 42 C.F.R. § 438.6(c)(1)(i) and (ii), the State is requiring the MCO, PIHP, or PAHP to implement value-based purchasing models for provider reimbursement, such as alternative payment models (APMs), pay for performance arrangements, bundled payments, or other service payment models intended to recognize value or outcomes over volume of services; or the State is requiring the MCO, PIHP, or PAHP to participate in a multi-payer or Medicaid-specific delivery system reform or performance improvement initiative.

If checked, please answer all questions in Subsection IIA.

b. ☐ **FEE SCHEDULE REQUIREMENTS:** In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(B) through (D), the State is requiring the MCO, PIHP, or PAHP to adopt a minimum or maximum fee schedule for network providers that provide a particular service under the contract; or the State is requiring the MCO, PIHP, or PAHP to provide a uniform dollar or percentage increase for network providers that provide a particular service under the contract. **[Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules using State plan approved rates as defined in 42 C.F.R. § 438.6(a).]**

If checked, please answer all questions in Subsection IIB.

SUBSECTION IIA: VALUE-BASED PAYMENTS (VBP) / DELIVERY SYSTEM REFORM (DSR):

This section must be completed for all state directed payments that are VBP or DSR. This section does not need to be completed for state directed payments that are fee schedule requirements.

10. Please check the type of VBP/DSR State directed payment the State is seeking prior approval for. *Check all that apply; if none are checked, proceed to Section III.*

- ☐ Quality Payment/Pay for Performance (Category 2 APM, or similar)
- ☒ Bundled Payment/Episode-Based Payment (Category 3 APM, or similar)
- ☐ Population-Based Payment/Accountable Care Organization (Category 4 APM, or similar)
- ☐ Multi-Payer Delivery System Reform
- ☐ Medicaid-Specific Delivery System Reform
- ☐ Performance Improvement Initiative
- ☐ Other Value-Based Purchasing Model

11. Provide a brief summary or description of the required payment arrangement selected above and describe how the payment arrangement intends to recognize value or outcomes over volume of services. If "other" was checked above, identify the payment model. The State should specifically discuss what must occur in order for the provider to receive the payment (e.g., meet or exceed a performance benchmark on provider quality metrics).

An episode model incentivizes the participating provider to take comprehensive responsibility for the delivery of high-quality, efficient care for the enrollee. As services beyond professional obstetrical care are included in the episode definition for performance calculation and eligibility for incentives, the obstetrical provider is responsible not only for perinatal services that are delivered by their practice, but also for care delivered by other professionals and at other facilities.

To receive a payment, a participating provider must have at least 15 attributed, valid episodes, and meet the following requirements for the three, independently determined incentives of Performance Period 2: 1) Shared savings: providers must meet quality thresholds and spend benchmarks, 2) High Performer Bonus: providers must meet peer-based quality thresholds and spend benchmarks, 3) SUD Participation Incentive: providers must serve a high proportion of SUD patients (defined as when the provider ranks in the top 20% when all statewide providers are ranked by the percentage of their attributed, valid episodes that involve a SUD diagnosis). The purpose of the SUD Participation Incentive is to encourage participation in our voluntary program by those providers who have patient panels that are more clinically complex and are often associated with increased spend. Performance Period 4 will be upside only.

The value proposition of each of these three incentives are distinct, but support one another: 1) Shared savings recognizes a provider's improvement relative to their own historical performance, 2) High Performer Bonus recognizes a provider's excellence relative to their peer providers, 3) SUD Participation Incentive recognizes providers who deliver care to a medically complex sub-population and still choose to participate in this voluntary program.

12. In Table 1 below, identify the measure(s), baseline statistics, and targets that the State will tie to provider performance under this payment arrangement (provider performance measures). Please complete all boxes in the row. To the extent practicable, CMS encourages states to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures when applicable.

