DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

October 16, 2025

Greg Woods
Assistant Commissioner
Division of Medical Assistance and Health Services
State of New Jersey Department of Human Services
P.O. Box 712
Trenton, NJ 08625-0712

Dear Assistant Commissioner Woods:

The Centers for Medicare & Medicaid Services (CMS) completed its review of the Evaluation Design, which is required by the Special Terms and Conditions (STCs), specifically STC 13.3, of the section 1115 demonstration, "New Jersey FamilyCare Comprehensive Demonstration" (Project No. 11-W-00279/2), effective through June 30, 2028. CMS determined that the Evaluation Design, which was submitted on October 28, 2024 and subsequently resubmitted with revisions on May 9, 2025, meets the requirements set forth in the STCs and our evaluation design guidance, and therefore approves the state's Evaluation Design.

CMS has added the approved Evaluation Design to the demonstration's STCs as Attachment K. A copy of the STCs, which includes the new attachment, is enclosed with this letter. In accordance with 42 CFR 431.424, the approved Evaluation Design may now be posted to the state's Medicaid website within 30 days. CMS will also post the approved Evaluation Design as a standalone document, separate from the STCs, on Medicaid.gov.

Please note that the Interim Evaluation Report, consistent with the approved Evaluation Design, is due to CMS by June 30, 2027, or at the time of the extension application, if the state chooses to extend the demonstration. Likewise, a Summative Evaluation Report, consistent with this approved design, is due to CMS within 18 months of the end of the demonstration's current approval period. In accordance with 42 CFR 431.428 and the STCs, we look forward to receiving updates on evaluation activities in the demonstration monitoring reports.

We appreciate our continued partnership with New Jersey on the FamilyCare Comprehensive section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

DANIELLE DALY -S

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Date: 2025.10.16 11:15:39 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Terri Fraser, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-25-26
Baltimore, Maryland 21244-1850

State Demonstrations Group

June 25, 2025

Greg Woods
Assistant Commissioner
Division of Medical Assistance and Health Services
State of New Jersey Department of Human Services
PO Box 712
Trenton, NJ 08625-0712

Dear Assistant Commissioner Woods:

The Centers for Medicare & Medicaid Services (CMS) is updating the section 1115 demonstration monitoring approach to reduce state burden, promote effective and efficient information sharing, and enhance CMS's oversight of program integrity by reducing variation in information reported to CMS.

Federal section 1115 demonstration monitoring and evaluation requirements are set forth in section 1115(d)(2)(D)-(E) of the Social Security Act (the Act), in CMS regulations in 42 CFR 431.428 and 431.420, and in individual demonstration special terms and conditions (STCs). Monitoring provides insight into progress with initial and ongoing demonstration implementation and performance, which can detect risks and vulnerabilities to inform possible course corrections and identify best practices. Monitoring is a complementary effort to evaluation. Evaluation activities assess the demonstration's success in achieving its stated goals and objectives.

Key changes of this monitoring redesign initiative include introducing a structured template for monitoring reporting, updating the frequency and timing of submission of monitoring reports, and standardizing the cadence and content of the demonstration monitoring calls.

Updates to Demonstration Monitoring

Below are the updated aspects of demonstration monitoring for the New Jersey FamilyCare Comprehensive Demonstration (Project Number 11-W-00279/2 and 21-W-00068/2)..

Reporting Cadence and Due Date

CMS determined that, when combined with monitoring calls, an annual monitoring reporting cadence will generally be sufficient to monitor potential risks and vulnerabilities in

demonstration implementation, performance, and progress toward stipulated goals. Thus, pursuant to CMS's authority under 42 CFR 431.420(b)(1) and 42 CFR 431.428, CMS is updating the cadence for this demonstration to annual monitoring reporting (see also section 1115(d)(2)(D)-(E) of the Act). This transition to annual monitoring reporting is expected to alleviate administrative burden for both the state and CMS. In addition, CMS is extending the due date of the annual monitoring report from 90 days to 180 days after the end of each demonstration year to balance Medicaid claims completeness with the state's work to draft, review, and submit the report timely.

CMS might increase the frequency of monitoring reporting if CMS determines that doing so would be appropriate. The standard for determining the frequency of monitoring reporting will ultimately be included in each demonstration's STCs. CMS expects that this standard will permit CMS to make on-going determinations about reporting frequency under each demonstration by assessing the risk that the state might materially fail to comply with the terms of the approved demonstration during its implementation and/or the risk that the state might implement the demonstration in a manner unlikely to achieve the statutory purposes of Medicaid. *See* 42 CFR 431.420(d)(1)-(2).

The New Jersey FamilyCare Comprehensive Demonstration will transition to annual monitoring reporting effective June 25, 2025. The next annual monitoring report will be due on December 29, 2025, which reflects the first business day following 180 calendar days after the end of the current demonstration year. The demonstration STCs will be updated in the next demonstration amendment or extension approval to reflect the new reporting cadence and due date.

Structured Monitoring Report Template

As noted in STC 12.8, "Monitoring Reports," monitoring reports "must follow the framework provided by CMS, which is subject to change as monitoring systems are developed / evolve and be provided in a structured manner that supports federal tracking and analysis." Pursuant to that STC, CMS is introducing a structured monitoring report template to minimize variation in content of reports across states, which will facilitate drawing conclusions over time and across demonstrations with broadly similar section 1115 waivers or expenditure authorities. The structured reporting framework will also provide CMS and the state opportunities for more comprehensive and instructive engagement on the report's content to identify potential risks and vulnerabilities and associated mitigation efforts as well as best practices, thus strengthening the overall integrity of demonstration monitoring.

This structured template will include a set of base metrics for all demonstrations. For demonstrations with certain waiver and expenditure authorities, there are additional policy-specific metrics that will be collected through the structured reporting template.

Some of the metrics currently required for Substance Use Disorder (SUD) and Serious Mental Illness (SMI)/Serious Emotional Disturbance (SED) demonstrations will no longer be required.

The base and policy-specific metrics include applicable established measures of quality of care and correlated outcomes, which will be standardized across all similar demonstrations. The state may continue reporting additional quality measures to address state goals and priorities. CMS will no longer expect the state to report metrics that include elements from the draft CMS disparities-sensitive measure set, referenced in the demonstration STCs.

CMS is also removing the requirement for a Monitoring Protocol deliverable, which has been required under certain types of section 1115 demonstration, including but not limited to the SUD, SMI/SED, Health-Related Social Needs (HRSN), and reentry demonstrations. Removal of the Monitoring Protocol requirement simplifies and streamlines demonstration monitoring activities for states and CMS.

The demonstration STCs, specifically STCs 9.8 and 9.8.a, include requirements to submit a Home and Community Based Services (HCBS) Quality Improvement Strategy (QIS) Report, HCBS Performance Measure Report, HCBS Evidentiary Report, HCBS Deficiency Report and HCBS Enrollment Number Report that previously may have been included as part of the quarterly or annual monitoring reports. The state is still required to submit the HCBS specific deliverables and reports stipulated in the STCs, but separately from the structured monitoring reports. CMS will provide applicable instructions in the coming weeks.

Demonstration Monitoring Calls

As STC 12.12 "Monitoring Calls" describes, CMS may "convene periodic conference calls with the state," and the calls are intended "to discuss ongoing demonstration operation, including (but not limited to) any significant actual or anticipated developments affecting the demonstration." Going forward, CMS envisions implementing a structured format for monitoring calls to provide consistency in content and frequency of demonstration monitoring calls across demonstrations. CMS also envisions convening quarterly monitoring calls with the state and will follow the structure and topics in the monitoring report template. We anticipate that standardizing the expectations for and content of the calls will result in more meaningful discussion and timely assessment of demonstration risks, vulnerabilities, and opportunities for intervention. The demonstration STCs will be updated in the next demonstration amendment or extension approval to reflect that monitoring calls will be held no less frequently than quarterly.

CMS will continue to be available for additional calls as necessary to provide technical assistance or to discuss demonstration applications, pending actions, or requests for changes to demonstrations. CMS recognizes that frequent and regular calls are appropriate for certain demonstrations and at specific points in a demonstration's lifecycle.

In the coming weeks, CMS will reach out to schedule a transition meeting to review templates and timelines outlined above. As noted above, the pertinent New Jersey FamilyCare Comprehensive section 1115 demonstration STCs will be updated in the next demonstration amendment or extension approval to reflect these updates.

If you have any questions regarding these updates, please contact Danielle Daly, Director of the Division of Demonstration Monitoring and Evaluation, at Danielle.Daly@cms.hhs.gov.

Sincerely,

[redacted]

Karen LLanos
Acting Director

Enclosure
cc: Terri Fraser, State Monitoring Lead, Medicaid and CHIP Operations Lead

CENTERS FOR MEDICARE & MEDICAID SERVICES

WAIVER AUTHORITY

NUMBER: **11-W-00279/2 and 21-W-00068/2**

TITLE: **New Jersey FamilyCare Comprehensive Demonstration**

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

All requirements of the Medicaid program expressed in law, regulation, and policy statement, not expressly waived in this list, shall apply to the demonstration project beginning April 1, 2023 through June 30, 2028, unless otherwise specified. In addition, these waivers may only be implemented consistent with the approved Special Terms and Conditions (STCs).

All previously approved waivers for this demonstration are superseded by those set forth below with respect to the state's operation of the demonstration during the period from April 1, 2023 through June 30, 2028.

Under the authority of Section 1115(a)(1) of the Social Security Act (the Act), the following waivers of state plan requirements contained in Section 1902 of the Act are granted in order to enable New Jersey (state) to carry out the New Jersey FamilyCare Comprehensive Section 1115 demonstration.

Statewide Operation **Section 1902(a)(1)**

To the extent necessary to enable the state to provide managed care plans or different types of managed care plans, only in certain geographic service areas.

To enable the state to provide health-related social needs (HRSN) services on a geographically limited, county-by-county, basis.

To enable the state to provide services under the Integrated Care for Kids (InCK) model only in designated intervention counties. Payments to states made under this paragraph shall be considered to have been under, and are subject to the requirements, of Section 1903 of the Act (42 U.S.C. 1396b).

To the extent necessary, to enable the state to provide services through specified Certified Community Behavioral Health Clinics (CCBHC) in designated areas of the state. This waiver authority starts from the effective date of New Jersey's CCBHC State Plan Amendment (SPA), once the necessary SPA is approved.

To the extent necessary, to enable the state to provide services under the Universal Home Visiting Pilot in designated areas of the state. This waiver authority starts from the effective date of New Jersey's Universal Home Visiting SPA, once the necessary SPA is approved.

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

To the extent necessary to enable the state to vary the amount, duration, and scope of services offered to individuals under this demonstration, regardless of eligibility category, by providing additional services to enrollees in certain targeted programs to provide home and community-based services (HCBS) and/or managed long-term services and supports.

Transfer of Assets **Section 1902(a)(18) insofar incorporates Section 1917(c)**

To the extent necessary to enable the state to allow individuals, who have incomes at or below 100 percent of the FPL, to self-attest at the time of application that no transfers were made during the look back period.

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

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

To permit the state to restrict providers from whom Medicaid eligible beneficiaries may obtain supportive visitation services. This waiver authority starts from the effective date of New Jersey's Supportive Visitation Services SPA.

To permit the state to restrict providers from whom Medicaid eligible beneficiaries may obtain universal home visitation services. This waiver authority starts from the effective date of New Jersey's Universal Home Visitation Services SPA.

Direct Provider Reimbursement **Section 1902(a)(32)**

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

CENTERS FOR MEDICARE & MEDICAID SERVICES

EXPENDITURE AUTHORITY

NUMBER: **11-W-00279/2 and 21-W-00068/2**

TITLE: **New Jersey FamilyCare Comprehensive Demonstration**

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

Under the authority of Section 1115(a)(2) of the Social Security Act (the Act), expenditures made by New Jersey for the items identified below, which are not otherwise included as expenditures under Section 1903 or Section 2107(e)(2)(A) of the Act, incurred during the period of this demonstration, for the period of this demonstration extension (April 1, 2023 through June 30, 2028) unless otherwise specified, shall be regarded as expenditures the state's title XIX and XXI plans. All previously approved expenditure authorities for this demonstration are superseded by those set forth below for the state's expenditures relating to dates of service during this demonstration extension (April 1, 2023 through June 30, 2028) unless otherwise specified.

The following expenditure authorities may only be implemented consistent with the approved Special Terms and Conditions (STCs) and shall enable New Jersey to operate the New Jersey FamilyCare Comprehensive 1115 demonstration.

Title XIX – Expenditure Authorities

1. **Targeted HCBS Demonstration Expenditures.** The following expenditures are for the provision of targeted home and community-based services (HCBS) (as specified in the STCs) that are not described in Section 1905(a) of the Act, and not otherwise available under the approved state plan, but that could be provided under the authority of a Section 1915(c) waiver, that are delivered to demonstration participants, Fee for Service (FFS) with qualifying income and resources, and meet an institutional level of care.

    a. **Supports Program.** Expenditures for health-care related costs for individuals who are over the age of 21, or between the age of 18 to 21 and have graduated from, or are no longer eligible for, the services they are entitled to through their local educational authority (educational entitlement), who meet the functional eligibility criteria for the Supports Program as prescribed in the STCs, and are Medicaid eligible or have income up to 300 percent of the Federal Benefit Rate (FBR).

    b. **Children's Support Services Program (SED).** Expenditures for health-care related costs to provide behavioral health and/or home and community-based services and supports to youth ages 0-21, using institutional deeming rules where appropriate, that have a serious emotional disturbance (SED) which places them at risk of hospitalization, out of home treatment, or at hospital level of care.

        a. Individuals who are Medicaid eligible or Children's Health Insurance Program (CHIP) eligible receive targeted HCBS services authorized under the demonstration;

b. Individuals who are not otherwise eligible for Medicaid State Plan due to family income, with income up to 300 percent of the FBR (including treatment as a "Household of One") receive state plan services and targeted HCBS services authorized under the demonstration;

c. Individuals who do not qualify for Medicaid or CHIP under the state plan, and whose household income is above 300 percent of the FBR receive targeted HCBS services authorized under the demonstration and otherwise State Plan covered behavioral health services only.

c. **Children's Support Services Program (I/DD).** Expenditures for health-care related costs for home and community based services for youth with intellectual/developmental disabilities (I/DD) or a co-occurring mental health diagnosis (I/DD-MI), ages 0-21, who meet the functional eligibility criteria, using institutional deeming rules where appropriate, as prescribed in the STCs.

a. Individuals who are Medicaid or CHIP eligible receive targeted HCBS services authorized under the demonstration;

b. Individuals who are not otherwise eligible for Medicaid state plan benefits due to family income, with income up to 300 percent of the FBR receive state plan services and targeted HCBS services authorized under the demonstration;

c. Individuals who do not qualify for Medicaid or CHIP under the state plan, and whose household income is above 300 percent of the FBR, members receive targeted HCBS services authorized under the demonstration and state plan for behavioral health services only.

d. **Community Care Program (CCP).** Expenditures for health-care related costs for services and supports under the CCP as described in the STCs for Medicaid eligible individuals who are over the age of 21, or between the ages of 18 to 21 and have graduated from, or are no longer eligible for, the services they are entitled to through their local educational authority (educational entitlement), or meet the requirements described in STC 5.11, with developmental disabilities who meet the Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID) level of care criteria and specific Medicaid requirements regarding income and resources**.**

e. **Autism Spectrum Disorder Program.** Expenditures for specialized services that are not otherwise covered under the Medicaid state plan for children who are Medicaid eligible and have been diagnosed with Autism Spectrum Disorder (ASD).

f. **New Jersey Home Visiting Program.** Expenditures to deliver evidence-based home visiting services in identified areas throughout the state as set forth in STC 5.13.

2. **MLTSS Demonstration Expenditures**

a. **Managed Long Term Services and Supports (MLTSS) Program.** Expenditures for health-care related costs for HCBS services provided to the elderly and disabled through a managed care delivery system, as authorized under this demonstration, (as specified in Attachment D of the STCs) that are not described in Section 1905(a) of the Act, and not

otherwise available under the approved state plan and that are provided to demonstration participants with qualifying income and resources, and meet an institutional level of care.

b. **Caregiver Support Services.** Expenditures to expand access to health services for informal or unpaid caregivers to receive group or individual counseling services when experiencing emotional or psychological difficulties while caring for individuals receiving MLTSS, as described in STC 5.19.

3. **Income Eligibility Specific Expenditures**

a. **217-Like Expansion Populations.** Expenditures for the provision of Medicaid state plan services, targeted HCBS services and MLTSS service, authorized under this demonstration, for individuals identified in the STCs who would otherwise be Medicaid-eligible under Section 1902(a)(10)(A)(ii)(VI) of the Act and 42 CFR § 435.217 in conjunction with Section 1902(a)(10)(A)(ii)(V) of the Act, including applying the Spousal Impoverishment Eligibility and Post Eligibility Rules specified at Section 1924 of the Act to all married individuals, the regular post eligibility rules specified at 42 CFR 435.725 and 435.726 of the federal regulations for unmarried individuals, and the requirements of being a Miller Trust state specified at Section 1917 of the Act, if they received such services under a HCBS waiver granted to the state under Section 1915(c) of the Act.

4. **SUD Services in Institutions for Mental Diseases (SUD IMD Services MEGs 1, 2, and 3).** Expenditures for Medicaid state plan services and benefits to the extent not available under the Medicaid state plan, furnished to otherwise eligible individuals who are primarily receiving treatment and/or withdrawal management services for substance use disorder (SUD) who are short-term residents in facilities that meet the definition of an institution for mental diseases (IMD).

5. **Expedited Eligibility Determination for Individuals under the Guardianship of the Office of the Public Guardian (OPG).** Expenditures for health-care related costs up to 12 months for individuals under the guardianship of the OPG during the expedited eligibility determination period as set forth in STC 5.14 and Attachment H.

6. **Postpartum Extension**

a. **Expenditures for Benefits for Postpartum Individuals.** Expenditures for Medicaid state plan benefits to extend the postpartum eligibility period from the end of the month in which the 60th postpartum day occurs to the end of the 12th month following the end of the pregnancy, as described in STC 5.15.

a. This expenditure authority starts on April 1, 2022 for Medicaid "lawfully residing" pregnant individuals covered by the state under Section 1903(v)(4)(A)(i) of the Act.

b. **Expenditures for Continuous Eligibility for State Plan Benefits For the Full Pregnancy and 12-Month Postpartum Period:** Expenditures for pregnant and postpartum individuals to be continuously eligible without regard to changes in circumstances through the end of the 12-month extended postpartum eligibility period as set forth in STC 5.15.

a. This expenditure authority starts on April 1, 2022 for Medicaid "lawfully residing" pregnant individuals covered by the state under Section 1903(v)(4)(A)(i) of the Act.

7. **Twelve-Month Continuous Eligibility Period.** Expenditures for continued benefits for individuals who have been determined eligible under groups specified in STC 5.16.a for a 12-month continuous eligibility period who would otherwise lose coverage if subject to an eligibility redetermination, except as noted in STC 5.16.c.

8. **Health-Related Social Needs (HRSN) Services**. Expenditures for health-related social needs services not otherwise covered that are furnished to individuals who meet the qualifying criteria as described in Section 10 of the STCs. This expenditure authority is contingent upon adherence to the requirements within Section 11 of these STCs, as well as all other applicable STCs.

9. **Expenditures for HRSN Services Infrastructure**. Expenditures for payments for allowable administrative costs and infrastructure not otherwise eligible for Medicaid payment, to the extent such activities are authorized under Section 10 of the STCs. This expenditure authority is contingent upon adherence to the requirements within Section 11 of the STCs, as well as all other applicable STCs.

10. **Behavioral Health Promoting Interoperability Program (BH PIP).** Expenditures for the state's BH PIP incentive program that will strengthen Medicaid providers' ability to participate in the state's health information exchange (HIE), in accordance with the requirements in STC 5.17.

11. **Community Health Workers Pilot.** Expenditures for the state's community health workers program pilot to provide evidence-based services within defined communities, in accordance with the requirements in STC 5.18.

Title XIX Requirements Not Applicable to the Supports Program, Children Support Services Program and I/DD:

Reasonable Promptness **Section 1902(a)(8)**

To the extent necessary to enable the state to limit enrollment through waiting lists for the following demonstration programs: Community Care Program, Children Support Services Program and I/DD to receive targeted HCBS services outlined in the STCs.

Title XIX Requirements Not Applicable to the Supports Program and Community Care Program:

Income and Asset Standards **Section 1902(a)(17)**

To enable the state to disregard Title II benefits received based on parents' income for an individual who was not receiving Supplemental Security Income (SSI) as of their 18th birthday. Therefore, these individuals can qualify for the Supports Program and Community Care Program.

Title XIX Requirements Not Applicable to the Evidence-Based Home Visiting Pilot Program

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

To enable the state to operate the New Jersey Home Visiting Pilot Programs only in certain counties in the state as specified in STC 5.13 and Attachment L.

Title XIX Requirements Not Applicable to the HRSN Expenditure Authority

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

To the extent necessary to enable New Jersey to provide HRSN services or certain types of HRSN services, only in certain geographical areas of the state.

Comparability: Amount, Duration, and Scope **Section 1902(a)(10)(B), Section 1902(a)(17)**

To the extent necessary to enable the state to provide medically indicated meals to a subset of up to 300 beneficiaries per demonstration year for a varying amount, duration, and scope of HRSN services depending on beneficiary needs.

Comparability and Provision of Medical Assistance & Reasonable Promptness **Sections 1902(a)(10)(B), 1902(a)(17), 1902(a)(8)**

To the extent necessary to allow the state to offer HRSN services only to an individual who meets the qualifying criteria for HRSN services, including delivery system enrollment, as described in Section 10 of the STCs.

To the extent necessary to allow the state to delay the application review process for HRSN services in the event the state does not have sufficient funding to support providing these services to eligible beneficiaries.

Title XXI EXPENDITURE AUTHORITY

1. **Expenditures for Benefits for Postpartum Individuals.** Expenditures for CHIP state plan benefits to extend the postpartum eligibility period from the end of the month in which the 60th postpartum day occurs to the end of the 12th month following the end of the pregnancy, as described in STC 5.15.

    a. This expenditure authority starts on April 1, 2022 for CHIP "lawfully residing" pregnant individuals covered by the state under Section 2107(e)(1)(O) of the Act.

2. **Expenditures for Continuous Eligibility for State Plan Benefits for the Full Pregnancy and 12-Month Postpartum Period:** Expenditures for pregnant and postpartum individuals to be continuously eligible without regard to changes in circumstances through the end of the 12-month extended postpartum eligibility period as set forth in STC 5.15.

    a. This expenditure authority starts on April 1, 2022 for CHIP "lawfully residing" pregnant individuals covered by the state under Section 2107(e)(1)(O) of the Act.

CENTERS FOR MEDICARE & MEDICAID SERVICES

SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00279/2 and 21-W-00068/2**

TITLE: **New Jersey FamilyCare Comprehensive Demonstration**

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

1. PREFACE

The following are the Special Terms and Conditions (STCs) for the "New Jersey FamilyCare Comprehensive Demonstration" Section 1115(a) Medicaid and Children's Health Insurance Plan (CHIP) demonstration (hereinafter "demonstration"), to enable the New Jersey Department of Human Services, Division of Medical Assistance and Health Services (the state) to operate this demonstration. The Centers for Medicare & Medicaid Services (CMS) has granted waivers of requirements under Section 1902(a) and 2102(b)(2) of the Social Security Act (Act), and expenditure authorities authorizing federal matching of demonstration costs not otherwise matchable, which are separately enumerated. These STCs set forth conditions and limitations on those waivers and expenditure authorities, and describe in detail the nature, character, and extent of federal involvement in the demonstration and the state's obligations to CMS related to the demonstration. These STCs neither grant additional waivers or expenditure authorities, nor expand upon those separately granted.

These STCs are effective as of April 1, 2023 through June 30, 2028, unless otherwise specified. All previously approved STCs are superseded by the STCs set forth below for the state expenditures related to the dates of service during this demonstration extension.

The STCs have been arranged into the following subject areas:

1. Preface
2. Program Description and Objectives
3. General Program Requirements
4. Eligibility and Enrollment
5. Demonstration Programs and Benefits
6. Opioid Use Disorder/Substance Use Disorder Program
7. Cost Sharing
8. Title XXI Premium Support Program
9. Delivery System
10. Health-Related Social Needs Services
11. Provider Payment Rate Increase Requirement
12. Monitoring and Reporting Requirements
13. Evaluation of the Demonstration
14. General Financial Requirements Under Title XIX
15. Monitoring Budget Neutrality for the Demonstration
16. Financial and Allotment Neutrality Monitoring Requirements under Title XXI
17. Schedule of Deliverables During the Demonstration

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

Attachment A:	Developing the Evaluation Design
Attachment B:	Preparing the Interim and Summative Evaluation Reports
Attachment C:	HCBS-FFS Program Service Definitions (Reserved)
Attachment D:	MLTSS Program Service Definitions (Reserved)
Attachment E:	SUD Implementation Plan
Attachment F:	Protocol for HRSN Infrastructure and HRSN Services
Attachment G:	New Initiatives Implementation Plan
Attachment H:	OPG Financial Eligibility Implementation Plan
Attachment I:	SUD Monitoring Protocol (Reserved)
Attachment J:	Monitoring Protocol for Other Policies (Reserved)
Attachment K:	Evaluation Design (Reserved)
Attachment L:	New Jersey Home Visiting Services Protocol
Attachment M:	COVID-19 Emergency Preparedness and Response Addendum 1
Attachment N:	COVID-19 Emergency Preparedness and Response Addendum 2
Attachment O:	Proxy Claiming Methodology
Attachment P:	Behavioral Health Promoting Interoperability Program (PIP) Protocol
Attachment Q:	Community Health Workers Pilot Protocol (Reserved)
Attachment R:	Provider Rate Increase Attestation Table
Attachment S:	Participant Direction by Representative Guardrails (Reserved)
Attachment T:	Continuous Eligibility Calculation Methodology Protocol (Reserved)

2. PROGRAM DESCRIPTION AND OBJECTIVES

The New Jersey Section 1115 Demonstration began with the first demonstration entitled "New Jersey Comprehensive Waiver Demonstration" approved on October 1, 2012 to operate a statewide health reform effort to expand existing managed care programs to include managed long-term services and supports and expand home and community-based services. In addition, the new demonstration consolidated the delivery of services under a number of separate state initiatives, including four previous 1915(c) waiver programs and two standalone section 1115 demonstrations.

On July 27, 2017, the state was awarded an extension of its demonstration renaming the demonstration to "New Jersey FamilyCare Comprehensive Demonstration". Under this demonstration extension, the state was approved to continue the expansion of managed care to long-term services and supports and behavioral health services, targeted home and community-based services program for children and in-home community supports for individuals with intellectual and developmental disabilities. The state was also provided an extension on its Delivery System Reform Incentive Payment (DSRIP) Program to continue healthcare delivery reforms through June 30, 2020. In addition, the state implemented new targeted initiatives to provide behavioral health and substance use disorder services, and to expand the scope and duration of support services for individuals with intellectual and developmental disabilities.

During the demonstration period of demonstration years 6 through 10, CMS approved two amendments into this demonstration. The first amendment approved December 21, 2018

incorporated a new process to expedite financial eligibility determinations for Medicaid coverage and who are placed under the guardianship of the Office of the Public Guardian (OPG), and provided expenditure authority for the New Jersey Home Visiting (NJHV) pilot program. The second CMS approved amendment from October 28, 2021 extended full benefits to postpartum individuals enrolled in Medicaid or CHIP for up to 12 months from the last day of an individual's pregnancy.

Demonstration Objectives

In this demonstration extension approved for State Fiscal Year (SFY) 2023-2028, the state seeks to achieve the following objectives, including but not limited to:

- Effectively addressing or reducing the severity of unmet health-related social needs which improve the health of these individuals by removing non-clinical barriers to their wellbeing, reducing utilization of and costs from potentially avoidable high-acuity health care (e.g., emergency department use and institutional care), and improving physical and mental health;
- Maintaining its MLTSS program;
- Achieving better care coordination, and the promotion of integrated behavioral and physical health for a more patient centered care experience and to offer aligned financial incentives and value-based payments;
- Simplifying and streamlining the administration and oversight of services in order to better monitor the overall health of the Medicaid population; as well as act as the first step to remove silos of care for I/DD youth transitioning from the children's system into the adult system;
- Providing access to services earlier in life in order to prevent avoidable out-of-home placements, decrease interaction with the juvenile justice system, and generate savings in the adult behavioral health and I/DD systems;
- Building on current processes to further streamline continuous eligibility and enrollment for New Jersey FamilyCare (NJFC) beneficiaries;
- Reducing hospitalizations and costs associated with disease and injury;
- Establishing an integrated behavioral health delivery system that includes a flexible and comprehensive substance use disorder (SUD) benefit and the state's continuum of care, including for the BH PIP group;
- Expediting financial eligibility for Medicaid in a timely manner for individuals placed under the OPG in order to receive needed Medicaid coverage;
- Expanding the available options for youth with an ASD diagnosis by offering a limited package of adjunct services to individuals up to age 21;
- Providing evidence-based home visiting services to low-income families to promote enhanced health outcomes, whole person care, and community-integration;
- Addressing the dietary needs of pregnant individuals with a diagnosis of either pre-existing diabetes and/or gestational diabetes; and
- Providing full benefits to post-partum individuals enrolled in Medicaid or CHIP for up to 12 months from the last day of an individual's pregnancy, rather than required 60 days.

3. GENERAL PROGRAM REQUIREMENTS

3.1. **Compliance with Federal Non-Discrimination Statutes**. The state must comply with all applicable federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 (Section 504), the Age Discrimination Act of 1975, and Section 1557 of the Patient Protection and Affordable Care Act (Section 1557).

3.2. **Compliance with Medicaid and Children's Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs, expressed in federal law, regulation, and policy statement, that are not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), apply to the demonstration.

3.3. **Changes in Medicaid and CHIP Law, Regulation, and Policy.** The state must, within the timeframes specified in federal law, regulation, or policy statement, come into compliance with changes in federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable. In addition, CMS reserves the right to amend the STCs to reflect such changes and/or changes as needed without requiring the state to submit an amendment to the demonstration under STC 3.7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

3.4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**

a. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement for the demonstration as necessary to comply with such change. The modified budget neutrality and/or modified allotment neutrality agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this subparagraph. Further, the state may seek an amendment to the demonstration (as per STC 3.7 of this section) as a result of the change in FFP.

b. If mandated changes in the federal law, regulation, or policy require state legislation, unless otherwise prescribed by the terms of the federal law, the changes must take effect on the earlier of the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law, whichever is sooner.

3.5. **State Plan Amendments**. The state will not be required to submit title XIX or XXI state plan amendments (SPAs) for changes affecting any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the

appropriate state plan is required, except as otherwise noted in these STCs. In all such cases, the Medicaid and CHIP state plan governs.

3.6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, beneficiary rights, delivery systems, cost sharing, evaluation design, sources of non-federal share of funding, budget neutrality, and other comparable program elements authorized through these STCs must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with Section 1115 of the Act. The state must not implement changes or begin optional changes to these demonstration elements without prior approval. Amendments to the demonstration are not retroactive and no FFP of any kind, including for administrative or medical assistance expenditures, will be available for amendments to the demonstration that have not been approved through the amendment process set forth in STC 3.7 below, except as provided in STC 3.3 or as otherwise specified in the STCs.

3.7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including, but not limited to the failure by the state to submit required elements of a complete amendment request as described in this STC, and failure by the state to submit required reports and other deliverables according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

a. An explanation of the public process used by the state, consistent with the requirements of STC 3.13. Such explanation must include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS.

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

c. A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis must include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

d. An up-to-date CHIP allotment worksheet, if necessary; and

e. The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the Evaluation Design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

3.8. **Extension of the Demonstration**. States that intend to request an extension of the demonstration must submit an application to CMS from the Governor of the state in accordance with the requirements of 42 CFR §431.412(c). States that do not intend to request an extension of the demonstration beyond the period authorized in these STCs must submit a phase-out plan consistent with the requirements of STC 3.9.

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

a. **Notification of Suspension or Termination**. The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a transition and phase-out plan. The state must submit its notification letter and a draft transition and phase-out plan to CMS no less than six months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft transition and phase-out plan to CMS, the state must publish on its website the draft transition and phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with STC 3.13, if applicable. Once the 30-day public comment period has ended, the state must provide a summary of the issues raised by the public during the comment period and how the state considered comments received when developing the revised transition and phase-out plan.

b. **Transition and Phase-out Plan Requirements**. The state must include, at a minimum, in its transition and phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct redeterminations of Medicaid and CHIP eligibility prior to the termination of the demonstration for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities the state will undertake to notify affective beneficiaries, including community resources that are available.

c. **Transition and Phase-out Plan Approval**. The state must obtain CMS approval of the transition and phase-out plan prior to the implementation of transition and phase-out activities. Implementation of transition and phase-out activities must be no sooner than 14 calendar days after CMS approval of the transition and phase-out plan.

d. **Transition and Phase-out Procedures**. The state must redetermine eligibility for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to making a determination of ineligibility as required under 42 CFR 35.916(f)(1), or for children in CHIP consider eligibility for other insurance affordability programs under 42 CFR 457.350. For individuals determined ineligible for Medicaid and CHIP, the state must determine potential eligibility for other insurance affordability programs and comply with the procedures set forth in 42 CFR 435.1200(e). The state must comply with all applicable notice requirements for Medicaid found in 42 CFR, part 431 subpart E, including Sections

431.206 through 431.214 or for CHIP found at 42 CFR 457.340(e), including information about a right to review consistent with 42 CFR 457.1180. In addition, the state must assure all applicable Medicaid appeal and hearing rights are afforded to Medicaid beneficiaries in the demonstration as outlined in 42 CFR, part 431 subpart E, including Sections 431.220 and 431.221. If a beneficiary in the demonstration requests a hearing before the date of action, the state must maintain Medicaid benefits as required in 42 CFR §431.230.

e. **Exemption from Public Notice Procedures 42 CFR Section 431.416(g)**. CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

f. **Enrollment Limitation during Demonstration Phase-Out**. If the state elects to suspend, terminate, or not extend this demonstration, during the last six months of the demonstration, enrollment of new individuals into the demonstration must be suspended. The limitation of enrollment into the demonstration does not impact the state's obligation to determine Medicaid eligibility in accordance with the approved Medicaid state plan.

g. **Federal Financial Participation (FFP)**. If the project is terminated or any relevant waivers suspended by the state, FFP must be limited to normal closeout costs associated with terminating the demonstration or expiration of the demonstration including services, continued benefits as a result of beneficiaries' appeals, and administrative costs of disenrolling participants.

3.10. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the demonstration, in whole or in part, at any time before the date of expiration, whenever it determines following a hearing that the state has materially failed to comply with the terms of the project. CMS will promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

3.11. **Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waivers and/or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX or title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authority, including services, continued benefits as a result of beneficiary appeals, and administrative costs of disenrolling participants.

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

3.13. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must comply with the state notice procedures set forth in 42 CFR 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for charge in statewide methods and standards for setting payment rates.

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

3.14. **Federal Financial Participation (FFP).** No federal matching funds for expenditures for this demonstration, including for administrative and medical assistance expenditures, will be available until the effective date identified in the demonstration approval letter, or later, as expressly stated within these STCs.

3.15. **Administrative Authority**. When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency (SSMA) must maintain authority, accountability, and oversight of the program. The State Medicaid Agency (SMA) must exercise oversight of all delegated functions to operating agencies, managed care plans, and any other contracted entities. The SSMA is responsible for the content and oversight of the quality strategies for the demonstration.

3.16. **Common Rule Exemption.** The state shall ensure that the only involvement of human subjects in research activities that may be authorized and/or required by this demonstration is for projects which are conducted by or subject to the approval of CMS, and that are designed to study, evaluate, or otherwise examine the Medicaid or CHIP program – including public benefit or service programs; procedures for obtaining Medicaid or CHIP benefits or services; possible changes in or alternatives to those Medicaid or CHIP programs and/or procedures; or possible changes in methods or level of payment for Medicaid and CHIP benefits or services under those programs. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.104(b)(5).

4. ELIGIBILITY AND ENROLLMENT

4.1. **Eligible Populations.** This demonstration affects mandatory and optional Medicaid state plan populations as well as populations eligible for benefits only through the demonstration. Table A, at the end of Section 4 of the STCs, shows each specific group of individuals; the program name, population descriptions and statutory/regulatory citations, income standards/methodologies, service package received under the demonstration; and expenditure group under which expenditures are reported to CMS.

Individuals eligible for both Medicare and Medicaid (duals) are covered under this demonstration for Medicaid services.

In addition, populations eligible under the state plan, as identified in Table A below, may be affected by the demonstration, including through requirements to enroll in the Medicaid managed care program under the demonstration to receive state plan benefits.

4.2. **State Plan Eligibility Groups Affected By the Demonstration.** Benefits and service delivery options for the mandatory and optional state plan groups described in Table A below are affected by the demonstration. To the extent indicated in STC 5.6, these groups receive covered benefits through managed care organizations (MCOs).

4.3. **Expansion Groups.** Non-Medicaid eligible groups described in Table A below are eligible under the demonstration, to the extent included in expenditure authorities separately granted to facilitate this demonstration. To the extent indicated in STC 5.6, these groups receive covered benefits through MCOs.

4.4. **Eligibility/Post-Eligibility Treatment of Income and Resources for Institutionalized Individuals.** In determining eligibility (except for short-term stays) for institutionalized individuals, the state must use the rules specified in the currently approved Medicaid state plan. Individuals with monthly income above the Medicaid Only institutional income limit ($2,742 in 2023) must establish a Qualified Income Trust (QIT) if they meet an institutional level of care and are trying to obtain Medicaid eligibility for MLTSS, Community Care Program (CCP), the Supports program and the Supports plus PDN program, if operationalized.

4.5. **Individuals Receiving Home and Community Based Services or Managed Long-Term Services and Supports.**

a. **217-Like Group of Individuals Receiving HCBS Services (MLTSS)**. Institutional eligibility and post eligibility rules apply in the same manner as specified under 42 CFR 435.217, 435.236, 435.726 and 1902(m)(1), and 1924 of the Act, if the state had 1915(c) waivers.

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

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

4.6. **Transfer of Assets.** At the time of application or redetermination for long term care and home and community-based services, based on self-attestation, New Jersey will not review assets pursuant to Section 1917(c) of the Act for applicants or beneficiaries seeking

MLTSS with income at or below 100 percent of the Federal Poverty Level (FPL). Individuals are required to complete a self-attestation form at the time of the application or redetermination. The self-attestation form is collected by the state. The state completes a quality control check on a sample of cases as part of the demonstration evaluation. When the applicant does not complete the self-attestation form upon application for long term care and HCBS, the state must perform a full look back.

4.7. **Eligibility Exclusions.** Notwithstanding the criteria outlined in this Section or in Table A below, the following individuals are excluded from this demonstration:

Qualified Medicare Beneficiaries – 1902(a)(10)(E)(i); 1905(p)
Special Low Income Medicare Beneficiaries – 1902(a)(10)(E)(iii); 1905(p)
Qualifying Individuals – 1902(a)(10)(E)(iv); 1905(p)
Qualified Disabled Working Individuals – 1902(a)(10)(E)(iii); 1905(s)
Program of All-Inclusive Care of the Elderly Participants

Table A. State Plan and Demonstration Eligibility Groups and Description

Population Eligibility Group	Population Description	Authorities	MAGI or Non-MAGI	Service Package	Reporting MEG
Parents and Other Caretaker Relatives	Parents and other caretaker relatives of dependent children with household income at or below a standard established by the state.	42 CFR 435.110; 1902(a)(10)(A)(i)(I); 1931(b) and (d)	MAGI	Plan A	Title XIX
Transitional Medical Assistance	Families with Medicaid eligibility extended for up to 12 months because of earnings.	§408(a)(11)(A); §1902(a)(52); §1902(e)(1); §1925; §1931(c)(2)	Non-MAGI	Plan A	Title XIX
Pregnant Individuals	Individuals who are pregnant or postpartum, with household income at or below a standard established by the state.	42 CFR 435.116; §1902(a)(10)(A)(i)(III) and (IV); §1902(a)(10)(A)(ii)(I), (IV) and (IX); §1931(b) and (d)	MAGI	Plan A	Title XIX through month ending 60 day postpartum. Postpartum Extension from 60 days to 12 months postpartum.
Deemed Newborns	Children born to individuals covered under Medicaid or a separate CHIP for the date of the child's birth, who are deemed eligible	42 CFR 435.117; §1902(e)(4) and 2112(e)	MAGI	Plan A	Title XIX

Population Eligibility Group	Population Description	Authorities	MAGI or Non-MAGI	Service Package	Reporting MEG
	for Medicaid until the child turns age 1.				
Infants and Children under Age 19	Infants and children under age 19 with household income at or below standards established by the state based on age group.	42 CFR 435.118 §1902(a)(10)(A)(i)(III), (IV), (VI) and (VII); §1902(a)(10)(A)(ii)(IV) and (IX); 1931(b) and (d)	MAGI	Plan A	Title XIX
Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care	Individuals for whom an adoption assistance agreement is in effect or foster care or kinship guardianship assistance maintenance payments are made under Title IV-E of the Act.	42 CFR 435.145; §473(b)(3); §1902(a)(10)(A)(i)(I)	Non-MAGI	Plan A	Title XIX
Former Foster Care Children	Individuals under the age of 26, not otherwise mandatorily eligible, who were in foster care and on Medicaid either when they turned	42 CFR 435.150; §1902(a)(10)(A)(i)(IX)	Non-MAGI	Plan A	Title XIX

Population Eligibility Group	Population Description	Authorities	MAGI or Non-MAGI	Service Package	Reporting MEG
	age 18 or aged out of foster care.				
Expansion Adults	Non-pregnant individuals aged 19 through 64, not otherwise mandatorily eligible, with income at or below 133% FPL.	42 CFR 435.119; §1902(a)(10)(A)(i)(VIII)	MAGI	Plan ABP	New Adult Group
Individuals Receiving SSI	Individuals who are aged, blind or disabled who receive SSI.	42 CFR 435.120; §1902(a)(10)(A)(i)(II)(aa)	Non-MAGI	Plan A and HCBS services if applicable	(1) If receiving community-based MLTSS, then "HCBS – State Plan." (2) If residing in a NF, ICF/ID, or other institutional setting, then "LTC." (3) If enrolled in the Supports Program, "Supports." (4) If enrolled in the Community Care Program,

Population Eligibility Group	Population Description	Authorities	MAGI or Non-MAGI	Service Package	Reporting MEG
					"Community Care Program." (5) If none of the above, then "ABD."
Individuals Receiving Mandatory State Supplements	Individuals receiving mandatory State Supplements to SSI benefits.	42 CFR 435.130	Non-MAGI	Plan A and HCBS services if applicable	(1) If receiving community-based MLTSS, then "HCBS – State Plan." (2) If residing in a NF, ICF/ID, or other institutional setting, then "LTC." (3) If enrolled in the Supports Program, "Supports." (4) If enrolled in the Community Care Program, "Community Care Program." (5) If none of the above, then "ABD."

Population Eligibility Group	Population Description	Authorities	MAGI or Non-MAGI	Service Package	Reporting MEG
Institutionalized Individuals Continuously Eligible Since 1973	Institutionalized individuals who were eligible for Medicaid in 1973 as inpatients of Title XIX medical institutions or intermediate care facilities, and who continue to meet the 1973 requirements.	42 CFR 435.132	Non-MAGI	Plan A	LTC
Blind or Disabled Individuals Eligible in 1973	Blind or disabled individuals who were eligible for Medicaid in 1973 who meet all current requirements for Medicaid except for the blindness or disability criteria.	42 CFR 435.133	Non-MAGI	Plan A and HCBS services if applicable	(1) If receiving community-based MLTSS, then "HCBS – State Plan." (2) If residing in a NF, ICF/ID, or other institutional setting, then "LTC." (3) If enrolled in the Supports Program, "Supports." (4) If enrolled in the Community

Population Eligibility Group	Population Description	Authorities	MAGI or Non-MAGI	Service Package	Reporting MEG
					Care Program, "Community Care Program." (5) If none of the above, then "ABD."
Individuals Who Lost Eligibility for SSI/SSP Due to an Increase in OASDI Benefits in 1972	Individuals who would be eligible for SSI/SSP except for the increase in OASDI benefits in 1972, who were entitled to and receiving cash assistance in August 1972.	42 CFR 435.134	Non-MAGI	Plan A and HCBS services if applicable	(1) If receiving community-based MLTSS, then "HCBS – State Plan." (2) If residing in a NF, ICF/ID, or other institutional setting, then "LTC." (3) If enrolled in the Supports Program, "Supports." (4) If enrolled in the Community Care Program, "Community Care Program."

Population Eligibility Group	Population Description	Authorities	MAGI or Non-MAGI	Service Package	Reporting MEG
					(5) If none of the above, then "ABD."
Individuals Who Would be Eligible for SSI/SSP but for OASDI COLA increases since April, 1977	Individuals who are receiving OASDI and became ineligible for SSI/SSP after April 1977, who would continue to be eligible if the cost of living increases in OASDI since their last month of eligibility for SSI/SSP/OASDI were deducted from income.	42 CFR 435.135	Non-MAGI	Plan A and HCBS services if applicable	(1) If receiving community-based MLTSS, then "HCBS – State Plan." (2) If residing in a NF, ICF/ID, or other institutional setting, then "LTC." (3) If enrolled in the Supports Program, "Supports." (4) If enrolled in the Community Care Program, "Community Care Program." (5) If none of the above, then "ABD."

Population Eligibility Group	Population Description	Authorities	MAGI or Non-MAGI	Service Package	Reporting MEG
Disabled Widows and Widowers Ineligible for SSI due to Increase in OASDI	Disabled widows and widowers who would be eligible for SSI/SSP, except for the increase in OASDI benefits due to the elimination of the reduction factor in P.L. 98-21, who therefore are deemed to be SSI or SSP recipients.	42 CFR 435.137; §1634(b)	Non-MAGI	Plan A and HCBS services if applicable	(1) If receiving community-based MLTSS, then "HCBS – State Plan." (2) If residing in a NF, ICF/ID, or other institutional setting, then "LTC." (3) If enrolled in the Supports Program, "Supports." (4) If enrolled in the Community Care Program, "Community Care Program." (5) If none of the above, then "ABD."
Disabled Widows and Widowers Ineligible for SSI due to Early	Disabled widows and widowers who would be eligible for SSI/SSP, except for the early receipt	42 CFR 435.138; §1634(d)	Non-MAGI	Plan A and HCBS services if applicable	(1) If receiving community-based MLTSS, then "HCBS – State Plan."

Population Eligibility Group	Population Description	Authorities	MAGI or Non-MAGI	Service Package	Reporting MEG
Receipt of Social Security	of OASDI benefits, who are not entitled to Medicare Part A, who therefore are deemed to be SSI recipients.				(2) If residing in a NF, ICF/ID, or other institutional setting, then "LTC." (3) If enrolled in the Supports Program, "Supports." (4) If enrolled in the Community Care Program, "Community Care Program." (5) If none of the above, then "ABD."
Working Disabled under 1619(b)	Blind or disabled individuals who participated in Medicaid as SSI cash recipients or who were considered to be receiving SSI, who would still qualify for SSI except for earnings. Many members in this	§1619(b); §1905(q)	Non-MAGI	Plan A and HCBS services if applicable	(1) If receiving community-based MLTSS, then "HCBS – State Plan." (2) If residing in a NF, ICF/ID, or other institutional setting, then "LTC."

Population Eligibility Group	Population Description	Authorities	MAGI or Non-MAGI	Service Package	Reporting MEG
	category ultimately transition to the Ticket to Work Basic Group.				(3) If enrolled in the Supports Program, "Supports." (4) If enrolled in the Community Care Program, "Community Care Program." (5) If none of the above, then "ABD."
Disabled Adult Children	Individuals who lose eligibility for SSI at age 18 or older due to receipt of or increase in Title II OASDI child benefits.	1634(c)	Non-MAGI	Plan A and HCBS services if applicable	(1) If receiving community-based MLTSS, then "HCBS – State Plan." (2) If residing in a NF, ICF/ID, or other institutional setting, then "LTC." (3) If enrolled in the Supports Program, "Supports." (4) If enrolled in the Community

Population Eligibility Group	Population Description	Authorities	MAGI or Non-MAGI	Service Package	Reporting MEG
					Care Program, "Community Care Program." (5) If none of the above, then "ABD."
Qualified Medicare Beneficiaries	Individuals with income equal to or less than 100% of the FPL who are entitled to Medicare Part A, who qualify for Medicare cost-sharing.	§1902(a)(10)(E)(i); §1905(p)	Non-MAGI	Medicare Savings Plan	N/A – Excluded* from Demonstration
Specified Low Income Medicare Beneficiaries	Individuals with income between 100% and 120% of the FPL who are entitled to Medicare Part A, who qualify for payment of Medicare Part B premiums.	§1902(a)(10)(E)(iii); §1905(p)(3)(A)(ii)	Non-MAGI	Medicare Savings Plan	N/A – Excluded* from Demonstration
Qualifying Individuals	Individuals with income between 120% and 135% of the FPL who are entitled to Medicare Part A, who qualify for payment of	§1902(a)(10)(E)(iv); §1905(p)(3)(A)(ii)	Non-MAGI	Medicare Savings Plan	N/A – Excluded* from Demonstration

Population Eligibility Group	Population Description	Authorities	MAGI or Non-MAGI	Service Package	Reporting MEG
	Medicare Part B premiums.				
Children with Non-IV-E Adoption Assistance	Children with special needs for whom there is a non-IV-E adoption assistance agreement in effect with a state, who either were eligible for Medicaid or had income at or below a standard established by the state.	42 CFR 435.227; §1902(a)(10)(A)(ii)(VIII)	MAGI	Plan A	Title XIX
Independent Foster Care Adolescents	Individuals under an age specified by the state, up to age 21, who were in foster care on their 18th birthday and who meet the income standard established by the state.	42 CFR 435.226; §1902(a)(10)(A)(ii)(XVII)	MAGI	Plan A	Title XIX
Certain Individuals Needing Treatment for	Uninsured individuals under age 65 who received a screening for breast or cervical cancer	42 CFR 435.213; §1902(a)(10)(A)(ii)(XVIII); §1902(aa)	Non-MAGI	Plan A	Title XIX

Population Eligibility Group	Population Description	Authorities	MAGI or Non-MAGI	Service Package	Reporting MEG
Breast or Cervical Cancer	from a qualified screening site and have been found to need treatment.				
Individuals Eligible for Family Planning Services	Individuals who are not pregnant, with income equal to or below the highest standard for pregnant individuals, as specified by the state, limited to family planning and related services.	42 CFR 435.214; §1902(a)(10)(A)(ii)(XXI)	MAGI	Family planning and family planning related	Title XIX
Aged, Blind or Disabled Individuals Eligible for but Not Receiving Cash Assistance	Individuals who meet the requirements of SSI or Optional State Supplement, but who do not receive cash.	42 CFR 435.210 & 230; §1902(a)(10)(A)(ii)(I)	Non-MAGI	Plan A and HCBS services if applicable	(1) If receiving community-based MLTSS, then "HCBS – State Plan." (2) If residing in a NF, ICF/ID, or other institutional setting, then "LTC." (3) If enrolled in the Supports Program, "Supports."

Population Eligibility Group	Population Description	Authorities	MAGI or Non-MAGI	Service Package	Reporting MEG
					(4) If enrolled in the Community Care Program, "Community Care Program." (5) If none of the above, then "ABD."
Individuals Eligible for Cash Assistance except for Institutionalization	Individuals who meet the requirements of AFDC, SSI or Optional State Supplement, and would be eligible if they were not living in a medical institution.	42 CFR 435.211; §1902(a)(10)(A)(ii)(IV)	Non-MAGI	Plan A	LTC
Individuals Receiving Home and Community Based Services under Institutional Rules	Individuals who would be eligible for Medicaid under the State Plan if in a medical institution, who would live in an institution if they did not receive home and community-based services.	42 CFR 435.217; §1115; §1902(a)(10)(A)(ii)(VI); STCs: 5.6, 5.9(b)(ii), 5.10(b)(ii), 5.8, 5.11	Non-MAGI	Plan A and HCBS services if applicable	(1) If enrolled in MLTSS "HCBS 217-Like." (2) If enrolled in Children's System of Care – "SED 217-Like" or "I/DD 217-Like." (3) If enrolled in the Supports

Population Eligibility Group	Population Description	Authorities	MAGI or Non-MAGI	Service Package	Reporting MEG
					Program, "Supports." (4) If enrolled in the Community Care Program, "Community Care Program."
Optional State Supplement Recipients - 1634 States, and SSI Criteria States with 1616 Agreements	Individuals in 1634 States and in SSI Criteria States with agreements under 1616, who receive a state supplementary payment (but not SSI).	42 CFR 435.232; §1902(a)(10)(A)(ii)(IV)	Non-MAGI	Plan A and HCBS services if applicable	(1) If receiving community-based MLTSS, then "HCBS – State Plan." (2) If residing in a NF, ICF/ID, or other institutional setting, then "LTC." (3) If enrolled in the Supports Program, "Supports." (4) If enrolled in the Community Care Program, "Community Care Program."

Population Eligibility Group	Population Description	Authorities	MAGI or Non-MAGI	Service Package	Reporting MEG
					(5) If none of the above, then "ABD."
Institutionalized Individuals Eligible under a Special Income Level	Individuals who are in institutions for at least 30 consecutive days who are eligible under a special income level.	42 CFR 435.236; 42 CFR 435.231; §1902(a)(10)(A)(ii)(V)	Non-MAGI	Plan A	LTC
Individuals participating in a PACE Program under Institutional Rules	Individuals who would be eligible for Medicaid under the State Plan if in a medical institution, who would require institutionalization if they did not participate in the PACE program.	§1934; 42 CFR 435.217	Non-MAGI	Plan A	N/A – Excluded* from Demonstration
Poverty Level Aged or Disabled	Individuals who are aged or disabled with income equal to or less than 100% of the FPL.	§1902(a)(10)(A)(ii)(X); §1902(m)(1)	Non-MAGI	Plan A	(1) If enrolled in the Supports Program, "Supports." (2) If enrolled in the Community Care Program, "Community Care Program."

Population Eligibility Group	Population Description	Authorities	MAGI or Non-MAGI	Service Package	Reporting MEG
					(3) If none of the above, then "ABD."
Ticket to Work Basic Group	Individuals with earned income between ages 16 and 64 with a disability, with income and resources equal to or below a standard specified by the state.	§1902(a)(10)(A)(ii)(XV)	Non-MAGI	Plan A	(1) If enrolled in the Supports Program, "Supports." (2) If enrolled in the Community Care Program, "Community Care Program." (3) If none of the above, then "ABD."
Supports Expansion	Individuals who meet functional criteria for Supports, are not eligible under state plan, and have income up to 300% of the SSI federal benefit rate.	§1115 STC: 5.8	Non-MAGI	Plan A	Hypo Supports
Community Care Program	Individuals who meet functional and ICF/ID LOC requirements, are not eligible under	§1115 STC: 5.11	Non-MAGI	Plan A	Hypo Community Care Program

Population Eligibility Group	Population Description	Authorities	MAGI or Non-MAGI	Service Package	Reporting MEG
	state plan and have income up to 300% of the SSI federal benefit rate.				
SED at Risk	Children with SED who are not eligible for New Jersey Medicaid or CHIP state plan services and who are at risk of hospitalization, out of home treatment or at hospital level of care, have a household income above 300% of the FBR, and meet criteria for CSOC services.	§1115 STC: 5.9(b)(iii)	Non-MAGI	Behavioral Health and HCBS Services Only	SED at Risk
SED 217-Like	Children with SED who are not eligible for New Jersey Medicaid or CHIP state plan services and who are at risk of hospitalization, out of home treatment or at hospital level of care, have	§1115 STC: 5.9(b)(ii)	Non-MAGI	Plan A and HCBS services if applicable	SED 217-Like

Population Eligibility Group	Population Description	Authorities	MAGI or Non-MAGI	Service Package	Reporting MEG
	household income up to 300% of FBR, using institutional deeming rules where appropriate (including treatment as a "Household of One").				
I/DD at Risk	Children with I/DD who are not eligible for New Jersey Medicaid or CHIP state plan services and who are at risk of hospitalization, out of home treatment or at hospital level of care, have a household income above 300% of the FBR, and meet criteria for CSOC services.	§1115 STC: 5.10(b)(iii)	Non-MAGI	Behavioral Health and HCBS Services Only	I/DD at Risk
I/DD 217-Like	Children with I/DD who are not eligible for New Jersey Medicaid or CHIP state plan services and who are at risk	§1115 STC: 5.10(b)(ii)	Non-MAGI	Plan A and HCBS services if applicable	I/DD 217-Like

Population Eligibility Group	Population Description	Authorities	MAGI or Non-MAGI	Service Package	Reporting MEG
	of hospitalization, out of home treatment or at hospital level of care, have household income up to 300% of the FBR, using institutional deeming rules where appropriate (including treatment as a "Household of One").				
Medically Needy Pregnant People	People who are pregnant, who would qualify as categorically needy, except for income.	42 CFR 435.301(b)(1)(i) and (iv); §1902(a)(10)(C)(ii)(II)	Non-MAGI	Medically Needy Benefit Plan	Title XIX
Medically Needy Children under Age 18	Children under 18 who would qualify as categorically needy, except for income.	42 CFR 435.301(b)(1)(ii); §1902(a)(10)(C)(ii)(II)	Non-MAGI	Medically Needy Benefit Plan	Title XIX
Medically Needy Children Age 18 through 20	Children over 18 and under an age established by the state (less than age 21), who would qualify as	42 CFR 435.308; §1902(a)(10)(C)(ii)(II)	Non-MAGI	Medically Needy Benefit Plan	Title XIX

Population Eligibility Group	Population Description	Authorities	MAGI or Non-MAGI	Service Package	Reporting MEG
	categorically needy, except for income.				
Medically Needy Aged, Blind, or Disabled People	Individuals who are age 65 or older, blind, or disabled, who are not eligible as categorically needy, who meet income and resource standards specified by the state, or who meet the income standard using medical and remedial care expenses to offset excess income.	42 CFR 435.320, 435.322, 435.324, and 435.330; §1902(a)(10)(C)	Non-MAGI	Medically Needy Benefit Plan	(1) If residing in a NF, ICF/ID, or other institutional setting, then "LTC." (3) If enrolled in the Supports Program, "Supports" (4) If enrolled in the Community Care Program, "Community Care Program" (5) If none of the above, then "ABD."
OPG Financial Eligibility Determination Pilot	Individuals under the guardianship of the New Jersey OPG who qualify for expedited financial eligibility determination.	§1115 STC: 5.14	Non-MAGI	Plan A	Financial Eligibility (OPG)

Population Eligibility Group	Population Description	Authorities	MAGI or Non-MAGI	Service Package	Reporting MEG
Targeted Low-Income Children	Uninsured children under age 19 who do not have access to public employee coverage and whose household income is within standards established by the state.	42 CFR 457.310; §2102(b)(1)(B)(v)	MAGI	Plan B, C, or D, depending on FPL	N/A - Title XXI*
Deemed Newborn	Children born to targeted low-income pregnant individuals who are deemed eligible for CHIP or Medicaid for one year.	42 CFR 435.117(b)(2) §2112(e)	MAGI	Plan A	N/A - Title XXI*
Targeted Low-Income Pregnant Individuals	Uninsured pregnant individuals who do not have access to public employee coverage and whose household income is within standards established by the state.	§2112	MAGI	Plan A	N/A - Title XXI*

*These eligibility groups are not part of the demonstration – all changes to these groups require approved state plan amendments.

5. DEMONSTRATION PROGRAMS AND BENEFITS

Individuals affected by, or eligible under, the demonstration will receive benefits based on criteria as outlined in the Table A above. Individuals may receive additional benefits specifically authorized in demonstration expenditure authorities as described below.

5.1. **FamilyCare Plan A.** Individuals enrolled in FamilyCare Plan A receive Medicaid state plan services. The state provides Personal Care Assistance, Medical Day and adult dental in its state plan package.

5.2. **FamilyCare Plan B.** Individuals enrolled in FamilyCare Plan B receive the Title XXI, benefit package, for children and families with income between 133-150% FPL. Benefits provided under this package echo the benefits provided in Plan A.

5.3. **FamilyCare Plan C.** Individuals enrolled in FamilyCare Plan C receive the Title XXI benefit package, for children and families with income between 150-200% FPL. Benefits provided under this package echo the benefits provided in Plan A.

5.4. **FamilyCare Plan D.** This plan provides benefits to children and families with income between 200-350% FPL. Individuals enrolled in FamilyCare Plan D receive Title XXI benefits provided in this package echo the most widely sold commercial package in the state.

5.5. **NJFC Alternative Benefit Plan.** The state's FamilyCare ABP is for individuals in the New Adult Group, ages 21-64. The ABP provides medical and behavioral health services; including additional mental health and substance use disorder services. All Medicaid state plan benefits are included. Services are provided via managed care with the exception of mental health and substance use disorder services, which are provided Fee-for-Service (FFS). There are no cost-sharing requirements in the ABP.

5.6. **Managed Long Term Services and Supports Program.** The MLTSS program provides home and community-based services to elderly and disabled individuals through a managed care delivery system.

a. **Operations**: The administration of the MLTSS Program is through DMAHS in conjunction with the Division of Aging Services (DoAS) and the Division of Developmental Disability Services (DDS).

b. **Eligibility**:

i. Meets Nursing Facility (NF) Level of Care (LOC) defined as:

1. An adult (ages 21 and older) individual must be clinically eligible for MLTSS services when the individual's standardized assessment demonstrates that the individual satisfies any one or more of the following three criteria:

a. The individual:

i. Requires limited assistance or greater with three or more activities of daily living;

ii. Exhibits problems with short-term memory and is minimally impaired or greater with decision making ability and requires supervision or greater with three or more activities of daily living; and/or

iii. Is minimally impaired or greater with decision making and, in making himself or herself understood, is often understood or greater and requires supervision or greater with three or more activities of daily living.

ii. A child (ages birth through 20) must be clinically eligible for MLTSS services when:

1. The child exhibits functional limitations, identified in terms of developmental delay or functional limitations in specific age-appropriate activities of daily living, requiring nursing care over and above routine parenting and meets one of the following nursing care criteria:

a. Medical and/or intense therapeutic services for the medically complex child who exhibits a severe illness that requires complex skilled nursing interventions 24 hours per day, seven days per week.

b. Skilled Nursing Services must be based upon, but not limited to, at least one of the following:

i. Dependence on mechanical ventilation;

ii. The presence of an active tracheostomy;

iii. The need for deep suctioning;

iv. The need for around-the-clock nebulizer treatments with chest physiotherapy;

v. Gastrostomy feeding when complicated by frequent regurgitation and/or aspiration; or is on continuous feeding for more than 4 hours at a time;

vi. A seizure disorder manifested by frequent prolonged seizures requiring emergency administration of anticonvulsant medication in the last four months; and/or

vii. Medical and/or intense therapeutic services for the technology dependent child who requires a medical device that the Federal Food and Drug Administration has classified pursuant to 21 C.F.R. 860.3, as amended and supplemented, as a life-supporting or life-sustaining device that is essential to, or that yields information that is essential to, the restoration or continuation of a bodily function important to the continuation of human life.

2. These services must be provided if the life-supporting or life-sustaining device is necessary to compensate for the loss of a vital function, to avert death or further disability, and if the use of the device requires ongoing skilled nursing intervention.

iii. Meets all financial criteria listed for a MLTSS eligible Medicaid group listed under Table A in accordance with the Medicaid state plan or this demonstration.

iv. The individual must be receiving care management services including, but not limited to, outreach and face-to-face visits.

c. **Exclusions**:

i. Individuals cannot be enrolled into the MLTSS program if they are enrolled in another HCBS program (e.g., CCP, Supports Program, etc.).

ii. Individuals may be disenrolled if they refuse to participate in any part of the program requirements, including but not limited to: quarterly face-to-face care management meetings and annual LOC assessments. Disenrolled individuals will be provided with a notice of containing information on the right to appeal.

d. **Level of Care Assessment for Enrollees**: The following procedures and policies must be applied to enrollees receiving MLTSS:

i. An evaluation for LOC must be given to all applicants for whom there is reasonable indication that services may be needed by either the state or the MCO.

ii. The plans and the state will use the “NJ Choice” tool as the standardized functional assessment for determining a LOC.

iii. In addition to the NJ Choice tool, the state and the MCOs may also utilize the "Home and Community-Based Long-Term Care Assessment" Form (CP-CM-1).

iv. The state must perform the assessment function for individuals not presently enrolled in managed care. The MCO must complete the LOC assessment as part of its comprehensive needs assessment for its members and will forward to the state for final approval for those individuals determined to meet NF LOC.

v. The MCOs must not fundamentally alter the nature of the NJ Choice tool when accommodating it to their electronic/database needs.

vi. The MCOs and/or the state must perform functional assessments within 45 days of the time a referral is received.

vii. All enrollees must be reevaluated at least annually or as otherwise specified by the state, as a contractual requirement by the MCO.

viii. Individuals in the Supports program who are in need of Private Duty Nursing services are to be assessed for NF LOC in the same manner as a MLTSS

applicant, however, upon approval will only be able to access the private duty nursing benefit.

ix. Individuals currently enrolled in the MLTSS program that are also determined eligible for the Supports Program may enroll in the Supports Program and access only the private duty nursing benefit from the MLTSS program without being reassessed until their annual reassessment date.

e. **Enrollment in MLTSS**: The effective date of enrollment in MLTSS must be established by the state based on a determination that an applicant is eligible for and must begin receiving LTSS. Enrollment procedures differ depending on whether or not the individual is already enrolled in NJFC.

f. **Benefits/Services, Limitations, and Provider Specifications**: Individuals enrolled in the MLTSS Program receive, with limited exceptions, all Medicaid State Plan services included in FamilyCare Plan A, including behavioral health, through their Medicaid MCO. This population also receives an additional HCBS package of benefits, specifically authorized in demonstration expenditure authorities, listed in Attachment C. Individuals in an Assisted Living Facility at the time of Medicaid eligibility will have their MLTSS services paid FFS until MCO enrollment.

g. **Stakeholder Engagement**. The state's Medical Assistance Advisory Committee per 42 CFR 431.12 will include MLTSS representation.

h. **Money Follows the Person (MFP)**. The state will continue to operate its MFP demonstration program outside of the Section 1115 demonstration. Under the state's MFP program, the state will continue its responsibilities for developing transitional plans of services for enrollees. The MLTSS plans' responsibilities include:

i. Identifying enrollees who may be appropriate to transition from nursing homes;

ii. Referring enrollees to state staff in the MFP office;

iii. Providing ongoing care, case management and coordination when the enrollee returns to the community;

iv. The delivery of MLTSS, and

v. Reassessing the MFP participant prior to the 365th day in the MFP program and designating which HCBS services are the most appropriate.

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

a. The state assures CMS that it will conduct necessary and timely PASRR screening, NF and HCBS waiver level of care assessments, and regularly update the individualized person-centered care plans and ensures the beneficiary receives all necessary state plan and waiver services in order to function at the highest level possible.

b. Such HCBS/MLTSS demonstration participants must meet the nursing facility level of care upon admission, and in such case, while receiving short-term nursing facility care may continue enrollment in the demonstration pending discharge from the nursing facility within no more than 180 days or until such time it is determined that discharge within 180 days from admission is not likely to occur, at which time the person must be transitioned to an institution, as appropriate.

c. The community maintenance needs allowance must continue to apply during the provision of short-term nursing facility care in order to allow sufficient resources for the member to maintain his or her community residence for transition back to the community.

5.8. **Supports Program.** The Supports Program provides a basic level of support services to individuals with developmental disabilities who meet eligibility criteria.

a. **Operations**: The administration of the program is through the Division of Developmental Disabilities (DDD).

b. **Eligibility**: Individuals who meet the following criteria are eligible for the Supports program.

i. Are otherwise Medicaid eligible (including via a QIT if operationalized), or have income of up to 300% of the FBR;

ii. Are over the age of 21, or between the ages of 18 to 21, and have graduated from, or are no longer eligible for, the services they are entitled to through their local educational authority (educational entitlement); and

iii. Meet all criteria for functional eligibility using the LOC assessment process in STC 5.8(c) for DDD services including the following definition of "developmental disability". Developmental disability is defined as: "a severe, chronic disability of an individual which:

1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
2. Is manifest before age 22;
3. Is likely to continue indefinitely;
4. Results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction capacity for independent living and economic self-sufficiency;

5. Reflects the need for a combination and sequences of special interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and are individually planned and coordinated; and
6. Includes, but is not limited to, severe disabilities attributable to intellectual disability, autism, cerebral palsy, epilepsy, spina bifida and other neurological impairments where the above criteria are met."

c. **Level of Care (LOC) Assessment**: The participant has a developmental disability and substantial functional limitations in three or more major life activities as determined by DDD's assessment process.

d. **POC Referral**. When it has been confirmed that a candidate has met all of the requirements for enrollment, DDD will refer the case to the appropriate support coordination provider for development of the participant's plan of care (PoC) and initiation of services.

e. **Exclusions**: Individuals may not enroll in the Supports Program if:

   i. They are enrolled in another HCBS/MLTSS program, Children Support Services Program, or the CCP, except that individuals who require private duty nursing services may access only that service from the MLTSS program and still remain on the Supports Program. Individuals enrolled in the Supports Program who are accessing Private Duty Nursing (PDN) from the MLTSS Program may be enrolled in any Medicaid eligibility group recognized within the Supports Program, MLTSS and will be able to access all Supports Program services.

   ii. They require institutional care and cannot be maintained safely in the community.

f. **Expenditure Cap**. Participants in the program will have an individual expenditure cap per person per year that is based on functional assessment. This expenditure cap is reevaluated annually during development of the annual plan of care.

g. **Case Management**. Every Participant will have access to Support Coordination (case management) which is outside of the expenditure cap. Every participant will have access to Financial Management Services (fiscal intermediary). This will also be outside of the expenditure cap.

h. **Bump–Up**. This program also contains a unique feature whereby participants who experience a major change in life circumstances which results in a need for additional temporary services may be eligible to receive a short-term "bump up" in their expenditure cap. This "bump up" is capped at $5,000 per participant. The bump up will be effective for up to one year. Participants may only seek bump up services annually. The services that may be purchased with bump up dollars are any services described in Attachment C under Supports Program, with the exception of the Day Program Related Services.

i. **Enrollment**: All referrals for the Supports Program are screened by DDD to determine if the individual meets the target population criteria, is Medicaid eligible, meets LOC clinical criteria, is in need of support services, the participant agrees to comply with all program requirements, and participant's needs can be safely met in the community. Individuals will be assessed for Medicaid eligibility and LOC clinical criteria and enrolled into the program. When potential new participants are referred, they will be assessed for eligibility and enrolled based on availability of annual state budget allocations.

j. **Assessment tool**: DDD's comprehensive statewide assessment tool is used to assess clinical LOC and functional level for budget determination(s). A statement will be included certifying that an individual meets the functional criteria for DDD and is eligible for the Supports Program.

k. **LOC Reassessment**: LOC will be reviewed annually and reassessment will occur when there is a significant change in a participant's functional level that warrants less supports. The initial LOC assessment is based on an individual being diagnosed with a developmental disability and substantial functional limitation in three or more major life activities. This is unlikely to change from year to year.

l. **Transition**: If health and safety cannot be maintained for a participant on this program because s/he requires a higher level of services than are available, the IDT will make the recommendation and the participant will voluntarily disenroll from the program prior to transition onto a more comprehensive HCBS program (e.g., CCP, MLTSS, etc.). The IDT will commence transition planning to identify service needs and necessary resources. Referrals will be made to all services, as applicable including the CCP.

m. **Disenrollment**: Participants will be disenrolled from the program if they lose Medicaid eligibility, choose to decline participation in the program, enroll in another HCBS program (e.g., CCP, MLTSS, etc.), no longer need support services, or no longer reside in the state.

n. **Benefits/Services, Limitations, and Provider Specifications**: In addition to NJFC Plan A services, Supports program participants receive the benefits outlined in Attachment C.

o. **Cost Sharing**: See Attachment C.

p. **Delivery System**: Medicaid State Plan services for this population will be delivered and coordinated through their Medicaid MCO as outlined in the MCO contracts. HCBS services, described in Attachment C, are provided FFS and will be delivered either through providers that are enrolled as Medicaid providers and are approved by DDD or through non-traditional service providers that are approved by DDD and bill for services through a fiscal intermediary. Services can be either provider-managed, self-directed, or a combination thereof, as approved in the participant's Plan of Care.

5.9. **Children's Support Services Program (CSSP) SED.** This program provides behavioral health and HCBS services and supports to individuals under age 21, that have a SED which places them at risk of hospitalization, out of home treatment or at hospital level of care. Disability determinations, beyond those required to establish SED/IDD, are not required for enrollment in the CSSP SED.

a. **Operations**: The program is administered through the Department of Children and Families (DCF), Children's System of Care (CSOC) for individuals under 21 who have SED.

b. **Eligibility/Benefits**:

i. Individuals who are eligible for New Jersey Medicaid or CHIP state plan services and meet criteria for DCF/CSOC services will receive coverage for HCBS SED services listed in Attachment C following an assessment by the Administrative Services Organization (ASO) (STC 9.8) and referral to the Care Management Organization (CMO) or Mobile Response and Stabilization Services for development of a plan of care.

ii. Individuals who are not otherwise eligible for New Jersey Medicaid or CHIP state plan services and who are at risk of hospitalization, out of home treatment or at hospital level of care, have household income up to 300% of FBR, using institutional deeming rules where appropriate (including treatment as a "Household of One") will receive coverage for state plan services and services listed in Attachment C, based on the individual's plan of care as developed by the CMO.

iii. Individuals who are not otherwise eligible for New Jersey Medicaid or CHIP state plan services and who are at risk of hospitalization, out of home treatment or at hospital level of care, have a household income above 300% of the FBR, and meet criteria for DCF/CSOC services will receive coverage for HCBS SED services and State Plan Behavioral Health Services, based on the individual's plan of care as developed by the CMO.

c. **Exclusions**. Individuals are not eligible for CSSP in the following circumstances:

i. The individual is not a resident of New Jersey.

ii. The family/caregiver(s) with authority to consent to treatment for the individual declines program services.

iii. Current assessment or other relevant information indicates that the individual can be safely maintained and effectively supported at a less intensive level of care.

iv. The behavioral symptoms are the result of a medical condition that warrants a medical setting formed and documented by the individual's primary care physician and/or the DCF/CSOC or its designee.

v. For all services, the services and supports cannot be provided if the family/caregiver is unwilling or unable to comply with all program requirements.

vi. The individual has a sole diagnosis of substance use and there is no identified, co-occurring emotional or behavioral disturbances consistent with the current version of Diagnostic and Statistical Manual of Mental Disorders (DSM).

vii. The individual's sole diagnosis is an Intellectual/Developmental Disability.

d. **LOC Assessment**: The DCF/CSOC level of care will be reviewed at least annually using DCF/CSOC's criteria and the New Jersey DCF/CSOC's Information and Management Decision Support (IMDS) tools.

e. **Disenrollment**: An individual may be disenrolled from the program if:

i. The individual no longer is at risk of hospitalization, out of home treatment or at hospital level of care;

ii. The family/caregiver is unable or unwilling to implement the treatment plan developed by the CMO or fails to comply with the terms as outlined in the plan. Prior to disenrollment, the team will collaborate and make substantial efforts to ensure the individual's success in the program, working to remedy any barriers or issues that have arisen, including those involving family/caregiver cooperation with the treatment plan. An individual will only be disenrolled after significant efforts have been made to achieve success. If they will be disenrolled, the team will make recommendations and identify alternative local community and other resources for the individual prior to disenrollment;

iii. The individual's documented treatment plan goals and objectives have been met; or

iv. The individual is no longer a resident of New Jersey.

f. **Delivery System**: Medicaid State Plan Services are delivered through the MCO. HCBS and behavioral health services are coordinated and authorized through the DCF/CSOC ASO. HCBS programs outlined in Attachment C will be delivered FFS.

5.10. **Children's Support Services Program (I/DD).** Program for individuals with intellectual/ developmental disabilities (I/DD) provides HCBS services and supports to individuals under the age of 21. Youth that meet the DCF/CSOC functional eligibility criteria as defined by state and federal law and in this STC (functional eligibility criteria) for I/DD. Individuals may also have a co-occurring I/DD and mental health diagnosis (I/DD-MI). Disability determinations, beyond those required to establish SED/IDD, are not required for enrollment in the CSSP I/DD.

a. **Operations**: The program is administered through the DCF/CSOC.

b. **Eligibility/Benefits**:

i. Individuals who are eligible for New Jersey Medicaid or CHIP state plan services and meet criteria for DCF/CSOC services will receive coverage for HCBS I/DD services listed in Attachment C following an assessment by the ASO (STC 9.8) and referral to the CMO or Mobile Response and Stabilization Services for development of a plan of care.

ii. Individuals who are not otherwise eligible for New Jersey Medicaid or CHIP state plan services and who are at risk of hospitalization, out of home treatment or at hospital level of care, have household income up to 300% of the FBR, using institutional deeming rules where appropriate (including treatment as a "Household of One"), will receive coverage for state plan services and services listed in Attachment C, based on the individual's plan of care as developed by the CMO.

iii. Individuals who are not otherwise eligible for New Jersey Medicaid or CHIP state plan services and who are at risk of hospitalization, out of home treatment, or at hospital level of care, have a household income above 300% of the FBR, and meet criteria for DCF/CSOC services will receive coverage for HCBS I/DD services listed in Attachment C and state plan behavioral health services, based on the individual's plan of care as developed by the CMO.

c. **Functional eligibility for developmental disability**. To meet the functional eligibility criteria for I/DD, an individual must be diagnosed with a severe, chronic disability that:

i. is attributable to a mental or physical impairment or combination of mental and physical impairments.

ii. is manifested before age 22.

iii. is likely to continue indefinitely.

iv. results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction capacity for independent living and economic self-sufficiency.

v. reflects the need for a combination and sequences of special interdisciplinary or generic care, treatment or other services which are of lifelong or extended duration and are individually planned and coordinated.

vi. includes but is not limited to severe disabilities attributable to intellectual disability, autism, cerebral palsy, epilepsy, spina bifida and other neurological impairments where the above criteria are met.

vii. Infants and young children. An individual from birth to age nine, inclusive, who has a substantial developmental delay or specific congenital or acquired condition, may be considered to have a developmental disability without meeting three or more of the criteria described in (a) through (f), if the

individual, without services and supports, has a high probability of meeting those criteria later in life.

d. **Exclusions**:

   i. Individuals who are not residents of New Jersey are not eligible for CSSP (I/DD).

   ii. Services that are provided under the individualized educational program are not covered under this demonstration.

   iii. For all services, these cannot be provided if the family/caregiver is unwilling or unable to comply with all program requirements.

e. LOC Assessments will be in alignment with standards in STC 5.9.d.

f. **Disenrollment**: An individual will be disenrolled from the program for the following reasons:

   i. The family/caregiver declines participation or requests to be disenrolled from the program;

   ii. The family/caregiver is unable or unwilling to implement the treatment plan or fails to comply with the terms as outlined in the plan. Prior to disenrollment, the team will collaborate and make substantial efforts to ensure the individual's success in the program, working to remedy any barriers or issues that have arisen, including those involving family/caregiver implementation of the treatment plan. An individual will only be disenrolled after significant efforts have been made to achieve success. If they will be disenrolled, the team will make recommendations and identify alternative Local community and other resources for the individual prior to disenrollment;

   iii. The individual's documented treatment plan goals and objectives have been met;

   iv. The individual is no longer receiving HCBS services; or

   v. The individual is no longer a resident of New Jersey.

g. **Delivery System**: Medicaid State Plan and certain behavioral health services will be delivered through the individual's Medicaid MCO. HCBS and other behavioral health services and supports are coordinated and authorized through the DCF/CSOC ASO and will be delivered FFS. The services will be defined in the respective contracts with the MCO and ASO.

5.11. **Community Care Program (CCP).** This program is administered by the Division of Developmental Disabilities providing services and supports for individuals with developmental disabilities, who are Medicaid eligible and meet the Intermediate Care Facility (ICF/ID) level of care requirements, to aid them in living in the community setting.

The state transitioned this program from operation under a 1915(c) waiver to the 1115(a) demonstration authority in 2017.

a. **Eligibility**: In order to be eligible for the CCP, an individual must meet the following criteria:

    i. Be otherwise eligible for Medicaid (including via a QIT, if operational) or have an income of up to 300% of the FBR

    ii. Are over the age of 21, or between the ages of 18 to 21, and have graduated from, or are no longer eligible for, the services they are entitled to through their local educational authority (educational entitlement)

    iii. Be determined eligible for DDD services

    iv. Meet ICF/ID clinical level of care (LOC) and

    v. Be at the top of the waiting list, be deemed an emergency, or else be part of Olmstead.

b. **Exclusions**:

    i. An applicant may not be enrolled while receiving another HCBS program (e.g., Supports Program, MLTSS, CSOC, etc.).

c. **Enrollment**: CCP participants must meet NJ DDD Eligibility criteria, clinical and financial eligibility criteria, are part of the target population, and require and receive at least one program service quarterly, in addition to Support Coordination. Additionally, participants need to sign the CCP Participant Agreement.

d. **Enrollment cap**: In cases where the state determines, based on advance budget projections that it cannot continue to enroll CCP participants without exceeding the funding available for the program the state can establish an enrollment cap for the CCP.

    i. Notice - before affirmatively implementing the caps authorized in subparagraph (c), the state will notify CMS at least 60 days in advance. This notice will also include the impact on budget neutrality.

    ii. Implementing the Limit - if the state imposes an enrollment cap, it will implement a waiting list whereby applicants will be added to the demonstration based on date of application starting with the oldest date. Should there be several applicants with the same application date, the state will enroll based on date of birth starting with the oldest applicant.

    iii. Individuals on the CCP Wait Lists have been and will continue to be offered enrollment on the Supports Program providing they meet eligibility criteria.

    iv. Removing the Limit – the state will notify CMS in writing at least 30 days in advance when removing the limit.

e. **Level of care**:

   i. LOC Assessment: The state will use the CMS approved and defined ICF-ID level of care to mean the recipient has been determined eligible for DDD services in accordance with N.J.A.C. 10:46 and has substantial functional limitations which require care and/or treatment in an ICF/ID or alternately, in a community program under the DDD CCP.

   ii. The responsibility of conducting the level of care evaluations and re-evaluations falls to DDD staff or Support Coordinators that meet the qualifications of a Qualified Intellectual/Developmental Disability Professional (QIDP) as defined in 42 CFR 483.430. The CMS approved LOC assessment is embedded in the NJ Comprehensive Assessment Tool (NJ CAT) and is completed by an informant knowledgeable with regard to the prospective program participant. This individual may include a family member or a paid caregiver who can best describe the abilities and needs of the individual. The completed tool is then reviewed by a QIDP to ensure the assessment is consistent with both the QIDP's observations and the skills/needs that are ultimately presented in the individual's Service Plan (Plan of Care).

   iii. **LOC Reassessment**: The re-evaluation of LOC is completed by a QIDP annually as a result of reviewing the NJ CAT questions related to level of care during the service planning (Plan of Care) process each year.

f. **Plan of Care**: The assigned support coordinator/case manager works with the participants and/or their representative(s), a legal representative or an individual selected by the participant to act on his/her behalf, to develop a plan of care that addresses the participant's needs, and then coordinates the delivery of services with the providers. The Plan of Care describes: (a) the services that are furnished to the participant and their projected frequency; and (b) the other services (including state plan services and natural supports) that complement the HCBS under this program.

g. **Transition**: There is no maximum age limit for this program.

h. **Disenrollment**: Members will be disenrolled in the following circumstances:

   i. The enrollee requests to dis-enroll;

   ii. The enrollee chooses to enroll in another HCBS Program or MLTSS;

   iii. The enrollee no longer meets the ICF/ID level of care criteria;

   iv. The enrollee has not maintained compliance with the CCP Participant Agreement;

   v. The enrollee no longer meets the income requirements;

   vi. The enrollee becomes incarcerated or is placed in an institutional placement;

   vii. The enrollee no longer resides in New Jersey;

viii. Death of the enrollee.

i. **Benefits/Services, Limitations, and Provider Specifications**: In addition to Plan A services, CCP participants receive the benefits outlined in Attachment C.

j. **Delivery System**:

i. State plan and behavioral health services will be delivered through a Medicaid MCO as outlined in the MCO contract. Services not delivered by the Medicaid MCO will be covered under FFS.

k. **Payment**: Payment for the CCP is under a Fee for Service (FFS) Payment System.

5.12. **Adjunct Services Autism Spectrum Disorder (ASD) Pilot.** This pilot would test the impact of expanding the available options for youth with an ASD diagnosis by offering a limited package of adjunct services that are not coverable under the state plan, to individuals up to age 21.

a. **Program Overview**: This pilot is intended to provide NJFC/Medicaid eligible children with adjunct or specialized services that they are unable to access via the state plan. All 1905(a) services under EPSDT will be provided through the state plan to state plan eligible individuals. The state will provide individuals up to their 21st birthday who have a diagnosis of ASD with adjunct or specialized services to support and assist the individual with activities as outlined in their plan of care. These services are intended to enhance inclusion in the community rather than clinic based settings or the member's home, and they must be associated with and support goals within the overall treatment plan. Services offered through the demonstration would be limited to Art therapy, Aquatic therapy, Hippotherapy/therapeutic horseback riding, Music therapy, Drama therapy, Dance/movement therapy, and Recreation therapy. All services are subject to state-developed cost-effectiveness requirements.

b. **Eligibility**: Individuals up to their 21st birthday who are eligible for either the New Jersey Medicaid or CHIP programs and have an ASD diagnosis as defined by ICD 10 diagnoses F84.0 through F84.9 by a qualified healthcare provider using an approved assessment tool referenced below:

i. Approved Assessment Tools include:

1. ABAS – Adaptive Behavior Assessment System II
2. CARS – Childhood Autism Rating Scale
3. DDRT – Developmental Disabilities Resource Tool
4. GARS – Gilliam Autism Rating Scale
5. ADOS – Autism Diagnostic Observation Scale
6. ADI – Autism Diagnostic Interview-Revised
7. ASDS – Asperger's Syndrome Diagnostic Scale

c. **Exclusions**:

   i. Individuals over the age of 21

   ii. Individuals without an ASD diagnosis

   iii. Individuals with private insurance that offers these types of benefits, whether or not they have exhausted the benefits.

d. **Enrollment**: Potential ASD program participants will be referred to DMAHS for screening and assessment. Once a child has been determined to have an ASD and a treatment plan has been approved, she/he will be referred for enrollment in the program.

e. **Disenrollment**: A participant will be disenrolled from the demonstration for the following reasons:

   i. Age out at age 21

   ii. Participant is deemed no longer in need of services, as per the reassessment process

   iii. Loss of NJFC/Medicaid eligibility

   iv. Participant no longer resides in New Jersey.

5.13. **New Jersey Home Visiting Pilot (NJHV) Program.** Under this pilot program, the state will provide evidence-based home visiting services to up to 500 families each demonstration year by licensed practitioners or certified home visitors to promote enhanced health outcomes, whole person care, and community-integration for high-risk pregnant individuals, parents of children up to three (3) years old, and children up to two (2) years old for the Nurse Family Partnership (NFP) and up to three (3) years old for Healthy Families America (HFA) and Parents as Teachers (PAT) in all counties throughout the state. The program is aligned with three evidence-based models that are focused on the health of pregnant individuals. Additional information regarding the NJHV pilot program is in Attachment L.

a. **Nurse Family Partnership**: The NFP is designed for reinforcing maternal behaviors that encourage positive parent child relationship and maternal, child, and family accomplishments. The New Jersey FamilyCare Section 1115 demonstration NFP will adhere to the NFP national program standards.

b. **Healthy Families America**: The HFA model targets parents facing issues such as single parenthood, low income, childhood history of abuse, SUD, mental health issues, and domestic violence.

c. **Parents as Teachers**: PAT targets at-risk pregnant individuals and new parents with infants and children to age three to identify and address perinatal and infant/child health issues and developmental delays, and parent knowledge and support.

5.14. **Financial Eligibility Determination Pilot Program.** For individuals under the guardianship of the New Jersey Office of the Public Guardian (OPG) and applying for Medicaid coverage, the state will provide an expedited financial eligibility determination (process outlined in Attachment H). Specifically, the state, when such an individual applies for Medicaid, will allow OPG to provide an attestation that the individual's resources are less than the $2,000 resource limit due to financial obligations not yet paid. The state may use an OPG attestation for such individuals applying for Medicaid for the first time as of the pilot approval throughout this demonstration approval period. Financial eligibility rules for individuals to be under the guardianship of the OPG are the same as individuals applying for Medicaid regardless of guardianship status. The state must use Asset Verification System (AVS) and other electronic verification tools to verify known financial resources and identify unknown financial resources both at application and at redetermination.

a. Program Requirements

i. After the individual's obligations are paid, for individuals determined to have been ineligible for Medicaid services due to exceeding the resource limit, the state will be responsible for funding services provided to the ineligible individual for the determination period which relied upon the OPG attestation and no FFP may be claimed for the individual.

ii. Attestations from the OPG will be accepted only for 12 months ("12-month eligibility span") and may not be used to renew eligibility beyond the "12-month end date" regardless of whether or not the OPG has completed settling the individual's financial obligation.

iii. If the OPG settles the individual's accounts during 180 calendar days after the 12-month end date, and the state determines the individual was eligible for Medicaid during the 12-month eligibility span, the state may claim FFP for the 12-month eligibility span. If the OPG settles the individual's accounts after 180 days after the 12-month end date, the state does not claim FFP for the 12-month eligibility span, regardless of whether or not the individual was eligible during the 12-month eligibility span.

iv. For individuals determined to have been ineligible for Medicaid due to exceeding the income or resource limit during the 12-month eligibility span, the state will be responsible for funding services provided to the ineligible individual for the 12-month eligibility span and no FFP may be claimed for the individual. If FFP was claimed for the individual prior to the determination of ineligibility, the state is required to return the FFP.

v. The state must require the OPG to maintain records of individuals – for whom the expedited financial eligibility determination is utilized: report to the state when the OPG settles the count of an individual who has been made eligibility based on the OPG's attestation. The state must also maintain records of the results of the asset verification process throughout the demonstration approval period (July 25, 2019 through June 30, 2028).

5.15. **Postpartum Extension.** The state will extend postpartum coverage for individuals from the end of the state plan 60-day postpartum period to the end of the 12th month following the end of the pregnancy.

a. To be eligible for continuous extended postpartum coverage, individuals must be enrolled in any CHIP or Medicaid eligibility group while pregnant (including during a period of retroactive eligibility). Individuals who are eligible for extended postpartum coverage will remain enrolled continuously within their CHIP or Medicaid eligibility group regardless of changes in circumstances (except for changes in state residency, if the individual requests voluntary termination or the individual is deceased) from pregnancy through the duration of the extended 12-month postpartum period.

b. The state will conduct any required redetermination or renewal of eligibility at the end of the extended postpartum period consistent with 42 CFR 435.916 and 42 CFR 457.343. This includes determining Medicaid eligibility on all bases consistent with 42 CFR 435.916(f)(1) prior to determining an individual ineligible. Individuals determined eligible on another basis at the end of the postpartum period will be moved to the appropriate group at that time. Individuals determined ineligible for Medicaid on all bases will be provided advance notice of termination in accordance with 42 C.F.R. §435.917 and 42 C.F.R. Part 431, Subpart E and assessed for potential eligibility for other insurance affordability programs in accordance with 42 CFR 435.916(f)(2). Separate CHIP enrollees no longer eligible for CHIP must be screened for eligibility in other insurance affordability programs in accordance with 42 CFR §457.350(b) and receive timely written notice of termination in accordance with 42 CFR §457.340(e).

c. **Postpartum coverage for the Adult Group.** The state has submitted to CMS a proxy methodology for state expenditures to qualify for the newly eligible FMAP under Section 1905(y) of the Act, consistent with requirements provided in 42 CFR 433.206(d). This methodology must be approved by CMS and incorporated as Attachment O to these STCs, prior to the state claiming enhanced newly eligible FMAP. The proxy methodology identifies the proportion of claimed expenditures for beneficiaries receiving post-partum benefits who are reasonably estimated to meet the definition of newly eligible under Section 1905(y)(2)(A) of the Act for whom enhanced newly eligible FMAP may be claimed, and the proportion claimed for beneficiaries who do not meet this definition for whom the regular FMAP must be claimed.

5.16. **Continuous Eligibility.**

a. **Affected Individuals**. All adult populations whose eligibility is determined by Modified Adjust Gross Income (MAGI) methodologies under New Jersey's Medicaid state plan shall qualify for a 12-month continuous eligibility period.

b. **Continuous Eligibility Period**. Upon state submission and CMS acceptance of the protocol described in STC 14.13, the state is authorized to provide continuous eligibility for the populations and associated durations specified in STC 5.16.a, regardless of the delivery system through which these populations receive Medicaid

benefits. For individuals that qualify for 12 months of continuous eligibility, the continuous eligibility period begins on the effective date of the individual's eligibility under 42 CFR 435.915, or the effective date of the most recent renewal of eligibility. Given individuals are continuously eligible regardless of changes in circumstances (except as provided under STC 5.16.c), the state will conduct renewals of eligibility consistent with 42 CFR 435.916 for individuals who qualify for 12 months of continuous eligibility at the end of the individual's continuous eligibility period. The state will continue to redetermine eligibility during a period of continuous eligibility in limited circumstances, if appropriate, as described in STC 5.16.c.

c. **Exceptions**. Notwithstanding STC 5.16.b, if any of the following circumstances occur during an individual's designated continuous eligibility period, the individual's Medicaid eligibility shall be re-determined or terminated:

   i. The individual is no longer a New Jersey resident;

   ii. The individual requests termination of eligibility;

   iii. The individual dies; or

   iv. The agency determines that eligibility was erroneously granted at the most recent determination, redetermination, or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the individual.

d. **Beneficiary-Reported Information and Periodic Data Checks**. The state must have procedures designed to ensure that beneficiaries can make timely and accurate reports of any change in circumstances that may affect their eligibility as outlined in this demonstration, such as a change in state residency, and are able to report other information potentially relevant to the state's implementation or monitoring and evaluation of this demonstration, such as changes in income. The beneficiary must be able to report this information through any of the modes of submission available at application (online, in person, by telephone, or by mail).

   Additionally, the state must redetermine eligibility if the state receives information that indicates a change in state residency or that the individual is deceased, verifying the change consistent with 42 CFR 435.916(d) and in accordance with 42 CFR 435.940 through 435.960 and the state's verification plan developed under 42 CFR 435.945(j).

   As part of a deliverable titled New Initiatives Implementation Plan (see STC 12.5), the state must submit a description of the processes to perform the verifications described above. Furthermore, the state is required to provide CMS a narrative update annually on the processes it conducted and a summary of its findings regarding the successes and challenges in conducting such verifications. This information shall be provided in the demonstration's Annual Monitoring Reports (see STC 12.8).

5.17. **Behavioral Health Promoting Interoperability Program (BH PIP)**. The state may claim as allowable expenditures, up to $6 million (total computable) for five years, payments to incentivize health information technology (HIT) use. Incentive payments for Medicaid

providers support the state's goals of expanding HIT use, increasing New Jersey' health information exchange (HIE) connectivity, and assisting providers with improving beneficiary outcomes and reducing disparities through the use of HIE tools.

a. **Eligibility**. Behavioral health facilities that are eligible to receive incentive payments to purchase tools are limited to those whose Medicaid patient volume is at least 20% (CHIP does not count toward the Medicaid patient volume criteria).

b. **Reporting**. The state will report on the activities of the BH PIP in the Annual Monitoring Reports (see STC 12.8). The state will report the amount and types of providers participating, the amount of funding given to providers, and an annual update of how the incentive is helping New Jersey move its data systems forward. For example, one update would include how many providers statewide are connected to the New Jersey HIE. All expenditures must be reported as specified in STC 14.2.

c. **BH PIP Incentive Payment Protocol**. The BH PIP Incentive Payment Protocol establishes rules and guidelines for participation as well as how the state will claim FFP for incentive payments. The approved BH PIP Incentive Payment Protocol will be appended into these STCs as Attachment P. The state must submit the BH PIP Incentive Payment Protocol to CMS for approval. CMS and New Jersey will work collaboratively with the expectation of CMS approval of the protocol within 120 calendar days after it receives the protocol. The state cannot claim FFP for any incentive payments until the BH PIP Incentive Payment Protocol has been submitted to and approved by CMS, but once approved, payments may be claimed retroactively to the beginning of the demonstration approval period.

d. **Payments.** The state will pay providers directly, and payments to BH facilities will not be included in managed care capitation rates. Payments cannot duplicate reimbursement for provider activities already reimbursed by managed care plans.

e. **Unallowable Expenditures**. Under no circumstances, may the state receive FFP under this expenditure authority for provider incentive payments made to any facility that was previously included under the Health Information Technology for Economic and Clinical Health (HITECH) Act.

    i. The BH PIP will be limited to providing incentives for BH facilities and not individual providers.

5.18. **Community Health Workers Pilot Program.** The state may claim as allowable expenditures up to $5 million for each demonstration year over the course of the demonstration extension period to establish a Community Health Workers (CHW) Pilot program. The CHW program will build evidence-based programs that support health outcomes and addresses health disparities impacting communities within the state. Subject to CMS approval, the state will be required to submit a post-approval protocol within 90 days of implementation. Specific initiatives to be funded would be proposed and operationalized by the state's contracted MCOs, and approved by the state, subject to the restrictions described below.

a. **Proposal Process**. In order to participate in this initiative, MCOs must submit a proposal to the state that at a minimum includes the following elements:

   i. Population of individuals to be targeted, along with a description of how these individuals will be identified using available data sources. Proposals must target Medicaid or CHIP beneficiaries enrolled in the MCO who have been diagnosed with or are at risk for a specific chronic condition, such as asthma, diabetes, depression, or HIV. The pilot may have a cap on enrollment and may be limited to certain geographies within the state or to patients of certain providers participating in the pilot.

   ii. A detailed description of the intervention, including detail around the specific patient education, care management, or other related tasks the CHWs will perform, and how the initiative will be aligned with and/or be integrated into the larger health care delivery system.

   iii. A detailed description on implementation timeline and the scope of benefits and services available to eligible Medicaid enrollees. The initiatives may not be approved unless the proposal clearly demonstrates an implementation period of 36 – 42 months, such that the pilot program can provide performance data and evidence over a span of time.

   iv. A set of implementation and/or quality improvement milestones the MCO expects to meet for each year of the initiative.

   v. A description of the impacts expected from the intervention, expressed in terms of specific quantitative metrics of patient utilization, health expenditures, processes or outcomes of care, or patient experience of care. To the extent possible, MCOs should define expected quality impacts using metrics from the core sets of health care quality measures for Medicaid enrollees. The selection of metrics must also align with the milestones identified for the initiatives, per STC 5.18.a.4.

   vi. A description of the control or comparison group that will be used for the purposes of evaluating the impact of the proposed program. Randomized control groups must be used wherever feasible. The proposals must also include plans for making all applicable data available for pre- and post-implementation of the pilots.

   vii. An identification of how the proposed intervention could be scaled to the broader Medicaid and/or CHIP population, if the pilot successfully achieves its cost, quality, and/or patient experience objectives. This must include identification of specific potential Medicaid authorities that could be used to scale the proposal.

   viii. A detailed budget of expenses associated with the implementation of the proposal.

   ix. Each pilot initiative must be evaluated by an independent third-party evaluator (the state's demonstration evaluator). The pilot proposal must provide clear

information on how the MCOs will make all applicable and relevant data available to the independent evaluator for this purpose.

1. The evaluation must be conducted focusing on each pilot separately but also is expected to contextualize observed beneficiary outcomes within the scope of how the broader demonstration program components affect beneficiary outcomes.
2. The state must set up the contract with the demonstration's independent evaluator such that the independent entity is involved in the review process of the pilot proposals from the perspective of viability for gathering robust evidence. The evaluator should review the discussion of milestones, goals, proposed performance metrics, evaluation measures, availability of data, and other aspects (such as control or comparison groups) to assure comprehensive implementation, outcomes, and impact evaluations of the pilots.

x. The state shall review all MCO proposals and approve only those that it judges to (a) be consistent with the goals of the Medicaid program, (b) be reasonably likely to lead to improvements in the quality, experience, and/or efficiency of member care, (c) have a viable path to expansion if successful, and (d) be operationally feasible and financially viable.

xi. MCOs may only implement proposals that have been approved by the state. Once approved, MCOs must adhere to the terms of their proposal, which will be incorporated by reference into the MCO contract. Any changes to the initial proposal must be approved in writing by the state.

b. **Expenditures.** Total statewide annual expenditures on the CHW pilot are limited to $5 million.

i. Expenditures for the CHW pilot must be separate and distinct payments to the applicable managed care plans. The state must ensure that expenditures related to this pilot are not factored into managed care capitation payments, services are not otherwise covered under the managed care contract, and that there is no duplication of funds.

ii. Payments to MCOs are contingent on continued compliance with all program requirements and all relevant state and federal laws and regulations.

c. **Beneficiary Rights and Protections.**

i. No Medicaid or CHIP beneficiary is entitled to receive services under or participate in the CHW pilot.

ii. No Medicaid or CHIP beneficiary is required to participate in the CHW pilot. A beneficiary's decision to decline to participate in the pilot may not in any way adversely affect their Medicaid or CHIP eligibility, their enrollment in their MCO, or their ability to access any services to which they are entitled.

iii. Services offered under the demonstration may not duplicate or replace services to which beneficiaries are entitled.

iv. MCOs must provide all beneficiaries included in the pilot with advance written notification of their potential participation. This notification must describe the program, describe the extent and nature of the beneficiary's potential participation, make clear that participation is voluntary, including specific instructions on how beneficiaries may opt out. Notifications must be pre-submitted to the state for review and approval.

v. The MCOs shall also inform beneficiaries that data on their participation and associated healthcare utilization will be assessed for effectiveness of the pilots. Eligible beneficiaries shall also be informed that they may be randomly selected for participating in beneficiary surveys and/or focus groups.

d. **Post-Approval Protocol**.

i. After receiving, and giving preliminary approval to MCO proposals, the state shall submit to CMS a post-approval CHW Pilot protocol, that will include the following elements:

1. Overall summary of preliminarily approved CHW pilot proposals, documented at individual proposal/initiative-level, including milestones for payment, and linkage to attainment of performance metrics thresholds as outlined in STC 5.18 (b).
2. Description of individualized monitoring and evaluation strategies for each approved proposal, including assessment on the strength and limitations of those strategies form the state's independent evaluator(s).
3. In the event that the state short-lists more than one proposal from one MCO, the proposals must outline how funding will be linked to performance on distinct sets of metrics, aligned with initiative-specific milestones.
4. Copies of all preliminarily approved MCO proposals.
5. Draft MCO contract language incorporating MCO proposals by reference (but payment must be separate and distinct from managed care capitation for this pilot).
6. No expenditures may be made under this provision, until the post-approval protocol has been received for review and approved by CMS.

e. **Monitoring and Evaluation**

i. As part of its annual demonstration monitoring reports, the state shall report on achievement of milestones, payments, number of beneficiaries served, and other relevant information for each approved MCO initiative.

ii. An independent entity must evaluate each pilot initiative and shall be involved from early in the process.

5.19. **Caregiver Supports Program**. The state may provide counseling services for individuals serving as unpaid caregivers to assist the caregiver in meeting the care needs of an individual receiving MLTSS to continue to support the individual's independence and/or expand the individual's participation in the community. Services will include individual and/or facilitated peer group counseling through licensed behavioral health provider under contract with the MCO. Caregivers may receive unlimited counseling sessions as needed. Services will be subject to regular review (quarterly through the plan of care) by the MCO to determine the continued appropriateness for the need of services.

a. Eligibility: For a caregiver to be eligible for counseling services, the caregiver must:

i. Provide caregiver services to a MLTSS individual for at least ten hours a week.

ii. Receive a recommendation by the MCO (as part of plan of care development) as in need of counseling services to continue to support the member's independence and/or expand the member's participation in the community.

iii. The caregiver must attest they do not have any third-party coverage that would cover the counseling services.

6. OPIOID USE DISORDER/SUBSTANCE USE DISORDER PROGRAM

6.1. **Opioid Use Disorder (OUD)/Substance Use Disorder (SUD) Program**. Under this demonstration component, New Jersey Medicaid recipients will continue to have access to high-quality, evidence-based OUD and other SUD treatment services including services provided in residential and inpatient treatment settings that qualify as an IMD, which are not otherwise reimbursable expenditures under Section 1903 of the Act. The state will continue to be eligible to receive FFP for Medicaid beneficiaries residing in IMDs under the terms of this demonstration for coverage of medical assistance, including OUD/SUD benefits that would otherwise be reimbursable if the beneficiary were not residing in an IMD. The state will continue to aim for a statewide average length of stay of 30 days or less in residential treatment settings, to be monitored pursuant to the SUD Monitoring Protocol as outlined in STC 12.7, to ensure short-term residential treatment stays.

The coverage of OUD/SUD, as outlined in the table below, reflect a continuum of care that ensures Medicaid recipients can enter SUD treatment at a level appropriate to their needs and step up or down to a different intensity of treatment based on their responses. The American Society of Addiction Medicine (ASAM) Criteria Assessment shall continue to be used for all beneficiaries to determine placement into the appropriate level of care. Room and board costs are not considered allowable costs for residential treatment service providers unless they qualify as inpatient facilities under Section 1905(a) of the Act.

As is currently the case, New Jersey FamilyCare anticipates the Division of Mental Health and Addiction Services, which is the single state authority on SUD services, will continue to fund primary prevention efforts, including education campaigns and community prevention coalitions. Intervention and initial treatment will be available to New Jersey FamilyCare members, as described below, in a number of different settings (as set forth herein) and allow for a bio-psycho-social clinical assessment, based on the ASAM principles, to gain an

understanding of addiction severity, co-occurring mental health issues and trauma, physical health issues, family and social supports, housing stability, and other issues.

Table B: New Jersey OUD/SUD Benefits Coverage with Expenditure Authority

SUD Benefit	Medicaid Authority	Expenditure Authority
Early Intervention (Screening, Brief Intervention and Referral to Treatment)	State plan (Individual services covered)	
Outpatient Services	State plan (Individual services covered)	
Intensive Outpatient Services	State plan (Individual services covered)	
Partial Care Services	State plan (Individual services covered)	
Residential Treatment	State plan (Individual services covered)	Services provided to individuals in IMDs
Withdrawal Management	State plan	Services provided to individuals in IMDs
Medication-Assisted Treatment (MAT)	State plan	Services provided to individuals in IMDs
Peer Support (including Parent/Family Peer Support)	State plan	
Care Management	State plan	

a. **SUD Program Requirements**. The following requirements that reflect key goals and objectives of this SUD project apply to this demonstration:

b. **Access to Critical Levels of Care for OUD and other SUDs.** Coverage of OUD/SUD treatment services across a comprehensive continuum of care including: outpatient; intensive outpatient; medication assisted treatment (medication as well as counseling and other services with sufficient provider capacity to meet the needs of Medicaid beneficiaries in the state); intensive levels of care in residential and inpatient settings; and medically supervised withdrawal management.

c. **Use of Evidence-based SUD-specific Patient Placement Criteria.** Providers will assess treatment needs based on SUD-specific, multidimensional assessment tools, such as the ASAM Criteria or other assessment and placement tools that reflect evidence-based clinical treatment guidelines.

d. **Patient Placement.** The state will continue to employ a utilization management approach, in accordance with state law, such that beneficiaries have access to SUD services at the appropriate level of care and that the interventions are appropriate for the diagnosis and level of care, including an independent process for reviewing placement in residential treatment settings.

e. **Use of Nationally Recognized SUD-specific Program Standards to set Provider Qualifications for Residential Treatment Facilities**. Residential treatment providers must align with the program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding in particular the types of services, hours of clinical care, and credentials of staff for residential treatment settings. Residential treatment providers must also be in compliance with state licensure requirements for substance use disorder treatment programs.

f. **Standards of Care for Residential Treatment Settings.** The state will review residential treatment providers to ensure that providers deliver care consistent with the specifications in the ASAM Criteria or other comparable, nationally recognized SUD program standards based on evidence-based clinical treatment guidelines for types of services, hours of clinical care, and credentials of staff for residential treatment settings.

g. **Standards of Care for Medication Assisted Treatment.** Residential treatment providers must offer MAT on-site or facilitate access to MAT off-site.

h. **Sufficient Provider Capacity at each Level of Care including Medication Assisted Treatment for SUD/OUD**. The state must ensure sufficient provider capacity in the critical levels of care throughout the state, including those that offer MAT.

i. **Improved Care Coordination and Transitions between levels of care.** The state will continue to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities.

j. **SUD Health IT Plan.** Implementation of the milestones and metrics as detailed in STC 6.2.b and Attachment E.

6.2. **SUD Health Information Technology Plan ("SUD Health IT Plan").** The SUD Health IT Plan applies to all states where the health IT functionalities are expected to impact beneficiaries within the demonstration. As outlined in SMDL #17-003, states must submit to CMS the applicable SUD Health IT Plan(s), to be included within the approved SUD Implementation Plan as Attachment E to the STCs, to develop infrastructure and capabilities consistent with the requirements outline in each demonstration type.

a. The SUD Health IT Plan must detail the necessary health IT capabilities in plan to support beneficiary health outcomes to address the SUD goals of the demonstration. The SUD Health IT Plan(s) will also be used to identify areas of health IT ecosystem improvement. The SUD Health IT Plan must include implementation milestones and projected dates for achieving them (see Attachment E) and must be aligned with the state's broader Medicaid Health IT Plan (SMHP) and, if applicable, the state's SMI IT Health Plan.

b. The state must include in its Monitoring Protocol (see STC 12.7) an approach to monitoring its SUD Health IT Plan which will include performance metrics to be approved in advance by CMS.

c. The state will monitor progress, each DY, on the implementation of its SUD Health IT Plan in relationship to its milestones and timelines – and report on its progress to CMS in an addendum to its Annual Report (see STC 12.8).

d. As applicable, the state should advance the standards identified in the 'Interoperability Standards Advisory – Best Available Standards and Implementation Specifications' (ISA) in developing and implementing the state's SUD health IT policies and all related applicable state procurements (e.g., including managed care contracts) that are associated with this demonstration.

e. Where there are opportunities at the state- and provider-level to leverage federal funds associated with a standard not already referenced in 45 CFR 170, but included in the ISA, the state should use the federally-recognized ISA standards, barring no other compelling state interest.

f. Components of the SUD Health IT Plan include:

    i. The SUD Health IT Plan must describe the state's goals, each DY, to enhance the state's prescription drug monitoring program's (PDMP).[1]

    ii. The SUD Health IT Plan must address how the state's PDMP will enhance ease of use for prescribers and other state and federal stakeholders.[2] This must also include plans to include PDMP interoperability with a statewide, regional or local HIE. Additionally, the SUD Health IT Plan must describe ways in which the state will support clinicians in consulting the PDMP reviewing the patients' history of controlled substance prescriptions prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription.

    iii. The SUD Health IT Plan will, as applicable, describe the state's capabilities to leverage a master patient index (or master data management service, etc.) in

[1] Prescription drug monitoring programs (PDMP) are electronic databases that track controlled substance prescriptions in states. PDMPs can provide health authorities timely information about prescribing and patient behaviors that contribute to the "opioid" epidemic and facilitate a nimble and targeted response.

[2] *Ibid*.

support of SUD care delivery. Additionally, the SUD Health IT Plan must describe current and future capabilities regarding PDMP queries—and the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP. The state will also indicate current efforts or plans to develop and/or utilize current patient index capability that supports the programmatic objectives of the demonstration.

iv. The SUD Health IT Plan will describe how the activities described in STC 6.3 (a) through (e) above will support broader state and federal efforts to diminish the likelihood of long-term opioid use directly correlated to clinician prescribing patterns.[3]

v. The SUD Health IT Plan will describe the state's current and future capabilities to support providers implementing or expanding Health IT functionality in the following areas: 1) Referrals, 2) Electronic care plans and medical records, 3) Consent, 4) Interoperability, 5) Telehealth, 6) Alerting/analytics, and 7) Identity management.

vi. In developing the Health IT Plan, states shall use the following resources.

vii. States may use resources at Health IT.Gov (https://www.healthit.gov/topic/behavioral-health) including but not limited to "Behavioral Health and Physical Health Integration" and "Section 34: Opioid Epidemic and Health IT" (https://www.healthit.gov/playbook/health-information-exchange/).

viii. States may also use the CMS 1115 Health IT resources available on "Medicaid Program Alignment with State Systems to Advance HIT, HIE and Interoperability" at https://www.medicaid.gov/medicaid/data-and-systems/hie/index.html. States should review the "1115 Health IT Toolkit" for health IT considerations in conducting an assessment and developing their Health IT Plans.

ix. States may request from CMS technical assistance to conduct an assessment and develop plans to ensure they have the specific health IT infrastructure with regards to PDMP plans, electronic care plan sharing, care coordination, and behavioral health-physical health integration, to meet the goals of the demonstration.

6.3. **Unallowable Expenditures Under the SUD Expenditure Authority**. In addition to the other unallowable costs and caveats already outlined in these STCs, the state may not receive FFP under any expenditure authority approved under the SUD expenditure authority for any of the following:

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[3] Shah, Anuj, Corey Hayes and Bradley Martin. *Characteristics of Initial Prescription Episodes and Likelihood of Long-Term Opioid Use — United States, 2006–2015*. MMWR Morb Mortal Wkly Rep 2017;66.

a. Room and board costs for residential treatment service providers unless they qualify as inpatient facilities under Section 1905(a) of the Act.

7. COST SHARING

7.1. **Cost Sharing.** Cost sharing imposed upon individuals enrolled in the demonstration is consistent with the provisions of the approved state plan. There is no cost sharing for Medicaid. Children enrolled in CHIP with family income between 150-350% FPL are required to pay co-payments. All cost sharing for state plan populations must be in compliance with Medicaid and CHIP requirements that are set forth in statute, regulation and polices. In addition, aggregate cost sharing imposed on any individual adult demonstration participant on an annual basis must be limited to five percent of the individual's aggregate family income.

8. TITLE XXI PREMIUM SUPPORT PROGRAM (PSP)

8.1. **Program Overview.** The PSP is designed to cover individuals eligible for NJFC who have access to cost effective employer-sponsored health plans. Some uninsured families have access to health insurance coverage through an employer, but have not purchased the coverage because they cannot afford the premiums. Assistance is provided in the form of a direct reimbursement to the employee for the dependent's premium deduction, required for participation in the employer-sponsored health insurance plan. Employed parents are reimbursed on a regular schedule, to coincide with their employer's payroll deduction, so as to minimize any adverse financial impact on the employee. Unless otherwise specified in these STCs, all processes for eligibility, enrollment, redeterminations, terminations, appeals, etc. must comply with federal law and regulations governing Medicaid and CHIP.

a. **Eligibility Requirements**: Parents and/or their children must be determined eligible for NJFC Plan B, C, or D 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 PSP will reimburse the premiums for the eligible family members only if it is cost-effective in the aggregate.

b. **Benefit Package**: NJ's FamilyCare Plan D mirrors the benchmark health plan offered through an HMO with the largest commercial, non-Medicaid enrollment in the state. If the employer's health plan is not equal to Plan D, then the state provides wraparound services for children and adults through Medicaid fee-for-service (Dental and Vision). "Wraparound service" means any service that is not covered by the enrollee's employer plan that is an eligible service covered by NJFC for the enrollee's category of eligibility.

8.2. **Process for Benefit Analysis**: If a previously uninsured parent has access to employer-sponsored insurance, the PSP Unit evaluates the application and assesses the employer's plan and a description of the benefits covered by the employer's plan. The PSP reviews the employer's response and compares the services to NJFC services, taking into account any limitations on coverage.

8.3. **Cost Sharing**: Premiums and co-payments vary under employer-sponsored plans regardless of FPL, but cost sharing is capped at 5 percent of the individual or family's gross income. This protection applies equally to parents enrolled in NJFC Plan B, C, or D and to parents enrolled in an employer-sponsored plan through the PSP.

a. The PSP will reimburse the beneficiary for the difference between the NJFC/PSP co-payment amount and that of the employer-sponsored plan co-payment amount. For example, if the NJFC/PSP co-payment amount for a physician's office visit is $5.00 and the employer-sponsored plan co-pay charge is $15.00 for the same service, the PSP will reimburse the beneficiary the difference in excess of the NJFC/PSP co-payment amount ($10.00).

b. If the PSP participant makes an out-of-pocket payment after the 5 percent limit is reached, any additional charges submitted to the PSP for the remainder of the calendar year are reimbursed at 100 percent as long as the parent submits proof of additional expenses.

8.4. **Employer Contribution**: Each plan must provide an employer contribution amount as required under 2105(c)(3). The amount will not be specified by the state and can vary by plan. The contribution amount may range from 20 percent to 100 percent.

8.5. **Cost-Effectiveness Test**

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

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

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

d. If the employer-sponsored plans are determined by the Division to be cost-effective in the aggregate in accordance with (i) above, the applicant is advised of this and participation in the PSP is further assessed for NJFC eligibles. If the employer-sponsored plan is determined not cost-effective, in accordance with (i) above, the beneficiary will continue to participate solely in the NJFC program.

9. DELIVERY SYSTEM

9.1. **Overview.** This demonstration allows the state to mandate mandatory enrollment into managed care to receive certain benefits. Some services, including certain Family Planning services, behavioral health services and HCBS services may be provided FFS. This section describes how the state operates the various delivery systems and specific requirements for the implementation programs authorized under this demonstration. Benefits are delivered through the following delivery systems:

a. Fee-for-Service;

b. Primary Managed Care Organization;

c. Managed Long Term Services and Supports; and

d. Administrative Services Organization

9.2. **HCBS Fee-for-Service Programs.** HCBS services are provided FFS for the following demonstration programs as described in Attachment C. Enrollees are allowed to be enrolled in one of the HCBS FFS program at a time, unless otherwise specified in these STCs:

a. Supports Program

b. Children Supports Services Program SED

c. Children Supports Services Program I/DD

d. Community Care Program

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

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

9.5. **Managed Care Delivery Systems.**

a. **Compliance with Managed Care Requirements.** The state, its MCOs and any subcontractor delegated to perform activities under the managed care contract, must comply with all federal requirements, including but not limited to, the managed care regulations published in 42 CFR part 438, except as expressly waived or specified as not applicable to an expenditure authority. Capitation rates must be developed and certified as actuarially sound, in accordance with federal requirements, including 42

CFR 438.4, 438.5 and 438.7. The following populations are excepted from mandatory enrollment in managed care:

American Indians and Alaskan Natives
Individuals with access to cost effective Student Health Insurance

b. **Advisory Committee as required in 42 CFR 438.110.** The state must maintain for the duration of the demonstration a managed care advisory group comprised of individuals and interested parties impacted by the demonstration's use of managed care, regarding the impact and effective implementation of these changes to seniors and persons with disabilities. Membership on this group must be periodically updated to ensure adequate representation of individuals receiving MLTSS.

9.6. **Additional Delivery System Requirements for HCBS and MLTSS Program.** In addition to the requirements described in STC 9.2, the following additional delivery system requirements apply to all the HCBS programs and MLTSS programs in this demonstration.

a. **Administrative Authority.** There are multiple state agencies involved in the administration of the HCBS; therefore, the SSMA must maintain authority over the programs. The SMA must exercise appropriate monitoring and oversight over the state agencies involved, the MCO's, and other contracted entities.

b. **Electronic Visit Verification System**. The state will demonstrate compliance with the Electronic Visit Verification System (EVV) requirements for personal care services (PCS) by January 1, 2021 and home health services by January 1, 2023 in accordance with Section 12006 of the 21st Century CURES Act.

c. **Home and Community-Based Characteristics.** Residential settings located in the community will provide members with the following:

i. Private or semi-private bedrooms including decisions associated with sharing a bedroom.

ii. All participants must be given an option to receive HCBS services in more than one residential setting appropriate to their needs.

iii. Private or semi-private bathrooms that include provisions for privacy.

iv. Common living areas and shared common space for interaction between participants, their guests, and other residents.

v. Enrollees must have access to a food storage or food pantry area at all times.

vi. Enrollees must be provided with an opportunity to make decisions about their day to day activities including visitors, when and what to eat, in their home and in the community.

vii. Enrollees will be treated with respect, choose to wear their own clothing, have private space for their personal items, have privacy to visit with friends, family,

be able to use a telephone with privacy, choose how and when to spend their free time, and have opportunities to participate in community activities of their choosing.

viii. For participants involved with the Children's System of Care:

1. Enrollees participate in identifying individuals that will be involved in the development of the plan of care
2. Requires enrollees have the right to identify goals and the choice of providers and resources
3. Requires that the enrollee is engaged as full-time partner in the child family team and participates in assessment, planning, and delivery of services
4. The day to day activities are more structured and the milieu is designed to foster skill building as these are not assessed to be long term settings.
5. There is a distinction between CSOC out of home settings and those for adults. Not all of the HCBS characteristics associated with adults in out of home settings are applicable and or appropriate/safe for youth. CSOC out of home is intended to be a time limited intervention that focuses on stabilization and skill building to provide the youth and family with the necessary support to successfully transition back into the home and community.

d. **Critical Incident Management System**. The state must have policies and procedures in place through which providers must identify, report and investigate critical incidents that occur within the delivery of services. Provider contracts must reflect the requirements of this system. The state also has a system as well as policies and procedures in place through which to detect, report, investigate, and remediate abuse, neglect, and exploitation. Providers and participants must be educated about this system. Provider obligations must include specific action steps that providers must take in the event of known or suspected abuse, neglect or exploitation.

e. The state must have a system as well as policies and procedures in place through which providers must identify, report and investigate critical incidents that occur within the delivery of HCBS/MLTSS. Provider contracts must reflect the requirements of this system. The state must also have a system as well as policies and procedures in place through which to detect, report, investigate, and remediate abuse, neglect, and exploitation described in herein. Providers and participants must be educated about this system. Provider obligations must include specific action steps that providers will take in the event of known or suspected abuse, neglect or exploitation. All known and substantiated incidents must be tracked and reported to CMS on a quarterly and annual basis.

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

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

h. **Plan of Care (PoC)**. A "Plan of Care" is a written plan designed to provide the demonstration enrollee with appropriate services and supports in accordance with his or her individual needs. For individuals receiving HCBS FFS under the demonstration, the state must ensure the individual will lead the person-centered planning process where possible, the service plan will encompass needed services and supports identified by the functional assessment with respects to the individuals preferences for service and support delivery, and the person-centered service plan will be reviewed and revised with reassessment of functional need at least annually, upon changes to the individual's circumstances or needs, or at the request the individual, as outlined in 42 CFR 441.301(c)(1)-(3).

    i. Individuals receiving MLTSS under the demonstration must have a PoC and will be provided services in accordance with their plan. The state must establish minimum guidelines regarding the PoC that will be reflected in contracts and/or provider agreements. These must include at a minimum: 1) a description of qualification for individuals who will develop the PoC; 2) PoC will be updated at least annually to document and address any changes in participants' life circumstances and needs; 3) types of assessments; 4) how enrollees are informed of the services available to them; and 5) the MCOs' responsibilities for implementing and monitoring the PoC.

    ii. Each member's PoC must include team-based Person-Centered Planning, which is a highly individualized and ongoing process to develop care plans that focus on the person's abilities and preferences. Person-Centered Planning includes consideration of the current and unique bio-psycho-social and medical needs and history of the enrollee, as well as the person's functional level, and support systems.

    iii. The state or the MCO, for those enrolled in MLTSS will emphasize services provided in home and community-based settings, maximizing health and safety, whenever possible.

    iv. Meetings related to the enrollee's PoC will be held at a location, date, and time convenient to the enrollee and his/her invited participants.

    v. A back-up plan must be developed and incorporated into the plan to assure that the needed assistance will be provided in the event that the regular services and supports identified in the PoC are temporarily unavailable. The back-up plan may include other assistance or agency services.

    vi. The state (not the MCOs) will be responsible for the PoC developed for each enrollee transitioning from an institutional setting to a community-based setting through the state's Money Follows the Person demonstration. The state will track transitioning enrollees to ensure services are received in a timely manner throughout the transitioning process.

vii. The state or the MCO for those enrolled in MLTSS must ensure that services are delivered in accordance with the PoC including the type, scope, amount and frequency.

viii. The state or the MCO, for those enrolled in MLTSS must ensure that enrollees have the choice of participating providers within the plan network as well as access to non-participating providers when the appropriate provider type is not on the MCO's network.

ix. Individuals served in I/DD programs must have the choice of institutional placements and community settings.

x. Each enrollee's PoC must be reviewed and updated annually at a minimum, or more frequently with individual circumstances as warranted.

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

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

k. **Information and Assistance in Support of Participant Direction**. The state/MCO must have a support system that provides participants with information, training, counseling, and assistance, as needed or desired by each participant, to assist the participant to effectively direct and manage their self-directed services and budgets. Participants must be informed about self-directed care, including feasible alternatives, before electing the self-direction option. Participants must also have access to the support system throughout the time that they are self-directing their care. Support activities must include, but is not limited to Support for Participant Direction service which includes two components: Financial Management Services and Support Brokerage. Providers of Support for Participant Direction must carry out activities associated with both components. The Support for Participant Direction service provides assistance to participants who elect to self-direct their personal care services.

    i. **Participant Direction by Representative**. The participant who self-directs the personal care service may appoint a volunteer designated representative to assist with or perform employer responsibilities to the extent approved by the participant. CCP and Supports Program services may be directed by a legal representative of the participant when such services are deemed extraordinary care and in the best interest of the participant. Services may be directed by a non-legal representative freely chosen by an adult participant. Additional guardrails must be submitted to CMS for review and approval before the legal

representative may direct CCP and Supports Program services, to be codified in a post-approval Attachment S to this demonstration.

ii. **Independent Advocacy**. Each enrollee must have access to an independent advocate or advocacy system in the state. This function is performed by individuals or entities that do not provide direct services, perform assessments, or have monitoring, oversight or fiscal responsibilities for the demonstration. The plans will provide participants with information regarding independent advocacy such as the Ombudsman for Institutionalized Elderly and state staff who approved LOC determination and did options counseling.

iii. **Participant Employer Authority**. The participant (or the participant's representative) must have decision-making authority over workers who provide personal care services.

1. **Participant/Common Law Employer**. The participant (or the participant's representative) is the common law employer of workers who provide personal care services. An IRS-Approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

2. **Decision Making Authorities**. The participant exercises the following decision making authorities: Recruit staff, select staff, hire staff as common law employer, verify staff qualifications, specify additional staff qualifications based on participant needs and preferences, evaluate staff performance, verify time worked by staff and approve time sheets, and discharge staff.

l. **Disenrollment from Participant-Direction**. A participant may voluntarily disenroll from the self-directed option at any time and return to a traditional service delivery system. To the extent possible, the member must provide his/her provider ten (10) days advance notice regarding his/her intent to withdraw from participant direction. A participant may also be involuntarily disenrolled from the self-directed option for cause, if continued participation in the participant-directed services option would not permit the participant's health, safety, or welfare needs to be met, or the participant demonstrates the inability to self-direct by consistently demonstrating a lack of ability to carry out the tasks needed to self-direct personal care services, or if there is fraudulent use of funds such as substantial evidence that a participant has falsified documents related to participant directed services. If a participant is terminated voluntarily or involuntarily from the self-directed service delivery option, the MCO must transition the participant to the traditional agency direction option and must have safeguards in place to ensure continuity of services.

m. **Appeals**. The following actions must be considered an adverse action under both 42 CFR 431 Subpart E (state fair hearing) and 42 CFR 438 Subpart F (MCO grievance process):

i. A reduction in services;

ii. A denial of a requested adjustment to the budget; or

iii. A reduction in amount of the budget.

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

o. **Service Plan Reductions.** The state must review a sample of LTSS plans of care that includes a reduction, suspension, or termination in personal care and/or private duty nursing services for the first year to ensure that reductions, suspensions, and terminations were done appropriately. This review must include a determination of whether consistent with 42 CFR 438.420, enrollees were provided all appeal rights afforded through the CMS and state fair hearing process with the ability to continue services during the appeal.

p. **Nursing Facility Diversion.** Each MCO, with assistance from the state, will develop and implement a "NF Diversion Plan" to include processes for enrollees receiving HCBS and enrollees at risk for NF placement, including short-term stays. The diversion plan will comply with requirements established by the state and be prior approved by the state, and CMS. The Plan will include a requirement for the MCOs to monitor hospitalizations and short-stay NF admission for at-risk enrollees, and identify issues and strategies to improve diversion outcomes.

q. **Nursing Facility Transition to Community Plan.** Each MCO, with assistance from the state, will develop and implement a "NF to Community Transition Plan" for each enrollee placed in a NF when the enrollee can be safety transitioned to the community, and has requested transition to the community. The Plan will include a requirement for the MCOs to work with state entities overseeing services to older adults and other special populations utilizing NF services. Each MCO will have a process to identify NF residents with the ability and desire to transition to a community setting. MCOs will also be required to monitor hospitalizations, re-hospitalizations, and NF admissions to identify issues and implement strategies to improve enrollee outcomes.

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

i. The state will ensure that these linkages are in place before, during, and after the transition to MLTSS.

ii. The state/MCO's will develop and implement a process for community-based providers to conduct efficient, effective, and economical background checks on all prospective employees/providers with direct physical access to enrollees.

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

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

ii. Enrollees receiving MLTSS will typically have costs limited/aligned to the annual expenditure associated with their LOC assessment (e.g. Hospital, Nursing Facility).

iii. Exceptions are permitted to the above provisions in situations where a) an enrollee is transitioning from institutional care to community-based placement; b) the enrollee experiences a change in health condition expected to last no more than six months that involve additional significant costs; c) special circumstances where the state determines an exception must be made to accommodate an enrollee's unique needs. The state will establish a review procedure to describe the criteria for exceptional service determinations between the state and the MCOs which must be approved by CMS.

iv. MCOs may require community-based placements, provided the enrollee's PoC provides for adequate and appropriate protections to assure the enrollee's health and safety.

v. If the estimated cost of providing the necessary community-based MLTSS to the enrollee exceeds the estimated cost of providing care in an institutional setting, the MCO may refuse to offer the community-based MLTSS. In this circumstance, individuals will be provided with a notice of decision with appeal rights. However, as described in (c) above, exceptions may be made in individual special circumstances where the state determines the enrollee's community costs must be permitted to exceed the institutional costs.

vi. If an enrollee whose community-based costs exceed the costs of institutional care refuses to live in an institutional setting and chooses to remain in a community-based setting, the enrollee and the MCO will complete a special risk assessment detailing the risks of the enrollee in remaining in a community-based setting, and outlining the safeguards that have been put in place. The risk assessment will include a detailed back-up plan to assure the health and safety of the enrollee under the cost cap that has been imposed by the state.

vii. Nothing in these STCs relieves the state of its responsibility to comply with the Supreme Court *Olmstead* decision, and the Americans with Disabilities Act.

t. **Care Coordination for MLTSS.** Care Coordination is services to assist enrollees in gaining access to needed demonstration and other services, regardless of the funding source. Care Coordinators are responsible for ongoing monitoring of the provision of services included in the PoC and assuring enrollee health and safety. Care Coordinators initiate the process to evaluate or re-evaluate the enrollee's PoC, his or her level of care determination (where appropriate), and other service needs.

i. Integrated care coordination for physical health and MLTSS will be provided by the MCOs in a manner that is "conflict-free."

ii. The state will establish a process for conflict free care coordination, to be approved by CMS that will include safeguards, such as separation of services and other structural requirements, state/enrollee oversight, and administrative review.

iii. Each MCO must also assign a Behavioral Health Administrator to develop processes to coordinate behavioral health care with physical health care and MLTSS, in collaboration with the care coordinators.

iv. The state will assure that there are standard, established timelines for initial contact, assessment, development of the PoC, the individual service agreement, and authorization and implementation of services between the state and the MCOs.

v. Care coordinators must monitor the adequacy and appropriateness of services provided through self-direction, and the adequacy of payment rates for self-directed services.

9.7. **Administrative Services Organizations (ASOs).** Coverage of behavioral health services will vary depending on population and level of care, with some services being provided via managed care and others on a FFS basis. The state will maintain a contract with one or more ASOs on a non-risk basis to support the provision of behavioral health services that are not part of the managed care delivery system. During the demonstration extension period, the state will review and phase in coverage of additional behavioral health services via managed care. The inclusion of additional behavioral health services within managed care will be undertaken after consultation with stakeholders, and will be governed by the provisions of the state's MCO contract, changes to which are subject to approval by CMS.

a. **Behavioral Health for Children**. Upon the effective date of this demonstration, children's behavioral health services not included in the benefit package provided by the primary MCO may have their care coordinated by a behavioral health ASO.

i. The ASO must perform the following functions on behalf of the state:

1. 24/7 Call Center
2. Member services
3. Medical Management
4. Provide and manage MIS/EMR for Children's System of Care
5. Dispatch Mobile Response/Crisis Response
6. Clinical Phone Triage (performed by licensed clinicians)
7. Facilitate Needs Assessments
8. Clinical Reviews of Needs Assessments
9. Care Coordination
10. Intensity of Service Determinations

11. Treatment Plan Reviews
12. Prior Authorizations
13. Quality Monitoring in Coordination with DCF
14. Utilization Management
15. Data Sharing and Reporting
16. Grievance and Intensity of Service Dispute Resolution
17. Behavioral Health and Primary Health Coordination

ii. Excluded Children's ASO functions.

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

b. **Behavioral Health for Adults**. Behavioral health services not included in the benefit package provided by the primary managed care organization may be coordinated by a behavioral health ASO.

c. **Functions of the Adult ASO**. The ASO must perform the following functions:

i. 24/7 Call Center
ii. Member services
iii. Screening and assessment
iv. Prior authorization
v. Network management
vi. Utilization management, including level of care determination and continuing care review
vii. Care management
viii. Medical management
ix. Care coordination
x. Quality management
xi. Information technology
xii. Data submission and reporting requirements
xiii. Financial management, including claims processing and payment
xiv. Development of care models and service arrays for consumers with intellectual and developmental disabilities; non-SNP dual eligibles (Medicare and Medicaid), and Medicaid expansion populations
xv. Coordination with the MCOs regarding high-utilizing consumers and consumers screened with behavioral health/medical conditions.

d. **Duplication of Payment**. To avoid duplication of payment for services for demonstration participants who require behavioral health any services not covered by managed care (as defined by the CMS approved MCO contract) will be covered fee-for-service.

9.8. **Quality Improvement Strategy (QIS)**. The state is expected to implement systems that measure and improve its performance to meet the waiver assurances set forth in 42 CFR 441.301 and 441.302. The Quality Review provides a comprehensive assessment of the state's capacity to ensure adequate program oversight, detect and remediate compliance issues and assess the effectiveness of implemented quality improvement activities. For MLTSS services that could have been authorized to individuals under a 1915(c) waiver, the state's Quality Assessment and Performance Improvement Plan must encompass LTSS specific measures set forth in the federal managed care rule at 42 CFR 438.330 and should also reflect how the state will assess and improve performance to demonstrate compliance with applicable federal waiver assurances set forth in 42 CFR 441.301 and 441.302.

a. The state must have an approved QIS and is required to develop and measure performance indicators for the following waiver assurances:

i. **Administrative Authority**: A performance measure should be developed and track any authority that the SMA delegates to another agency, unless already captured in another performance measure.

ii. **Level of Care**: Performance measures are required for the following two sub-assurances: applicants with reasonable likelihood of needing services receive a level of care determination and the processes for determining level of care are followed as documented. While a performance measure for annual levels of care is not required to be reported, the state is expected to be sure that annual levels of care are determined.

iii. **Qualified Providers**: The state must have performance measures to track that providers meet licensure/certification standards, that non-certified providers are monitored to assure adherence to waiver requirements, and that the state verifies that training is given to providers in accordance with the waiver.

iv. **Service Plan**: The state must demonstrate it has designed and implemented an effective system for reviewing the adequacy of service plans for HCBS participants. Performance measures are required for choice of waiver services and providers, service plans address all assessed needs and personal goals, and services are delivered in accordance with the service plan including the type, scope, amount, duration, and frequency specified in the service plan.

v. **Health and Welfare**: The state must demonstrate it has designed and implemented an effective system for assuring HCBS participants health and welfare. The state must have performance measures tracking that on an ongoing basis it identifies, addresses and seeks to prevent instances of abuse, neglect, exploitation and unexplained death; that an incident management system is in place that effectively resolves incidents and prevents further singular incidents to the extent possible; that state policies and procedures for the use or prohibition of restrictive interventions are followed; and, that the state establishes overall health care standards and monitors those standards based on the responsibility of the service provider as stated in the approved demonstration.

vi. **Financial Accountability**: The state must demonstrate that it has designed and implemented an adequate system for insuring financial accountability of the HCBS program. The state must have performance measures to track that it provides evidence that claims are coded and paid for in accordance with the reimbursement methodology specified in the approved demonstration and only for services rendered, and that it provides evidence that rates remain consistent with the approved rate methodology throughout the demonstration cycle.

For 1915(i)-like HCBS, the state must have an approved QIS and is required to develop performance measures to address the following requirements:

vii. **Service plans**:

1. address assessed needs of 1915(i) participants;
2. are updated annually; and
3. document choice of services and providers.

viii. **Eligibility Requirements**: a) an evaluation for 1915(i) state plan HCBS eligibility is provided to all applicants for whom there is reasonable indication that 1915(i) services may be needed in the future; b) the processes and instruments described in the approved program for determining 1915(i) eligibility are applied appropriately; and c) the 1915(i) benefit eligibility of enrolled individuals is reevaluated at least annually or if more frequent, as specified in the approved program.

ix. Providers meet required qualifications.

x. Settings meet the home and community-based setting requirements as specified in the benefit and in accordance with 42 CFR 441.710(a)(1) and (2).

xi. The SMA retains authority and responsibility for program operations and oversight.

xii. The SMA maintains financial accountability through payment of claims for services that are authorized and furnished to 1915(i) participants by qualified providers.

xiii. The state identifies, addresses, and seeks to prevent incidents of abuse, neglect, and exploitation.

xiv. The state must also describe the process for systems improvement as a result of aggregated discovery and remediation activities.

The state must report annually in conjunction with the Annual Monitoring Report described in STC 12.8 the actual number of unduplicated individuals served and the estimated number of individuals for the following year.

To demonstrate the assurances of STC 9.8 (a)(i)-(viii) above, the state must submit performance measures to CMS for review and approval within 90 days following approval of the demonstration extension.

The state will submit a report(s) to CMS following receipt of an Evidence Request letter and report template from the Division of HCBS Operations and Oversight (DHCBSO) no later than 21 months prior to the end of the approved demonstration period which includes evidence on the status of the HCBS quality assurances and measures for the 1915c and 1915i-like populations that adheres to the requirements outlined in the March 12, 2014, CMS Informational Bulletin, Modifications to Quality Measures and Reporting in §1915(c) Home and Community-Based Waivers. Following receipt of the state's evidence report(s), the DHCBSO will issue a DRAFT report(s) to the state and the state will have 90 days to respond. The DHCBSO will review and assess each evidentiary report(s) to determine whether the assurances and requirements have been met and will issue a final report to the state 60 days following receipt of the state's responses to the DRAFT report(s).

The state must submit in conjunction with the Annual Monitoring Report (see STC 12.8) the deficiencies found during the review, assessment, and reporting of the HCBS demonstration assurances and measures for the 1915(c) and 1915(i)-like populations, an explanation of how these deficiencies have been or are being corrected, as well as the steps that have been taken to ensure that these deficiencies do not reoccur. The state must also report on the number of substantiated instances of abuse, neglect, exploitation and/or death, the actions taken regarding the incidents and how they were resolved.

In the event that CMS issues new guidance regarding 1915(c)/(i) reporting, the state must come into compliance and align measures and reporting requirements within the prescribed timeframe(s). These STCs will be updated to reflect any new regulatory and/or subregulatory requirements and citations.

b. **Health and Welfare of Enrollees.** The state, or the MCO for MLTSS enrolled individuals, through an MCO contract, must be required on a continuous basis to identify, address, and seek to prevent instances of abuse, neglect and exploitation through the Critical Incident Management System referenced in subparagraph E of this STC.

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

    i. The state will ensure that these linkages are in place before, during, and after the transition to MLTSS as applicable.

    ii. The state/MCOs will develop and implement a process for community-based providers to conduct efficient, effective, and economical background checks on all prospective employees/providers with direct physical access to enrollees.

9.9. **State Oversight of Medical Loss Ratio (MLR).**

a. For risk-based plans, the state must submit the plan-generated reports detailed in 42 CFR 438.8(k) as well as any other documentation used to determine compliance with 42 CFR. 438.8(k) to CMS at DMCPMLR@cms.hhs.gov.

i. For managed care plans that delegate risk to subcontractors, the state's review of compliance with 42 CFR 438.8(k) must consider MLR requirements related to such subcontractors; see https://www.medicaid.gov/federal-policy-guidance/downloads/cib051919.pdf. The state must submit its plan to operationalize STC 9.9(a) through (d) to CMS for review and approval at DMCPMLR@cms.hhs.gov no later than August 1, 2023. The plan must outline key deliverables and timelines to meet the requirements of STC 9.910.15.a through d.

b. Effective July 1, 2024, the state must require risk-based plans contracted with the state to impose reporting requirements equivalent to the information required in 42 CFR 438.8(k) on their subcontractor plans or entities.

c. No later than July 1, 2025, the state must require risk-based plans contracted with the state to impose remittance requirements equivalent to 42 CFR 438.8(j) on their subcontractor plans or entities.

d. STC 9.9.a, 9.9.b, and 9.9.c must apply for all of the following entities:

i. Risk-based plans for which the state receives federal financial participation for associated expenditures;

ii. Full and partially delegated plans;

iii. Other subcontractors, as applicable, that assume delegated risk from either the primary managed care plan contracted with the state, or plans referenced in STC 9.9.d.ii; and

iv. Other subcontractors, as applicable, that assume delegated risk from entities referenced in STC 9.9.d.iii.

e. The state must work with CMS to effectuate an audit of the MLR data covering all years of this 1115 demonstration extension package. The audit must occur no sooner than June 30, 2027, and ideally later in calendar year 2027 to allow the state time to review and finalize the state fiscal year 2027 MLRs.

f. As HRSN (i.e., HRSN services defined in STC 10.2 for the covered populations outlined in STC 10.5) is included in risk-based capitation rates, HRSN services should be reported in the MLR reporting as incurred claims. Managed care plans should not report HRSN services in the MLR until after the transition to include HRSN services in risk-based capitation rates.

g. The state must develop an MLR monitoring and oversight process specific to HRSN services. If the HRSN services are incorporated in the capitation rates using a phased approach, the process must explain the approach. This process must be submitted to CMS, for review and approval, no later than 60 days prior to the implementation of HRSN services in risk-based capitation rate. The state may submit this process to CMS at DMCPMLR@cms.hhs.gov. This process must specify how HRSN services will be identified for inclusion in capitation rate setting and in the MLR numerator.

The state's plan must indicate how expenditures for HRSN administrative costs and infrastructure will be identified and reported in the MLR as non-claims costs.

10. HEALTH-RELATED SOCIAL NEEDS SERVICES

10.1. **Health-Related Social Needs (HRSN) Services.** The state may claim FFP for expenditures for certain qualifying HRSN services identified in Attachment F and this STC, subject to the restrictions described below, including Section 11. Expenditures are limited to expenditures for items and services not otherwise covered under Title XIX, but consistent with Medicaid demonstration objectives that enable the state to continue to increase the efficiency and quality of care. HRSN services must be clinically appropriate for the beneficiary and based on medical appropriateness using clinical and other health related-social needs criteria. The state is required to align clinical and health-related social criteria across services and with other non-Medicaid social support agencies, to the extent possible. The HRSN services may not supplant any other available funding sources such as housing or nutrition supports available to the beneficiary through local, state, or federal programs. The HRSN services will be the choice of the beneficiary; a beneficiary can opt out of HRSN services anytime; and the HRSN services do not absolve the state or its managed care plans of their responsibilities to provide required coverage for other medically necessary services. Under no circumstances will the state be permitted to condition Medicaid coverage, or coverage of any benefit or service, on receipt of HRSN services. The state must submit additional details on covered services as outlined in STC 10.7 (Service Delivery) and Attachment F.

10.2. **Allowable HRSN services.** The state may cover the following HRSN services:

a. Housing supports, including:

i. Medically necessary air conditioners, humidifiers, air filtration devices and asthma remediation, and refrigeration units as needed for medical treatment.

ii. Medically necessary home modifications and remediation services such as accessibility ramps, handrails, grab bars, repairing or improving ventilation systems, and mold/pest remediation.

iii. Pre-tenancy services.

1. Assistance with navigating the complexities of the housing application process through the progression of prospective tenant to tenant, including but not limited to, such as supporting the beneficiary when undergoing tenant screening, completing rental applications, negotiating lease agreements, and preparing for and attending tenant interviews.

2. Assistance with the housing search and application process, including contacting prospective housing options for availability and information, as well as researching the availability of rental assistance.

iv. Tenancy sustaining services, including tenant rights education and eviction prevention.

1. Assistance in linking beneficiaries to free or affordable legal services for beneficiaries facing housing-related issues.
2. Connecting the individual to available resources to assist in establishing a bank account and bill paying.
3. Assistance in connecting the individual with social services to assist with filling out applications and appropriate documentation in order to obtain sources of income necessary for community living, establishing credit, and in understanding and meeting the obligations of tenancy.
4. Assistance in addressing circumstances and/or behaviors that may jeopardize housing. This should include both direct interventions to address risks and connection of the beneficiary to relevant community resources that may offer assistance.
5. Assistance in resolving disputes with landlords and/or neighbors to reduce risk of eviction or other adverse action.
6. Assistance with housing recertification processes, including lease renewals and housing subsidy renewals.

v. Housing transition navigation services, including

1. Assistance with the set-up of the new housing unit, to address needs identified in the person-centered care plan, including clinically appropriate residential modifications to allow the beneficiary to move in and identified needs for assistance with arranging the move and supporting the details of the move, as appropriate.
2. Connecting the individual to resources aiding with housing costs and other expenses, including linkages to rental assistance vouchers, security deposits, application fees, moving costs, non-medical transportation to tour units and attend tenant interviews, furnishings, adaptive aids, environmental modifications, and food and clothing needed at transition, and other related expenses.
3. Provide a review of the living environment to ensure that it meets the clinical needs of the individual and appropriately support his/her medical needs is ready for move-in, including collaboration with relevant provider staff of where the individual is institutionalized (e.g. hospital or facility social worker) to ensure a seamless transition to the community.

b. Case management, outreach, and education including linkages to other state and federal benefit programs, benefit program application assistance, and benefit program application fees.

c. Nutrition Supports:

i. Nutrition counseling and education for MLTSS members, including on healthy meal preparation and connecting the individual with grocery budget resources.

ii. Medically-indicated home delivered meals to expectant individuals at risk of or diagnosed with diabetes.

iii. One-time transition costs including pantry stocking for any MLTSS eligible beneficiary who is transitioning from an institution to provide access to nutrition during the initial phase of transition into the community.

iv. Short-term (no more than 30 days) grocery provision, for an MLTSS beneficiary experiencing a significant disruption in the ability to obtain an adequate level of nutrition that would avoid an unnecessary emergency department visit, hospital admission, or institutional placement.

1. Eligibility. The MLTSS beneficiary eligible for this benefit has been identified by the MCO as being at-risk due to an acute behavioral or physical health episode or due to clinical factors is unable to procure groceries on an emergency basis.
2. Benefit Guidelines.
    a. The grocery benefit may only be used on purchases consistent with SNAP guidelines.
    b. The grocery benefit will be capped at 200% of the Maximum Monthly USDA SNAP Allowance.
    c. The benefit can be utilized no more than once per calendar year.
3. Transition. The state agrees it will work with the state SNAP agency and others to provide assistance to beneficiaries in enrolling with SNAP during the benefit period, where appropriate, and work with the beneficiary where appropriate to address lasting health or physical needs that lead to the disruption in nutrition.

10.3. HRSN Infrastructure.

a. The state may claim FFP in infrastructure investments in order to support the development and implementation of HRSN services, subject to STC 10.1. This FFP will be available for the following activities:

i. Technology – e.g., electronic referral systems, shared data platforms, EHR modifications or integrations, screening tool and/or case management systems, databases/data warehouses, data analytics and reporting, data protections and privacy, accounting and billing systems.

ii. Development of business or operational practices – e.g., procurement and planning, developing policies and workflows for referral management, privacy, quality improvement, trauma-informed practices, evaluation, member navigation.

iii. Workforce development – e.g., cultural competency training, trauma-informed training, traditional health worker certification, training staff on new policies and procedures.

iv. Outreach, education, and stakeholder convening – e.g., design and production of outreach and education materials, translation, obtaining community input, investments in stakeholder convening.

b. The state may claim FFP in HRSN infrastructure expenditures for no more than the annual amounts outlined in Table C. In the event that the state does not claim the full amount of FFP for a given demonstration year, the unspent amounts will roll over to one or more demonstration years not to exceed this demonstration period and the state may claim the remaining amount in a subsequent demonstration year.

Table C. Annual Limits of Total Computable Expenditures for HRSN Infrastructure

	DY12	DY13	DY14	DY15	DY16	DY17
Total Computable Expenditures	$3.75M	$15M	$15M	$15M	$15M	$15M

c. Infrastructure investments will receive the applicable administrative match for the expenditure.

d. This infrastructure funding is separate and distinct from the payment to the applicable managed care plans for delivery of HRSN services. The state must ensure that HRSN infrastructure expenditures described in STC 10.3(a) are not factored into managed care capitation payments, and that there is no duplication of funds.

e. The state may not claim any FFP in HRSN infrastructure expenditures until the Protocol for HRSN Infrastructure and HRSN Services is approved, as described in STC 10.6. Once approved, the state can claim FFP in HRSN infrastructure expenditures retrospectively to the beginning of the demonstration approval date.

f. To the extent the state requests any additional infrastructure funding, or changes to its scope as described within this STC, it must submit an amendment to the demonstration for CMS's consideration.

10.4. **Excluded HRSN Services**. Excluded items, services, and activities that are not covered as HRSN services include, but are not limited to:

i. Construction costs (bricks and mortar) except as needed for approved medically necessary home modifications as described in STC 10.2.a.ii.

ii. Capital investments;

iii. Room and board outside of specifically enumerated care or housing transitions or beyond 6 months;

iv. Research grants and expenditures not related to monitoring and evaluation;

v. Costs for services in prisons, correctional facilities or services for people who are civilly committed and unable to leave an institutional setting;

vi. Services provided to individuals who are not lawfully present in the United States or are undocumented;

vii. Expenditures that supplant services and activities funded by other state and federal governmental entities;

viii. School based programs for children that supplant Medicaid state plan programs, or that are funded under the Department of Education or state, and the local education agency;

ix. General workforce activities, not specifically linked to Medicaid or Medicaid beneficiaries; and

x. Any other projects or activities not specifically approved by CMS as qualifying for demonstration coverage as a HRSN item or service under this demonstration.

10.5. **Covered Populations.** Expenditures for HRSN services may be made for the targeted populations specified below, consistent with this STC. To receive HRSN services, individuals in the target populations must have a documented medical need for the services and the services must be determined medically appropriate, as described in the HRSN Services Section in STC 10.2, for the documented need. Medical appropriateness must be based on clinical and health-related social risk factors. This determination must be documented in the beneficiary's care plan or medical record. Additional detail on targeted populations, including the clinical and other health related-social needs criteria, is outlined in Attachment F.

a. **Medically Indicated Meals Pilot Population.** Medical Meal Program will support up to 300 pregnant individuals per year by addressing dietary risk factors related to adverse perinatal outcomes, such as gestational diabetes.

b. **Nutrition Support Population.** The Nutrition Support Program will support MLTSS individuals by providing food resources including one-time pantry stocking, short-term provision of groceries, and nutrition/skill education to support the individual to continue to remain in the community setting.

c. **Tenancy/Housing Supports Population.** The Tenancy and Housing Supports Program will support Medicaid beneficiaries in accessing and transitioning to stable housing, such as those individuals transitioning from an institution to the community setting or who could potentially transition to the community, individuals being released from correctional facilities, individuals at risk of institutionalization who require a new housing arrangement to remain in the community, individuals who are

transitioning out of high-risk or unstable housing situations, and individuals who meet one of the criteria established by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5(1)(iii), or who are homeless or at risk of becoming homeless as defined by 24 CFR 91.5(2) or (3).

10.6. **Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications for HRSN Services**. The state must submit, for CMS approval, a Protocol for Assessment of Beneficiary Eligibility and Needs, Infrastructure Planning, and Provider Qualifications to CMS no later than 90 days after approval of these authorities. The protocol(s) must include, as appropriate, a list of the HRSN services and service descriptions, the criteria for defining a medically appropriate population for each service, the process by which that criteria will be applied including care plan requirements or other documented processes, proposed uses of HRSN infrastructure funds, and provider qualification criteria for each service. Each protocol may be submitted and approved separately. The state must resubmit an updated protocol, as required by CMS feedback on the initial submission. The protocol may be updated as details are changed or added. The state may not claim FFP in HRSN services or HRSN infrastructure expenditures until CMS approves the associated protocol, except as otherwise provided herein. Once the associated protocol is approved, the state can claim FFP in HRSN services and HRSN infrastructure expenditures retrospectively to the beginning of the demonstration approval date. The approved protocols will be appended to the STCs as Attachment F.

Specifically, the protocol must include the following information:

a. Proposed uses of HRSN infrastructure expenditures, including the type of entities to receive funding, the intended purpose of the funding, the projected expenditure amounts, and an implementation timeline.

b. A list of the covered HRSN services (not to exceed those allowed under STC 10.2), with associated service descriptions and service-specific provider qualification requirements.

c. A description of the process for identifying beneficiaries with health-related social needs, including outlining beneficiary eligibility, implementation settings, screening tool selection, and rescreening approach and frequency, as applicable.

d. A description of the process by which clinical criteria will be applied, including a description of the documented process wherein a provider, using their professional judgment, may deem the service to be medically appropriate.

    i. Plan to identify medical appropriateness based on clinical and social risk factors.

    ii. Plan to publicly maintain these clinical/social risk criteria to ensure transparency for beneficiaries and stakeholders.

e. A description of the process for developing care plans based on assessment of need.

i. Plan to initiate care plans and closed-loop referrals to social services and community providers based on the outcomes of screening.

ii. Description of how the state will ensure that HRSN screening and service delivery are provided to beneficiaries in ways that are culturally responsive and/or trauma-informed.

10.7. **Service Delivery**:

a. Terms applicable to all HRSN Services.

i. Any applicable HRSN 1115 services that are delivered by managed care plans must be included in the managed care contracts submitted to CMS for review and approval in accordance with 42 CFR 438.3(a).

ii. HRSN 1115 services may be paid on an FFS basis when provided by the state. HRSN 1115 services, when provided by a managed care plan, must be paid as outlined below. The state must also comply with Section 10 for all HRSN services.

b. In accordance with STC 10.13, CMS expects the state to have appropriate encounter data associated with each HRSN. This is necessary to ensure appropriate fiscal oversight for HRSN as well as monitoring and evaluation. This is also critical to ensure appropriate base data for Medicaid managed care rate development purposes as well as appropriate documentation for claims payment in both managed care and FFS. Therefore, CMS requires that for HRSN provided in a managed care delivery system, the state must include the name and definition of each HRSN as well as the coding to be used on claims and encounter data in the managed care plan contracts. For example, the state must note specific Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology costs that identify each HRSN. Additionally, for HRSN provided in an FFS delivery system, this information must be clearly documented for FFS providers. CMS will also consider this documentation necessary for approval of any rate methodologies per STC 10.14.

10.8. **Contracted Providers**. Consistent with the managed care contract and applicable to all HRSN services:

a. Managed care plans will contract with HRSN service providers ("Contracted Providers") to deliver the elected HRSN services authorized under the demonstration.

b. Managed care plans must establish a network of providers and ensure the Contracted Providers have sufficient experience and training in the provision of the HRSN services being offered. Contracted Providers do not need to be licensed, however, staff offering services through Contracted Providers must be licensed when appropriate and applicable.

c. The managed care plan and Contracted Provider must agree to a rate for the provision of applicable HRSN services, consistent with state guidance for these services, and in compliance with all related federal requirements.

    i. Any state direction on the payment arrangement would be considered a state directed payment subject to the requirements in 42 CFR 438.6(c).

10.9. **Provider Network Capacity.** Managed care plans must ensure the HRSN services authorized under the demonstration are provided to eligible beneficiaries in a timely manner, and shall develop policies and procedures outlining its approach to managing provider shortages or other barriers to timely provision of the HRSN services, in accordance with the managed care plan contracts and other state Medicaid/operating agency guidance.

10.10. **Compliance with Federal Requirements.** The state shall ensure HRSN services are delivered in accordance with all applicable federal statute, regulation or guidance.

10.11. **Person Centered Plan**. The state shall ensure there is a person-centered service plan for each individual receiving HRSN services that is person-centered, identifies the member's needs and individualized strategies and interventions for meeting those needs, and be developed in consultation with the member and the member's chosen support network as appropriate. The service plan is reviewed and revised at least every 12 months, when the individual's circumstances or needs change significantly, or at the request of the individual.

10.12. **Conflict of Interest**. The state shall ensure appropriate protections against conflicts of interest in the service planning. The state also agrees that appropriate separation of service planning and service provision functions are incorporated into the state conflict of interest policies.

10.13. **Medicaid Beneficiary Protections.** As part of the state's submission of associated Medicaid managed care plan contracts to implement HRSN services through managed care, the state must provide documentation including, but not limited to:

a. Beneficiary and plan protections, including but not limited to:

    i. HRSN services must not be used to reduce, discourage, or jeopardize Medicaid beneficiaries' access to Medicaid covered services.

    ii. Medicaid beneficiaries always retain their right to receive the Medicaid covered service on the same terms as would apply if HRSN services were not an option.

    iii. Medicaid beneficiaries who are offered or utilized an HRSN retain all right and protections afford under 42 CFR 438.

    iv. Managed care plans are not permitted to deny a beneficiary a medically appropriate Medicaid covered service on the basis that they are currently receiving HRSN services, have requested those services, or have previously received these services.

v. Managed care plans are prohibited from requiring a beneficiary to utilize HRSN services.

b. Managed care plans must timely submit data requested by the state or CMS, including, but not limited to:

i. Data to evaluate the utilization and effectiveness of the HRSN services.

ii. Any data necessary to monitor health outcomes and quality of care metrics at the individual and aggregate level through encounter data and supplemental reporting on health outcomes and equity of care. When possible, metrics must be stratified by age, sex (including sexual orientation and gender identify), race, ethnicity, disability status and preferred language to inform health quality improvement efforts, which may thereby mitigate health disparities.

iii. Any data necessary to monitor appeals and grievances for beneficiaries.

iv. Documentation to ensure appropriate clinical support for the medical appropriateness of HRSN services.

v. Any data determined necessary by the state or CMS to monitor and oversee the HRSN initiatives.

c. All data and related documentation necessary to monitor and evaluate the HRSN services initiatives, including cost assessment, to include but not limited to:

i. The managed care plans and the state must submit timely and accurate encounter data to the state for beneficiaries eligible for HRSN services. When possible, this encounter data must include data necessary for the state to stratify analyses by age, sex (including sexual orientation and gender identity), race, ethnicity, disability status and preferred language to inform health quality improvement efforts and subsequent efforts to mitigate health disparities undertaken by the state.

ii. Any additional information requested by CMS, the state or legally authorized oversight body to aid in on-going evaluation of the HRSN services or any independent assessment or analysis conducted by the state, CMS, or a legally authorized independent entity.

iii. The state must monitor and provide narrative updates through its Quarterly and Annual Monitoring Reports its progress in building and sustaining its partnership with existing housing agencies and nutrition agencies to utilize their expertise and existing housing resources and avoid duplication of efforts.

iv. Any additional information determined reasonable, appropriate and necessary by CMS.

10.14. **Rate Methodologies**. All rate and/or payment methodologies for authorized HRSN services outlined in these STCs must be submitted to CMS for review and approval prior to implementation, including but not limited to FFS payment as well as non-risk payments and

capitation rates in managed care delivery systems, as part of the HRSN Implementation Plan (see STC 10.6) at least 60 days prior to implementation. States must submit all documentation requested by CMS, including but not limited to the payment rate methodology as well as other documentation and supporting information (e.g., state responses to Medicaid non-federal share financing questions). The state must also comply with the Public Notice Procedures set forth in 42 CFR 447.205 for changes in statewide methods and standards for setting FFS payment rates.

10.15. **Maintenance of Effort (MOE).** The state must maintain a baseline level of state funding for ongoing social services related to housing transition supports and nutrition supports for the duration of the demonstration, not including one time or non-recurring funding. Within 90 days of demonstration approval, the state will submit a plan to CMS as part of the New Initiatives Implementation Plan that specifies how the state will determine baseline spending on these services throughout the state. The annual MOE will be reported and monitored as part of the Annual Monitoring Report described in STC 14.5, with any justifications, including declines in available state resources, necessary to describe the findings.

10.16. **Partnerships with State and Local Entities.** The state must have in place partnerships with other state and local entities (e.g., HUD Continuum of Care Program, local housing authority, SNAP state agency) to assist beneficiaries in obtaining non-Medicaid funded housing and nutrition supports, if available, upon the conclusion of temporary Medicaid payment for such supports, in alignment with beneficiary needs identified in the care plans as appropriate. The state will submit a plan to CMS as part of the HRSN Implementation Plan that outlines how it will put into place the necessary arrangements with other state and local entities and also work with those entities to assist beneficiaries in obtaining available non-Medicaid funded housing and nutrition supports upon conclusion of temporary Medicaid payment as stated above. The plan must provide a timeline for the activities outlined. As part of the Monitoring Reports described in STC 12.8, the state will provide the status of the state's fulfillment of its plan and progress relative to the timeline, and whether and to what extent the non-Medicaid funded supports are being accessed by beneficiaries as planned. Once the state's plan is fully implemented, the state may conclude its status updates in the Monitoring Reports.

10.17. **Provider Payment Rate Increase.** As a condition of the HRSN services and infrastructure expenditure authorities, New Jersey must comply with the provider rate increase requirements in Section 11 of the STCs.

11. PROVIDER PAYMENT RATE INCREASE REQUIREMENT

11.1. The provider payment rate increase requirements described hereafter is a condition for HRSN expenditure authority as referenced in Expenditure Authorities 8 and 9.

11.2. As a condition of approval and ongoing provision of FFP in HRSN expenditures over this demonstration period of performance, DY12 through DY17, the state will in accordance with these STCs increase and (at least) subsequently sustain Medicaid FFS provider base rates, and require any relevant Medicaid managed care plan to increase and (at least) subsequently sustain network provider payment rates, by at least two percentage points in

the ratio of Medicaid to Medicare provider rates for one of the service categories that comprise the state's definition of primary care, behavioral health care, or obstetric care, as relevant, if the average Medicaid to Medicare provider payment rate ratio for a representative sample of these services for any of these three categories of services is below 80 percent. If the average Medicaid to Medicare provider payment rate ratio for a representative sample of these services for any of these three categories of services is below 80 percent for only the state's Medicaid fee-for-service program or only Medicaid managed care, the state shall only be required to increase provider payments for the delivery system for which the ratio is below 80 percent.

11.3. The state may not decrease provider payment rates for other Medicaid- or demonstration-covered services for the purpose of making state funds available to finance provider rate increases required under this STC (i.e., cost-shifting).

11.4. The state will, for the purposes of complying with these requirements to derive the Medicaid to Medicare provider payment rate ratio and to apply the rate increase as may be required under this STC, identify the applicable service codes and provider types for each of the primary care, behavioral health, and obstetric care services, as relevant, in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition of behavioral health care services.

11.5. By June 30, 2023 and if the state makes FFS payments, the state must establish and report to CMS the state's average Medicaid to Medicare FFS provider rate ratio for each of the three service categories – primary care, behavioral health and obstetric care, using either of the methodologies below:

a. Provide to CMS the average Medicaid to Medicare provider rate ratios for each of the three categories of services as these ratios are calculated for the state and the service category as noted in the following sources:

    i. For primary care and obstetric care services, in Zuckerman, et al. 2021. "Medicaid Physician Fees Remained Substantially Below Fees Paid by Medicare in 2019." Health Affairs 40(2): 343–348 (Exhibit 3); and

    ii. For behavioral health services, the category called, 'Psychotherapy' in Clemans-Cope, et al. 2022. "Medicaid Professional Fees for Treatment of Opioid Use Disorder Varied Widely Across States and Were Substantially Below Fees Paid by Medicare in 2021." Substance Abuse Treatment, Prevention, and Policy (2022) 17:49 (Table 3); OR

b. Provide to CMS for approval for any of the three service categories the average ratio, as well as the code sets, code level Medicaid utilization, Medicaid and Medicare rates, and other data used to calculate the ratio, and the methodology for the calculation of the ratio under this alternative approach as specified below:

    i. Service codes must be representative of each service category as defined in STC 11.5(b).

ii. Medicaid and Medicare data must be from the same year and not older than 2019.

iii. The state's methodology for determining the year of data, the Medicaid code-level utilization, the service codes within the category, the geographic rate differentials for Medicaid and/or Medicare services and their incorporation into the determination of the category average rate, the selection of the same or similar Medicare service codes for comparison, and the timeframes of data and how alignment is ensured should be comprehensively discussed in the methodology as provided to CMS for approval.

11.6. To establish the state's ratio for each service category identified in STC 11.5(a) as it pertains to managed care plans' provider payment rates in the state, the state must provide to CMS either:

a. The average FFS ratio as provided in STC 11.5(a), if the state and CMS determine it to be a reasonable and appropriate estimate of, or proxy for, the average provider rates paid by managed care plans (e.g., where managed care plans in the state pay providers based on state plan FFS payment rate schedules); or

b. The data and methodology for any or all of the service categories as provided in STC 11.5.b using Medicaid managed care provider payment rate and utilization data.

11.7. In determining the ratios required under STC 11.5 and 11.6, the state may not incorporate FFS supplemental payments that the state made or plans to make to providers, or Medicaid managed care pass-through payments in accordance with 42 CFR 438.6(a) and 438.6(d).

11.8. If the state is required to increase provider payment rates for managed care plans per STC 11.2 and 11.3, the state must:

a. Comply with the requirements for state-directed payments in accordance with 42 CFR 438.6(c), as applicable; and

b. Ensure that the entirety of a two percentage point increase applied to the provider payment rates in the service category whose Medicaid to Medicare average payment rate ratio is below 80 percent is paid to providers, and none of such payment rate increase is retained by managed care plans.

11.9. For the entirety of DY14 through DY17, the provider payment rate increase for each service in the service category and delivery system for which the average ratio is less than 80 percent will be an amount necessary so that the Medicaid to Medicare ratio increases by two percentage points over the highest rate for each service in DY12, and such rate will be in effect on the first day of DY14. A required payment rate increase shall apply to all services in the service category as defined under STC 11.4.

11.10. If the state uses a managed care delivery system for any of the service categories defined in STC 11.4, for the beginning of the first rating period as defined in 42 CFR 438.2(a) that starts in each demonstration year from DY14 through DY17 the managed care plans'

provider payment rate increase for each service in the affected category will be no lower than the highest rate in DY12 plus an amount necessary so that the Medicaid to Medicare ratio for that service increases by two percentage points. The payment rate increase shall apply to all services in a service category as defined under STC 11.4.