TABLE 1: Payment Arrangement Provider Performance Measures

Measure Name and NQF # (if applicable)	**Measure Steward/ Developer**[1]	**Baseline**[2] **Year**	**Baseline**[2] **Statistic**	**Performance Measurement Period**[3]	**Performance Target**	**Notes**[4]
Example: Percent of High-Risk Residents with Pressure Ulcers – Long Stay	*CMS*	*CY 2018*	*9.23%*	*Year 2*	*8%*	*Example notes*
a. Prenatal Depression Screening	NJ	CY 2022	Provider-specific baseline	Performance Period 5	Lower of: 50% or 20% improvement from self	Numerator: Episodes where patient receives a prenatal screening for depression. Denominator: All of the provider's valid episodes.
b. Gestational Diabetes Screening	NJ	CY 2022	Provider-specific baseline	Performance Period 5	87%	Numerator: Episodes where patient receives a gestational diabetes screening or has existing diabetes diagnosis. Denominator: All of the provider's valid episodes.
c. Delivery Mode	NJ	CY 2022	Provider-specific baseline	Performance Period 5	Lower of: 86% or 2% improvement from self	Numerator: Episodes from the denominator where patient delivered vaginally. Denominator: All of the provider's valid episodes for individuals w/o a prior c-section and with singleton term neonate in vertex positions.
d. Postpartum Clinical Visit within 3 weeks of discharge	NJ	CY 2022	Provider-specific baseline	Performance Period 5	15%	Numerator: Episodes where patient receives an obstetrical follow-up visit within 21 days. Denominator: All of the provider's valid episodes.
e. Neonatal Visit within 5 days of discharge	NJ	CY 2022	Provider-specific baseline	Performance Period 5	Lower of: 50% or 5% improvement from self	Numerator: Episodes from the denominator where the neonate receives a primary care visit within 5 days. Denominator: All of the provider's valid episodes where patient can be matched to neonate.

1. Baseline data must be added after the first year of the payment arrangement
2. If state-developed, list State name for Steward/Developer.
3. If this is planned to be a multi-year payment arrangement, indicate which year(s) of the payment arrangement that performance on the measure will trigger payment.
4. If the State is using an established measure and will deviate from the measure steward's measure specifications, please describe here. Additionally, if a state-specific measure will be used, please define the numerator and denominator here.

13. For the measures listed in Table 1 above, please provide the following information:

a. Please describe the methodology used to set the performance targets for each measure.

All measures were set to maintain consistent requirements from Period 3-5 to give providers more time for practice transformation. The baseline year is CY2022, which was used to set expectations for Period 3.

Three metrics allow for an option where the provider's minimum threshold is set as an improvement-relative-to-self if the provider's CY2022 performance is below the minimum threshold shown in Table 1: Prenatal Depression Screening allows for 20% improvement relative to self. Delivery Mode allows for 2% improvement relative to self. Neonatal Visit allows for 5% improvement relative to self.

b. If multiple provider performance measures are involved in the payment arrangement, discuss if the provider must meet the performance target on each measure to receive payment or can providers receive a portion of the payment if they meet the performance target on some but not all measures?

1) Shared savings: Providers must meet minimum thresholds on all 5 quality metrics. (Spend requirements: Providers receive 50% of the savings amount if they reduce their average episode spend in Performance Period 4 relative to their own CY2022 spend by more than 3%.)

2) High Performer Bonus: Providers must meet minimum thresholds on all 5 quality metrics and meet commendable thresholds on at least two quality metrics (Spend requirements: Providers must have an average episode spend in Performance Period 4 that meets or is less than the CY2022 median for all statewide providers.) If they qualify, providers share in a set payment pool on a per episode basis. Minimum thresholds are the Performance Targets in Table 1 and Question 13a, commendable thresholds are: Prenatal Depression Screening - 60%; Gestational Diabetes Screening - 93%; Delivery Mode - 91%; Postpartum Clinical Visit - 21%; Neonatal Visit - 58%.

3) SUD Participation Incentive: N/A

Providers must fully meet the targets for each incentive. There are no partial payments.

When "CY2022" is used above, it refers to spend benchmarks set empirically based on historical analysis: Episode performance calculations were run on historical claims for a theoretical "performance period" for episodes ending in CY2022, assuming all eligible statewide providers were participating. The benchmarks are based on performance during that "CY2022 performance period".

c. For state-developed measures, please briefly describe how the measure was developed?

The State had the following goals with measure development: 1) Develop measures that could be calculated wholly by administrative means to minimize the burden on participating providers; and 2) Align measure definition to up-to-date clinical best practice based on the consensus recommendations of professional organizations.

The selection and design of quality metrics was informed by a stakeholder group (NJ Perinatal Episode of Care Steering Committee) including clinicians, non-clinicians, and advisors. The State utilized a contractor that developed our episode code set for measures that has undergone independent clinical stakeholder review and has been utilized in sister Medicaid programs for their perinatal episodes of care.