11.11. If the state has a biennial legislative session that requires provider payment rate approval and the timing of that session precludes the state from implementing a required payment rate increase by the first day of DY14 (or, as applicable, the first day of the first rating period that starts in DY14), the state will provide an alternative effective date and rationale for CMS review and approval.

11.12. The state will provide the information to document the payment rate ratio required under STC 11.5 and 11.6, via submission to the Performance Metrics Database and Analytics (PDMA) portal for CMS review and approval.

11.13. For demonstration years following the first year of provider payment rate increases, the state will provide an annual attestation within the state's annual demonstration monitoring report that the provider payment rate increases subject to these STCs were at least sustained from, if not higher than, the previous year.

11.14. No later than June 30, 2023, the state will provide to CMS the following information and Attestation Table signed by the State Medicaid Director, or by the Director's Chief Financial Officer (or equivalent position), to PMDA, along with a description of the state's methodology and the state's supporting data for establishing ratios for each of the three service categories in accordance with STC 11.5 and 11.6 for CMS review and approval, at which time the Attestation Table will be appended to the STCs as Attachment R:

New Jersey HRSN Related Provider Payment Rate Increase Assessment – Attestation Table		
The reported data and attestations pertain to Health-Related Social Needs related provider payment increase requirements for the demonstration period of performance DY 11 thru DY 17.		
Category of Service	**Medicaid Fee-for-Service to Medicare Fee-for-service Ratio**	**Medicaid Managed Care to Medicare Fee-for-service Ratio**
Primary Care Services	[*insert percent, or N/A if state does not make Medicaid fee-for-service payments*]	[*insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories*]
	[*insert approach, either ratio derived under STC 11.5.a or STC 11.5.b*]	[*insert approach, either ratio derived under STC 11.6.a or STC 11.6.b insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid*

		and Medicare to derive the ratio]
Obstetric Care Services	[*insert percent, or N/A if state does not make fee-for-service payments*]	[*insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for providers for covered service categories*]
	[*insert approach, either ratio derived under STC 11.5.a or STC 11.5.b]*	[*insert approach, either ratio derived under STC 11.6.a or STC 11.6.b insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio*]
Behavioral Health Care Services	[*insert percent, or N/A if state does not make fee-for-service payments*]	[*insert percent, or N/A if state does not utilize a Medicaid managed care delivery system for applicable covered service categories]*
	[*insert approach, either ratio derived under STC 11.5(a) or STC 11.5(b)*]	[*insert approach, either ratio derived under STC 11.6(a) or STC 11.6(b)*]; insert data source and time period (e.g., applicable 12-month rating period) for each of Medicaid and Medicare to derive the ratio]

In accordance with STCs 11.1 through 11.14, including that the Medicaid provider payment rates used to establish the ratios do not reflect FFS supplemental payments or Medicaid managed care pass-through payments under 42 CFR § 438.6(a) and 438.6(d), I attest that at least a two percentage point payment rate increase will be applied to each of the services in the one service category in each delivery system, as applicable to the state's Medicaid or demonstration service delivery model, if for that delivery system the ratio is both the lowest ratio among the three and below 80 percent. Such provider payment increases for each service will be effective beginning on [*insert date*] and will not be lower than the highest rate for that service code in XX plus an amount necessary so that the Medicaid to Medicare ratio increases by at least two percentage points relative to the rate for the same or similar Medicare billing code through at least [*insert date*].

For the purpose of deriving the Medicaid to Medicare provider payment rate ratio, and to apply the rate increase as may be required under a FFS delivery system or under managed care delivery system, as applicable, the state agrees to define primary care, behavioral health care, and obstetric care, and to identify applicable service codes and providers types for each of these service categories in a manner consistent with other state and federal Medicaid

program requirements, except that inpatient behavioral health services may be excluded from the state's definition.

The services that comprise any service category to which the rate increase must be applied will include all service codes that fit under the state's definition of the category, except the behavioral health codes do not have to include inpatient care services.

For provider payment rates paid under managed care delivery system, the data and methodology for any one of the service categories as provided in STC 11.6.b will be based on Medicaid managed care provider payment rate and utilization data.

[*Select the applicable effective date, must check either a. or b. below*]
☐a. The effective date of the rate increases is the first day of DY [*3, provide the actual year*] and will be at least sustained, if not higher, through DY [*5, provide the actual year*]
☐b. New Jersey has a biennial legislative session that requires provider payment approval and the timing of that session precludes the state from implementing the payment increase on the first day of DY [*3, provide the actual year*]. New Jersey will effectuate the rate increases no later than the CMS approved date of [*insert date*], and will sustain these rates, if not made higher, through DY [*5, provide the accrual year*].

New Jersey [*insert does or does not*] make Medicaid state plan FFS payments for the following categories of service for at least some populations: primary care, behavioral health care, and/or obstetric care.

For any such payments, as necessary to comply with the Health-Related Social Need STCs, I agree to submit by no later than [*insert date*] for CMS review and approval the Medicaid state plan FFS payment increase methodology, including the Medicaid code set to which the payment rate increases are to be applied, code level Medicaid utilization, Medicaid and Medicare rates for the same or similar Medicare billing codes, and other data used to calculate the ratio, and the methodology, as well as other documents and supporting information (e.g., state responses to Medicaid financing questions) as required by applicable statutes, regulations and CMS policy, through the submission of a new SPA, following the normal SPA process including publishing timely tribal and public notice and submitting to CMS all required SPA forms (e.g., SPA transmittal letter, CMS-179, Attachment 4.19-B pages from the state), by no later than [*insert date*]

New Jersey [*insert does or does not*] include the following service categories within a Medicaid managed care delivery system for which the managed care plans make payments to applicable providers for at least some populations: primary care, behavioral health, and or obstetric care.

For any such payments, as necessary to comply with the Health-Related Social Need STCs, I agree to submit the Medicaid managed care plans' provider payment increase methodology, including the information listed in STC 11.11 through the state directed payments submission process and in accordance with 42 CFR 438.6(c), as applicable, by no later than *[insert date*]

If the state utilizes a managed care delivery system for the applicable service categories, then in accordance with STC 11.10, I attest that necessary arrangements will be made to assure that 100 percent of the two percentage point managed care plans' provider payment increase will

be paid to the providers of those service categories and none of this payment rate increase is retained by the managed care plans.
New Jersey further agrees not to decrease provider payment rates for other Medicaid- or demonstration-covered services to make state funds available to finance provider rate increases required under this STC 11.
I, *[insert name of SMD or CFO (or equivalent position*] [*insert title*], attest that the above information is complete and accurate. [*Provide signature*_____] [*Provide printed name of signator*] [*Provide date*_____]

12. MONITORING AND REPORTING REQUIREMENTS

12.1. **Deferral for Failure to Submit Timely Demonstration Deliverables.** CMS may issue deferrals in accordance with 42 CFR part 430 subpart C, in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. A deferral shall not exceed the value of the federal amount for the demonstration period. The state does not relinquish its rights provided under 42 CFR part 430 subpart C to challenge any CMS finding that the state materially failed to comply with the terms of this agreement.

a. The following process will be used: 1) 30 calendar days after the deliverable was due if the state has not submitted a written request to CMS for approval of an extension as described in STC 12.1.b; or 2) 30 calendar days after CMS has notified the state in writing that the deliverable was not accepted for being inconsistent with the requirements of this agreement and the information needed to bring the deliverable into alignment with CMS requirements.

b. CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.

c. For each deliverable, the state may submit to CMS a written request for an extension to submit the required deliverable. The extension request must explain the reason why the required deliverable was not submitted, the steps the state has taken to address such issue, and the state's anticipated date of submission. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided. CMS may agree to a corrective action plan as an interim step before applying the deferral, if corrective action is proposed in the state's written extension request.

d. If CMS agrees to an interim corrective process in accordance with STC 12.1.c, and the state fails to comply with the corrective action plan or, despite the corrective action plan, still fails to submit the overdue deliverable(s) that meets the terms of this

agreement, CMS may proceed with the issuance of a deferral against the next Quarterly Statement of Expenditures reported in Medicaid Budget and Expenditure System/State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES) following a written deferral notification to the state.

e. If the CMS deferral process has been initiated for state non-compliance with the terms of this agreement for submitting deliverable(s), and the state submits the overdue deliverable(s), and such deliverable(s) are accepted by CMS as meeting the standards outlined in these STCs, the deferral(s) will be released.

As the purpose of a Section 1115 demonstration is to test new methods of operation or service delivery, a state's failure to submit all required reports, evaluations, and other deliverables will be considered by CMS in reviewing any application for an extension, amendment, or for a new demonstration.

12.2. **Deferral of Federal Financial Participation (FFP) from IMD claiming for Insufficient Progress Toward Milestones.** Up to $5 million in FFP for services in IMDs may be deferred if the state is not making adequate progress on meeting the milestones and goals as evidenced by reporting on the milestones in STC 6.1 and the required performance measures in the monitoring protocol agreed upon by the state and CMS. Once CMS determines the state has not made adequate progress, up to $5 million will be deferred in the next calendar quarter and each calendar quarter thereafter until CMS has determined sufficient progress has been made.

12.3. **Submission of Post-Approval Deliverables.** The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

12.4. **Compliance with Federal Systems Updates.** As federal systems continue to evolve and incorporate additional Section 1115 demonstration reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;

b. Ensure all Section 1115 demonstration, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and

c. Submit deliverables to the appropriate system as directed by CMS.

12.5. **New Initiatives Implementation Plan.** The state is required to submit a New Initiatives Implementation Plan ("Implementation Plan") to cover certain key policies being tested under this demonstration, including those approved through any amendments. The Implementation Plan will contain applicable information for the following expenditure authorities: HRSN Infrastructure, HRSN Services, and Continuous Eligibility. The Implementation Plan, at a minimum, must provide a description of the state's strategic approach to implementing these demonstration policies, including timelines for meeting critical implementation stages or milestones, as applicable, to support successful implementation.

The state must submit the MOE information required by STC 10.15 for CMS approval no later than 90 calendar days after approval of this demonstration. All other Implementation Plan requirements outlined in this STC must be submitted for CMS approval no later than 9 months after the approval of this demonstration. The state must submit any required clarifications or revisions to their Implementation Plan submission within 60 calendar days after receipt of CMS feedback. Once approved, the finalized Implementation Plan will be incorporated into the STCs as Attachment G and may be further altered only with CMS approval.

In the Implementation Plan, the state is expected only to provide additional details regarding the implementation of the demonstration policies that are not already captured in the STCs or available elsewhere publicly. Furthermore, for the state's HRSN-related authorities, the Implementation Plan does not need to repeat any information submitted to CMS in the Protocol for HRSN Infrastructure and HRSN Services (see STC 10.6); however, as applicable, the information provided in the two deliverables must be aligned and consistent with one another.

The Implementation Plan does not need to duplicate information that pertains to more than one initiative, assuming the information is the same. The Implementation Plan can be updated as necessary to align with state operations. CMS may provide the state with a template to support the state in developing and obtaining approval of the Implementation Plan.

The New Initiatives Implementation Plan must include information on, but not limited to, the following:

a. A plan for establishing and/or improving data sharing and partnerships with an array of health system and social services stakeholders to the extent those entities are vital to provide needed administrative and HRSN-related data on screenings, referrals, and provision of services, which are critical for understanding program implementation and conducting demonstration monitoring and evaluation

b. Information about key partnerships related to HRSN service delivery, including plans for capacity building for community partners and for soliciting and incorporating input from impacted groups (e.g., community partners, health care delivery system partners, and beneficiaries)

c. Plans for changes to IT infrastructure that will support HRSN-related data exchange, including development and implementation of data systems necessary to support program implementation, monitoring, and evaluation. These existing or new data systems should, at a minimum, collect data on beneficiary characteristics, eligibility and consent, screening, referrals, and service provision

d. A plan for tracking and improving the share of Medicaid beneficiaries in the state who are eligible and enrolled in the Supplemental Nutrition Assistance Program (SNAP), the Special Supplemental Nutrition Program for Women, Infants and Children (WIC),

Temporary Assistance for Needy Families (TANF), and federal and state housing assistance programs, relative to the number of total eligible beneficiaries in the state

e. An implementation timeline and evaluation considerations impacted by the timeline, such as staged rollout, that can facilitate robust evaluation designs

f. A description of processes to perform verifications on beneficiary residency and other checks and to update beneficiary contact information on an annual basis, as described in STCs 5.16.d

g. Information as required per STC 10.14 (HRSN Rate Methodologies)

h. Information as required per STC 10.15 (MOE)

i. Information as required per STC 10.16 (Partnerships with State and Local Entities)

Failure to submit the Implementation Plan will be considered a material failure to comply with the terms of the demonstration project as described in 42 CFR 431.420(d) and, as such, would be grounds for termination or suspension of authority for HRSN Infrastructure, HRSN Services, and/or Continuous Eligibility under this demonstration.

12.6. **Monitoring Protocol.** The state must submit to CMS a Monitoring Protocol no later than 150 calendar days after the approval of the demonstration. The state must submit a revised Monitoring Protocol within 60 calendar days after receipt of CMS's comments. Once approved, the Monitoring Protocol will be incorporated in the STCs as Attachment J. In addition, the state must submit an updated or a separate Monitoring Protocol for any amendments to the demonstration no later than 150 calendar days after the approval of the amendment. Such amendment Monitoring Protocols are subject to same requirement of revisions and CMS approval, as described above.

At a minimum, the Monitoring Protocol will affirm the state's commitment to conduct Quarterly and Annual Monitoring Reports in accordance with CMS's guidance and technical assistance and using CMS-provided reporting templates, if applicable. Any proposed deviations from CMS's guidance should be documented in the Monitoring Protocol. The Monitoring Protocol will describe the quantitative and qualitative elements on which the state will report through Quarterly and Annual Monitoring Reports. For the overall demonstration as well as for specific policies where CMS provides states with a suite of quantitative monitoring metrics (e.g., the performance metrics described in STC 12.8.b), the state is required to calculate and report such metrics leveraging the technical specifications provided by CMS. The Monitoring Protocol must specify the methods of data collection and timeframes for reporting on the demonstration's progress as part of the Quarterly and Annual Monitoring Reports. In alignment with CMS guidance, the Monitoring Protocol must additionally specify the state's plans and timeline on reporting metrics data stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography) and demonstration component.

For the HRSN services authorized through this demonstration, the Monitoring Protocol also requires specifying a selection of quality of care and health outcomes metrics and population stratifications based on CMS's upcoming guidance on the Health Equity Measure Slate, and outlining the corresponding data sources and reporting timelines. This slate of measures represents a critical set of equity-focused metrics known to be important for closing key equity gaps in Medicaid/CHIP (e.g. the National Quality Forum (NQF) "disparities-sensitive" measures) and prioritizes key outcome measures and their clinical and non-clinical (i.e. social) drivers. The Monitoring Protocol must also outline the state's planned approaches and parameters to track performance relative to the goals and milestones, as provided in the implementation plan, for the HRSN infrastructure investments.

In addition, the state must describe in the Monitoring Protocol methods to collect and analyze non-Medicaid administrative data to help calculate applicable monitoring metrics. These sources may include, but are not limited to: (1) community resource referral platforms, (2) records of social services receipt from other agencies (such as SNAP or TANF benefits, or HUD assistance), (3) other data from social services organizations linked to beneficiaries (e.g., services rendered, resolution of identified need, as applicable), and (4) social needs screening results from electronic health records, health plans, or other partner agencies, as applicable. Across data sources, the state must make efforts and consult with relevant non-Medicaid social service agencies to collect data in ways that support analyses of data on beneficiary subgroups.

For the qualitative elements (e.g., operational updates as described in STC 12.8.a), CMS will provide the state with guidance on narrative and descriptive information which will supplement the quantitative metrics on key aspects of the demonstration policies. The quantitative and qualitative elements will comprise the state's Quarterly and Annual Monitoring Reports.

12.7. **SUD Monitoring Protocol.** The state must submit a draft Monitoring Protocol for the SUD programs authorized by this demonstration no later than 150 calendar days after the effective date of the demonstration. The SUD Monitoring Protocol must be developed in cooperation with CMS and is subject to CMS approval. The state must submit a revised Monitoring Protocol within 60 calendar days after receipt of CMS' comments. Once approved, the SUD Monitoring Protocol will be incorporated into the STCs, as Attachment I. Progress on the performance measures identified in the Monitoring Protocol must be reported via the Quarterly and Annual Monitoring Reports. Components of the Monitoring Protocol include:

a. An assurance of the state's commitment and ability to report information relevant to each of the program implementation areas outlined in Attachment E and reporting relevant information to the state's Health IT plan described in STC 6.3;

b. A description of the methods of data collection and timeframes for reporting on the state's progress on required measures as part of the general reporting requirements described in Section XII (Monitoring and Reporting Requirements) of the demonstration; and

c. A description of baselines and targets to be achieved by the end of the demonstration. Where possible, baselines will be informed by state data, and targets will be benchmarked against performance in best practice settings.

12.8. **Monitoring Reports.** The state must submit three Quarterly Monitoring Reports and one Annual Monitoring Report each DY. The fourth-quarter information that would ordinarily be provided in a separate Quarterly Monitoring Report should be reported as distinct information within the Annual Monitoring Report. The Quarterly Monitoring Reports are due no later than 60 calendar days following the end of each demonstration quarter. The Annual Monitoring Report (including the fourth-quarter information) is due no later than 90 calendar days following the end of the DY. The state must submit a revised Monitoring Report within 60 calendar days after receipt of CMS's comments, if any. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography Section. The Quarterly and Annual Monitoring Reports must follow the framework to be provided by CMS, which is subject to change as monitoring systems are developed/evolve, and will be provided in a structured manner that supports federal tracking and analysis.

a. **Operational Updates.** Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports must provide sufficient information to document key operational and other challenges, underlying causes of challenges, and how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. In addition, Monitoring Reports should describe key achievements, as well as the conditions and efforts to which these successes can be attributed. Monitoring reports should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

b. **Performance Metrics.** The performance metrics will provide data to demonstrate how the state is progressing toward meeting the goals and milestones – including relative to their projected timelines – of the demonstration's program and policy implementation and infrastructure investments, and must cover all key policies under this demonstration. Additionally, per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration on beneficiaries' outcomes of care, quality and cost of care, and access to care. This should also include the results of beneficiary satisfaction or experience of care surveys, if conducted, as well as grievances and appeals.

The demonstration's metrics reporting must cover categories including, but not limited to: enrollment and renewal, including enrollment duration, access to providers, utilization of services, and quality of care and health outcomes. The state must undertake robust reporting of quality of care and health outcomes metrics aligned with the demonstration's policies and objectives, to be reported for all demonstration

populations. Such reporting must also be stratified by key demographic subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography) and by demonstration components, to the extent feasible. Subpopulation reporting will support identifying any existing shortcomings or disparities in quality of care and health outcomes, and help track whether the demonstration's initiatives help improve outcomes for the state's Medicaid population, including the narrowing of any identified disparities. To that end, CMS underscores the importance of the state's reporting of quality of care and health outcomes metrics known to be important for closing key equity gaps in Medicaid/CHIP (e.g. NQF "disparities-sensitive" measures) and prioritizing key outcome measures and their clinical and non-clinical (i.e. social) drivers of health. In coordination with CMS, the state is expected to select such measures for reporting in alignment with a critical set of equity-focused measures CMS is finalizing as part of its upcoming guidance on the Health Equity Measure Slate.

In addition, in alignment with any applicable CMS guidance and technical assistance related to specific program components of the demonstration, the state's monitoring efforts must satisfy the below requirements, to be finalized through the state's two Monitoring Protocols (STCs 12.6 and 12.7) described above, which are subject to CMS approval.

i. For this demonstration's HCBS, MLTSS, and 217-like expansion initiatives, the state must leverage appropriate metrics that are in alignment with CMS' HCBS Quality Measure Set, and may include other nationally standardized and tested measures in key measurement areas such as service plan, health and welfare, access, rebalancing, and community integration. Furthermore, the state's reporting should align with, but not duplicate, reporting efforts outlined in Section 9 on Delivery Systems. The state's reporting must accommodate, but may not be limited to, the following:

    - As feasible, by HCBS program and/or institution type, enrollment, reenrollment, and disenrollment.
    - Functional reassessment and service plan updates.
    - Measures derived from experience of care surveys that cover each of the state's HCBS populations. Some experience of care surveys have not been tested with all populations enrolled in HCBS programs, so the state may need to use multiple experience of care surveys depending on the populations served by the state's HCBS programs.
    - Annual HCBS QIS requirements in accordance with STC 9.8.

ii. For the SUD component, the state's monitoring must align with the CMS-approved SUD Monitoring Protocol (see STC 12.7), and will cover metrics in alignment with assessment of need and qualification for SUD treatment services

and the demonstration's six milestones as outlined in the State Medicaid Director Letter (SMDL) dated November 1, 2017 (SMDL #17-003)[4].

iii. For the extension of postpartum care component, the state's reporting must cover metrics for domains including but not limited to: enrollment, primary and preventative care, maternal health, infant health, and if applicable, behavioral health.

iv. In addition to the enrollment and renewal metrics that support tracking Medicaid churn, systematic monitoring of the continuous eligibility policy must – at a minimum – capture data on utilization of preventive care services, including vaccination among populations of focus, and utilization of costlier and potentially avoidable services, such as inpatient hospitalizations and non-emergent use of emergency departments.

v. For the HRSN initiatives, in addition to reporting on the quality of care and health outcomes metrics described above, the state must track beneficiary participation, screening, rescreenings and receipt of referrals and social services over time. The state's enrollment and renewal metrics must also capture baseline data and track progress via Monitoring Reports for the percent of Medicaid renewals completed ex-parte (administratively), as well as the percentage of Medicaid beneficiaries enrolled in other public benefit programs (such as SNAP and WIC) for which they are eligible. The state's reporting of metrics must also capture the number of pregnant individuals with a diagnosis of either pre-existing diabetes and/or gestational diabetes served under the Medically Indicated Meals Pilot, and corresponding service utilization.

Other than the quantitative monitoring metrics, the state must also narratively report on the progress in adoption of IT infrastructure to support data sharing between the state or partner entities assisting in the administration of the demonstration and social services organizations. In alignment with STC 10.16, the state must additionally monitor and provide narrative updates on its progress in building and sustaining its partnership with existing housing and nutrition agencies to leverage their expertise and existing housing and nutrition resources instead of duplicating services. Finally, the Monitoring Reports must also provide status updates in accordance with the Monitoring Protocol on the implementation of infrastructure investments tied to the HRSN initiatives.

As applicable, if the state, health plans, or health care providers will contract or partner with organizations to implement the demonstration, the state must use monitoring metrics that track the number and characteristics of contracted or participating organizations in specific demonstration programs and corresponding payment-related metrics.

[4] SMDL #17-003, Strategies to Address the Opioid Epidemic. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf

vi. The state must report on monitoring metrics that reflect the take-up of the caregiver support services and report, at a minimum, the number and types of services rendered as well as the number denied coverage under this policy.

vii. The state must, in coordination with CMS through the Monitoring Protocol of Other Policies (STC 12.8), also establish monitoring metrics to help track operational and implementation progress and performance of the demonstration's pilot programs. At a minimum, the metrics must capture the number of individuals eligible for these pilots, the number and composition of service utilization, and corresponding health outcomes, as applicable.

The required monitoring and performance metrics must be included in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.

c. **Budget Neutrality and Financial Reporting Requirements.** Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in STC 13.11, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly and annual expenditures associated with the populations affected by this demonstration on the Form CMS-64. Administrative costs should be reported separately on the CMS-64.

d. **Evaluation Activities and Interim Findings.** Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

12.9. **SUD Mid-Point Assessment.** The state must contract with an independent entity to conduct a mid-point assessment for the demonstration's SUD component by December 31, 2025. This timeline will allow for the Mid-Point Assessment Report to capture approximately the first two-and-a-half years of demonstration program data, accounting for data run-out and data completeness. The state must provide a copy of the report to CMS no later than 60 calendar days after December 31, 2025. The state must brief CMS on the report, if requested. The state must submit a revised Mid-Point Assessment Report within 60 calendar days after receipt of CMS' comments, if any.

In the design, planning and conduction of the mid-point assessment, the state must require that the independent assessor consult with key stakeholders including, but not limited to: representatives of MCOs, if applicable, SUD treatment providers, beneficiaries, and other key partners. The state must require that the assessor provide a Mid-Point Assessment Report to the state that includes the methodologies used for examining progress and assessing risk, the limitations of the methodologies, its determinations and any recommendations. For milestones and measure targets at medium to high risk of not being achieved, the state must submit to CMS modifications to the SUD Implementation Plan and

the SUD Monitoring Protocol for ameliorating these risks. Modifications to the applicable Implementation Plan and Monitoring Protocol are subject to CMS approval.

In the event of demonstration extensions, the SUD mid-point assessment must account for milestones met during prior approval periods and progress achieved toward the programs original goals and objectives, and accommodate those considerations in the current period mid-point assessment.

Elements of the Mid-Point Assessment Report include:

a. An examination of progress toward meeting each milestone and timeframe approved in the SUD Implementation Plan, and toward meeting the targets for performance measures as approved in the SUD Monitoring Protocol;

b. A determination of factors that affected achievement on the milestones and performance measure gap closure percentage points to date;

c. A determination of selected factors likely to affect future performance in meeting milestones and targets not yet met and information about the risk of possibly missing those milestones and performance targets;

d. For milestones or targets at medium to high risk of not being met, recommendations for adjustments in the state's SUD Implementation Plan to pertinent factors that the state can influence that will support improvement; and

e. An assessment of whether the state is on track to meet the budget neutrality requirements.

12.10. **Corrective Action Plan Related to Monitoring**. If monitoring indicates that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. A state corrective action plan could include a temporary suspension of implementation of demonstration programs in circumstances where monitoring data indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.11. CMS will withdraw an authority, as described in STC 3.11, when metrics indicate substantial and sustained directional change inconsistent with the state's demonstration goals, and the state has not implemented corrective action. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

12.11. **Close-Out Report.** Within 120 calendar days after the expiration of the demonstration, the state must submit a draft Close-Out Report to CMS for comments.

a. The Close-Out Report must comply with the most current guidance from CMS.

b. In consultation with CMS, and per guidance from CMS, the state will include an evaluation of the demonstration (or demonstration components) that are to phase out or expire without extension along with the Close-Out Report. Depending on the timeline of the phase-out during the demonstration approval period, in agreement with CMS, the evaluation requirement may be satisfied through the Interim and/or Summative Evaluation Reports stipulated in STCs 13.7 and 13.8, respectively.

c. The state will present to and participate in a discussion with CMS on the Close-Out report.

d. The state must take into consideration CMS's comments for incorporation into the final Close-Out Report.

e. A revised Close-Out Report is due to CMS no later than 30 days after receipt of CMS's comments.

f. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 12.1.

12.12. **Monitoring Calls.** CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, trends in reported data on metrics and associated mid-course adjustments, enrollment and access, budget neutrality, and progress on evaluation activities.

b. CMS will provide updates on any pending actions, as well as federal policies and issues that may affect any aspect of the demonstration.

c. The state and CMS will jointly develop the agenda for the calls.

12.13. **Post Award Forum**. Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 calendar days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state must also post the most recent Annual Monitoring Report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the public comments in the Annual Monitoring Report associated with the year in which the forum was held.

13. EVALUATION OF THE DEMONSTRATION

13.1. **Cooperation with Federal Evaluators and Learning Collaborative.** As required under 42 CFR 431.420(f), the state shall cooperate fully and timely with CMS and its contractors in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation

documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state shall include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they shall make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. This may also include the state's participation – including representation from the state's contractors, independent evaluators, and organizations associated with the demonstration operations, as applicable – in a federal learning collaborative aimed at cross-state technical assistance, and identification of lessons learned and best practices for demonstration measurement, data development, implementation, monitoring and evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 12.1.

13.2. **Independent Evaluator**. The state must use an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in an independent manner in accord with the CMS-approved Draft Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

13.3. **Draft Evaluation Design.** The state must submit, for CMS comment and approval, a draft Evaluation Design no later than 180 calendar days after the approval of the demonstration. The Evaluation Design must be drafted in accordance with Attachment A (Developing the Evaluation Design) of these STCs and any applicable CMS evaluation guidance and technical assistance for the demonstration's policy components. The Evaluation Design must also be developed in alignment with CMS guidance on applying robust evaluation approaches, such as quasi-experimental methods like difference-in-differences and interrupted time series, as well as establishing valid comparison groups and assuring causal inferences in demonstration evaluations. In addition to these requirements, if determined culturally appropriate for the communities impacted by the demonstration, the state is encouraged to consider implementation approaches involving randomized control trials and staged rollout (for example, across geographic areas, by service setting, or by beneficiary characteristic) – as these implementation strategies help create strong comparison groups and facilitate robust evaluation.

The state is strongly encouraged to use the expertise of the independent party in the development of the draft Evaluation Design. The draft Evaluation Design also must include a timeline for key evaluation activities, including the deliverables outlined in STC 12.8.

For any amendment to the demonstration, the state will be required to update the approved Evaluation Design to accommodate the amendment component. The amended Evaluation Design must be submitted to CMS for review no later than 180 calendar days after CMS's approval of the demonstration amendment. Depending on the scope and timing of the

amendment, in consultation with CMS, the state may provide the details on necessary modifications to the approved Evaluation Design via the monitoring reports. The amendment Evaluation Design must also be reflected in the state's Interim (as applicable) and Summative Evaluation Reports, described below.

In the event of demonstration extensions, for components that are continuing from the prior demonstration approval period, the state's Evaluation Design must reframe and refocus as needed the evaluation hypotheses and research questions to appropriately factor in where it can reasonably expect continued improvements, and where the demonstration's role might be more to help stabilize outcomes. Likewise, for continuing policies, the state must revisit its analytic approaches compared to those used in the prior approval period evaluation activities, to ensure that the evaluation of those policies taps into the longer implementation time span.

13.4. **Evaluation Design Approval and Updates.** The state must submit a revised draft Evaluation Design within 60 calendar days after receipt of CMS's comments, if any. Upon CMS approval of the draft Evaluation Design, the document will be included as Attachment K to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within 30 days of CMS approval. The state must implement the Evaluation Design and submit a description of its evaluation progress in each of the Quarterly and Annual Monitoring Reports. Once CMS approves the Evaluation Design, if the state wishes to make changes, the state must submit a revised Evaluation Design to CMS for approval if the changes are substantial in scope; otherwise, in consultation with CMS, the state may include updates to the Evaluation Design in Monitoring Reports.

13.5. **Evaluation Questions and Hypotheses.** Consistent with Attachments A and B (Developing the Evaluation Design and Preparing the Interim and Summative Evaluation Report) of these STCs, the evaluation deliverables must include a discussion of the evaluation questions and hypotheses that the state intends to test. In alignment with applicable CMS evaluation guidance and technical assistance, the evaluation must outline and address well-crafted hypotheses and research questions for all key demonstration policy components that support understanding of the demonstration's impact and its effectiveness in achieving the demonstration's goals.

The hypothesis testing should include, where possible, assessment of both process and outcome measures. The evaluation must cover outcomes, such as enrollment and enrollment continuity, and various measures of access, utilization, and health outcomes, as appropriate and in alignment with applicable CMS evaluation guidance and technical assistance, for the demonstration policy components. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Core Set of Health Care Quality Measures for Medicaid-Eligible Adults, the Behavioral Risk Factor Surveillance System (BRFSS) survey, and/or measures endorsed by NQF.

The evaluation questions and hypotheses should address the impacts of the following demonstration initiatives, including but not be limited to:

- Additional home and community-based services to Medicaid and CHIP beneficiaries covered under the demonstration
- Home and community-based services to expanded eligibility groups, who would otherwise have not been eligible for Medicaid or CHIP absent the demonstration
- SUD services to Medicaid beneficiaries, including paying for services rendered in an IMD and those for the BH PIP group
- Medical and behavioral health services for the ABP group
- Expedited eligibility determination for individuals under public guardianship
- Extended coverage and benefits for postpartum individuals and the 12-month continuous eligibility provision
- HRSN services to the populations eligible for such services under the demonstration
- Services and benefits rendered under the demonstration authorized pilot programs.

More specifically, the state's evaluation efforts must adhere to the following:

a. For the HCBS, MLTSS, and 217-like expansion policies, the state must evaluate the impact of the programs on all relevant populations focused on beneficiaries' experience of care, access to care, provision and utilization of care, the quality, efficiency, and coordination of care centered on rebalancing and community integration, and the costs of care. Furthermore, the evaluation is expected to assess the effectiveness of including long-term care services in the capitated managed care benefit on access to care, quality of care, and mix of care settings employed. In addition, the state must analyze the impact of providing additional home and community-based services to Medicaid and CHIP beneficiaries with serious emotional disturbance, opioid addiction, behavioral/mental health issues, or intellectual disabilities/developmental disabilities and of using self-attestation on the transfer of assets.

b. Evaluation hypotheses for the SUD program component—taking cue from the prior period successes and challenges—must focus on an assessment of the program's effectiveness in further achieving or maintaining the program goals. SUD evaluation, for example, is expected to incorporate outcomes such as: initiation and compliance with treatment, utilization of health services, including avoidable emergency department visits and inpatient hospitalizations, care coordination including access to care for physical health conditions, preventable or medically inappropriate readmissions, and opioid-related overdose deaths.

c. Hypotheses for the ABP program must accommodate an assessment of the effectiveness of the program in serving the medical and behavioral health needs of the New Adult Group.

d. Hypotheses for the extension of postpartum care initiative must cover outcomes related to primary and preventative care utilization, maternal and infant health, and if applicable, treatment for behavioral health, with a focus on addressing any demographic disparities.

e. For the continuous eligibility policy, the state must evaluate the impact of the program on all relevant populations tailored for the specific time span of eligibility. For example, the state must evaluate how the continuous eligibility policy affects coverage, enrollment and churn (i.e., temporary loss of coverage in which beneficiaries are disenrolled but then re-enroll within 12 months) as well as population-specific appropriate measures of service utilization and health outcomes. The state must also evaluate the effectiveness of the continuous eligibility authority. For example, for the state's populations of focus under the demonstration's continuous eligibility policy, to the extent feasible, the state may collect and analyze data such as changes in beneficiary income at 12-month intervals to inform how a longer period of eligibility can potentially help streamline the state's administrative processes around enrollment and eligibility determinations. In addition, or alternatively, the state may conduct a comprehensive qualitative assessment involving beneficiary focus groups and interviews with key stakeholders to assess the merits of such policies.

f. Evaluation hypotheses for the HRSN initiatives must focus on assessing the effectiveness of the HRSN services in mitigating identified needs of beneficiaries. Such assessment is expected to use applicable demonstration monitoring and other data on the prevalence and severity of beneficiaries' HRSNs and the provision of and beneficiary utilization of HRSN services. Furthermore, the HRSN evaluation must include analysis of how the initiatives affect utilization of preventive and routine care, utilization of and costs associated with potentially avoidable, high-acuity health care, and beneficiary physical and mental health outcomes. Hypotheses must be designed to help understand, in particular, the impacts of New Jersey's housing support and food assistance programs on beneficiary health outcomes and experience. The evaluation must also analyze the effectiveness of the Medically Indicated Meals Pilot in addressing pregnant individual's dietary risk factors related to adverse perinatal outcomes, through examining outcomes such as gestational diabetes.

In alignment with the demonstration's objectives to improve outcomes for the state's overall beneficiary populations eligible for the HRSN initiatives, the state must also include research questions and hypotheses focused on understanding the impact of the HRSN initiatives on advancing health quality, including through the reduction of health disparities, for example, by assessing the effects of the initiatives in reducing disparities in health care access, quality of care, or health outcomes at the individual, population, and/or community level.

The evaluation must also assess the effectiveness of the infrastructure investments authorized through the demonstration to support the development and implementation of the HRSN initiatives. The state must additionally examine whether and how state and local investments in housing and nutrition supports change over time in concert with new Medicaid funding toward those HRSN services. In addition, in light of how demonstration HRSN expenditures are being treated for purposes of budget neutrality, the evaluation of the HRSN initiative must include a cost analysis to support developing comprehensive and accurate cost estimates of providing such services. Evaluation of the HRSN initiative is also required to include a robust assessment of

potential improvements in the quality and effectiveness of downstream services that can be provided under the state plan authority, and associated cost implications.

g. Evaluation of the caregiver support services must analyze the effectiveness of these services through hypotheses focused on experiences of caregivers in terms of their emotional or psychological health, ideally in comparison with similar caregivers within or out-of-state who are not eligible for receiving such services.

h. The state must conduct comprehensive evaluation of its pilot programs, and develop robust evaluation questions and hypotheses to examine the impacts and effectiveness of:

    i. the ASD Pilot in assisting individuals with activities as outlined in their plan of care to enhance inclusion in the community for youth with an ASD diagnosis by offering a limited package of adjunct or specialized services. Furthermore, the state must include in its evaluation a cost assessment of the pilot services;

    ii. the NJHV Pilot Program in promoting health outcomes, whole person care, and community integration of mother and child;

    iii. the CHW Pilot Program in serving Medicaid and CHIP beneficiaries enrolled in MCOs who have been diagnosed with or are at risk for a specific chronic condition, such as asthma, diabetes, depression, or HIV; and

    iv. the Financial Eligibility Determination Pilot Program in expediting and providing Medicaid eligibility to individuals under public guardianship while procuring legal authority to unwind (or spend-down) their assets.

As part of its evaluation efforts, the state must conduct a demonstration cost assessment to include, but not be limited to, administrative costs of demonstration implementation and operation, Medicaid health services expenditures, and provider uncompensated care costs. As noted above, the state must analyze the budgetary effects of the HRSN services, as well as the overall medical assistance service expenditures and uncompensated care and associated costs for populations eligible for continuous eligibility, including in comparison to populations not eligible for such policies. The cost assessment should also analyze yearly LTSS and HCBS spending throughout the demonstration period. The state must use findings from hypothesis tests aligned with other demonstration goals and cost analyses to assess the demonstration's effects on the fiscal sustainability of the state's Medicaid program.

CMS underscores the importance of the state undertaking a well-designed beneficiary survey and/or interviews to assess, for instance, beneficiary understanding of and experience with the various demonstration policy components, including but not limited to the continuous eligibility and the HRSN demonstration components, and beneficiary experiences with access to and quality of care. In addition, the state is strongly encouraged to evaluate the implementation of the demonstration programs in order to better understand whether implementation of certain key demonstration policies happened as envisioned during the demonstration design process and whether specific factors acted as facilitators of

or barriers to successful implementation. Implementation research questions can also focus on beneficiary and provider experience with the demonstration. The implementation evaluation can inform the state's crafting and selection of testable hypotheses and research questions for the demonstration's outcome and impact evaluations and provide context for interpreting the findings.

Finally, the state must collect data to support analyses stratified by key subpopulations of interest (e.g., by sex, age, race/ethnicity, English language proficiency, primary language, disability status, and geography). Such stratified data analyses will provide a fuller understanding of existing disparities in access to and quality of care and health outcomes, and help inform how the demonstration's various policies might support reducing such disparities.

13.6. **Evaluation Budget.** A budget for the evaluations must be provided with the draft Evaluation Designs. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluations such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the designs are not sufficiently developed, or if the estimates appear to be excessive.

13.7. **Interim Evaluation Report.** The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for an extension of the demonstration, the Interim Evaluation Report should be posted to the state's website with the application for public comment.

a. The Interim Evaluation Report will discuss evaluation progress and present findings to date as per the approved Evaluation Design.

b. For demonstration authority or any components within the demonstration that expire prior to the overall demonstration's expiration date, and depending on the timeline of expiration/phase-out, the Interim Evaluation Report may include an evaluation of the authority, to be collaboratively determined by CMS and the state.

c. If the state is seeking to extend the demonstration, the draft Interim Evaluation Report is due when the application for extension is submitted, or one year prior to the end of the demonstration, whichever is sooner. If the state is not requesting an extension for a demonstration, an Interim Evaluation Report is due one year prior to the end of the demonstration.

d. The state must submit the revised Interim Evaluation Report 60 calendar days after receiving CMS's comments on the draft Interim Evaluation Report, if any. Once approved by CMS, the state must post the final Interim Evaluation Report to the state's Medicaid website within 30 calendar days.

e. The Interim Evaluation Report must comply with Attachment B of these STCs.

13.8. **Summative Evaluation Report.** The state must submit a draft Summative Evaluation Report for the demonstration's current approval period within 18 months of the end of the approval period represented by these STCs. The draft Summative Evaluation Report must be developed in accordance with Attachment B of these STCs, and in alignment with the approved Evaluation Design.

a. The state must submit a revised Summative Evaluation Report within 60 calendar days of receiving comments from CMS of the draft.

b. Once approved by CMS, the state must post the final Summative Evaluation Report to the state's Medicaid website within 30 calendar days.

13.9. **Corrective Action Plan Related to Evaluation.** If evaluation findings indicate that demonstration features are not likely to assist in promoting the objectives of Medicaid, CMS reserves the right to require the state to submit a corrective action plan to CMS for approval. These discussions may also occur as part of an extension process when associated with the state's Interim Evaluation Report, or as part of the review of the Summative Evaluation Report. A corrective action plan could include a temporary suspension of implementation of demonstration programs, in circumstances where evaluation findings indicate substantial and sustained directional change inconsistent with demonstration goals, such as substantial and sustained trends indicating increased difficulty accessing services. A corrective action plan may be an interim step to withdrawing waivers or expenditure authorities, as outlined in STC 3.11. CMS further has the ability to suspend implementation of the demonstration should corrective actions not effectively resolve these concerns in a timely manner.

13.10. **State Presentations for CMS.** CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the Interim Evaluation, and/or the Summative Evaluation.

13.11. **Public Access.** The state shall post the final documents (e.g., Implementation Plan, Monitoring Protocol, Monitoring Reports, Mid-Point Assessment, Close Out Report, approved Evaluation Design, Interim Evaluation Report, and Summative Evaluation Report) on the state's Medicaid website within 30 days of approval by CMS.

13.12. **Additional Publications and Presentations**. For a period of 12 months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given 30 calendar days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews.

14. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

14.1. **Allowable Expenditures.** This demonstration project is approved for authorized demonstration expenditures applicable to services rendered and for costs incurred during the demonstration approval period designated by CMS. CMS will provide FFP for allowable

demonstration expenditures only so long as they do not exceed the pre-defined limits as specified in these STCs.

14.2. **Standard Medicaid Funding Process.** The standard Medicaid funding process will be used for this demonstration. The state will provide quarterly expenditure reports through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES) to report total expenditures under this Medicaid Section 1115 demonstration following routine CMS-37 and CMS-64 reporting instructions as outlined in Section 2500 of the State Medicaid Manual. The state will estimate matchable demonstration expenditures (total computable and federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each federal fiscal year on the form CMS-37 for both the medical assistance payments (MAP) and state and local administration costs (ADM). 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 shall submit form CMS-64 Quarterly Medicaid Expenditure Report, showing Medicaid expenditures made in the quarter just ended. If applicable, subject to the payment deferral process, CMS shall reconcile expenditures reported on 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.

14.3. **Sources of Non-Federal Share.** As a condition of demonstration approval, the state certifies that its funds that make up the non-federal share are obtained from permissible state and/or local funds that, unless permitted by law, are not other federal funds. The state further certifies that federal funds provided under this section 1115 demonstration must not be used as the non-federal share required under any other federal grant or contract, except as permitted by law. CMS approval of this demonstration does not constitute direct or indirect approval of any underlying source of non-federal share or associated funding mechanisms and all sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable implementing regulations. CMS reserves the right to deny FFP in expenditures for which it determines that the sources of non-federal share are impermissible.

a. If requested, the state must submit for CMS review and approval documentation of any sources of non-federal share that would be used to support payments under the demonstration.

b. If CMS determines that any funding sources are not consistent with applicable federal statutes or regulations, the state must address CMS's concerns within the time frames allotted by CMS.

c. Without limitation, CMS may request information about the non-federal share sources for any amendments that CMS determines may financially impact the demonstration.

14.4. **State Certification of Funding Conditions.** As a condition of demonstration approval, the state certifies that the following conditions for non-federal share financing of demonstration expenditures have been met:

a. If units of state or local government, including health care providers that are units of state or local government, supply any funds used as non-federal share for expenditures under the demonstration, the state must certify that state or local monies have been expended as the non-federal share of funds under the demonstration in accordance with Section 1903(w) of the Act and applicable implementing regulations.

b. To the extent the state utilizes certified public expenditures (CPE) as the funding mechanism for the non-federal share of expenditures under the demonstration, the state must obtain CMS approval for a cost reimbursement methodology. This methodology must include a detailed explanation of the process, including any necessary cost reporting protocols, by which the state identifies those costs eligible for purposes of certifying public expenditures. The certifying unit of government that incurs costs authorized under the demonstration must certify to the state the amount of public funds allowable under 42 CFR 433.51 it has expended. The FFP paid to match CPEs may not be used as the non-federal share to obtain additional federal funds, except as authorized by federal law, consistent with 42 CFR 433.51(c).

c. The state may use intergovernmental transfers (IGT) to the extent that the transferred funds are public funds within the meaning of 42 CFR 433.51 and are transferred by units of government within the state. Any transfers from units of government to support the non-federal share of expenditures under the demonstration must be made in an amount not to exceed the non-federal share of the expenditures under the demonstration.

d. Under all circumstances, health care providers must retain 100 percent of their payments for or in connection with furnishing covered services to beneficiaries. Moreover, no pre-arranged agreements (contractual, voluntary, or otherwise) may exist between health care providers and state and/or local governments, or third parties to return and/or redirect to the state any portion of the Medicaid payments in a manner inconsistent with the requirements in Section 1903(w) of the Act and its implementing regulations. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, including health care provider-related taxes, fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

e. The State Medicaid Director or his/her designee certifies that all state and/or local funds used as the state's share of the allowable expenditures reported on the CMS-64 for this demonstration were in accordance with all applicable federal requirements and did not lead to the duplication of any other federal funds.

14.5. **Financial Integrity for Managed Care Delivery Systems.** As a condition of demonstration approval, the state attests to the following, as applicable:

a. All risk-based managed care organization, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) payments, comply with the requirements on payments in 42 CFR 438.6(b)(2), 438.6(c), 438.6(d), 438.60, and 438.74.

14.6. **Requirements for Health Care-Related Taxes and Provider Donations.** As a condition of demonstration approval, the state attests to the following, as applicable:

a. Except as provided in paragraph (c) of this STC, all health care-related taxes as defined by Section 1903(w)(3)(A) of the Act and 42 CFR 433.55 are broad-based as defined by Section 1903(w)(3)(B) of the Act and 42 CFR 433.68(c).

b. Except as provided in paragraph (c) of this STC, all health care-related taxes are uniform as defined by Section 1903(w)(3)(C) of the Act and 42 CFR 433.68(d).

c. If the health care-related tax is either not broad-based or not uniform, the state has applied for and received a waiver of the broad-based and/or uniformity requirements as specified by 1903(w)(3)(E)(i) of the Act and 42 CFR 433.72.

d. The tax does not contain a hold harmless arrangement as described by Section 1903(w)(4) of the Act and 42 CFR 433.68(f).

e. All provider-related donations as defined by 42 CFR 433.52 are bona fide as defined by Section 1903(w)(2)(B) of the Act, 42 CFR 433.66, and 42 CFR 433.54.

14.7. **State Monitoring of Non-federal Share.** If any payments under the demonstration are funded in whole or in part by a locality tax, then the state must provide a report to CMS regarding payments under the demonstration no later than 60 days after demonstration approval. This deliverable is subject to the deferral as described in STC 12.2. This report must include:

a. A detailed description of and a copy of (as applicable) any agreement, written or otherwise agreed upon, regarding any arrangement among the providers including those with counties, the state, or other entities relating to each locality tax or payments received that are funded by the locality tax;

b. Number of providers in each locality of the taxing entities for each locality tax;

c. Whether or not all providers in the locality will be paying the assessment for each locality tax;

d. The assessment rate that the providers will be paying for each locality tax;

e. Whether any providers that pay the assessment will not be receiving payments funded by the assessment;

f. Number of providers that receive at least the total assessment back in the form of Medicaid payments for each locality tax;

g. The monitoring plan for the taxing arrangement to ensure that the tax complies with Section 1903(w)(4) of the Act and 42 CFR 433.68(f); and

h. Information on whether the state will be reporting the assessment on the CMS form 64.11A as required under Section 1903(w) of the Act.

14.8. **Extent of Federal Financial Participation for the Demonstration.** Subject to CMS approval of the source(s) of the non-federal share of funding, CMS will provide FFP at the applicable federal matching rate for the following demonstration expenditures, subject to the budget neutrality expenditure limits described in the STCs in Section 15:

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 Medicaid state plan; and

c. Medical assistance expenditures and prior period adjustments made under Section 1115 demonstration authority with dates of service during the demonstration extension period; including those made in conjunction with the demonstration, net of enrollment fees, cost sharing, pharmacy rebates, and all other types of third-party liability.

14.9. **Program Integrity.** The state must have processes in place to ensure there is no duplication of federal funding for any aspect of the demonstration. The state must also ensure that the state and any of its contractors follow standard program integrity principles and practices including retention of data. All data, financial reporting, and sources of non-federal share are subject to audit.

14.10. **Medicaid Expenditure Groups.** Medicaid Expenditure Groups (MEG) are defined for the purpose of identifying categories of Medicaid or demonstration expenditures subject to budget neutrality, components of budget neutrality expenditure limit calculations, and other purposes related to monitoring and tracking expenditures under the demonstration. The Master MEG Chart table provides a master list of MEGs defined for this demonstration.

Table D: Master MEG Chart

MEG	Which BN Test Applies?	WOW Per Capita	WOW Aggregate	WW	Brief Description
Title XIX	**Main**	**X**		**X**	Individuals classified as Title XIX in Table A
ABD	**Main**	**X**		**X**	Individuals classified as ABD in Table A
LTC	**Main**	**X**		**X**	Individuals classified as LTC in Table A
HCBS – State Plan	**Main**	**X**		**X**	Individuals classified as HCBS State Plan in Table A

Community Health Worker Pilot	**Main**			**X**	Expenditures for the state's community health workers program pilot to provide evidence-based services within defined communities
Home Visiting Pilot	**Main**			**X**	Expenditures under the New Jersey Home Visiting Pilot Program
BH PIP	**Main**			**X**	Expenditures for the state's BH PIP incentive program that will strengthen Medicaid providers' ability to participate in the state's health information exchange (HIE)
Financial Eligibility (OPG)	**Main**			**X**	Expenditures for health-care related costs up to 12 months for individuals under the guardianship of the OPG during the expedited eligibility determination period
IDD at Risk	**Hypo 8**	**X**		**X**	Children in the CSSP IDD program who are not eligible under state plan, and who have incomes of more than 300% of FBR.
SED at Risk	**Hypo 8**	**X**		**X**	Children in the CSSP SED program who are not eligible under state plan, and who have incomes of more than 300% of FBR.
ADM	**N/A**				All additional administrative costs that are directly attributable to the demonstration and are not described elsewhere and are not subject to budget neutrality.
HCBS – 217 Like	**Hypo 2**	**X**		**X**	Individuals enrolled in MLTSS who live in the community and are not eligible under state plan.

SED – 217 Like	**Hypo 2**	**X**		**X**	Children in the SED program who are not eligible under state plan, and who have incomes of 300% of FBR or less.
IDD – 217 Like	**Hypo 2**	**X**		**X**	Children in the IDD program who are not eligible under state plan, and who have incomes of 300% of FBR or less.
New Adult Group	**Hypo 3**	**X**		**X**	Affordable Care Act new adult group, described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119
SUD IMD Services MEG 1	**Hypo 1**	**X**		**X**	All expenditures for costs of medical assistance that could be covered, were it not for the IMD prohibition under the state plan, provided to otherwise eligible individuals during a month in an IMD including no less than 8 hours per week of counseling services on at least five (5) separate occasions. A minimum of seven (7) hours per day of structured activities must be provided on each billable day.
SUD IMD Services MEG 2	**Hypo 1**	**X**		**X**	All expenditures for costs of medical assistance that could be covered, were it not for the IMD prohibition under the state plan provided to otherwise eligible individuals during a month in which they were in an IMD including no less than twelve (12) hours per week of counseling services on at least six (6) separate occasions

SUD IMD Services MEG 3	**Hypo 1**	**X**		**X**	All expenditures for costs of medical assistance that could be covered, were it not for the IMD prohibition under the state plan provided to otherwise eligible individuals during a month in an IMD for care of withdrawal signs and symptoms that are sufficiently severe to require 24-hour medical monitoring care. Detoxification includes a minimum of two (2) hours per week of counseling services
Postpartum Extension	**Hypo 4**	**X**		**X**	Expenditures for Medicaid members in a pregnancy eligibility group from the end of the month in which the 60th postpartum day occurs to the end of the 12th month following the end of the pregnancy
Caregiver Supports - Respite	**Hypo 5**	**X**		**X**	Expenditures to expand access to health services for informal or unpaid caregivers to receive respite services that are being newly authorized with the demonstration extension (31 days to 90 days)
Caregiver Supports - Therapy	**Hypo 5**	**X**		**X**	Expenditures to expand access to health services for informal or unpaid caregivers to receive services as defined in the STCs when experiencing emotional or psychological difficulties while caring for individuals receiving MLTSS

Continuous Eligibility – New Adult Group	**Hypo 6**	**X**		**X**	Expenditures for continued benefits for individuals who have been determined eligible under groups specified in STC 5.16.
Continuous Eligibility – Title XIX	**Hypo 6**	**X**		**X**	Expenditures for continued benefits for individuals who have been determined eligible under groups specified in STC 5.16.
Hypo - Community Care Program	**Hypo 7**	**X**		**X**	Expenditures for health-care related costs for individuals in the Community Care Program
Hypo - Supports	**Hypo 8**	**X**		**X**	Expenditures for health-related cost for individuals in the Supports Program
Autism Adjunct Pilot	**Hypo 9**	**X**		**X**	Expenditures for specialized services that are not otherwise covered under the Medicaid state plan for children who are Medicaid eligible and have been diagnosed with Autism Spectrum Disorder (ASD).
HRSN Services	**Capped Hypo 10**		**X**	**X**	All expenditures for certain HRSN initiatives.
HRSN Infrastructure	**Capped Hypo 10**		**X**	**X**	All infrastructure expenditures for certain HRSN initiatives.

14.11. **Reporting Expenditures and Member Months.** The state must report all demonstration expenditures claimed under the authority of title XIX of the Act and subject to budget neutrality each quarter on separate forms CMS-64.9 WAIVER and/or 64.9P WAIVER, identified by the demonstration project number assigned by CMS (11-W- 00279/2). Separate reports must be submitted by MEG (identified by Waiver Name) and Demonstration Year (identified by the two-digit project number extension). Unless specified otherwise, expenditures must be reported by DY according to the dates of service associated with the expenditure. All MEGs identified in the Master MEG Chart as WW must be reported for expenditures, as further detailed in the MEG Detail for Expenditure and Member Month Reporting table below. To enable calculation of the budget neutrality expenditure limits, the state also must report member months of eligibility for specified MEGs.

a. **Cost Settlements**. The state will report any cost settlements attributable to the demonstration on the appropriate prior period adjustment schedules (form CMS-64.9P WAIVER) for the summary sheet line 10b (in lieu of lines 9 or 10c), or line 7. For any cost settlement not attributable to this demonstration, the adjustments should be reported as otherwise instructed in the State Medicaid Manual. Cost settlements must be reported by DY consistent with how the original expenditures were reported.

b. **Premiums and Cost Sharing Collected by the State.** The state will report any premium contributions collected by the state from demonstration enrollees quarterly on the form CMS-64 Summary Sheet line 9D, columns A and B. In order to assure that these collections are properly credited to the demonstration, quarterly premium collections (both total computable and federal share) should also be reported separately by demonstration year on form CMS-64 Narrative, and on the Total Adjustments tab in the Budget Neutrality Monitoring Tool. In the annual calculation of expenditures subject to the budget neutrality expenditure limit, premiums collected in the demonstration year will be offset against expenditures incurred in the demonstration year for determination of the state's compliance with the budget neutrality limits.

c. **Pharmacy Rebates.** Because pharmacy rebates are included in the base expenditures used to determine the budget neutrality expenditure limit, the state must report the portion of pharmacy rebates applicable to the demonstration on the appropriate forms CMS-64.9 WAIVER and 64.9P waiver for the demonstration, and not on any other CMS-64.9 form (to avoid double counting). The state must have a methodology for assigning a portion of pharmacy rebates to the demonstration in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the demonstration population, and which identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. Each rebate amount must be distributed as state and federal revenue consistent with the federal matching rates under which the claim was paid.

d. **Administrative Costs.** The state will separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the forms CMS-64.10 WAIVER and/or 64.10P WAIVER. Unless indicated otherwise on the MEG Charts and in the STCs in Section 14, administrative costs are not counted in the budget neutrality tests; however, these costs are subject to monitoring by CMS.

e. **Member Months.** As part of the Quarterly and Annual Monitoring Reports described in Section XI, the state must report the actual number of "eligible member months" for all demonstration enrollees for all MEGs identified as WOW Per Capita in the Master MEG Chart table above, and as also indicated in the MEG Detail for Expenditure and Member Month Reporting table below. The term "eligible member months" refers to the number of months in which persons enrolled in the demonstration are eligible to receive services. For example, a person who is eligible for three months contributes three eligible member months to the total. Two individuals who are eligible for two

months each contribute two eligible member months per person, for a total of four eligible member months. The state must submit a statement accompanying the annual report certifying the accuracy of this information.

f. **Budget Neutrality Specifications Manual.** The state will create and maintain a Budget Neutrality Specifications Manual that describes in detail how the state will compile data on actual expenditures related to budget neutrality, including methods used to extract and compile data from the state's Medicaid Management Information System, eligibility system, and accounting systems for reporting on the CMS-64, consistent with the terms of the demonstration. The Budget Neutrality Specifications Manual will also describe how the state compiles counts of Medicaid member months. The Budget Neutrality Specifications Manual must be made available to CMS on request.

Table E: MEG Detail for Expenditure and Member Month Reporting

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
SUD 1	Report all medical assistance expenditures for services provided to an individual while they are a patient in an IMD for SUD treatment described in Table B of Section 5.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	07/01/2017	06/30/2028
SUD 2	Report all medical assistance expenditures for services provided to an individual while they are a patient in an IMD for SUD treatment described in Table B of Section 5.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	07/01/2017	06/30/2028
SUD 3	Report all medical assistance expenditures for services provided to an individual while they are a patient in an IMD for SUD treatment described in Table B of Section 5.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	07/01/2017	06/30/2028

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
HRSN Services	Report all expenditures for approved HRSN initiatives		Follow standard CMS 64.9 or 64.10 Category of Service Definitions	Date of service	MAP/ ADM	N	07/01/2023	06/30/2028
HRSN Infrastructure	Report all infrastructure expenditures for approved HRSN initiatives		Follow standard CMS 64.10 Category of Service Definitions	Date of service	ADM	N	07/01/2023	06/30/2028
Autism Adjunct Pilot	Report all expenditures for specialized services that are not otherwise covered under the Medicaid state plan for children who are Medicaid eligible and have been diagnosed with Autism Spectrum Disorder (ASD).		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	01/01/2024	06/30/2028
Continuous Eligibility - Title XIX	Report on expenditures for continued benefits for individuals who have been determined eligible under groups specified under STC 5.16		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	01/01/2024	06/30/2028
Continuous Eligibility - New Adult Group	Report on expenditures for continued benefits for individuals who have been determined eligible under groups specified under STC 5.16		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	01/01/2024	06/30/2028

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
BH PIP	Report on expenditures for the state's BH PIP incentive program		Follow standard 64.10 Category of Service Definitions	Date of service	ADM	N	07/01/2023	06/30/2028
Caregiver Support - Therapy	Report on expenditures related to health services provided to informal or unpaid caregivers experiencing emotional or psychological difficulties while caring for individuals receiving MLTSS		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	01/01/2024	06/30/2028
Caregiver Supports - Respite	Report on expenditures for respite services provided to informal or unpaid caregivers that are being newly authorized with the demonstration extension (31 days to 60 days).		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	07/01/2023	06/30/2028
ADM	Report all additional administrative costs that are directly attributable to the demonstration, are not described elsewhere, and are not subject to budget neutrality		Follow standard CMS 64.10 Category of Service Definitions	Date of payment	ADM	N	10/1/2012	06/30/2028
Title XIX	Individuals classified as Title XIX in Table A		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	10/1/2012	06/30/2028

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
New Adult Group	Affordable Care Act new adult group, described in 1902(a)(10)(A)(i)(VIII) and 42 CFR 435.119		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	7/1/2013	06/30/2028
ABD	Individuals classified as ABD in Table A		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	10/1/2012	06/30/2028
LTC	Individuals classified as LTC in Table A		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	10/1/2012	06/30/2028
HCBS – State Plan	Individuals classified as HCBS State Plan in Table A		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	10/1/2012	06/30/2028
HCBS – 217 Like	Individuals enrolled in MLTSS who live in the community and are not eligible under state plan.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	10/1/2012	06/30/2028
SED – 217 Like	Reports on children in the SED program who are not eligible under state plan, and who have incomes of 300% of FBR or less.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	10/1/2012	06/30/2028

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
IDD – 217 Like	Reports on children in the IDD program who are not eligible under state plan, and who have incomes of 300% of FBR or less.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	10/1/2012	06/30/2028
Postpartum	Reports on expenditures for Medicaid members in a pregnancy eligibility group from the end of the month in which the 60th postpartum day occurs to the end of the 12th month following the end of the pregnancy		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	10/28/2021	06/30/2028
Community Health Worker Pilot	Report on expenditures for the state's community health workers program pilot to provide evidence-based services within defined communities		Follow standard CMS 64.9 or 64.10 Category of Service Definitions	Date of service	MAP/ ADM	N	01/01/2024	06/30/2028
Home Visiting Pilot	Report on expenditures under the New Jersey Home Visiting Pilot Program		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	1/1/2024	06/30/2028
Hypo Community Care Program	Report on expenditures for health-care related costs for individuals in the Community Care Program		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	4/1/2023	06/30/2028

MEG (Waiver Name)	Detailed Description	Exclusions	CMS-64.9 or 64.10 Line(s) To Use	How Expend. Are Assigned to DY	MAP or ADM	Report Member Months (Y/N)	MEG Start Date	MEG End Date
Financial Eligibility (OPG)	Report on expenditures for health-care related costs up to 12 months for individuals under the guardianship of the OPG during the expedited eligibility determination period		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	7/1/2019	06/30/2028
Hypo Supports	Report on expenditures for health-related cost for individuals in the Supports Program		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	4/1/2023	06/30/2028
Hypo IDD at Risk	Report on children in the CSSP IDD program who are not eligible under state plan, and who have incomes of more than 300% of FBR.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	4/1/2023	06/30/2028
Hypo SED at Risk	Report on children in the CSSP SED program who are not eligible under state plan, and who have incomes of more than 300% of FBR.		Follow standard CMS 64.9 Category of Service Definitions	Date of service	MAP	Y	4/1/2023	06/30/2028

ADM – administration; DY – demonstration year; MAP – medical assistance payments; MEG – Medicaid expenditure group;

14.12. **Demonstration Years**. Demonstration Years (DY) for this demonstration are defined in the table below.

Table F: Demonstration Years		
Demonstration Year 11	July 1, 2022 to March 31, 2023	9 months
Demonstration Year 12	April 1, 2023 to June 30, 2023	3 months
Demonstration Year 13	July 1, 2023 to June 30, 2024	12 months
Demonstration Year 14	July 1, 2024 to June 30, 2025	12 months
Demonstration Year 15	July 1, 2025 to June 30, 2026	12 months
Demonstration Year 16	July 1, 2026 to June 30, 2027	12 months
Demonstration Year 17	July 1, 2027 to June 30, 2028	12 months

14.13. **Calculating the Federal Medical Assistance Percentage (FMAP) for Continuous Eligibility for the Adult Group.** Because not all "newly eligible" individuals in the Adult Group as defined in 42 CFR 433.204(a)(1) would be eligible for the entire continuous eligibility period if the state conducted redeterminations, CMS has determined a percentage of expenditures for individuals defined in 42 CFR 433.204(a)(1) will be matched at the state's regular Title XIX FMAP rate. After approval of these authorities, the state must submit for CMS approval, a protocol specifying its proposed methodology for calculating this percentage (Attachment T). The state must submit the Continuous Eligibility Calculation Methodology Protocol at least 90 days prior to the implementation of Continuous Eligibility, and the state may not implement Continuous Eligibility for the Adult Group until the protocol has been approved by CMS.

14.14. **State Reporting for the Continuous Eligibility FMAP Adjustment.** A reduced percentage of expenditures for "newly eligible" individuals in the Adult Group as defined in 42 CFR 433.204(a)(1) shall be claimed at the "newly eligible" FMAP rate as defined in 42 CFR 433.10(c)(6), as described in STC 14.13 above. The state must make adjustments on the applicable CMS-64 waiver forms to claim the remaining percent or other applicable percentage of expenditures for individuals defined in 42 CFR 433.204(a)(1) at the state's regular Title XIX FMAP rate.

14.15. **Budget Neutrality Monitoring Tool.** The state must provide CMS with quarterly budget neutrality status updates, including established baseline and member months data, using the Budget Neutrality Monitoring Tool provided through the performance metrics database and analytics (PMDA) system. The tool incorporates the "Schedule C Report" for comparing the

demonstration's actual expenditures to the budget neutrality expenditure limits described in Section 2. CMS will provide technical assistance, upon request.[5]

14.16. **Claiming Period.** The state will report all claims for expenditures subject to the budget neutrality agreement (including any cost settlements) within two years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within two years after the conclusion or termination of the demonstration. During the latter two-year period, the state will continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

14.17. **Future Adjustments to Budget Neutrality.** CMS reserves the right to adjust the budget neutrality expenditure limit:

a. To be consistent with enforcement of laws and policy statements, including regulations and guidance, regarding impermissible provider payments, health care related taxes, or other payments. CMS reserves the right to make adjustments to the budget neutrality limit if any health care related tax that was in effect during the base year, or provider-related donation that occurred during the base year, is determined by CMS to be in violation of the provider donation and health care related tax provisions of Section 1903(w) of the Act. Adjustments to annual budget targets will reflect the phase out of impermissible provider payments by law or regulation, where applicable.

b. To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in FFP for expenditures made under this demonstration. In this circumstance, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change. The trend rates for the budget neutrality agreement are not subject to change under this STC. The state agrees that if mandated changes in the federal law require state legislation, the changes shall take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the federal law.

The state certifies that the data it provided to establish the budget neutrality expenditure limit are accurate based on the state's accounting of recorded historical expenditures or the next best available data, that the data are allowable in accordance with applicable federal, state, and local statutes, regulations, and policies, and that the

[5] Per 42 CFR 431.420(a)(2), states must comply with the terms and conditions of the agreement between the Secretary (or designee) and the state to implement a demonstration project, and 431.420(b)(1) states that the terms and conditions will provide that the state will perform periodic reviews of the implementation of the demonstration. CMS's current approach is to include language in STCs requiring, as a condition of demonstration approval, that states provide, as part of their periodic reviews, regular reports of the actual costs which are subject to the budget neutrality limit. CMS has obtained Office of Management and Budget (OMB) approval of the monitoring tool under the Paperwork Reduction Act (OMB Control No. 0938 – 1148) and states agree to use the tool as a condition of demonstration approval.

data are correct to the best of the state's knowledge and belief. The data supplied by the state to set the budget neutrality expenditure limit are subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit.

14.18. **Budget Neutrality Mid-Course Correction Adjustment Request.** No more than once per demonstration year, the state may request that CMS make an adjustment to its budget neutrality agreement based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

a. **Contents of Request and Process**. In its request, the state must provide a description of the expenditure changes that led to the request, together with applicable expenditure data demonstrating that due to these expenditures, the state's actual costs have exceeded the budget neutrality cost limits established at demonstration approval. The state must also submit the budget neutrality update described in STC 14.16.c. If approved, an adjustment could be applied retrospectively to when the state began incurring the relevant expenditures, if appropriate. Within 120 days of acknowledging receipt of the request, CMS will determine whether the state needs to submit an amendment pursuant to STC 3.7. CMS will evaluate each request based on its merit and will approve requests when the state establishes that an adjustment to its budget neutrality agreement is necessary due to changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside of the state's control, and/or that result from a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

b. **Types of Allowable Changes.** Adjustments will be made only for actual costs as reported in expenditure data. CMS will not approve mid-demonstration adjustments for anticipated factors not yet reflected in such expenditure data. Examples of the types of mid-course adjustments that CMS might approve include the following:

i. Provider rate increases that are anticipated to further strengthen access to care;

ii. CMS or state technical errors in the original budget neutrality formulation applied retrospectively, including, but not limited to the following: mathematical errors, such as not aging data correctly; or unintended omission of certain applicable costs of services for individual MEGs;

iii. Changes in federal statute or regulations, not directly associated with Medicaid, which impact expenditures;

iv. State legislated or regulatory change to Medicaid that significantly affects the costs of medical assistance;

v. When not already accounted for under Emergency Medicaid 1115 demonstrations, cost impacts from public health emergencies;

vi. High cost innovative medical treatments that states are required to cover; or

vii. Corrections to coverage/service estimates where there is no prior state experience (e.g., SUD) or small populations where expenditures may vary widely.

c. **Budget Neutrality Update.** The state must submit an updated budget neutrality analysis with its adjustment request, which includes the following elements:

i. Projected without waiver and with waiver expenditures, estimated member months, and annual limits for each DY through the end of the approval period; and

ii. Description of the rationale for the mid-course correction, including an explanation of why the request is based on changes to the state's Medicaid expenditures that are unrelated to the demonstration and/or outside the state's control, and/or is due to a new expenditure that is not a new demonstration-covered service or population and that is likely to further strengthen access to care.

15. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

15.1. **Limit on Title XIX Funding.** The state will be subject to limits on the amount of federal Medicaid funding the state may receive over the course of the demonstration approval. The budget neutrality expenditure limits are based on projections of the amount of FFP that the state would likely have received in the absence of the demonstration. The limit consists of a Main Budget Neutrality Test, one or more Hypothetical Budget Neutrality Tests, and a Capped Hypothetical Budget Neutrality Test, as described below. CMS's assessment of the state's compliance with these tests will be based on the Schedule C CMS-64 Waiver Expenditure Report, which summarizes the expenditures reported by the state on the CMS-64 that pertain to the demonstration.

15.2. **Risk.** The budget neutrality expenditure limits are determined on either a per capita or aggregate basis as described in Table D, Master MEG Chart and Table E, MEG Detail for Expenditure and Member Month Reporting. If a per capita method is used, the state is at risk for the per capita cost for state plan and hypothetical populations, but not for the number of participants in the demonstration population. By providing FFP without regard to enrollment in the demonstration for all demonstration populations, CMS will not place the state at risk for changing economic conditions; however, by placing the state at risk for the per capita costs of the demonstration populations, CMS assures that the demonstration expenditures do not exceed the levels that would have been realized had there been no demonstration. If an aggregate method is used, the state accepts risk for both enrollment and per capita costs.

15.3. **Calculation of the Budget Neutrality Limits and They Are Applied.** To calculate the budget neutrality limits for the demonstration, separate annual budget limits are determined for each DY on a total computable basis. Each annual budget limit is the sum of one or more components: per capita components, which are calculated as a projected without-waiver PMPM cost times the corresponding actual number of member months, and aggregate components, which project fixed total computable dollar expenditure amounts.

The annual limits for all DYs are then added together to obtain a budget neutrality limit for the entire demonstration period. The federal share of this limit will represent the maximum amount of FFP that the state may receive during the demonstration period for the types of demonstration expenditures described below. The federal share will be calculated by multiplying the total computable budget neutrality expenditure limit by the appropriate Composite Federal Share.

15.4. **Main Budget Neutrality Test**. The Main Budget Neutrality Test allows the state to show that approval of the demonstration has not resulted in Medicaid costs to the federal government that are greater than what the federal government's Medicaid costs would likely have been absent the demonstration, and that federal Medicaid "savings" have been achieved sufficient to offset the additional projected federal costs resulting from expenditure authority. The table below identifies the MEGs that are used for the Main Budget Neutrality Test. MEGs designated as "WOW Only" or "Both" are components used to calculate the budget neutrality expenditure limit. MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against the budget neutrality expenditure limit. In addition, any expenditures in excess of the limit from Hypothetical Budget Neutrality Tests count as expenditures under the Main Budget Neutrality Test. However, excess expenditures from the Capped Hypothetical Budget Neutrality Test do not count as expenditures under the Main Budget Neutrality Test. The state is at risk for any amount over the capped hypothetical amount. The Composite Federal Share for this test is calculated based on all MEGs indicated as "Both."

Table G: Main Budget Neutrality Test

MEG	PC or Agg *	WOW Only, WW Only, or BOTH	Trend Rate	DY 12	DY 13	DY 14	DY 15	DY 16	DY 17
Title XIX	PC	Both	4.8%	$391.14	$402.77	$422.10	$442.36	$463.59	$485.84
ABD	PC	Both	4.5%	$1,316.74	$1,353.47	$1,414.38	$1,478.03	$1,544.54	$1,614.04
LTC	PC	Both	6.2%	$6,987.06	$7,254.75	$7,704.54	$8,182.22	$8,689.52	$9,228.27

Table G: Main Budget Neutrality Test									
MEG	**PC or Agg ***	**WOW Only, WW Only, or BOTH**	**Trend Rate**	**DY 12**	**DY 13**	**DY 14**	**DY 15**	**DY 16**	**DY 17**
HCBS – State Plan	PC	Both	6.2%	$5,481.38	$5,691.38	$6,044.25	$6,418.99	$6,816.97	$7,239.62
Home Visiting Pilot	Agg	WW	3%	$375,000	$1,511,250	$1,556,588	$1,603,285	$1,651,384	$1,700,925
BH PIP	Agg	WW	0%	$0	$ 6,000,000	$ 6,000,000	$ 6,000,000	$ 6,000,000	$ 6,000,000
Financial Eligibility (OPG)	Agg	WW	3%	$149,798	$603,686	$621,797	$640,450	$659,664	$679,454
Community Health Worker Pilot	Agg	WW	0%	$0	$ 5,000,000	$ 5,000,000	$ 5,000,000	$ 5,000,000	$ 5,000,000

15.5. **Hypothetical Budget Neutrality.** When expenditure authority is provided for coverage of populations or services that the state could have otherwise provided through its Medicaid state plan or other title XIX authority (such as a waiver under Section 1915 of the Act), or when a WOW spending baseline for certain WW expenditures is difficult to estimate due to variable and volatile cost data resulting in anomalous trend rates, CMS considers these expenditures to be "hypothetical," such that the expenditures are treated as if the state could

have received FFP for them absent the demonstration. For these hypothetical expenditures, CMS makes adjustments to the budget neutrality test which effectively treats these expenditures as if they were for approved Medicaid state plan services. Hypothetical expenditures, therefore, do not necessitate savings to offset the expenditures on those services. When evaluating budget neutrality, however, CMS does not offset non-hypothetical expenditures with projected or accrued savings from hypothetical expenditures; that is, savings are not generated from a hypothetical population or service. To allow for hypothetical expenditures, while preventing them from resulting in savings, CMS currently applies separate, independent Hypothetical Budget Neutrality Tests, which subject hypothetical expenditures to pre-determined limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If the state's WW hypothetical spending exceeds the Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to offset that excess spending through savings elsewhere in the demonstration or to refund the FFP to CMS.

15.6. **Hypothetical Budget Neutrality Test 1: SUD.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 1. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 1 are counted as WW expenditures under the Main Budget Neutrality Test.

Table H: Hypothetical Budget Neutrality Test 1									
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 12**	**DY 13**	**DY 14**	**DY 15**	**DY 16**	**DY17**
SUD 1	PC	Both	5.5%	$5,462.67	$5,648.56	$5,959.23	$6,286.99	$6,632.77	$6,997.57
SUD 2	PC	Both	5.5%	$3,584.20	$3,706.17	$3,910.01	$4,125.06	$4,351.94	$4,591.30
SUD 3	PC	Both	5.5%	$3,268.03	$3,379.24	$3,565.10	$3,761.18	$3,968.04	$4,186.28

15.7. **Hypothetical Budget Neutrality Test 2: HCBS-like Eligibility Groups.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 2. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 2 are counted as WW expenditures under the Main Budget Neutrality Test.

Table I: Hypothetical Budget Neutrality Test 2									
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 12**	**DY 13**	**DY 14**	**DY 15**	**DY 16**	**DY 17**
HCBS	PC	Both	6.2 %	$5,031.41	$5,224.17	$5,548.07	$5,892.05	$6,257.36	$6,645.32
SED	PC	Both	5%	$4,638.35	$4,781.97	$5,021.07	$5,272.12	$5,535.73	$5,812.52
IDD/MI	PC	Both	4.9 %	$4,963.27	$5,113.90	$5,364.48	$5,627.34	$5,903.08	$6,192.33

15.8. **Hypothetical Budget Neutrality Test 3: New Adult Group.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 3. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 3 are counted as WW expenditures under the Main Budget Neutrality Test.

Table J: Hypothetical Budget Neutrality Test 3									
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 12–PMPM**	**DY 13 PMPM**	**DY 14 PMPM**	**DY 15 PMPM**	**DY 16 PMPM**	**DY 17 PMPM**
New Adult Group	PC	Both	5.5%	$643.94	$665.85	$702.47	$741.11	$781.87	$824.87

15.9. **Hypothetical Budget Neutrality Test 4: Postpartum Extension.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 4. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 3 are counted as WW expenditures under the Main Budget Neutrality Test.

Table K: Hypothetical Budget Neutrality Test 4									
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 12 PMPM**	**DY 13 PMPM**	**DY 14 PMPM**	**DY 15 PMPM**	**DY 16 PMPM**	**DY 17 PMPM**
Postpartum Extension	PC	Both	5.1%	$428.00	$441.52	$464.04	$487.71	$512.58	$538.72

15.10. **Hypothetical Budget Neutrality Test 5: Caregiver Supports**. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 5. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 5 are counted as WW expenditures under the Main Budget Neutrality Test.

Table L: Hypothetical Budget Neutrality Test 5									
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 12 PMPM**	**DY 13 PMPM**	**DY 14 PMPM**	**DY 15 PMPM**	**DY 16 PMPM**	**DY 17 PMPM**
Caregiver Supports – Respite	PC	Both	4.5%	$4,600.00	$4,728.31	$4,941.08	$5,163.43	$5,395.78	$5,638.59
Caregiver Supports - Therapy	PC	Both	4.5%	$200.00	$205.58	$214.83	$224.50	$234.60	$245.16

15.11. **Hypothetical Budget Neutrality Test 6: Continuous Eligibility**. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 6. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 6 are counted as WW expenditures under the Main Budget Neutrality Test.

Table M: Hypothetical Budget Neutrality Test 6									
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 12 PMPM**	**DY 13 PMPM**	**DY 14 PMPM**	**DY 15 PMPM**	**DY 16 PMPM**	**DY 17 PMPM**
Continuous Eligibility – Title XIX	PC	Both	4.8%	$391.14	$402.77	$422.10	$442.36	$463.59	$485.84
Continuous Eligibility – New Adult Group	PC	Both	5.5%	$643.94	$665.85	$702.47	$741.11	$781.87	$824.87

15.12. **Hypothetical Budget Neutrality Test 7: Community Care Program**. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 7. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 7 are counted as WW expenditures under the Main Budget Neutrality Test.

Table N: Hypothetical Budget Neutrality Test 7									
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 12 PMPM**	**DY 13 PMPM**	**DY 14 PMPM**	**DY 15 PMPM**	**DY 16 PMPM**	**DY 17 PMPM**
Hypo Community Care Program	PC	Both	4.9 %	$13,602.41	$14,015.24	$14,701.99	$15,422.39	$16,178.09	$16,970.82

15.13. **Hypothetical Budget Neutrality Test 8: Supports**. The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 8. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 8 are counted as WW expenditures under the Main Budget Neutrality Test.

Table O: Hypothetical Budget Neutrality Test 8									
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 12 PMPM**	**DY 13 PMPM**	**DY 14 PMPM**	**DY 15 PMPM**	**DY 16 PMPM**	**DY 17 PMPM**
Hypo Supports	PC	Both	5.5%	$3,592.99	$3,715.26	$3,919.60	$4,135.18	$4,362.61	$4,602.55
Hypo IDD at Risk	PC	Both	4.9%	$1,559	$1,606.32	$1,685.03	$1,767.60	$1,854.21	$1,945.07
Hypo SED at Risk	PC	Both	5%	$1,318.45	$1,359.27	$1,427.23	$1,498.59	$1,573.52	$1,652.20

15.14. **Hypothetical Budget Neutrality Test 9: Autism Adjunct Services Pilot.** The table below identifies the MEGs that are used for Hypothetical Budget Neutrality Test 9. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from Hypothetical Budget Neutrality Test 9 are counted as WW expenditures under the Main Budget Neutrality Test.

Table P: Hypothetical Budget Neutrality Test 9									
MEG	**PC or Agg**	**WOW Only, WW Only, or Both**	**Trend Rate**	**DY 12 PMPM**	**DY 13 PMPM**	**DY 14 PMPM**	**DY 15 PMPM**	**DY 16 PMPM**	**DY 17 PMPM**
Autism Adjunct Services Pilot	PC	Both	5.1%	$360.00	$371.15	$389.71	$409.20	$429.66	$451.14

15.15. **Capped Hypothetical Budget Neutrality for Evidence-Based HRSN Initiatives.** When expenditure authority is provided for specified HRSN initiatives in the demonstration (in this approval, as specified in section 10), CMS considers these expenditures to be "capped hypothetical" expenditures; that is, the expenditures are eligible to receive FFP up to a specific aggregate spending cap per demonstration year, based on the state's expected expenditures. States can also receive FFP for capacity-building, infrastructure, and operational costs for the HRSN initiatives; this FFP is limited by a sub-cap of the aggregate spending cap and is determined by CMS based on the amount the state expects to spend. Like all hypothetical expenditures, capped hypothetical expenditures do not need to be

offset by savings, and cannot produce savings; however, unspent expenditure authority allocated for HRSN infrastructure in a given demonstration year can be applied to HRSN services in the same demonstration year. Any unspent HRSN services expenditure authority may not be used to fund HRSN infrastructure. To allow for capped hypothetical expenditures and to prevent them from resulting in savings that would apply to the rest of the demonstration, CMS currently applies a separate, independent Capped Hypothetical Budget Neutrality Test, which subjects capped hypothetical expenditures to pre-determined aggregate limits to which the state and CMS agree, and that CMS approves, as a part of this demonstration approval. If actual HRSN initiative spending is less than the Capped Hypothetical Budget Neutrality Test's expenditure limit for a given demonstration year, the difference is not considered demonstration savings. Unspent HRSN expenditure authority under the cap for each demonstration year can be carried, shifted, or transferred across future demonstration years. However, unspent HRSN expenditure authority cannot roll over to the next demonstration approval period. If the state's capped hypothetical spending exceeds the Capped Hypothetical Budget Neutrality Test's expenditure limit, the state agrees (as a condition of CMS approval) to refund any FFP in excess of the cap to CMS. Demonstration savings from the Main Budget Neutrality Test cannot be used to offset excess spending for the capped hypothetical.

15.16. **Capped Hypothetical Budget Neutrality Test 10: HRSN.** The table below identifies the MEGs that are used for the Capped Hypothetical Budget Neutrality Test. MEGs that are designated "WOW Only" or "Both" are the components used to calculate the budget neutrality expenditure limit. The Composite Federal Share for the Capped Hypothetical Budget Neutrality Test is calculated based on all MEGs indicated as "WW Only" or "Both." MEGs that are indicated as "WW Only" or "Both" are counted as expenditures against this budget neutrality expenditure limit. Any expenditures in excess of the limit from the Capped Hypothetical Budget Neutrality Test cannot be offset by savings under the Main Budget Neutrality Test or the Hypothetical Budget Neutrality Tests.

Table Q: Capped Hypothetical Budget Neutrality Test 10

MEG	PC or Agg	WOW Only, WW Only	DY 12	DY 13	DY 14	DY 15	DY 16	DY 17
HRSN Services	Agg	Both	$28,712,227	$117,729,467	$129,545,540	$142,567,193	$156,918,656	$172,737,040
HRSN Infrastructure	Agg	Both	$3,750,000	$15,000,000	$15,000,000	$15,000,000	$15,000,000	$15,000,000

15.17. **Composite Federal Share Ratios.** The Composite Federal Share is the ratio that will be used to convert the total computable budget neutrality limit to federal share. The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the state on actual demonstration expenditures during the approval period by total computable demonstration expenditures for the same period, as reported through the MBES/CBES and summarized on Schedule C. Since the actual final Composite Federal Share will not be known until the end of the demonstration's approval period, for the purpose of interim monitoring of budget neutrality, a reasonable estimate of Composite Federal Share may be developed and used through the same process or through an alternative mutually agreed to method. Each Budget Neutrality Test has its own Composite Federal Share, as defined in the paragraph pertaining to each particular test.

15.18. **Exceeding Budget Neutrality.** CMS will enforce the budget neutrality agreement over the demonstration period, which extends from April 1, 2023 to June 30, 2028. The Main Budget Neutrality Test for this demonstration period may incorporate carry-forward savings, that is, net savings, from up to 10 years of the immediately prior demonstration approval period(s) (excluding temporary extension periods) (July 1, 2012 to June 30, 2022 If at the end of the demonstration approval period the Main Budget Neutrality Test or a Capped Hypothetical Budget Neutrality Test has been exceeded, the excess federal funds will 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.

15.19. **Budget Neutrality Savings Cap**. The amount of savings available for use by the state during this demonstration period will be limited to the lower of these two amounts: 1) the savings amount the state has available in the current demonstration period, including carry-forward savings as described in STC 15.17 or 2) 15 percent of the state's projected total Medicaid expenditures in aggregate for this demonstration period. This projection will be determined by taking the state's total Medicaid spending amount in its most recent year with completed data and trending it forward by the President's Budget trend rate for this demonstration period. Fifteen percent of the state's total projected Medicaid expenditures for this demonstration period is $19,472,302,530.

15.20. **Corrective Action Plan**. If at any time during the demonstration approval period CMS determines that the demonstration is on course to exceed its budget neutrality expenditure limit, CMS will require the state to submit a corrective action plan for CMS review and approval. CMS will use the threshold levels in the tables below as a guide for determining when corrective action is required.

Table R. Budget Neutrality Test Corrective Action Plan Calculation		
Demonstration Year	**Cumulative Target Definition**	**Percentage**
DY12	Cumulative budget neutrality limit plus:	2.0 percent
DY12 through DY13	Cumulative budget neutrality limit plus:	1.5 percent
DY12 through DY14	Cumulative budget neutrality limit plus:	1.0 percent
DY12 through DY15	Cumulative budget neutrality limit plus:	0.5 percent
DY12 through DY16	Cumulative budget neutrality limit plus:	0.0 percent
DY12 through DY17	Cumulative budget neutrality limit plus:	0.0 percent

16. FINANCIAL AND ALLOTMENT NEUTRALITY MONITORING REQUIREMENTS UNDER TITLE XXI

16.1. **Reporting Expenditures Subject to the Title XXI Allotment.** The following describes the reporting of title XXI expenditures authorized under this demonstration, subject to the state's title XXI allotment limit:

a. **Tracking Expenditures**. In order to track expenditures under this demonstration, the state must report demonstration expenditures through the Medicaid and State Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-21 and CMS 64 reporting instructions as outlined in Section 2115 of the State Medicaid Manual.

b. **Use of Waiver Forms**. Title XXI demonstration expenditures will be reported on the following separate forms designed for the XXI funded Medicaid expansion population (i.e., Forms 64.21U Waiver and/or CMS-64.21UP Waiver) and the title XXI funded separate CHIP population (i.e., Forms 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 were rendered or for which capitation payments were made). The state must submit separate forms CMS-21 and CMS-21P waiver forms for each title XXI demonstration population.

c. **Premiums**. Any premium contributions under the demonstration shall be reported to CMS on Form CMS-21 Waiver and the CMS-64.21U Waiver forms (specifically lines 1A through 1D as applicable for each title XXI demonstration that is subject to premiums in order to assure that the demonstration is properly credited with premium collections.

d. **Claiming Period**. All claims for expenditures related to the demonstration (including any cost settlements) must be made within two 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 two years after

the conclusion or termination of the demonstration. During the latter two-year period, the state must continue to identify separately, on the CMS-21 and CMS 64.21U waiver forms, net expenditures related to dates of service during the operation of the demonstration.

16.2. **Standard CHIP Funding Process.** The standard CHIP funding process will be used during the demonstration. The state will estimate matchable CHIP expenditures on the quarterly Form CMS-21B for the title XXI funded separate CHIP population and CMS-37 for the title XXI funded Medicaid expansion population. On these forms estimating expenditures for the title XXI funded demonstration populations, the state shall separately identify estimates of expenditures for each applicable title XXI demonstration population.

a. 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 report demonstration expenditures through Form CMS-21 W and/or CMS-21P W Waiver for the title XXI funded separate CHIP population and report demonstration expenditures for the title XXI funded Medicaid expansion population through Form 64.21U Waiver and/or CMS-64.21UP Waiver. Expenditures reported on the waiver forms must be identified by the demonstration project number assigned by CMS (including project number extension, which indicated the demonstration year in which services were rendered or for which capitation payments were made). CMS will reconcile expenditures reported on the CMS-21W/CMS-21P Waiver and the CMS 64.21U Waiver/CMS 64.21UP Waiver forms with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

16.3. **Title XXI Administrative Costs.** Administrative costs will not be included in the allotment neutrality limit. All administrative costs (i.e., costs associated with the title XXI state plan and the title XXI funded demonstration populations identified in these STCs) are subject to the title XXI 10 percent administrative cap as described in Section 2105(c)(2)(A) of the Act.

16.4. **Limit on Title XXI Funding.** The state will be subject to a limit on the amount of federal title XXI funding that the state may receive on eligible CHIP state plan populations and the CHIP demonstration populations described in STC 8.1 during the demonstration period. Federal title XXI funds for the state's CHIP program (i.e., the approved title XXI state plan and the demonstration populations identified in these STCs) 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 CHIP state plan populations. Demonstration expenditures are limited to remaining funds.

16.5. **Exhaustion of Title XXI Funds.** If the state exhausts title XXI funds, expenditures for the title XXI funded CHIP populations described in STC 16.4, and as approved with the CHIP state plan, may be claimed as title XIX. The state must notify CMS in writing at least 90 days prior to an expected change in claiming of expenditures for the CHIP populations. The state shall report demonstration expenditures for these individuals on the Forms CMS 64.9W and/or CMS 64.9PW.

17. SCHEDULE OF DELIVERABLES DURING THE DEMONSTRATION

The state is held to all reporting requirements as outlined in the STCs. This schedule of deliverables should serve only as a tool for informational purposes.

Date	Deliverable	STC
30 days after approval date	State acceptance of demonstration Waivers, STCs, and Expenditure Authorities	Approval letter
150 days after approval date	SUD Monitoring Protocol	STC 12.7
60 days after receipt of CMS comments	Revised SUD Monitoring Protocol	STC 12.7
No later than 60 calendar days after December 31, 2025	SUD Mid-Point Assessment Report	STC 12.9
60 days after receipt of CMS comments	Revised SUD Mid-point Assessment Report	STC 12.9
180 days after approval date	Draft Evaluation Design	STC 13.3
60 days after receipt of CMS comments	Revised Evaluation Design	STC 13.4
120 days after approval date	Behavioral Health Promoting Interoperability Program Protocol	STC 5.17
At least 180 days prior to intended OPG Financial Eligibility Pilot Program implementation date	OPG Financial Eligibility Implementation Plan	STC 5.14
90 days after approval of demonstration; FFP for HRSN infrastructure and HRSN services is contingent on CMS approval of these deliverables (separately)	Protocols for HRSN Infrastructure and HRSN Services	STC 10.6
No later than nine months after demonstration approval	Draft New Initiatives Implementation Plan	STC 12.5
No later than 60 days after receipt of CMS comments	Revised New Initiatives Implementation Plan	STC 12.5
No later than 90 days after demonstration effective date	Provider Payment Rate Increase Assessment Attestation Table	STC 11.14
No later than 90 days after demonstration effective date	Average Medicaid to Medicare fee-for-service provider rate ratio	STCs 11.5 and 11.12
90 days prior to CE implementation	Continuous Eligibility Calculation Methodology Protocol	STC 14.13
One year prior to demonstration expiration or with extension	Draft Interim Evaluation Report	STC 13.7

Date	Deliverable	STC
application		
60 days after receipt of CMS comments	Revised Interim Evaluation Report	STC 13.7
No later than 18 months after the expiration of this demonstration period	Summative Evaluation Report	STC 13.8
60 days after receipt of CMS comments	Revised Summative Evaluation Report	STC 13.8
No later than 120 days after the end of the demonstration period, applicable only if not to be extended	Draft Close Out Report	STC 12.11
Monthly Deliverables	Monitoring Call	STC 12.12
Quarterly Deliverables Due 30 days after end of each quarter, except 4th quarter	Quarterly Monitoring Reports	STC 12.8
	Quarterly Expenditure Reports	STC 14.2
	Quarterly Budget Neutrality Report	STC 12.8
Annual Deliverables - Due 90 days after end of each 4th quarter	Annual Monitoring Reports (including Q4 monitoring information and budget neutrality, and HCBS QIS information)	STC 12.8
21 months before the end of the demonstration	HCBS Evidentiary Report	STC 9.8
90 days after approval of the demonstration extension	HCBS Quality Measures	STC 9.8

Attachment A
New Jersey FamilyCare Comprehensive Demonstration
Developing the Evaluation Design

Section 1115 Demonstrations
Developing the Evaluation Design

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions.

The evaluation design is the state's plan for how it will accomplish the evaluation. In most cases, states must arrange with an independent evaluator to conduct the evaluation. The state, per the Special Terms and Conditions (STC), is required to submit an evaluation design to CMS for CMS approval after the demonstration is approved. The evaluation design needs to specify the state's hypotheses, evaluation questions, associated measures and analytic methods. To support the development of the evaluation design in accordance with CMS priorities and expectations, CMS is providing the following outline for the evaluation design. It is recommended that states and independent evaluators use this outline to develop the evaluation design for submission to CMS.

The sections in this outline include background, evaluation questions and hypotheses, methodology, methodological limitations, and attachments. It is important to include as much detail as possible when completing this outline, to provide CMS with the best information with which to review the evaluation design.

CMS expects evaluation designs to be rigorous, incorporate baseline and comparison group assessments, as well as statistical significance testing. If the state needs technical assistance using this outline or developing the evaluation design, the state should contact its project officer.

Developing the Evaluation Design
Recommended Outline

Expectations for Evaluation Designs

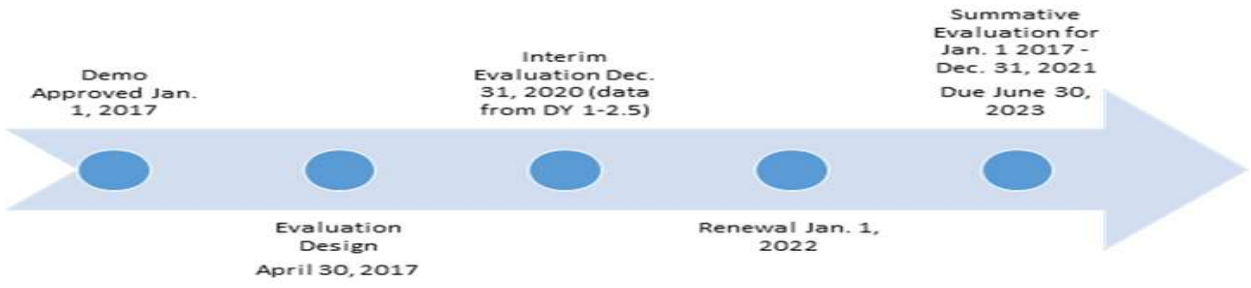
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

- **A.** General Background Information;
- **B.** Evaluation Questions and Hypotheses;
- **C.** Methodology;
- **D.** Methodological Limitations;
- **E.** Attachments.

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Design and Reports. (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within 30 days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of All Evaluation Designs

The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation. A copy of the state's Driver Diagram (described in more detail in paragraph B2 below) should be included with an explanation of the depicted information.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1) The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).

2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;

3) A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;

4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

5) Describe the population groups impacted by the demonstration.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1) Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.
2) Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf

3) Identify the state's hypotheses about the outcomes of the demonstration:
   a. Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;
   b. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references).

This section provides the evidence that the demonstration evaluation will use the best available data; reports on, controls for, and makes appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what will be measured and how. Specifically, this section establishes:

1) Evaluation *Design* – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?

2) *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

3) *Evaluation Period* – Describe the time periods for which data will be included.

4) *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:
    a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.
    b. Qualitative analysis methods may be used, and must be described in detail.
    c. Benchmarking and comparisons to national and state standards, should be used, where appropriate.
    d. Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).
    e. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).
    f. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.

5) *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources.

   If primary data (data collected specifically for the evaluation) – The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (Copies of any proposed surveys must be reviewed with CMS for approval before implementation).

6) *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:
   a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.
   b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.
   c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).
   d. The application of sensitivity analyses, as appropriate, should be considered.

7) *Other Additions* – The state may provide any other information pertinent to the Evaluation Design of the demonstration.

D. Methodological Limitations – This section provides detailed information on the limitations of the evaluation. This could include the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize the limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

E. Special Methodological Considerations- CMS recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. Examples of considerations include:

1) When the state demonstration is:
   a. Long-standing, non-complex, unchanged, or
   b. Has previously been rigorously evaluated and found to be successful, or
   c. Could now be considered standard Medicaid policy (CMS published regulations or guidance)

2) When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
    a. Operating smoothly without administrative changes; and
    b. No or minimal appeals and grievances; and
    c. No state issues with CMS 64 reporting or budget neutrality; and
    d. No Corrective Action Plans (CAP) for the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

F. Attachments

1) **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. The evaluation design should include "No Conflict of Interest" signed by the independent evaluator.

2) **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be

required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.

3) **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design shall incorporate an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation report is due.

Attachment B
New Jersey FamilyCare Comprehensive Demonstration
Preparing the Evaluation Report

Section 1115 Demonstrations
Preparing the Evaluation Report

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions.

The evaluation report provides the analysis and summary of the hypotheses tested in the evaluation. The hypotheses, evaluation questions, and measures should align with those identified in the CMS approved evaluation design. The state, per the Special Terms and Conditions (STC), is required to submit to CMS an interim evaluation report and a summative evaluation report. To support the development of the interim and summative evaluation reports, CMS is providing the following outline for the evaluation reports. It is recommended that states and independent evaluators use this outline to develop the evaluation reports for submission to CMS.

The sections in this outline include an executive summary, background information, evaluation questions and hypotheses, methodology, methodological limitations, results, conclusions, interpretations, lessons learned and recommendations, and attachments. It is important to provide as much detail as possible when completing this outline, to provide CMS with the best information with which to review the evaluation reports.

If the state needs technical assistance using this outline or preparing the evaluation reports, the state should contact its project officer.

Preparing the Evaluation Report
Recommended Outline

Expectations for Evaluation Reports

Medicaid section 1115 demonstrations are required to conduct an evaluation that is valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). To this end, the already approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States should have a well-structured analysis plan for their evaluation. With the following kind of information, states and CMS are best poised to inform and shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances. When submitting an application for renewal, the interim evaluation report should be posted on the state's website with the application for public comment. Additionally, the interim evaluation report must be included in its entirety with the application submitted to CMS.

Intent of this Attachment

Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

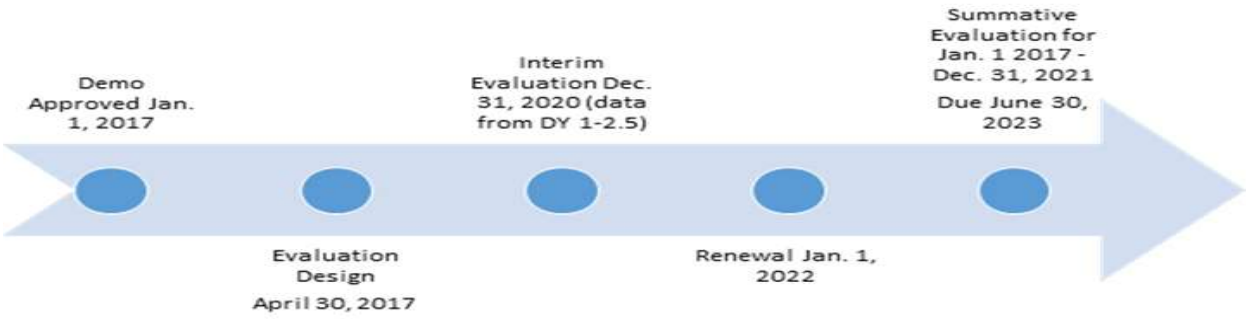
The format for the Interim and Summative Evaluation reports are as follows:

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;
E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and
J. Attachment(s).

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination

of the evaluation findings, lessons learned, and recommendations, the state is required to publish the evaluation design and reports to the state's website within 30 days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of Interim and Summative Evaluation Reports

The section 1115 Evaluation Report presents the research about the section 1115 Demonstration. It is important that the report incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. A copy of the state's Driver Diagram (described in the Evaluation Design Attachment) must be included with an explanation of the depicted information. The Evaluation Report should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy. Therefore, the state's submission must include:

A. Executive Summary – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. General Background Information about the Demonstration – In this section, the state should include basic information about the demonstration, such as:

1) The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
3) A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;
4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal

level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.

5) Describe the population groups impacted by the demonstration.

C. Evaluation Questions and Hypotheses – In this section, the state should:

1) Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.
2) Identify the state's hypotheses about the outcomes of the demonstration;
   a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;
   b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and
   c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design. The evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An interim report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an interim evaluation.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1) *Evaluation Design*—Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc?
2) *Target and Comparison Populations*—Describe the target and comparison populations; include inclusion and exclusion criteria.
3) *Evaluation Period*—Describe the time periods for which data will be collected
4) *Evaluation Measures*—What measures are used to evaluate the demonstration, and who are the measure stewards?

5) *Data Sources*—Explain where the data will be obtained, and efforts to validate and clean the data.
6) *Analytic methods*—Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
7) *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. Methodological Limitations
This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. Results – In this section, the state presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings should visually depict the demonstration results (tables, charts, graphs). This section should include information on the statistical tests conducted.

G. Conclusions – In this section, the state will present the conclusions about the evaluation results.
1) In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?

2) Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:
   a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other State Initiatives – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretation of the data using evaluative reasoning to make judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

I. Lessons Learned and Recommendations – This section of the Evaluation Report involves the transfer of knowledge. Specifically, the "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders is just as significant as identifying current successful strategies. Based on the evaluation results:
1) What lessons were learned as a result of the demonstration?
2) What would you recommend to other states which may be interested in implementing a similar approach?

J. Attachment

1) Evaluation Design: Provide the CMS-approved Evaluation Design

Attachment C
New Jersey FamilyCare Comprehensive Demonstration
HCBS-FFS Program Service Definitions

Placeholder for HCBS-FFS Program Service Definitions

Attachment D
New Jersey FamilyCare Comprehensive Demonstration
MLTSS Program Service Definitions

Placeholder for MLTSS Program Service Definitions

Attachment E
New Jersey FamilyCare Comprehensive Demonstration
SUD Implementation Plan

NJ DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

NJ FamilyCare Comprehensive Demonstration Implementation Protocol for the Opioid Use Disorder (OUD)/Substance Use Disorder (SUD) Program

5/7/2018

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Introduction

NJ FamilyCare's Comprehensive Demonstration ("The Waiver") was approved on October 31, 2017 and includes an Opioid Use Disorder (OUD)/Substance Use Disorder (SUD) continuum providing authority for the New Jersey Department of Human Services' Division of Medical Assistance and Health Services, to serve individuals with a substance use disorder or opioid use disorder in a full continuum of care. The continuum matches beneficiaries with the most appropriate services to meet their need, and provides an efficient use of resources grounded in evidence based practice. This includes services provided in residential treatment settings that qualify as an Institute for Mental Disease (IMD) consistent with key benchmarks from nationally recognized, SUD-specific program standards. Beneficiaries will have access to high quality, evidence based, OUD and SUD treatment services ranging from acute withdrawal management, ongoing chronic care in cost effective settings, and care for comorbid physical and mental health conditions.

Specifically, New Jersey was granted waiver authority to:

- Claim expenditures for services provided in an IMD for a statewide average length of stay of 30 days.
- Add a new level of care to the continuum for long term residential treatment, ASAM 3.5;
- Develop peer recovery support specialist and case management programs that will engage, support and link individuals with an SUD in the appropriate levels of care; and
- Move to a managed delivery system that integrates physical and behavioral health care.

As required by Standard Terms and Conditions (STC) #40 (A) of the Waiver, this document serves as the NJ FamilyCare 1115 Waiver OUD/SUD Continuum Implementation Protocol and is referred to as the Implementation Plan here forth. . The Implementation Plan provides details on DMAHS's strategic approach, project addresses the goals and required milestones to ensure the continuum succeeds in improving quality, accessibility, and outcomes for OUD/SUD treatment in the most cost-effective manner over the course of the Waiver period from October 31, 2017 to June 30, 2022.

Goals of the OUD/SUD Continuum:

1. Increase the rates of identification, initiation and engagement in treatment for OUD and other SUDs;
2. Increase adherence to and retention in treatment for OUD and other SUDs;

3. Reduction in overdose deaths, particularly those due to opioids;
4. Reduce utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment where the utilization is preventable or medically inappropriate
5. Reduce preventable, or potentially preventable readmission to the same or higher level of care for OUD and other SUD; and
6. Improve access to care for physical health conditions among beneficiaries with OUD or other SUDs.

Milestones of the OUD/SUD Continuum:

1. Access to critical levels of care for OUD and other SUDs;
2. Widespread use of evidence-based, SUD-specific patient placement criteria;
3. Use of nationally recognized, evidence-based, SUD program standards to set residential treatment provider qualifications;
4. Sufficient provider capacity at each level of care, including MAT;
5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD; and
6. Improved care coordination and transitions between levels of care.

Section I: Implementation Protocol Milestones

In order to achieve the aforementioned overarching goals, DMAHS will work with its internal and external stakeholders to develop, design, and operationalize the following six (6) milestones:

1. Access to Critical Levels of Care of OUD and other SUDS

To improve access to OUD and SUD treatment services for Medicaid beneficiaries, it is important to offer a range of services at varying levels of intensity across a continuum of care since the type of treatment or level of care needed may be more or less effective depending on the individual beneficiary. Coverage of outpatient, intensive outpatient, partial care, short term residential, and non-hospital based withdrawal management, ambulatory withdrawal management ASAM 2-WM services, medication assisted treatment, and medically supervised withdrawal management services are already in place and included in State Plan Services. Long term residential, ASAM 3.5 will be added to the continuum and IMD services in short term residential and non-hospital based withdrawal management services can begin upon approval within the proposed timeframe. In addition, under this Waiver authority, the state will create a Medicaid benefit of peer support and case management services for beneficiaries with an SUD diagnosis as part of the SUD Continuum.

Under the New Jersey's 1115 Comprehensive Demonstration, and in order to to facilitate access to OUD and SUD services, New Jersey established a non-risk bearing interim managing entity (IME) to manage a SUD hotline providing 24 hour access to screening, referrals, care coordination and utilization management.

The IME is an independent, non-risk bearing entity for reviewing placement in all SUD treatment settings.

a. The IME reviews clinical data submitted by providers in order to authorize services based on medical necessity and ASAM placement criteria for all SUD admissions

b. The IME has access to ten years of SUD individuals' treatment history at any licensed SUD facility.

c. The IME also reviews clinical care extension requests by providers and issues continuing care based on ASAM evidentiary standards.

d. Children and Adolescents who are covered by Children's System of Care (CSOC) utilize Perform Care as a Managing Entity for services. CSOC utilizes the LOCI-3 and/or a Strengths and Needs Tool for children seeking treatment under the age of 18.

Table A: Comparison of the current State Plan vs. the Future Plan, Milestone #1 Access to Critical Levels of Care for OUD and other SUD

Milestone #1 Access to Critical Levels of Care for OUD and other SUD's.	Current Plan	Future State	Summary of Actions Needed/Timetable
1.)To improve access to OUD and SUD treatment services for Medicaid beneficiaries, it is important to offer	1.) Outpatient Services are currently covered under NJ State Plan ASAM 1.0	Continue to monitor and evaluate services and expenditures.	No Action needed
	2.) Intensive outpatient services are currently covered under NJ State Plan ASAM 2.1	Continue to monitor and evaluate services and expenditures.	No Action needed

Milestone #1 Access to Critical Levels of Care for OUD and other SUD's.	Current Plan	Future State	Summary of Actions Needed/Timetable
a range of services at varying levels of intensity across a continuum of care since the type of treatment or level of care needed may be more or less effective depending on the individual beneficiary.	3.) Partial Care outpatient services are currently covered under NJ State Plan ASAM 2.5	Continue to monitor and evaluate services and expenditures.	No Action needed
	4.) Medication Assisted Treatment is currently covered under NJ State Plan.	Continue to monitor and evaluate services and expenditures.	No Action needed
	5.) Ambulatory Withdrawal Management ASAM 2WM has been implemented under State plan amendment.	NJ will Monitor and evaluate services and expenditures.	Currently 21 providers are in the process of applying for licensure to provide this service. NJ DMAHS and NJ DMHAS will work with providers and IME once the providers become licensed and apply for Medicaid provider status.
	6.) Short term residential, ASAM 3.7 and Withdrawal Management (WM) services ASAM 3.7WM are currently covered under State Plan but the IMD exclusion currently applies.	NJ will include residential treatment (ASAM 3.7 STR) and Withdrawal Management (ASAM 3.7WM) to improve access to care allowing coverage for all ages within 12-24 Months of program demonstration approval.	NJ DMAHS and DMHAS will review established policies and procedures in accordance with ASAM criteria for the delivery of benefits in short term rehab (STR) and WM. These services are currently under State Plan and in Regulation, Review and revise if necessary. Provider and stakeholder presentations and feedback **December 2017, January 2018, and February 2018.** Implement service **July, 2018**

Milestone #1 Access to Critical Levels of Care for OUD and other SUD's.	Current Plan	Future State	Summary of Actions Needed/Timetable
	7.) Long Term Residential (LTR), ASAM 3.5 is currently not a covered service in NJ but with Waiver approval we hope to implement this service October of 2018.	NJ will review policies and procedures, develop and submit a state plan amendment for coverage of ASAM 3.5 LTR.	Provider and stakeholder presentations and feedback **December 2017, January 2018, and February 2018.** NJ Medicaid will develop regulations for LTR treatment services in cooperation with DMHAS and Derpatment of Health (DOH), OOL. Submit State plan amendment for LTR in cooperation with DMHAS and DOH, OOL. DMHAS and DMAHS will work with IME to develop Utilization Management (UM) for ASAM clinical review. Implement service **October, 2018**
	8). Peer Support Recovery Specialist Service is currently not a benefit in the state plan available to individuals with an SUD.	The state will work with the Division of Mental Health and Addiction Services and current providers of SUD peer support services to develop this benefit. The state will pursue State Plan Amendment authority for this benefit.	DMAHS will meet with various agencies that currently provide this service funded through other state and federal grants to develop a structure for this service and draft regulations. The state will develop a rate that compensates for the expenses of an agency to provide this service. Implement service **July, 2019**

Milestone #1 Access to Critical Levels of Care for OUD and other SUD's.	Current Plan	Future State	Summary of Actions Needed/Timetable
	9). Case Management services are currently not a benefit in the state plan available to individuals with an SUD.	The state will work with the Division of Mental Health and Addiction Services and current providers of SUD case management services to develop this benefit The state will pursue State Plan Amendment authority for this benefit.	DMAHS will meet with various agencies that currently provide this service funded through other state and federal grants to develop a structure for this service and draft regulations. The state will develop a rate that compensates for the expenses of an agency to provide this service. Implement service **July, 2019**

2. Widespread use of Evidence-based, SUD-specific patient placement criteria

Currently, NJ providers assess treatment needs based on SUD-specific, multi-dimensional ASAM assessment tools that reflect evidence-based clinical guidelines. The IME makes initial and continued stay determinations based on review of the DSM 5 diagnosis, the ASAM LOCI-3, and supporting documentation submitted by the provider for SUD services that require determination of medical appropriateness by regulation. The IME's UM approach ensures that beneficiaries have access to SUD services at the appropriate level of care and that those services are appropriate for the diagnosis and treatment needs of the individual.

Table B: Comparison of the Current State Plan vs. the Future Plan, Milestone #2 Widespread use of Evidence-based, SUD-Specific Patient Placement Criteria

Milestone #2 Use of Evidence-based, SUD specific Patient Placement Criteria. (ASAM)	Current Plan	Future State	Summary of Actions Needed/Timetable
1) Providers assess treatment needs based on SUD-specific, multi-dimensional assessment tools, e.g., the ASAM Criteria, or other patient placement assessment tools that reflect evidence-based clinical treatment guidelines	NJ SUD providers currently assess treatment needs based on multi-dimensional ASAM assessment tools that reflect evidence-based clinical guidelines for all levels of care, residential and outpatient as per licensing regulation and state contracts. New regulation for state wide use of ASAM placement criteria and medical necessity review tool (LOCI 3) currently proposed in N.J.A.C. 10:163.	Formalize the use of ASAM criteria and the LOCI-3 assessment tool for use by all providers to include new residential and inpatient providers. Implement new regulation for state wide use of medical necessity review tool currently proposed in N.J.A.C. 10:163.	Provider and stakeholder presentations and feedback **December 2017, January 2018, and February 2018.** Rutgers (in partnership with DMHAS) is currently planning a statewide provider training on ASAM subject matter experts on ASAM. Tentatively planned to take place between **March-May 2018** NJ FamilyCare to work with MCO's to formalize ASAM placement criteria and use of LOCI-3 assessment tool and include in MCO contracts. **Target Date July, 2018**

Milestone #2 Use of Evidence-based, SUD specific Patient Placement Criteria. (ASAM)	Current Plan	Future State	Summary of Actions Needed/Timetable
2.)Utilization management approaches are implemented to ensure that (a) beneficiaries have access to SUD services at the appropriate level of care, (b) interventions are appropriate for the diagnosis and level of care, and (c) there is an independent process for reviewing placement in residential treatment settings.	NJ is currently contracted with an Interim Managing Entity (IME) which is an independent, non-risk bearing entity for reviewing placement in all SUD treatment settings. The IME's UM approach ensures that beneficiaries have access to SUD services at the appropriate level of care and that those services are appropriate for the diagnosis and treatment needs of the individual. If necessary, a retrospective, records-based review is conducted. The IME makes initial determinations based on review of the DSM 5 diagnosis, the ASAM LOCI-3, and supporting documentation submitted by the provider for all SUD services.	NJ will work with MCO's to implement the regulatory requirements.	Provider and stakeholder presentations and feedback **December 2017, January 2018, and February 2018** DMHAS and DMAHS will work with IME for ASAM criteria and LOCI-3 requirements to implement with new Residential and inpatient providers. **October 2018** NJ FamilyCare to work with MCO's to formalize ASAM placement criteria and use of LOCI-3 assessment tool and include in MCO contracts. **Target Date July 2018**

3. Use of Nationally recognized, evidence-based SUD program standards to set residential treatment provider qualifications

Outside of medical necessity, SUD and ASAM services are outlined in provider licensing regulations that include provider licensing inspections that occur every two years. New Jersey will look at other credentialing and/or certification options as we move forward into the demonstration period. Over the past year, NJ has also offered voluntary quality reviews to SUD providers to ensure compliance and utilize opportunities for targeted assistance and ongoing Medicaid audits will occur on a quarterly basis.

Currently, there is not a requirement that residential treatment facilities provide a MAT service but within this authority the state will work to remove the barriers and provide needed supports for this service to be included in residential treatment when clinically necessary.

Table C: Comparison of the Current State Plan vs. the Future Plan, Milestone #3, Use of Nationally Recognized, Evidence-based SUD Program Standards to set Residential Treatment Provider Qualifications

Milestone #3 Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities	Current Plan	Future State	Summary of Actions Needed/Timetable
1.) Implementation of residential treatment provider qualifications in licensure requirements, policy manuals, managed care contracts, or other guidance. Qualification should meet program standards in the ASAM Criteria or other nationally recognized, SUD-specific program standards regarding, in particular, the types of services, hours of clinical care, and credentials of staff for residential	All NJ State Licensing Regulations include ASAM level of care requirements for each level of care in the SUD Continuum that include services, hours of clinical care, staffing and staff credentials. (N.J.A.C. 10:161A, Residential) N.J.A.C. 10:161B, Outpatient) Any hours of care and scope of service not including in Licensing regulations are included in N.J.A.C. 10:66 Medicaid Independent Clinic Regulations.	NJ will review current regulations for residential treatment and crosswalk with ASAM requirements to ensure accuracy and make any necessary revisions.	Assemble team including the Division of Mental Health and Addiction Services and other related state departments to review, crosswalk and make recommendations for any changes to current regulation. **March 2018** NJ FamilyCare will meet with contracted MCO's to review provider contracts, manuals or other guidance to ensure ASAM program standards compliance. **July 2018**

Milestone #3 Use of Nationally Recognized SUD-specific Program Standards to Set Provider Qualifications for Residential Treatment Facilities	Current Plan	Future State	Summary of Actions Needed/Timetable
2.) Implementation of a state process for reviewing residential treatment providers to ensure compliance with these standards	NJ Department of Health (DOH) Office of Licensing (OOL) currently provides initial inspection review, bi-annual reviews, provider random surveys, and reviews following any complaints about a provider.	NJ will review and outline current licensing review procedures and develop additional procedures to be able to randomly review providers quarterly	Review and outline DOH, OOL process currently in use. **March 2018.** Develop written protocol for Medicaid quarterly audits. **July, 2018.** Continually train staff on Medicaid Reviewers on SUD Continuum and ASAM Placement criteria. **Throughout Wavier period.**
3. Implementation of requirement that residential treatment facilities offer MAT on-site or facilitate access off site	NJ providers are currently able to provide MAT on site and newer MAT such as Vivitrol are provided in Residential facilities. However, some obstacles remain related to billing, licensing, continuation of MAT following discharge and DEA requirements.	NJ will work toward the requirement that residential treatment facilities offer MAT on-site or ensure Beneficiaries have access to MAT off-site. NJ will work to overcome obstacles related to billing, licensing, and DEA requirements that impact delivery of MAT. NJ will also work to better ensure follow up care and continued MAT upon transition to community.	Establish a workgroup with Division of Mental Health and Addiction Services, Division of Medical Assistance and Health Services, Department of Children and Families and Department of Health, provider representation and other members to facilitate list of barriers and solutions. **January 2018** Review and revise policies and procedures that limit barriers to MAT treatment based on workgroup recommendations. **July 2018**

4. **Sufficient provider capacity at each level of care**

NJ is using data from the NJ Department of Health's licensing unit to complete the provider capacity study. This information includes any provider of SUD services in the state regardless of their involvement with NJ FamilyCare. The study will determine providers that are licensed and existing providers within NJ FamilyCare as well as providers that are not in the network. This capacity study will assist the state in identifying gaps in service availability and identify state strategies to engaging new providers to meet the gaps in service.

Table D: Comparison of the current State Plan vs. the Future Plan Milestone #4, Sufficient Provider Capacity at each Level of Care.

Milestone #4 Sufficient Provider Capacity at Critical Levels of Care including Medication Assisted Treatment	Current Plan	Future State	Summary of Actions Needed/Timetable
Completion of assessment of the availability of providers enrolled in Medicaid and accepting new patients in the following critical levels of care throughout the state including those that offer MAT: • Outpatient Services; • Intensive Outpatient Services; • Medication Assisted	NJ will compile a provider capacity study for key levels of care in the State. Compile data from Office of Licensing, IME statewide capacity management system, Molina and NJSAMs to look at utilization and bed availability in residential levels of care and opioid treatment capacity. NJ has mapped the residential beds by county to capture regional coverage of the service for Medicaid recipients in residential levels of care and opioid treatment.	NJ will submit a complete report to CMS of the existing provider capacity for all levels of care through-out the state. Included in the capacity plan, NJ will identify unmet needs and develop methods to address capacity insufficiency.	NJ FamilyCare will work with data sources from DOH and NJ's MMIS system to assemble and verify current and eligible Medicaid providers for residential levels of care and current capacity for each. **April 2018** NJ will complete an evaluation of treatment availability for ambulatory services; residential bed capacity; and, state-wide admissions to each residential level of care. **July 2018**

Treatment (medications as well as counseling and other services); • Intensive Care in Residential and Inpatient Settings; • Medically Supervised Withdrawal Management.			NJ will complete capacity study and submit to CMS. **October, 2018**

5. Implementation of comprehensive treatment and prevention strategies to address opioid abuse and OUD

New Jersey has taken significant effort to address the opioid addiction crisis in our state. Efforts have been made to provide education to prescribers, have best practices in place for opioid prescribers, pharmacy programs that lock certain Medicaid consumers into one pharmacy and state wide distribution and education on the use of Naloxone.

At this time, payers, including Medicaid, do not have access to the New Jersey Prescription Monitoring Program (NJPMP) prior to making prescription coverage decisions. There is currently pending state legislation to assure access to NJPMP by all payers

Currently there is no connectivity between the NJPMP and the NJ HIN. It is the state's goal to establish connectivity between these two systems.

Despite these state wide efforts the OUD crisis continues in NJ and the chart below details the various strategies that the state has or will put into place to continue to address the prescription drug abuse and OUD.

For additional information on Milestone 5 related to the state's SUD Health Information Technology (HIT) Plan, see Attachment A.

Table E: Comparison of the current State Plan vs. the Future Plan Milestone #5, Implementation of Comprehensive Treatment and Prevention Strategies to address Opioid Abuse and OUD

Milestone #5 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and Opioid Use Disorder (OUD).	Current State	Future State	Summary of Actions Needed
Implementation of opioid prescribing guidelines along with other interventions to prevent opioid abuse	State Law (S3) that sets a 5 day limit on initial prescriptions for Opioid pain medication to treat acute pain which is one of the toughest in the country. The New Jersey Board of Medical Examiners, the New Jersey Board of Nursing, the New Jersey State Board of Dentistry, and the New Jersey Board of Optometrists - implemented the rules on an emergency basis on March 1, 2017 to combat a staggering public health crisis brought about by prescription opioid and heroin abuse.	NJ will implement opioid prescribing guidelines.	Continue to meet with the State's Division of Consumer (DCA) within the Attorney General's Office and Department of Health (DOH) to ensure implementation of the guidelines.
Expanded coverage of, and access to, naloxone for overdose reversal	The Department of Health facilitates naloxone (Narcan ®) availability and training in its use through a variety of public and private partnerships across the state. State law allows physicians to prescribe Naloxone (Narcan ®) to anyone in a position to assist others during an overdose (e.g., bystanders). This is called third	NJ will continue to utilize and expand training and use of naloxone to prevent overdose.	Continue to meet with the State's DCA and DOH to maintain and expand training on the use of Naloxone and access to overdose prevention treatment and services.

Milestone #5 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and Opioid Use Disorder (OUD).	Current State	Future State	Summary of Actions Needed
	party prescribing. The three regional opioid overdose prevention programs provide individuals at-risk for overdose, their family members, friends, and loved ones with naloxone rescue kits and educate and train them on how to prevent, recognize and respond to an opioid overdose. Additionally, funded organizations have established a procedure to make naloxone (Narcan ®) available to those who are either at-risk or have family, friends or loved ones at-risk for an opioid overdose. Naloxone is covered through the Medicaid benefit to beneficiaries and their family members. New funding sources will expand the Provision of naloxone, in intranasal form, to individuals including, but not limited to, school nurses and other personnel at statewide school districts, medical and clinical staff at jails, and medical and clinical staff working for residential substance use disorder treatment programs, to include, but not limited to, programs providing withdrawal		

Milestone #5 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and Opioid Use Disorder (OUD).	Current State	Future State	Summary of Actions Needed
	management, short term and long term residential treatment services.		
Implementation of strategies to increase utilization and improve functionality of prescription drug monitoring programs	Within the NJDOH there is funding for DOH to enhance its data access and analysis; improve prevention planning, including implementing a statewide strategic plan; assess the impact of state-level policies on the opioid crisis; identify and engage communities most impacted by the effects of the opioid crisis; and maximize the NJPMP's public health surveillance potential.	NJ will implement strategies to increase utilization and improve functionality of the NJPMP by collaborating with the DOH in the strategic plan an involving DOH in NJNJPMP planning, evaluation and implementation.	Ongoing coordination with DOH, DCA and DHS to increase utilization and functionality of the NJPMP.
Other	Utilizing grant funds NJ has established a successful program, the Opioid Overdose Recovery Program (OORP) to deploy trained peer specialists to engage individuals reversed from an opioid overdose to provide non-clinical assistance, recovery supports and appropriate referrals for assessment and substance use disorder treatment. This has been an effective program in the state and with secured coverage for peer services under Medicaid it can continue to save lives.	NJ will sustain the Opioid Overdose Recovery Program (OORP) and design a Medicaid benefit to ensure individuals reversed from an overdose with Narcan are engaged with a peer to promote treatment and recovery for OUD. NJ will develop a state plan and regulation for the Medicaid covered service.	Work with the Professional Advisory Council (PAC) workgroup, DMHAS and DCF on SUD Peer services to formalize needs within the state that peers can best serve. (currently part of agenda for the SUD workgroup, a multi-agency group looking at statewide SUD services) Conduct a statewide survey to assess current specifications of roles, responsibilities, qualifications, certifications, supervision, documentation, guided

Milestone #5 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and Opioid Use Disorder (OUD).	Current State	Future State	Summary of Actions Needed
			treatment planning and settings employed. **(Currently in draft form estimated target date for completion of survey July 2018)** Develop Medicaid benefit, rates, regulations and state plan to initiate service. **July 2019**

6. Improved care coordination and transitions between levels of care

Currently within the Medicaid State Plan there is not a case management or peer recovery support service available to individuals with an SUD in any level of care. There is coverage of these services by grants and Federal Block Grant dollars within the state funded services. Case management and peer recovery support programs are currently included in the Medicaid state plan for adults with a serious mental illness and will be used to inform the establishment of the benefit for Medicaid beneficiaries with an SUD.

6. Table F: Comparison of the current State Plan vs. the Future Plan Milestone #6, Improved Care Coordination and Transitions between Levels of Care

Milestone #6 Improved Care Coordination and Transitions between Levels of Care	Current Plan	Future State	Summary of Actions Needed/Timetable
Implementation	NJ has procedures in place to	NJ will implement a	Benefit Development

Milestone #6 Improved Care Coordination and Transitions between Levels of Care	Current Plan	Future State	Summary of Actions Needed/Timetable
of policies to ensure residential and inpatient facilities link beneficiaries with community-based services and supports following stays in these facilities	ensure residential and inpatient facilities link beneficiaries with community-based services through the IME. This service through the IME's Care Coordination Department is reliant upon Providers initiating the transition with the IME. Current Licensing Regulations require Providers to develop Client Care Policies to include referrals to other levels of care in the continuum or to other health care providers.	case management benefit for individuals with a SUD over the course of the waiver period to ensure that recipients throughout the SUD continuum especially residential and inpatient facilities are linked with continued care in the community. NJ will implement a peer services benefit to support individuals with SUD during critical transitions in care and into recovery.	Rate Study State Plan Amendment Regulation update. **Target date for implementation of Service July, 2019** Benefit Development Rate Study State Plan Amendment Regulation update. **Target Date for Implementation of Service July, 2019**
Additional policies to ensure coordination of care for co-occurring physical and mental health conditions	Under New Jersey's current structure, physical health services are the responsibility of the managed care organizations and most behavioral health services are provided through a FFS system managed by the IME. The state has been given waiver authority to expand services provided in a at-risk managed care delivery system that integrates physical and behavioral health care.	The determination on a risk based managed system of care is expected to be made at the gubernatorial level and will occur over the course of the five-year waiver period under an amendment to the Waiver.	

Section II: NJ's point of contact for the Implementation plan.

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Section III: Relevant Documents

Attachment A: SUD Health Information Technology (IT) Plan

Attachment A, Section 1: SUD Health Information Technology (IT) Plan

This section is a continuation of Milestone 5 to detail the use of the Prescription Drug Monitoring Program and the State's Health Information Technology (HIT) Plan to address the SUD and OUD.

New Jersey in coordination with the State Medicaid Health Information Technology Plan (SMHP) conducted a Health Information Technology Environmental Scan in 2017. Details of this Environmental Scan can be found in the report in Appendix A, Section 3 Relevant Documents Attachment 2. Recommendations were provided for further research and development in the areas of EHR adoption, health information exchange, health information technology, broadband coverage and education. It is the intent of the state to use the goals of this SUD HIT Plan to further leverage the HIT infrastructure and capabilities achieved by the SMHP throughout the course of the Waiver Authority. New Jersey provides assurance that there is general health IT infrastructure to accomplish the goals of the demonstration related to the SUD treatment services.

Table 1: State Health IT/PDMP Assessment & Plan

Milestone #5 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and Opioid Use Disorder (OUD).	Current State	Future State	Summary of Actions Needed
1.) Prescription Drug Monitoring Program (PDMP) Functionalities			
A.) Enhanced interstate data sharing in order to better track patient specific prescription data	The NJPMP program of New Jersey provides doctors with the ability to see prescription history with fourteen (14) other states; CT, DE, MN, RI, VA, SC, NY, MA, WV, NH, ME, PA, OH, and VT .	Will update the HIT plan as more states are included in the program.	Collaboration with the Dept. of Health (DOH), Dept. of Community Affairs (DCA) and Dept. of Human Services (DHS) to establish connectivity between the NJPMP and NJHIN. This connectivity is contingent upon DCA. NJ FamilyCare will establish communication with the DCA Administrator of the PDMP to commence connectivity with NJHIN by the 2nd quarter 2018.

Milestone #5 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and Opioid Use Disorder (OUD).	Current State	Future State	Summary of Actions Needed
B.) Enhanced "ease of use" for prescribers and other state and federal stakeholders	There is no connectivity between the State NJPMP and the New Jersey Health Information Network (NJHIN), the statewide HIE infrastructure. Prescribers and pharmacists connected to both the NJPMP and the NJHIN have access to the necessary data. State and federal stakeholders and TPL payers do not have access to the NJPMP and NJHIN information.	Connection of the State PMP as a state node in the NJHIN to allow secure sharing of prescription data to HIE connected providers to allow access and ease of use to pharmacists, prescribers, and state and federal stakeholders.	Collaboration with the DOH, DCA and DHS to establish connectivity between the NJPMP and NJHIN. NJ FamilyCare will establish communication with the DCA Administrator of the PDMP to commence connectivity with NJ HIN by the 2nd quarter 2018. NJ FamilyCare will convene a meeting with the DCA, DOH and DHS to review the goals of this plan by the 3rd quarter of 2018 and continue these meetings on a quarterly basis (or more frequently if needed) throughout the course of this Waiver to achieve the goals of the HIT Plan.
C.) Enhanced connectivity between the state's PDMP and any statewide, regional or local health information exchange	Currently, there is no connectivity between the NJPMP and the New Jersey Health Information Network (NJHIN), the statewide HIE infrastructure.	Connection of the State PMP as a state node in the NJHIN to allow secure sharing of prescription data to HIE connected providers.	Collaboration with the DOH, DCA and DHS to establish connectivity between the NJPMP and NJHIN NJ FamilyCare will establish communication with the DCA Administrator of the PDMP to commence connectivity with NJHIN by the 2nd quarter 2018.

Milestone #5 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and Opioid Use Disorder (OUD).	Current State	Future State	Summary of Actions Needed
			NJ FamilyCare will convene a meeting with the DCA, DOH and DHS to review the goals of this plan by the 3rd quarter of 2018 and continue these meetings on a quarterly basis (or more frequently if needed) throughout the course of this Waiver to achieve the goals of the HIT Plan.
D.) Enhanced identification of long-term opioid use directly correlated to clinician prescribing patterns[1] (see also "Use of PDMP" #2 below)	Although the PMP/NJHIN connectivity has yet to be established, the NJHIN has other functionalities and use cases, such as event notification (admission discharge transfer or ADT events), that is utilized by HIE connected providers, including behavioral health providers. The event notification service may provide real-time information to OUD/SUD facilities when a client has sought care in a healthcare facility.(see also "Use of PDMP" #2 below)	The State secured HITECH funding to onboard providers to the NJHIN allowing them to leverage the HIE functionalities. (see also "Use of PDMP" #2 below)	Continue supporting providers to connect to the NJHIN (see also "Use of PDMP" #2 below). Within the meetings described above between State departments, NJ FamilyCare will develop pathways to collect data relevant to the identification of long-term opioid use and clinician prescribing
2.) Current and Future PDMP Query Capabilities			

Milestone #5 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and Opioid Use Disorder (OUD).	Current State	Future State	Summary of Actions Needed
A.) Facilitate the state's ability to properly match patients receiving opioid prescriptions with patients in the PDMP (i.e. the state's master patient index (MPI) strategy with regard to PDMP query)	Medicaid and other State programs do have access to the NJPMP for investigative purposes only, pursuant to N.J.S.A. 45:1-46(i)(7). The NJPMP has facilitated requests from NJ Medicaid in the past and will continue to assist with future requests.	There is active legislation that will allow payers and state Medicaid staff to obtain information from the NJPMP and the MPI at the time the prescription issued.	If legislative action passes, the state and the payers will need to obtain access to the NJPMP and the MPI. DOH, DCA and DHS will collaborate to establish this functionality Date of implementation is contingent upon State legislative approval.
3.) Use of PDMP – Supporting Clinicians with Changing Office Workflows / Business Processes			
A.) Develop enhanced provider workflow / business processes to better support clinicians in accessing the PDMP prior to prescribing an opioid or other controlled substance to address the issues which follow	Prescribers/clinicians use the NJPMP website to conduct a patient search. The NJPMP (Appriss Health) does not connect with electronic prescribing software systems.	The ability for the NJPMP to connect or integrate with electronic medical record (EMR) software systems so that a physician can run a patient PMP report from within their EMR software. NJ plans on evaluating this opportunity and its feasibility for clinician access.	Collaboration with the DOH, DCA and DHS to evaluate the feasibility of offering an integrated NJPMP and EMR. The state will include in MCO contract renewal a requirement to use Health IT standards referenced in 42 CFR 170 Subpart B and the ISA. The MCO amendment was submitted for review for the July 2018 contract . MCOs were instructed to submit an HIT plan and an annual submission of the HIT data for their provider

Milestone #5 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and Opioid Use Disorder (OUD).	Current State	Future State	Summary of Actions Needed
			network that includes, EHR usage, promoting interoperability program participation and HIE connectivity.
B.) Develop enhanced supports for clinician review of the patients' history of controlled substance prescriptions provided through the PDMP—prior to the issuance of an opioid prescription	Prescribers/clinicians use the NJPMP website to conduct a patient search and have access to a patient's history of controlled substance prescriptions.	The NJPMP can connect or integrate with electronic medical record (EMR) software systems so that a physician can run a patient PMP report from within their EMR software. NJ plans on evaluating this opportunity and its feasibility for clinician access.	Collaboration with the DOH, DCA and DHS to evaluate the feasibility of offering an integrated NJPMP and EMR. Within in the NJ FamilyCare convened meeting with the DCA, DOH and DHS, this group will discuss this goal and evaluate the feasibly of the offering of an integrated NJPMP and EMR to prescribers by 2nd quarter 2019.
4.) Master Patient Index / Identity Management			
A.) Enhance the master patient index (or master data management service, etc.) in support of SUD care delivery.	The NJHIN currently have established an MPI functionality that is being enhanced to a two-tiered MPI infrastructure.	At the time that the PMP is established as a state node to the NJHIN, the PMP will have access to the MPI functionality and its patient matching process.	Collaboration between state entities, (DMAHS, NJDOH, and DCA) to establish connectivity of the PMP to the NJHIN in order for OUD/SUD providers to leverage MPI functionality. When the PMP is established as a state node, NJ FamilyCare will offer this functionality within one year to providers that support SUD care

Milestone #5 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and Opioid Use Disorder (OUD).	Current State	Future State	Summary of Actions Needed
			delivery.
5.) Overall Objective for Enhancing PDMP Functionality & Interoperability			
E.) Leverage the above functionalities / capabilities / supports (in concert with any other state health IT, TA or workflow effort) to implement effective controls to minimize the risk of inappropriate opioid overprescribing—and to ensure that Medicaid does not inappropriately pay for opioids	Although the PMP/NJHIN connectivity has yet to be established, the NJHIN has other functionalities and use cases, such as event notification (admission discharge transfer or ADT events), that is utilized by HIE connected providers, including behavioral health providers. The event notification service may provide real-time information to OUD/SUD facilities when a client has sought care in a healthcare facility.	The State secured HITECH funding to onboard providers to the NJHIN allowing them to leverage the HIE functionalities.	Continue supporting behavioral providers to connect them to the NJHIN. NJ FamilyCare will continue onboarding providers with grant funding. Grant will expire Sept 30, 2019.
6.) Other:			
A.) Health IT infrastructure for State, Provider, IME and Federal Reporting	The New Jersey Substance Abuse Monitoring System (NJSAMS) is the Division of Mental Health and Addiction Services' (DMHAS) administrative data collection	The state is working to merge the data of the NJSAMS with the data from NJMMIS to be able to link data for	Ongoing meetings between the state Medicaid staff and staff from the DMHAS. Bi-weekly meetings with

Milestone #5 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and Opioid Use Disorder (OUD).	Current State	Future State	Summary of Actions Needed
	system for clients who receive substance abuse treatment in New Jersey and is used by all licensed substance abuse treatment providers in New Jersey. It collects demographic, substance use, financial, clinical and service information. The system contains all the clinical assessments DMHAS requires providers to complete. It produces the National Outcome Measures (NOMs) and generates the data needed for Provider Performance Reports. It is used to fulfill the Federal Substance Abuse Prevention and Treatment Block Grant and Treatment Episode Data System (TEDS) reporting requirements. Recent updates to NJSAMS include client Medicaid verification and some limited EHR capabilities for providers.	reporting and identifying funding sources.	IME, NJ FamilyCare, NJMMIS, and DMHAS. Target date for this to be complete is 4th quarter 2019.
B.) The State will include in its MCO contracts the requirement to use health IT standards referenced in 45 CFR 170 Subpart B and the ISA		New Jersey will work toward establishing electronic prescribing (as listed in the PDMP section), direct transport standards, document sharing and care plans, ADT alerting and Messaging, and Clinical quality	New Jersey will begin meeting with the MCO's to introduce these requirements and allow adequate time for MCOs to evaluate needs of their networks and readiness for compliance to 45CFR 170 Subpart B and the ISA prior to adding as a requirement in the MCO contract. See 3) A. above.

Milestone #5 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and Opioid Use Disorder (OUD).	Current State	Future State	Summary of Actions Needed
		measurement and reporting.	NJ will work with CMS and the ONC to ensure that appropriate contract language is consistent with this goal and developing measure's to monitor compliance.
C.) SUD Health IT plan and State Medicaid Health IT plan (SMHP) alignment	New Jersey has submitted to CMS the SMHP for review and approval process.		The initiatives in this SUD HIT Implementation Plan will leverage the provider HIE on-boarding and the HIE infrastructure and architecture projects being funded by HITECH described further in the SMHP. Examples of the proposed initiatives include the connection of the PDMP to the state HIE infrastructure, NJHIN. Once established, HIE defined opioid use cases to reduce opioid addiction risk may be implemented using the PMP/HIE connections.
D. Monitoring of SUD Health IT plan	At present, New Jersey does not have a formalized approach to monitor the SUD health IT plan.	Within the NJ SUD Monitoring Protocol, NJ will monitor the goals of this HIT Plan and report the progress of these goals quarterly to CMS	New Jersey is requesting assistance from CMS and ONC to further develop monitoring protocol related to this HIT Plan.

Milestone #5 Implementation of Comprehensive Treatment and Prevention Strategies to Address Opioid Abuse and Opioid Use Disorder (OUD).	Current State	Future State	Summary of Actions Needed

Attachment A, Section II – Implementation Administration

The following is the state's point of contact for the SUD Health IT Plan:

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Attachment A, Section III - Relevant Documents:

Behavioral Health Pilot to reduce Opioid Addiction

Executive Summary

There is no question as to the severity of the current Opioid crisis in the United States. The staggering impact on the lives of patients and the overall financial cost to our healthcare system are unacceptable. Fortunately, there is something that can be done about it. Pockets of information are available across the healthcare continuum that can be used to predict a risk factor of patients developing Opioid Use Disorder. Working with the State of NJ and informed by the *Integrating Behavioral and Physical Health Care in New Jersey* guidelines, transforming relevant behavioral health and medical data into real-time information is within reach.

NJII is proposing a pilot use case to collect data, aggregate it into an Opioid Use Disorder risk factor, and make that risk factor available to clinicians in real-time by sending alerts to Emergence departments at the time that a patient is admitted. Depending on the risk factor, clinical guidelines, including Alternatives to Opioids (ALTO), will be used as appropriate along with appropriate educational information, to be targeted at those who need it most. The pilot will 'connect the dots' and leverage prior infrastructure investments in the healthcare landscape to reduce the use of, and potential addictions to, Opioid pain medications.

Many research efforts and predictors of Opioid Use Disorder have been published. Some are basic demographic data points such as age and biological gender. Male patients in the age range of 15-46 represent a higher risk group than others. History of substance abuse and other mental health diagnosis are strong predictors. High utilizers of medical services and prior use of Opioid based medications are also key factors. By combining data from various sources, a risk profile can be built that can be used to adjust pain management and educate potential Opioid abusers before an Opioid problem begins.

Goal

Rapid development and implementation of an **Opioid risk and reduction Use Case** beginning with a subset of Emergency Departments in various demographic environments.

Approach

Step 1: Convene a **tactical** task force consisting of:

- Key stakeholders from NJII, NJ State and OAG
- Medical experts in medicine and behavioral health
- Technology experts from NJII, state and HIEs
- Policy and compliance experts

Step 2: Collect data points to create risk tool. This step will offer a proof-of-concept to the Behavioral Health data distribution methodology under consideration/development by NJII/NJHIN. Informed by current Opioid Risk Tools and various studies, key data points include (but not limited to):

Data Source	Data Description
PDMP	Number of Opioid Prescriptions in last 18 months
PDMP	Medications filled for treatment of depression
PDMP	Medications filled for treatment of other mental health disorder
HIE/HOSP	Utilization of Hospital in past 12 months (# of visits)
HIE/HOSP	History of Alcohol Abuse
HIE/HOSP	History of Drug Abuse
HIE/HOSP	Family History of Substance Abuse
MPI	Biological Gender
MPI	Age
MPI	Identity Confidence

Step 3: Due to the sensitive status of much of this information, a process of developing a rules-based filter will be piloted. Based on information published in the Seton Hall Law report, Integrating Behavioral and Physical Health Care in New Jersey, NJII is exploring the feasibility developing a computer based 'rules filter' designed to make Behavioral Health data available for clinical use as supported by federal and state legislation. Appropriate filtering for compliance with CFR 42 Part 2 rules and other restrictions are anticipated in this use case.

Step 4: Communicate risk factors via ED alerts for real-time notification of patients with an escalated risk for developing Opioid Use Disorder.

Step 5: Distribute alternative to Opioid guidelines (based on existing programs) for consideration for patients at high risk and target educational and information to patients at higher risk levels.

Step 5: Baseline and monitor indicators related to Opioid prescriptions and patients diagnosed with Opioid Use Disorders to assess effectiveness of program.

Logical Diagram



Appendix A, Attachment B NJ HIT Environmental Scan

http://www.state.nj.us/health/njhit/documents/NJ%20HIT%20Environmental%20Scan_Final%20Report_20170923.pdf

Attachment F
New Jersey FamilyCare Comprehensive Demonstration
Protocol for HRSN Infrastructure and HRSN Services

Attachment F
New Jersey FamilyCare Comprehensive Demonstration Protocol for HRSN Infrastructure

HRSN Infrastructure. In accordance with the state's Section 1115 Demonstration and Special Terms and Conditions, this protocol provides additional detail on the requirements on infrastructure investments for the Health-Related Social Needs (HRSN) program, as specifically required by STC 10.6.a. The state's HRSN program allows qualifying Medicaid beneficiaries to receive evidence-based clinically-appropriate services. Over the course of the demonstration the state is authorized to spend up to $78.75M on infrastructure investments necessary to support the development and implementation of HRSN services. This protocol outlines the proposed uses of HRSN infrastructure expenditures, types of entities that will receive funding, intended purposes of funding, projected expenditure amounts and implementation timeline.

HRSN Infrastructure

I. Implementation Timeline and Approach

a. Timeline for Disbursement of Infrastructure Funding

i. The state intends to begin awarding infrastructure funds to eligible entities no sooner than July 1, 2024. The state will utilize a phased approach to disbursing infrastructure funds to ensure providers beginning their participation at different times have sufficient infrastructure and capacity. The state will fund one or all HRSN service categories as needed to support implementation goals.

b. Approach to Infrastructure Funding Applications and Disbursements

i. The state, either directly or via existing or contracted fiscal relationships, will conduct the following activities:
   1. Develop the infrastructure funding application(s)
   2. Conduct outreach and education to eligible entities regarding infrastructure funding opportunities
   3. Review applications against minimum entity eligibility criteria
   4. Review funding request budget templates to ensure compliance with requirements
   5. Award infrastructure funding to eligible entities
   6. Disburse funding to awarded entities
   7. Monitor infrastructure funding uses or verify that milestone-based outcomes are achieved amongst eligible entities to prevent fraud, waste and abuse
   8. Develop reporting templates for awardees to report on funding uses or milestone-based outcomes
   9. Review and analyze reports from awardees on funding uses or milestone-based outcomes

ii. A state-defined process will be used to evaluate and approve applications and funding requests from eligible entities. The process will encompass several activities, including, for example:
   1. The state will set specific HRSN application windows in which entities can apply for and receive HRSN infrastructure funding.
   2. Standardized criteria to support evaluation of HRSN funding applications and requests will be used, considering the following categories:
      a. The entity has submitted a complete application and budget request or proof that certain outcomes-based milestones were achieved.
      b. The entity has requested HRSN funding within one of the allowable use categories listed in Section III, below.

c. The entity has provided a strong justification for the need for HRSN infrastructure funding.
d. Applicant has demonstrated ability to provide or support the provision of one or more HRSN services.
e. Priority consideration may be given if the entity demonstrates any of the following: hires staff that have lived experience with the HRSN service the entity is providing, their staff composition reflects the ethnic, linguistic, and/or cultural backgrounds of those they serve, they are currently serving NJ FamilyCare-eligible residents.

c. **Monitoring and Oversight**

i. The state will ensure that any HRSN infrastructure fund disbursements are consistent with these STCs. The state will ensure that any HRSN infrastructure funding is subject to program integrity standards, including:

1. **Participating in audit processes.** The state, either directly or via existing or contracted fiscal relationships, will conduct spot audits as needed to ensure that infrastructure funds are being spent on permissible uses and are being documented and reported on appropriately.
2. **Taking action to address non-compliance.** The state will ensure that action is taken to address any identified non-compliance with HRSN infrastructure funding parameters. If the funding recipient has failed to demonstrate appropriate performance, the state may impose corrective actions (e.g., caps on funding, discontinuation of funding and/or recoupment of funding). The state will provide notice to any funding recipient prior to initiating corrective action.
3. **Ensuring non-duplication of funds.** Funding recipients will be required to attest to non-duplication of funding with other federal, state and local funds. The state, either directly or via existing or contracted fiscal relationships, will monitor for funding irregularities and potential duplication of funds.
4. **Monitoring for fraud, waste and abuse.** The state, either directly or via existing or contracted fiscal relationships, will actively monitor all HRSN infrastructure disbursements for instances of fraud, waste and abuse. The state will suspend and/or terminate infrastructure funding in cases of confirmed fraud, waste and/or abuse. The state reserves the right to recoup funding as necessary.

II. **Eligible Entities.**

a. The following entities may be eligible to apply for and receive HRSN infrastructure funding:

i. Principle eligible entities include:

1. Entities that have the capacity to deliver housing-related HRSN services, including housing providers, community-based organizations, social-service agencies, traditional health care providers, and case management providers.

ii. Additional eligible entities include:

1. Entities that have the capacity to deliver other HRSN services, including food and nutrition service providers, community-based organizations, social-service agencies, traditional health care providers, and case management providers;
2. Entities that have the capacity to support the delivery of HRSN services, including state, city, county, and local governments; community-based organizations; or other entities who support HRSN contracting, implementation, invoicing and service delivery; and,
3. State agencies, local government, or contracted partners to facilitate setup, operation, and ongoing oversight of HRSN programs.

b. In addition, entities must meet the following minimum eligibility criteria in order to be considered eligible for the HRSN infrastructure funding. Minimum eligibility criteria may include:
    i. The entity is capable of providing or supporting the provision of one or more HRSN services to Medicaid beneficiaries within the state of New Jersey.
    ii. The entity has attested to being financially stable, as defined by the state.

III. **Intended Purpose and Proposed Uses of HRSN Infrastructure Funding.** The state may claim federal financial participation (FFP) in infrastructure investments to support the development and implementation of HRSN services across the following domains.

a. Technology
b. Development of business or operational practices
c. Workforce development
d. Outreach, education and stakeholder convening

The State intends to provide infrastructure funding to eligible entities for the following activities:

a. **Technology.** Qualifying entities can leverage HRSN infrastructure funding to support a range of technology needs, including those that support closed-loop referral platforms and other community information exchange priorities.
    i. Procuring IT infrastructure/data platforms/systems needed to enable, for example:
        1. Authorization of HRSN services
        2. Documentation of eligibility for HRSN services and track enrollment
        3. Closed loop referral to HRSN services
        4. Record plans of care
        5. HRSN service delivery
        6. HRSN service billing
        7. HRSN program oversight, monitoring and reporting, including for activities beyond HRSN infrastructure (e.g., reporting on HRSN services delivered, monitoring to ensure members receive the services for which they were authorized, activities to prevent fraud, waste and abuse across the HRSN program)
        8. Determine eligibility for other federal, state and local programs including Supplemental Nutrition Assistance Program (SNAP) and/or Women, Infants and Children (WIC)
    ii. Modifying existing systems (e.g., community information exchange) to support HRSN
    iii. Development of an HRSN eligibility/services screening tool
    iv. Integration of data platforms/systems/tools
    v. Onboarding to new, modified or existing systems
    vi. Training for use of new, modified or existing systems
b. **Development of business or operational practices**
    i. Development of polices/procedures related to:
        1. HRSN referral, service delivery workflows, and care plans
        2. Billing/invoicing
        3. Data sharing/reporting
        4. Program oversight/monitoring
        5. Evaluation
        6. Privacy and confidentiality
    ii. Training/technical assistance on HRSN program and roles/responsibilities
    iii. Administrative items necessary to perform HRSN duties and/or expand HRSN service delivery capacity
    iv. Procurement of administrative supports to assist implementation of HRSN

c. **Workforce development**
   i. Training provided by a technical assistance organization to support one or more HRSN providers
   ii. Cost of recruiting, hiring and training new staff to provide HRSN salary and fringe for staff that will have a direct role in overseeing, designing, implementing and/or executing HRSN responsibilities, time limited to a period of 18 months.
   iii. Necessary certifications, training, technical assistance and/or education for staff participating in the HRSN program (e.g., on culturally competent and/or trauma informed care)
   iv. Privacy/confidentiality training/technical assistance (TA) related to HRSN service delivery
   v. Production costs for training materials and/or experts as it pertains to the HRSN program

d. **Outreach, education and stakeholder convening**
   i. Production of materials necessary for marketing, outreach, training and/or education related to HRSN.
   ii. Translation of materials
   iii. Planning for and facilitation of community-based outreach events to support awareness of HRSN services
   iv. Planning for and facilitation of learning collaboratives or stakeholder convenings for HRSN
   v. Community engagement activities necessary to support HRSN program implementation and launch (e.g., roundtable to solicit feedback on guidance documents)
   vi. Administrative or overhead costs associated with outreach, education or convening directly tied to HRSN.

IV. **Projected Expenditure Amounts:** The state estimates the following infrastructure expenditure amounts by allowable use category over the course of the demonstration. The state used the annual infrastructure spending amounts articulated in the state's STCs, and an analysis of anticipated need across the state to develop the estimates below. The state anticipates that the percentage of spend permissible use categories (as illustrated in the table below) will stay relatively constant across the Demonstration Years. The state will notify CMS annually of any significant change to percentage spend, defined as greater than a fifteen (15) percentage point difference, across any of the allowable use categories below.

Allowable use category	% of spend	Estimated Amount
Technology	40%	$31.5M
Development of Operational or Business Practices	20%	$15.75M
Workforce Development	30%	$23.625M
Outreach, Education and Stakeholder Convening	10%	$7.875M
Total	100%	$78.75

HRSN Services Protocol

HRSN Services including housing supports, nutrition supports, and medically indicated meals. In accordance with the state's Section 1115 Demonstration and Special Terms and Conditions (STCs), this protocol provides additional detail on the requirements for the delivery of services for the Health-Related Social Needs (HRSN) Services including housing supports, nutritional supports, and medically indicated meals, as required by STC 10.6. New Jersey may claim Federal Financial Participation (FFP) for the specified evidence-based HRSN services identified in STC 10.2 (subject to the restrictions described below and the exclusions in STC 10.4). This protocol outlines the (I) social risk and clinical risk factor eligibility criteria, (II) covered HRSN services, (III) provider qualifications requirements, (IV) processes for identifying and screening eligible individuals, (V) processes for determining eligibility and authorizing services, (VI) care management and planning requirements, and (VII) processes to avoid conflicts of interests. The HRSN services (duration, scope, and definitions) are subject to the restrictions described below.

I. Updates to the Protocol for Assessment of Beneficiary Eligibility and Needs and Provider Qualifications for HRSN Services

a. The state may choose to cover a subset of the HRSN services and/or beneficiary qualifying criteria specified in this Attachment F. HRSN Services Protocol. Changes to the state's service offerings and eligibility criteria, within what CMS has approved in this Attachment F. HRSN Services Protocol, do not require additional CMS approval. The state must follow the following process to notify CMS of any such HRSN service or qualifying criteria change:
    i. The state must follow the same beneficiary notification procedures as apply in the case of changes to coverage and/or beneficiary service qualification criteria for state plan services, including with respect to beneficiaries who currently qualify for and/or are receiving services who may receive a lesser amount, duration, or scope of coverage as a result of the changes.
    ii. The state must provide public notice.
    iii. The state must submit a letter to CMS no less than 30 days prior to implementation describing the changes, which will be incorporated in the demonstration's administrative record.

b. In addition to the requirements in a. above, if the state seeks to implement additional clinical and social risk factors than what were included in approved Attachment F. HRSN Services Protocol, the state must follow the process below to update the protocol:
    i. The state must provide a budget neutrality analysis demonstrating the state's expected cost for the additional population(s). The state may only add additional clinical and social risk factors through the protocol process described in this STC if CMS determines the criteria are allowable and doing so would not increase the state's HRSN expenditure authority in Table Q.

ii. The state must receive CMS approval for the updated protocol prior to implementation of changes under this subpart (b).
iii. The state is limited to submitting to CMS one update to its protocol per demonstration year as part of this process outlined in this subpart (b). This restriction is not applicable to the process and scope of changes outlined in subpart (a).

II. Beneficiary Eligibility.

a. Housing Supports

i. **Covered Population**. Currently enrolled MCO Medicaid beneficiaries will be eligible to receive housing supports services provided that they also satisfy the applicable clinical and social risk criteria.
ii. **Clinical Risk Factors**. Individuals who meet one or more of the clinical-based criteria defined in Appendix Table 1.
iii. **Social Risk Factors.** Individuals must also meet one or more of the social risk factor criteria defined in Appendix Table 2.

b. **MLTSS Nutrition Supports**.

i. **Covered Population.** Currently enrolled Medicaid MLTSS beneficiaries will be eligible to receive nutrition supports services provided that they also satisfy the applicable clinical and social risk criteria.
ii. **Clinical Risk Factors.** Individuals who meet one of the following MLTSS clinical eligibility criteria.
    1. An individual 21 years and older meets the clinical eligibility for Nursing Facility level of care, which means the individual requires hands on assistance with three or more activities of daily living such as bathing, dressing, toileting, locomotion, transfers, eating, and bed mobility or has cognitive deficits and requires supervision and cueing with three or more activities of daily living.
    2. Children ages birth through 20
        a. With functional limitations, identified in terms of developmental delay or functional limitations for age-appropriate activities of daily living, and require nursing care over and above routine parenting and meets the criteria for skilled nursing care that requires complex skilled nursing interventions 24 hours per day, seven days a week.
        b. Or, with functional limitations, identified in terms of developmental delay or functional limitations for age-appropriate activities of daily living, and require nursing care over and above routine parenting and meets the criteria for medical and/or intense therapeutic services for the technology dependent child who requires a medical device that the Federal Food and Drug Administration has classified as a life-supporting or life-sustaining device that is essential to or that yields information that is essential to

the restoration or continuation of bodily function and continuation of human life and the use of the device requires ongoing skilled nursing intervention 24 hours per day seven days a week.

iii. **Social Risk Factors.** Individuals must also meet one of the following social risk factors described respective to each service:

1. **Nutrition Counseling and Education**
    a. Eligible individuals are experiencing challenges understanding, obtaining, or preparing foods to meet their nutritional needs.
2. **Transitional Pantry Stocking**
    Individuals:
    a. Meet either the USDA definition of low or very low food security.
    b. Transitioning to a community residence from an institutional setting, including
        i. Certified nursing homes
        ii. Mental health facility
        iii. Acute care hospitals with an extended stay (30+ days)
        iv. Carceral settings (i.e., state prison, county correctional facility, youth correctional facility)

    AND
    c. Indicate a lack of community or family support and challenges accessing and obtaining needed food during transition to a community residence.
3. **Short-Term Grocery Provision**
    Individuals:
    a. Meet either the USDA definition of low or very low food security.
    b. Experiencing a significant or emergent disruption in the ability to obtain an adequate level of nutrition[1] due to an acute behavioral or physical health episode or due to clinical factors that would put them at risk of an unnecessary emergency department visit, hospital admission, or institutional placement

c. Medically Indicated Meals Pilot

i. **Covered Populations**. The Medically Indicated Meals Pilot will be conducted with selected MCOs. MCO Medicaid beneficiaries, currently enrolled with a participating MCO, will be eligible to participate in the

[1] Individuals meet the USDA definition of food insecurity as a result of the clinical disruption they are experiencing which is limiting their ability to access adequate food. U.S. Department of Agriculture, Economic Research Service. Definitions of food security

pilot (up to 300 individuals per Demonstration year) provided that they also satisfy the applicable clinical and social risk criteria. Additional details on covered populations will be determined in collaboration with MCO(s) upon selection of MCO(s) for the pilot.

ii. **Clinical Risk Factors**. Pregnant individuals with one of the following clinical risk factors:
    1. Was diagnosed with diabetes prior to pregnancy
    2. Is diagnosed with gestational diabetes during pregnancy
    3. Is at-risk of gestational diabetes during pregnancy

iii. **Social Risk Factors.**

    a. The member meets either the USDA definition of low or very low food security.
    AND
    b. Individuals must also be experiencing challenges understanding, obtaining, or preparing foods to meet their nutritional needs.

d. **Medical Appropriateness**. To ensure the services are medically appropriate, the state will require that individuals identified as in need of one of these HRSN services meet the described relevant clinical and social risk criteria. To qualify for an HRSN service, a beneficiary must:
    i. Meet the eligibility criteria of the covered populations, clinical risk factor, and social risk factor for the requested HRSN service; and
    ii. Meet any additional eligibility criteria and requirements that apply in connection with the specific HRSN service.

e. **Publicly Maintained Criteria**. The state will maintain eligibility criteria for each HRSN program consistent with the clinical and social risk criteria detailed above on a public facing DMAHS webpage and require that MCOs also maintain the same eligibility criteria on a public facing webpage. The content will be updated if the criteria is changed.

III. HRSN Services

a. **Nonduplication of services.** No HRSN service will be covered that is found to be duplicative of a state, federally, or locally funded service or other HRSN service the beneficiary is already receiving.

b. **Providing culturally and linguistically appropriate services.** To the fullest extent possible, all HRSN services must be provided in a way that is culturally responsive and ensures meaningful access to language services. MCOs and their contracted providers must ensure that the HRSN services follow all existing contract requirements defined in the New Jersey DMAHS for the delivery of culturally responsive services, screening, education and care planning.

c. **Covered HRSN Services.** The state will cover the following HRSN services as defined below:

Program	Service	Description
Housing Supports	Pre-tenancy services	Services that support beneficiaries in obtaining housing, including but not limited to: • Developing an individualized housing support plan. The plan should establish short and long-term measurable goals, describing how goals will be achieved and how barriers will be addressed. The plan should also include prevention and early intervention services if housing is jeopardized. An example of a housing support plan may include: o For individuals exiting institutions (e.g., nursing facilities), thorough and proactive discharge planning and other transitionary tasks. • Assisting with navigating the complexities of the housing application process through the progression of prospective tenant to tenant as well as assisting with the housing search o Searching for housing, presenting options to the beneficiary, and contacting prospective housing options for availability and information. o Facilitating enrollment in the local Continuum of Care's Coordinated Entry System or in the school's McKinney-Vento program. o Assisting the beneficiary in undergoing tenant screening. o Completing rental applications. o Assisting the beneficiary to communicate with the landlord or property manager, including accompanying the head of household to appointments, lease negotiations, and signings. o Review of the living environment to ensure it is safe and ready for move-in. o Assisting in arranging for and supporting the details of the move.

		• Identifying, coordinating, and securing resources to assist with housing costs and other expenses ○ Assisting in obtaining required documentation (e.g., Social Security card, birth certificate, income and benefits statements, prior rental history) for housing assistance programs and applications or any social service program, as needed to transition to tenancy. ○ Helping complete applications and navigating the process to obtain financial supports to afford housing, including linkages to rental assistance, security deposits, application fees, moving costs, non-medical transportation to tour units and attend tenant interviews, and food and clothing needed at transition. ○ Providing financial education including credit repair and credit counseling, 1:1 budgeting assistance, assistance with setting up a bank account, and bill paying. ○ Identifying and connecting the beneficiary to resources that promote long-term housing stability, including mental health resources, affordable childcare, employment, transportation, and school enrollment. ○ Identifying and making referrals to legal services to address complex tenancy issues preventing a individual from entering a housing arrangement.
Housing Supports	Tenancy sustaining services	Services that support beneficiaries achieve their goal of maintaining safe and stable tenancy, including but not limited to: • Developing or revising an individualized housing support plan. The plan should establish short and long-term measurable goals, describing how goals will be

		achieved and how barriers will be addressed. • Assisting with the housing recertification processes, including lease renewals and housing subsidy renewals. • Educating and training the beneficiary on the role, rights and responsibilities of the tenant and landlord. • Supporting the beneficiary in development of independent living and tenancy skills, including: housekeeping; cleanliness; time management; financial literacy skills; budgeting; fraud prevention; establishing a bank account; connections to community services including grocery stores, transportation, schools, and jobs; as well as connecting the individual to social services based on additional needs as identified in the housing support plan. Connections to social services can include programs and services for employment, education, health, food (e.g., SNAP), legal services, eviction prevention, or other social services • Identifying and helping secure benefits or supports to help pay for rent and utilities, including assistance filling out applications and gathering appropriate documentation in order to obtain sources of income necessary for community living (e.g., Social Security, HUD Housing Choice Vouchers, etc.). Providing assistance in addressing circumstances or behaviors that may jeopardize housing such as late payment, lease violation, maintenance issues, disputes with landlords or neighbors, or other identified issues. This should include both direct interventions to address risks and connection of the beneficiary to relevant community resources that may offer assistance with those risks.
Housing Supports	Move-in supports	Payment for non-recurring, one-time transitional expenses provided to a beneficiary during the transition period to their own home., including:

		• Payment for the set-up of the new housing unit, to address needs identified in the person-centered care plan ○ Services required for a beneficiary's health and safety, such as pest eradication and one-time cleaning prior to move in ○ Purchase of household furnishings needed to establish community-based tenancy including furniture, food preparation items, pantry stocking, or bed/bath linens. If necessary, assistance may also be provided to help set up these items • Payment for items to support the details of the move, as appropriate, including: ○ Costs for filing applications and payment of application fees ○ Payment for move-in costs including movers to ensure transportation of self and possessions to new housing arrangement ○ Payment of security deposits ○ Payment of set-up fees or deposits for utility or service access, including telephone, electricity, heating and water
Housing Supports	Residential modifications and remediation	Physical modifications, adaptations, or remediation services to a beneficiary's private primary residence required by their care plan which are necessary to ensure the health, welfare and safety of the beneficiary, or which enable the beneficiary to function with greater independence in the home or community. • Modifications can include: the installation of ramps and grab bars, widening of doorways, modifications of bathrooms, the installation of accessibility ramps, the installation of wheelchair-level counters with cutouts for the sink, special mirrors and lighting accommodations for individuals with epilepsy, the installation of specialized electrical or plumbing systems that are necessary to accommodate the

		medical equipment and supplies which are needed for the health, safety and welfare of the individual. • Remediation services can include: repairing or improving ventilation systems, and mold/pest remediation. • Heating and cooling services can include: Medically necessary air conditioners, heaters, humidifiers, air filtration devices and other asthma remediation, and refrigeration units as needed for medical treatment.
MLTSS Nutrition Supports	Nutrition counseling and education	Nutrition counseling assesses a beneficiary's dietary intake, identifies areas where changes are needed, and provides individualized advice and guidance about options and methods for improving nutritional status. Nutrition education strategies can be provided to an individual or a group and are meant to motivate and facilitate voluntary adoption of food choices, meal preparation, and other food and nutrition-related behaviors conducive to health and wellbeing. These services must: • Include connection and assistance with obtaining other nutritional support services available through MLTSS (e.g., home delivered meals, short term grocery delivery, etc.) • Connect to external nutrition resources for which the beneficiary qualifies and assistance with the application to SNAP, WIC, and other state or federal benefit programs to enable access to those resources to meet nutritional needs. • Be offered in accordance with evidence-based nutrition guidelines. These services may be supplemented with handouts, take-home materials, and other informational resources that support nutritional health and well-being.

MLTSS Nutrition Supports	Transitional pantry stocking	The purchase of essential pantry stocking items to ensure adequate and necessary access to food and goods immediately following transition from an institutional setting. This service must: • Be a maximum of 6 months supply of pantry stocking items, provided in 30 day increments, renewed each month, unless otherwise specified by the beneficiary. • Be provided in weekly or bi-weekly installments depending on beneficiary preference and be delivered and be available to the individual starting on the day of discharge for up to 3 meals a day, for up to 6 months. • Be offered in accordance with evidence-based nutrition guidelines. • Follow food safety standards. • Meet the needs of beneficiary's personal and cultural dietary preferences. • Include connection and assistance with obtaining other nutritional support services available through MLTSS for which the beneficiary qualifies (e.g., home delivered meals, nutrition counseling and education) • Connection to and assistance with the applications to SNAP, WIC, and other state or federal benefit programs to enable continued access to resources to meet nutritional needs after 30-day supply of pantry stocking.
MLTSS Nutrition Supports	Short-term grocery provision	The provision of short-term groceries purchased and delivered from a food retailer, for an MLTSS beneficiary who meets eligibility requirements. This service must: • Be delivered and stocked for the beneficiary or provided in a manner that is suitable for the disruption that the beneficiary is experiencing.