Prenatal Depression Screening was designed to be broadly aligned with the administrative aspect of HEDIS measure PND-E and is reflective of best practice recommendations in USPSTF 2019 "Interventions to Prevent Perinatal Depression" and ACOG 2023 Screening and Diagnosis of Mental Health Conditions During Pregnancy and Postpartum."

Gestation Diabetes Screening was reflective of best practice recommendations in ACOG 2024 "ACOG Clinical Practice Update"

Delivery Mode was designed to be broadly aligned with Joint Commission measure PC-02 for Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate but is based on a Primary C-section definition instead of a Nulliparous birth definition.

Postpartum Clinical Visit was designed to be broadly aligned with the administrative aspect of the HEDIS measure PPC but the 3 week timing is reflective of best practice recommendations in ACOG 2018 "Optimizing Postpartum Care."

Neonatal Visit within 5 days was designed to broadly aligned with HEDIS measure W30 but the 5 day timing focus on the first neonatal visit after birth is reflective of best practice recommendations from AAP 2021 "Bright Futures."

14. Is the State seeking a multi-year approval of the state directed payment arrangement?
☐ Yes ☒ No

a. If this payment arrangement is designed to be a multi-year effort, denote the State's managed care contract rating period(s) the State is seeking approval for.

b. If this payment arrangement is designed to be a multi-year effort and the State is **NOT** requesting a multi-year approval, describe how this application's payment arrangement fits into the larger multi-year effort and identify which year of the effort is addressed in this application.

The State is continuing the episode program while we await CMS guidance on requirements for the perinatal payment model associated with our participation in the CMMI TMaH model, whose implementation will be delayed until 2029 based on the most current CMMI guidance. This application is the continuation of the episode program after a three-year Performance Period pilot. All providers must be actively recruited for each Performance Period.

15. Use the checkboxes below to make the following assurances:

a. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(A), the state directed payment arrangement makes participation in the value-based purchasing initiative, delivery system reform, or performance improvement initiative available, using the same terms of performance, to the class or classes of providers (identified below) providing services under the contract related to the reform or improvement initiative.

b. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(B), the payment arrangement makes use of a common set of performance measures across all of the payers and providers.

c. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(C), the payment arrangement does not set the amount or frequency of the expenditures.

d. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(iii)(D), the payment arrangement does not allow the State to recoup any unspent funds allocated for these arrangements from the MCO, PIHP, or PAHP.

SUBSECTION IIB: STATE DIRECTED FEE SCHEDULES:
This section must be completed for all state directed payments that are fee schedule requirements. This section does not need to be completed for state directed payments that are VBP or DSR.

16. Please check the type of state directed payment for which the State is seeking prior approval. *Check all that apply; if none are checked, proceed to Section III.*

a. ☐ Minimum Fee Schedule for providers that provide a particular service under the contract *using rates other than State plan approved rates* [1] (42 C.F.R. § 438.6(c)(1)(iii)(B))

b. ☐ Maximum Fee Schedule (42 C.F.R. § 438.6(c)(1)(iii)(D))

c. ☐ Uniform Dollar or Percentage Increase (42 C.F.R. § 438.6(c)(1)(iii)(C))

[1] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

17. If the State is seeking prior approval of a fee schedule (options a or b in Question 16):

a. Check the basis for the fee schedule selected above.

i. ☐ The State is proposing to use a fee schedule based on the **State-plan approved rates** as defined in 42 C.F.R. § 438.6(a). [2]

ii. ☐ The State is proposing to use a fee schedule based on the **Medicare or Medicare-equivalent rate**.

iii. ☐ The State is proposing to use a fee schedule based on an **alternative fee schedule established by the State**.

1. If the State is proposing an alternative fee schedule, please describe the alternative fee schedule (e.g., 80% of Medicaid State-plan approved rate)

b. Explain how the state determined this fee schedule requirement to be reasonable and appropriate.

18. If using a maximum fee schedule (option b in Question 16), please answer the following additional questions:

a. ☐ Use the checkbox to provide the following assurance: In accordance with 42 C.F.R. § 438.6(c)(1)(iii)(C), the State has determined that the MCO, PIHP, or PAHP has retained the ability to reasonably manage risk and has discretion in accomplishing the goals of the contract.

b. Describe the process for plans and providers to request an exemption if they are under contract obligations that result in the need to pay more than the maximum fee schedule.

c. Indicate the number of exemptions to the requirement:

i. Expected in this contract rating period (estimate)

ii. Granted in past years of this payment arrangement

d. Describe how such exemptions will be considered in rate development.