		• Be provided based on beneficiary preference or need in at minimum every other week installments. • Be provided in accordance with evidence-based nutrition guidelines. • Follow food safety standards. • Meet the needs of beneficiary's personal and cultural dietary preferences. • Include connection and assistance with obtaining other nutritional support services available through MLTSS (e.g., home delivered meals, nutrition education and counseling) for which the beneficiary qualifies • Connection to and assistance with the applications to SNAP, WIC, and other state or federal benefit programs to enable access to resources to meet nutritional needs. Limitations: • This service may not be provided for more than 30 days. • This service may only be used on purchases consistent with SNAP guidelines. • The total dollar value of the groceries provided over the period is capped at 200% of the Maximum Monthly USDA SNAP Allowance based on the household size. • This service can be utilized no more than once per calendar year.
Medically Indicated Meals Pilot	Medically indicated meals	Delivery of up to three prepared meals a day to eligible beneficiaries, starting as early as the identification of pregnancy through two months after the end of the pregnancy. This service must: • Be provided to the address where individual resides. • Include detailed instructions for the individual to safely store and re-heat prepared meals. This service may:

		• Be extended for one additional 6-month period if the individual continues to meet the social risk factor criteria and continues to have diabetes in the second month after the end of pregnancy. • Include additional nutrition support to the household if that household includes an individual participating in the pilot.

IV. Provider Qualifications

a. **Housing Supports** providers will be required to meet the following minimum qualification requirements for the service(s) they are providing. DMAHS will provide additional guidance on how organizations can demonstrate compliance with these qualifications.
   i. Pre-tenancy and tenancy sustaining service providers must have knowledge of principles, methods, and procedures of housing services covered under the waiver or have experience providing comparable services meant to support individuals in obtaining and maintaining stable housing
   ii. Medically necessary home modification and remediation services and devices providers must have the ability to timely and appropriately deliver services to beneficiaries' homes
   iii. Move-in supports providers must have the ability to timely and appropriately deliver services to beneficiaries' homes

b. **Nutrition Counseling and Education** providers will be required to meet the following minimum qualification requirements:
   i. Staff providing the nutrition counseling and education must demonstrate the capacity and experience to provide nutrition counseling services by meeting one or more of the following criteria:
      1. Education (e.g. Bachelor's degree, Associate's degree, certificate) in a nutrition, human services, social services, or other related field
      2. Completed training specific to nutrition education or counseling (e.g., webinar courses provided by SNAP-Ed, CDC-approved training for the National Diabetes Prevention Program Lifestyle Coach position, or other trainings from accredited nutrition organizations)
      3. Certification or Credential specific to nutrition education or counseling (e.g., Registered Dietician, Certified Nutrition & Wellness Educator by the American Association of Family & Consumer Sciences, Certified Nutrition Specialist, or Certified Diabetes Educator)

ii. Adhere to relevant national guidelines such as the Dietary Guidelines for Americans, evidence-based practice guidelines for specific chronic diseases and conditions, and/or guidelines on cultural competence and culturally appropriate meals.
iii. The organization or provider must have a qualified nutritionist on staff to oversee nutrition counseling and education who meets at least one of the following criteria:
    1. Is a Registered Dietician or Registered Dietician Nutritionist and have a current registration with the Commission on Dietetic Registration
    2. A Master's degree in nutrition or related field
    3. Three years of recent, relevant experience working with individuals in a food and nutrition education related capacity

c. **Transitional Pantry Stocking and Short-term Grocery Provision** providers will be required to meet the following minimum qualification requirements:
    i. Care Managers or staff employed by Managed Care Organizations delivering these nutrition support services as part of transition planning or ongoing care management services must meet MLTSS Care Management staff qualification outlined in the New Jersey DMAHS *MCO contract Article 9.5.2*
    ii. External vendor providers such as grocery stores, grocery delivery companies, or nutrition assistance organizations must:
        1. Follow best practice guidelines and industry standards for food safety.
        2. Have the ability to meet the needs of beneficiary's personal and cultural dietary preferences.
        3. Have the capacity to provide services on a one-time, daily, weekly, or monthly basis, depending on the specific service's permitted frequency and beneficiary's preference.
d. **Medically Indicated Meals Pilot** providers will be required to meet the following minimum qualification requirements:
    i. Must be able to deliver meals to New Jersey residences.
    ii. Must design meals that are approved by a Registered Dietician Nutritionist that meet the individual's needs. When possible, provider should design meals that meet the needs of individual's personal and cultural dietary preferences.
    iii. Must prepare and deliver meals following best practice guidelines and industry standards for food safety.

V. Beneficiary Identification and Assessment of Service Need

a. **Identification**.

    i. **Housing Supports**. MCOs will ensure multiple pathways to identify and engage MCO Medicaid beneficiaries who potentially have one or more

housing supports service needs. Pathways for beneficiary identification must include:

1. MCOs proactively identifying and engaging beneficiaries through a review of encounter and claims data
2. MCOs accepting self-referrals from the beneficiary or their family/caregivers
3. MCO care managers identifying beneficiaries through ongoing engagement including through transition planning processes for individuals transitioning from institutional settings to the community
4. MCO accepting referrals from the MCO's health care provider network
5. MCOs accepting referrals from county social service agencies and organizations that connect or enroll individuals in other housing-related assistance programs (i.e., Continuum of Care, Public Housing Authorities, etc.)
6. MCO accepting referrals from community-based providers, agencies or organizations who offer housing support services and/or engage beneficiaries who may have housing support needs, which could include:
    a. Private and public housing service agencies and housing supports providers (e.g., homeless shelters, permanent supportive housing organizations)
    b. Correctional institutions
    c. Other CBOs who engage MCO Medicaid beneficiaries

ii. **MLTSS Nutrition Supports**. MCOs will ensure multiple pathways to identify and engage Medicaid MLTSS beneficiaries with potentially one or more nutrition supports service needs. Pathways for beneficiary identification must include:

1. MCOs proactively identifying and engaging beneficiaries through a review of encounter and claims data
2. MCOs accepting self-referrals from the beneficiary or their family/caregivers
3. MLTSS care managers identifying beneficiaries through ongoing engagement including through transition planning processes for individuals transitioning from institutional settings to the community
4. MCO accepting referrals from the MCO's health care provider network
5. MCOs accepting referrals from county social service agencies and organizations that connect or enroll individuals in other nutrition-related assistance programs (i.e., NJ SNAP, WIC, etc.)

6. MCO accepting referrals from community-based providers, agencies or organizations who offer MLTSS nutrition services and/or engage MLTSS beneficiaries who may have nutrition support needs, which could include:
    a. Area Agencies on Aging
    b. Nutrition assistance provider organizations
    c. Child welfare workers and other case managers
    d. Correctional institutions
    e. Private and public housing service agencies and housing supports providers
    f. Other CBOs who engage with New Jersey Medicaid MLTSS beneficiaries

iii. **Medically Indicated Meals Pilot**. The Medically Indicated Meals pilot will be conducted with selected MCOs and will only be available to the MCO Medicaid beneficiaries enrolled with a participating MCO. Additional details on beneficiary identification will be determined in collaboration with the MCO(s) upon selection of MCO(s) for the pilot. At minimum, pathways for beneficiary identification must include all of:
    1. MCO(s) proactively identifying and engaging eligible individuals through their current workflows
    2. Individuals or their providers contacting the MCO(s) for self-referral or direct referral and request screening and eligibility determination for the pilot

b. **Assessment of Service Need**.

i. **Housing Supports**. MCOs will collect necessary information about beneficiaries identified with a housing support service need for an approval decision. MCOs will collect this information through multiple pathways, including through referrals for services sent to MCOs, as described above, and through MCO care managers identifying beneficiaries' needs through ongoing engagement.

ii. **MLTSS Nutrition Supports.** MCOs will collect necessary information about Medicaid MLTSS beneficiaries identified with a nutrition support service need for an approval decision through service referrals as described above. In addition, DMAHS will integrate nutritional need screening into existing MLTSS care planning requirements by updating the Plan of Care and Community Transition plan development criteria specified in the New Jersey DMAHS *MCO Contract Article* 9.6.4. The Care Manager shall screen MLTSS beneficiaries for nutritional need, review each service to ensure that the frequency, duration, or scope of the services accurately reflects the beneficiary's current need, and update the plan of care to document the need and use of the approved service as necessary. Assessment of food security status may be determined by

methods such as but not limited to USDA's Food Security Survey Modules or a method developed by DMAHS.

iii. **Medically Indicated Meals Pilot.** The Medically Indicated Meals Pilot will be conducted with selected MCOs. Additional details on beneficiary identification will be determined in collaboration with MCO(s) upon selection of MCO(s) for the pilot. At minimum, MCO(s) must screen for eligibility based on clinical and HRSN risk factors using data sources that include, but are not limited to: encounter and claims data, NJ's Perinatal Risk Assessment, and MCO's obstetrical care management activities. In the case of self-referral or direct referral, or when other data sources for screening information are not available, MCO(s) may accept a clinical referral as long as it is documented. Assessment of food security status may be determined by methods such as but not limited to USDA's Food Security Survey Modules or a method developed by DMAHS.

VI. Eligibility Determination and Services Approval

a. **Housing Supports.**

i. MCOs will utilize their existing infrastructure and process for the service authorizations and reauthorizations.

ii. Upon receipt of the information regarding the beneficiary's housing needs, the MCO will use reasonable efforts to obtain all other information necessary to 1) determine whether the beneficiary is eligible for housing support and 2) to authorize the appropriate services. The MCO's reasonable efforts must include:

1. Obtaining the results from housing need screening questions to assess eligibility to receive housing supports services
2. Collecting beneficiary information from the beneficiary's transition or care plan, or from the plan's own beneficiary records
3. Collecting relevant and appropriate information obtained via follow up with the beneficiary or referring organization/individual if necessary

iii. Service approval, including amount, duration, and scope of services, will be based on the following criteria:

1. Confirmation that the beneficiary is enrolled in the MCO
2. Determination that the beneficiary meets at least one social and clinical risk factor eligibility criteria for at least one of the housing supports services
3. Assessment of the beneficiary's clinical and social needs that justify the medical appropriateness of the service

iv. MCOs will expeditiously notify the beneficiary of authorization for the housing support services; and provide information about appeals and hearing rights.

v. MCOs will communicate the approval or denial of services to the individual.

vi. MCOs will communicate the approval or denial of services to the referring organization, where appropriate and with the beneficiary's consent, to create a closed loop referral. MCOs must have processes in place to rescreen and reauthorize beneficiaries receiving housing support services every 12 months, or after a change in housing conditions.

b. **MLTSS Nutrition Supports.**
   i. MCOs will utilize their existing MLTSS infrastructure and process for the service authorizations, reauthorizations and beneficiary notifications for the nutrition support services.
   ii. Upon receipt of the information regarding the beneficiary's nutritional needs, the MCO will use reasonable efforts to obtain all other information necessary to 1) determine whether the beneficiary is eligible for nutritional support and 2) to authorize the appropriate services. The plan's reasonable efforts must include:
      1. Utilizing the results from the New Jersey Choice Home Care assessment of Nursing Facility Level of Care to confirm MLTSS eligibility
      2. Obtaining the results from nutritional need screening questions to assess eligibility to receive nutrition supports services
      3. Collecting beneficiary information from the beneficiary's transition or care plan, or from the plan's own patient records
      4. Collecting relevant and appropriate information obtained via follow up with the beneficiary or referring organization/individual if necessary
   iii. Service approval will be based on the following criteria:
      1. Confirmation that the beneficiary is enrolled in MLTSS and meets the clinical and financial MLTSS eligibility criteria.
      2. Determination that the beneficiary meets the social risk factor eligibility criteria for at least one of the nutrition supports services.
      3. Assessment of the beneficiary's clinical and social needs that justify the medical appropriateness of the service
   iv. MCOs will make best efforts to expeditiously notify the beneficiary of authorization for the nutrition support services; and provide information about appeals and hearing rights. MCOs will communicate the approval or denial of services to the individual.
   v. MCOs will communicate the approval or denial of services to the referring organization, where appropriate and with the beneficiary's consent, to create a closed loop referral.

c. **Medically Indicated Meals Pilot.**
   i. The Medically Indicated Meals Pilot will be conducted with selected MCOs. Additional details on eligibility determination and services approval will be determined in collaboration with MCO(s) upon selection

of MCO(s) for the pilot. MCOs will utilize their existing infrastructure and process for the service authorizations and reauthorizations.

ii. The MCO(s) will use reasonable efforts to identify eligible beneficiaries for the pilot, including:
    1. Collecting beneficiary information from NJ's Perinatal Risk Assessment and other data sources
    2. Collecting beneficiary information from the plan's own patient records
    3. In the case of self-referral or direct referral, collecting relevant and appropriate information obtained via follow up with the beneficiary or referring organization/individual

iii. Service approval, including amount, duration, and scope of services, will be based on the following criteria:
    1. Confirmation that the beneficiary is enrolled in the MCO participating in the pilot
    2. Determination that the beneficiary meets social and clinical risk factor eligibility criteria for the pilot

iv. The MCO(s) will use reasonable efforts to expeditiously notify and enroll interested beneficiaries in the pilot so that individuals initiate services in a timely manner during pregnancy.

v. The MCO(s) will use reasonable efforts to continuously engage participating beneficiaries to remain in the pilot and continue to receive meal deliveries.

vi. For the subset of beneficiaries who continue to meet the social risk criteria and continue to have diabetes in the second month after the end of the pregnancy, MCOs must have a process for approval of an extension of the pilot for one additional 6-month period of meals.

VII. Care Plan Development Process

a. **Housing Supports**. MCOs will leverage and significantly expand their existing housing infrastructure and process for care planning for beneficiaries to ensure the needs of the member are met.

    i. The MCO will offer care management for beneficiary approved for housing support services. The care management will include:
        1. Developing a care plan with the beneficiary, with review at least every 12 months; MCO housing specialists will utilize their housing expertise to help develop appropriate care plans for members.
        2. Referring the beneficiary to an HRSN provider for the approved services, and supporting beneficiary choice of provider, ensuring beneficiary needs are met by the Provider in a timely manner,

including through regular communication with the individual and HRSN Provider delivering the service, and finding alternative providers if needed;
3. Identifying other HRSN services the beneficiary may need;
4. Determining what other services the beneficiary is receiving or may be eligible to receive under Medicaid or other programs;
5. Coordinating with other social support services and care management the beneficiary is already receiving or becomes eligible for while receiving the HRSN service;
6. Conducting reassessment for services prior to the conclusion of the service; and
7. At a minimum, conducting a 6-month check-in to understand if HRSN services are meeting their needs, if additional/new services are needed if the service duration is longer than 6 months, or if HRSN services are duplicating other services they are receiving.

ii. The MCO will create the care plan with the beneficiary to obtain the HRSN service as approved by the MCO. The MCO will gather input from the MCO housing specialist and relevant organizations that have a trusted existing relationship with the beneficiary, including the organization that referred the beneficiary for services or is currently delivering services to the beneficiary. The care plan will be in writing and developed with and agreed upon by the beneficiary.
    1. The care plan will include:
        a. The recommended HRSN service;
        b. The service duration;
        c. The determination that the recommended service, unit of service, and service duration is medically appropriate based on clinical and social risk factors;
        d. The goals of the service(s);
        e. The follow-up and transition plan;
        f. The MCO care management team responsible for managing the beneficiary's HRSN services.

iii. Care management must include at least one meeting with the beneficiary, either in person or by telephone or videoconference during the development of the care plan. If efforts to have a meeting are unsuccessful, the MCO is required to document connection attempts, barriers to having a meeting, and justification for continued provision of service.

iv. Beneficiaries may choose to initiate services, consistent with their Services Approval, prior to the completion of the care plan documentation process.

b. MLTSS Nutrition Supports. MCOs will be required to incorporate care planning and documentation for HRSN nutrition supports into the existing MLTSS care management and planning practices for beneficiaries.

i. As part of existing MLTSS care management requirements, MCOs must assign all MLTSS beneficiaries a care manager. MLTSS care management functions already include the screening, care planning, navigation and closed loop referrals for all MLTSS HRSN nutrition supports services. include the screening, care planning, navigation and closed loop referrals for all MLTSS HRSN nutrition supports services.

ii. The MCO's Care Managers shall use a person-centered approach regarding the beneficiary assessment and needs, taking into account not only covered services, but also formal and informal support services as applicable. Care Managers shall:

1. Obtain a copy of an existing assessment or conduct a NJ Choice assessment system, complete the initial face-to-face visit and complete the Plan of Care, including beneficiary's signature, within forty-five (45) calendar days of enrollment notification.
2. Meet with the beneficiary and review their care plan
    a. At least every one hundred eighty (180) calendar days for a beneficiary in a community alternative residential setting, or
    b. At least every ninety (90) calendar days for a beneficiary residing in pediatric SCNF or beneficiaries residing in a community setting. All visits shall be face-to-face with at least two (2) visits occurring within the beneficiary's place of residence.
3. Ensure the involvement of the beneficiary and beneficiary's family in strengths/needs identification as well as decision making.
4. Develop goals that address the issues that are identified during the assessment and care planning process.
5. Develop the care plan with the beneficiary and/or authorized representative, based on the beneficiary's assessed needs pursuant to program requirements. This shall include unmet needs, personal goals, risk factors, and Back-up Plans.
6. Arrange plan of care services using both formal and informal supports.
7. Monitor all beneficiary needs and services and document them in the beneficiary's electronic Care Management record pursuant program requirements outlined in the New Jersey DMAHS *MCO contract Article 9.2.2.*
8. Coordinate with other social support services and care management the beneficiary is already receiving or becomes eligible for while receiving nutrition supports

iii. The MLTSS care plan shall be based upon:
    1. NJ Choice assessment system data including the Care Assessment Protocols (CAPS) and any other state mandated tools,
    2. Options Counseling and Interim Plan of Care, inclusive of recommended and approved HRSN and nutrition supports services
    3. The face-to-face discussion with the beneficiary that includes a systematic approach to the assessment of the beneficiary's strengths and needs, inclusive of the beneficiary's nutrition and other HRSN needs,
    4. Recommendations from the beneficiary's primary care provider (PCP), and
    5. Input from service providers, as applicable.

iv. The MLTSS care plan must contain, but is not limited to, the essential elements:
    1. Beneficiary Demographics
    2. Beneficiary Goal(s)
    3. Beneficiary's Assessed Needs, inclusive of assessed nutrition support and other HRSN needs,
    4. Service and Support Needs, inclusive of nutrition support service and other HRSN service needs,
    5. Medical Review
    6. Caregiver's Support Need
    7. Beneficiary Rights and Responsibilities
    8. Special Instructions/Comments (Including beneficiary and beneficiary Representative signature page)

v. MCPs must also adhere to all MLTSS community transition planning and documentation requirements outlined in the New Jersey DMAHS *MCO contract Article 9.7.2*.

vi. The beneficiary's signature and acknowledgement of participation in the plan of care process shall be documented in the beneficiary's electronic care management record.

c. **Medically Indicated Meals Pilot**. The Medically Indicated Meals Pilot will be conducted with selected MCOs. At minimum, the MCO(s) must document a written care plan to address a beneficiary's dietary and social needs at the time of the beneficiary's enrollment into the pilot. Additional details on care planning for eligible beneficiaries will be determined in collaboration with MCO(s) upon selection of MCO(s) for the pilot.

VIII. Conflict of Interest

a. To protect against conflict of interest and ensure compliance with HCBS conflict of interest standards, the state will require that the MCOs perform the service authorization function and develop the care plan, and prohibit the subcontracting of such functions where that would result in a single entity conducting the service

authorization, care planning, and service provision, except as provided in subsection (b) below, or otherwise approved by DMAHS.

b. Service authorization, care planning, and service provision for select services may be provided by the MCO, subject to protocols established by the state to ensure that service authorization, care planning, and service provision are performed in a manner that guards against conflicts of interest and ensures that beneficiaries receive counseling and education on provider and services options in accordance with all applicable requirements.

Appendix

Table 1. Housing Supports Clinical Risk Factor Criteria

Clinical-Based Criteria	Description
Chronic health condition	One or more chronic conditions consistent with those identified in Social Security Act section 1945(h)(2). Examples of conditions can include: diabetes, BMI over 25, cardiovascular disease, respiratory disease, HIV/AIDS diagnosis, hypertension, physical disability (e.g. amputation, visual impairment), cancer, hyperlipidemia, chronic obstructive pulmonary diseases, chronic kidney disease
Mental health condition	An individual with at least one serious mental health illness, consistent with conditions included in the definition in N.J.A.C. 10:37B and/or at least two concurrent mental health conditions that require support and are impacting the ability to maintain a stable housing situation. Applicable mental health conditions include but are not limited to: Bipolar Disorder; Borderline Personality Disorder; Depression; Dissociative Disorders; Eating Disorders; Obsessive-compulsive Disorder Posttraumatic Stress Disorder; Psychosis Schizoaffective Disorder; and Schizophrenia.
Substance misuse	An individual with a substance use disorder who is in need of substance use treatment.
Pregnancy	Identified as: I. An individual who is currently pregnant II. An individual who is up to 12 months after the end of pregnancy.
Complex medical health condition caused by an intellectual or developmental disability	Qualifying physical, neurological, or behavioral, condition that directly impacts the ability to maintain a healthy and stable lifestyle.
Individuals experiencing intimate partner violence, domestic violence, and/or victims of human trafficking	An individual who is experiencing or has experienced intimate partner violence (IPV), domestic violence, or human trafficking.

Assistance with ADLs and IADLS	Individual assessed to have a need for assistance with: 1. 1 or more activity of daily living (ADL), or 2. 3 or more instrumental activities of daily living (IADL) and has a behavioral health condition or cognitive impairment (e.g., impairment to decision making or memory).
Repeated emergency department use or hospital admissions	An individual with repeated use of emergency department care (defined as two or more visits in the past 6 months or four or more visits in the past 12 months).

Table 2. Housing Supports Social Risk Factor Criteria

Social-Risk Criteria	Description
Currently experiencing homelessness	Meets any of the 4 categories of "homeless" established by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5: 1. Literally Homeless 2. Imminent Risk of Homelessness 3. Homeless Under Other Federal Regulations 4. Fleeing/Attempting to Flee Domestic Violence
At risk of homelessness	Meets any of the categories of "at risk of homelessness" detailed in Section (1)(iii), (2), or (3) of the definition, established by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5.
Individuals at risk of institutionalization who require a new housing arrangement to remain in the community	Qualifying institutions include: hospitals, mental health residential treatment facilities, substance use disorder treatment facilities, and long-term care facilities.

Transitioning from an institution to the community	This includes beneficiaries who could potentially transition from an institution to the community but are unable due to insufficient placement options. Qualifying institutions include: hospitals, mental health residential treatment facilities, substance use disorder treatment facilities, and long-term care facilities.
Individuals released from correctional facilities	Includes beneficiaries released from incarceration within the past 12 months. Qualifying institutions include: state and federal prisons, local correctional facilities, and juvenile detention facilities.

New Jersey 1115 HRSN Services Matrix

Target Populations	Housing Supports				MLTSS Nutrition Supports			MIM Pilot
	Pre-tenancy services	Tenancy sustaining services	Move-in supports	Residential modifications and remediation	Nutrition counseling and education	Transitional pantry stocking	Short-term grocery delivery	Medically indicated meals
MCO Enrolled Members*	x	x	x	x				x**
MLTSS Enrolled Members					x	x	x	

*MCO-enrolled members includes members enrolled in MLTSS

**The Medically Indicated Meals Pilot will be conducted with selected MCOs. MCO Medicaid beneficiaries, currently enrolled with a participating MCO, will be eligible to participate in the pilot (up to 300 individuals per Demonstration year).

Service	Eligible Population	Social Risk Factor	Clinical Criteria for the pop
Pre-tenancy services	MCO enrolled members	- Currently experiencing homelessness - At risk of homelessness - Individuals at risk of institutionalization who require a new housing arrangement to remain in the community - Transitioning from an institution to the community - Individuals released from correctional facilities	- Chronic health condition - Mental health condition - Substance misuse - Pregnancy - Complex medical health condition caused by an intellectual or developmental disability - Individuals experiencing intimate partner violence, domestic violence, and/or victims of human trafficking - Assistance with ADLs and IADLS - Repeated emergency department use or hospital admissions
Tenancy sustaining services	MCO enrolled members	- Currently experiencing homelessness - At risk of homelessness - Individuals at risk of institutionalization who require a new housing arrangement to remain in the community - Transitioning from an institution to the community - Individuals released from correctional facilities	- Chronic health condition - Mental health condition - Substance misuse - Pregnancy - Complex medical health condition caused by an intellectual or developmental disability - Individuals experiencing intimate partner violence, domestic violence, and/or victims of human trafficking - Assistance with ADLs and IADLS - Repeated emergency department use or hospital admissions
Move-in supports	MCO enrolled members	- Currently experiencing homelessness - At risk of homelessness - Individuals at risk of institutionalization who require a new housing arrangement to remain in the community - Transitioning from an institution to the community - Individuals released from correctional facilities	- Chronic health condition - Mental health condition - Substance misuse - Pregnancy - Complex medical health condition caused by an intellectual or developmental disability - Individuals experiencing intimate partner violence, domestic violence, and/or victims of human trafficking - Assistance with ADLs and IADLS - Repeated emergency department use or hospital admissions
Residential modifications and remediation	MCO enrolled members	- Currently experiencing homelessness - At risk of homelessness - Individuals at risk of institutionalization who require a new housing arrangement to remain in the community - Transitioning from an institution to the community - Individuals released from correctional facilities	- Chronic health condition - Mental health condition - Substance misuse - Pregnancy - Complex medical health condition caused by an intellectual or developmental disability - Individuals experiencing intimate partner violence, domestic violence, and/or victims of human trafficking - Assistance with ADLs and IADLS - Repeated emergency department use or hospital admissions

New Jersey 1115 HRSN Services Matrix: Nutrition

Service	Eligible Population	Social Risk Factor	Clinical Criteria for the pop
Nutrition counseling and education	MLTSS enrolled Members	- Individuals experiencing challenges understanding, obtaining, or preparing foods to meet their nutritional needs. - Meets USDA definition of low or very low food security.	NJ DMAHS MLTSS Clinical Eligiblity Critera
Transitional Pantry Stocking	MLTSS enrolled Members	Individuals: a.Transitioning to a community residence from an institutional setting, including i. Certified nursing homes ii. Mental health facility iii. Acute care hospitals with an extended stay (30+ days) iv. Carceral settings (i.e., state prison, county correctional facility, youth correctional facility) AND b. Indicate a lack of community or family support and challenges accessing and obtaining needed food during transition to a community residence. Meets USDA definition of low or very low food security.	NJ DMAHS MLTSS Clinical Eligiblity Critera
Short Term Grocery Delivery	MLTSS enrolled Members	- Individuals experiencing a significant or emergent disruption in the ability to obtain an adequate level of nutrition due to an acute behavioral or physical health episode or due to clinical factors that would put them at risk of an unnecessary emergency department visit, hospital admission, or institutional placement - Meets USDA definition of low or very low food security.	NJ DMAHS MLTSS Clinical Eligiblity Critera

Service	Eligible Population	Social Risk Factor	Clinical Criteria for the pop
Medically Indicated Meals	MCO enrolled Members at participating MCOs, up to 300 individuals per demonstration year.	- Individuals experiencing challenges understanding, obtaining, or preparing foods to meet their nutritional needs. - Meets USDA definition of low or very low food security.	At risk pregnant individuals

Applicable Services	Social Risk Factor	Social Risk Factor Detail
Housing Supports	Currently experiencing homelessness	Meets any of the 4 categories of "homeless" established by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5: 1. Literally Homeless 2. Imminent Risk of Homelessness 3. Homeless Under Other Federal Regulations 4. Fleeing/Attempting to Flee Domestic Violence
Housing Supports	At risk of homelessness	Meets any of the categories of "at risk of homelessness" detailed in Section (1)(iii), (2), or (3) of the definition, established by the U.S. Department of Housing and Urban Development (HUD) in 24 CFR 91.5.

Applicable Services	Social Risk Factor	Social Risk Factor Detail
Housing Supports	Individuals at risk of institutionalization who require a new housing arrangement to remain in the community	Qualifying institutions include: hospitals, mental health residential treatment facilities, substance use disorder treatment facilities, and long-term care facilities.
Housing Supports	Transitioning from an institution to the community	This includes beneficiaries who could potentially transition from an institution to the community but are unable due to insufficient placement options. Qualifying institutions include: hospitals, mental health residential treatment facilities, substance use disorder treatment facilities, and long-term care facilities.
Housing Supports	Individuals released from correctional facilities	Includes beneficiaries released from incarceration within the past 12 months. Qualifying institutions include: state and federal prisons, local correctional facilities, and juvenile detention facilities.
MLTSS Nutrition Supports: Nutrition Counseling and Education	MLTSS individuals experiencing challenges understanding, obtaining, or preparing foods to meet their nutritional needs. Meets USDA definition of low or very low food security	Eligible individuals are experiencing challenges understanding, obtaining, or preparing foods to meet their nutritional needs. Meets USDA definition of low or very low food security.
MLTSS Nutrition Supports: Transtional Pantry Stocking	MLTSS Individuals transitioning from an institution without community or family support Meets USDA definition of low or very low food security	Individuals: a. Transitioning to a community residence from an institutional setting, including i. Certified nursing homes ii. Mental health facility iii. Acute care hospitals with an extended stay (30+ days) iv. Carceral settings (i.e., state prison, county correctional facility, youth correctional facility) AND b. Indicate a lack of community or family support and challenges accessing and obtaining needed food during transition to a community residence. Meets USDA definition of low or very low food security.
MLTSS Nutrition Supports: Short Term Grocery Delivery	MLTSS individuals experiencing a significant or emergent disruption in the ability to obtain an adequate level of nutrition Meets USDA definition of low or very low food security	Individuals experiencing a significant or emergent disruption in the ability to obtain an adequate level of nutrition due to an acute behavioral or physical health episode or due to clinical factors that would put them at risk of an unnecessary emergency department visit, hospital admission, or institutional placement Meets USDA definition of low or very low food security.
MIM Pilot	Individuals experiencing challenges understanding, obtaining, or preparing foods to meet their nutritional needs. Meets USDA definition of low or very low food security	Individuals experiencing challenges understanding, obtaining, or preparing foods to meet their nutritional needs. Meets USDA definition of low or very low food security.

Applicable Services	Clinical Risk Factor	Clinical Criteria Detail
Housing Supports	Chronic health condition	One or more chronic conditions including but not limited to those identified in Social Security Act section1945(h)(2). Examples of conditions can include: diabetes, BMI over 25, cardiovascular disease, respiratory disease, HIV/AIDS diagnosis, hypertension, physical disability (e.g. amputation, visual impairment), cancer, hyperlipidemia, chronic obstructive pulmonary diseases, chronic kidney disease
Housing Supports	Mental health condition	An individual with at least one serious mental health illness, including but not limited to conditions included in the definition in N.J.A.C. 10:37B and/or at least two concurrent mental health conditions that require support and are impacting the ability to maintain a stable housing situation. Applicable mental health conditions include but are not limited to: Bipolar Disorder; Borderline Personality Disorder; Depression; Dissociative Disorders; Eating Disorders; Obsessive-compulsive Disorder Posttraumatic Stress Disorder; Psychosis Schizoaffective Disorder; and Schizophrenia.
Housing Supports	Substance misuse	An individual with a substance use disorder who is in need of substance use treatment.
Housing Supports	Pregnancy	Identified as an individual who is currently pregnant or up to 12 months after the end of pregnancy.
Housing Supports	Complex medical health condition caused by an intellectual or developmental disability	Qualifying physical, neurological, or behavioral, condition that directly impacts the ability to maintain a healthy and stable lifestyle.
Housing Supports	Individuals experiencing intimate partner violence, domestic violence, and/or victims of human trafficking	An individual who is experiencing or has experienced intimate partner violence (IPV), domestic violence, or human trafficking.

Applicable Services	Clinical Risk Factor	Clinical Criteria Detail
Housing Supports	Assistance with ADLs and IADLS	Individual assessed to have a need for assistance with: 1. One or more activity of daily living (ADL), or 2. Three or more instrumental activities of daily living (IADL) and has a behavioral health condition or cognitive impairment (e.g., impairment to decision making or memory).
Housing Supports	Repeated emergency department use or hospital admissions	An individual with repeated use of emergency department care (defined as two or more visits in the past 6 months or four or more visits in the past 12 months).
MLTSS Nutrition Supports	NJ DMAHS MLTSS Clinical Eligibility	1. An individual 21 years and older meets the clinical eligibility for Nursing Facility level of care, which means the individual requires hands on assistance with three or more activities of daily living such as bathing, dressing, toileting, locomotion, transfers, eating, and bed mobility or has cognitive deficits and requires supervision and cueing with three or more activities of daily living. 2. Children ages birth through 20: a. With functional limitations, identified in terms of developmental delay or functional limitations for age-appropriate activities of daily living, and require nursing care over and above routine parenting and meets the criteria for skilled nursing care that requires complex skilled nursing interventions 24 hours per day, seven days a week. b. Or, with functional limitations, identified in terms of developmental delay or functional limitations for age-appropriate activities of daily living, and require nursing care over and above routine parenting and meets the criteria for medical and/or intense therapeutic services for the technology dependent child who requires a medical device that the Federal Food and Drug Administration has classified as a life-supporting or life-sustaining device that is essential to or that yields information that is essential to the restoration or continuation of bodily function and continuation of human life and the use of the device requires ongoing skilled nursing intervention 24 hours per day seven days a week.
MIM Pilot	At risk pregnant individuals	Pregnant individuals with one of the following clinical risk factors: 1. Was diagnosed with diabetes prior to pregnancy 2. Is diagnosed with gestational diabetes during pregnancy 3. Is at-risk of gestational diabetes during pregnancy

Attachment G
New Jersey FamilyCare Comprehensive Demonstration
New Initiatives Implementation Plan

Attachment G
New Initiatives Implementation Plan (NIIP)

In accordance with the state's Section 1115 Demonstration and Special Terms and Conditions (STCs), the state is required to submit a New Initiatives Implementation Plan to cover certain key policies being tested under this demonstration. The Implementation Plan will contain applicable information for the following expenditure authorities: HRSN Infrastructure, HRSN Services, and Continuous Eligibility. The Implementation Plan, at a minimum, must provide a description of the state's strategic approach to implementing these demonstration policies, including timelines for meeting critical implementation stages or milestones, as applicable, to support successful implementation.

I. New Initiatives Implementation Approach and Timeline

a. Housing Supports

i. Launch of Services

1. DMAHS intends to launch the Housing Supports program in early 2025. If needed, the state may explore a phasing in approach of the program.

ii. MCO Responsibilities DMAHS will update its contracts with its MCO partners to support the delivery of Housing Supports services. Key responsibilities of the MCOs will include:

1. Building a network of qualified Housing Supports providers
2. Proactively screening and identifying members who may be eligible for Housing Supports
3. Accepting referrals and requests for authorization for Housing Supports from housing organizations, member self-referrals, health care providers, and other community based organizations
4. Conducting eligibility determination and service authorization
5. Providing care management to members referred to Housing Supports, including developing or updating care plans to reflect members' housing needs and employing Housing Specialists to support member housing needs
6. Referring eligible members to Housing Supports providers
7. Paying Housing Supports providers for services rendered

iii. HRSN Infrastructure

1. DMAHS is partnering with the New Jersey Department of Community Affairs (DCA) to distribute infrastructure funding to organizations capable of delivering Housing Supports services. DMAHS intends to distribute funding via multiple rounds of grant funding over the duration of the 1115 waiver, distributing the first round no earlier than September 2024. For at least the first round of grant funding, grants will be awarded to organizations as they complete key milestones that demonstrate their progress towards readiness to deliver Housing Support services.
2. DMAHS is partnering with New Jersey's Regional Health Hubs to deliver training, technical assistance, and general supports to Housing Supports providers and organizations seeking to become

Housing Supports Providers. This partnership will start no earlier than July 2024.

b. **MLTSS Nutrition Supports:**
    i. Launch of Services
        1. DMAHS intends to launch MLTSS Nutritional Supports Services in January 2025.
        2. The implementation will be statewide to any person who meets screening criteria.
        3. The January 2025 MCO contract will be updated to include additional entries to the MLTSS Dictionary. The services will be:
            a. Nutritional Counseling
            b. Transitional Pantry Stocking
            c. Short Term Grocery Provision
    ii. MCO Responsibilities DMAHS will update its contracts with its MCO partners to support the delivery of MLTSS Nutritional Support services. Key responsibilities of the MCOs will include:
        1. Building a network of qualified Nutritional Support Services providers
        2. Proactively screening and identifying members who may be eligible for Nutritional Supports
        3. Accepting referrals and requests for authorization for Nutritional Supports from community-based organizations, member self-referrals, health care providers
        4. Conducting eligibility determination and service authorization
        5. MCO MLTSS Care Managers will coordinate the authorization and delivery of nutritional supports services as part of their overall MLTSS Care Management responsibility.
        6. MCO MLTSS care managers will ensure these services are documented in the member person centered plan of care
        7. Paying providers for services rendered
        8. MCOs will utilize their existing MLTSS infrastructure and process for the service authorizations, reauthorizations and beneficiary notifications for the nutrition support services.
        9. Upon receipt of the information regarding the beneficiary's nutritional needs, the MCO will use reasonable efforts to obtain all other information necessary to 1) determine whether the beneficiary is eligible for nutritional support and 2) to authorize the appropriate services.
            a. The plan's reasonable efforts must include:
                i. Utilizing the results from the New Jersey Choice Home Care assessment of Nursing Facility Level of Care to confirm MLTSS eligibility
                ii. Obtaining the results from nutritional need screening questions to assess eligibility to receive nutrition supports services
                iii. Collecting beneficiary information from the beneficiary's transition or care plan, or from the plan's own patient records

iv. Collecting relevant and appropriate information obtained via follow up with the beneficiary or referring organization/individual if necessary

c. **Medically Indicated Meal Pilot:**
   i. Launch of Services DMAHS intends to launch the Medically Indicated Meal (MIM) Pilot in January 2025.
      1. DMAHS intends to partner with no more than 2 MCOs to provide MIM services to their eligible managed care enrollees.
      2. DMAHS will actively monitor progress with enrollee recruitment into the pilot for equitable enrollee engagement and the level of enrollment relative to the maximum allowed 300 beneficiaries per Demonstration Year.
   ii. MCO Responsibilities The MCO partner(s) is expected to actively collaborate with the state on the pilot, including:
      1. Prior to launch, the MCO will be responsible for recruiting a MIM vendor, completing systems implementation to support reimbursement and payment reporting to DMAHS, and developing the enrollee recruitment strategy.
      2. Throughout pilot operations, the MCO is expected to align existing obstetric case management efforts for their pregnant, diabetic enrollees with pilot operations—including enrollee recruitment, monitoring of enrollee engagement, and enrollees‘ transition at the end of their participation in the pilot.
      3. At the conclusion of the pilot, the MCO is expected to participate in any monitoring and evaluation efforts of the pilot’s impact.
   iii. At the conclusion of the pilot, as part of the 1115 demonstration evaluation requirements, DMAHS will engage with Rutgers to conduct independent evaluation of the pilot impact.

II. Data Sharing and Partnerships

a. **Housing Supports:**
   i. The state will work with MCOs, Housing Support providers, and community partners on an approach to data sharing that meets entities where they are today. For the initial implementation, DMAHS will require MCOs to operationalize closed loop referrals, acceptance of referrals (request for housing supports services), coordination with Housing Supports providers, and data reporting to DMAHS via existing technologies and systems. DMAHS aims to standardize these processes as much as reasonably possible.
   ii. To improve data sharing among the homeless and Medicaid sectors, DMAHS is exploring possible partnerships with the statewide HMIS system, operated by the New Jersey Housing and Mortgage Finance Agency. Please see Section VI.(d) for more information on the HMFA partnership.

b. **MLTSS Nutrition Supports:**
   i. MCOs will coordinate with other nutritional benefit programs (e.g., SNAP and WIC) and care management the beneficiary is already receiving or

becomes eligible for while receiving nutrition supports. See "Partnership with State and Local Entities" below for additional details on efforts with SNAP and WIC.

ii. MCOs will submit to the state claims level data using existing processes to allow DMAHS to understand the utilization and value of the service

iii. MCOs will utilize internal data to assist in determining the need for nutritional counseling. An example of this would be diagnostic information related to a medical condition that would necessitate access to nutritional counseling.

iv. DMAHS will utilize member experience surveys to gain insight into the impact of the service on member quality of life

v. MCOs will work to establish formal/official connections with external social support entities such as SNAP and WIC to streamline access to more permanent sources of nutrition and assist members with avoiding food insecurity. See "Partnership with State and Local Entities" below.

c. **Medically Indicated Meal Pilot:**

i. The MCO partner(s) with DMAHS will leverage existing resources supporting obstetric case management efforts to screen for HRSN and address identified needs among eligible enrollees—which can include referral to other 1115 HRSN benefits like housing supports. These resources include data from paid claims, NJ's Perinatal Risk Assessment, case management intake forms, and case management activities. The participating MIM vendor(s) will work with MCO(s) and DMAHS to support these activities.

ii. Given that the pilot is focused on addressing nutritional needs of pregnant and diabetic enrollees, pilot operations will pay particular attention to comprehensive screening and identification of nutrition-related needs, and, referrals of participating enrollees to WIC and SNAP. The MCO partner(s) will provide updates on participants' self-reported status on receipt of WIC and SNAP benefits as part of routine monitoring of pilot operations. At the conclusion of the pilot, DMAHS will engage with Rutgers to conduct independent evaluation of pilot impact on enrollee's participation in WIC and SNAP.

iii. DMAHS is working closely with nutritional benefit programs within state government (e.g., WIC, SNAP) to explore improved data-sharing to facilitate enrollment in those benefits by Medicaid enrollees and to facilitate tracking of benefits access without relying on enrollees' self-reporting their status. See "Partnership with State and Local Entities" for additional details. Depending on the status of data sharing and partnerships, DMAHS may leverage those new efforts for pilot operations based on readiness and appropriateness, over the course of the demonstration.

d. DMAHS may procure a statewide closed loop referral technology to provide more efficient mechanisms to conduct closed loop referrals and service provision between HRSN providers, referrers, and the MCOs. The state may work with these entities to phase in the use of closed loop referral technology based on readiness and appropriateness, over the course of the demonstration.

III. HRSN Service Delivery Partnerships

a. **Housing Supports:** DMAHS has designed the Housing Supports program with extensive input from stakeholders, including likely Housing Supports providers, MCOs, advocacy groups, community-based organizations, and beneficiaries. After go-live, DMAHS will continue to convene stakeholders, acting on their feedback to improve the program.

   i. **CBOs:** DMAHS has and continues to operate a stakeholder workgroup in which DMAHS meets regularly with community partners to test and develop program design.

   ii. **MCOs:** DMAHS expects MCOs to develop robust provider networks, partnerships, and expertise in several areas, including, for example:

      1. Care coordination, navigation and case management activities
      2. Housing services and supports, including tenancy case management, set-up costs, critical repairs, air conditioners, items to improve mobility, and environmental remediation
      3. Trauma-informed services and supports across sectors

   iii. The state will support MCOs in building upon these existing networks, partnerships, and resources to provide HRSN services.

   iv. The state will require MCOs to have networks of HRSN providers to sufficiently meet the needs of their members for nutrition and housing services, including culturally and linguistically appropriate and responsive services.

   v. To inform this design, the state has and will continue to engage with MCOs on a regular basis.

   vi. **RHHs:** DMAHS, in partnership with New Jersey's Regional Health Hubs (RHH), plans to conduct a series of interviews with Medicaid members who are experiencing housing instability or homelessness.

   vii. **DMAHS:** Additionally, DMAHS may conduct site visits at local housing developments and housing service organizations to facilitate meaningful partnership and identify strategic methods in which DMAHS can supplement the existing housing service landscape.

   viii. DMAHS is aware of the complexity for housing service providers to integrate into the Medicaid system. It is DMHAS's goal to ensure as smooth a transition as possible for providers to begin providing services. To achieve these goals, the state is exploring pathways to simplify provider enrollment and foster greater connectivity between housing and behavioral health providers. DMAHS may also explore how to form partnerships or "hubs" of connected Housing Supports providers to reduce the administrative burdens of credentialing, contracting, and billing MCOs.

   ix. **HRSN Infrastructure** DMAHS plans to distribute Provider Readiness grants to potential Housing Supports providers to help them build capacity to better deliver services. These grants will be distributed through the New Jersey Department of Community Affairs (DCA). DMAHS seeks to leverage the expertise of DCA as the statewide housing authority and its role in overseeing several housing production, housing service, and general housing grant programs. DMAHS also plans to partner with New

Jersey's Regional Health Hubs to offer provider trainings and other troubleshooting supports.

b. **MLTSS Nutrition Supports:**
   i. MCOs will create new partnerships with community based providers to ensure member food insecurity and/or nutritional needs are addressed in a person centered way**.**
   ii. MCOs will connect these newly established partners with existing nutritional supports such as SNAP and WIC. See "Partnership with State and Local Entities" for additional details.

c. **Medically Indicated Meal Pilot:**
   i. Throughout pilot planning, DMAHS has periodically engaged regional medical meals vendors to provide expertise and feedback.
   ii. Prior to launch, DMAHS will support the MCO partner(s) efforts to recruit a qualified, engaged medical meals vendor to provide meals to their participating enrollees.
   iii. Throughout pilot operations, DMAHS will actively collaborate with MCO partner(s) and the MIM vendor on monitoring equitable enrollee recruitment, monitoring of enrollee engagement, and other aspects of service delivery operations—including effective meal delivery to participants, and whether meals are meeting individual personal and cultural preferences.
   iv. At the conclusion of the pilot, DMAHS will engage with Rutgers to conduct independent evaluation of the pilot, which will include a qualitative assessment of: participant engagement; service delivery operations; and effectiveness of partnership across MCO, MIM vendor, and DMAHS.
   v. Throughout pilot operations, DMAHS will be monitoring for additional opportunities to maximize the impact of the pilot for the benefit of eligible enrollees.

IV. IT Infrastructure

a. **Housing Supports:**
   i. DMAHS and MCOs will primarily implement the program using existing data systems. These systems will collect data on beneficiary characteristics, eligibility and consent, screening, referrals, service provision, outcomes, and other quality measures. Within these existing systems, DMAHS is exploring ways in which to reduce administrative burden on both the provider and MCO by attempting to better align certain systems together, including service authorization.
   ii. DMAHS plans to develop a simplified and standardized provider enrollment process to reduce the administrative burden on housing service providers. DMAHS is also planning on requiring MCOs to utilize a standardized credentialing application for all housing service providers.
   iii. As described in other sections of this document, in future years, DMAHS may pursue changes to IT infrastructure, including a statewide closed-loop referral system or connection between the Homeless Management

Information System (HMIS) and the Medicaid Management Information System (MMIS).

b. **MLTSS Nutrition Supports:**
    i. DMAHS and MCOs will primarily implement the program using existing data systems. These systems will collect data on beneficiary characteristics, eligibility and consent, screening, referrals, service provision, outcomes, and other quality measures.
c. **Medically Indicated Meal Pilot:**
    i. DMAHS will leverage existing resources for this pilot, including those supporting obstetric case management efforts. These resources include data from paid claims, NJ's Perinatal Risk Assessment, case management intake forms, and case management activities. These existing resources include the required data on beneficiary characteristics, eligibility and consent, screening, referrals and service provision. DMAHS is working closely with nutritional benefits programs within state government (e.g., WIC, SNAP) to explore improved data-sharing to facilitate enrollment in those benefits by Medicaid enrollees and to facilitate tracking of benefits access without relying on enrollees self-reporting their status. See "Partnership with State and Local Entities" for additional details. Depending on the status of data sharing and partnerships, DMAHS may leverage those new efforts for pilot operations based on readiness and appropriateness, over the course of the demonstration.

V. Partnerships with State and Local Entities

a. **Housing Supports:**
    i. DMAHS has engaged the support of Continuums of Care (CoCs) and local public housing authorities in the design and implementation of the program. DMAHS will leverage CoCs and local public housing authorities to identify members who need housing supports and refer them to MCOs to request authorization for services.
    ii. **Continuums of Care.** Throughout the demonstration, the state may seek to formalize partnerships between the Medicaid delivery system and CoCs. For example, the state may encourage MCOs to be active partners by joining the board, attending meetings, or joining subcommittees of their local CoC to build the relationships with their local housing partners. DMAHS is also considering requiring Housing Supports providers to be active participants in their local CoC as a condition of enrollment. The state, in partnership with other entities, including MCOs and CoCs, will consider opportunities to support identification of additional housing resources that members may require, and to provide a more sustainable funding source for ongoing services beyond what is covered under Medicaid. As part of this partnership, the state is exploring ways to support MCOs to connect to HMIS in a way that preserves informed consent and creates mechanisms for sharing sensitive data cross-sectors. Additionally, the state may encourage MCOs to have their care coordinators become Coordinated Entry (CE) access points, along with any other member facing positions the MCO may have that could serve as a connection to CE.

iii. **Local Public Housing Authorities**. The state will seek to formalize and oversee partnerships between DMAHS and local housing authorities over the course of the demonstration. Specifically, the state may seek to identify opportunities to provide additional and longer-term housing supports to members beyond what is covered through HRSN or other Medicaid initiatives, including through partnerships with MCOs, local housing authorities and others. For example, MCO care coordination staff can work with local public housing authorities to identify funding sources to support rental payments and/or housing units for members.

b. **MLTSS Nutrition Supports:**
   i. MCOs will ensure members are referred to appropriate long term nutrition supports. This will be accomplished through MCO assistance to the member in applying for and obtaining services such as SNAP or WIC to enable smooth transition from Transitional Pantry Stocking and Short Term Grocery Delivery.
   ii. With respect to Short Term Grocery Delivery, MCOs will ensure appropriate referral to additional supports that help address the root cause of food insecurity and the need for this service. Examples include but are not limited to, Behavioral Health Supports, Chronic Disease self-management, specialty medical services (such as a cardiologist if heart disease is implicated).
   iii. MCOs will seek to establish formal working relationships and data sharing agreements with external entities to ensure members avoid food insecurity.

c. **Medically Indicated Meal Pilot:**
   i. Throughout pilot planning and operations, DMAHS has and will continue to periodically engage external stakeholders, including food security entities within state government (i.e., WIC, SNAP, NJ Office of the Food Security Advocate), to provide expertise and feedback on pilot operations.
   ii. The MCO partner(s) will leverage existing resources supporting obstetric case management efforts to screen for HRSN and address identified needs among eligible enrollees. Given that the pilot is focused on addressing nutritional needs of pregnant and diabetic enrollees, pilot operations will pay particular attention to comprehensive screening and identification of nutrition-related needs, and, referrals of participating enrollees to WIC and SNAP.
   iii. DMAHS is working closely with nutrition benefits programs within state government (e.g., WIC, SNAP) to explore improved data-sharing to facilitate enrollment in those benefits by Medicaid enrollees and to facilitate tracking of benefits access without relying on enrollees‘ self-reporting their status. See “Partnership with State and Local Entities” for additional details. Depending on the status of data sharing and partnerships, DMAHS may leverage those new efforts for pilot operations based on readiness and appropriateness, over the course of the demonstration.

VI. Tracking eligibility & enrollment in other programs.

Background: Housing and nutrition programs are administered by several state agencies in New Jersey. The Department of Human Services Division of Family Development (DFD), a sister division to DMAHS, operates both SNAP and TANF. The Department of Health (DOH) operates WIC. Multiple state entities operate housing programs, but the Housing and Mortgage Finance Agency (HMFA) manages the Homeless Management Information System (HMIS) for 19 of New Jersey's 21 counties, the other two are run by their respective counties. NJHelps supports individuals to determine if they are likely eligible for SNAP, TANF and Medicaid, but individuals must apply for each program separately.

a. **WIC**: Existing practices and requirements facilitate enrolling Medicaid members who are likely eligible for WIC into WIC. Specifically, an existing data-sharing agreement allows DMAHS to regularly share Medicaid eligibility information with DOH to facilitate establishing adjunctive eligibility (i.e., automatically verifying income eligibility) for WIC. In addition, DMAHS's MCO contract requires MCOs to require their participating providers to refer potentially eligible individuals to WIC.

   DMAHS and DOH are working to build on this partnership to facilitate higher WIC enrollment by Medicaid members. In the short-term, both entities are exploring the use of an existing API to enable real-time adjunctive eligibility determinations to support WIC enrollment. Over the longer term, DMAHS and DOH are exploring sharing more information from Medicaid to start and prepopulate WIC certifications and/or conduct proactive outreach to Medicaid members who are likely eligible for WIC. DMAHS and DOH are also defining requirements to regularly measure and report the share of Medicaid members likely eligible for WIC who are enrolled in WIC.

b. **SNAP**: As part of New Jersey's PHE unwinding mitigation plan, DFD and DMAHS established a data-sharing agreement to share SNAP enrollment data to facilitate Medicaid eligibility determinations. Through this agreement DMAHS receives SNAP participation data on a monthly basis, allowing Medicaid to make *ex parte* income eligibility determinations for Medicaid. New Jersey plans to continue using this *ex parte* strategy through June 2025, when such waivers are currently scheduled to expire.

   To facilitate greater program coordination going forward, DMAHS and DFD are exploring expanding data-sharing and other mechanisms to help Medicaid members enroll in SNAP. In the short-term, DMAHS and DFD are exploring how MCOs can share information about and even screen members for SNAP. DFD has trained other contracted entities as SNAP navigators, including staff at Area Agencies on Aging (AAAs). DFD could do similar training for MCO care coordinators. Furthermore, DMAHS is exploring requiring MCOs to screen members receiving care management (e.g., MLTSS; Housing Supports, Nutrition Supports and Medically Indicated Meals through 1115 waiver) for SNAP and TANF participation and to make referrals for interested individuals. Finally, DMAHS and DFD are also defining requirements to regularly measure and report

the share of Medicaid members likely eligible for SNAP who are enrolled in SNAP.

Over the long-term, DFD and DMAHS are considering data-matching to identify Medicaid members likely eligible for but not yet enrolled in SNAP and conducting proactive outreach to those individuals. Such efforts would build on comparable efforts by DFD and DOH, which conduct regular data-matching to identify SNAP recipients who are likely eligible for but not enrolled in WIC and WIC recipients who are likely eligible for but not enrolled in SNAP. Using this information, DFD and DOH contact individuals who are enrolled in one but not both programs and encourage them to apply. This effort has been successful at increasing enrollment among contacted individuals. Further discussion is needed to determine level of effort and responsibilities for such an effort between DMAHS and DFD.

c. **TANF**: There is limited existing coordination between DFD and DMAHS to support TANF, in part due to the nature of TANF eligibility requirements. Moving forward, comparable to efforts in support of SNAP, DMAHS and DFD are exploring how MCOs can share information about and even screen members for TANF. DMAHS is also exploring requiring MCOs to screen members receiving care management (e.g., MLTSS; Housing Supports, Nutrition Supports and Medically Indicated Meals through 1115 demonstration) for SNAP and TANF participation and make referrals for interested individuals. Finally, DMAHS and DFD are defining requirements to regularly measure and report the share of Medicaid members likely eligible for TANF who are enrolled in TANF.

d. **Federal and state housing programs**: As discussed in Sections I-V of this document, DMAHS will leverage New Jersey's existing housing infrastructure and resources to launch the Housing Supports program. As part of those efforts, DMAHS is exploring how it can leverage the HMIS used by most of the state to conduct both individual-level case management and tracking as well as analyze population-level outcomes. DMAHS is also hopeful that by working with the statewide HMIS data collaborative, the two counties that operate independent HMIS may join the short- and long-term efforts described below.

   In the short-term, DMAHS will work with HMFA (which manages the HMIS for 19 of 21 counties) to enable appropriate MCO staff to access HMIS. This will allow MCO care managers and housing specialists to observe services being rendered to and status changes for MCO members enrolled in Housing Supports. Over time, DMAHS will work with HMFA to seek to facilitate more real-time coordination between MCOs and CoCs by utilizing the search, data-entry and reporting functions in HMIS.

   To facilitate initial identification of Medicaid members receiving state and federal housing benefits, DMAHS will work with HMFA to conduct a one-time, retrospective data match between HMIS and Medicaid information systems. This effort can build on previous, deidentified analysis of housing and health outcomes among Medicaid members conducted by the Rutgers University Center for State

Health Policy utilizing HMIS and MMIS data. Completing identified data-matching can facilitate initial identification of Medicaid members who may benefit from Housing Support services. Over time, DMAHS and HMFA are exploring conducting regular data-sharing to track individual member outcomes and the share of Medicaid members participating in state and federal housing programs.

VII. Verifications on beneficiary residency for Continuous Eligibility.

a. DMAHS has been approved for Continuous Eligibility for the MAGI adult population but has not decided to move forward with this authority at this time. Should NJ excercise this authority in the future, this Protocol will be updated to reflect that decision

VIII. HRSN Rate Methodologies

a. DMAHS to submit to CMS at least 60 days prior to implementation.

IX. Maintenance of Effort

a. DMAHS is seperately preparing a Maintenance of Effort report for submission to CMS.

Attachment H
New Jersey FamilyCare Comprehensive Demonstration
OPG Financial Eligibility Implementation Plan

NJ DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Attachment H

NJ FamilyCare Comprehensive Demonstration Implementation Plan

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STC 5.14 Process for Improving the Efficiency of the Financial Eligibility Determination Process for Individuals Under the Guardianship of the OPG

4/1/2023

The New Jersey Office of the Public Guardian (OPG) is a state agency that serves as guardian for legally incapacitated individuals aged 60 and older. The Office makes all decisions for the protected individuals in its care, including medical, financial and legal decisions. All individuals served have serious cognitive issues that render them unable to provide meaningful information about their income and assets. Furthermore, in most cases there are no involved or helpful family members or friends to assist with this process. OPG staff must therefore attempt to piece together each individual's financial profile with minimal or no background information.

OPG currently serves as guardian for roughly 1700 individuals. Over the course of each year, hundreds of these individuals pass away and are replaced by other seniors who require protection. The need for OPG's services continues to grow as the population ages and the ranks of those impacted by elder abuse swell.

Once all of the required information is collected, if needed, OPG files a paper application and submits it for processing for Medicaid Eligibility. To assist the OPG with Medicaid determinations, DMAHS has established two eligibility units in Salem and Cumberland counties to process Medicaid applications for OPG wards. These two dedicated units allow the OPG staff to establish relationships with the staff of the county eligibility units to ensure good communication to speed up the eligibility process instead of communicating with 21 different county offices across the state. These two designated county eligibility units are typically processing between 20-40 applications for OPG clients at any given time. The eligibility units verify the information on the applications electronically and are able to provide the OPG with information on other found bank account, property, and other assets discovered during the verification process.

To improve the efficiency of the financial eligibility determination for OPG wards, the eligibility system, has been enhanced to allow electronic transfers from all other counties throughout the state to Salem and Cumberland. This was implemented in September 2021. The eligibility system has an OPG attestation indicator so that OPG and the state can monitor the special timelines set forth in the Demonstration. Unique notices were developed to obtain information and the he online processing allows for more immediate electronic verifications (name, date of birth, SSN, citizenship/identity, and immigration status), to validate the information provided and reduce the need for locating paper documents as proofs. The online system has immediate access to the AVS system and therefore, the state has the opportunity to help OPG identify any resources not known at the time of the application.

The eligibility system enhancements allows any OPG application submitted for the OPG Attestation program to be tracked by the state. All applications in the OPG Attestation

program are monitored by both the state and OPG a through to completion to expedite access to health care.

OPG has a database to improve efficiency and has obtained additional skilled staff to manage relationships with financial institutions that are historically reluctant to turn over client assets to OPG. Unfortunately, the OPG, in spite of having legal authority and improved efficiencies, continues to have some issues with the time it takes to actually be able to access the assets in order to spend down. All of the above efficiencies are being pursued so that abandoned and confused seniors no longer languish inappropriately in acute care settings or remain at risk in isolated community settings pending Medicaid eligibility.

Attachment I
New Jersey FamilyCare Comprehensive Demonstration
SUD Monitoring Protocol

Placeholder for SUD Monitoring Protocol

Attachment J
New Jersey FamilyCare Comprehensive Demonstration
Monitoring Protocol for Other Policies

Placeholder for Monitoring Protocol for Other Policies

Attachment K

RUTGERS

Center for State Health Policy

A Unit of the Institute for Health, Health Care Policy and Aging Research

Evaluation Design: New Jersey FamilyCare Comprehensive Demonstration 4/1/2023-6/30/2028

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May 2025

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Introduction

Evaluation Design Partners

Building on its longstanding relationship to the New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), Rutgers Center for State Health Policy (CSHP) was selected to serve as the independent evaluator for the New Jersey FamilyCare Comprehensive Demonstration 4/1/2023-6/30/2028. CSHP has been the independent evaluator for New Jersey's §1115 Demonstrations since 2012 in collaboration, where applicable, with experts outside the Center. For this evaluation design, we have partnered with Cynthia Minkovitz and Anne Lilly of the Johns Hopkins Bloomberg School of Public Health. Dr. Minkovitz and Ms. Lilly are experts in maternal and child health and currently partner with New Jersey's Department of Children and Families to evaluate the department's Maternal, Infant and Early Childhood Home Visiting Initiatives. So, they were a natural partner for CSHP for the Home Visiting component of the Comprehensive Demonstration. The CSHP team, Dr. Minkovitz and Ms. Lilly declare no conflicts of interest with respect to this evaluation.

Structure of the Evaluation Design

The New Jersey FamilyCare Comprehensive Demonstration 4/1/2023-6/30/2028 is significantly more expansive and complex than previous demonstrations. For the sake of manageability, CSHP has divided the Demonstration into 12 component parts and will apply CMS' design guidance to each part separately. Each component has its own chapter in this design report, followed by a budget encompassing all components. We have organized the components thematically, with youth programs in Chapters 1 and 2 (the Adjunct Services Autism Spectrum Disorder (ASD) Pilot and Children's Support Services Programs (SED, I/DD)), maternity-related components in Chapters 3-5 (Postpartum Eligibility Extension, the New Jersey Home Visiting Pilot (NJHV) Program, and the Medically-indicated Meals Pilot), programs facilitating timely access to essential health services for a variety of populations in Chapters 6-9 (Continuous Eligibility for MAGI Adults, the Community Health Workers (CHW) Pilot Program, Tenancy and Housing Supports, and the Opioid Use Disorder (OUD) /Substance Use Disorder (SUD) Program) and long-term services for adults in Chapters 10-12 (Adult IDD Services: Supports and Community Care Programs, Managed Long Term Services and Supports (MLTSS) Program, and Administrative Simplifications for LTSS).

We recognize that CMS has specific guidance around health-related social needs (HRSN) and that there are three demonstration components that include HRSN—the housing component, the medically-indicated meals component, and the MLTSS component with the added counseling, respite, and nutrition supports. To address cross-cutting themes within the demonstration, we will include a summary deliverable report that presents themes across components. Our draft workplan and deliverables are detailed in Attachment 2.

Summary of Demonstration History, by Component

Component	Description
1. Adjunct Services Autism Spectrum Disorder (ASD) Pilot	• Behavioral therapies for Medicaid/CHIP members with Autism Spectrum Disorder began under the first §1115 Comprehensive

Component	Description
	Demonstration (October 2012-July 2017) and continued during the renewal period (starting in August 2017). • In 2020, New Jersey amended its Medicaid state plan to include coverage of "medically necessary autism benefits." • The Adjunct Services Autism Spectrum Disorder (ASD) Pilot in the current demonstration represents a new set of services.
2. Children's Support Services Programs (SED, I/DD)	• The first §1115 Comprehensive Demonstration (October 2012-July 2017) included the Children with Serious Emotional Disturbance (SED) and Intellectual/Developmental Disabilities with Co-Occurring Mental Health Diagnosis (I/DD-MI) waivers with additional services rolled out from 2015-2017. • The "Plan A" eligibility expansion in July 2016 granted Medicaid State Plan services for youth with SED in out-of-home settings. • These prior waivers were incorporated into the Children's Support Services Program during the first §1115 Comprehensive Demonstration renewal period (starting in August 2017); eligibility for children with I/DD no longer required a co-occurring mental health diagnosis, but many children with SED enrolled in CSSP were not Medicaid/CHIP eligible for State Plan services.
3. Postpartum Eligibility Extension	While there was an extension of postpartum eligibility approved in October 2021, it was not evaluated due to the COVID-19 pandemic extending eligibility for all beneficiaries.[2]
4. New Jersey Home Visiting Pilot (NJHV) Program	While the NJHV program was first approved in July 2019,[3] it was not implemented due to the COVID-19 pandemic.
5. Medically-indicated Meals Pilot	New
6. Continuous Eligibility for MAGI Adults	New
7. Community Health Worker (CHW) Pilot Programs	New
8. Tenancy and Housing Supports	New
9. Opioid Use Disorder (OUD) /Substance Use Disorder (SUD) Program	• Approved under the §1115 Comprehensive Demonstration (October 2012-July 2017, this piece in October 2017) and allowed expenditures for services within Institutions for Mental Disease. • With the exception of moving the Substance Use Disorder Promoting Interoperability Program into the Behavioral Health

[2] See https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nj-1115-request-pa.pdf

[3] See https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nj-1115-request-cms-amend-appvl-07252019.pdf

Component	Description
	Promoting Interoperability Program, CMS has authorized the State to continue its OUD/SUD from the previous demonstration without modification. • The program has been expanded to include a carve-in of behavioral health services to managed care.
10. Adult IDD Services: Supports and Community Care Programs	• First approved in 1985 for adults who met an institutional level of care, under 1915(c) the "Community Care Waiver" was incorporated into the §1115 Comprehensive Demonstration in 2017, as the Community Care Program (CCP). • In 2016 CMS approved amendment to the first §1115 Comprehensive Demonstration (October 2012-July 2017) that expanded income eligibility for the Supports program allowing individuals up to 300% FBR.
11. Managed Long Term Services and Supports (MLTSS) Program	MLTSS began in July 2014 under New Jersey's first 1115 Comprehensive Demonstration and continued during each renewal demonstration including this one. MLTSS is extended into the 2023-2028 demonstration, largely as constructed under prior waiver authorities, but with a few additional services. New services: 1. Housing-related services: case management, outreach, education, and housing transition or tenancy-sustaining services 2. Caregiver supports a. Individual or group therapy for caregivers b. Expanded respite benefit (from 30 days in the previous demonstration period to 90 days per calendar year) 3. Nutritional supports a. One-time pantry stocking for a beneficiary transitioning home from an institution b. Short-term provision of groceries c. Nutritional education and skills development
Administrative Simplifications for LTSS	• Qualified Income Trusts (QITs) were adopted in December 2014 and continue with this demonstration. • The process for self-attestation regarding asset transfers was first approved in December 2012 and continues with this demonstration. • The program for attestation by the NJ Office of the Public Guardian regarding assets for individuals under their care was effective as of July 25, 2019 and continues with this demonstration.

1. Adjunct Services Autism Spectrum Disorder (ASD) Pilot

A. General Background Information

Autism Spectrum Disorder (ASD) is a lifelong neurodevelopmental disorder that affects social interaction, communication, learning, and behavior, and typically first presents during early childhood.[4] Data from the Autism and Developmental Disabilities Monitoring Network suggests that 2.9% of 8-year-olds in New Jersey have ASD with a higher prevalence among non-Hispanic Black and Hispanic children.[5] As part of the Early and Periodic Screening Diagnosis and Treatment (EPSDT), all Medicaid-enrolled children under age 21 are entitled to appropriate "preventive, dental, mental health, developmental, and specialty services."[6]

Behavioral therapies for Medicaid/CHIP members with Autism Spectrum Disorder began under the first §1115 Comprehensive Demonstration (October 2012-July 2017) and continued during the first renewal period (August 1, 2017 – June 30, 2022). In 2020, New Jersey amended its Medicaid state plan to also include coverage of medically necessary autism benefits.[7] Eligibility for the Autism benefits has been limited to the "NJ FamilyCare Medicaid child member, under the age of 21, who has been diagnosed with ASD, defined by ICD-10-CM diagnosis codes F84.0 through F84.9" (i.e., Pervasive Developmental Disorders).[8] Currently operationalized **State Plan Autism Benefits** include:

- Applied Behavior Analysis (ABA)
- Allied health services (Occupational, Physical, Speech, and Language Therapies)
- Developmental and Relationship-based Approaches
- Sensory Integration Therapy
- Skill Acquisition and Capacity Building

[4]National Institute of Mental Health. Autism Spectrum Disorder. U.S. Department of Health and Human Services, National Institutes of Health, 2023. Retrieved February 2024, from https://www.nimh.nih.gov/health/topics/autism-spectrum-disorders-asd.

[5] Shaw KA, Bilder DA, McArthur D, Williams AR, Amoakohene E, Bakian AV, Durkin MS, Fitzgerald RT, Furnier SM, Hughes MM, Pas ET. Early Identification of Autism Spectrum Disorder Among Children Aged 4 Years—Autism and Developmental Disabilities Monitoring Network, 11 Sites, United States, 2020. MMWR Surveillance Summaries. 2023 Mar 3;72(1):1.

[6] Medicaid.gov. Early and Periodic Screening, Diagnostic, and Treatment. Centers for Medicare & Medicaid Services, 2023. Retrieved February 2024. https://www.medicaid.gov/medicaid/benefits/early-and-periodic-screening-diagnostic-and-treatment/index.html

[7] NJFamilyCare. Family Guide to Autism Services. Division of Medical Assistance and Health Services, 2023. Retrieved February 2024. https://www.nj.gov/humanservices/dmahs/news/DMAHS_Guide_to_Autism_Services_eng.pdf

[8] World Health Organization. ICD10-2019: F84 Pervasive developmental disorders, nd. Retrieved February 2024. https://icd.who.int/browse10/2019/en#/F84

Autism Spectrum Disorder Adjunct Services Pilot

The goal of the ASD Pilot is "to enhance inclusion in the community rather than clinic-based settings or the member's home, and they must be associated with and support goals within the overall treatment plan" (STC 5.12.a). During the current 1115 demonstration period (April 1, 2023 through June 30, 2028), the Adjunct Services ASD Pilot (hereafter, "ASD Pilot") will provide eligible Medicaid/CHIP enrolled children with specialized services that they would otherwise be unable to access via the state plan. Eligibility for ASD Pilot will be limited to NJ Medicaid/CHIP beneficiaries up to age 21, who do not have concurrent private insurance that offers similar benefits and have an ASD diagnosis determined by the approved assessment tools, listed below:

- ABAS – Adaptive Behavior Assessment System II
- CARS – Childhood Autism Rating Scale
- DDRT – Developmental Disabilities Resource Tool
- GARS – Gilliam Autism Rating Scale
- ADOS – Autism Diagnostic Observation Scale
- ADI – Autism Diagnostic Interview-Revised
- ASDS – Asperger's Syndrome Diagnostic Scale

Per the CMS approval letter from CMS Administrator Brooks-LaSure, dated March 30, 2023, **"the pilot's effectiveness will be evaluated based on how the adjunct services enhance community inclusion for beneficiaries up to age 21 with an ASD diagnosis."** Services offered through the demonstration will be limited to those listed below and will be evaluated to assess the extent to which the services enhance community inclusion for beneficiaries.

- *Art therapy*
- *Aquatic therapy*
- *Hippotherapy/therapeutic horseback riding*
- *Music therapy*
- *Drama therapy*
- *Dance/movement therapy*
- *Recreation therapy*

B. Evaluation Questions and Hypotheses

We posit that the introduction of ASD Pilot to eligible children will enhance inclusion in the community and support beneficiaries' treatment plan goals. The primary drivers for this inclusion is the facilitation of social interaction, emotional regulation, mobility, and behavioral skills through access to therapeutic activities provided within community settings as described above. Below we present the *driver diagram* (Figure 1.1) that delineates the pathway from the policy change to overall program goals. Here the secondary drivers include the services offered through the ASD Pilot.

Figure 1.1 Adjunct Services Autism Services Disorder (ASD) Pilot Aim Driver Diagram

Aim 1 ASD Pilot	Primary Driver	Secondary Drivers
Support treatment plan goals that	• Facilitate social interaction through	• Adjunct Autism Services ○ Art therapy

enhance communication and inclusion in the Community.	access to therapeutic activities provided within community settings • Promote emotional regulation, mobility, and behavioral skills	○ Aquatic therapy ○ Hippotherapy/therapeutic horseback riding ○ Music therapy ○ Drama therapy ○ Dance/movement therapy ○ Recreation therapy
⟸	Causality	⟸

Evaluation Questions and Hypotheses

Hypothesis 1: Authorizing adjunct autism services among eligible Medicaid youth will lead to utilization of the available services.

Research Question 1a: What are the trends in overall utilization of, and spending on, ASD Pilot services? How do trends vary across different subgroups (e.g., race/ethnicity, age, geography, and sex, or co-occurring conditions)?

Hypothesis 2: Providing adjunct autism services to eligible Medicaid children/youths/young adults will enhance community participation among those children/youths/young adults and their families.

Research Question 2: Is utilization of the ASD Pilot associated with greater community engagement and how do experiences with ASD Pilot services vary across subgroups (e.g., race/ethnicity, age, age at identified ASD, geography, gender, co-occurring conditions, and socio-economic factors)?

C. Methodology

To evaluate the above hypotheses and research questions, the study will utilize descriptive analysis of claims to measure utilization of ASD. The evaluators will also conduct a cross-sectional analysis of community engagement through a survey of adult beneficiaries and parents/guardians. Measures for the studies are outlined below (Tables 1.1 and 1.2) and a summary of the methods, organized by hypotheses and research questions can be found at the end of this section in Table 1.3.

Measures

Table 1.1 Inventory of Claims-based Measures

Measures		Brief Description
ASD Pilot Utilization		
1.	ASD service use	Rates of child/youth utilization of the ASD among eligible beneficiaries, for the services listed below: • Art therapy • Aquatic therapy • Hippotherapy/therapeutic horseback riding • Music therapy

		• Drama therapy • Dance/movement therapy • Recreation therapy
2.	Number of ASD Pilot sessions	Number of ASD Pilot services sessions per participating youth, including overall and by specific service type.
3.	Total spending on ASD Pilot service use	Total spending on ASD sessions per participating youth, including overall and by specific service type.
State Plan Autism Benefit Services Utilization		
4.	Utilization of Autism Benefit Services	Rates of child/youth utilization of the Autism Services benefit: • Applied Behavior Analysis (ABA) • Allied health services (Occupational, Physical, Speech, and Language Therapies) • Developmental and Relationship-based Approaches • Sensory Integration Therapy • Skill Acquisition and Capacity Building

Table 1.2 Experience of Supports and Services Survey Domains*

Youth/Child with ASD and Family Experience		
1	Services Access	• Availability of ASD Pilot and/or Autism benefit eligibility and enrollment opportunities • Transportation
2	Community Engagement	• Children's/youths' opportunities to participate in the community, including activities outside the home, and time with other children/youths/young adults • The presence of community networks (e.g., church, recreational activities, parent-to-parent groups, and sibling groups) • My Family's Accessibility and Community Engagement Tool[9, 10]
Survey Sample Characteristics		
4	Child/Youth/Young Adult Characteristics	• Child/youth characteristics available via linked Medicaid claims file (see data collection for Hypothesis 2, Research Question 2) • Age at ASD diagnosis • Child/youth's gender • Equipment used by the child (e.g., wheelchair or speech generating device) • Activities of daily living (e.g., feeding, bathing, getting dressed)
5	Parent/Guardian Characteristics	• Age • Race/Ethnicity • Gender • Location (urbanicity/rurality) • Educational attainment of parent/guardian • (Parent or beneficiary aged 18-20) Patient Health Questionnaire 4 (PHQ-4): Four-item validated composite depression/anxiety screening scale screening tool.[11]
6	Household and Environmental Characteristics	• Household income • Child's school type (public/private/home-based) • Language spoken in home • Household composition

[9] Bourke-Taylor, H. M., Joyce, K. S., & Tirlea, L. (2022). Initial development and evaluation of the My Family's Accessibility and Community Engagement (MyFACE) Tool for families of children with disabilities. The American Journal of Occupational Therapy, 76(4), 7604205150.

[10] Bourke-Taylor, H. M., Tirlea, L., & Joyce, K. S. (2021). Further psychometric evaluation of the My Family's Accessibility and Community Engagement (My FACE) tool: Mothers' ratings of perceptions of community accessibility and engagement for their child with disabilities. Research in Developmental Disabilities, 114, 103955;

[11] Kroenke K, Spitzer RL, Williams JB, Löwe B. An ultra-brief screening scale for anxiety and depression: the PHQ–4. Psychosomatics. 2009 Nov 1;50(6):613-21.

		• Other supports/services used (e.g., CSSP I/DD, educationally-based supports) • Caregiving arrangements • Perceptions of home and neighborhood safety
7	Recommendations	• Barriers and facilitators to ASD Pilot and/or State Plan Autism Benefit utilization • Recommendations for additional services or other requested modifications
NOTES: *Adapted from National Core Indicators, IDD Survey™ and Child Family Survey™, PHQ-4, and MyFACE tools.[6,7,8,12]		

Hypotheses 1, RQ 1

Study population for Hypothesis 1, RQ 1:

For examining trends in utilization of ASD services, ASD Pilot services, and ASD Pilot associated spending, the study population will be comprised of children, youth, and young adults up to age 21 with a qualifying diagnosis for ASD Pilot participation during the demonstration period (April 1, 2023, through June 30, 2028).

Analytic strategy for Hypothesis 1, RQ 1:

For calculating adjusted trends in levels of ASD Pilot utilization on a quarterly or annual basis (as feasible given sample size concerns). We will implement a repeated cross-sectional approach for all ASD Pilot eligible beneficiaries and will estimate differences by subpopulation (e.g., race/ethnicity, age, geography, and sex, or co-occurring conditions) using regression models. We will use line graphs and tables to describe results. Sample sizes permitting, the adjusted trends will also be calculated by subgroups of interest (e.g., age distribution, race/ethnicity, gender, and presence of comorbidities or co-occurring conditions).

The empirical models will be specified as described below:

Main Models:

$$Outcome_{it} = \alpha_0 + \alpha_1(Time_Indicator)_i + \alpha_2(Group)_{it} + \lambda X_{it} + \varepsilon_{it}$$

Secondary Models:

$$Outcome_{it} = \alpha_0 + \alpha_1(Time_Indicator)_i + \alpha_2(Group)_{it} + \alpha_3(Time_Indicator * Group)_{it} + \lambda X_{it} + \varepsilon_{it}$$

For the Main Models, $Outcome_{it}$ represents the outcome of interest for an individual respondent *i* in year t (e.g., ASD Benefit/Pilot Utilization or ASD Pilot spending). $Group_{it}$ represents a group attribute (e.g., age distribution, race/ethnicity, gender, and presence of comorbidities or co-

[12] NCI (National Core Indicators). 2022. *Child Family Survey 2020-21 Final Report.* National Association of State Directors of Developmental Disabilities Services and Human Services Research Institute. Retrieved on 7/25/2023 from: https://legacy.nationalcoreindicators.org/upload/core-indicators/2020-21_CFS_National_Report_Final.pdf

occurring conditions). α represents the corresponding coefficients for the model. X_i represents a set of independent variables (e.g., child/youth characteristics, parent/guardian characteristics, household and environmental factors) for individual *i* at time *t* and λ represents the vector of coefficients for each of the corresponding variables of *X*. ε represents the error term. Models will be estimated using ordinary least squares regression, Poisson regression (i.e., for modeling number of events used), and for spending, a generalized linear model as dollars would be the dependent variable (e.g., Gamma distribution with log link function).[13] Marginal analysis will be applied after running each regression to generate adjusted trends over time based on these models (i.e., using predictive margins).[14]

Specifications for the Secondary Models will be identical to the Main Models, except that we will introduce an interaction term of $Time_Indicator * Group$, used to capture time-varying differences by group with the α_3 coefficient. This would allow us to plot the adjusted trends by group of interest (as indicated above) through the post hoc marginal analysis.

Hypothesis 2, RQ 2

Study population for Hypothesis 2, RQ 2:

For examining the effect of ASD Pilot on community engagement, the study population will be comprised of adult parents, guardians, or other primary caregivers of any children, youth, or young adults up to age 21 with an ASD diagnosis observed in the Medicaid claims, as described above. Responses from respondents whose child who utilize the ASD Pilot will be compared to primary guardian of children and youth who are eligible for ASD Pilot but had not yet participated. We will draw a sample based on claims as described below.

Data collection for Hypothesis 2, Research Question 2: We will hire a survey research contractor to serve as a trusted third party to handle Medicaid member identifiers needed to conduct a confidential caregiver survey.

Survey sample selection and participant recruitment will take place in 4 steps:

1. Using ASD Pilot utilization indicators (see Table ASD.1), CSHP will select a stratified random sample of parents or other primary guardian of any children, youth, or young adult up to age 21 with an ASD diagnosis from de-identified Medicaid claims and encounter data held by CSHP, including both those who used ASD Pilot and those that did not.
2. CSHP will then send a list of Rutgers unique study IDs for the sampled members to DMAHS which will in turn send a file to the third-party survey vendor which includes the Rutgers study ID and member identifiers (names, addresses, telephone, and other contact information). *The vendor will not receive Medicaid claims or encounter data*.
3. The vendor will contact families to request their voluntary participation in the survey. An initial letter of invitation will be followed up with a reminder postcard and, possibly, telephone or email reminders. The letter/postcard will be on Rutgers and/or DMAHS letterhead and will include the unique and one-time use ASD Survey ID and a QR code to

[13] Deb P, Manning W, Norton E. Modeling health care costs and counts. IniHEA World Congress in Sydney, Australia 2013.

[14] Williams R. Using the margins command to estimate and interpret adjusted predictions and marginal effects. The Stata Journal. 2012 Jun;12(2):308-31.

access the survey. The survey will include a screener for parents/guardians (i.e., those who are the primary caregivers for children and youth up to age 21 with an ASD diagnosis) followed by an approximate 30-45 minute survey. If feasible and necessary, telephone surveys may be utilized to increase recruitment and accessibility.

4. The vendor will securely send completed survey responses to CSHP. The response files will include the Rutgers study ID but *no personal identifiers* of members or parent/guardians. CSHP will then link the survey responses to de-identified claims and encounter records for analysis.

The survey will be voluntary and brief; a screener to identify respondents will take approximately 2-3 minutes to complete and, for eligible respondents, the full survey of approximately 30-45 minutes will include 45 question prompts including both close-ended and open-ended questions. The survey questionnaire will include questions on services access, community engagement, child/youth characteristics, parent/guardian characteristics, household and environmental factors, and recommendations. The survey will be available in English and Spanish. Qualifying participants (i.e., after completing the screener) will be offered a study incentive of $25 per completed survey (incentive limited to one per eligible family). In the second round, we will resurvey families from the first round to examine changes between intervals.

Analytic strategy for Hypothesis 2, Research Question 2:

We will measure the effect of the ASD Pilot on services access and community engagement, between respondents who participated in the ASD Pilot (or whose children participated) and those of children/youth/young adults who are eligible but did not yet participate at time of the survey collection. We will present both a bivariate and multiple regression-based approach (e.g., adjusting for demographic and clinical characteristics) to describe cross-sectional differences in experiences between ASD Pilot participants and those eligible that did not participate. We will first create bar charts or line diagrams to examine measures of community participation. To adjust estimates, the survey will collect basic information on child/youth characteristics, parent/guardian characteristics, household, and environmental characteristics, which will be supplemented by child characteristics available on the Medicaid claims files.

Model of ASD Pilot Survey:

$$Outcome_{it} = \alpha_0 + \lambda X_{it} + \varepsilon_{it}$$

For the Main Models, $Outcome_{it}$ represents the outcome of interest for an individual respondent *i* in year t. X_i represents a set of control variables for individual *i* at time *t* and λ represents the coefficients for each of the corresponding control variables of *X*. ε represents the error term. Models will be estimated using ordinary least squares regression.