[2] Please note, per the 2020 Medicaid and CHIP final rule at 42 C.F.R. § 438.6(c)(1)(iii)(A), States no longer need to submit a preprint for prior approval to adopt minimum fee schedules that use State plan approved rates as defined in 42 C.F.R. § 438.6(a).

19. If the State is seeking prior approval for a uniform dollar or percentage increase (option c in Question 16), please address the following questions:

a. Will the state require plans to pay a ☐ uniform dollar amount **or** a ☐ uniform percentage increase? (*Please select only one.*)

b. What is the magnitude of the increase (e.g., $4 per claim or 3% increase per claim?)

c. Describe how will the uniform increase be paid out by plans (e.g., upon processing the initial claim, a retroactive adjustment done one month after the end of quarter for those claims incurred during that quarter).

d. Describe how the increase was developed, including why the increase is reasonable and appropriate for network providers that provide a particular service under the contract

SECTION III: PROVIDER CLASS AND ASSESSMENT OF REASONABLENESS

20. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), identify the class or classes of providers that will participate in this payment arrangement by answering the following questions:

a. Please indicate which general class of providers would be affected by the state directed payment (check all that apply):

- ☐ inpatient hospital service
- ☐ outpatient hospital service
- ☐ professional services at an academic medical center
- ☐ primary care services
- ☐ specialty physician services
- ☐ nursing facility services
- ☐ HCBS/personal care services
- ☐ behavioral health inpatient services
- ☐ behavioral health outpatient services
- ☐ dental services
- ■ Other: Obstetrical providers

b. Please define the provider class(es) (if further narrowed from the general classes indicated above).

The participating provider must be an obstetrical provider of prenatal and/or labor and delivery care that receives reimbursement for a professional claim for that service and is identified at the level of billing provider.

Eligible providers include: physicians (including obstetricians), midwives (including nurse midwives and other licensed midwives), advanced practice nurses. Physicians, midwives, and advance practice nurses belong to hospital-affiliated group practices or standalone group practices.

c. Provide a justification for the provider class defined in Question 20b (e.g., the provider class is defined in the State Plan.) If the provider class is defined in the State Plan, please provide a link to or attach the applicable State Plan pages to the preprint submission. Provider classes cannot be defined to only include providers that provide intergovernmental transfers.

The participating provider in the pilot must be an obstetrical provider of prenatal and/or labor and delivery care. The eligible providers and the references to coverage within our State Plan are as follows: Physicians are covered under Physicians Services (e.g., see Addendum to Attachment 3.1A on page 5(a) of NJ Title XIX State Plan.). Midwives are covered either under Nurse-Midwives (i.e., CNMs; see Addendum to Attachment 3.1A on page 17 of NJ's Title XIX State Plan) or under Other Practitioners' Services (i.e., CMs, CPMs; e.g., see Addendum to Attachment 3.1A on page 6(d)(1) of NJ's Title XIX State Plan.) Advanced practice nurses are covered under Other Practitioners' Services (e.g., see Addendum to Attachment 3.1-A on page 6(d) of NJ's Title XIX State Plan). These are all providers covered by managed care and included in NJ's managed care contract.

Note on FQHC participation: FQHCs are not permitted to participate independently given their unique reimbursement structure, but may participate if they enter as an associated provider of an eligible provider class.

The justification for the participating provider to be the obstetrical provider of care is that this is a perinatal episode of care and the obstetrical provider is the lead clinician for perinatal care. Attribution of valid episodes is first made to a participating prenatal provider whenever possible. When a prenatal provider is not participating in the episode program, or cannot be identified, valid episodes will be assigned to a participating delivering provider, meaning a provider who has a professional claim for the delivery. The justification for attribution of the valid episodes primarily to the prenatal provider is that the prenatal provider has the best opportunity to establish a long-standing relationship with the enrollee throughout the perinatal period to support high-quality, efficient care.

21. In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(B), describe how the payment arrangement directs expenditures equally, using the same terms of performance, for the class or classes of providers (identified above) providing the service under the contract.

All participating providers will be held to the same standards for eligibility for the incentives across all of NJ's managed care organizations including: 1) Episode volume minimum of 15 attributed, valid episode, 2) Same quality thresholds and spend benchmarks requirements for Shared savings and High Performer Bonus 3) Same definition of eligibility for SUD Participation Incentive. The Shared savings percentage (50% of savings for providers who reduce spend by at least 3%) is uniform across all managed care providers. The payments for High Performer Bonus and SUD Participation Incentive is based on a similarly uniform per episode payment across all managed care providers; though each provider will get a different total amount for these two payments due to variations in total attributed, valid episode volume.