Open-ended free-text responses will be independently coded by two researchers. In addition to predetermined thematic areas aligned with ASD Pilot aims, the research team will identify emergent themes and patterns in the data after conducting a coding consensus process.

In a prior validation study, MyFace scores ranged from 13-36 with mean of 23.6 and standard deviation of 5.24.[4] This suggests that to detect a 1.5-point group mean change in instrument scores

from baseline survey, 302 respondents would be required for power at the 0.80 level. For data collection, a maximum of 800 completed surveys will be collected via the internet, and possibly telephone, in two intervals (approximately 400, each round). Depending on sample size concerns, we will consider a supplemental analysis that would include additional recruitment for the second round.

Table 1.3: Summary of Questions, Hypotheses and Methodology for Evaluation of the Adjunct Autism Services Pilot

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
Hypothesis 1: Authorizing adjunct autism services among eligible Medicaid youth will lead to utilization of the available services.				
RQ1a. What are the trends in overall utilization of, and spending on, ASD Pilot services? How do trends vary across different subgroups (e.g., race/ethnicity, age, geography, and sex, or co-occurring conditions)?	• Rates of overall ASD Pilot service use • Rates of specific service use • Number of ASD Pilot sessions per participant • Total spending on ASD Pilot sessions per participant	Children and youth up to 21 years of age who receive ASD pilot services.	Medicaid Fee-for-Service and Encounter Claims Records	Examine adjusted trends in study outcomes through analytic summaries and regression analysis and by race/ethnicity, age, geography, and sex, or co-occurring conditions.

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
Hypothesis 2: Providing adjunct autism services to eligible Medicaid children/youths/young adults will enhance community participation among those children/youth/young adults and their families.				
RQ2. Are eligible children/youths/young adults and their families able to effectively access ASD Pilot services and is utilization associated with greater community engagement and how do experiences with ASD Pilot services vary across subgroups (e.g., race/ethnicity, age, age at identified ASD, geography, gender, and co-occurring conditions)?	Service Access and Community Engagement	Adult parents/guardians/primary caregivers (age 18+) of children/ youths/young adults that participate in ASD pilot compared to those who had not yet participated in the pilot.	Survey questionnaire administered to eligible families, based on screening of Medicaid claims in two data collection rounds. See "Data collection for Hypothesis 2, Research Question 2" for detailed description of data collection process.	Close-ended questions analyzed through analytic summaries and regression analysis and by race/ethnicity, age, age at identified ASD, geography, gender, co-occurring conditions, and socio-economic factors. Open-ended free text questions will be analyzed with qualitative thematic analysis.

Table 1.4 shows an activity timeline for the research activities

Table 1.4 Key Milestones, Adjunct Services Autism Spectrum Disorder (ASD) Pilot

Analytic Activity	Year 1 2025	Year 2 2026	Year 3 2027	Year 4 2028	Year 5 2029	Year 6 2030
1. Utilization and spending assessment (RQ1)	Define appropriate population and customized metrics for MMIS analysis	Begin analysis of MMIS-based utilization and spending metrics	Complete interim analysis		Conduct analysis	Complete analysis
2. Community inclusion assessment (RQ2)	Identify survey vendor and execute contract Finalize survey instrument and member list	Work with vendor to conduct round 1 member surveys (n=300-400)	Analyze member surveys	Work with vendor to conduct round 2 member surveys (n=300-400)	Analyze member surveys	Complete analysis
3. Submit reports to CMS			Interim report			Final report

RQ=Research Question.

NOTE: Evaluation project years are March-Feb. (subject to change depending on date of authorization to begin).

D. Methodological Limitations

In measuring ASD Pilot utilization, the Medicaid claims-based analyses are descriptive and used to measure the extent to which eligible services were utilized and how utilization may differ by child characteristics. While these estimates will not support causal inference, they will provide valuable information in describing the population of beneficiaries who used ASD Pilot. This work will contribute an understanding of differences in utilization by race and ethnicity, co-occurring conditions, and location, which will inform future efforts for outreach and sustainment. Our claims-based metrics will not account for all clinical factors that may also impact the likelihood of outcomes.

Due to the voluntary nature of our survey, the findings of ASD participation may not be generalizable to all eligible beneficiary parents, guardians, and caregivers. To mitigate this bias, the survey vendor will make multiple attempts to recruit the randomly sampled respondents. We will also collect information on child and caregiver characteristics through the questionnaire which will allow us to adjust estimates on characteristics not observable within the Medicaid claims (e.g., severity of symptoms and environmental factors). While the adjusted analyses will account for differences between study groups, the associations determined through the cross-sectional analyses are not intended to provide causal inference.

E. Attachments

Appendix 1.1: Parent/Caregiver/Guardian Adjunct Services Autism Spectrum Disorder Pilot Questionnaire

Version 2024.2.19

Would you prefer to complete this survey in English or Spanish?

a. English
b. Spanish -> GO TO SPANISH TRANSLATED SURVEY

Source: New question

Introduction

On behalf of Rutgers University and the New Jersey Division of Medical Assistance and Health Services, thank you for your interest in the ***Adjunct Services Autism Spectrum Disorder Pilot Survey***! We have asked you to participate because you are the primary caregiver, parent, or guardian of a child, youth, or young adult who is eligible for the Adjunct Services Autism Spectrum Disorder Pilot. As you may know, the State of New Jersey, in partnership with the Federal government offers medically necessary autism benefits to eligible individuals in New Jersey. You may be familiar with some of these services. **The Autism Benefit includes:**

- Applied Behavior Analysis (ABA)
- Allied health services (Occupational, Physical, Speech, and Language Therapies)
- Developmental and Relationship-based Approaches
- Sensory Integration Therapy
- Skill Acquisition and Capacity Building

Since 2023, New Jersey has been working to provide additional services through what is known as the Adjunct Services Autism Spectrum Disorder (ASD) Pilot. **The ASD Pilot includes:**

- Art therapy
- Aquatic therapy
- Hippotherapy/therapeutic horseback riding
- Music therapy
- Drama therapy
- Dance/movement therapy
- Recreation therapy

The goal of the ASD Pilot is to increase community engagement for New Jersey families and to support goals within the overall treatment plan for Medicaid/NJFamilyCare enrolled children, youth, and young adults with ASD. We would like to know more about your experience in New Jersey in accessing the ASD Benefit, ASD Pilot services, and resources in your community so that we can better support individuals with ASD and their families. Your knowledge and expertise on these programs are very important. By taking this survey, you will inform program changes and improvements. After a brief screening exercise, the survey is estimated to take approximately 30-45 minutes to complete. The participating parent, guardian, or primary caregiver will be provided with $25 for completing this survey.

Screening Survey

[To proceed, must answer "A" to I, II, and III.]

[Consent form scroll box; language to be approved by DMAHS, CMS, Rutgers IRB]

1. **Do you consent to participate in the survey?**
    a. Yes
    b. No, exit the survey

    Source: New question

2. **Are you at least 18 years of age?**
    a. Yes
    c. No, exit the survey

    Source: New question

3. **Are you the parent/guardian/primary caregiver of a child, youth, or young adult with ASD whose health benefits are provided through New Jersey's Medicaid program (i.e., NJFamilyCare)?**
    a. Yes
    d. No, exit the survey
    e. Not sure, exit the survey

    Source: New question

NOTE: You may have heard of this type of insurance as being referred to NJFamilyCare, Medicaid, or one of the five health plans (also known as MCOs) that participate in New Jersey's NJ FamilyCare Medicaid program: Aetna Better Health of New Jersey Wellpoint New Jersey (formerly known as Amerigroup) Fidelis Care (formerly known as WellCare) Horizon NJ Health UnitedHealthcare Community Plan

[Estimated Time; <45 Minutes]

Child/Youth/Young Adult Characteristics – These questions ask about the child, youth, or young adult with ASD.

1. **Starting with your youngest child, youth, or young adult with ASD that is covered by Medicaid, how old are they (in years, at their last birthday)?**

   __ years old [Number]

   Source: Adapted from CSHP/Eagleton/Department of Children and Families - IDD Caregiver Survey

2. **Does this child [youth| young adult] identify as male, female, or in some other way?**
   a. Male
   b. Female
   c. Non-binary
   d. Some other way (please specify)
   e. Prefer not to answer

   Source: Adapted from CSHP/Eagleton/Department of Children and Families - IDD Caregiver Survey

3. **In general, how would you describe this child[youth| young adult]'s health?**
   a. Excellent
   b. Very Good
   c. Good
   d. Fair
   e. Poor

   Source: National Survey on Child's Health, https://www.childhealthdata.org/learn-about-the-nsch/NSCH

4. **What age was the child[youth| young adult] with ASD when they were first diagnosed with ASD?**
      a. As an infant (by age 2)
      b. Age 2-4
      c. Age 5-12
      d. Age 13-18
      e. Age 19-20
      f. Not sure

   Source: New question

5. **What is this child[youth| young adult]'s preferred means of communication? (choose one)**

a. Spoken Language
b. Gestures or Body language
c. Sign language or finger spelling
d. Communication aid or device
e. Other (please specify) [Open-ended free text]

Source: National Core Indicators - Child Family Survey, https://idd.nationalcoreindicators.org/

6. **Would you describe the child[youth| young adult]'s autism or autism spectrum disorder as mild, moderate, or severe?**
   a. Mild
   b. Moderate
   c. Severe

   Source: NJ CATS Survey, https://www.nj.gov/humanservices/ddd/assets/documents/sample-njcat-assessment.pdf

7. **How much support does this child[youth| young adult] need to prevent or manage self-injurious, disruptive, and/or destructive behaviors? (choose one)**
   a. None
   b. Some
   c. Extensive

   Source: National Core Indicators- Child Family Survey, https://idd.nationalcoreindicators.org/

8. **The next questions ask about difficulties this child[youth| young adult] may have doing certain activities.**

	1= no difficulty	2 = some difficulty	3 = a lot of difficulty	4 = unable to do
Does the child [youth| young adult] with ASD have difficulty seeing even if wearing glasses?				
Does the child [youth| young adult] with ASD have difficulty hearing even if using a hearing aid?				
Does the child [youth| young adult] with ASD have difficulty walking or climbing steps?				
Does the child [youth| young adult] with ASD have difficulty remembering or concentrating?				
Does the child [youth| young adult] with ASD have difficulty with self-care such as washing all over or dressing?				
Using their usual language, does the child [youth| young adult] with ASD have difficulty communicating, for example understanding or being understood?				

Source: Adapted from *Washington Group Short Set of Questions on Disability*, http://www.washingtongroup-disability.com/

9. **Do you have any other children with ASD in New Jersey Medicaid?**
   [List ages of children reported to this point]

   a. Yes (Repeat 1-8)
   b. No

ASD Pilot Services Use – These questions ask about experiences accessing the Autism Benefit and ASD Pilot Services available through the child [youth| young adult]'s Medicaid coverage.

10. **How did you learn about the Autism Benefit available through NJFamilyCare? (One or more categories may be selected)**

Note: Available **Autism Benefit** services include, -Applied Behavior Analysis (ABA) -Allied health services (Occupational, Physical, Speech, and Language Therapies) -Developmental and Relationship-based Approaches -Sensory Integration Therapy -Skill Acquisition and Capacity Building

- Text/call/email/letter from a managed care organization that manages the benefits

NOTE: You may have heard of this type of insurance as being referred to NJFamilyCare, Medicaid, or one of the five health plans (also known as MCOs) that participate in New Jersey's NJ FamilyCare Medicaid program: Aetna Better Health of New Jersey Wellpoint New Jersey (formerly known as Amerigroup) Fidelis Care (formerly known as WellCare) Horizon NJ Health UnitedHealthcare Community

- Text/call/email/letter from the New Jersey government (NJFamilyCare, Children's System of Care, Division of Medical Assistance and Health Services, or Division of Developmental Disabilities)
- Community events or other community outreach
- Online/television advertisement
- Primary care physician/pediatrician
- Allied health professional/therapist
- This is the first time I have learned about the available autism benefits
- Some other way (please specify) [Open-ended free text]
- Don't know/not sure

Source: New question

How did you learn about the ASD Pilot Services now available through NJFamilyCare? (One or more categories may be selected)

Note: Available **ASD Pilot Services** include,
- Art therapy
-Aquatic therapy
-Hippotherapy/therapeutic horseback riding
-Music therapy
-Drama therapy
-Dance/movement therapy
-Recreation therapy

- Text/call/email/letter from a managed care organization that manages the benefits

NOTE: You may have heard of this type of insurance as being referred to NJFamilyCare, Medicaid, or one of the five health plans (also known as MCOs) that participate in New Jersey's NJ FamilyCare Medicaid program:
Aetna Better Health of New Jersey
Wellpoint New Jersey (formerly known as Amerigroup)
Fidelis Care (formerly known as WellCare)
Horizon NJ Health
UnitedHealthcare Community

- Text/call/email/letter from the New Jersey government (NJFamilyCare, Children's System of Care, Division of Medical Assistance and Health Services, or Division of Developmental Disabilities)
- Community events or other community outreach
- Online/television advertisement
- Primary care physician/pediatrician
- Allied health professional/therapist
- This is the first time I have learned about the available autism benefits
- Some other way (Please specify)[Optional free text]
- Don't know/not sure

Source: New question

11. **For each of the following Autism Benefit services, please tell us if you have received or tried to access the service:**

Service	**Received service**	**Have not tried to access**	**Tried but was unable to access**
Applied Behavior Analysis (ABA)			
Allied health services (Occupational,			

Physical, Speech, and Language Therapies)			
Developmental and Relationship-based Approaches			
Sensory Integration Therapy			
Skill Acquisition and Capacity Building			
None of these			

Source: Response categories from IDD Survey (CSHP/Eagleton/DCF)

12. [For services received above, ask] **How was the service paid?**

Service	**NJFamilyCare**	**Another type of insurance**	**Privately paid from personal resources**	**Not sure**
Applied Behavior Analysis (ABA)				
Allied health services (Occupational, Physical, Speech, and Language Therapies)				
Developmental and Relationship-based Approaches				
Sensory Integration Therapy				
Skill Acquisition and Capacity Building				

Source: Response categories from IDD Survey (CSHP/Eagleton/DCF)

13. **How difficult is it [or would it be] for the child [youth| young adult] to attend therapies, services, or appointments such as those listed in the Autism Benefit?**

	Not sure	Not difficult at all	Somewhat difficult	Very difficult	Not possible
Applied Behavior Analysis (ABA)					
Allied health services (Occupational, Physical, Speech, and Language Therapies)					
Developmental and Relationship-based Approaches					
Sensory Integration Therapy					
Skill Acquisition and Capacity Building					

Source: Adapted from National Core Indicators - Child Family Survey, https://idd.nationalcoreindicators.org/

14. **What makes it difficult (or would make it difficult) to take part in Autism Benefit services? (One or more categories may be selected.)**

	Lack of transportation	Cost	Lack of support staff	Stigma	Availability (time of day/week or too far away)	Something else (please specify)
Applied Behavior Analysis (ABA)						

Allied health services (Occupational, Physical, Speech, and Language Therapies)						
Developmental and Relationship-based Approaches						
Sensory Integration Therapy						
Skill Acquisition and Capacity Building						

Source: Adapted from National Core Indicators - Child Family Survey, https://idd.nationalcoreindicators.org/

15. **What would make it easier to take part in Autism Benefit services?**
    __ [Open-ended free text]

16. **For each of the following Autism Pilot services, please tell us if you have received or tried to use the service:**

Service	**Received service**	**Have not tried to access**	**Tried but was unable to access**
Art therapy			
Aquatic therapy			
Hippotherapy/therapeutic horseback riding			
Music therapy			
Drama therapy			
Dance/movement therapy			
Recreation therapy			
None of these			

Source: Response categories from IDD Survey (CSHP/Eagleton/DCF)

17. [for services received above, ask] **How was the service paid?**

Service	NJFamilyCare	Another type of insurance	Privately paid from personal resources	Not sure
Art therapy				
Aquatic therapy				
Hippotherapy/therapeutic horseback riding				
Music therapy				
Drama therapy				
Dance/movement therapy				
Recreation therapy				

Source: Response categories from IDD Survey (CSHP/Eagleton/DCF)

18. **How difficult is it [or would it be] for the child [youth| young adult] to attend therapies, services, or appointments such as those listed in the Autism Pilot Services?**

	Not sure	Not difficult at all	Somewhat difficult	Very difficult	Not possible
Art therapy					
Aquatic therapy					
Hippotherapy, therapeutic horseback riding					
Music therapy					
Drama therapy					
Dance/movement therapy					
Recreation therapy					

Source: Adapted from National Core Indicators - Child Family Survey, https://idd.nationalcoreindicators.org/

19. **What makes it difficult (or would make it difficult) to take part in ASD Pilot services? (One or more categories may be selected.)**

	Lack of transportation	Cost	Lack of support staff	Stigma	Availability (time of day/week or too far away)	Something else (please specify)

Art therapy						
Aquatic therapy						
Hippotherapy, therapeutic horseback riding						
Music therapy						
Drama therapy						
Dance/movement therapy						
Recreation therapy						

Source: Adapted from National Core Indicators - Child Family Survey, https://idd.nationalcoreindicators.org/

20. **What would make it easier to take part in ASD Pilot services?**
__ [Open-ended free text]

Community Engagement – These questions ask about experiences in your community.

21. **In the last two weeks, how often have you felt lonely?**

    a. Never
    b. Rarely
    c. Sometimes
    d. Usually
    e. Always

    Source: Adapted from Parenting Stress, RAPID, https://rapidsurveyproject.com/

22. **In the last two weeks, when you felt overwhelmed or stressed when caring for or making decisions about the child(ren)/youth(s)/young adult(s) in your household, how often did you get the support you needed?**

    a. Never
    b. Rarely
    c. Sometimes
    d. Usually
    e. Always

    Source: Adapted from Parenting Stress, RAPID, https://rapidsurveyproject.com/

23. **Tell me if you strongly agree, somewhat agree, somewhat disagree, or strongly disagree with the following statement:**

    "I would know where to go for help if I had trouble making ends meet."

    a. Strongly agree

b. Somewhat agree
c. Somewhat disagree
d. Strongly disagree
e. Not sure

Source: Adapted from Protective Factors Survey, https://friendsnrc.org/wp-content/uploads/Protective-Factors-Survey.pdf

24. **Does the child [youth| young adult] with ASD take part in activities in the community?**
    a. Yes
    b. No
    c. Not sure

    Source: Adapted from National Core Indicators - Child Family Survey, https://idd.nationalcoreindicators.org/

25. **What makes it difficult to take part in activities in the community?**
    a. Lack of transportation
    b. Cost
    c. Lack of support staff
    d. Stigma
    e. Other (please specify) [Open-ended free text]

    Source: Adapted from National Core Indicators - Child Family Survey, https://idd.nationalcoreindicators.org/

26. **In your community, are there resources that your family can use that are not provided through the Autism Benefit or ASD Pilot (for example, recreational programs, community housing, library programs, religious groups, etc.)?**
    a. Yes
    b. No
    c. Not sure

    Source: Adapted from National Core Indicators - Child Family Survey, https://idd.nationalcoreindicators.org/

27. **Does your family take part in any family-to-family networks in your community (for example, Parent to Parent, sibling networks, etc.)?**
    a. Yes
    b. No
    c. Not sure

    Source: Adapted from National Core Indicators - Child Family Survey, https://idd.nationalcoreindicators.org/

28. [Adapted from developer] **The statements below are about leisure, recreation and activities that families engage with in their communities. We are interested in the child**

[youth| young adult] with ASD and family's experiences engaging with desired services, programs, and activities in your community. For each statement, please indicate your family's level of inclusion and involvement.

	0 = not interested/not applicable to us	1=excluded, maximal changes and/or support required	2=somewhat included and involved, many changes and/or support required	3=moderately included and involved, minor changes and/or support required	4=included and involved, no changes and/or support required
Using local parks, beaches, or other open spaces,					
Walking or wheeling around my local neighborhood,					
Dining or socializing at restaurants or similar venues,					
Using local shopping facilities,					
Using local recreational facilities such as those for indoor sport and swimming,					
Attending health, dental and medical facilities for my child with a disability,					
Attending health, dental and medical facilities for myself or my other child(ren),					
Being invited to and attending					

other people's homes, and					

Source: Bourke-Taylor, Tirlea, Joyce, 2021. https://pubmed.ncbi.nlm.nih.gov/33894506/

Parent/Primary Caregiver/Guardian Characteristics – These questions ask about your experiences as the parent, primary caregiver, or guardian of the child [youth] young adult] with ASD.

29. **To ensure we are reaching people of all ages, would you please tell me your age?**
    __[Number]
    Prefer not to answer/unsure

    Source: CSHP/Eagleton/Department of Children and Families, IDD Caregiver Survey

30. **[For prefer not to answer/unsure above, ask] Would you be willing to tell us whether it's between…**
    a. 18 - 20
    b. 21 - 24
    c. 25 - 29
    d. 30 - 34
    e. 35 – 44
    f. 45 – 49
    g. 50 - 54
    h. 55 - 64
    i. 65 OR OVER
    j. Prefer not to answer

    Source: CSHP/Eagleton/Department of Children and Families - IDD Caregiver Survey

31. **What is the highest degree or level of school you have completed?**
    a. no schooling completed
    b. nursery school to 8th grade
    c. 9th-12th grade, no diploma
    d. high school graduate (high school diploma or the equivalent)
    e. vocational/technical/business/trade school certificate or diploma (beyond the high school level)
    f. some college, but no degree
    g. associate degree
    h. bachelor's degree
    i. master's, professional or doctorate degree
    j. don't know
    k. prefer not to answer

    Source: CMS, https://www.cms.gov/data-research/research/medicare-current-beneficiary-survey/questionnaires/2023-questionnaires

32. **Are you of Latino or Hispanic origin, such as Mexican, Puerto Rican, Cuban or some other Spanish background?**
    a. Yes
    b. No

    Source: Adapted from US Department of Health and Human Services, Office of Minority Health, https://minorityhealth.hhs.gov/explanation-data-standards-race-ethnicity-sex-primary-language-and-disability

33. **Are you White, Black or of Asian origin, or are you some other race, or multi-racial?**
    a. White (includes Caucasian, European, Middle Eastern)
    b. Black (includes African American)
    c. Asian (includes Asian-Indian, South Asian, East Asian, Chinese, Japanese)
    d. Hispanic / Latino / Spanish
    e. Other (please specify) [Open-ended free text]
    f. Multi-racial (please specify) [Open-ended free text]

    Source: Adapted from US Department of Health and Human Services, Office of Minority Health, https://minorityhealth.hhs.gov/explanation-data-standards-race-ethnicity-sex-primary-language-and-disability

34. **How do you describe your gender? [Select ONE]**
    a. Female
    b. Male
    c. Trans Male/Trans Man
    d. Trans Female/Trans Woman
    e. Genderqueer/Gender Nonconforming
    f. Prefer to self-describe, please specify: [open field]
    g. Prefer not to answer

    Source: Q7-8 Two Step Gender Identity, https://registrar.ucsc.edu/gender-identity/index.html

35. **Over the last 2 weeks, how often have you been bothered by the following problems?**

    34.A Feeling nervous, anxious or on edge
    34.B Not being able to stop or control worrying
    34.C Little interest or pleasure in doing things
    34.D Feeling down, depressed or hopeless

        i. Not at all
        ii. Several days
        iii. More than half the days
        iv. Nearly every day

    Source: PHQ-4, https://pubmed.ncbi.nlm.nih.gov/19996233

Household and Environment – These questions refer to the home and apply to all members of the household

36. **What is the primary language spoken in your home?**
    a. English
    b. Spanish
    c. Other (please specify) [Open-ended free text]

    Source: Adapted from US Department of Health and Human Services, Office of Minority Health, https://minorityhealth.hhs.gov/explanation-data-standards-race-ethnicity-sex-primary-language-and-disability

37. **Please tell me how many children are in your household in each of the following age groups, according to their age at their last birthday:**
    a. How many children are aged 0-2? __[Number]
    b. How many children are aged 3-5? __[Number]
    c. How many children are aged 6-9? __[Number]
    d. How many children are aged 10-12? __[Number]
    e. How many children are aged 13-17? __[Number]

    Source: Adapted from NJ Population Cohort Study

38. **Next, please tell me how many adults (not including you) are in your household in each of the following age groups, according to their age at their last birthday:**
    a. How many adults are aged 18-24? __[Number]
    b. How many adults are aged 25-44? __[Number]
    c. How many adults are aged 45-64? __[Number]
    d. How many adults are aged 65+? __[Number]

    Source: Adapted from NJ Population Cohort Study

39. **Did you or any other adult in the household have to reduce their working hours to provide care?**

    a. Yes
    b. No

    Source: CSHP/Eagleton/Department of Children and Families, IDD Caregiver Survey

40. **In the past 12 months, how often were you worried that your food would run out before you got money to buy more?**
    a. Often
    b. Sometimes
    c. Never

    Source: Hager et al., 2-Item Screen to Identify Families at Risk for Food Insecurity, https://doi.org/10.1542/peds.2009-3146

41. **In the past 12 months, how often did the food you bought just not last, and you didn't have money to get more?**
    a. Often
    b. Sometimes
    c. Never

    Source: Hager et al., 2-Item Screen to Identify Families at Risk for Food Insecurity, https://doi.org/10.1542/peds.2009-3146

42. **In the past 12 months, did you or any member of this household receive benefits from the Food Stamp Program or SNAP (the Supplemental Nutrition Assistance Program)?**
    a. Yes
    b. No
    c. Not sure/prefer not to answer

    Source: Census, https://www.census.gov/programs-surveys/acs/about/forms-and-instructions.html

43. **Overall, how safe do you feel in your home?**
    a. Very safe
    b. Somewhat safe
    c. Not very safe
    d. Not safe at all

    Source: Modified from JHU COVID-19 Community Response Surveyv1.3, used in CSHP/Eagleton, https://tools.niehs.nih.gov/dr2/files/jhu_covid19_community_response_survey_v13_508.pdf

44. **Overall, how safe do you feel in your neighborhood?**
    a. Very safe
    b. Somewhat safe
    c. Not very safe
    d. Not safe at all

    Source: Modified from JHU COVID-19 Community Response Surveyv1.3, used in CSHP/Eagleton, https://tools.niehs.nih.gov/dr2/files/jhu_covid19_community_response_survey_v13_508.pdf

Additional Feedback

45. **Thank you again for participating in the Adjunct Services Autism Spectrum Disorder Pilot Survey. Are there are any additional recommendations, comments, or concerns regarding the ASD Benefit, ASD Pilot services, and resources in your community that you would like us to know about?**

a. Yes (Please specify) [Open-ended free text]
b. No

2. Children's Support Services Programs (SED, I/DD)

A. General Background Information

NEW JERSEY DEPARTMENT OF CHILDREN AND FAMILIES CHILDREN'S SYSTEM OF CARE ADMINISTERED PROGRAMS

The New Jersey Department of Children and Families (DCF), Division of Children's System of Care (CSOC) administers two separate programs under the authority of the demonstration: one for children, youths, and young adults with serious emotional disturbances (SED) and one for those who meet DCF Children's System of Care's functional eligibility for children, youths, and young adults with intellectual and developmental disabilities (I/DD). Collectively, these programs are the Children's Support Services Program (CSSP). There are three eligibility categories for the CSSP:

1. **State Plan Members** "who qualify for Medicaid under the State Plan";
2. **217-like**, "who do not qualify for Medicaid or CHIP under the State Plan, and whose household income is less than 300% of the Federal Benefit Rate"; and
3. **1915-like**, "do not qualify for Medicaid or CHIP under the State Plan, and whose household income is too high to qualify as 217-like members."[15]

The first §1115 Comprehensive Demonstration (October 2012-July 2017) included the Children with Serious Emotional Disturbance (SED) and Intellectual/Developmental Disabilities with Co-Occurring Mental Health Diagnosis (I/DD-MI) waivers with additional services rolled out from 2015-2017. These prior waivers were combined into the Children's Support Services Program during the §1115 Comprehensive Demonstration initial renewal period (August 1, 2017 – June 30, 2022). Additionally, in July 2016, the "Plan A" eligibility expansion granted Medicaid State Plan services to youth with SED in out-of-home settings. As part of the current demonstration renewal (April 1, 2023, through June 30, 2028), CMS approved two critical changes to the CSSP:

- **Disregarding parental income when determining Medicaid eligibility** for children/youth within the CSSP SED or the CSSP I/DD (described below). This allows those who currently have access only to waiver and behavioral health services to receive full State Plan benefits, and
- implementation of **existing waiver authority policies for children, youths, and young adults with I/DD**.

These changes to service provision by eligibility category are described in the sections that follow.

[15] New Jersey Department of Human Services. NJ FamilyCare Comprehensive Demonstration: Draft renewal proposal. New Jersey Department of Human Services Division of Medical Assistance and Health Services. https://www.nj.gov/humanservices/dmahs/home/1115_NJFamilyCare_Comprehensive_Demonstration_Draft_Proposal.pdf

CSSP SED Program

The CSSP SED program provides behavioral health and Home and Community Based Services (HCBS) benefits to beneficiaries under the age of 21 with SED who are at risk of institutionalization, out-of-home treatment, or hospitalization. Specific covered HCBS continued under the demonstration include:

- social and emotional learning services,
- interpreter services, and
- non-medical transportation.

New Jersey seeks to build upon the successes of the existing CSSP SED program to further reduce the institutionalization of New Jersey children, youths, and young adults with SED. Parental income will be disregarded for calculating household income for a children, youths, and young adults who remains in home and in community. This would expand eligibility for youth who qualify as a 217-like (i.e., at risk for institutionalization and child meets income eligibility requirement) under CSSP SED. Additionally, this would mean that most members currently in the 1915-like (i.e., at risk for institutionalization but who exceeds the income threshold for 217-like eligibility) category would now instead qualify as 217-like. Accordingly, **most children, youths, and young adults with SED who meet the clinical and other non-income eligibility criteria and have not been institutionalized would now have access to full Medicaid State Plan services**, in most instances as a backstop to their existing health coverage.

Table 2.1. Changes for CSSP SED

Group	Change	What does this mean?
State Plan Members	No changes	N/A
217-like Individuals	• Parental income will now be disregarded when calculating household income for children, youths, and young adults that remain in home and in community, and not just for those who have been institutionalized.	• This means that most members currently in the 1915-like category would now instead qualify as 217-like and ensures that eligible beneficiaries have access to all state plan services (both behavioral and physical).
1915-like Individuals	• Parental income will now be disregarded when calculating household income for children, youths, and young adults that remain in home and in community, and not just for those who have been institutionalized. • Most 1915-like individuals will now qualify as 217-like individuals due to theparental disregard and receive all State	• Relatively few members are expected to remain in this eligibility category.

	Plan Services and HCBS benefits.	

CSSP I/DD Program

The CSSP I/DD program provides HCBS benefits to children, youths, and young adults under the age of 21 who meet DCF/CSOC's functional eligibility for I/DD (as defined by State and Federal law). These beneficiaries may also have co-occurring mental health diagnoses. In the renewal, eligibility for children with I/DD no longer required a co-occurring mental health diagnosis, but many children with SED enrolled in CSSP were not Medicaid/CHIP eligible for State Plan services Under the existing demonstration, the State is authorized to provide services under CSSP I/DD to three categories of beneficiaries, mentioned above. However, in the prior demonstration, **the State had only utilized demonstration authority to provide Medicaid services for State Plan members, and not for the 217-like or 1915-like groups.** During the renewal period New Jersey intends to fully implement the 1915-like and 217-like programs for which it currently has authority under the ongoing 2017-2023 demonstration. While various operational and budget constraints have prevented full implementation to date, the State has identified solutions to these barriers, and it intends to move forward with full implementation.

Specific HCBS benefits covered under the demonstration include:

- social and emotional learning services,
- interpreter services,
- non-medical transportation,
- individual support services,
- intensive in-community/in-home services, and
- agency hired respite services.

The current demonstration **will align with the changes proposed under CSSP SED to disregard parental income when assessing whether a child qualifies as a 217-like or 1915-like member under CSSP I/DD.**

Table 2.2. Changes for CSSP I/DD

Group	Change	What does this mean?
State Plan Members	No changes	N/A
217-like Individuals	• DMAHS and DCF plan to operationalize this group • Parental income will now be disregarded when calculating household income for children, youths, and young adults that remain in home and in community, and not just for those who have been institutionalized.	• I/DD children, youths, and young adults who previously did not qualify for Medicaid due to exceeding the income requirement under state plan will now have access to state plan services; • CSOC HCBS services that are currently funded using state-only dollars for this population will be eligible for federal match. • Members who would have previously qualified in the 1915-like category (if implemented) will now instead qualify as

		217-like and have access to all state plan services (both behavioral and physical).
1915-like Individuals	• DMAHS and DCF plan to operationalize this group • Parental income will now be disregarded when calculating household income for children, youths, and young adults that remain in home and in community, and not just for those who have been institutionalized.	• This group will be newly operationalized – however, relatively few members are expected to qualify for Medicaid within this category.

B. Evaluation Hypotheses and Questions

Evaluation of CSSP SED & I/DD Programs

We posit that the expansion of CSSP eligibility and implementation of previously established HCBS benefits to the CSSP I/DD 217-like and 1915-like groups will provide improved access to both behavioral and physical health services that will allow holistic and coordinated medical and behavioral health treatment. This is expected to improve care delivery, reduce rates of institutionalization, and enhance beneficiary experience.

Below we present the *driver diagram* (Figure 2.1) that delineates the pathway from the policy change to overall program aims. Here the secondary drivers represent the various services offered through the CSSP SED and CSSP I/DD programs.

Figure 2.1. Children's Support Services Program Aim Driver Diagram

<table>
<tr><th>Aim</th><th>Primary Drivers</th><th>Secondary Drivers</th></tr>
<tr><td rowspan="2">1.A. Ensure that eligible beneficiaries have access to all necessary services (both behavioral and physical) to allow holistic and coordinated treatment

1.B. Reduce the institutionalization of New Jersey children, youths, and young adults with SED or I/DD</td><td>Full Medicaid State Plan services for children, youths, and young adults at-risk of hospitalization or out-of-home services</td><td>• Parental income disregarded when calculating household income for children, youths, and young adults that remain in home and in community
• Extension of eligibility for full State Plan benefits to children, youths, and young adults who currently have access only to waiver and behavioral health services</td></tr>
<tr><td>Expand access to person-centered care delivered in the home and community</td><td>HCBS (SED & I/DD)
• Social and emotional learning services
• Interpreter services
• Non-medical transportation
HCBS (I/DD only)
• Individual support services
• Intensive in-community/in-home services
• Agency respite services</td></tr>
<tr><td colspan="3">⟸ Causality ⟸</td></tr>
</table>

Research Hypotheses and Questions

We next detail the hypotheses and corresponding research questions about the effects of providing HCBS and full state plan Medicaid services on care and health outcomes among children, youths, and young adults with SED or I/DD.

Hypothesis 1: *Providing full State Plan services and HCBS* to children, youths, and young adults *within (1) CSSP SED and (2) CSSP I/DD who are at-risk for institutionalization, out-of-home care, and hospitalization and who would otherwise have not been eligible for Medicaid or CHIP due to parental income (i.e., "CSSP eligibility expansion"), will increase access to preventive services, reduce reliance on out of home treatment, reduce avoidable hospitalization and emergency services, and* improve beneficiary experience.

Research Question 1a: What are the trends in **preventative services** (i.e., child and adolescent well-care visits and follow-up after hospitalization for mental illness) among the CSSP expanded eligibility groups over the course of the current demonstration (2023-2028)? How do these trends vary across different subgroups (e.g., race/ethnicity, gender, presence of comorbidities, and eligibility category)?

Research Question 1b: What are the trends in **overall utilization of care** (i.e. inpatient hospitalizations, emergency department (ed) treat-and-release visits, and primary care utilization) among the CSSP expanded eligibility groups over the course of the current demonstration (2023-2028)? How do these trends vary across different subgroups (e.g., race/ethnicity, gender, presence of comorbidities, and eligibility category)?

Research Question 1c: What are the trends in **out of home treatment** (i.e., out-of-home stays in residential treatment, total number of days in residential treatment) among the CSSP expanded eligibility groups over the course of the current demonstration (2023-2028)? How do these trends vary across different subgroups (e.g., race/ethnicity, gender, presence of comorbidities, and eligibility category)?

Research Question 1d: What are the trends in **avoidable utilization and spending** (i.e., avoidable hospitalizations, hospitalization for mental illness, 30-day hospital readmissions, inpatient days, and spending related to all inpatient hospitalizations and ed visits) among the CSSP expanded eligibility groups over the course of the current demonstration (2023-2028)? How do these trends vary across different subgroups (e.g., race/ethnicity, gender, presence of comorbidities, and eligibility category)?

Research Question 1e: How has CSSP participation affected the experience of **services and supports and overall satisfaction of beneficiaries** as the health care consumer, as evidenced by the child/youths' parents, guardians, or other primary caregivers?

Hypothesis 2: *Providing home and community-based services (HCBS) to child/youth Medicaid beneficiaries with intellectual disabilities/developmental disabilities (I/DD) through operationalizing the Children's Support Services Program for I/DD (i.e., newly operationalized 217-like and 1915-like eligibility groups) will increase access to preventive services, reduce reliance on out of home*

treatment, reduce avoidable hospitalization and emergency services, and improve beneficiary experience.

Research Question 2a: What are the trends in **preventative services** (i.e., child and adolescent well-care visits and follow-up after hospitalization for mental illness) among the CSSP I/DD beneficiaries, who utilize HCBS, in the newly operationalized eligibility categories over the course of the current demonstration (2023-2028)? How do these trends vary across different subgroups (e.g., race/ethnicity, gender, presence of comorbidities, and eligibility category)?

Research Question 2b: What are the trends in **utilization of care** (i.e., inpatient hospitalizations, emergency department (ed) treat-and-release visits, and primary care utilization) among the CSSP I/DD beneficiaries, who utilize HCBS, in the newly operationalized eligibility categories over the course of the current demonstration (2023-2028)? How do these trends vary across different subgroups (e.g., race/ethnicity, gender, presence of comorbidities, and eligibility category)?

Research Question 2c: What are the trends in **out of home treatment** (i.e., out-of-home stays in residential treatment, total number of days in residential treatment) among the CSSP I/DD beneficiaries, who utilize HCBS, in the newly operationalized eligibility categories over the course of the current demonstration (2023-2028)? How do these trends vary across different subgroups (e.g., race/ethnicity, gender, presence of comorbidities, and eligibility category)?

Research Question 2d: What are the trends in **avoidable utilization and spending** (i.e., avoidable hospitalizations, hospitalization for mental illness, 30-day hospital readmissions, inpatient days, and spending related to all inpatient hospitalizations and ed visits) among the CSSP I/DD beneficiaries, who utilize HCBS, in the newly operationalized eligibility categories over the course of the current demonstration (2023-2028)? How do these trends vary across different subgroups (e.g., race/ethnicity, gender, presence of comorbidities, and eligibility category)?

C. Methodology

Below, we provide brief descriptions of the proposed measures and methods. A summary of the methods, organized by hypotheses and research questions can be found at the end of this section in Table 2.6.

Claims-based Outcomes:

We will assess the claims-based outcomes listed and described in Table 2.3 below.

Table 2.3. Inventory of Claims-based Measures

Measure		Brief Description
Preventative Services		
1.	Child and Adolescent Well-Care Visits	"Children 3–21 years of age who received one or more well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year."[16]

[16] NCQA (National Committee for Quality Assurance). 2023. *HEDIS 2023: Healthcare Effectiveness Data and Information Set. Vol. 2: Technical Specifications for Health Plans.* Washington, DC: NCQA.

2.	Follow-up after Hospitalization for Mental Illness (age 6+)	"Inpatient discharges for a diagnosis of mental illness or intentional self-harm among patients aged 6 years and older that resulted in follow-up care with a mental health provider within 7 and 30 days."[2]
Overall Utilization of Services		
3.	Inpatient hospitalizations (all-cause) (all ages)	Individuals receive inpatient hospital treatment including pregnancy and childbirth, for surgery, or for nonsurgical medical treatment, and those for psychiatric inpatient admissions.
4.	Emergency department (ED) treat-and-release visits (all ages)	Individuals seek ambulatory care in the emergency department because of pregnancy and childbirth, for surgery, or for nonsurgical medical treatment
5.	Emergency screening center services (all ages)	Individuals seek emergency psychiatric screening services at state-designated sites for services including but not limited to crisis intervention and stabilization.
6.	Primary care utilization	Indicator that youth receives routine outpatient or preventative medical care, includes frequency of visits per year.
Out-of-home Care		
7.	Out-of-home stays in residential treatment (all ages)	Count of children/youths/young adults' residential treatment center stays including residential treatment facilities and group home settings.
8.	Total number of days in residential treatment (all ages)	Total number of days in out-of-home treatment in the year, excluding leaves.
Avoidable Utilization and Spending		
9.	Avoidable Hospitalizations (age 6-17 and 18+, separately)	Preventable or potentially avoidable hospitalization that may occur due to inadequate ambulatory/primary care within communities. Includes hospitalization for conditions typically treatable in outpatient settings: asthma, diabetes with short-term complications, gastroenteritis, or urinary tract infection.[17]
10.	Hospitalization for mental illness (age 6+)	Individuals receive inpatient hospital treatment for mental illness.[1]
11.	30-day hospital readmissions (all-cause) (all ages)	Indicates readmission for any cause within 30 days of the discharge date for the index hospitalization, excluding a specified set of planned readmissions.[18, 19]

[17] Agency for Healthcare Research and Quality. Pediatric Quality Overall Composite Technical Specifications. Agency for Healthcare Research and Quality; 2013.

[18] Benbassat J, Taragin M. Hospital readmissions as a measure of quality of health care: advantages and limitations. Archives of internal medicine. 2000 Apr 24;160(8):1074-81.

[19] Feng JY, Toomey SL, Zaslavsky AM, Nakamura MM, Schuster MA. Readmission after pediatric mental health admissions. Pediatrics. 2017 Dec 1;140(6):e20171571.

12.	Inpatient days (all ages)	Number of days for inpatient stays at general acute care hospitals
13.	Spending related to all inpatient hospitalizations and ED visits (all ages)	Payments on facility claims for inpatient and treat-and-release ED visits, inflation adjusted.

Qualitive Domains:

We will collect qualitative data within the domains in Table 2.4. This is not meant to be an exhaustive list, but qualitative analyses will include inquiries into these areas.

Table 2.4. Beneficiary Experience

Domain		**Brief Description**
1.	Services and Supports Access	Family experience in a. accessing information used to understand health services choices and health decision-making and accessing special equipment or accommodations (i.e., health literacy)[20] b. Children, youths, and young adults 's access to primary care physicians c. Children, youths, and young adults 's access to specialists.
2.	Community Engagement	a. Children, youths, and young adults 's opportunities to participate in the community, including activities outside the home, and time with other children/youths. Including but not limited to families' participation in recreational groups and programs, and presence of family networks (e.g., parent-to-parent groups and sibling groups).
3.	Satisfaction and Recommendations	a. Satisfaction with the services and support provided. b. Impact of services and support on experience of care and out-of-pocket costs. c. Recommendations for additional services or other requested modifications.
NOTES: Adapted from National Core Indicators, Child Family Survey™. [21]		

[20] Muscat DM, Shepherd HL, Nutbeam D, Trevena L, McCaffery KJ. Health literacy and shared decision-making: exploring the relationship to enable meaningful patient engagement in healthcare. Journal of general internal medicine. 2021 Feb;36:521-4.

[21] NCI (National Core Indicators). 2022. *Child Family Survey 2020-21 Final Report.* National Association of State Directors of Developmental Disabilities Services and Human Services Research Institute. Retrieved on 7/25/2023 from: https://legacy.nationalcoreindicators.org/upload/core-indicators/2020-21_CFS_National_Report_Final.pdf

For research questions 1a-1d & 2a-2d

Study population for research questions 1a-1d: Data on the healthcare experiences of child, youth, and young adult beneficiaries prior to enrollment are not available, which precludes testing the effect of reform using pre-post comparisons. Additionally, child, youth, and young adult beneficiaries will enter the waiver programs at different times throughout the demonstration.[22] As a result of these constraints, the study population will include individuals who were "ever enrolled" in the CSSP SED or I/DD programs (in the quarter or year as described below), respectively, and had a minimum of 10 months of enrollment. We will compare trends by subpopulation (e.g., race/ethnicity, gender, presence of comorbidities, and eligibility category).

Study population for research questions 2a-2d: The study populations for hypotheses 2a-2d are comprised of children and youth up to age 21 who were eligible for I/DD CSSP during the demonstration period. For hypotheses 2a-2d, we will compare the experiences of children, youths, and young adults with I/DD who utilized HCBS within the newly operationalized eligibility categories (i.e., those in the newly operationalized 217-like and 1915-like CSSP I/DD categories who were not given access to CSSP HCBS prior to the demonstration) to eligible CSSP I/DD children, youths, and young adults who did not utilize HCBS. As above, the study population will include individuals who were "ever enrolled" in the CSSP SED or I/DD programs (in the quarter or year as described below), respectively, and had a minimum of 10 months of enrollment.

Analytic strategy for research questions 1a-1d and 2a-2d:

We will calculate adjusted trends, estimating levels of outcome measures on a quarterly or annual basis (as feasible relative to sample size concerns) to examine preventative services, utilization of services, out of home treatment, and avoidable utilization and spending (see Table CSSP.3 for complete list of proposed outcome measures).

We will use two approaches to estimate yearly measures of study outcomes. First, we will implement a repeated cross-sectional approach for all beneficiaries enrolled in the respective eligibility categories (SED or I/DD). We will then restrict the samples to cohorts of individuals enrolled in CSSP SED or I/DD, respectively, during the baseline period (2023) and examine changes in outcomes over the current demonstration period (2023-2028). We will adjust for possible changes in population composition using regression models. We will use line graphs and tables to describe results. Sample sizes permitting, the adjusted trends will also be stratified by subgroups of interest such as race/ethnicity, gender, presence of comorbidities, and eligibility categories.

The models will be specified as follows:

Main Models:

$$Outcome_{it} = \alpha_0 + \alpha_1(Time_Indicator)_i + \alpha_2(Group)_{it} + \lambda X_{it} + \varepsilon_{it}$$

[22] Chakravarty, S, Lloyd, K, Farnham, J, Pizzi, L, Agrawal, M, Nova, J, Prioli, KM, Nasiri, M. 2022. *Examining the Effect of the NJ FamilyCare Comprehensive Demonstration on Access to Care, Quality, and Cost of Care: Draft Interim Evaluation Report*. New Brunswick, New Jersey: Rutgers Center for State Health Policy.

Secondary Models:

$$Outcome_{it} = \alpha_0 + \alpha_1(Time_Indicator)_i + \alpha_2(Group)_{it} + \alpha_3(Time_Indicator * Group)_{it} + \lambda X_{it} + \varepsilon_{it}$$

For the Main Models, $Outcome_{it}$ represents the outcome of interest for an individual respondent *i* in year t (e.g., annual dental visit, avoidable hospitalizations, etc., as described in Table CSSP.3). $Group_{it}$ represents a group attribute (i.e., race/ethnicity, gender, eligibility category, presence of comorbidities, and, for RQ2, HCBS utilization). α represents the corresponding coefficients for the model. X_i represents a set of control variables for individual *i* at time *t* and λ represents the coefficients for each of the corresponding control variables of *X*. ε represents the error term. Models will be estimated using ordinary least squares regression except those measured as a count variable (i.e., Poisson distribution) and for spending, which will be estimated using a generalized linear model as dollars would be the dependent variable (e.g., Gamma distribution with log link function).[23] Marginal analysis will be applied after running each regression to generate adjusted trends over time based on these models (i.e., using predictive margins).[24]

Specifications for the Secondary Models will be identical to the Main Models, except that we will introduce an interaction term of $Time_Indicator * Group$, used to capture time-varying differences by group (i.e., race/ethnicity, gender, and presence of comorbidities) with the α_3 coefficient. This would allow us to plot the adjusted trends by group of interest through the post hoc marginal analysis.

The cohorts approach compares trends for a fixed group of individuals over time to ensure that observed changes in utilization are not due to changes in population composition resulting from beneficiaries newly enrolling or disenrolling from the program. Change in beneficiary characteristics, such as age, disease diagnoses and burden of illness over time, will be accounted for in these models (e.g., with CDPS scores, beneficiary age, and morbid conditions). While the cohort analysis mitigates the likelihood for differences in the composition of the sample over time, the cross-sectional analyses will offer larger sample sizes and, as a result, more statistical power to detect differences. The study team will also conduct sensitivity analyses regarding the effect of comorbid conditions and CDPS score on study outcomes. This would include running the main and secondary models with and without the comorbidity and CDPS independent variables and monitoring changes in these measures over time.

For research question 1e

Study population for research question 1e:

We will also conduct a qualitative study of beneficiary and caregiver experience. The study populations will include (1) parents, guardians, and other primary caregivers of children, youths, and young adults with SED and (2) parents, guardians, and other primary caregivers of children, youths, and young adults with I/DD enrolled in CSSP with experience with CSSP components, who

[23] Deb P, Manning W, Norton E. Modeling health care costs and counts. IniHEA World Congress in Sydney, Australia 2013.

[24] Williams R. Using the margins command to estimate and interpret adjusted predictions and marginal effects. The Stata Journal. 2012 Jun;12(2):308-31.

have knowledge of the beneficiaries' experiences with services and supports and overall satisfaction as the health care consumer.

Data collection for research question 1e:

The study team will utilize focus groups to elicit family and caregiver experience, from the groups described above, to gather reflections on family and caregiver experience and recommendations, and to inform study findings.[25] Participants will be recruited to participate in the focus group session most relevant to their experience (i.e., related to youth in CSSP SED or CSSP I/DD). DMAHS will provide eligible households (i.e., those with a child/youth who participate in the CSSP SED or CSSP I/DD) with an access pin to complete a brief online survey to collect basic information on demographics and beneficiary characteristics (limited to one per family). Focus groups will be constructed from a random sample of those who complete the screening survey. The focus groups will have two strata based on CSSP participation of the child in either CSSP SED or CSSP I/DD (approximately 50 people total, 2-3 focus groups per strata).[26] The focus groups will be held virtually and recorded via video conferencing software in compliance with the evaluator's Institutional Review Board. We propose a study incentive of up to $125 per participant ($25 for completing the initial survey and an additional $100 for participating in the focus group).

We will begin the focus groups with a brief introduction followed by a set of open-ended interview questions to elicit participants' views on experiences of beneficiaries and families regarding program components in either the CSSP SED or CSSP I/DD, and satisfaction and recommendations. Sessions will be approximately 60 to 90 minutes in length.

Analytic strategy for research question 1e:

Focus group recordings will be transcribed and then de-identified, then independently coded by two researchers. In addition to predetermined thematic areas aligned with CSSP aims, the research team will identify emergent themes and patterns in the data after conducting a coding consensus process.

Table 2.5: Research Questions and Interview Strategies for RQ1e

Research Question	Number	Interview Strategy
RQ2e: How has CSSP participation affected the experience of services and supports and overall satisfaction of beneficiaries as the health care consumer, as evidenced by the child/youths' parents, guardians, or other primary caregivers?	Up to 10 participants per focus group, 4-6 groups following the interim evaluation (n=~50)	In consultation with DMAHS and CSOC, CSHP will identify individuals for recruitment through a brief online screening survey to inquire about CSSP participation, including HCBS utilization. Interviews will be conducted with purposively sampled CSSP parents, guardians, and other primary caregivers, to obtain viewpoints about benefits and program success. Interviews will be approximately 60-90 minutes.

[25] Crabtree, BF and Miller, WL. 2022. *Doing qualitative research*. Sage publications.

[26] Hennink MM, Kaiser BN, Weber MB. What influences saturation? Estimating sample sizes in focus group research. Qualitative health research. 2019 Aug;29(10):1483-96.

Table 2.6: Summary of Questions, Hypotheses and Methodology for Evaluation of the CSSP SED and CSSP I/DD Programs

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
Hypothesis 1: Providing full State Plan services and HCBS to children, youths, and young adults within (1) CSSP SED and (2) CSSP I/DD who are at-risk for institutionalization, out-of-home care, and hospitalization and who would otherwise have not been eligible for Medicaid or CHIP due to parental income (i.e., "CSSP eligibility expansion"), will increase access to preventive services, reduce reliance on out of home treatment, reduce avoidable hospitalization and emergency services, and improve beneficiary experience.				
RQ1a. What are the trends in preventative services (i.e., child and adolescent well-care visits and follow-up after hospitalization for mental illness) among the CSSP expanded eligibility groups over the course of the current demonstration (2023-2028)? How do these trends vary across different subgroups (e.g., race/ethnicity, gender, presence of comorbidities, and eligibility category)?	• child and adolescent well-care visits • follow-up after hospitalization for mental illness	Children and youth up to age 21 who were eligible for CSSP during the demonstration period.	Medicaid Fee-for-Service and Encounter Claims Records	Examine adjusted trends in study outcomes through analytic summaries and regression analysis and stratification of models by race/ethnicity, gender, and presence of comorbidities.
RQ 1b. What are the trends in overall utilization of care (i.e. inpatient hospitalizations, emergency department (ed) treat-and-release visits, and primary care utilization) among the CSSP expanded eligibility groups over the course of the current demonstration (2023-2028)? How do these trends vary across different subgroups (e.g., race/ethnicity, gender, presence of comorbidities, and eligibility category)?	• inpatient hospitalizations (all-cause) • emergency department (ED) treat-and-release visits • primary care utilization	As above	As above	As above
RQ1c. What are the trends in out of home treatment (i.e., out-of-home stays in	• stays in out of home treatment such as	As above	As above	As above

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
residential treatment, total number of days in residential treatment) among the CSSP expanded eligibility groups over the course of the current demonstration (2023-2028)? How do these trends vary across different subgroups (e.g., race/ethnicity, gender, presence of comorbidities, and eligibility category)?	behavioral health homes and residential treatment centers • total number of days in residential treatment			
RQ1d. What are the trends in avoidable utilization and spending (i.e., avoidable hospitalizations, hospitalization for mental illness, 30-day hospital readmissions, inpatient days, and spending related to all inpatient hospitalizations and ed visits) among the CSSP expanded eligibility groups over the course of the current demonstration (2023-2028)? How do these trends vary across different subgroups (e.g., race/ethnicity, gender, presence of comorbidities, and eligibility category)?	• avoidable hospitalizations • spending related to all inpatient hospitalizations and ED visits	As above	As above	As above
RQ1e. How has CSSP participation affected the experience of services and supports and overall satisfaction of beneficiaries as the health care consumer, as evidenced by the child/youths' parents, guardians, or other primary caregivers?	• reported experiences of beneficiaries and caregivers relating to services and supports, • community engagement, and • consumer satisfaction.	Purposively sampled parents, guardians, and primary caregivers, to obtain viewpoints about benefits and program success, no comparison group (n=~50). There will be two strata, parents, guardians, and other primary caregivers	Remote (via video conference) focus groups to be conducted after the interim evaluation.	Qualitative thematic analysis

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
		of children/youth/young adults within the SED program and those within the I/DD program.		
Hypothesis 2: Providing home and community-based services (HCBS) to child/youth Medicaid beneficiaries with intellectual disabilities/developmental disabilities (I/DD) through operationalizing the Children's Support Services Program for I/DD (i.e., newly operationalized 217-like and 1915-like eligibility groups) will increase access to preventive services, reduce reliance on out of home treatment, reduce avoidable hospitalization and emergency services, and improve beneficiary experience.				
RQ2a. What are the trends in preventative services (i.e., child and adolescent well-care visits and follow-up after hospitalization for mental illness) among the CSSP I/DD beneficiaries, who utilize HCBS, in the newly operationalized eligibility categories over the course of the current demonstration (2023-2028)? How do these trends vary across different subgroups (e.g., race/ethnicity, gender, presence of comorbidities, and eligibility category)?	• child and adolescent well-care visits • follow-up after hospitalization for mental illness	Children, youth, and young adults enrolled in the newly operationalized 217-like and 1915-like CSSP I/DD HCBS, compared to children, youth, and young adults up to age 21 who were eligible for CSSP I/DD during the demonstration period.	Medicaid Fee-for-Service and Encounter Claims Records	Examine adjusted trends in study outcomes through analytic summaries and regression analysis and stratification of models by race/ethnicity, gender, and presence of comorbidities.
RQ2b., What are the trends in utilization of care (i.e., inpatient hospitalizations, emergency department (ed) treat-and-release visits, and primary care utilization) among the CSSP I/DD beneficiaries, who utilize HCBS, in the newly operationalized eligibility categories over the course of the current demonstration (2023-2028)? How do these trends vary across different subgroups	• inpatient hospitalizations (all-cause) • emergency department (ED) treat-and-release visits • primary care utilization	As above	As above	As above

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
(e.g., race/ethnicity, gender, presence of comorbidities, and eligibility category)?				
RQ2c. What are the trends in out of home treatment (i.e., out-of-home stays in residential treatment, total number of days in residential treatment) among the CSSP I/DD beneficiaries, who utilize HCBS, in the newly operationalized eligibility categories over the course of the current demonstration (2023-2028)? How do these trends vary across different subgroups (e.g., race/ethnicity, gender, presence of comorbidities, and eligibility category)?	• stays in out of home treatment such as behavioral health homes and residential treatment centers • total number of days in residential treatment	As above	As above	As above
RQ2d. What are the trends in avoidable utilization and spending (i.e., avoidable hospitalizations, hospitalization for mental illness, 30-day hospital readmissions, inpatient days, and spending related to all inpatient hospitalizations and ed visits) among the CSSP I/DD beneficiaries, who utilize HCBS, in the newly operationalized eligibility categories over the course of the current demonstration (2023-2028)? How do these trends vary across different subgroups (e.g., race/ethnicity, gender, presence of comorbidities, and eligibility category)?	• avoidable hospitalizations • spending related to all inpatient hospitalizations and ED visits	As above	As above	As above

Table 2.7 shows an activity timeline for the research activities.

Table 2.7 Key Milestones, Children's Support Services Programs (SED, I/DD)

Analytic Activity	Year 1 2025	Year 2 2026	Year 3 2027	Year 4 2028	Year 5 2029	Year 6 2030
1. Quality of care, health service utilization, and spending assessment: Analyze MMIS data (RQ1a-1d;RQ2a-2d)	Define appropriate population and customized metrics for MMIS analysis	Begin analysis of MMIS-based utilization and quality metrics	Complete interim analysis		Conduct analysis	Complete analysis
2. Qualitative beneficiary experience assessment (RQ1e)		Review documents, observe meetings	Conduct CSSP focus groups screening survey	Conduct CSSP 4-6 focus groups (N=~50) Conduct analysis	Complete analysis	
3. Submit reports to CMS			Interim report			Final report

RQ=Research Question.

NOTE: Evaluation project years are March-Feb. (subject to change depending on date of authorization to begin).

D. Methodological Limitations

The evaluation methods describe above have several limitations. The two major revisions to the CSSP include populations that were previously ineligible for state plan medical services, which precludes the possibility of observing them in the Medicaid claims prior to the policy change. Additionally, our claims-based metrics may not account for clinical factors such as severity that may also impact the likelihood of outcomes over time. To address this limitation, we will adjust trends by beneficiary characteristics, including CDPS risk score to adjust for the effect of differences in beneficiary characteristics on trends.

Our cohort analysis will also mitigate the possibility that changes in the composition of beneficiaries could drive differences in study outcomes. However, the cohort analysis may be subject to small sample size which could limit the ability to detect meaningful differences (i.e., insufficient statistical power). The sample sizes will be larger in the repeated cross-sectional analysis, but characteristics of individuals determining service utilization may change over time. By engaging in both approaches, we will be able to compare results for consistency, and we will compare observed peaks and troughs in adjusted outcome trends to align with exogenous shocks (such as those observed during the COVID-19 pandemic in the previous demonstration period).

Give the absence of a pre-period observation, our alternative strategies to examine the newly operationalized CSSP I/DD initiatives have their own limitations, like those mentioned above in monitoring the CSSP eligibility expansion. Our cohort analysis may be subject to small sample size due to disenrollment or other losses to follow-up. As mentioned above, the sample size will be larger in repeated cross-sectional analysis but characteristics of individuals determining outcomes may change over time.

Regarding the qualitative component, focus groups offer the opportunity for in-depth, experience-based interpretation of quantitative findings. However, findings from the focus groups may not necessarily be generalizable to the experiences of all parents, guardians, and other primary caregivers. Participation will depend first on program take-up and then on caregiver availability, interest, and willingness to participate. Differences between participants and other CSSP participants may be driven, in part, by willingness to participate in the research activity. We will aim to mitigate this issue by recruiting study participants that reflect the demographic characteristics of the study population but acknowledge that participants may differ from the other participants in the CSSP in ways that are not observable.

E. Attachments

Appendix 2.1: CSSP, SED & IDD Parent & Guardian Questionnaire

Version 2024.2.23

Would you prefer to complete this survey in English or Spanish?

c. English
d. Spanish -> GO TO SPANISH TRANSLATED SURVEY

Source: New question

Introduction

On behalf of Rutgers University and the New Jersey Division of Medical Assistance and Health Services, thank you for your interest in the evaluation of the ***Children's Support Services Program***. We have asked you to participate because you are the parent, guardian, or other primary caregiver of a child, youth, or young adults who is enrolled in services within the Children's Support Services Program. You are likely familiar with some of the services available through the Children's Support Services Program**:**

- Extension of eligibility for full State Plan medical benefits (NJFamilyCare) to children/youths who currently have access only to waiver and behavioral health services (disregarding parental income)
- Social and emotional learning services
- Interpreter services
- Non-medical transportation
- Individual support services (**I**/DD Only)
- Intensive in-community/in-home services (I/DD Only)
- Agency respite services (I/DD Only)

The following brief survey is part of our recruitment for focus groups on the Children's Support Services Program. We will ask about your child, you, and your household.

Screener [To proceed, must answer "A" to I, II, III, IV, and a number for V.]

[Consent form scroll box; language to be approved by DMAHS, CMS, CSOC, Rutgers **I**RB]

4. **Do you consent to participate in the survey?**
   f. Yes
   g. No, exit the survey

   Source: New question

5. **Are you at least 18 years of age?**
   a. Yes
   b. No, exit the survey

   Source: New question

6. **Are you the parent, guardian, or other primary caregiver of at least one child, youth, or young adult who participates in New Jersey's Children's Support Services Program through Medicaid (i.e., NJFamilyCare)?**
    a. Yes
    b. No, exit the survey

7. **The following survey is part of our recruitment for an online meeting (Zoom) to discuss New Jersey's Children's Support Services Program. The online meeting will be 60-90 minutes. The following survey will take about 20 minutes.**

    -Participation is limited to one participant per family.
    -Every participant who completes the survey will receive $25.
    -Each online meeting (Zoom) participant will receive an additional $100 ($125 total).
    -There are a limited number of spots for the online meeting (Zoom). If you are not chosen for the online meeting but complete the survey, you will still be given $25.
    -If you would like to only participate in the survey, you will still be given $25.

    Are you interested in participating in the online meeting?

    a. Yes
    b. No

    Source: New question

8. **[If IV. is "Yes"] When would you most likely be able to meet for the online meeting? This will be used to schedule the focus group activity (via Zoom or similar video conferencing tool).**
    Indicate what time you are typically able to meet online (Zoom) for 60-90 minutes.

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Morning (After 9a-12p)							
Afternoon (After 12p-4p)							
Evening (After 4p-9p)							
Night (After 9p-12a)							

    - Other or special circumstances (Please specify)

    Source: New question

9. **[If IV. is "Yes"] Please provide your contact details so that we may schedule the interview.**
    - First name:___ [text response]
    - Last name: ___[text response]

- email address: __ [text response]
- phone number: __ [text response]
- Other or special circumstances (Please specify) __ [text response]

Child/Youth/Young Adult Characteristics – These questions ask about the experiences of the child, youth, or young adult covered by the Children's Support Services Program.

46. **Starting with your youngest child, youth, or young adult that participated in the Children's Support Services Program, how old are they (in years, at their last birthday)?**

    __ years old [Number]

    Source: Adapted from CSHP/Eagleton/Department of Children and Families - IDD Caregiver Survey

47. **Does this child [youth| young adult] identify as male, female, or in some other way?**
    f. Male
    g. Female
    h. Non-binary
    i. Some other way (please specify)
    j. Prefer not to answer

    Source: Adapted from CSHP/Eagleton/Department of Children and Families - IDD Caregiver Survey

48. **In general, how would you describe this child[youth| young adult]'s health?**
    f. Excellent
    g. Very Good
    h. Good
    i. Fair
    j. Poor

    Source: National Survey on Child's Health, https://www.childhealthdata.org/learn-about-the-nsch/NSCH

49. **What is this child[youth| young adult]'s preferred means of communication? (choose one)**
    f. Spoken Language
    g. Gestures or Body language
    h. Sign language or finger spelling
    i. Communication aid or device
    j. Other (please specify) [Open-ended free text]

    Source: National Core Indicators - Child Family Survey, https://idd.nationalcoreindicators.org/

50. **How much support does this child[youth| young adult] need to prevent or manage self-injurious, disruptive, and/or destructive behaviors? (choose one)**
    d. None
    e. Some
    f. Extensive

    Source: National Core Indicators- Child Family Survey, https://idd.nationalcoreindicators.org/

51. **Do you have any other children with Serious Emotional Disturbance or Intellectual and Developmental Disability who participate in New Jersey's Children's Support Services Program as part of Medicaid?**

    [List ages of children reported to this point]

    a. Yes (Repeat 1-6)
    b. No

    Source: New Question

<u>Parent/Guardian/Primary Caregiver Characteristics –</u> These questions ask about you as the parent, guardian, or other primary caregiver of the child/youth/young adult with SED or I/DD.

52. **What is your relationship to the child/youth/young adult?**
    - Mother
    - Father
    - Legal guardian
    - Other primary caregiver (Please specify)
    - Don't know/Not sure
    - Refused

    Source: CSHP/Eagleton/Department of Children and Families, IDD Caregiver Survey

53. **To ensure we are reaching people of all ages, would you please tell me your age?**
    __[Number]
    Prefer not to answer/unsure

    Source: CSHP/Eagleton/Department of Children and Families, IDD Caregiver Survey

54. **[For prefer not to answer/unsure above, ask] Would you be willing to tell us whether it's between…**
    k. 18 - 20
    l. 21 - 24
    m. 25 - 29
    n. 30 - 34
    o. 35 – 44
    p. 45 – 49
    q. 50 - 54

r. 55 - 64
s. 65 OR OVER
t. Prefer not to answer

Source: CSHP/Eagleton/Department of Children and Families - IDD Caregiver Survey

55. **What is the highest degree or level of school you have completed?**
    a. no schooling completed
    b. nursery school to 8th grade
    c. 9th-12th grade, no diploma
    d. high school graduate (high school diploma or the equivalent)
    e. vocational/technical/business/trade school certificate or diploma (beyond the high school level)
    f. some college, but no degree
    g. associate degree
    h. bachelor's degree
    i. master's, professional or doctorate degree
    j. don't know
    k. prefer not to answer

    Source: CMS, https://www.cms.gov/data-research/research/medicare-current-beneficiary-survey/questionnaires/2023-questionnaires

56. **Are you of Latino or Hispanic origin, such as Mexican, Puerto Rican, Cuban or some other Spanish background?**
    c. Yes
    d. No

    Source: Adapted from US Department of Health and Human Services, Office of Minority Health, https://minorityhealth.hhs.gov/explanation-data-standards-race-ethnicity-sex-primary-language-and-disability

57. **Are you White, Black or of Asian origin, or are you some other race, or multi-racial?**
    g. White (includes Caucasian, European, Middle Eastern)
    h. Black (includes African American)
    i. Asian (includes Asian-Indian, South Asian, East Asian, Chinese, Japanese)
    j. Hispanic / Latino / Spanish
    k. Other (please specify) [Open-ended free text]
    l. Multi-racial (please specify) [Open-ended free text]

    Source: Adapted from US Department of Health and Human Services, Office of Minority Health, https://minorityhealth.hhs.gov/explanation-data-standards-race-ethnicity-sex-primary-language-and-disability

58. **How do you describe your gender? [Select ONE]**
    h. Female
    i. Male
    j. Trans Male/Trans Man

k. Trans Female/Trans Woman
l. Genderqueer/Gender Nonconforming
m. Prefer to self-describe, please specify: [open field]
n. Prefer not to answer

Source: Q7-8 Two Step Gender Identity, https://registrar.ucsc.edu/gender-identity/index.html

59. **What is the primary language spoken in your home?**
    d. English
    e. Spanish
    f. Other (please specify) [Open-ended free text]

    Source: Adapted from US Department of Health and Human Services, Office of Minority Health, https://minorityhealth.hhs.gov/explanation-data-standards-race-ethnicity-sex-primary-language-and-disability

60. **Last year, that is in 2022, what was your total household income from all sources, before taxes?**

    a. Less than $25,000
    b. 25 to under $50,000
    c. 50 to under $75,000
    d. 75 to under $100,000
    e. 100 to under $150,000
    f. $150,000 or more
    g. Prefer not to answer

    Source: CSHP/Eagleton/Department of Children and Families - IDD Caregiver Survey

61. **In the past 12 months, did you or any member of this household receive benefits from the Food Stamp Program or SNAP (the Supplemental Nutrition Assistance Program)?**

    a. Yes
    b. No
    c. Not sure/prefer not to answer

    Source: Census, https://www.census.gov/programs-surveys/acs/about/forms-and-instructions.html

Appendix 2.2: CSSP, SED & I/DD Parent/Caregiver Focus Group Guide

(Version 2024.2.23)

Thank you for meeting with us. Today, we will be discussing healthcare and support programs in New Jersey. Over the next 60-90 minutes, we will focus on ways to improve services for children and youth with **[depending on focus group strata; "Serious Emotional Disturbance" | "Intellectual and Developmental Disabilities"]** in New Jersey. We will ask the group guiding questions. After each question, a prompt will pop-up on your screen with an opportunity write a brief response. We will then share the responses and each member will have the opportunity to explain their answers to the group.

We are aiming to get as many different opinions as possible. We will not be using job titles, degrees, or affiliations. Instead, we will be using first names. For this focus group to be successful, please remember that your perspective cannot be wrong, and your opinion is incredibly valuable to this work. It may be that someone will say something that you disagree with. To encourage everyone to feel free to take part, we will not have a debate or argument over one another's opinions. As mentioned, your perspective cannot be wrong.

[Question appears on screen with a free text box below it]

[INSTRUCTIONS: Type your first name and then a brief response. Example, "John: There are too many appointments to keep track of." We will then have a discussion where each person will have the opportunity to discuss what they wrote and provide additional details.]

Services and Supports Access

1.a. Parents, guardians, and other primary caregivers often explain that there can be so much to learn and navigate when considering decisions that affect the health and wellbeing of their child with complex needs. **What three words describe your experience in navigating decision-making opportunities (also known as health literacy) related to your child's health and wellbeing, emotional stability, behavioral regulation?** These can be positive/negative/or neutral.

1.b. **What three words come to mind when you think about helping your child with ["Serious Emotional Disturbance" | "Intellectual and Developmental Disabilities"] get basic medical care (think of your pediatrician or regular doctor)?** These can be positive/negative/or neutral. *(Probe) What would make appointments easier to schedule or attend?*

1.c. Specialists are important for children with ["Serious Emotional Disturbance" | "Intellectual and Developmental Disabilities"]. Think of your child's therapists, such as allied health professionals like speech therapists and physical therapists, or mental health providers. **What three words come to mind when you think about helping your child with ["Serious Emotional Disturbance" | "Intellectual and Developmental Disabilities"] to see specialists?** These can be

positive/negative/or neutral. *(Probe) Are some of these services easier or more difficult to find or use than others? (Probe) What would make these easier to schedule or attend?*

Community Engagement

2.a. Community can be good for sharing in life experiences and can be a way to access emotional or financial support. We'd like you to think of the people outside your home that you have formed relationships with. **What three words describe your experience forming relationships with other people outside of your home, including families with children?** These can be positive/negative/or neutral. *(Probe) What might make it easier to find a community?*

Satisfaction and Recommendations [No pop-up box to write comments, open discussion]

1.a. New Jersey has been offering special services for children with ["Serious Emotional Disturbance" | "Intellectual and Developmental Disabilities"]. These include social and emotional learning therapies to learn about empathy for others, keeping friendships, and making good decisions.[27] There are also transportation services and interpreter services to make health care and other services more accessible. If your child has I/DD, you may have also used other supports, including intensive in-home services and respite services. ***If you have used these services, how would you describe your experience? If you haven't, why have you not been able to or chosen not to use these services?***

2.b. Parents, guardians, and other primary caregivers sometimes pay for things to support the health and wellbeing of their child with complex needs, sometimes referred to as "out of pocket" costs. **How has participation in the Children's Support Services Program affected what you need to pay for yourself?**

2.c. **What would you like New Jersey systems leaders (like the directors at Medicaid, the governor's office, and state agencies) to know about what it is like to be a family member of a child with ["Serious Emotional Disturbance" | "Intellectual and Developmental Disabilities"]?** *(Probe) What improvements should be made (this includes policies, services, and systems)?*

Thank you again for helping us know more about your experience in New Jersey in accessing the Children's Support Services Program. This will help find ways to better support children and youth with **["Serious Emotional Disturbance" | "Intellectual and Developmental Disabilities"]** and their families.

[27] Collaborative for Academic, Social, and Emotional Learning (CASEL). Fundamentals of SEL; nd. https://casel.org/fundamentals-of-sel/

3. Postpartum Eligibility Extension

A. General Background Information

In this section, we describe the plan to evaluate the impact of CMS approval of a policy change to extend postpartum coverage to 12 months after the end of pregnancy under the 1115 Demonstration (i.e., from April 1, 2023 through June 30, 2028). Prior coverage was 60 days after the end of pregnancy.

Under this initiative, this extended coverage will apply only to pregnant people who meet all other requirements for NJ FamilyCare eligibility, and do not otherwise qualify for continued coverage (after 60 days) through another eligibility category. New Jersey projected that approximately 8,700 people will be affected by this change annually, representing about 23% of all Medicaid births in New Jersey.[28]

Prior to this initiative, some post-pregnancy and postpartum people may have struggled to find alternative sources of coverage after exhausting their Medicaid eligibility, and as a result, they fail to receive essential care.[29] Others may successfully find alternative coverage, including through GetCoveredNJ, the state's health insurance marketplace, but nonetheless need to switch providers and have their continuity of care disrupted as a result. Some clinicians may choose to participate in Medicaid or private coverage, but not both, making sustaining a care relationship challenging. Depending on how comprehensive a postpartum person's new source of coverage is, they may also lose access to critical services such as dental care or certain behavioral health benefits. Postpartum care is especially important considering that approximately 12% of postpartum deaths occur between 43-365 days after the end of a pregnancy.[30] Importantly, preliminary analysis shows that 53% of pregnant people who lost Medicaid coverage postpartum re-enrolled at some point over the two years after their coverage initially terminated.[31] When this re-enrollment occurs with such frequency, the health care issues associated with lack of coverage in the interim, and the disruption of coverage become an issue for the Medicaid program to address both clinically and financially.

New Jersey is seeking to test the impact of extending coverage to eligible pregnant people for 12 months after the end of pregnancy on postpartum outcomes and expenditures, paying particular attention to health disparities in access and outcomes.

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[28] "NJ 1115 Comprehensive Demonstration Amendment" (Center for Medicare & Medicaid Services, February 27, 2020), https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nj-1115-request-pa.pdf.
[29] Sarah Gordon et al., "Medicaid After Pregnancy: State-Level Implications of Extending Postpartum Coverage," 2021.
[30] Roosa Tikkanen et al., "Maternal Mortality and Maternity Care in the United States Compared to 10 Other Developed Countries" (Commonwealth Fund, November 18, 2020), https://doi.org/10.26099/411v-9255; Building U.S. capacity to review and prevent maternal deaths, et al., "Report from Nine Maternal Mortality Review Committees.," Center for Disease Control and Prevention, 2018, https://stacks.cdc.gov/view/cdc/51660.
[31] "NJ 1115 Comprehensive Demonstration Amendment."

B. Evaluation Questions and Hypotheses

We posit that allowing individuals to maintain their Medicaid coverage for a longer period after the end of pregnancy is likely to improve their access to and continuity of care and ultimately lead to improvements in their experience of care and health and mental health outcomes. For pregnancies that end in live births, childbirth and the postpartum period are exciting life experiences for many people, but this is also a period of physical, mental, and social change. Given these challenges, requiring birthing people to switch their source of coverage only two months after birth may lead to worse outcomes and quality of care.

Below we present the *driver diagram* (Figure 3.1: Postpartum Extension Driver Diagram) that delineates the pathway from the policy change to improved outcomes. Here the secondary drivers represent the various services available to birthing people.

Figure 3.1: Postpartum Extension Driver Diagram

Aim	Primary Drivers	Secondary Drivers
1.A. Ensure that eligible people have access to all necessary services (both physical and behavioral) to improve health and well-being after the end of pregnancy 1.B. Improve access, utilization, and quality of physical and behavioral health care -Reduce preventable hospitalizations -Improve postpartum and well-child follow-up care 1.C. Reduce disparities among individuals after the end of pregnancy	Address the need for comprehensive, consistent health care coverage for individuals after the end of pregnancy	Extension of eligibility for Medicaid benefits from 60 days to 12 months after the end of pregnancy for people with incomes above 138% FPL and below 205% FPL
⟸	Causality	⟸

We next detail the hypotheses and corresponding research questions that help assess the impact of extending postpartum coverage to eligible pregnant people to 12 months after the end of pregnancy. For all measures that have sufficient sample size, we will investigate differences by demographic and geographic characteristics (e.g., race/ethnicity and county). These are also summarized in Table 3.2.

Hypothesis 1: Extending coverage to 12 months after the end of pregnancy will result in greater continuity of coverage, improved utilization of recommended services, improved quality of care, and altered Medicaid spending in the period after pregnancy—for pregnant beneficiaries and, where relevant, their infants.

Research Question 1a: Does extending Medicaid eligibility to those with 12 months after the end of pregnancy improve trends in **continuity of Medicaid coverage**?

Research Question 1b: What are the trends in utilization of **maternal and newborn preventative services** (e.g., depression and anxiety screening, well-child visits, postpartum and well-woman visits, dental visits, contraceptive counseling, mental health visits) among those with 12 months of coverage after the end of pregnancy?

Research Question 1c: What are the trends in **overall and postpartum-related emergency department (ED) use** among those with 12 months of coverage after the end of pregnancy?

Research Question 1d: Does providing 12 months of coverage after the end of pregnancy change the **composition of spending on outpatient services, emergency department, and hospital admissions**?

Hypothesis 2: Extending postpartum coverage to 12 months after the end of pregnancy will reduce hospitalization admissions, ED utilization, and the number of uninsured ED visits and hospitalizations after delivery.

Research Question 2a: Does providing 12 months of coverage after the end of pregnancy reduce **overall and postpartum-related ED use, ambulatory care sensitive hospital admissions, inpatient hospital stays for postpartum-related causes**?

Research Question 2b: Does providing 12 months of coverage after the end of pregnancy decrease the **uninsured ED visits and hospitalizations** after delivery?

C. Methodology

Outcomes:

We will assess the outcomes listed in Table 3.1 below using Medicaid fee-for-service and encounter claims records and hospital uniform billing (UB) data.

Table 3.1: Inventory of Measures

Measure		Brief Description
Enrollment		
1.	Medicaid enrollment	Total number of months enrolled during study period. Enrollment gaps: the number of days between enrollment periods for a beneficiary who experiences gaps.
Utilization of Care		
2.	Postpartum and well-woman visits	Receipt of postpartum visit 7-84 days after delivery. (Dichotomous: 0=No; 1=Yes)

		Receipt of well-woman visit in past year.[32] (Dichotomous: 0=No; 1=Yes).
3.	Well-child care	Receipt of 6 visits in 15 months for infants. (Dichotomous: 0=No; 1=Yes) Number of visits in 15 months. (Continuous: 0-6)
4.	Emergency department (ED) visits	Number of ED visits in the 12 months after delivery or end of pregnancy.[33] *Using all-payer hospital uniform billing (UB) data (hypothesis 2):* -Likelihood of any and number of ED visits overall between 61-365 days post-pregnancy/postpartum. -Likelihood of any and number of ED visits between 61-365 days by expected payer.
5.	Inpatient hospitalization	Individuals receive inpatient hospital treatment because of pregnancy and childbirth, for surgery, or for nonsurgical medical treatment. Using ICD-10, primary diagnoses for hospitalization will be placed into two categories: those with a primary diagnosis related to complications of pregnancy, childbirth, and the puerperium, and all other diagnoses.[34] *Using all-payer hospital uniform billing (UB) data (hypothesis 2):* -Likelihood of any and number of inpatient hospitalizations overall between 61-365 days post-pregnancy/postpartum. -Likelihood of any and number of inpatient hospitalizations between 61-365 days by expected payer. Among those with any hospitalizations: -Length of inpatient hospitalizations between 61 and 365 days.

[32] "HEDIS: Prenatal and Postpartum Care (PPC)," *NCQA* (blog), accessed April 3, 2024, https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/; "Optimizing Postpartum Care," Presidential Task Force on Redefining the Postpartum Visit (The American College of Obstetricians and Gynecologists, May 2018), https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care.

[33] Steven L. Clark et al., "Emergency Department Use during the Postpartum Period: Implications for Current Management of the Puerperium," *American Journal of Obstetrics & Gynecology* 203, no. 1 (July 1, 2010): 38.e1-38.e6, https://doi.org/10.1016/j.ajog.2010.02.033.

[34] Maria W. Steenland and Laura R. Wherry, "Medicaid Expansion Led To Reductions In Postpartum Hospitalizations," *Health Affairs* 42, no. 1 (January 2023): 18–25, https://doi.org/10.1377/hlthaff.2022.00819.

Quality		
6.	Avoidable hospitalizations	Rates of Ambulatory Care Sensitive (ACS) inpatient (IP) hospitalizations that may occur due to inadequate ambulatory/primary care within communities, during the 12 months after delivery or end of pregnancy. [35]
7.	Screening and rates of anxiety and depression	Individuals receive postpartum depression screening at either maternal or infant follow-up visit in the 12 months after delivery or end of pregnancy. [36] (Dichotomous: 0=No; 1=Yes) Number of times screened (American Academy of Pediatrics recommends screenings at 1-, 2-, 4-, and 6-month well-infant visits). [37] ICD-10 Mental Health diagnosis codes at different periods (e.g., 1 month postpartum, 2 months, 4 months, and 6 months).
8.	Mental health visit	Receipt of outpatient mental health visit among Medicaid beneficiaries with a diagnosed mental health disorder (NCQA) in the 12 months after delivery or end of pregnancy. (Dichotomous: 0=No; 1=Yes) Number of outpatient mental health visits among those diagnosed with a mental health disorder in the 12 months after delivery or end of pregnancy.
9.	Dental visit	Individuals had one or more dental visit in the 12 months after delivery or end of pregnancy. (Dichotomous: 0=No; 1=Yes)
10.	Contraceptive counseling	Receipt of family planning/contraceptive counseling in the 12 months after delivery or end of pregnancy. (Dichotomous: 0=No; 1=Yes) Percentage of birthing individuals provided with long-acting reversible method of contraception (LARC) within 3 and 90 days of delivery. [38]

[35] Clark et al., "Emergency Department Use during the Postpartum Period"; "HEDIS: Prenatal and Postpartum Care (PPC)"; "Optimizing Postpartum Care."

[36] "HEDIS: Postpartum Depression Screening and Follow-Up," *NCQA* (blog), accessed April 3, 2024, https://www.ncqa.org/hedis/measures/postpartum-depression-screening-and-follow-up/.

[37] Steenland and Wherry, "Medicaid Expansion Led To Reductions In Postpartum Hospitalizations."