The episode has the same expectations regardless of the specific provider class of the participating provider of obstetrical care.

The State will be calculating performance for the episode directly from paid claims so will be able to ensure uniform calculation across managed care episodes.

22. For the services where payment is affected by the state directed payment, how will the state directed payment interact with the negotiated rate(s) between the plan and the provider? Will the state directed payment:

a. ☐ Replace the negotiated rate(s) between the plan(s) and provider(s).

b. ☐ Limit but not replace the negotiated rate(s) between the plans(s) and provider(s).

c. ☒ Require a payment be made in addition to the negotiated rate(s) between the plan(s) and provider(s).

23. For payment arrangements that are intended to require plans to make a payment in addition to the negotiated rates (as noted in option c in Question 22), please provide an analysis in Table 2 showing the impact of the state directed payment on payment levels for each provider class. This provider payment analysis should be completed distinctly for each service type (e.g., inpatient hospital services, outpatient hospital services, etc.).

This should include an estimate of the base reimbursement rate the managed care plans pay to these providers as a percent of Medicare, or some other standardized measure, and the effect the increase from the state directed payment will have on total payment. *Ex: The average base payment level from plans to providers is 80% of Medicare and this SDP is expected to increase the total payment level from 80% to 100% of Medicare.*

TABLE 2: Provider Payment Analysis

Provider Class(es)	Average Base Payment Level from Plans to Providers (absent the SDP)	Effect on Total Payment Level of State Directed Payment (SDP)	Effect on Total Payment Level of Other SDPs	Effect on Total Payment Level of Pass-Through Payments (PTPs)	Total Payment Level (after accounting for all SDPs and PTPs
Ex: Rural Inpatient Hospital Services	*80%*	*20%*	*N/A*	*N/A*	*100%*
a. Obstetrical practices	86.26%	8.74%	0.00%	0.00%	95.00%
b.	0.00%	0.00%	0.00%	0.00%	0.00%
c.	0.00%	0.00%	0.00%	0.00%	0.00%
d.	0.00%	0.00%	0.00%	0.00%	0.00%
e.	0.00%	0.00%	0.00%	0.00%	0.00%
f.	0.00%	0.00%	0.00%	0.00%	0.00%
g.	0.00%	0.00%	0.00%	0.00%	0.00%

24. Please indicate if the data provided in Table 2 above is in terms of a percentage of:

- **a.** ☒ Medicare payment/cost
- **b.** ☐ State-plan approved rates as defined in 42 C.F.R. § 438.6(a) *(Please note, this rate cannot include supplemental payments.)*
- **c.** ☐ Other; Please define:

25. Does the State also require plans to pay any other state directed payments for providers eligible for the provider class described in Question 20b? ☒ Yes ☐ No

If yes, please provide information requested under the column "Other State Directed Payments" in Table 2.

26. Does the State also require plans to pay pass-through payments as defined in 42 C.F.R. § 438.6(a) to any of the providers eligible for any of the provider class(es) described in Question 20b? ☐ Yes ☒ No

If yes, please provide information requested under the column "Pass-Through Payments" in Table 2.

27. Please describe the data sources and methodology used for the analysis provided in response to Question 23.

It was difficult to delineate the MAPS payments from the base payments for these providers; however, the MAPS payments are captured in the base rates. The performance pools total $3 million and we estimate shared savings of $500,000. Therefore, the estimated total State Directed Payment for the Performance Period is $3.5 million. Percentages were determined by calculating CY2019 NJ Medicaid payments to participating providers as a percentage of current Medicare rates.

28. Please describe the State's process for determining how the proposed state directed payment was appropriate and reasonable.

The State has set Shared Savings at 50%, so that the obstetrical provider who has contributed to the savings through management of the enrollee's perinatal care can share in the savings that would typically only be available to the managed care organization. The Shared Savings was set at 50% to: 1) recruit provider participation in the Performance Period of this voluntary episode of care; and 2) ensure that savings are available to both provider and managed care organization.

The State has set two pools of funding for the separate incentives of the High Performer Bonus ($2 million) and SUD Participation Incentive ($1 million). The High Performer Bonus was created to provide an incentive to providers who have already improved on spend to the degree where their eligibility for Shared Savings is limited. The SUD Participation Incentive was created to recruit provider participation in the Performance Period of this voluntary episode of care from those providers who serve high SUD populations that can be associated with increased episode spend.

SECTION IV: INCORPORATION INTO MANAGED CARE CONTRACTS

29. States must adequately describe the contractual obligation for the state directed payment in the state's contract with the managed care plan(s) in accordance with 42 C.F.R. § 438.6(c). Has the state already submitted all contract action(s) to implement this state directed payment? ☒ Yes ☐ No

a. If yes:

i. What is/are the state-assigned identifier(s) of the contract actions provided to CMS?

MCR-NJ-0016-NJFAMILYCARE

ii. Please indicate where (page or section) the state directed payment is captured in the contract action(s).

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b. If no, please estimate when the state will be submitting the contract actions for review.

SECTION V: INCORPORATION INTO THE ACTUARIAL RATE CERTIFICATION

Note: Provide responses to the questions below for the first rating period if seeking approval for multi-year approval.

30. Has/Have the actuarial rate certification(s) for the rating period for which this state directed payment applies been submitted to CMS? ☒ Yes ☐ No

a. If no, please estimate when the state will be submitting the actuarial rate certification(s) for review.

b. If yes, provide the following information in the table below for each of the actuarial rate certification review(s) that will include this state directed payment.

Table 3: Actuarial Rate Certification(s)

Control Name Provided by CMS (List each actuarial rate certification separately)	Date Submitted to CMS	Does the certification incorporate the SDP?	If so, indicate where the state directed payment is captured in the certification (page or section)
i. MCR-NJ-ACUTE-20260701-20270630-CERTIFICATION-20260622	06/29/2026	Yes	Section 5
ii. MCR-NJ-MLTSS-20260701-20270630-CERTIFICATION-20260622	06/29/2026	Yes	Delivery System and Provider Payment Initative
iii.			
iv.			
v.			

Please note, states and actuaries should consult the most recent Medicaid Managed Care Rate Development Guide for how to document state directed payments in actuarial rate certification(s). The actuary's certification must contain all of the information outlined; if all required documentation is not included, review of the certification will likely be delayed.)

c. If not currently captured in the State's actuarial certification submitted to CMS, note that the regulations at 42 C.F.R. § 438.7(b)(6) requires that all state directed payments are documented in the State's actuarial rate certification(s). CMS will not be able to approve the related contract action(s) until the rate certification(s) has/have been amended to account for all state directed payments. Please provide an estimate of when the State plans to submit an amendment to capture this information.

31. Describe how the State will/has incorporated this state directed payment arrangement in the applicable actuarial rate certification(s) (please select one of the options below):

- **a.** ☐ An adjustment applied in the development of the monthly base capitation rates paid to plans.
- **b.** ☐ Separate payment term(s) which are captured in the applicable rate certification(s) but paid separately to the plans from the monthly base capitation rates paid to plans.
- **c.** ☒ Other, please describe: BOTH - 31.a. (shared savings payment) and 31.b.(high performer and SUD bonus)

32. States should incorporate state directed payment arrangements into actuarial rate certification(s) as an adjustment applied in the development of the monthly base capitation rates paid to plans as this approach is consistent with the rate development requirements described in 42 C.F.R. § 438.5 and consistent with the nature of risk-based managed care. For state directed payments that are incorporated in another manner, particularly through separate payment terms, provide additional justification as to why this is necessary and what precludes the state from incorporating as an adjustment applied in the development of the monthly base capitation rates paid to managed care plans.
The High Performer Bonus and SUD Incentive Payments are based on fixed statewide pools that cannot be distributed in advance until we verify which participating providers are earning the incentive, and which MCOs they are contracted with.

33. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(i), the State assures that all expenditures for this payment arrangement under this section are developed in accordance with 42 C.F.R. § 438.4, the standards specified in 42 C.F.R. § 438.5, and generally accepted actuarial principles and practices.

SECTION VI: FUNDING FOR THE NON-FEDERAL SHARE

34. Describe the source of the non-federal share of the payment arrangement. Check all that apply:

- **a.** ☒ State general revenue
- **b.** ☐ Intergovernmental transfers (IGTs) from a State or local government entity
- **c.** ☐ Health Care-Related Provider tax(es) / assessment(s)
- **d.** ☐ Provider donation(s)
- **e.** ☐ Other, specify:

35. For any payment funded by **IGTs (option b in Question 34)**,

- **a.** Provide the following (respond to each column for all entities transferring funds). If there are more transferring entities than space in the table, please provide an attachment with the information requested in the table.