[38] "Measure CCP: Contraceptive Care - Postpartum Women Ages 15 to 44" (HHS Office of Population Affairs, 2022), https://opa.hhs.gov/sites/default/files/2023-04/2022-CCP-Measure-Specs.pdf.

Spending, Claims/Encounter data		
11.	Spending related to outpatient care	Payments on claims for outpatient care (e.g., postpartum and well-woman visits, mental health visits, dental visits, etc.), inflation adjusted, in the 12 months after delivery or end of pregnancy.
12.	Spending related to inpatient hospitalizations and ED visits	Payments on facility claims for inpatient and ED visits, inflation adjusted, in the 12 months after delivery or end of pregnancy.

For hypotheses 1 and research questions 1a-1d

Study population: This hypothesis and research questions relate to trends in utilization, spending, and quality health care available to postpartum and post-pregnancy beneficiaries eligible for 12-months of continued coverage after the end of pregnancy. Using Medicaid Claims & Encounter Data, we will only be able to observe those individuals who maintain Medicaid coverage in the postpartum period, thus there is no available comparison group.

Analytic strategy: We will calculate adjusted trends, estimating levels of outcome measures on a quarterly or annual basis (as appropriate) to examine utilization and quality of care (e.g., depression/anxiety, well-child visits, postpartum and well-woman visits, dental visits, contraceptive counseling, mental health visits, ED utilization), composition of spending, and continuity of Medicaid enrollment over the demonstration period. We will implement a repeated cross-sectional approach for all eligible beneficiaries impacted by the 12-month coverage extension.

Spending analyses will differentiate between spending over time comparing potentially avoidable spending (e.g., ED and hospital use) to preventative care spending (e.g., postpartum and well-woman visits, dental care, contraceptive counseling, etc.). We will produce line diagrams to examine trends. We will rely on trend analyses to differentiate between spending that positively increases because of higher utilization of preventative care vs spending on preventable hospital use as a result of inadequate ambulatory/primary care use within communities.

We will explore demographic and geographic differences across outcomes. As such, models may be stratified by race/ethnicity, county, and other demographic or geographic characteristics as appropriate to estimate results separately where sample size is sufficient. This analytic strategy will be applied to all research questions and hypotheses to understand disparities in outcomes related to the 12-month coverage extension.

For hypothesis 2 and research question 2a-2b

Study population: Using Hospital all-payer uniform billing (UB) data, accessed through the New Jersey Integrated Population Health Data (iPHD) project, we will identify two cohorts of birthing people who had a Medicaid-covered delivery at baseline. The first cohort will be drawn from 2017-2022 data, the second will be drawn from 2023-2025 data. The two cohorts will allow a comparison before and after the policy implementation. Procedures similar to those used in prior studies to enable UB-MMIS linkage while using only de-identified data will be used for the planned analyses.

Analytic strategy: We will first conduct descriptive analyses to understand trends and distribution of expected payer (e.g., Medicaid, other public, private insurance, self-pay/uninsured) for ED utilization and hospitalizations over time before and after the policy implementation. We will produce line diagrams to examine trends and bar charts to understand the distribution of payers.

We will then conduct a difference-in-differences (DID) analysis, with ED utilization and hospitalizations as the outcomes. Initial models will predict the likelihood and frequency of ED or hospital utilization before/after policy implementation. Subsequent models will be run conditional on having an ED or hospital visit to determine the likelihood of having an *uninsured* visit before/after policy implementation.

Our study period includes the current demonstration period (2023-2028) as well as 3 full calendar years prior to the public health emergency (PHE) as baseline (2017-2019). We may use longer or shorter baseline period if required by our model specifications. Additionally, dependent on the parallel pre-trends analysis (explained in more detail below) and comparison cohort, the PHE years may be excluded from the analysis. For these models, an interaction variable between exposure group (individuals with incomes between 138% and 205% FPL) versus control group (individuals with incomes below 138% FPL) and an indicator variable for pre-policy (2017-2019), the PHE (2020-2023), and the post-policy implementation (2024-2028) will be constructed. Given the PHE went into effect prior to the policy implementation and this demonstration period, ensuring continuous coverage for 2 additional years, the models for outcomes will be run using three time periods. We will estimate a count model regressions (e.g., Poisson or negative binomial) for hospital and emergency department utilization. If sample sizes are sufficient, regressions will control for maternal and child demographic characteristics (e.g., maternal age, marital status, race/ethnicity, type of delivery, parity, dual eligible status, presence of comorbidities, CDPS risk score) with specifications including geographic and year fixed effects to control for any time- and geography-invariant effects. To account for non-independence of error terms by geography and time, standard errors will be calculated to allow for clustering at the zip code and year levels. Standard errors may be adjusted in the event of repeated observations in the data.

The overall modeling strategy is illustrated by the linear specification below:

$$Outcome_{it} = \alpha_0 + \alpha_1(time)_i + \alpha_2(TreatmentGroup)_i + \alpha_3(policyPHEpost)_{it} + \alpha_4(policypost)_{it} + \alpha_5(TreatmentGroup * Post)_{it} + \alpha_6(TreatmentGroup * PHEpost)_{it} + \lambda X_{it} + \varepsilon_{it}$$

$Outcome_{it}$ represents the annualized outcome of interest for an individual member *i* in year t. α represents the coefficients that correspond to each model component. The $time$ variable is a continuous variable indicating time in months or calendar years from the start of the study period and subsequent policy changes (PHE and postpartum coverage extension). The variable $policyPHEpost$ is a binary (0/1) variable for the period during the public health emergency, which initiated a postpartum extension. The variable $policypost$ is a binary (0/1) variable for the period subsequent to the policy changes under the postpartum extension. The interaction term of $TreatmentGroup * Post$ yields the difference-in-differences estimator (the α_5 coefficient), which estimates how much utilization changed among individuals above 138% FPL after policy implementation relative to the utilization among individuals below 138% FPL whose eligibility is unchanged. The interaction term of $TreatmentGroup * PHEpost$ yields the difference-in-

differences estimator (the α_6 coefficient), which estimates how much utilization changed among individuals above 138% FPL after the public health emergency when the policy was initially implemented, relative to the utilization among individuals below 138% FPL whose eligibility remained unchanged. X_{it} represents a set of control variables for individual *i* at time *t*. ε represents the stochastic error term.

A primary assumption for a valid DID inference is parallel pre-treatment trends.[39] This assumption is necessary to indicate whether, in the absence of the policy change, the trends in outcomes would have been similar between treatment and comparison groups. Event studies will be conducted to establish the parallel trends hold for all groups. If the parallel trends assumption is violated, we will explore alternative strategies such a lagged dependent variable regression approach and matching on pre-intervention outcome trends.[40]

[39] Andrew M Ryan et al., "Now Trending: Coping with Non-Parallel Trends in Difference-in-Differences Analysis," *Statistical Methods in Medical Research* 28, no. 12 (December 1, 2019): 3697–3711, https://doi.org/10.1177/0962280218814570; Joshua D. Angrist and Jörn-Steffen Pischke, *Mostly Harmless Econometrics: An Empiricist's Companion* (Princeton University Press, 2009), https://press.princeton.edu/books/paperback/9780691120355/mostly-harmless-econometrics.

[40] Stephen O'Neill et al., "Estimating Causal Effects: Considering Three Alternatives to Difference-in-Differences Estimation," *Health Services & Outcomes Research Methodology* 16 (2016): 1–21, https://doi.org/10.1007/s10742-016-0146-8.

Table 3.2: Summary of Questions, Hypotheses and Methodology

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
***Hypothesis 1:** Extending coverage to 12 months after the end of pregnancy will result in greater continuity of coverage, improved utilization of recommended services, improved quality of care, and altered Medicaid spending in the period after pregnancy—for pregnant beneficiaries and, where relevant, their infants.*				
RQ1a: Does extending Medicaid eligibility to those with 12 months after the end of pregnancy improve trends in continuity of Medicaid coverage?	-Medicaid enrollment	No comparison group Subgroup analyses by race/ethnicity and county	Medicaid Fee-for-Service and Encounter Claims Records	Adjusted analysis of trends, descriptive
RQ1b: What are the trends in utilization of maternal and newborn preventative services (e.g., depression and anxiety screening, well-child visits, postpartum and well-woman visits, dental visits, contraceptive counseling, mental health visits) among those with 12 months of coverage after the end of pregnancy?	-Postpartum and well-woman visit and timing of visit -Well-child visit and timing of visit -Annual dental visit -Postpartum depression screening -Rates of anxiety and depression -Contraceptive counseling -Mental health visit	As above	As above	As above
RQ1c: What are the trends in overall and postpartum-related emergency department (ED) use among those with 12 months of coverage after the end of pregnancy?	-ED utilization overall -Postpartum-related ED utilization	As above	As above	As above

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
RQ1d: Does providing 12 months of coverage after the end of pregnancy change the composition of spending on outpatient services, emergency department, and hospital admissions?	-Spending related to outpatient care (e.g., postpartum and well-woman visits, mental health visits, dental visits, etc.) -Spending related to ED utilization -Spending related to avoidable hospitalizations	As above	As above	As above
Hypothesis 2: Extending postpartum coverage to 12 months after the end of pregnancy will reduce hospitalization admissions, ED utilization, and the number of uninsured ED visits and hospitalizations after delivery.				
RQ2a: Does providing 12 months of coverage after the end of pregnancy reduce overall and postpartum-related ED use, ambulatory care sensitive hospital admissions, inpatient hospital stays for postpartum-related causes?	-Preventable hospitalizations -Ambulatory care sensitive hospital admission -Inpatient hospital stay for postpartum-related cause -ED utilization overall -Postpartum-related ED utilization	2017-2022 cohort & 2023-2025 cohort Subgroup analyses by race/ethnicity and county	Hospital uniform billing (UB) data linked to MMIS indicator of having a delivery	Examine trends in outcomes, descriptive analysis, difference-in-differences
RQ2b: Does providing 12 months of coverage after the end of pregnancy decrease the uninsured ED visits and hospitalizations after delivery?	-ED utilization overall by expected payer (number of ED visits) -Number of inpatient hospitalizations overall -Number of inpatient hospitalizations between 61-365 days by expected payer -Length of inpatient hospitalizations	As above	As above	As above

Table 3.3 shows an activity timeline for the research activities.

Table 3.3 Key Milestones, Postpartum Eligibility Extension

Analytic Activity	Year 1 2025	Year 2 2026	Year 3 2027	Year 4 2028	Year 5 2029	Year 6 2030
1. Enrollment, quality of care and health service utilization assessment: Analyze MMIS data (RQ1a-RQ1d)	Define appropriate population and customized metrics for MMIS analysis	Begin analysis of MMIS-based utilization and quality metrics	Complete interim analysis		Conduct analysis	Complete analysis
2. Link and analyze MMIS and UB data (RQ2a, RQ2b)	Execute data use agreements to link MMIS and UB data 2017-2028 and begin data linkage	Finalize linkage of MMIS and UB data sets and conduct baseline analysis	Complete interim analysis of linked data		Update linkage & analysis	Complete analysis of linked data
3. Submit reports to CMS			Interim report			Final report

RQ=Research Question.

NOTE: Evaluation project years are March-Feb. (subject to change depending on date of authorization to begin).

D. Methodological Limitations

This analysis has several limitations. First, as with other studies using claims data, the data may not include all relevant visits and services, and some data may be missing from this analysis. This will be the case if there are gaps in Medicaid enrollment. To avoid bias from unobserved periods of utilization, our models will adjust for number of days enrolled in each year. Relatedly, balance checks will be performed to test for statistically significant differences in sample characteristics over time despite possible gaps in Medicaid enrollment. Our proposed analysis of all-payer hospital uniform billing (UB) data will allow us to examine hospital utilization during gaps in Medicaid coverage. Use of UB data will require approval by the iPHD governing board and DMAHS to create linked- cohorts based on MMIS data, although we anticipate that these approvals will be forthcoming. Screening for anxiety/depression is also subject to under-reporting and a concurrent perinatal episode of care pilot is seeking to address this issue. As a result, we may observe spurious trends if beneficiaries enrolled in the pilot see providers participating in the ongoing episode of care pilot. Diagnostic patterns may vary by provider and provider biases and results may incorrectly estimate the prevalence of malnutrition, anxiety, or depression. Lastly, stratified analyses by race/ethnicity and geography could result in small sample sizes, limiting our ability to detect statistically significant effects.

4. New Jersey Home Visiting Pilot (NJHV) Program

A. General Background Information

In this section, we describe the plan to evaluate the impact of a NJ Home Visitation (NJHV) pilot program designed to support pregnant or postpartum individuals and their families. The pilot will support up to 500 eligible people, statewide, per demonstration year.

Under this initiative, New Jersey will leverage an existing statewide home visiting network that is supported by the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program. New Jersey's home visiting network is implemented by NJ Department of Children and Families (NJDCF). New Jersey's network utilizes the following three voluntary, evidence-based models focused on the health of pregnant people and families:

- Nurse-Family Partnership (NFP): NFP is designed to reinforce maternal behaviors that encourage positive parent-child relationship and maternal, child, and family accomplishments. First-time, low-income mothers are expected to enroll by 28 weeks gestation and are eligible to receive home visits up until their child's 2nd birthday.

- Healthy Families America (HFA): HFA is an in-home health, parenting education, and supportive service to eligible at-risk families, especially those overburdened by stressors that may contribute to child neglect and abuse. Families can enroll prenatally or up until three months after the child's birth and are eligible to receive services up to the child's 3rd birthday.

- Parents as Teachers (PAT): PAT is an in-home health, parenting education, and supportive service to eligible at-risk families, especially those overburdened by stressors that may contribute to child neglect and abuse. Families can enroll in PAT prenatally and postnatally up to age three and are eligible to receive services until the child's 5th birthday. PAT aims to provide home visits to each family for two years.

The New Jersey Medicaid Home Visiting Pilot expects to provide 3,000 months of services annually (500 families served annually × an average of six months duration of services) at an average cost of $500 per member per month.

With funding from the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program (Health Resources and Services Administration or HRSA) in addition to State and TANF funding, New Jersey currently offers the same three evidence-based home visiting programs -- NFP, HFA, and PAT-- in each of the state's 21 counties. The state annually collects and reports performance measures across several areas including: improved maternal and newborn health; reduction of child injuries, and emergency department visits; improved school readiness and achievement; and improvements in the coordination and referrals for other community resources and supports. Johns Hopkins University (JHU) collects and processes these Annual Performance Report (APR) measures in partnership with state agencies and the home visiting programs. In addition, JHU routinely analyzes data from the home visiting program data system as part of New Jersey's home visiting continuous quality improvement efforts. New Jersey intends to leverage this partnership with JHU and their data sources as part of the evaluation the NJHV pilot program.

New Jersey is seeking to study the effect of the NJHV pilot program on perinatal outcomes and expenditures, paying particular attention to health disparities in access and outcomes.

B. Evaluation Questions and Hypotheses

Since MIECHV supports established evidence-based strategies, we propose to test whether the New Jersey pilot achieved **similar outcomes** to the established MIECHV New Jersey initiatives. We have prioritized performance measures aligned with New Jersey Medicaid as relates to health outcomes (e.g., safe sleep, child injury, developmental screening), whole person care (e.g., depression screening, well-child visit, postpartum care) and community integration (e.g., completed depression referrals, completed developmental referrals). We expect more families enrolled in NJHV to receive appropriate well-child visits, postpartum care, and well-woman visits consistent with clinical guidelines since home visitors across each of the models reinforce the importance of children and women receiving preventive health care services.

Below we present the *driver diagram* (Figure 4.1: NJHV Program Aims Driver Diagram) that delineates the pathway from policy to program aims. Here the secondary drivers represent the various services offered through the NJHV pilot.

Figure 4.1. NJHV Program Aims Driver Diagram

Aim	Primary Drivers	Secondary Drivers
Related to Hypothesis 1, we expect that families served by NJHV will achieve comparable outcomes to families served by MIECHV. These outcomes are: In families served by NJHV, caregivers: • Complete depression screening • Complete postpartum care • Complete referrals to care to address depressive symptoms In families served by NJHV, children: • Receive well-child visits • Are placed to sleep in a safe manner • Have reduced rates of injury-related ED visits • Are screened for developmental delay • Complete referrals to care to address developmental delays **Related to Hypothesis 2, we expect that families served by NJHV will achieve improved outcomes compared to families served by Medicaid alone. These outcomes are:** In families served by NJHV, caregivers: • Complete postpartum care • Complete well-visits • Reduce visits to Emergency Department (ED)	• Caregivers understand the importance of their mental and physical health; their child's health; safe sleep; and child development. • Caregivers have referrals to needed services related to their mental and physical health and that of their children and to services related to child development. • Caregivers and their children are enrolled in Medicaid and have healthcare coverage. • Caregivers have a medical home for themselves and their children where their family can attend well visits. • Caregivers plan logistics for completing medical visits and referrals to care.	• Home visitors provide information and coaching to families about the importance of caregiver mental and physical health; child physical health; safe sleep; and child development. • Home visitors provide referrals to needed services related to mental and physical health for caregiver and children and to services related to child development. • Home visitors work with caregivers to enroll and maintain enrollment in Medicaid. • Home visitors work with caregivers to identify and maintain a relationship with a medical home for themselves and their children. • Home visitors work with caregivers to plan logistics for completing medical visits and referrals to care (i.e. transportation, childcare)

In families served by NJHV, children: • Receive well-child visits • Reduce visits to Emergency Department (ED)		
⟸ Causality ⟸		

We next detail the hypotheses and associated research questions that help assess the impact of NJHV. These are also summarized in Table 4.2. For all measures that have sufficient sample size, we will investigate differences by demographic and geographic characteristics (e.g., race/ethnicity and zip code).

Hypothesis 1: Families enrolled in NJHV achieve outcomes comparable to those reported for families enrolled in the MIECHV program in New Jersey.

Research Question 1a: Do families enrolled in NJHV achieve outcomes comparable to those reported for families enrolled in the MIECHV program in New Jersey with regard to **maternal and newborn health** (depression screening, well-child visit, postpartum care)?

Research Question 1b: Do families enrolled in NJHV achieve outcomes comparable to those reported for families enrolled in the MIECHV program in New Jersey with regard to **child injuries and emergency department visits** (safe sleep, child injury)?

Research Question 1c: Do families enrolled in NJHV achieve outcomes comparable to those reported for families enrolled in the MIECHV program in New Jersey with regard to **school readiness and achievement** (developmental screening)?

Research Question 1d: Do families enrolled in NJHV achieve outcomes comparable to those reported for families enrolled in the MIECHV program in New Jersey with regard to **coordination and referrals** (completed depression referrals, completed developmental referrals)?

Hypothesis 2: Families enrolled in NJHV will achieve improved rates of preventive services for children and women and reduced emergency department visits and spending compared to those enrolled in Medicaid and not enrolled in NJHV or MIECHV.

Research Question 2a: Do children born to families enrolled in NJHV achieve higher rates of **preventive services for children** (**well-child visits)** compared to those reported for families enrolled in New Jersey Medicaid and not enrolled in NJHV or MIECHV?

Research Question 2b: Do birthing persons in families enrolled in NJHV achieve higher rates of **preventive services for women** (postpartum visits and well-woman visits) compared to those reported for families enrolled in New Jersey Medicaid and not enrolled in NJHV or MIECHV?

Research Question 2c: Do children born to families enrolled in NJHV and their birthing persons have lower emergency department (ED) visits, lower hospital admissions, and lower ED and inpatient spending compared to those reported for families enrolled in New Jersey Medicaid and not enrolled in NJHV or MIECHV?

C. Methodology

Table 4.1. Inventory of Measures

Measure		Brief Description
Maternal and Newborn Health, NJ Home Visiting Program Data		
1.	Depression screening	Percent of primary caregivers enrolled in home visiting who are screened for depression using a validated tool within 3 months of enrollment (for those not enrolled prenatally) or within 3 months of delivery (for those enrolled prenatally)
2.	Well-child visit	Percent of children enrolled in home visiting who received last recommended visit based on the American Academy of Pediatrics (AAP) periodicity schedule
3.	Postpartum care	Percent of mothers enrolled in home visiting prenatally or within 30 days after birth who received postpartum visit with healthcare provider within 8 weeks (56 days) of delivery
Child Injuries and Maltreatment, NJ Home Visiting Program Data		
4.	Safe sleep	Percent of infants enrolled in home visiting that are always placed to sleep on their backs, without bed-sharing and without soft bedding
5.	Child injury	Rate of injury-related visits to the Emergency Department (ED) during the reporting period among children enrolled in home visiting
School Readiness and Achievement, NJ Home Visiting Program Data		
7.	Developmental screening	Percent of children enrolled in home visiting with a timely screen for developmental delays using a validated parent-completed tool
Coordination and Referrals, NJ Home Visiting Program Data		
8.	Completed depression referrals	Percent of primary caregivers referred to services for a positive depression screen who receive one or more service contacts
9.	Completed developmental referrals	Percent of children enrolled in home visiting with positive screens for developmental delays (measured using a validated tool) who receive services in a timely manner
Preventive Services, Claims/Encounter data		
10.	Well-child care	Receipt of 6 visits in 15 months (Dichotomous: 0=No; 1= Yes) Number of visits in 15 months (Continuous: 0-6)
11.	Postpartum and well-woman visits	Receipt of post- partum visit 7-84 days after delivery (Dichotomous: 0=No; 1= Yes) Receipt of well-woman visit in past year (Dichotomous: 0=No; 1= Yes)
Emergency Department Use and Inpatient Hospitalizations, Claims/Encounter data		
12.	Emergency department visits and spending for birthing persons and newborns	Number of ED visits and associated spending in the *prenatal period* for birthing persons. Number of ED visits and associated spending in the 12 months *after delivery or end of pregnancy* for birthing persons.

		Number of ED visits and associated spending in the 12 months *after delivery* for newborns.
13.	Inpatient hospitalization and spending for birthing persons	Individuals receive inpatient hospital treatment because of pregnancy and childbirth, for surgery, or for nonsurgical medical treatment. Using ICD-10, primary diagnoses for hospitalization will be placed into two categories: those with a primary diagnosis related to complications of pregnancy, childbirth, and the puerperium, and all other diagnoses.[41] Among those with any hospitalizations: -Length of inpatient hospitalizations in the *prenatal period* and in the 12 months *after delivery or end of pregnancy* for birthing persons. Payments on facility claims for inpatient hospitalizations, inflation adjusted.[42]

For hypothesis 1 and research questions 1a-1d

Study population: The study design is cross sectional. We will compare performance measures for clients enrolled in NJHV vs. MIECHV programs in New Jersey. To strengthen inferences about program impacts, we will use propensity matching along with multi-variable statistical modeling to adjust for differences between study groups.

Data sources: RQ1a-RQ1d rely on analysis of New Jersey home visiting data. **Table 4.2** defines the data sources for specific measures; each is defined as a continuous measure, specifically the percent of clients achieving the desired outcome or the rate of child injuries.[43] Home visiting agencies delivering home visiting services to clients in NJHV will collect similar outcomes data as those collected for clients in MIECHV; the data home visiting programs provide to the state comprises the NJ HV Data System.

Analytic strategy: Analytics for this aspect of the study will be conducted solely by JHU team. First, we will conduct descriptive analysis to compare characteristics of the NJHV sample and the MIECHV comparison group with regard to HV model, timing and duration of home visiting enrollment, demographic characteristics (race/ethnicity, primary language, maternal age, education, county) and health characteristics (parity, pre-term birth, health insurance). Second, we will explore creating a matched comparison group of MIECHV participants if the NJHV sample is limited to select counties, and will match based on insurance status, county, and other demographic and health characteristics. Third, we will compare percentages using regression analyses and adjust for baseline differences in characteristics as needed. We also will examine

[41] Maria W. Steenland and Laura R. Wherry, "Medicaid Expansion Led To Reductions In Postpartum Hospitalizations," *Health Affairs* 42, no. 1 (January 2023): 18–25, https://doi.org/10.1377/hlthaff.2022.00819.
[42] "CPI Inflation Calculator," U.S. Bureau of Labor Statistics, accessed September 6, 2023, https://www.bls.gov/data/inflation_calculator.htm.
[43] https://mchb.hrsa.gov/sites/default/files/mchb/programs-impact/performance-indicators-sys-outcomes-summary.pdf

comparisons between the NJHV sample and MIECHV comparison group within each study year; we will pool data if findings are consistent over time and/or include time as covariate in the models. Lastly, we will explore demographic and geographic differences across outcomes. As such, models may be stratified by race/ethnicity, zip code, and other demographic or geographic characteristics as appropriate to estimate results separately where sample size is sufficient. This analytic strategy will be applied to all research questions and hypotheses in order to understand disparities in outcomes related to the NJHV pilot.

Human Subjects considerations: When a client enrolls in a home visiting program in New Jersey, they complete two consent forms. One consent form for receipt of services and the data collection involved in service provision. A second consent form that enables their program data to be used for evaluation and quality improvement. Addressing the Hypothesis 1 research questions will require that DMAHS ensure that all NJHV participants complete the required consent forms.

The JHU team receives home visiting program data for consenting clients with identifiers. To maximize protection against breaches of confidentiality, the JHU team has a dedicated, secure server which houses these data. The JHU server is accessible only to those on the JHU team with direct data management and analysis responsibilities. The server is located in a locked rack in a restricted access, locked space in the Johns Hopkins Bloomberg School of Public Health building. The server provides two layers of firewall security: at both the network and server level. On the network level there are hardware firewalls between the outside internet and secure perimeter network. These hardware devices are managed by an independent IT consulting group. Windows Firewall is installed on the server to help protect it at the local level. Data are encrypted in transit and at rest. Accounts for the server are configured so that only the partitions for which they have been approved to use are accessible. Accounts are also configured by project to ensure that read/write access is provided according to guidelines made by data providers. Access to the internet is disabled for all user accounts. Strong passwords are required for all accounts. Client identifiers will be removed to create files for analysis. The JHU team will conduct all data analysis on the server.

To further ensure the minimum necessary access to identifying information, the CSHP team will not have access to client consent forms or client identifiers. (CSHP will require the NJHV program participation information be available to them in de-identified encounter and claims files). In addition, as discussed above, the JHU team will not have access to individual level Medicaid encounter or claims records. They will receive only aggregated statistical results of analyses of Medicaid encounter/claims data.

For hypothesis 2 and research questions 2a-2c

Study population: The study design is cross sectional. We will compare Medicaid clients enrolled in NJHV to Medicaid clients not enrolled in NJHV or MIECHV programs. To strengthen inferences about program impacts, we will use propensity matching along with multi-variable statistical modeling to adjust for differences between study groups.

Data sources: RQ2a-RQ2c rely on analysis of Medicaid encounter and claims data. **Table 4.2** defines the data sources for each measure; each, except ED visits and inpatient hospitalizations and associated spending, are defined as dichotomous measures indicating whether a client

received a specific health care service. ED visits and inpatient hospitalizations and associated spending are measured as continuous variables. In addition, although the binary outcome measures the desired outcome, we will also use a continuous measure of the number of well-child visits in RQ2a.

Analytic strategy: Analytics for this aspect of the study will be conducted solely by Rutgers team. First, we will follow methods developed by DMAHS we will link Medicaid claims for the mother and child and then link those records to New Jersey birth records. (Birth record linkage will follow other CSHP Medicaid work preserving de-identification of Medicaid records.) Second, we will create a propensity matched comparison group (5 matches/participant) on the basis of demographic characteristics (race/ethnicity, primary language, maternal age, education, county) and birth characteristics (parity, plurality, birthweight). Excluded from the matched comparison group will be families enrolled in Medicaid and participating in MIECHV. Removing records of participants in these alternative home visiting programs will require matching program participation records to Medicaid claims. Third, we will use regression analyses to compare differences in outcomes for NJHV and families in Medicaid not participating in alternative home visiting programs. Fourth, among the NJHV families, we also will explore differences in outcomes among the 3 different HV models if sufficient numbers of families are enrolled in each and claims records support identification of program model. Fifth, among the NJHV families, we will explore whether number of home visits is associated with outcomes. Finally, for RQ2c (total Medicaid spending), we will compare spending changes to per-family NJHV participation costs. We will rely on DMAHS to provide program costs data, although can provide guidance on the collection of cost data if needed. Lastly, we will explore demographic and geographic differences across outcomes. Models may be stratified by race/ethnicity, zip code, and other demographic or geographic characteristics as appropriate to estimate results separately where sample size is sufficient. This analytic strategy will be applied to all research questions and hypotheses in order to understand disparities in outcomes related to the NJHV pilot.

Human Subjects considerations: The Rutgers CSHP evaluation team will use only a de-identified Limited Data Set for this and other components of the waiver evaluation. Execution of data linkages that require identifiers will be conducted by DMAHS or a trusted third party that they designate. Birth record data will be provided by the Integrated Population Health Data (iPHD) Project, which is managed by CSHP. To prevent the possibility of re-identification, CSHP staff using identifiable birth record data ("iPHD team") will not participate in the analyses described herein and CSHP staff working in Medicaid claims for this analysis ("Waiver team") will not have access to identified iPHD records. To execute the linkage, the iPHD team will send a finder file that contains identifiers and a study ID to DMAHS (or its designee) and provide de-identified birth record information to the Waiver team with the Study ID but no direct identifiers. Once the linkage is executed, DMAHS (or its designee) will share a crosswalk file containing only study IDs that do not include information that could be used to re-identify study subjects with the Waiver team.

Table 4.2: Summary of Questions, Hypotheses and Methodology

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic methods
Hypothesis 1- Families enrolled in NJHV achieve outcomes comparable to those reported for families enrolled in the MIECHV program in New Jersey				
RQ1a. Do families enrolled in NJHV achieve outcomes comparable to those reported for families enrolled in the MIECHV program in New Jersey with regard to **maternal and newborn health** (depression screening, well-child visit, postpartum care)?	• Depression screening (Continuous: Percent) • Well-child visit (Continuous: Percent) • Postpartum care (Continuous: Percent)	Birthing people and newborns in New Jersey, participating in NJHV compared to propensity score matched dyads enrolled in MIECHV.	NJ Home Visiting Program Data	Examine differences in outcomes, descriptively and through regression analysis
RQ1b. Do families enrolled in NJHV achieve outcomes comparable to those reported for families enrolled in the MIECHV program in New Jersey with regard to **child injuries and emergency department visits** (safe sleep, child injury)?	• Safe sleep (Continuous: Percent) • Child injury (Continuous: Rate)	Newborns in New Jersey, participating in NJHV compared to propensity score matched dyads enrolled in MIECHV.	NJ Home Visiting Program Data	Examine differences in outcomes, descriptively and through regression analysis
RQ1c. Do families enrolled in NJHV achieve outcomes comparable to those reported for families enrolled in the MIECHV program in New Jersey with regard to **school readiness and achievement** (developmental screening)?	• Developmental screening (Continuous: Percent)	Newborns in New Jersey, participating in NJHV compared to propensity score matched dyads enrolled in MIECHV.	NJ Home Visiting Program Data	Examine differences in outcomes, descriptively and through regression analysis

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic methods
RQ1d. Do families enrolled in NJHV achieve outcomes comparable to those reported for families enrolled in the MIECHV program in New Jersey with regard to **coordination and referrals** (completed depression referrals, completed developmental referrals)?	• Completed depression referrals (Continuous: Percent) • Completed developmental referrals (Continuous: Percent)	Birthing people and newborns in New Jersey, participating in NJHV compared to propensity score matched dyads enrolled in MIECHV.	NJ Home Visiting Program Data	Examine differences in outcomes, descriptively and through regression analysis
Hypothesis 2- Families enrolled in NJHV will achieve improved rates of preventive services for children and women and reduced emergency department visits and spending compared to those not enrolled in NJHV or MIECHV				
RQ2a. Do children born to families enrolled in NJHV achieve higher rates of well-child visits compared to those enrolled in New Jersey Medicaid and not enrolled in NJHV or MIECHV?	Well-child care: • Receipt of 6 visits in 15 months (Dichotomous: 0=No; 1= Yes) • Number of visits in 15 months (Continuous: 0-6)	NJHV and Other Medicaid (not enrolled in MIECHV)	Medicaid Fee-for-Service and Encounter Claims Records	Examine differences in outcomes, descriptively and through regression analysis
RQ2b. Do birthing persons in families enrolled in NJHV achieve higher rates of preventive services for women (postpartum visits and well-woman care) compared to those reported for families enrolled in New Jersey Medicaid and not enrolled in NJHV or MIECHV?	• Receipt of post- partum visit 7-84 days after delivery (Dichotomous: 0=No; 1= Yes) • Receipt of well-woman visit in past year (Dichotomous: 0=No; 1= Yes)	NJHV and Other Medicaid (not enrolled in MIECHV)	Medicaid Fee-for-Service and Encounter Claims Records	Examine differences in outcomes, descriptively and through regression analysis
RQ2c. Do children born to families enrolled in NJHV and their birthing persons have lower emergency department (ED) visits, lower	• Number of ED visits and associated spending in the prenatal period and 12 months after delivery or end of pregnancy for birthing persons	NJHV and Other Medicaid (not enrolled in MIECHV)	Medicaid Fee-for-Service and Encounter	Examine differences in outcomes, descriptively and

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic methods
hospital admissions, and lower ED and inpatient spending compared to those reported for families enrolled in New Jersey Medicaid and not enrolled in NJHV or MIECHV?	• Number of ED visits and associated spending in the prenatal period and 12 months after delivery for newborns • Number of inpatient hospitalizations and associated spending in the prenatal period and 12 months after delivery for birthing persons		Claims Records	through regression analysis

Table 4.3 shows an activity timeline for the research activities.

Table 4.3 Key Milestones, New Jersey Home Visiting Pilot (NJHV) Program

Analytic Activity	Year 1 2025	Year 2 2026	Year 3 2027	Year 4 2028	Year 5 2029	Year 6 2030
1. School readiness and achievement, quality of care, health service utilization, and referrals assessment: Analyze NJ Home Visiting Program Data (RQ1a-RQ1d)	Establish agreement with RU/JHU	Conduct analysis	Complete interim analysis		Conduct analysis	Complete analysis
2. Quality of care, health service utilization, and spending assessment: Link and analyze MMIS and birth record data (RQ2a-RQ2c)	Define appropriate population and customized metrics for MMIS analysis (includes program cost variables)	Finalize linkage of MMIS and birth record data sets and conduct baseline analysis	Complete interim analysis of linked data	Update linkage & analysis	Update linkage & analysis	Complete analysis of linked data
3. Submit reports to CMS			Interim report			Final report

RQ=Research Question.

NOTE: Evaluation project years are March-Feb. (subject to change depending on date of authorization to begin).

D. Methodological Limitations

Design: First, the goal of the pilot program is to enroll up to 500 eligible families per demonstration year. Elements of the analysis may be statistically underpowered to detect differences attributed from the pilot given the limitations of a program of this size. Second, the study design is cross sectional. As such, our analyses do not assess causality and we may observe systematic differences between the sample and comparison groups. We will assess and adjust for baseline differences in demographic and birth characteristics. To the extent that NJHV participants are distributed across 3 home visiting models and sample sizes and data permit, we will examine differences in subgroups and comparisons by home visiting model.

Data sources/collection: For Hypothesis 1, we rely on existing home visiting data systems. However, programmatic data are collected, in part, for federal evaluation purposes and New Jersey engages in continuous quality improvement efforts to enhance data quality. In these analyses, we focus on New Jersey performance measures with more complete data and robust denominators. We will rely on DMAHS to obtain and provide programmatic data from NJHV program participants using the standard instruments to be provided by JHU.

We rely on Medicaid claims data for Hypothesis 2. As such, we are limited in available measures. However, the selected measures are among those proximate to receipt of home visiting, important for promoting maternal and child health, and aligned with both MIECHV and HEDIS performance measures.

Methods: Hypothesis 1: Some APR measures have small denominators limiting ability to detect differences; we focused in this evaluation strategy on measures with more robust denominators. Some APR data have significant missing data, similarly, these measures are not included.

For Hypothesis 2, we rely on proximate outcomes. While families on average remain in home visiting for < 1 year, well-child visit outcome over first 15 months reflects that health seeking behaviors start early and that home visiting has potential to impact health seeking behaviors.

Impact of additional supportive programs: Beneficiaries of NJHV may also be receiving home visits through other supportive services. Specifically, birthing individuals may be receiving doula care, which typically involves home visits throughout the perinatal period. Also, NJ has launched universal home visiting (Family Connects NJ) in 5 counties in 2024, with plans for statewide availability by the end of the demonstration period. Family Connects NJ is not as intensive as the NJHV models, typically involving a single visit in the immediate postpartum period. We will attempt to control for participation in these supportive services, as the intended impacts of these services align with those of the NJHV pilot. Use of NJ Medicaid community doula services can be identified if Medicaid claims are submitted for those services. JHU is involved in evaluating Family Connects NJ for New Jersey and will be able to identify families receiving Family Connects NJ visits for the purposes of the NJHV evaluation.

5. Medically Indicated Meals Pilot

A. General Background Information

In this section, we describe the plan to evaluate the impact of a Medically Indicated Meals (MIM) pilot designed to address the dietary needs of pregnant people with a diagnosis of either pre-existing diabetes and/or gestational diabetes. The pilot will support the delivery of medically indicated meals to up to 300 eligible pregnant people per demonstration year.

Under this initiative, New Jersey will partner with selected Managed Care Organizations (MCOs) which will contract with meal preparation vendors to provide medically indicated meals to qualifying pregnant people. Selected vendors will provide medically indicated meals, which are to be made fresh and either delivered locally or shipped. Each meal delivery will come with information on how to store, heat, and keep the meals fresh, as well as information explaining how to recreate the meals at home.

Gestational diabetes is a key risk factor for adverse perinatal outcomes. Medical Nutrition Therapy (MNT), which aims to address dietary risk factors among pregnant women, is a critical intervention to address gestational diabetes.[44] Research has shown that combining MNT with medically appropriate home-delivered meals supports better health outcomes and significantly reduces costs for the health care system by keeping patients in their homes rather than in hospitals or nursing homes.[45] A recent study conducted by the University of North Carolina School of Medicine showed positive results for high healthcare utilizing participants who received medically tailored meal intervention.[46] The authors found that through 18 months of follow-up, participants showed a 70% decrease in emergency department use, a 50% reduction in hospitalization rates, and a decrease of $220 in health care costs per participant per month. Another study conducted by Health Partner Plans concluded similar results finding that patients who received medically tailored meals three times a day, seven days a week for 6 to 18 weeks experienced a reduction of 19% in medical costs per month, as well as decreases in inpatient admission and emergency room visits by 26% and 7%, respectively.[47]

New Jersey is seeking to study the effectiveness of the implementation of the MIM pilot and to test the effect of the pilot on perinatal outcomes and expenditures, paying particular attention to health disparities in access and outcomes.

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[44] Neda Dolatkhah, Majid Hajifaraji, and Seyed Kazem Shakouri, "Nutrition Therapy in Managing Pregnant Women With Gestational Diabetes Mellitus: A Literature Review," *Journal of Family & Reproductive Health* 12, no. 2 (June 2018): 57–72.No Reference

[45] Laura C. Kusinski et al., "Dietary Intervention in Pregnant Women with Gestational Diabetes; Protocol for the DiGest Randomised Controlled Trial," *Nutrients* 12, no. 4 (April 2020): 1165, https://doi.org/10.3390/nu12041165.

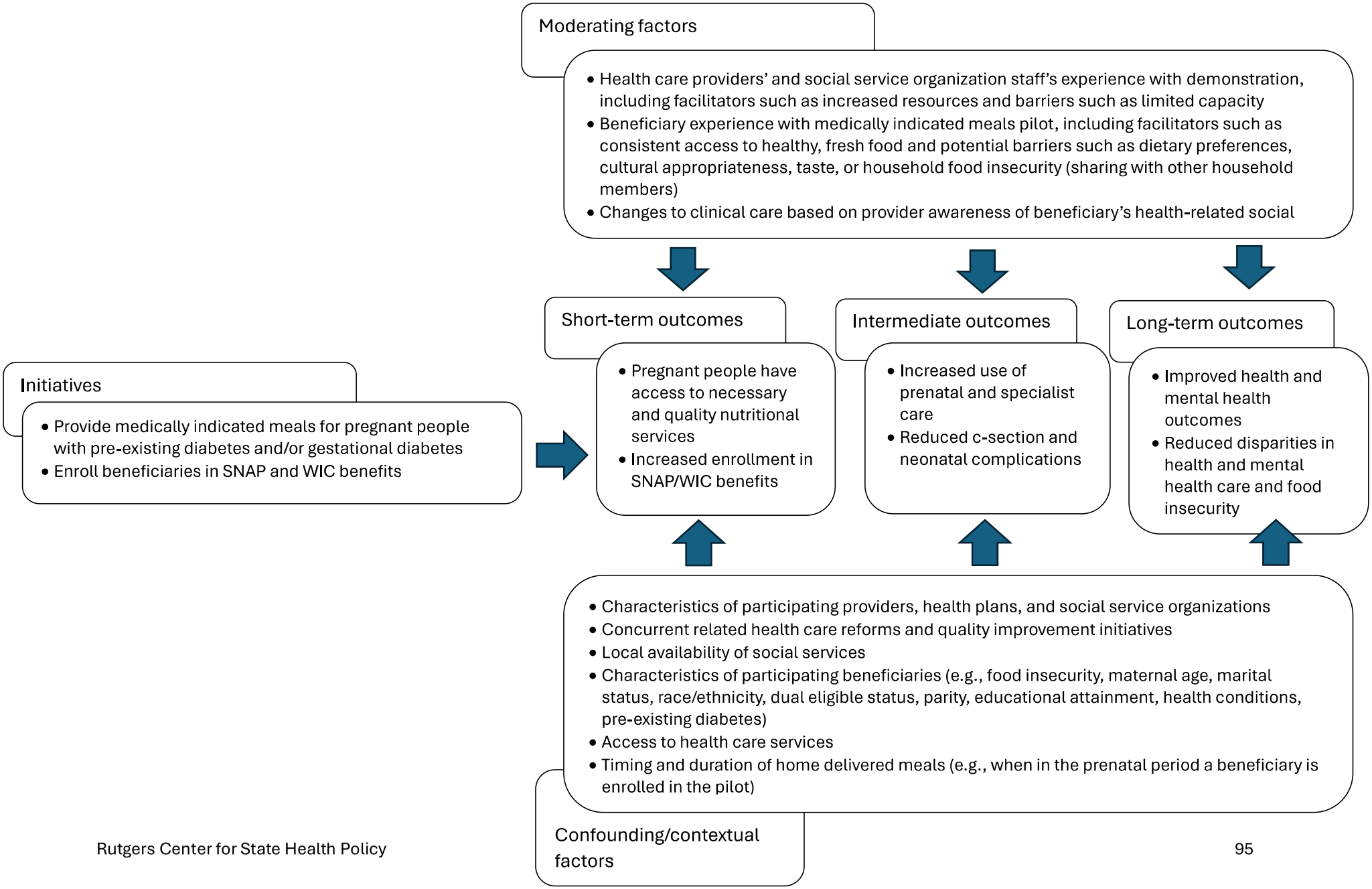
[46] Seth A. Berkowitz et al., "Meal Delivery Programs Reduce The Use Of Costly Health Care In Dually Eligible Medicare And Medicaid Beneficiaries," *Health Affairs* 37, no. 4 (April 2018): 535–42, https://doi.org/10.1377/hlthaff.2017.0999.

[47] "Food as Medicine Model: A Framework for Improving Member Health Outcomes and Lowering Health Costs" (Health Partners Plans, 2018), https://www.healthpartnersplans.com/media/100225194/food-as-medicine-model.pdf.

B. Evaluation Questions and Hypotheses

Our evaluation of the Medically Indicated Meals Pilot includes an implementation study as well as research questions related to demonstration outcomes. Figure 5.1 is a logic model showing the implementation questions and the expected outcomes.

Figure 5.1 Medically Indicated Meals Logic Model



1. Implementation Study

To understand the implementation of the medically indicated meals pilot, researchers will review available administrative data and monitoring reports and conduct in-depth individual interviews with entities responsible for the demonstration such as MCOs and their vendors, DMAHS staff, other state and local experts such as health-care providers serving at-risk Medicaid beneficiaries, and other key informants involved in the implementation of the pilot itself. The complete interview guide for proposed implementation questions modeled on the suggested implementation questions in CMS' technical assistance guide for evaluating health related social needs can be found in the Appendix. These questions will provide context for quantitative analyses and assess the design and implementation of the MIM pilot.

1.1 Methodology

Data Collection: In-depth individual interviews will be conducted using semi-structured, open-ended questions that probe key informants on their experiences implementing the medically indicated meals pilot, identifying how roles or participation changed throughout the demonstration period. Interviews will offer insights into pilot implementation as well as identifying barriers and opportunities to improve the pilot. Participant recruitment will be based on criteria established during protocol development and will primarily involve staff and key informants with existing relationships to the evaluators such as MCOs and their vendors, DMAHS staff, and other state and local experts. Up to 20 interviews of approximately 45-60 minutes will be completed, with attention to diversity by MCO and geographical region. Key informant interviewees participating in their professional roles (e.g., DMAHS, MCO staff, vendors) will not be offered participation incentives, but others (e.g., community advocates) will receive a $50 participation incentive. Interviews will be conducted virtually over Zoom and transcribed.

Analytic Strategy for Interview Data: NVivo or similar software will be used to analyze for themes. A general inductive approach will be used to allow for themes to emerge. Where appropriate, themes will be categorized as a barrier or facilitator to provide a coherent analysis to MCOs on the implementation of the medically indicated meals pilot.

2. Outcomes Study

We posit that home delivered medically indicated meals for pregnant people with pre-existing diabetes and/or gestational diabetes will improve perinatal outcomes. Additionally, while the pilot will have costs associated with the meal delivery, we anticipate potential reductions in Medicaid expenditures receiving the meals.

Below we present the *driver diagram* (Figure 5.2: Medically Indicated Meals Driver Diagram) that delineates the pathway from the pilot to improved outcomes. Here the secondary drivers represent the services available to pregnant people.

Figure 5.2: Medically Indicated Meals Driver Diagram

Aim	Primary Drivers	Secondary Drivers
1.A. Ensure that eligible pregnant people have access to necessary and quality nutritional services to improve perinatal outcomes -Improve access to prenatal and postpartum care -Reduce delivery and neonatal complications -Improve maternal mental health and nutritional adequacy -For population with gestational diabetes, reduce incidence of long-term diabetes diagnosis after the end of pregnancy 1.B. Reduce disparities among birthing people with gestational and/or existing diabetes	Address the dietary needs of pregnant people with pre-existing diabetes and/or gestational diabetes, like those related to diet and food insecurity.	• Provide medically indicated meals for pregnant people with pre-existing diabetes and/or gestational diabetes • Enroll more beneficiaries in SNAP and WIC benefits
⟸	Causality	⟸

We next detail the hypotheses and corresponding research questions that help assess the impact of the pilot on perinatal outcomes and expenditures. For all measures that have sufficient sample size, we will investigate differences by demographic and geographic characteristics (e.g., race/ethnicity and county).

Hypothesis 2.1: Implementing a pilot that meets the dietary needs of pregnant people with a diagnosis of either pre-existing diabetes and/or gestational diabetes will improve access to and quality of care for both pregnant persons and infants.

Research Question 2.1a: What is the impact of providing medically indicated meals to pregnant people with pre-existing and/or gestational diabetes on **prenatal and specialist care, postpartum and well-woman visits, well-child care, postpartum glucose screening, emergency room (ED) visits, and hospital admissions**?

Research Question 2.1b: What is the impact of providing medically indicated meals to pregnant people with pre-existing and/or gestational diabetes on **type of delivery (e.g., cesarean deliveries) and neonatal complications (e.g., birth weight)**?

Hypothesis 2.2: Implementing a pilot that meets the dietary needs of pregnant people with a diagnosis of either pre-existing diabetes and/or gestational diabetes will improve maternal mental health and reduce indicators of nutritional inadequacy.

Research Question 2.2a: What is the impact of providing medically indicated meals to pregnant people with pre-existing and/or gestational diabetes on **screening and rates of anxiety and depression**?

Research Question 2.2b: What is the impact of providing medically indicated meals to pregnant people with pre-existing and/or gestational diabetes on **indicators of nutritional inadequacy**?

Hypothesis 2.3: Implementing a pilot that meets the dietary needs of pregnant people with a diagnosis of either pre-existing diabetes and/or gestational diabetes will change the levels and balance of spending on maternal and neonatal expenditures.

Research Question 2.3a: What is the impact of providing medically indicated meals to pregnant people with pre-existing and/or gestational diabetes on the levels and balance of **spending on inpatient hospitalizations, ED visits, and outpatient expenditures**?

2.1 Methodology

Outcomes:

We will assess the outcomes listed in Table 5.1 below using Medicaid fee-for-service and encounter claims records.

Table 5.1: Inventory of Measures

Measure		Brief Description
Utilization of Care		
1.	Prenatal care	Number of prenatal care visits with primary provider (OBGYN or equivalent). Number of visits with maternal fetal medicine specialist. Number and timing of ultrasounds conducted (e.g., week 18 to 20, week 28, and 32 to 36).
2.	Postpartum and well-woman visits	Receipt of postpartum visit 7-84 days after delivery. (Dichotomous: 0=No; 1=Yes) Receipt of well-woman visit in past year. (Dichotomous: 0=No; 1=Yes)[48, 49]
3.	Well-child care	Receipt of 6 visits in 15 months. (Dichotomous: 0=No; 1=Yes) Number of visits in 15 months. (Continuous: 0-6)

[48] American College of Obstetricians and Gynecologists (ACOG). (2018). Optimizing Postpartum Care. ACOG Committee Opinion No. 736. Obstet Gynecol, 131:140-150.

[49] HEDIS measure: https://www.ncqa.org/hedis/measures/prenatal-and-postpartum-care-ppc/

4.	Emergency department (ED) visits	Number of ED visits in the *prenatal period* for birthing persons. Number of ED visits in the 12 months *after delivery or end of pregnancy* for birthing persons.[50] Number of ED visits in the 12 months *after delivery* for newborns.
5.	Inpatient hospitalization	Individuals receive inpatient hospital treatment because of pregnancy and childbirth, for surgery, or for nonsurgical medical treatment. Using ICD-10, primary diagnoses for hospitalization will be placed into two categories: those with a primary diagnosis related to complications of pregnancy, childbirth, and the puerperium (including gestational diabetes), and all other diagnoses.[51] Among those with any hospitalizations: -Length of inpatient hospitalizations in the *prenatal period* and in the 12 months *after delivery or end of pregnancy* for birthing persons.[52]
6.	Type of delivery	Cesarean delivery method.[53] (Dichotomous: 0=No; 1=Yes)
7.	Birth weight	Low birth weight.[54] (Dichotomous: 0=No; 1=Yes)
Quality		
8.	Glucose screening	*Postpartum* glucose screening in the 6-12 weeks after the end of pregnancy (ACOG recommendation).[55]

[50] Clark, S. L. et al. (2010). Emergency department use during the postpartum period: implications for current management of the puerperium. *American Journal of Obstetrics and Gynecology, 203*(1), 38.e1-38.e6. https://doi.org/10.1016/j.ajog.2010.02.033; Harris, A. et al. (2015). Emergency room utilization after medically complicated pregnancies: a Medicaid claims analysis. *Journal of Women's Health, 24*(9), 745-754.

[51] Maria W. Steenland and Laura R. Wherry, "Medicaid Expansion Led To Reductions In Postpartum Hospitalizations," *Health Affairs* 42, no. 1 (January 2023): 18–25, https://doi.org/10.1377/hlthaff.2022.00819.

[52] Garrison, E.A. & Jagasia, S. (2014). Inpatient management of women with gestational and pregestational diabetes in pregnancy. *Current Diabetes Reports, 14*(2), 457. https://doi.org/10.1007/s11892-013-0457-x.

[53] Nayak et al., "Feto-Maternal Outcomes in Women with and without Gestational Diabetes Mellitus According to the International Association of Diabetes and Pregnancy Study Groups (IADPSG) Diagnostic Criteria"; Wenrui Ye et al., "Gestational Diabetes Mellitus and Adverse Pregnancy Outcomes: Systematic Review and Meta-Analysis," *BMJ* 377 (May 25, 2022): e067946, https://doi.org/10.1136/bmj-2021-067946.

[54] Nayak et al., "Feto-Maternal Outcomes in Women with and without Gestational Diabetes Mellitus According to the International Association of Diabetes and Pregnancy Study Groups (IADPSG) Diagnostic Criteria"; Ye et al., "Gestational Diabetes Mellitus and Adverse Pregnancy Outcomes."

[55] American College of Obstetricians and Gynecologists, "Gestational Diabetes Mellitus. ACOG Practice Bulletin No. 190," *Obstetrics & Gynecology* 131, no. 2 (2018): e49-64, http://dx.doi.org/10.1097/AOG.0000000000002501.

		(Dichotomous: 0=No; 1=Yes)
9.	Screening and rates of anxiety and depression	Individuals receive *prenatal* depression screening (yes/no). Number of times screened (ACOG recommends at least 1 screening in prenatal period).[56] ICD-10 Mental Health diagnosis codes at different periods (e.g., *10 to 14 weeks, 24-28 weeks, and 30 to 32 weeks of pregnancy*).[57] Individuals receive *postpartum* depression screening at either maternal or infant follow-up visit (yes/no).[58] Number of times screened (AAP recommends screenings at *1-, 2-, 4-, and 6-month well-infant visits*).[59] ICD-10 Mental Health diagnosis codes at different periods (e.g., *1 month postpartum, 2 months, 4 months, and 6 months*).
10.	Nutritional adequacy	Incidents of ICD-10 Codes that measure nutritional adequacy in the *prenatal and postpartum* periods: Z59.4 Lack of adequate food and safe drinking water [60] O25 Malnutrition in pregnancy, childbirth and the puerperium
Spending		

[56] "Committee Opinion No. 630: Screening for Perinatal Depression," *Obstetrics & Gynecology* 125, no. 5 (May 2015): 1268, https://doi.org/10.1097/01.AOG.0000465192.34779.dc.

[57] B. N. Gaynes et al., "Perinatal Depression: Prevalence, Screening Accuracy, and Screening Outcomes: Summary," in *AHRQ Evidence Report Summaries* (Agency for Healthcare Research and Quality (US), 2005), https://www.ncbi.nlm.nih.gov/books/NBK11838/; D. D. Affonso et al., "A Standardized Interview That Differentiates Pregnancy and Postpartum Symptoms from Perinatal Clinical Depression," *Birth (Berkeley, Calif.)* 17, no. 3 (September 1990): 121–30, https://doi.org/10.1111/j.1523-536x.1990.tb00716.x.

[58] HEDIS measure: https://www.ncqa.org/hedis/measures/postpartum-depression-screening-and-follow-up/

[59] "Integrating Postpartum Depression Screening in Your Practice in 4 Steps," American Academy of Pediatrics, accessed January 24, 2024, https://www.aap.org/en/patient-care/perinatal-mental-health-and-social-support/integrating-postpartum-depression-screening-in-your-practice-in-4-steps/.

[60] S DeSilvey et al., "An Overview of Food Insecurity Coding in Health Care Settings: Existing and Emerging Opportunities." (Boston, MA: Hunger Vital Sign™ National Community of Practice, 2018), http://childrenshealthwatch.org/foodinsecuritycoding/.

11.	Spending related to inpatient hospitalizations and ED visits	Payments on facility claims for inpatient and ED visits, inflation adjusted.[61]
12.	Spending related to outpatient care	Payments on claims for outpatient care (e.g., prenatal care, postpartum and well-woman visits, well-child care, glucose screening, etc.), inflation adjusted.[62]

For hypothesis 2.1-2.3 and research questions 2.1a-2.1b, 2.2a-2.2b, and 2.3a

Study population and comparison group: Our study population comprises pregnant people with a diagnosis of either pre-existing diabetes and/or gestational diabetes. The treatment group would be those who are enrolled in the selected MCO and receive meals through the pilot. The comparison group will consist of eligible pregnant people (i.e., have a diagnosis of either pre-existing and/or gestational diabetes), but who do not receive meals through the pilot.

Analytic strategy: We will conduct descriptive trend analysis and utilize a difference-in-differences (DID) design, sample size permitting, to estimate the effects of the pilot on medical and neonatal complications for the study population relative to the comparison group, both defined above. For these models, an interaction variable between exposure group (individuals who receive meals through the pilot) versus control group (individuals within the same MCO, but who did not receive meals through the pilot) and an indicator variable for pre-policy or post-policy will be constructed. For spending analysis, trends will be compared between treatment and control group before and after the implementation of the pilot and differentiate between spending over time comparing avoidable spending (e.g., ED visits, hospital admissions) to preventative care spending (e.g., prenatal visits, postpartum and well-woman visits, etc.). We will produce bar charts and line diagrams to examine types of spending and trends. We will rely on trend analyses to differentiate between spending that positively increases because of higher utilization of preventative care vs spending on preventable ED visits as a result of inadequate ambulatory/primary care use within communities. We will estimate a linear probability model for binary outcomes (e.g., ED visits, hospital admissions, postpartum and well-woman visits, well-child visits, cesarean delivery, low birth weight, depression screening, glucose screening) and ordinary least squares regression for remaining utilization and spending outcomes. Given sufficient sample size, regressions will control for maternal and infant demographic characteristics (e.g., food insecurity, maternal age, marital status, race/ethnicity, dual eligible status, parity, educational attainment, presence of comorbidities, pre-existing diabetes diagnosis) with adjustments such as zip code and year fixed effects to control for any time-invariant geographic variation and time-specific effects. Models may also control for duration of enrollment in the pilot to estimate when a beneficiary started receiving meals in the perinatal period. Efforts to account for autocorrelation, such as the use of robust standard errors clustered by zip code, will also be implemented.

The model is specified below:

[61] "CPI Inflation Calculator," U.S. Bureau of Labor Statistics, accessed September 6, 2023, https://www.bls.gov/data/inflation_calculator.htm.
[62] "CPI Inflation Calculator."

$$Outcome_{it} = \alpha_0 + \alpha_1(TreatmentGroup)_i + \alpha_2(Post)_{it} + \alpha_3(TreatmentGroup * Post)_{it} + \lambda X_{it} + \varepsilon_{it}$$

$Outcome_{it}$ represents the outcome of interest for an individual respondent *i* in year t. α represents the coefficients that correspond to each model component. The interaction term of $TreatmentGroup * Post$ yields the difference-in-differences estimator (the α_3 coefficient), which estimates how much outcomes changed among individuals receiving medically indicated meals after the pilot implementation relative to outcomes among individuals who do not receive meals. X_i represents a set of control variables, with λ being the corresponding coefficients for each variable in *X,* for individual *i* at time *t*. ε represents the stochastic error term.

A primary assumption for a valid DID inference is parallel pre-treatment trends.[63] This assumption is necessary to indicate whether, in the absence of the policy change, the trends in outcomes would have been similar between treatment and comparison groups. Event studies will be conducted to establish the parallel trends hold for all groups. If the parallel trends assumption is violated, we will explore alternative strategies such a lagged dependent variable regression approach and matching on past outcomes.[64]

There may be demographic and geographic differences in access, utilization, and spending outcomes. As a result, logit regressions will be utilized to predict pilot enrollment by demographic and clinical factors, including race/ethnicity and geographic region. Additionally, models may be stratified by race/ethnicity, county, and other demographic or geographic characteristics (e.g., nulliparous, pre-existing diabetes diagnosis, etc.) as appropriate to estimate results separately where sample size is sufficient. This analytic strategy will be applied to all research questions and hypotheses in order to understand disparities in outcomes related to the medically indicated meals pilot.

[63] Angrist JD, Pischke J-S. *Mostly harmless econometrics: an empiricist's companion*, Princeton: Princeton University Press, 2009; Ryan et al. (2018). Now trending: Coping with non-parallel trends in difference-in-differences analysis. *Statistical Methods in Medical Research, 28*(12). https://doi.org/10.1177/0962280218814570

[64] O'Neill S, Kreif N, Grieve R, Sutton M, Sekhon JS. Estimating causal effects: considering three alternatives to difference-in-differences estimation. Health Services and Outcomes Research Methodology. 2016 Jun;16:1-21.

Table 5.2: Summary of Questions, Hypotheses and Methodology

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
Hypothesis 2.1: Implementing a pilot that meets the dietary needs of pregnant people with a diagnosis of either pre-existing diabetes and/or gestational diabetes will improve access to and quality of care for both pregnant persons and infants.				
RQ2.1a: What is the impact of providing medically indicated meals to pregnant people with pre-existing and/or gestational diabetes on prenatal and specialist care, postpartum and well-woman visits, well-child care, postpartum glucose screening, emergency room (ED) visits, and hospital admissions?	-Number of prenatal care visits with primary provider (OBGYN or equivalent) -Number of visits with maternal fetal medicine specialist -Postpartum and well-woman visits -Well-child care -Number and timing of ultrasounds conducted (e.g., week 18 to 20, week 28, and 32 to 36) -ED visits in the prenatal and postpartum period -Inpatient hospital stay for pregnancy/postpartum related cause -Length of inpatient hospitalizations -Postpartum glucose screening	-Pregnant people who receive home delivered meals compared to those who are also eligible, but do not receive meals. -Infants whose parent received home delivered meals compared to those who had an eligible parent, but did not receive meals.	Medicaid Fee-for-Service and Encounter Claims Records	Difference-in-differences & descriptive adjusted trend analyses
RQ2.1b: What is the impact of providing medically indicated meals to pregnant people with pre-existing and/or gestational diabetes on type of delivery (e.g., cesarean deliveries) and neonatal complications (e.g., birth weight)?	-Cesarean delivery -Low birth weight	As above	As above	As above

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
Hypothesis 2.2: Implementing a pilot that meets the dietary needs of pregnant people with a diagnosis of either pre-existing diabetes and/or gestational diabetes will improve maternal mental health and reduce indicators of nutritional inadequacy.				
RQ2.2a: What is the impact of providing medically indicated meals to pregnant people with pre-existing and/or gestational diabetes on screening and rates of anxiety and depression?	-Timing and number of depression screenings -ICD-10 Mental Health diagnosis codes at different periods (e.g., *10 to 14 weeks, 24-28 weeks, and 30 to 32 weeks of pregnancy*) -ICD-10 Mental Health diagnosis codes at different periods (e.g., *1 month postpartum, 2 months, 4 months, and 6 months*).	Pregnant people who receive home delivered meals compared to those who are also eligible, but do not receive meals.	Medicaid Fee-for-Service and Encounter Claims Records	Difference-in-differences & descriptive adjusted trend analyses
RQ2.2b: What is the impact of providing medically indicated meals to pregnant people with pre-existing and/or gestational diabetes on indicators of nutritional inadequacy?	Incidents of ICD-10 Codes that measure nutritional adequacy in the *prenatal and postpartum* periods: -ICD 10 codes: (e.g., Z59.4 Lack of adequate food and safe drinking water, O25 Malnutrition in pregnancy, childbirth and the puerperium)	As above	As above	As above
Hypothesis 2.3: Implementing a pilot that meets the dietary needs of pregnant people with a diagnosis of either pre-existing diabetes and/or gestational diabetes will change the levels and balance of spending on maternal and neonatal expenditures.				
RQ2.3a: What is the impact of providing medically indicated meals to pregnant people with pre-existing and/or gestational diabetes on the levels and balance of spending on inpatient hospitalizations, ED visits, and outpatient expenditures?	-Payments on facility claims for inpatient and treat-and-release ED visits -Payments on claims for outpatient care (e.g., prenatal care, postpartum and well-woman visits, well-child care, glucose screening, etc.)	Pregnant people who receive home delivered meals compared to those who are also eligible, but do not receive meals.	Medicaid Fee-for-Service and Encounter Claims Records	Difference-in-differences & descriptive adjusted trend analyses

Table 5.3 shows an activity timeline for the research activities.

Table 5.3 Key Milestones, Medically-indicated Meals Pilot

Analytic Activity	Year 1 2025	Year 2 2026	Year 3 2027	Year 4 2028	Year 5 2029	Year 6 2030
1. Qualitative implementation assessment	Plan for key informant interviews – consult on informant list and finalize recruitment strategy and materials Finalize and test question bank for key informant interviews	Conduct and analyze key informant interviews (n=20)	Finish analyzing key informant interviews Complete interim analysis			Complete analysis
2. Quality of care, health service utilization, and spending assessment: Analyze MMIS data (RQ2.1a-RQ2.1b, RQ2.2a-RQ2.2b, RQ2.3a)	Define appropriate population and customized metrics for MMIS analysis (includes program cost variables)	Begin analysis of MMIS-based utilization and quality metrics	Complete interim analysis	Conduct analysis	Conduct analysis	Complete analysis
3. Submit reports to CMS			Interim report			Final report

RQ=Research Question.

NOTE: Evaluation project years are March-Feb. (subject to change depending on date of authorization to begin).

C. Methodological Limitations

This analysis has several limitations. First, as with other studies using claims data, the data may not have included all relevant visits and services, and some data may be missing from this analysis. Relatedly, while ICD-10 codes provide some indicator of mental health and nutritional inadequacy, they are subject to coding incentives and biases and may be inaccurate or unreliable.[65] Screening for anxiety/depression is also subject to under-reporting and a concurrent perinatal episode of care pilot is seeking to address this issue. As a result, we may observe spurious trends if beneficiaries enrolled in the pilot see providers participating in the ongoing episode of care pilot. Diagnostic patterns may vary by provider and provider biases and results may incorrectly estimate the prevalence of malnutrition and anxiety or depression. Additionally, some individuals may be misclassified as having gestational diabetes or pre-existing diabetes—though we would expect this number to be small and not have a meaningful impact on the analysis.

The goal of the pilot is to enroll up to 300 eligible pregnant people per demonstration year. Elements of the analysis may be statistically underpowered to detect differences attributed from the pilot given the limitations of a pilot of this size. Similarly, stratified analyses by race/ethnicity and geography could result in small sample sizes, limiting our ability to detect statistically significant effects. In addition, there may be a number of participants whose pregnancy does not end in a live birth, which may have an impact on our analyses. Depending on the size of this group, we will adjust our analyses to account for differences in their experience of the pilot and subsequent outcomes.

Comparing pregnant people who do or do not receive home delivered meals could result in misclassification in both directions. For example, beneficiaries enrolled in the pilot may not receive their meals for a variety of reasons such as theft or scheduling difficulties. Whereas those in the comparison group, not receiving meals, may receive equivalent nutrition from sources outside of the pilot and not captured in this analysis.

To address potential implementation gaps and resulting evaluation biases, this analysis will conduct up to 20 interviews with MCOs, DMAHS staff, and other key informants to understand the implementation of this pilot. While we expect these interviews to enhance our understanding of the pilot, the interviews are focused on indirect reporters and not the beneficiaries themselves, which will limit our ability to interpret the impact of the pilot for beneficiaries. Further analyses using beneficiary surveys or interviews would add substantially to the cost of the evaluation. These could be added if deemed appropriate.

[65] DeSilvey et al., "An Overview of Food Insecurity Coding in Health Care Settings: Existing and Emerging Opportunities."

Appendix 5.1: In-depth key informant implementation interviews

Goal: 60 minutes

Purpose of the Interview

I am speaking with you today because you were identified as a key informant in the State's Medically Indicated Meals pilot. The Medically Indicated Meals pilot is a Medicaid 1115 demonstration project that started in 2025. The pilot supports up to 300 eligible pregnant people with a diagnosis of either pre-existing diabetes and/or gestational diabetes through home delivered, medically indicated meals. The overarching goal of the pilot is to improve perinatal and postpartum outcomes and expenditures.

We are interested in your experiences with the implementation of the Medically Indicated Meals pilot thus far as a ***{say role: administrator, subject matter expert, provider, advocate}*** *and any recommendations you have to make the pilot better.*

Question Bank

1. First, tell me a little bit about your specific role or relationship to the medically indicated meals pilot and how long you've been in that role?

2. Which key entities are collaborating to implement and operationalize the medically indicated meals pilot. How were they identified, and what are their main roles?
   Probe: *How and why have the roles or participation of those key entities changed throughout the demonstration period?*

3. What lessons have you learned about promising practices for identifying and engaging members to participate in the medically indicated meals pilot?
   a. What strategies or tools were used to identify or engage members? If relevant, how and why were any strategies or tools adapted during the course of the pilot?
   b. What role did NJ's Perinatal Risk Assessment play?
   c. Did you observe any differences in engagement in the pilot by race/ethnicity/geography/gender or other demographic or geographic characteristics?

4. Thinking about participation in the medically indicated meals pilot, what are some facilitators and barriers that you have observed that members experienced in agreeing to participate? If members choose not to participate, do you know why? What does this information suggest about the need for refinements to member outreach?

5. Were meal contents sufficiently nutritious, storable/packable, and appealing to support successful assembly, delivery, and consumption by the member?
   Probe: *How do entities assess whether members are receiving and using the meals for their own nutritional needs?*

6. Do participating members stay enrolled in the medically indicated meals pilot for as long as meals were offered to them? What do you think are some reasons members dropped out of the pilot?

7. [*For MIM vendors only]:* How did you view your role as a vendor in the MIM pilot? What level of interaction was there with participating members? Can you share a bit more about your experience carrying out the pilot?
   Probe: *Were members able to communicate directly with vendors to provide real-time feedback on meals, scheduling difficulties, preferences, etc.?*

8. Thinking about the food insecurity of members, was there any way to know or track whether participating members were more likely to enroll in WIC, SNAP, or other similar social services?
   Probe: How do you think participation in the pilot impacted participating members' health-related social needs (including food insecurity), if at all?

9. *[If infrastructure dollars are used for the Medically Indicated Meals pilot]:* What infrastructure did key entities develop or acquire using demonstration funds? What did you learn about promising practices to build infrastructure to support this pilot and other health related social needs benefits like it?

10. Thinking about the pilot and how it was rolled out, what are 1-2 recommendations you would make to ensure the State meets its goals of supporting pregnant people with pre-existing diabetes and/or gestational diabetes?
    Probe: *What strategies would you use to overcome barriers? What components of the pilot worked well? What should be changed?*

11. Before we close, is there something else about the medically indicated meals pilot that you would like to share that hasn't been covered?

12. Who else might I talk to get insights?

Demographics

I'd like to end with some basic demographic questions to help us describe who we interviewed. Remember, your personal identification will not be linked with any of your answers. You may choose to skip any of these questions.

13. What is your formal training?

14. How many years have you worked at *{organization name}*?

15. How many years have you worked in health care?

16. What is your gender identity?

17. Do you identify as Hispanic or Latino?

18. What is your race?

19. In the workplace, what languages do you speak most often?

Thank you for taking the time to talk to us. We learned so much about how the Medically Indicated Meals Pilot is going. If you have additional comments or questions, please don't hesitate to contact us.

6. Continuous Eligibility for MAGI Adults

A. General Background Information

In this section, we describe plans to evaluate the impact of a policy change that enables 12 months of continuous eligibility for adults whose Medicaid eligibility is based on Modified Adjusted Gross Income (MAGI). CMS is authorizing the continuous eligibility initiative to support consistent coverage and continuity of care by keeping beneficiaries enrolled for 12 months, regardless of income fluctuations or other changes that would affect eligibility (except for death or ceasing to be a resident of the state). Eligible beneficiaries are adults age 19 to 64 with incomes up to 138% FPL.

Upon state submission and CMS acceptance of the protocol described in STC 14.13, the state is authorized to provide continuous eligibility for the populations and associated durations specified in STC 5.16.a, regardless of the delivery system through which these populations receive Medicaid benefits. For individuals who qualify for 12 months of continuous eligibility, the continuous eligibility period begins on the effective date of the individual's eligibility under 42 CFR 435.915, or the effective date of the most recent renewal of eligibility. Given individuals are continuously eligible regardless of changes in circumstances (except as provided under STC 5.16.c), the state will conduct renewals of eligibility consistent with 42 CFR 435.916 at the end of the individual's continuous eligibility period.

A growing body of literature has found Medicaid "churn" (when beneficiaries move in and out of Medicaid coverage) results in poorer quality and delayed health care access, increased administrative costs, less predictable state expenditures, and higher monthly health care costs.[66] Coverage disruptions can happen for a variety of reasons, the most common being income fluctuation from irregular sources of employment.[67] This phenomenon disproportionately impacts low-income adults who are more likely to lose eligibility for a brief period of time as a result of seasonal employment, overtime pay, or other irregularities, only to reenroll when the additional income period ends and they become eligible once again.[68] When this re-enrollment occurs with such frequency, the health care issues associated with lack of coverage in the interim, and the disruption of coverage become an issue for the Medicaid program to address both clinically and financially.

Using a simulation model of twelve months of continuous eligibility, one study found a 30% reduction in the number of people churning when reenrolling in Medicaid. Moreover, the authors concluded a

[66] Anna L. Goldman and Benjamin D. Sommers, "Among Low-Income Adults Enrolled In Medicaid, Churning Decreased After The Affordable Care Act: This Study Examines Whether the Affordable Care Act's Expansion of Medicaid Eligibility Had an Impact on Coverage Disruptions – Known as 'Churning' – among Medicaid Enrollees.," *Health Affairs* 39, no. 1 (January 1, 2020): 85–93, https://doi.org/10.1377/hlthaff.2019.00378; Sarah Sugar et al., "Medicaid Churning and Continuity of Care: Evidence and Policy Considerations Before and After the COVID-19 Pandemic" (Assistant Secretary for Planning and Evaluation, Office of Health Policy, April 2021); Katherine Swartz et al., "Reducing Medicaid Churning: Extending Eligibility For Twelve Months Or To End Of Calendar Year Is Most Effective," *Health Affairs* 34, no. 7 (July 2015): 1180–87, https://doi.org/10.1377/hlthaff.2014.1204.

[67] Goldman and Sommers, "Among Low-Income Adults Enrolled In Medicaid, Churning Decreased After The Affordable Care Act."

[68] Swartz et al., "Reducing Medicaid Churning."

20% increase in people who were covered for a full year.[69] Continuous coverage may reduce periods of uninsurance and underinsurance while improving continuity of care. New Jersey is seeking to test the impact of continuous coverage for MAGI adults age 19 to 64 with incomes up to 138% FPL. For the population receiving extended coverage under this proposed renewal, the delivery system and benefit package would remain unchanged, building upon already approved elements of the demonstration.

B. Evaluation Hypotheses and Questions

We posit that continuous eligibility will minimize coverage gaps and maintain continuity of access to program benefits and continuity of care, thereby improving health outcomes. Continuous coverage may lead to improved outcomes by improving continuity of care or reducing periods of underinsurance or uninsurance. This would ultimately lead to improvements in experience of care and outcomes, and it could lead to potential reductions in future expenditures.

Below we present the *driver diagram* (Figure 6.1: MAGI Adults Continuous Coverage Driver Diagram) that delineates the pathway from the policy change to improved outcomes. Here the secondary drivers represent the various services available to MAGI adults.

Figure 6.1. MAGI Adults Continuous Coverage Driver Diagram

Aim	Primary Drivers	Secondary Drivers
1.A. Improve duration of enrollment during extension period. 1.B. Improve access, continuity, and quality of care. -Improve access to ambulatory care visits (e.g., preventative care). -Reduce ED visits, overall hospitalizations, and avoidable hospitalizations.	Full Medicaid State plan services for eligible MAGI adults.	• Consistent coverage for Medicaid benefits for 12 months, regardless of income fluctuations or other changes that would otherwise affect eligibility for adults age 19 to 64 with incomes up to 138% FPL.
⟸	Causality	⟸

We next detail the hypotheses and corresponding research questions that help assess the impact of ensuring continuous coverage to eligible MAGI adults. These are also summarized in Table 6.2.

Hypothesis 1: Extending continuous coverage for MAGI adults will result in improved access, continuity, and quality of care among eligible beneficiaries.

[69] Swartz et al.

Research Question 1a: What is the impact of providing 12 months of continuous eligibility to adults age 19-64 whose Medicaid eligibility is based on MAGI on **enrollment, utilization, and quality of care**?

Research Question 1b: What is the impact of providing 12 months of continuous eligibility to adults age 19-64 whose Medicaid eligibility is based on MAGI on **avoidable hospitalizations and associated spending**?

C. Methodology

Table 6.1. Inventory of Measures

Measure		Brief Description
Enrollment		
1.	Medicaid enrollment	Total number of months enrolled during study period. Enrollment gaps: the number of months between two enrollment periods for an enrollee.[70]
Hospital and emergency department (ED) utilization		
2.	Inpatient hospitalizations	Individuals receive inpatient hospital treatment for pregnancy and childbirth, surgery, or for nonsurgical medical treatment.
3.	ED treat-and-release visits	Individuals seek ambulatory care in the emergency department because of pregnancy and childbirth, for surgery, or for nonsurgical medical treatment.
4.	ED visits for behavioral health conditions	Number of ED visits for behavioral health conditions among Medicaid recipient (e.g., SUD, OUD, or mental health dx).
Access to, continuity of, and quality of ambulatory care		
5.	Ambulatory preventative care visit	Individuals seek ambulatory care in an outpatient setting, measured by number of office-visits per month.[71] Percentage with any primary care visits in a year.
6.	Continuity of primary care among those with 2 or more visits	The Continuity of Care Index (COCI): the number of visits to the most frequent physician divided by

[70] Bradley Corallo et al., "Medicaid Enrollment Churn and Implications for Continuous Coverage Policies" (Kaiser Family Foundation, December 14, 2021), https://www.kff.org/medicaid/issue-brief/medicaid-enrollment-churn-and-implications-for-continuous-coverage-policies/; Jamie R. Daw et al., "Women In The United States Experience High Rates Of Coverage 'Churn' In Months Before And After Childbirth," *Health Affairs* 36, no. 4 (April 1, 2017): 598–606, https://doi.org/10.1377/hlthaff.2016.1241.

[71] Eric T. Roberts and Craig Evan Pollack, "Does Churning in Medicaid Affect Health Care Use?," *Medical Care* 54, no. 5 (May 2016): 483, https://doi.org/10.1097/MLR.0000000000000509.

		the total number of visits that patient had overall.[72]
7.	Avoidable hospitalizations	Rates of ACS inpatient (IP) hospitalizations that may occur due to inadequate ambulatory/primary care within communities.[73]
Spending		
8.	Spending related to total inpatient utilization, total treat-and-release ED visits, and avoidable hospitalizations.	Payments on facility claims for all inpatient and treat-and-release ED visits as well as avoidable hospitalizations that may occur due to inadequate ambulatory/primary care within communities, inflation adjusted.[74]

For hypothesis 1 and research questions 1a-1b

Study population: For examining the overall effect of the continuous coverage provision for MAGI-eligible adults, the study population will be comprised of adults age 19-64 with incomes up to 138% FPL and whose Medicaid eligibility is based on modified adjusted gross income during the demonstration period. Trends among MAGI-eligible adults will be compared between the baseline period (2017-2019), the public health emergency (PHE) period (2020-2023), and after the policy implementation (2024-2028). As a robustness check, models will adjust for periods of PHE and Waiver policy transitions, e.g., by excluding the first quarter of the respective period from the analysis.

Analytic strategy: The analysis will rely upon a repeated cross-sectional design to produce unbiased estimates of individuals enrolled in Medicaid whose eligibility is based on MAGI and examine their outcomes on selected metrics over the demonstration period while they remain continuously enrolled under this policy change.

We will calculate both monthly and yearly enrollment-adjusted rates of outcomes for all beneficiaries ever enrolled under the continuous coverage provision for the demonstration period (i.e., repeated cross sections). A repeated cross-sectional approach allows for good sample representation for a given time period, without necessarily following respondents over time, which is appropriate for this analysis where individuals may experience changes in coverage based on eligibility from year to year. Small sample sizes may limit the monthly analysis, in which case we will rely on pooled cross-sections at the annual level. The repeated cross-sectional rates examine outcomes for all individuals gaining eligibility under the expansion controlling for changes in composition of each year's enrolled population.

[72] Norman Frohlich et al., "Profiling Primary Care Physician Practice in Manitoba" (Winnipeg, MB: Manitoba Centre for Health Policy, August 2006), http://mchp-appserv.cpe.umanitoba.ca/deliverable.php?referencePaperID=51203.
[73] "AHRQ QI: Prevention Quality Indicators Overview," accessed December 12, 2023, https://qualityindicators.ahrq.gov/measures/pqi_resources.
[74] "CPI Inflation Calculator," U.S. Bureau of Labor Statistics, accessed September 6, 2023, https://www.bls.gov/data/inflation_calculator.htm.

We will conduct both descriptive analysis and a regression-based approach. We will first create bar charts or line diagrams to examine trends over time at a monthly and yearly basis dependent on available data and sample size. Next, we will use interrupted time series (segmented regression analysis) to examine the effect on policy groups given there is no available comparison group. Interrupted time series analysis assumes that the policy effect may lead to a change in level, and also a change in the existing time trend of the metric measuring quality or any other relevant outcome of interest. The regression analysis is able to measure this change in trend or level. Potential confounding may arise from factors that determine our outcomes of interest and change at the same time as the policy implementation. However, our multivariate analysis adjusts for demographic and geographic factors to mitigate such effects. Interrupted time series analysis will be an additional strategy to examine the impact of continuous eligibility policies overall on a cohort of MAGI-eligible adults in the absence of a robust comparison group. Standard errors will be cluster-corrected by zip codes to adjust for non-independence of observations. Given the PHE went into effect prior to the policy implementation and this demonstration period, ensuring continuous coverage for 2 additional years, the models for outcomes will be run using three time periods: baseline (2017-2019), the public health emergency (2020-2023), and policy implementation (2024-2028). This will allow us to differentiate between outcomes driven by the PHE and outcomes driven by the policy change.

The model is specified below:

$$Outcome_{it} = \beta_0 + \beta_1(time)_t + \beta_2(policyPHEpost)_t + \beta_3(PHEtime)_t + \beta_4(policypost)_t + \beta_5(policytime)_t + \gamma X_{it} + \varepsilon_{it}$$

$Outcome_{it}$ reflects the outcome of interest for an individual recipient *i* in year t. β represents the coefficients that correspond to each model component. Coefficient β_0 estimates the baseline level of the outcome at the first time period, and coefficient β_1 indicates the baseline trend, i.e., the trend in the outcome prior to the first policy change. The $time$ variable is a continuous variable indicating time in months or calendar years from the start of the study period. The variable $policyPHEpost$ is a binary (0/1) variable for the period during the public health emergency, which initiated a continuous eligibility policy. The variable $PHEtime$ is a continuous variable equaling the number of months (or years) after the corresponding PHE policy change. The variable $policypost$ is a binary (0/1) variable for the period subsequent to the policy changes under the MAGI continuous eligibility policy. The variable $policytime$ is a continuous variable equaling the number of months (or years) after the corresponding MAGI policy change. For interpretability purposes, we will further compare predicted values of outcomes post-policy with counterfactual values (that simulate a scenario where the policy implementation did not occur). We will further compute whether this difference is statistically significant.

Table 6.2: Summary of Questions, Hypotheses and Methodology

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
Hypothesis 1: Extending continuous coverage for MAGI adults will result in improved access, continuity, and quality of care among eligible beneficiaries.				
RQ1a: What is the impact of providing 12 months of continuous eligibility to adults age 19-64 whose Medicaid eligibility is based on MAGI on enrollment, utilization, and quality of care?	-Medicaid enrollment -Outpatient preventative care visits -ED utilization -Inpatient hospitalizations -Continuity of outpatient preventative care visit (primary care) -ED visits for behavioral health conditions	Outcomes among MAGI-eligible adults age 19-64 will be compared between the baseline period (2017-2019), PHE period (2020-2023), and policy implementation period (2024-2028).	Medicaid Fee-for-Service and Encounter Claims Records	Examine trends in outcomes, descriptive, cross-sectional analysis
RQ1b: What is the impact of providing 12 months of continuous eligibility to adults age 19-64 whose Medicaid eligibility is based on MAGI on avoidable hospitalizations and associated spending?	-Avoidable hospitalizations Spending related to: -Total inpatient utilization -Total treat-and-release ED visits -Avoidable hospitalizations	Avoidable hospitalizations and associated spending among MAGI-eligible adults age 19-64 will be compared between the baseline period (2017-2019), PHE period (2020-2023), and policy implementation period (2024-2028).	As above	As above

Table 6.3 shows an activity timeline for the research activities.