Table 4: IGT Transferring Entities

Name of Entities transferring funds (enter each on a separate line)	Operational nature of the Transferring Entity (State, County, City, Other)	Total Amounts Transferred by This Entity	Does the Transferring Entity have General Taxing Authority? (Yes or No)	Did the Transferring Entity receive appropriations? If not, put N/A. If yes, identify the level of appropriations	Is the Transferring Entity eligible for payment under this state directed payment? (Yes or No)
i.					
ii.					
iii.					
iv.					
v.					
vi.					
vii.					
viii.					
ix.					
x.					

b. ☐ Use the checkbox to provide an assurance that no state directed payments made under this payment arrangement funded by IGTs are dependent on any agreement or arrangement for providers or related entities to donate money or services to a governmental entity.

c. Provide information or documentation regarding any written agreements that exist between the State and healthcare providers or amongst healthcare providers and/or related entities relating to the non-federal share of the payment arrangement. This should include any written agreements that may exist with healthcare providers to support and finance the non-federal share of the payment arrangement. Submit a copy of any written agreements described above.

36. For any state directed payments funded by **provider taxes/assessments (option c in Question 34)**,

a. Provide the following (respond to each column for all entries). If there are more entries than space in the table, please provide an attachment with the information requested in the table.

Table 5: Health Care-Related Provider Tax/Assessment(s)

Name of the Health Care-Related Provider Tax / Assessment (enter each on a separate line)	Identify the permissible class for this tax / assessment	Is the tax / assessment broad-based?	Is the tax / assessment uniform?	Is the tax / assessment under the 6% indirect hold harmless limit?	If not under the 6% indirect hold harmless limit, does it pass the "75/75" test?	Does it contain a hold harmless arrangement that guarantees to return all or any portion of the tax payment to the tax payer?
i.						
ii.						
iii.						
iv.						
v.						

b. If the state has any waiver(s) of the broad-based and/or uniform requirements for any of the health care-related provider taxes/assessments, list the waiver(s) and its current status:

Table 6: Health Care-Related Provider Tax/Assessment Waivers

Name of the Health Care-Related Provider Tax/Assessment Waiver (enter each on a separate line)	Submission Date	Current Status (Under Review, Approved)	Approval Date
i.			
ii.			
iii.			
iv.			
v.			

37. For any state directed payments funded by **provider donations (option d in Question 34)**, please answer the following questions:

a. Is the donation bona-fide? ☐ Yes ☐ No

b. Does it contain a hold harmless arrangement to return all or any part of the donation to the donating entity, a related entity, or other provider furnishing the same health care items or services as the donating entity within the class?
☐ Yes ☐ No

38. ☒ **For all state directed payment arrangements**, use the checkbox to provide an assurance that in accordance with 42 C.F.R. § 438.6(c)(2)(ii)(E), the payment arrangement does not condition network provider participation on the network provider entering into or adhering to intergovernmental transfer agreements.

SECTION VII: QUALITY CRITERIA AND FRAMEWORK FOR ALL PAYMENT ARRANGEMENTS

39. ■ Use the checkbox below to make the following assurance, "In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(C), the State expects this payment arrangement to advance at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340."

40. Consistent with 42 C.F.R. § 438.340(d), States must post the final quality strategy online beginning July 1, 2018. Please provide:

- **a.** A hyperlink to State's most recent quality strategy: https://www.state.nj.us/humanservices/dmahs/news/NJ_DMAHS_Quality_Strategy_2022.pdf
- **b.** The effective date of quality strategy. July 26, 2022

41. If the State is currently updating the quality strategy, please submit a draft version, and provide:

- **a.** A target date for submission of the revised quality strategy (month and year):
- **b.** Note any potential changes that might be made to the goals and objectives.

Note: The State should submit the final version to CMS as soon as it is finalized. To be in compliance with 42 C.F.R. § 438.340(c)(2) the quality strategy must be updated no less than once every 3-years.

42. To obtain written approval of this payment arrangement, a State must demonstrate that each state directed payment arrangement expects to advance at least one of the goals and objectives in the quality strategy. In the Table 7 below, identify the goal(s) and objective(s), as they appear in the Quality Strategy (include page numbers), this payment arrangement is expected to advance. If additional rows are required, please attach.

Table 7: Payment Arrangement Quality Strategy Goals and Objectives

Goal(s)	Objective(s)	Quality strategy page
Example: Improve care coordination for enrollees with behavioral health conditions	*Example: Increase the number of managed care patients receiving follow-up behavior health counseling by 15%*	*5*
a. Serve people the best way possible through benefits, service delivery, quality, and equity	Improve maternal/child health outcomes	9
b. Experiment with new ways to solve problems through innovation, technology, and troubleshooting	Demonstrate new value-based models that drive outcomes	9
c.		
d.		

43. Describe how this payment arrangement is expected to advance the goal(s) and objective(s) identified in Table 7. If this is part of a multi-year effort, describe this both in terms of this year's payment arrangement and in terms of that of the multi-year payment arrangement.

The State's perinatal episode of care is an alternative payment model for perinatal services statewide. Participating providers are financially incentivized to take on comprehensive responsibility for the quality and cost of the enrollee's care. The State is holding all participating providers to the same five quality metrics (reflecting both maternal and child measures) and seeks to advance statewide improvements in the quality of care--with the goal of improving outcomes for birthing individuals and their infants.

44. Please complete the following questions regarding having an evaluation plan to measure the degree to which the payment arrangement advances at least one of the goals and objectives of the State's quality strategy. To the extent practicable, CMS encourages States to utilize existing, validated, and outcomes-based performance measures to evaluate the payment arrangement, and recommends States use the CMS Adult and Child Core Set Measures, when applicable.

a. ☒ In accordance with 42 C.F.R. § 438.6(c)(2)(ii)(D), use the checkbox to assure the State has an evaluation plan which measures the degree to which the payment arrangement advances at least one of the goals and objectives in the quality strategy required per 42 C.F.R. § 438.340, and that the evaluation conducted will be *specific* to this payment arrangement. *Note:* States have flexibility in how the evaluation is conducted and may leverage existing resources, such as their 1115 demonstration evaluation if this payment arrangement is tied to an 1115 demonstration or their External Quality Review validation activities, as long as those evaluation or validation activities are *specific* to this payment arrangement and its impacts on health care quality and outcomes.

b. Describe how and when the State will review progress on the advancement of the State's goal(s) and objective(s) in the quality strategy identified in Question 42. For each measure the State intends to use in the evaluation of this payment arrangement, provide in Table 8 below: 1) the baseline year, 2) the baseline statistics, and 3) the performance targets the State will use to track the impact of this payment arrangement on the State's goals and objectives. Please attach the State's evaluation plan for this payment arrangement.

TABLE 8: Evaluation Measures, Baseline and Performance Targets

Measure Name and NQF # (if applicable)	**Baseline Year**	**Baseline Statistic**	**Performance Target**	**Notes**[1]
Example: Flu Vaccinations for Adults Ages 19 to 64 (FVA-AD); NQF # 0039	*CY 2019*	*34%*	*Increase the percentage of adults 18–64 years of age who report receiving an influenza vaccination by 1 percentage point per year*	*Example notes*
i. Gestational diabetes screening	CY2022	87%	Increase the peer median (statewide providers) by 1 percentage point between Performance Period 3 and Performance Period 5	
ii. Delivery mode	CY2022	86%	Increase the peer median (statewide providers) by 1 percentage point between Performance Period 3 and Performance Period 5	
iii. Postpartum visit within 3 weeks of discharge	CY2022	9%	Increase the peer median (statewide providers) by 1 percentage point between Performance Period 3 and Performance Period 5	
iv. Neonatal visit within 5 days of discharge	CY2022	50%	Increase the peer median (statewide providers) by 1 percentage point between Performance Period 3 and Performance Period 5	

1. If the State will deviate from the measure specification, please describe here. If a State-specific measure will be used, please define the numerator and denominator here. Additionally, describe any planned data or measure stratifications (for example, age, race, or ethnicity) that will be used to evaluate the payment arrangement.

c. If this is any year other than year 1 of a multi-year effort, describe (or attach) prior year(s) evaluation findings and the payment arrangement's impact on the goal(s) and objective(s) in the State's quality strategy. Evaluation findings must include 1) historical data; 2) prior year(s) results data; 3) a description of the evaluation methodology; and 4) baseline and performance target information from the prior year(s) preprint(s) where applicable. If full evaluation findings from prior year(s) are not available, provide partial year(s) findings and an anticipated date for when CMS may expect to receive the full evaluation findings.

As of submission of this pre-print, prior period Final Performance Reports are still being quality checked and payments have not yet been made.