Table 6.3 Key Milestones, Continuous Eligibility for MAGI Adults

Analytic Activity	Year 1 2025	Year 2 2026	Year 3 2027	Year 4 2028	Year 5 2029	Year 6 2030
1. Enrollment, quality of care, health service utilization, and spending assessment: Analyze MMIS data (RQ1a, RQ1b)	Define appropriate population and customized metrics for MMIS analysis (includes program cost variables)	Begin analysis of MMIS-based utilization and quality metrics	Complete interim analysis		Conduct analysis	Complete analysis
2. Submit reports to CMS			Interim report			Final report

RQ=Research Question.

NOTE: Evaluation project years are March-Feb. (subject to change depending on date of authorization to begin).

D. Methodological Limitations

This analysis has several limitations. First, claims data may not have included all relevant visits and services therefore some data may be missing from this analysis. Secondly, some individuals may be misclassified in their Medicaid eligibility, but we expect that number to be negligible to this analysis overall. Moreover, this analysis lacks an appropriate comparison group such that findings from this analysis do not reflect a causal relationship. Additionally, there may be other exogenous events driving the differences and changes in the composition of the MAGI population over time. Lastly, it may be difficult to differentiate between the PHE and policy implementation and the continuous coverage that has been in place since 2020 as a result of the PHE and continued on through the waiver. A sensitivity analysis will adjust for periods of PHE and waiver policy transitions (e.g., excluding the first quarter of the respective period from the analysis).

7. Community Health Worker (CHW) Pilot Programs

A. General Background Information

Community Health Workers (CHWs) can play critical roles in enhancing care coordination, addressing disparities, and improving outcomes for Medicaid beneficiaries. Various health care providers and entities, community-based organizations, managed care organizations (MCOs), and New Jersey state agencies actively engage CHWs in a variety of roles throughout the state. To build on this existing work, and support, advance and assess the efficacy of CHWs within NJ FamilyCare, the Centers for Medicare and Medicaid Services (CMS) has granted an expenditure authority of $5 million per year for the length of the New Jersey FamilyCare 1115 Comprehensive Demonstration period (2023-2028). Funds will support CHW pilot programs administered by NJ FamilyCare MCOs in collaboration with DMAHS and various community partners.

For the purposes of this pilot, the State's pilot strategy aligns with the Centers for Disease Control and Prevention's (CDC) definition of Community Health Workers (CHWs) who are defined as: non-clinical frontline public health workers who are members of or have a close understanding of the communities they serve. Acting as a liaison between health and social services, CHWs aim to facilitate access to care through enhancing communication and understanding. CHWs may engage their communities through a range of activities such as outreach, education, counseling, social support and advocacy.

To participate in the pilot, MCOs must submit a proposal that represents an innovative approach to the CHW Demonstration. Proposals will go through a review process by DMAHS and Rutgers Center for State Health Policy (CSHP). After preliminary approval by DMAHS, CMS must review the proposed pilots per the 1115 Demonstration Implementation Protocol. Upon receiving formal CMS approval, DMAHS will grant final approval of the proposals to initiate implementation as well as specific reporting and monitoring requirements.

Pilot programs must include interventions that target a specific Medicaid or CHIP population with, or at-risk of, a chronic condition. For the purposes of the pilot, chronic conditions are defined broadly as health conditions or diseases that are persistent or have long-lasting effects and may limit activities of daily living and/or require ongoing medical attention, including physical and behavioral health conditions. Additionally, the proposal must describe the target population in detail, including demographic characteristics, and must describe how individuals will be identified using available data, including technical details of inclusion/exclusion criteria and the process the MCO will use to identify members for intervention and/or control groups.

The intervention description must clearly define how CHWs will work with members or caregivers to access services, community resources, and/or offer resources that aid in the adoption of healthy behaviors to address the identified chronic condition. The description must include standardized duties and responsibilities of the CHWs including the specific education or activities the CHWs will perform under the pilot. The description must define an intervention that is specific and scalable. Additionally, the proposal should describe how the initiative will be aligned with or be integrated into the broader health care delivery system.

MCOs must propose a control or comparison group for the purposes of evaluating the impact of the proposed intervention. A randomized control group (e.g., cluster randomization by member zip code or primary care provider, as appropriate for the pilot design) is strongly preferred wherever feasible – if the MCO is not proposing randomization, it must explain in its proposal why it believes randomization is not feasible, and how it will select the comparison group to ensure comparability to the intervention group. The proposal must detail how data on the control or comparison group will be collected and reported pre- and post- implementation. Proposals will be reviewed by Rutgers CSHP and approved by DMAHS.

The proposals must include a description of anticipated impacts in terms of quantitative metrics such as utilization of services, healthcare expenditures, outcomes of care, or patient experience of care. In addition, the proposal should contain a description of any planned qualitative measures. Wherever applicable, the use of CMS Core Quality measures is recommended. If metrics other than or in addition to Child and Adult Core Sets measures are proposed, the sources of those measures, reasons for their selection, and documentation of their validity (if available) should be provided. The proposal should specify the platform or other technology that is planned for tracking CHW activities, if known. The metrics must be aligned with the milestones expected to be met through the initiative.

The driver diagram below shows the primary and secondary drivers toward the aim of improved health outcomes and reduced disparities in care. We hypothesize exposure to CHWs will improve members' access to care, leading to reduced avoidable utilization, and increased recommended utilization. We also hypothesize CHWs will influence and improve the members' self-efficacy, healthy behaviors, and assist them in addressing health-related social needs, which should improve their ability to care for themselves in a way that improves their health.

Figure 7.1. CHW Aims Driver Diagram

Aim	Primary Drivers	Secondary Drivers
For Medicaid/CHIP populations with or at risk of chronic conditions, use of CHWs will improve health outcomes and reduce disparities in care	• Improved access to care • Better matching between members and needed types of care • Improved patient self-efficacy • Healthier behaviors	• Enhanced care coordination • Improved member experience of care • Culturally competent teaching and support • Assistance with health-related social needs
⟸ Causality ⟸		

B. Evaluation Questions and Hypotheses

There may be up to five (5) separate CHW interventions, one for each MCO. Where feasible, Rutgers CSHP will use common research designs, measures and instruments across the interventions and aligned with national research efforts (e.g., implementation science literature and the CHW Common Indicators Project by the National Association of Community Health Workers); however,

the evaluation will need to be tailored to each intervention, possibly requiring up to 5 evaluations with distinct measures and study designs. We describe below a general framework we will use in the designs of the evaluations, once the MCO projects are finalized. Our framework is influenced by previous work we have done in New Jersey which found significant improvements in healthy behaviors in a small CHW intervention, but no significant improvements in utilization.[75] Given that the MCOs will likely have different programs, our ability to detect effects in less common events such as hospital utilization may be limited, so we measure different more common, proximate impacts, such as self-reported behaviors. We are also cognizant of the fact that outreach and education interventions are becoming more common as their importance is recognized, and that comparison group members may have received such interventions from sources other than their MCO. Exposure to such interventions may limit our ability to detect effects of the CHW interventions. We will address this challenge by asking survey questions designed to identify such exposures, allowing us to employ analysis strategies (e.g., exclude comparison group members enrolled in similar interventions) to allow us to produce the most informative evaluation results.

The evaluation hypotheses focus on key anticipated outcomes of the CHW projects. In addition, to the extent supported by sample sizes and the diversity of program enrollment, under each hypothesis and research question we will examine the extent to which the projects address disparities in outcomes. Finally, to strengthen inferences about project impacts, we will examine whether dose-response relationships are observed, e.g., whether more intensive engagement with CHWs is associated with greater improvements in outcomes. In dose-response analyses, we will use caution in interpreting findings, which may be confounded by participant self-selection or motivation to improve.

H1: Quality-of-care outcomes for members served by CHWs will show more improvement than outcomes for comparison group members.

- RQ1a-z (for each type of quality-of-care outcome): What is the difference in outcome measures between members served by CHWs and comparison group members (for example, are members with diabetes served by CHWs more likely to have A1c testing done than comparison group members with diabetes who were not served by CHWs)? Is there a dose-response relationship, where members having more CHW engagement have better outcomes? Are there reduced disparities among members served by CHWs compared to those served by comparison group members?

H2: Avoidable health service utilization will show more improvement for members served by CHWs than for comparison group members.

- RQ2a-z (for each type of health service utilization measured, such as avoidable emergency department visits and preventable hospitalizations): What is the difference in utilization between members served by CHWs and comparison group members? Is there a dose-response relationship, where members having more CHW engagement have less avoidable

[75] Cantor JC, Chakravarty S, Agrawal A, Nova J. Impact of the New Jersey In-Home Asthma Intervention Pilot Project on NJ FamilyCare Utilization and Spending. Rutgers Center for State Health Policy, July 2022. https://www.cshp.rutgers.edu/publications/impact-of-the-new-jersey-inhome-asthma-intervention-pilot-project-on-nj-familycare-utilization-and-spending

utilization? Are there reduced disparities among members served by CHWs compared to those served by comparison group members? Measures will be identified based on target populations selected and may include condition-specific measures such as ED visits for asthma or during the pre-natal period, as appropriate.

H3: Recommended health service utilization will show more improvement for members served by CHWs than for comparison group members.

- RQ3a-z (for each type of recommended care, such as preventive care visits): What is the difference in recommended health service utilization between members served by CHWs and comparison group members? Is there a dose-response relationship, where members having more CHW engagement have better recommended service utilization? Are there reduced disparities among members served by CHWs compared to those served by comparison group members?

H4: Patient experience of care metrics will show more improvement for members served by CHWs than for comparison group members.

- RQ4a – What is the difference in experience of care survey metrics between members served by CHWs and comparison group members (satisfaction with providers, culturally competent care, etc.)? Is there a dose-response relationship, where members having more CHW engagement have more improvement? Are there reduced disparities among members served by CHWs compared to those served by comparison group members?

H5: Members served by CHWs will show more improvement in favorable healthy behaviors than comparison group members.

- RQ5a – What is the difference in healthy behaviors between members served by CHWs and comparison group members? Is there a dose-response relationship, where members having more CHW engagement have more improvement? Are there reduced disparities among members served by CHWs compared to those served by comparison group members?
- RQ5b – Are members served by CHWs more likely to report that someone discussed healthy behaviors with them compared with comparison group members? Is there a dose-response relationship, where members having more CHW engagement are more likely to report such discussions? Are there reduced disparities among members served by CHWs compared to those served by comparison group members?

H6: Members served by CHWs will show more improvement in having their health-related social needs addressed than comparison group members (e.g., by identifying sources of supplemental food or utility assistance, as needed).

- RQ6a – What is the difference in the incidence of health-related social needs between members served by CHWs and comparison group members? Is there a dose-response relationship, where members having more CHW engagement have more improvement? Are there reduced disparities among members served by CHWs compared to those served by comparison group members?
- RQ6b – Are members served by CHWs more likely to report that someone discussed health-related social needs with them compared with comparison group members? Is there a

dose-response relationship, where members having more CHW engagement are more likely to report such discussions? Are there reduced disparities among members served by CHWs compared to those served by comparison group members?

H7: Key informants selected for their ability to provide insights about program implementation (e.g., CHWs, MCOs, DMAHS, providers or advocacy groups that work with affected members, and state or national experts on CHW) will identify facilitators of, and barriers to successful program implementation.

- RQ7a – What barriers, facilitators, and suggestions for improvement do key informants who work with this beneficiary group identify with respect to the program's ability to improve beneficiary health and reduce disparities in outcomes?

C. Methodology

Hypotheses 1-3 will be addressed with about 12 health-related metrics tailored to each of the MCO pilot programs, as determined by CSHP in consultation with DMAHS and participating MCOs (considering recommended measures such as CMS' Core Sets, where applicable). Our primary analyses will be conducted on an intent-to-treat (ITT) basis (i.e., by assignment to CHW or comparison groups), with supplemental analyses conducted using per-protocol (PP) methods (i.e., comparing members who received CHW services according to MCO plans relative to comparison members).

Metrics will be calculated either by MCOs and provided to CSHP for intervention and comparison group members, or CSHP will calculate the metrics for intervention and comparison group members in MMIS or other data provided to CSHP by DMAHS or the MCOs. For randomized designs, between-group comparisons will be made using appropriate statistical methods (e.g., Analysis of Variance or regression analysis). For non-randomized designs, regression models comparing outcomes for those assigned to CHW support compared to a matched comparison group and, where feasible, difference-in-differences models will be used to estimate intervention-related changes in metrics. Analyses will examine program impact overall and will test for demographic differences in models interacting treatment assignment with, or stratified by, demographic information available in the data such as race/ethnicity, age, language spoken, urbanicity, disability, and sexual/gender minority. Depending on sample sizes and the demographic composition of the pilot interventions, we expect to be limited in the extent to which we can apply formal statistical tests of disparities. In cases where formal tests are not supported by the data, we will conduct descriptive comparisons.

We will consider assigning or augmenting comparison group samples for MMIS-based outcomes using up to five propensity matched Medicaid members. Comparison populations will be limited to those meeting inclusion criteria for the CHW pilot and be based on member demographic and relevant clinical characteristics. Separate analyses will be conducted for each MCO pilot. In addition, to enhance statistical power, where feasible, we will pool analyses for multiple MCOs that focus on the same target populations and use common CHW strategies. To the extent that it is feasible to match claims or clinical data with survey responses and/or process data about the intervention, sensitivity analyses may be used to examine dose-response relationships among

those members receiving the CHW intervention, exercising caution about the attribution of causality to the dose of engagement. We will also measure the extent to which comparison group members have engaged in similar interventions and adjust our analysis strategies accordingly.

Hypotheses 4-6 will be addressed through member surveys conducted twice over the intervention period (upon enrollment and about 12 months later) to be developed and fielded by CSHP (or its data collection subcontractor) to intervention and control group members. Tailored to the content of each CHW pilot intervention, survey questionnaires will be developed in consultation with DMAHS and MCOs. Survey items will be standardized across MCOs to the maximum extent appropriate, with project-specific questions used when necessary. Where feasible, survey items will be drawn from validated or other well-established instruments (e.g., the CDC Behavioral Risk Factor Surveillance System) to ensure validity and enable comparisons to population norms. Questions will address patient experience of care (generally and in relation to pilot-relevant conditions), healthy behaviors (such as exercise, healthy eating, and use of tobacco/alcohol as well as pilot-relevant behaviors), and health related social needs (such as housing, food security, social support, depression/anxiety, and safety, as well as any specific needs designed to be addressed by the pilot). Members will also be asked if anyone has asked them about these topics. Using a confidential study ID, survey responses can be matched to MMIS data and possibly other information about the member. The Appendices contain sample questions CSHP may propose, but the final questionnaires are subject to discussions with DMAHS and the MCOs.

If enrollment exceeds the number of surveys budgeted, pilot participants and comparison group members will be selected probabilistically, and responses will be weighted, to help ensure representativeness. When appropriate and feasible, members who are at high-risk for adverse outcomes being addressed by the pilot will be oversampled. Again, to the extent feasible, participants surveyed at enrollment will be re-surveyed a year later. Samples will include members assigned to a CHW intervention (regardless of the degree to which they participated) and comparison group members. Members will be offered approximately $25 for each completed survey in the form of a gift card. Up to 400 members from each MCO may be recruited for surveys depending on final enrollment numbers. Data analysis strategies will use the same methods discussed above under hypotheses 1-3, as appropriate.

Hypothesis 7 will be addressed through key informant interviews with 15-25 individuals knowledgeable about program implementation and/or CHW policy in NJ and beyond, done shortly after intervention launch and again toward the end of the demonstration, and 5 focus groups of 5-8 community health workers for each MCO will be conducted toward the end of the demonstration. For the individual key informant interviews, each MCO will be invited to nominate staff members to be interviewed, along with relevant staff from DMAHS, providers or advocacy groups that work with affected members, and state or national experts on CHW. The interview guide will be refined in consultation with DMAHS, the MCOs, and other interested parties once pilot details are known. Interviews will be conducted via web conference software or phone. Focus groups will be conducted via web conference software. Both interviews and focus groups will be recorded and transcribed, with participant consent. At least two evaluation team members will independently review the transcripts, develop and apply thematic coding procedures. The results will then be analyzed for themes relating to barriers and facilitators of program implementation, effectiveness of the pilots, and key informant ideas for program improvement. All community health workers will

be asked to complete a brief confidential, on-line screening survey about their CHW experiences and demographics so that CSHP can select a diverse group of CHW focus group participants. CHWs will be offered an incentive gift card of about $10 to complete the screening survey and about $75 for the up to 90-minute focus group. Focus group guides will be refined in consultation with DMAHS, the MCOs, and other interested parties once pilot details are known. As with the member survey, questions will be standardized across MCOs to the maximum appropriate extent, with project-specific questions used when necessary.

Table 7.1: Summary of Questions, Hypotheses and Methodology

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
Hypothesis 1: Quality-of-care outcomes for members served by CHWs will be better than outcomes for comparison group members.				
RQ1a-z (for each type of quality-of-care outcome): What is the difference in outcome measures between members served by CHWs and comparison group members? Is there a dose-response relationship, where members having more CHW engagement have better outcomes?	Measures will be identified based on target populations selected and may include condition-specific measures such as HbA1c testing for members with diabetes.	Members served by CHWs Comparison group members, selected using sampling or matching techniques which maximize comparability.	Claims/encounter data from MMIS or provided/calculated by MCOs	Regression for randomized designs; Difference in difference for non-randomized designs
Hypothesis 2: Avoidable health service utilization will be lower for members served by CHWs than for comparison group members.				
RQ2a-z: (for each type of health service utilization measured, such as avoidable emergency department visits and preventable hospitalizations): What is the difference in utilization between members served by CHWs and comparison group members? Is there a dose-response relationship, where members having more CHW engagement have less avoidable utilization?	Avoidable/preventable hospital use Measures will be identified based on target populations selected and may include condition-specific measures such as ED visits for asthma or during the pre-natal period, as appropriate.	Members served by CHWs Comparison group members, selected using sampling or matching techniques which maximize comparability	Claims/encounter data from MMIS or provided/calculated by MCOs	Regression for randomized designs; Difference in difference for non-randomized designs
Hypothesis 3: Recommended health service utilization will be higher for members served by CHWs than for comparison group members.				

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
RQ3a-z: (for each type of recommended care, such as preventive care visits): What is the difference in recommended health service utilization between members served by CHWs and comparison group members? Is there a dose-response relationship, where members having more CHW engagement have better recommended service utilization?	Measures will be identified based on target populations selected and may include condition-specific measures such as primary care visits, HbA1c testing where relevant, etc.	Members served by CHWs Comparison group members, selected using sampling or matching techniques which maximize comparability	Claims/encounter data from MMIS or provided/calculated by MCOs	Regression for randomized designs; Difference in difference for non-randomized designs
Hypothesis 4: Patient experience of care metrics will be higher for members served by CHWs than for comparison group members.				
RQ4a: What is the difference in experience of care metrics between members served by CHWs and comparison group members (satisfaction with providers, culturally competent care, etc.)? Is there a dose-response relationship, where members having more CHW engagement have more improvement?	Measures will be identified based on target populations selected and may include condition-specific measures such as satisfaction related to condition-specific care as well as cultural competence.	Members served by CHWs Comparison group members, selected using sampling or matching techniques which maximize comparability	Member surveys	Regression for randomized designs; Difference in difference for non-randomized designs
Hypothesis 5: Members served by CHWs will have more favorable healthy behaviors than comparison group members.				
RQ5a – What is the difference in healthy behaviors between members served by CHWs and comparison group members? Is	Measures will be identified based on pilot targeted behaviors and may include condition-specific behaviors if targeted by the pilot as well as more	Members served by CHWs	Member surveys	Regression for randomized designs;

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
there a dose-response relationship, where members having more CHW engagement have more improvement?	general behaviors like exercise, healthy eating, and use of tobacco/alcohol.	Comparison group members, selected using sampling or matching techniques which maximize comparability		Difference in difference for non-randomized designs
RQ5b – Are members served by CHWs more likely to report that someone discussed healthy behaviors with them compared with comparison group members? Is there a dose-response relationship, where members having more CHW engagement are more likely to report such discussions?	Measures will be identified based on target populations selected and may include discussions about specific conditions, as appropriate.	Members served by CHWs Comparison group members, selected using sampling or matching techniques which maximize comparability	Member surveys	Regression for randomized designs; Difference in difference for non-randomized designs
Hypothesis 6: Members served by CHWs will be more likely to have their health-related social needs addressed than comparison group members				
RQ6a – What is the difference in the incidence of health-related social needs between members served by CHWs and comparison group members? Is there a dose-response relationship, where members having more CHW engagement have more improvement?	Questions selected from tool such as https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf , based on what CHWs are using with members	Members served by CHWs Comparison group members, selected using sampling or matching techniques which maximize comparability	Member surveys	Regression for randomized designs; Difference in difference for non-randomized designs

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
RQ6b – Are members served by CHWs more likely to report that someone discussed health-related social needs with them compared with comparison group members? Is there a dose-response relationship, where members having more CHW engagement are more likely to report such discussions?	Wording to be determined in consultation with MCOs depending on CHW scope	Members served by CHWs Comparison group members, selected using sampling or matching techniques which maximize comparability	Member surveys	Regression for randomized designs; Difference in difference for non-randomized designs
Hypothesis 7: Key informants will identify facilitators of, and barriers to successful program implementation.				
RQ7a – What barriers, facilitators, and suggestions for improvement do key informants identify?	Questions to be determined based on demo implementation	Key informant interviews at time 1 with interviews and focus groups at time 2. Stratify feedback by institutional location and individual factors *such as* demographics, training, experience, or other characteristics that align with differences in perspectives.	Key informant interviews (15-25) at beginning and toward end of demo CHW focus groups toward the end of demo period	Qualitative thematic analysis

Table 7.2 shows an activity timeline for the research activities.

Table 7.2 Key Milestones, Community Health Worker (CHW) Pilot Programs

Analytic Activity	Year 1 2025	Year 2 2026	Year 3 2027	Year 4 2028	Year 5 2029	Year 6 2030
1. Quality of care and health service utilization assessment: Link and analyze MCO and MMIS or related administrative measures (RQ1-3)	Work with MCOs to identify 12 health-related metrics tailored to each MCO Execute data use agreements to link MCO data and other admin data (data set start date may vary by MCO and measure)	Finalize linkage of data sets Specify comparison group for each MCO and conduct baseline analysis	Complete baseline analysis of linked administrative data		Conduct analysis of linked administrative data	Complete analysis
2. Patient experience and behavior assessment: MCO members (RQ4-6)	Identify survey vendor and execute contract Work with DMAHS and MCOs to develop member survey instrument and member list	Work with vendor to conduct baseline member surveys (N=400 per MCO, including comparison group) Begin to analyze member surveys	Finish analyzing member surveys	Work with vendor to conduct follow-up member surveys (N=400 per MCO, including comparison group) Begin to analyze member surveys	Continue to analyze member surveys	Complete analysis

Analytic Activity	Year 1 2025	Year 2 2026	Year 3 2027	Year 4 2028	Year 5 2029	Year 6 2030
3. Qualitative implementation assessment (RQ7a)	Review documents, observe meetings Conduct and analyze N=15-25 KIIs	Update document review and meeting observations as needed	Update document review and meeting observations as needed	Review documents, observe meetings Conduct and analyze N=15-25 KIIs Conduct CHW focus group screening survey (N= all CHWs) Conduct CHW focus groups (N=25-40)	Update document review and meeting observations as needed Finish analysis of CHW focus groups	Complete analysis
4. Submit reports to CMS			Interim report			Final report

KII=key informant interviews; RQ=Research Question.

NOTE: Evaluation project years are March-Feb. (subject to change depending on date of authorization to begin).

D. Methodological Limitations

It is difficult to fully specify the evaluation designs before pilot projects are proposed, reviewed, and approved to proceed. Thus, the design described here includes contingency plans. Further, as intervention plans are approved, we will work closely with DMAHS and the MCOs to develop written final evaluation protocols for each pilot that ensure feasibility and rigor.

Hypotheses 1-3 – May be limited by enrollment numbers, including unique pilot features that preclude combination of members across MCOs. Many metrics have inclusion/exclusion criteria that could reduce the numbers of included members. We will pool evaluation samples across MCOs, when possible.

Hypotheses 4-6 – Survey results may be limited by sample sizes, response rates, pilot enrollment numbers, and unique pilot features that preclude combination of members across MCOs. There is a risk that survey participants will not be representative of pilot participants or comparison groups. We will use the following procedures to minimize that risk. We will seek to sample CHW participants and comparison group members from member lists and strongly recommend against using non-systematic sampling techniques (e.g., broadly distrusting invitations seeking volunteers) or anonymous surveys, as these methods would greatly compromise our ability to distinguish intervention from comparison groups, enrich survey data with MMIS other member information, match responses at baseline and 12 months later, and protect against fraudulent survey responses. We anticipate working with a trusted third party (e.g., a survey research firm) to handle member identifiers, and enable CSHP to receive only de-identified data.

Hypothesis 7 – Some interview or focus group subjects may decline participation, leading to possible response bias or limited sample sizes. We typically do not offer financial incentives for key informant interviews as they are generally done by people in the course of their work. For the focus group recruitment, we will include more recently hired CHWs along with those with more tenure to prevent groups composed only of those who have stayed in the position. Because the groups will be done toward the end of the demonstration, we may not be as likely to pick up issues that occurred earlier but have been addressed.

E. Attachments

Appendix 7.1: Survey Question Bank for Medicaid Members Receiving CHW Services

All surveys will contain:

- Questions that probe the respondent's **recent experience with CHW-like interventions** (since many such interventions exist and comparison group members may be receiving outreach from a source other than their MCO).
- Measures of **key respondent characteristics** such as demographic factors and health status, to help us ensure that we are comparing similar intervention and comparison members.

We will work with DMAHS and the MCOs to design surveys that measure the most relevant health-related social needs, care experiences and behaviors for each CHW intervention. Where possible, we will utilize comparable questions so that we can combine surveys across MCOs to maximize the responses available for analysis. To find our questions, we used well-known sources such as the US Census, CDC BRFSS, CAHPS, and CMS' Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool, which contains a variety of validated questions.

Experience with CHW-like interventions – all surveys, possible questions

CHW1. In the past year, has anyone **come to your home** to talk with you about your health and help you identify ways to improve your health? This could include things like figuring out how you can access health care appointments, education about your health, and advice on diet, exercise, and medication management.

1. Yes
2. No

Source: new

[if CHW1=yes]

CHW1a. How many different people have come to your home?

1. One
2. Two
3. Three or more

[if CHW1a>1]

CHW1a1. Did the different person or people have access to information discussed in previous visits, or was it a completely new relationship?

1. Completely new [instruction if CHW1a=2: "When answering questions below, refer to the last person you spoke with."; instruction if CHW1a=3: ""When answering questions below, refer to the last person or people you spoke with who had access to information on previous visits"]
2. Some access to previous information [instruction: "When answering questions below about your experiences, think of all the people you've spoken with who have access to your information"]

CHW1b. How long has it been since your most recent in-person, phone, or video visit with this person/organization?

1. Less than 1 month
2. At least 1 months but less than 3 months
3. At least 3 months but less than 6 months

4. At least 6 months

Source: Modified CAHPS Clinician & Group Visit Adult Survey 4.0 (beta) #3

CHW1c. How many times would you estimate that you talked to someone about these issues, including visits to your home and follow-up voice or video conversations?

1. One time only
2. Two or three times
3. Four or five times
4. More than five times

Source: new

CHW1d. Over what time period have you been seeing this person, or people from this organization?

1. Less than 1 month
2. At least 1 months but less than 3 months
3. At least 3 months but less than 6 months
4. At least 6 months

Source: new

CHW1e. During your visits, did this person explain things in a way that was easy to understand?

1. Never,
2. Sometimes,
3. Usually, or
4. Always?
5. Don't know

Source: Modified CAHPS Home- and Community-Based Services Survey 1.0 #31

CHW1f. During your visits, did this person listen carefully to you?

1. Never,
2. Sometimes,
3. Usually, or
4. Always?
5. Don't know

Source: Modified CAHPS Home- and Community-Based Services Survey 1.0 #32

CHW1g. During your visits, did this person treat you with courtesy and respect?

1. Never,
2. Sometimes,
3. Usually, or
4. Always?

5. Don't know

Source: Modified CAHPS Home- and Community-Based Services Survey 1.0 #28

CHW1h. During your most recent visit, did this person spend enough time with you?

1. Yes, definitely
2. Yes, somewhat
3. No

Source: Modified CAHPS Clinician & Group Visit Adult Survey 4.0 (beta) #17

CHW1i. Using any number from 0 to 10, where 0 is the worst visit possible and 10 is the best visit possible, what number would you use to rate your most recent visit with this person?

0 (Worst visit possible) 1 2 3 4 5 6 7 8 9 10 (Best visit possible)

Source: Modified CAHPS Clinician & Group Visit Adult Survey 4.0 (beta) #21

CHW1j. What went well with this person during your most recent visit? Please explain what happened, how it happened, and how it felt to you. [open end]

Source: Modified Narrative CAHPS Clinician & Group Visit Survey 4.0 (beta) PN3

CHW1k. Was there anything you wish had gone differently during your most recent visit with this person? If so, please explain what happened, how it happened, and how it felt to you. [open end]

Source: Modified Narrative CAHPS Clinician & Group Visit Survey 4.0 (beta) PN4

[if LANG1 (regarding language)=1, ask]

CHW1l. Did this person speak with you in [fill language from LANG1a]?

1. Yes
2. No

[if CHW1j=2]

CHW1l1. How did you communicate with this person? (select all that apply)

1. In English
2. In another language
3. Used interpreter services with a live person [definition "An interpreter is someone who helps you talk with others who do not speak your language"]
4. Used a text or speech to text interpreter application like Google translate
5. A relative or friend translated
6. A child younger than 18 translated
7. Other (specify)

[if more than 1 option selected in CHW1l1, show in followup so they can pick most frequent]

CHW1l1a. How did you communicate most frequently?

1-7 [select one of those selected earlier]

8 Don't know

CHW1m. In your visits with this person, how often were the explanations they gave you hard to understand because of an accent or translation difficulty?

1. Never,
2. Sometimes,
3. Usually, or
4. Always?
5. Don't know

Source: Modified CAHPS Home- and Community-Based Services Survey 1.0 #29

Key Respondent Characteristics/Social Context – all surveys, possible questions

LANGUAGE

LANG1. Do you speak a language other than English at home?

1. Yes
2. No

LANG1a. What is this language [open-end]?

LANG1b. How well do you speak English?

1. Very well
2. Well
3. Not well
4. Not at all

Source: ACS 2024 #14a-c, modified

PHYSICAL/MENTAL HEALTH STATUS

PMH1. In general, how would you rate your overall health?

- Excellent
- Very good
- Good
- Fair
- Poor

Source: CAHPS Health Plan Survey

PMH2. In general, how would you rate your overall **mental or emotional** health?

- Excellent
- Very good
- Good
- Fair
- Poor

Source: CAHPS Health Plan Survey

PMH3. Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions?

- Yes
- No

Source: The AHC Health-Related Social Needs Screening Tool

PMH4. Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping?

- Yes
- No

Source: The AHC Health-Related Social Needs Screening Tool

LON1. How often do you feel lonely or isolated from those around you?

- Never
- Rarely
- Sometimes
- Often
- Always

Source: The AHC Health-Related Social Needs Screening Tool

PHQ1. Over the past 2 weeks, how often have you been bothered by any of the following problems?

PHQ1a. Little interest or pleasure in doing things?

- Not at all (0)
- Several days (1)
- More than half the days (2)
- Nearly every day (3)

PHQ1b. Feeling down, depressed, or hopeless?

- Not at all (0)
- Several days (1)
- More than half the days (2)
- Nearly every day (3)

Source: The AHC Health-Related Social Needs Screening Tool

FINANCIAL STATUS/FOOD SECURITY

Please indicate if each of the following statements is OFTEN, SOMETIMES, or NEVER true for you and your household in the last 12 months:

FS1. Within the past 12 months, you worried that your food would run out before you got money to buy more.

- Often true
- Sometimes true
- Never true

Source: The AHC Health-Related Social Needs Screening Tool

FS2. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.

- Often true
- Sometimes true
- Never true

Source: The AHC Health-Related Social Needs Screening Tool

TRANSPORTATION

TRAN1. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

- Yes
- No

Source: The AHC Health-Related Social Needs Screening Tool

HOUSING/INTERNET ACCESS

HSG1. What is your living situation today?

- I have a steady place to live
- I have a place to live today, but I am worried about losing it in the future
- I do not have a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)

Source: The AHC Health-Related Social Needs Screening Tool

HSG2. Think about the place you live. Do you have problems with any of the following? CHOOSE ALL THAT APPLY

- Pests such as bugs, ants, or mice
- Mold
- Lead paint or pipes
- Lack of heat
- Oven or stove not working
- Smoke detectors missing or not working
- Water leaks
- None of the above

Source: The AHC Health-Related Social Needs Screening Tool

HSG3. Do you have access to the Internet in your home through a cell phone company or internet service provider?

- Yes
- No
- Not sure

Source: Census ACS 2024

DEMOGRAPHICS

HH1. How many children (less than 18 years of age) live in your household? ___

Source: BRFSS

HH2. How many adults (18 years of age or older), including yourself, live in your household? ___

Source: BRFSS

GID1. Do you identify as male, female, or in some other way?

a. Male
b. Female
c. Non-binary
d. Some other way (please specify)
e. Prefer not to answer

AGE1. What is your age?

__[Number]
Prefer not to answer/unsure

Source: Modified CAHPS Clinician & Group Visit Adult Survey 4.0 (beta) #27

AGE2. [For prefer not to answer/unsure above, ask] Would you be willing to tell us whether it's between...

(a) 18 - 24
(b) 25 - 34
(c) 35 – 44
(d) 45 –54
(e) 55 - 64
(f) 65 - 74
(g) 75 or older
(h) Prefer not to answer

Source: Modified CAHPS Clinician & Group Visit Adult Survey 4.0 (beta) #27

ED1. What is the highest grade or year of school you have completed?

1 Never attended school or only attended kindergarten
2 Grades 1 through 8 (Elementary)
3 Grades 9 through 11 (Some high school)
4 Grade 12 or GED (High school graduate)
5 College 1 year to 3 years (Some college or technical school)
6 College 4 years or more (College graduate)

Source: Eagleton Polling, maps to Census categories

HISP1. Are you of Latino or Hispanic origin, such as Mexican, Puerto Rican, Cuban or some other Spanish background?

a. Yes
b. No

Source: Adapted from US Department of Health and Human Services, Office of Minority Health, https://minorityhealth.hhs.gov/explanation-data-standards-race-ethnicity-sex-primary-language-and-disability

RACE1. Are you White, Black or of Asian origin, or are you some other race, or multi-racial? (select all that apply)

a. White (includes Caucasian, European, Middle Eastern)
b. Black (includes African American)
c. Asian (includes Asian-Indian, South Asian, East Asian, Chinese, Japanese)
d. Hispanic / Latino / Spanish
e. Other (please specify) [Open-ended free text]
f. Multi-racial (please specify) [Open-ended free text]

Source: Adapted from US Department of Health and Human Services, Office of Minority Health, https://minorityhealth.hhs.gov/explanation-data-standards-race-ethnicity-sex-primary-language-and-disability

Possible Outcomes to Examine for Improvement, Depending on Pilot

ACCESS TO HEALTHCARE SERVICES

AC1. In the last ___ months, when you needed care right away, how often did you get care as soon as you needed?

- Never
- Sometimes
- Usually
- Always

Source: CAHPS Health Plan Survey

AC2. In the last__ months, how often was it easy to get the care, tests, or treatment you needed?

- Never
- Sometimes
- Usually
- Always

Source: CAHPS Health Plan Survey

HEALTH BEHAVIORS

EX1. In the last 30 days, other than the activities you did for work, on average, how many days per week did you engage in moderate exercise (like walking fast, running, jogging, dancing, swimming, biking, or other similar activities)?

[Dropdown 1-7]

Source: The AHC Health-Related Social Needs Screening Tool

EX2. On average, how many minutes did you usually spend exercising at this level on one of those days? [dropdown 0 ,10, 20, 30 ,40 ,50 ,60,90,120, 150 or greater]

Source: The AHC Health-Related Social Needs Screening Tool

The next questions relate to your experience with alcohol, cigarettes, and other drugs. Some of the substances are prescribed by a doctor (like pain medications), but only count those if you have taken them for reasons or in doses other than prescribed. One question is about illicit or illegal drug use, but we only ask in order evaluate the services provided by your MCO.

SU1. How many times in the past 12 months have you had 5 or more drinks in a day (males) or 4 or more drinks in a day (females)? One drink is 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of 80-proof spirits.

☐ Never ☐ Once or Twice ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily

Source: The AHC Health-Related Social Needs Screening Tool

SU2. How many times in the past 12 months have you used tobacco products (like cigarettes, cigars, snuff, chew, electronic cigarettes)?

☐ Never ☐ Once or Twice ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily

Source: The AHC Health-Related Social Needs Screening Tool

SU3. How many times in the past year have you used prescription drugs for non-medical reasons?

☐ Never ☐ Once or Twice ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily

Source: The AHC Health-Related Social Needs Screening Tool

SU4. How many times in the past year have you used illegal drugs?

☐ Never ☐ Once or Twice ☐ Monthly ☐ Weekly ☐ Daily or Almost Daily

Source: The AHC Health-Related Social Needs Screening Tool

Appendix 7.2: Key Informant Interview Guide

Adapted from: EPIS (exploration, planning, implementation, sustainment) implementation science framework to assess factors affecting implementation; CHW Common Indicators (questions are mapped to Common Indicator categories)

Participants: Key informant groups including state leadership, MCO leadership, and CHW program leadership

Purpose of the Interview

I am speaking with you today because you were identified as a key informant in the State's Community Health Worker (CHW) pilot program. The CHW pilot program is part of a Medicaid 1115 demonstration project aimed at improving health outcomes and reducing disparities in care. It began in [insert start year] and is ongoing. The overarching goal of the program is to leverage CHWs to enhance care coordination, address disparities, and improve outcomes for Medicaid beneficiaries in New Jersey.

We are interested in hearing about your experiences with the CHW pilot program thus far, as well as any recommendations you have to make the program more effective in achieving its goals.

Throughout this interview, we will also share some data with you. We would appreciate your insights to better understand trends in the data.

Obtain Participant Consent to Participate and Audio Record

Question Bank

1. First, tell me a little bit about your specific role or relationship to the CHW program and how long you've been in that role. *Possible probes:*
    a. What sort of setting do you work in? How many CHWs/staff do you work with?
    b. What led you to this role?

2. Could you tell me about a client that received optimal services as part of the CHW program? [CHW ENACTMENT OF THE 10 CORE ROLES; CHW FACILIATED REFERRALS] *Possible probes:*
    a. How often do you think that happens? Why is that?
    b. Are there clients with whom it is more challenging to offer this type of service?
    c. Who else did the CHW work with? [CHW INTEGRATION INTO TEAMS]
    d. In what other situations would CHWs be helpful?
    e. How do you know if things are going well? [SUPPORTIVE AND REFLECTIVE SUPERVISION]

3. Could you tell me about some of your experiences in this program where things went well? [CHW ENACTMENT OF THE 10 CORE ROLES; CHW FACILIATED REFERRALS] *Possible probes:*
    a. Who facilitated adoption of this program?
    b. Who else was involved? [CHW INTEGRATION INTO TEAMS]
    c. Who or what was instrumental in implementing this program?
    d. What characteristics did that person/entity have?
    e. What were changes to patient/client outcomes that you observed? Health outcomes, access to care, reducing disparities? Patient engagement, self-efficacy, and health

behavior change? [PARTICIPANT SELF-REPORTED MENTAL, PHYSICAL, AND EMOTIONAL HEALTH; PARTICIPANT SOCIAL SUPPORT; PARTICIPANT EMPOWERMENT]

4. Could you tell me about experiences in this program where things did not work so well? [CHW ENACTMENT OF THE 10 CORE ROLES; CHW FACILIATED REFERRALS] *Possible probes:*
    a. What were some of the challenges/obstacles?
    b. What are things that could prevent the program from expanding?
    c. How were challenges addressed?

5. What are your experiences with leadership in implementing this program? [SUPPORTIVE AND REFLECTIVE SUPERVISION] *Possible probes:*
    a. What are your experiences with partner organizations?

6. How were CHWs integrated into the broader healthcare delivery system. [POLICY AND SYSTEMS CHANGE] *Possible probes:*
    a. What role did they play in enhancing care coordination and addressing social determinants of health?
    b. How do you envision the role of CHWs evolving in the broader context of healthcare delivery and community-based care coordination?

7. Can you share any insights or lessons learned from the pilot program that could inform future CHW initiatives or similar interventions?

8. Is there anything else you would like to add regarding the outcomes or impact of the CHW pilot program within NJ FamilyCare?

Demographics

I'd like to end with some basic demographic questions to help us describe who we interviewed. Remember, your personal identification will not be linked with any of your answers. You may choose to skip any of these questions.

1. What is your formal training?

2. How many years have you worked at *{organization name}*?

3. How many years have you worked in health care?

4. What is your gender identity?

5. Do you identify as Hispanic or Latino?

6. What is your race?

Thank you for taking the time to talk to us. We learned so much about how the new components of the CHW pilot program are going. If you have additional comments or questions, please don't hesitate to contact us.

Appendix 7.3: CHW Focus Group Screening Survey

Adapted from: CHW Common Indicators

Participants: CHWs across the 5 MCOs

INTRODUCTION

On behalf of Rutgers Center for State Health Policy, thank you for your interest in the evaluation of the Community Health Worker (CHW) Pilot Program. We have asked you to participate because you are a CHW in the CHW Pilot Program. The following brief survey is part of our recruitment for focus groups on the CHW Pilot Program.

PARTICIPANT ELIGIBILITY

1. **Are you currently a CHW in the CHW Pilot Program?**
    a. Yes
    b. No, exit the survey

2. **Do you consent to participate in the survey?**
    a. Yes
    b. No, exit the survey

3. **Are you at least 18 years of age?**
    a. Yes
    b. No, exit the survey

4. **Which MCO (managed care organization) are you a part of?**
    a. Aetna
    b. Fidelis
    c. Horizon
    d. United Healthcare
    e. Wellpoint
    f. None of the above, exit the survey

5. **The following survey is part of our recruitment for an online meeting (Zoom) where we hope to learn from you about your experience in the CHW Pilot Program. The online meeting will be 60-90 minutes. The following survey will take about 20 minutes. Are you interested in participating in the online meeting?**
    a. Yes
    b. No

6. **[If 4 is "Yes"] When would you most likely be able to meet for the online meeting? This will be used to schedule the focus group activity (via Zoom or similar video conferencing tool). Indicate what time you are typically able to meet online (Zoom) for 60-90 minutes.**

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Morning (After 9a-12p)							
Afternoon (After 12p-4p)							
Evening (After 4p-9p)							
Night (After 9p-12a)							

- Other or special circumstances (Please specify)

7. **[If 4. is "Yes"] Please provide your contact details so that we may schedule the interview.**
   - First name:___ [text response]
   - Last name: ___[text response]
   - email address: __ [text response]
   - phone number: __ [text response]
   - Other or special circumstances (Please specify) __ [text response]

SURVEY QUESTION BANK

The following are questions that may be included in the survey instrument.
The final instrument will be shorter, adjusted to MCO feedback after CHW programs are confirmed.

COMPENSATION, BENEFITS, AND OPPORTUNITIES FOR ADVANCEMENT

8. **What is your current hourly rate or annual salary? _____**

9. **What is the FTE of your CHW position (or how many hours per week do you typically work)?** __ FTE or ___ hours per week

10. **Does your employer currently offer you the following benefits? (check all that apply)**
    - Insurance
    - Paid leave/vacation
    - Reimbursement for work-related expenses

- Other benefits

11. Are you eligible for promotions/step-ups with pay increases at your place of employment?

- Yes
- No

CHW ENACTMENT OF THE 10 CORE ROLES

12. What roles do you play as a CHW in this program? (check all that apply)

ROLE	SUB-ROLES
❑ 1. Cultural Mediation Among Individuals, Communities, and Health and Social Service Systems	a. Educating individuals and communities about how to use health and social service systems (including understanding how systems operate) b. Educating systems about community perspectives and cultural norms (including supporting implementation of Culturally and Linguistically Appropriate Services [CLAS] standards) c. Building health literacy and cross-cultural communication
❑ 2. Providing Culturally Appropriate Health Education and Information	a. Conducting health promotion and disease prevention education in a manner that matches linguistic and cultural needs of participants or community b. Providing necessary information to understand and prevent diseases and to help people manage health conditions (including chronic disease)
❑ 3. Care Coordination, Case Management, and System Navigation	a. Participating in care coordination and/or case management b. Making referrals and providing follow-up c. Facilitating transportation to services and helping address barriers to services d. Documenting and tracking individual and population level data e. Informing people and systems about community assets and challenges
❑ 4. Providing Coaching and Social Support	a. Providing individual support and coaching b. Motivating and encouraging people to obtain care and other services c. Supporting self-management of disease prevention and management of health conditions (including chronic disease) d. Planning and/or leading support groups
❑ 5. Advocating for Individuals and Communities	a. Advocating for the needs and perspectives of communities b. Connecting to resources and advocating for basic needs (e.g. food and housing) c. Conducting policy advocacy

❑ 6. Building Individual and Community Capacity	a. Building individual capacity b. Building community capacity c. Training and building individual capacity with peers and among CHW groups
❑ 7. Providing Direct Service	a. Providing basic screening tests (e.g. height, weight, blood pressure) b. Providing basic services (e.g. first aid, diabetic foot checks) c. Meeting basic needs (e.g., direct provision of food and other resources)
❑ 8. Implementing Individual and Community Assessments*	a. Participating in design, implementation, and interpretation of individual-level assessments (e.g. home environmental assessment) b. Participating in design, implementation, and interpretation of community-level assessments (e.g. windshield survey of community assets and challenges, community asset mapping)
❑ 9. Conducting Outreach*	a. Case-finding/recruitment of individuals, families, and community groups to services and systems b. Follow-up on health and social service encounters with individuals, families, and community groups c. Home visiting to provide education, assessment, and social support d. Presenting at local agencies and community events
❑ 10. Participating in Evaluation and Research*	a. Engaging in evaluating CHW services and programs b. Identifying and engaging community members as research partners, including community consent processes c. Participating in evaluation and research: a. Identification of priority issues and evaluation/research questions b. Development of evaluation/research design and methods c. Data collection and interpretation d. Sharing results and findings e. Engaging stakeholders to take action on findings

Source: C3 Project CHW Roles and Competencies Review Checklist
https://www.c3project.org/_files/ugd/7ec423_cb744c7b87284c75af7318614061c8ec.pdf

CHW INTEGRATION INTO TEAMS

13. **How frequently do you communicate with the other healthcare, social service, and/or education providers with whom you work about CHW program participants?** (1= never, 2 = rarely, 3 = occasionally, 4 = often, 5 = constantly)

14. **Do the other healthcare, social service, and/or education providers with whom you work communicate with you in a timely way about CHW program participants?** (1= never, 2 = rarely, 3 =

occasionally, 4 = often, 5 = always)

15. **Do the other healthcare, social service, and/or education providers with whom you work communicate with you accurately about CHW program participants?** (1= never, 2 = rarely, 3 = occasionally, 4 = often, 5 = always)

16. **When an error has been made about CHW program participants, do the other healthcare, social service, and/or education providers with whom you work blame others rather than sharing responsibility?** (1= never, 2 = rarely, 3 = occasionally, 4 = often, 5 = always)

17. **To what extent do the other healthcare, social service, and/or education providers with whom you work share your goals for the care of CHW program participants?** (1 = not at all, 2 = a little, 3 = some, 4 = a lot, 5 = completely)

18. **How much do the other healthcare, social service, and/or education providers with whom you work know about the work you do with CHW program participants?** (1 = nothing, 2 = little, 3 = some, 4 = a lot, 5 = everything)

19. **How much do the other healthcare, social service, and/or education providers with whom you work respect you and the work you do with CHW program participants?** (1 = not at all, 2 = a little, 3 = some, 4 = a lot, 5 = completely)

Thinking about other healthcare, social service, and/or education providers with whom you work, please indicate how much you agree or disagree with the following statements (1= strongly disagree, 4 = strongly agree):

20. I feel isolated from them because of my race/ethnicity or culture.
21. I feel like I have to be the only voice for my race/ethnicity or culture among them.
22. I feel dismissed or devalued by them because of my racial/ethnic or cultural background.
23. I feel they make assumptions about me because of my race/ethnicity or culture.

24. They understand my roles and what I do as a CHW.
- Not at all
- A little
- Some
- A lot
- Completely

25. I feel comfortable going to other healthcare, social service, and/or education providers with whom I work to talk about participants' needs.
- Not at all

- A little
- Some
- A lot
- Completely

SUPPORTIVE AND REFLECTIVE SUPERVISION

26. **How many hours of individual (one-on-one) supervision were provided to you in the last 30 days?**
    One-on-one: _____ hours
    Group: _____ hours

27. **How many hours of group supervision (supervision conducted with more than 1 CHW) were provided to you in the last 30 days?**

28. **Please rate the overall quality of the individual supervision you received within the last 30 days (including administrative and/or clinical supervision)** (1 = poor, 2 = fair, 3 = good, 4 = excellent)

29. **Please rate the overall quality of the group supervision you received in the last 30 days (including administrative and/or clinical supervision).** (1 = poor, 2 = fair, 3 = good, 4 = excellent)

Thinking of the person you consider to be your primary supervisor over the past 30 days, please rate the following items: (1= strongly disagree, 4 = strongly agree)

30. **My supervisor appreciates my role as a CHW.**
31. **My supervisor advocates for the role of CHWs with upper management (staff who rank above the supervisor).**
32. **My supervisor has participated in training about the CHW profession.**
33. **My supervisor encourages my professional growth (e.g., by regularly encouraging me and/or accepting my suggestions within supervision sessions to pursue training opportunities, attend conferences, develop leadership skills, etc.).**
34. **My supervisor understands the strengths and needs of the community/ies we serve.**
35. **My supervisor understands that improving health requires addressing racism and other forms of oppression.**
36. **In my organization, CHWs participate on hiring panels when CHW supervisors are selected.**

CHW CHARACTERISTICS AND DEMOGRAPHICS

37. **How many years have you been working as a CHW? ____**

38. **How many months have you been working in the CHW program? ____**

39. **What is your average patient/client load in the CHW program? ____**

40. **What is your formal CHW training?** [Open text entry]

41. **Do you identify as male, female, or in some other way?**
    a. Male
    b. Female
    c. Non-binary
    d. Some other way (please specify)
    e. Prefer not to answer

42. **To ensure we are reaching people of all ages, would you please tell me your age?** __[Number]
    Prefer not to answer/unsure
    Source: CSHP/Eagleton/Department of Children and Families, IDD Caregiver Survey

43. **[For prefer not to answer/unsure above, ask] Would you be willing to tell us whether it's between...**
    a. 18 - 24
    b. 25 - 34
    c. 35 – 44
    d. 45 –54
    e. 55 - 64
    f. 65 or over
    g. Prefer not to answer
    Source: CSHP/Eagleton

44. **What is the highest degree or level of school you have completed?**

    1 Never attended school or only attended kindergarten
    2 Grades 1 through 8 (Elementary)
    3 Grades 9 through 11 (Some high school)
    4 Grade 12 or GED (High school graduate)
    5 College 1 year to 3 years (Some college or technical school)
    6 College 4 years or more (College graduate)

Source: Eagleton Polling, maps to Census categories

45. **Are you of Latino or Hispanic origin, such as Mexican, Puerto Rican, Cuban or some other Spanish background?**
    b. Yes
    c. No

Source: Adapted from US Department of Health and Human Services, Office of Minority Health, https://minorityhealth.hhs.gov/explanation-data-standards-race-ethnicity-sex-primary-language-and-disability

46. **Are you White, Black or of Asian origin, or are you some other race, or multi-racial?** (select all that apply)
    b. White (includes Caucasian, European, Middle Eastern)
    e. Black (includes African American)
    f. Asian (includes Asian-Indian, South Asian, East Asian, Chinese, Japanese)
    g. Hispanic / Latino / Spanish
    f. Other (please specify) [Open-ended free text]
    g. Multi-racial (please specify) [Open-ended free text]

    Source: Adapted from US Department of Health and Human Services, Office of Minority Health, https://minorityhealth.hhs.gov/explanation-data-standards-race-ethnicity-sex-primary-language-and-disability

Appendix 7.4: CHW Focus Group Guide

Adapted from: CHW Common Indicators (questions are mapped to Common Indicator categories)

Participants: CHWs recruited from the screener survey

Thank you for meeting with us. Over the next 60-90 minutes, we will focus on ways to improve services for people participating in the CHW pilot program in New Jersey. We will ask the group guiding questions. After each question, a prompt will pop-up on your screen with an opportunity write a brief response. We will then share the responses and each member will have the opportunity to explain their answers to the group.

We are aiming to get as many different opinions as possible. We will not be using job titles, degrees, or affiliations. Instead, we will be using first names. For this focus group to be successful, please remember that your perspective cannot be wrong, and your opinion is incredibly valuable to this work. It may be that someone will say something that you disagree with. To encourage everyone to feel free to take part, we will not have a debate or argument over one another's opinions. As mentioned, your perspective cannot be wrong.

Where relevant, we will show up some data from the pilot program and ask for your reflections.

Focus Group Question Bank

1. As a Community Health Worker involved in the pilot program, you're likely assisting individuals in navigating various healthcare decisions. **What three words describe your experience in helping individuals with complex needs access healthcare services and support? These can be positive, negative, or neutral.** [CHW ENACTMENT OF THE 10 CORE ROLES]
   Possible probes:
   a. How has your experience been working as a CHW in the pilot program so far?
   b. What specific roles and responsibilities do you have as a CHW within the pilot program?

2. The pilot program aims to improve access to healthcare and support services for individuals in the community. **How would you describe your experience with the pilot program in facilitating access to necessary services?** [CHW FACILITATED REFERRALS]
   Possible probes:
   a. What improvements would you suggest to enhance the effectiveness of the pilot program?
   b. Can you describe successful interventions or outcomes you've achieved as a CHW in the pilot program?
   c. What challenges have you encountered while serving as a CHW, and how have you addressed them?
   d. Who else do you work with? [CHW INTEGRATION INTO TEAMS]

3. What support or resources do you think CHWs need to be successful in their roles within the pilot program? [COMPENSATION, BENEFITS, AND OPPORTUNITIES FOR ADVANCEMENT]

Possible probes:

a. Tell me about working with your supervisor(s). [SUPPORTIVE AND REFLECTION SUPERVISION]
b. What happens to feedback that you give to your supervisor? To leadership? To the community? [CHW INVOLVEMENT IN DECISION- AND POLICY-MAKING]

4. Please describe any changes you would like to see in the CHW role, should this program be extended or expanded.

   Possible probes:

   a. Level of pay, FTE level, number of hours worked, number of patients/clients) [COMPENSATION, BENEFITS, AND OPPORTUNITIES FOR ADVANCEMENT]
   b. In what ways do you think the CHW pilot program could be improved to better meet the needs of the participants you serve? [CHW ENACTMENT OF THE 10 CORE ROLES]

5. As a CHW, you play an important role in advocating for the needs of individuals in the community. **What message would you like to convey to New Jersey systems leaders regarding the experiences of individuals accessing healthcare services?** [CHW INVOLVEMENT IN DECISION- AND POLICY-MAKING]

8. Tenancy and Housing Supports

A. General Background Information

Lack of affordable, appropriate housing is a critical barrier to wellness for many Medicaid beneficiaries. Unstable housing may lead to avoidable hospitalization, institutionalization, or other instances of high-cost care, negative clinical outcomes, worsening of chronic conditions, and inability to achieve key life goals. We anticipate that housing supports can lead to better care and outcomes for many beneficiaries, particularly for those with serious mental illness, substance use disorders, pregnant individuals, disabilities, formerly incarcerated, older adults, and individuals and families who have experienced or are at risk for homelessness. Unstable housing is also a driver of disparate health and life outcomes among racial and ethnic groups and other vulnerable populations. A 2022 ASPE brief summarizes needs and strategies regarding social determinants of health, including housing.[76]

As part of the NJ FamilyCare Comprehensive Demonstration Waiver approved in March 2023, New Jersey is implementing a multifaceted, integrated housing strategy for Medicaid beneficiaries that incorporates enhancements to infrastructure, coverage for additional targeted services, and coordination across State and community resources involved in the provision of health and housing services. Core elements of this strategy include:

- Strengthened requirements for MCOs to employ dedicated housing specialists;
- Managed Care Organization (MCO) accountability for achieving housing-related goals;
- A newly created and dedicated State office responsible for implementing the above, as well as tracking progress towards key housing-related milestones for Medicaid-related populations;
- Ongoing, enhanced engagement between MCOs and public housing authorities, developers, shelters, and other housing-related community resources; and
- Targeted Medicaid coverage of key housing-related services, including housing transition and tenancy support services.

Each of these elements is described in greater detail below.

Infrastructure

As part of its enhanced focus on housing for vulnerable subpopulations, New Jersey will significantly strengthen the Medicaid infrastructure dedicated to addressing housing needs, fostering greater accountability and focus among both Medicaid MCOs and State staff. This enhanced infrastructure will help ensure that housing-related services are being efficiently and appropriately targeted towards beneficiaries in need. While the State's plan focused specifically on housing-related needs, the Medicaid infrastructure that is developed to implement this initiative

[76] Whitman A., et al. (2022). Addressing Social Determinants of Health: Examples of Successful Evidence-Based Strategies and Current Federal Efforts. Available at https://aspe.hhs.gov/sites/default/files/documents/e2b650cd64cf84aae8ff0fae7474af82/SDOH-Evidence-Review.pdf

may also serve as a platform or model to implement future Medicaid initiatives focused on other social determinants of health.

MCO Housing Specialists (MHSs) and Accountability

Prior to this demonstration initiative, New Jersey's MCO contract required each MCO to employ at least one housing specialist who was responsible for "helping to identify, secure, and maintain community-based housing for MLTSS members and for developing, articulating, and implementing a broader housing strategy within the Contractor to expand housing availability/options."[77] Housing specialists play an important role in transitioning beneficiaries from institutions to community settings and maintaining beneficiaries who require long-term care in the community.

Under the demonstration, New Jersey will enhance contractual requirements around housing specialists, including:

- Establishing caseload requirements for housing specialists based on the number of enrolled beneficiaries eligible for housing-related services, including both MLTSS and other populations (for more on beneficiary eligibility, see "Eligibility" section below);
- Developing specific requirements for regular and timely assessments of beneficiaries' housing needs, and standards around referrals and provision of services for those for whom housing needs are identified;
- Requiring housing specialists to be directly accessible (via phone or secure e-mail) to beneficiaries, beneficiaries' family members or caregivers, providers, and community-based organizations; and
- Requiring housing specialists to use technical platforms (where they are determined to be appropriate and helpful) to coordinate with community-based organizations (CBOs) that provide housing services or other related resources to address social determinants of health.

In addition, the state is expected to establish housing-related standards and requirements for MCOs. In particular, MCOs will be expected to develop sufficient networks (potentially including both traditional providers and other community-based organizations) to meet the need for housing-related services described below. MCOs will also be expected to fully participate in multi-agency and stakeholder working groups established by the DHS Housing Unit (see below). They will also be expected to maintain an inventory of possible housing options (i.e., units and rental assistance) based on information obtained during housing searches for individuals and through regular consultations with housing service providers. In addition, MCOs will be expected to report and be accountable for key performance metrics related to housing-related services, including metrics related to total members assessed, cases open/closed/pending (with reasons/disposition), successful member transitions, utilization of housing-related services, and health equity measures.

Medicaid Housing Unit

To provide infrastructure supporting Medicaid's enhanced focus on housing, DMAHS will create a new staff unit focused on housing-related issues. They believe that this will bring renewed energy

[77] See Article 7, Section 3 of New Jersey's MCO contract, available at https://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-contract.pdf

and focus to Medicaid beneficiaries' housing-related challenges and needs and provide a platform for functional collaboration across State and local government. This unit will have responsibility for a number of functions, including:

- Developing policies and guidance around implementation of new Medicaid-related housing benefits;
- Monitoring and enforcement of the new MCO housing-related contract requirements (described above);
- Maximizing collaboration between DMAHS and other State agencies and departments on housing initiatives, including exploring the possibility of braided funding streams; [78]
- Serving as a bridge between MHSs and other housing stakeholders (see more details in "Enhanced Engagement" section below);
- Leading initiatives and collaborating with sister agencies related to community transitions for nursing facility residents, including Money Follows the Person transitions; and
- Analyzing the level of impact and health equity outcomes, including reporting of performance metrics to CMS.

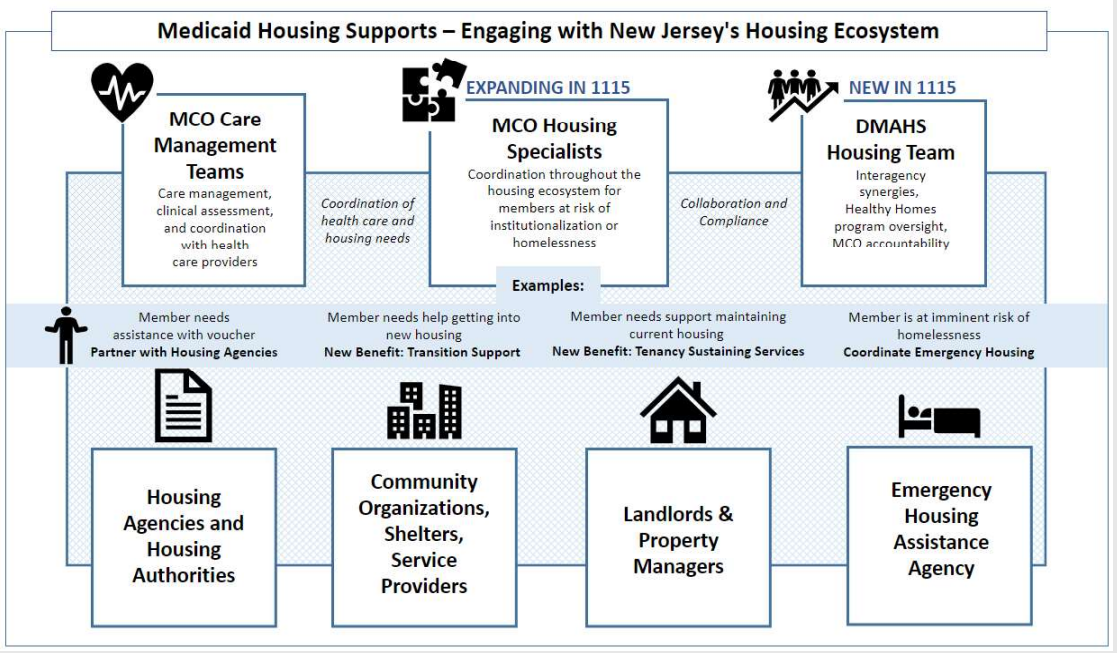
This new unit will create a central locus of accountability for Medicaid-related housing implementation and policy, consistent with Medicaid's envisioned increased involvement in this space and will leverage, rather than replicate, existing work underway at sister agencies.

Enhanced Engagement between Medicaid and Housing Stakeholders

As referenced above, a key responsibility of the Medicaid Housing Unit will be to facilitate connections between DMAHS and MCOs and other housing actors, including housing assistance agencies (e.g., Section 8 and similar programs), CBOs (e.g., shelters and providers of emergency housing assistance like the New Jersey Division of Family Development and county welfare agencies), housing finance organizations (e.g., the New Jersey Housing and Mortgage Finance Agency/HMFA), and other local organizations such as Continuums of Care and Coordinated Entry Programs. The State's goal is to better connect and align Medicaid's involvement with beneficiaries to existing housing systems and supports, and to enhance access to those services rather than replace or duplicate resources or infrastructure that currently operate in this space.

In so doing, the housing unit aims to establish regular multidirectional channels of communication between DMAHS, MCOs, and housing resources. That is, MHSs will be expected to seek assistance from these external partners in identifying appropriate resources for MCO members facing housing challenges. Conversely, housing and other community-based organizations will have a channel to signal MHSs when they have identified a Medicaid beneficiary as experiencing or at-risk of homelessness and in need of additional services or supports (see diagram below).

[78] This will include multiple DHS divisions in addition to DMAHS, including the Division of Mental Health and Addiction Services, the Division of Aging Services, the Division of Developmental Disabilities, and the Division of Family Development. The populations served by each of these agencies overlap significantly with Medicaid beneficiaries. This will also include other state Departments, including (but not necessarily limited to) the Department of Children and Families, Department of Community Affairs, Department of Corrections, and the Department of Health.



Source: NJ DMAHS 1115 proposal

Medicaid Covered Housing-Related Services
This enhanced infrastructure will be paired with Medicaid coverage of new housing-related services for beneficiaries in need. Additional details around anticipated beneficiary eligibility, delivery system, and services covered are below.

Eligibility for Housing Specialist Support and Housing-Related Services
Eligibility for Medicaid-covered housing-related services (described below) will be based on beneficiary need and is intended to identify those beneficiaries where housing supports are likely to have the greatest positive impact on health and life outcomes. Under this approach, MCOs will follow a two-step process for identifying beneficiaries who are eligible for housing-related services.

First, all new MCO beneficiaries or beneficiaries who are experiencing a trigger event (e.g., served for eviction, released from incarceration, leaving an institutional setting, or self-referral) will be required to undergo an initial screen to identify potential need for housing-related services. This initial assessment will consist of a small number (perhaps 2-3) of high-level questions and will be integrated into the Initial Health Screen that MCOs are currently required to complete for all new members.[79] In addition, the screening will be woven into the care planning conducted with current members and the NJ Choice assessment for members seeking or enrolled in MLTSS. The initial assessment may also include additional information or support from family members or caregivers.

Second, beneficiaries whose initial assessment indicated a potential need for housing-related services will receive a second, more comprehensive assessment using a standardized instrument. The results of this second assessment will determine the member's eligibility for housing-related services and will also be used by the MHS to develop a person-centered service plan. This assessment will be repeated at least annually.

[79] For more details, please see Section 4.6.5.B.1 of New Jersey's managed care contract, available here: https://www.state.nj.us/humanservices/dmahs/info/resources/care/hmo-contract.pdf

In addition to the process described above, Medicaid beneficiaries (or their care managers) could request an assessment for housing-related services at any time on top of the initial and annual assessments. DMAHS will also consider requiring that certain high-risk populations, including but not limited to individuals being released from correctional facilities and individuals transitioning from nursing facilities, receive a full (second stage) assessment for housing-related needs, regardless of the results of the initial screen. Finally, to support rebalancing goals, DMAHS will also require MCO care managers to assess housing-related needs for MLTSS members during each face-to-face visit. These visits occur at least twice yearly.

Medicaid Covered Housing-Related Services

As part of the demonstration renewal, New Jersey will offer expanded Medicaid coverage for targeted housing-related services that are expected to result in improved beneficiary health and reduced institutionalization while realizing opportunities for better efficiency of the Medicaid delivery system. These services will be made available exclusively through the managed care delivery system, as authorized under the demonstration, to promote accountability and efficiency. Doing so will also put the MCOs' Housing Specialists at the center of care coordination.

The State's intention is to better connect Medicaid beneficiaries to the existing housing ecosystem, particularly community-based organizations, and to enhance this ecosystem through direct support using Medicaid funding. They do not expect to replace or replicate existing infrastructure nor are they proposing MCOs become housing providers. Rather, the aim is for MCOs to better support the existing programs in the communities and assist beneficiaries in accessing these services. Four categories of services are offered (collectively referred to as "**demonstration housing services**"): [80]

1. **Pre-Tenancy Services**
   - Develop an individualized housing support plan to help members achieve their goals.
   - Assist with the housing search and application process.
   - Provide connections to resources aiding with housing costs and other expenses.
2. **Tenancy Sustaining Services**
   - Develop an individualized housing support plan to help members achieve their goals.
   - Assist with lease renewals and housing certifications.
   - Connect members to financial resources and social services (e.g., education, employment, and legal services).
   - Assist in addressing circumstances and/or behaviors that may jeopardize housing.
   - Assist in resolving disputes with landlords.
3. **Move-in Supports**
   - Pay for the set-up of the new housing unit to address needs identified in the person-centered care plan.

[80] Note that some of these services are already offered to certain Medicaid beneficiaries – e.g. MLTSS members.

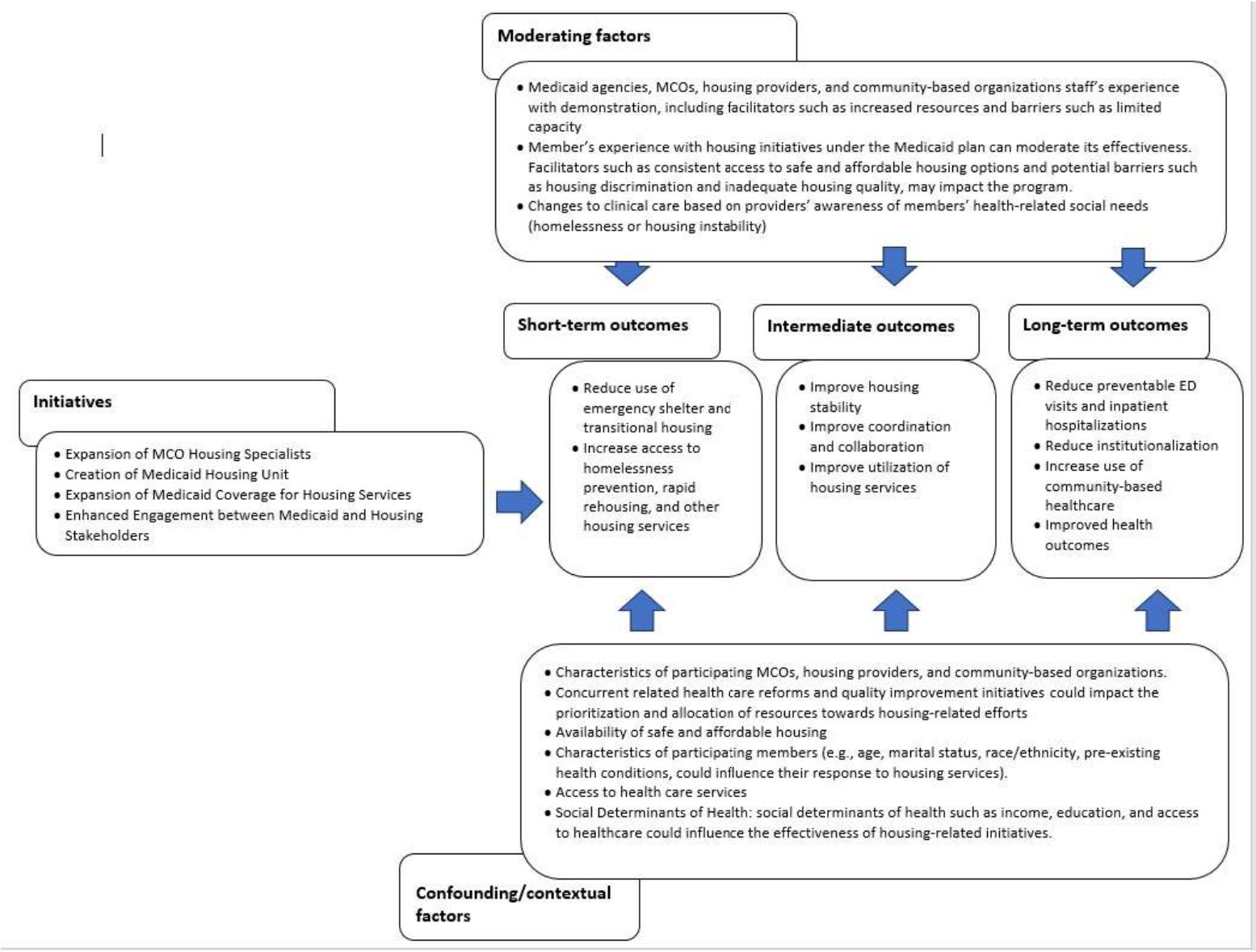
- Pay for the move and support the details of the move.

4. **Residential Modifications and Remediation**
   - Provide remediation services, including air filtration devices and asthma remediation.
   - Modify home environment (e.g., ramps, handrails, and grab bars).
   - Provide medically necessary heating and cooling.

B. Research Questions and Hypotheses

Our evaluation of the Medicaid Housing Program includes an implementation study and research questions related to program outcomes. Figure 8.1 is a logic model showing the implementation questions and the expected outcomes.

Figure 8.1 Housing Logic Model



1. Implementation Study

To understand the implementation of the Medicaid housing program, researchers will review available administrative data and monitoring reports. They will also conduct in-depth individual interviews with entities responsible for the program, such as Medicaid agencies, MCOs, housing providers, and CBOs. These interviews will involve key informants involved in the implementation of the housing program itself.

The following implementation questions will be examined:

1. Which key entities are collaborating to implement and operationalize the Medicaid housing program, how were they identified, and what are their main roles? How and why have the roles or participation of those key entities changed throughout the demonstration period?
2. What are facilitators and barriers for key entities implementing the Medicaid housing program and what strategies have key entities used to overcome these barriers? What suggestions do key entities have for improving the program?
    a. How do entities identify housing options that will be suitable and accessible for Medicaid beneficiaries, considering factors such as affordability, safety, and location?
3. What facilitators and barriers to participation do beneficiaries experience, and what does this information suggest about the need for refinements to beneficiary and provider outreach as well as program implementation or design more broadly?
    a. How do entities assess whether beneficiaries are accessing and utilizing housing services for their own needs?
4. What strategies and tools do key entities use to identify beneficiaries with housing needs and facilitate beneficiary participation in the program? How, if at all, and why, have key entities adapted these strategies? What did the state learn about promising practices for identifying and engaging beneficiaries?
    a. Do beneficiaries identified through housing risk factors agree to participate? If beneficiaries don't participate, do entities know why?
5. How are key entities implementing case management and providing housing assistance through the program? What did the state learn about promising practices for delivering services to address beneficiaries' housing-related social needs? Do participating beneficiaries stay enrolled? What are key reasons for dropping out of the program?
    a. How, if at all, did the program establish a process to share and receive screening or other results among key entities? How, if at all, have housing providers modified their practices in response to this information?
    b. How do key entities form and maintain organizational partnerships to promote integration of health and housing services?
    c. To what extent is the state integrating the program with its existing programs and infrastructure? What did the state learn about promising practices to support this integration?
6. What infrastructure are key entities developing or acquiring using program funds? What did the state learn about promising practices to build infrastructure to support housing screening, case management, and service delivery?

7. Do Medicaid housing services (described above) substitute for other available resources and what is their incremental contribution beyond other available services?

1.1 Methodology

Data Collection: Systematic qualitative interviews will be conducted to address the implementation questions, focusing on the effectiveness of implementation of infrastructure investments within DMAHS, MCOs, and housing CBOs. Interviews will offer insights into program implementation as well as identifying barriers and opportunities to improve the plan. Interviews will be recorded, transcribed, and analyzed using established qualitative thematic analysis techniques. Participant recruitment will be based on criteria established during protocol development and will primarily involve staff and key informants with existing relationships to the evaluators such as MCOs and their vendors, DMAHS staff, housing CBOs, and other state and local experts. Interviews will be conducted twice over the course of the demonstration. We will attempt to recruit the same individuals for both rounds, with comparisons between responses from the first and second rounds to assess progress. All interviews will be conducted confidentially to encourage candid responses.

Analytic Strategy for Interview Data: NVivo or similar software will be used to analyze for themes. A general inductive approach will be used to allow for themes to emerge. Where appropriate, themes will be categorized as a barrier or facilitator in order to provide an analysis of value to DMAHS, MCOs and other program stakeholders.

For Implementation question (IQ)7, we will interview housing services providers, including those facilitating or delivering Medicaid-funded housing support services. Table 8.1 below describes planned qualitative interview recruitment strategies.

Table 8.1: Research Questions and Interview Strategies for Implementation Question (IQ) 7

Research Question	Number	Interview Strategy
IQ7: Do Medicaid pre-tenancy transition and tenancy sustaining services substitute for other available resources and what is their incremental contribution beyond other available services?	≈30 Twice over the course of the demonstration	In consultation with DMAHS and New Jersey housing officials from HMFA and/or the Dept. of Community Affairs, CSHP will identify an initial group of housing service providers, including those who do and do not facilitate or provide Medicaid housing-related services. We will ask initial interviewees to recommend other service providers who can address our questions (i.e., "snowball sampling"). Semi-structured interview guides will indirectly ask about possible substitution of funding sources and the overlap/alignment between different types of housing-related services (e.g., "before Medicaid funded these services, how would they be funded? If you had a source that could fully or partly fund these services before the waiver, how are you using those funds now?") to avoid signaling concerns about possible substitution. Further, we will ask about complementary and coordination (i.e., "blending and braiding") sources to best meet the needs of clients. Interviews will be approximately 45 to 60 minutes and response incentives will be offered (e.g., $50).

2. Outcomes Study

Figure 8.2 describes hypothesized drivers connecting demonstration activities to improved beneficiary health and wellbeing. The secondary drivers in the figure represent the demonstration components that address housing and healthcare changes that are expected to lead to improved housing stability and access to essential community-based services. These, in turn, lead to the primary drivers that are expected to lead to increased use of essential community-based physical and behavioral health services and reduced use of avoidable hospital inpatient and emergency department and institutional settings and, ultimately, better health and wellbeing. Further, given known racial/ethnic disparities in homelessness and housing insecurity, we expect the demonstration to drive reductions in disparities in health services outcomes described in the diagram.

Figure 8.2: Housing Services Driver Diagram

Aim	Primary Drivers	Secondary Drivers
Improve housing stability and decrease risk of homelessness. Improve health and wellbeing of persons at risk of housing insecurity ○ Increase use of essential community-based physical and behavioral health services. ○ Reduce preventable ED utilization, inpatient hospitalizations, and institution use, as well as spending on institutional and hospital care. Narrow racial/ethnic health services disparities that stem from unstable housing.	○ Reduce evictions ○ Reduce homelessness ○ Improve access to healthy and safe housing ○ Increase housing tenure ○ Improve access to community-based physical and behavioral health services for people experiencing or at risk of homelessness.	○ Improve cross-sector collaboration & service coordination among health, housing, housing court, corrections and other relevant systems ○ Screen and identify members experiencing or at risk of housing insecurity or homelessness ○ Deliver pre-tenancy services, tenancy sustaining services, move-in supports, and residential modification and remediation benefits to eligible members
⟸ Causality ⟸		

Infrastructure and benefit enhancements described above are expected to substantially improve housing stability for beneficiaries at risk of avoidable hospitalization, institutionalization, and homelessness. Three hypotheses and associated research questions guide the evaluation of this component of the demonstration.

Hypothesis 1: New infrastructure to support Medicaid's enhanced focus on housing within DMAHS, the MCOs, and housing CBOs will result in improved housing stability for members at risk of housing insecurity and a higher share of members at risk of institutionalization remaining in the community.

Research Question 1a: Do (a) the monitoring of MCO efforts to meet housing needs and (b) the establishment of partnerships between MCOs and housing entities lead to enhanced engagement between Medicaid and housing stakeholders?

Research Question 1b: Do MCOs, through MHS or care management staff, reach and provide referrals to members with housing-related needs?

Research Question 1c: Do Medicaid members who have interacted with MHSs or other MCO staff about their housing-related needs perceive that those needs are appropriately addressed?

Research Question 1d: Do members experiencing homelessness or at greatest risk of homelessness receive referrals for demonstration housing services (i.e., pre-tenancy transition, tenancy sustaining, move-in supports, or residential modification and remediation services) from MCO staff?

Hypothesis 2: Delivery of Medicaid demonstration housing services will improve housing tenure and reduce associated racial/ethnic disparities.

Research Question 2a: Does delivery of demonstration housing services improve community housing tenure and reduce tenure disparities?

Hypothesis 3: Delivery of Medicaid demonstration housing services will (a) reduce use of preventable or avoidable health services and associated spending, and (b) increase use of essential health services and associated spending on Medicaid services, as well as improve health care outcomes, and reduce associated racial/ethnic disparities.

Research Question 3a: Does delivery of demonstration housing services lead to more optimal Medicaid service utilization and spending and reduced disparities?

2.1 Methodology

Table 8.2 enumerates the beneficiary-level outcomes associated with the Aims and Research Questions above (and in Figure 8.2). These measures will be constructed in the MMIS data and augmented with data from the Homeless Management Information System (for measure #20).

Table 8.2: Medicaid Beneficiary Outcome Measures

Spending Outcomes
1. Total spending for Medicaid members receiving housing support
2. Total Medicaid housing services spending for members receiving housing support
3. Total Medicaid healthcare (non-housing services) spending for members receiving housing support
4. Prescription drug spending (total and for chronic condition maintenance medications)
5. Nursing facilities and other institutions
6. Hospital inpatient care
7. Hospital emergency department visits
8. All other
Utilization Outcomes
9. Primary care provider visits
10. Mental health visits
11. Substance use treatment service initiation and engagement[a]
12. Admission to nursing facilities or other institutions

13. Days in nursing facilities and other institutions
14. Community behavioral health visits (mental health and SUD)
15. All-cause hospital inpatient admissions
16. Potentially avoidable admissions (AHRQ prevention quality indicators)[b]
17. 30-day all-cause hospital inpatient readmissions
18. Emergency department visits[c]
19. Preventable ED visits
20. Return to the ED within 72 hours following ED discharge[a]
21. Emergency department visits for behavioral health conditions
22. Follow-up after mental health or SUD-related ED visits[a]
23. Emergency homeless shelter use within 14 days of hospital inpatient or ED discharge
24. Referrals to community-based organizations (housing and other supports)
25. Incidence of homeless service utilization, disaggregated by service type
26. Duration of homeless service utilization, disaggregated by service type

[a]Center for Medicaid and CHIP Services. Core set of adult health care quality measures for Medicaid (adult core set): technical specifications and resource manual. Baltimore, MD: Centers for Medicare & Medicaid Services, 2019. Available from: https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-adult-core-set-manual.pdf.
[b]Agency for Healthcare Research and Quality. Prevention quality indicators overview [Internet]. Rockville, MD: Agency for Healthcare Research and Quality; n.d. Available from: https://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx.
[c]Billings, J., Parikh, N., Mijanovich, T. (2000). Emergency Department Use in New York City: A Substitute for Primary Care?

Methodology for Hypothesis 1, Research Questions (RQ) 1a & 1c

The research questions (RQs) under Hypothesis 1 focus on the effectiveness of implementation of infrastructure investments within DMAHS and the MCOs. RQ1a and RQ1c use systematic qualitative interviews. Analyses for RQ1 will be augmented with reviews of relevant documents and observations of relevant meetings. For qualitative interviews, we will consult with DMAHS on strategies for participant recruitment and the development of semi-structured interview guides. With participant permission, interviews will be recorded, transcribed, and analyzed using established qualitative thematic analysis techniques. Interviews for both RQs will be conducted twice over the course of the demonstration. For interviews involving key informants (RQ1), we will attempt to recruit the same individuals for both rounds; where that is not possible, individuals in the same or similar roles will be recruited. Analysis of second-round interviews will include comparisons to responses from the first round to assess progress. Table 8.3 below describes planned qualitative interview recruitment strategies. All interviews will be conducted on a confidential basis to encourage candor. In the case of key informants (RQ1a) absolute confidentiality will not be promised because the small number of interviewees of each type could enable a knowledgeable person to discern the identity of some participants.

Table 8.3: Research Questions and Interview Strategies for RQ1a and RQ1c

Research Question	Number	Interview Strategy
RQ1a: Do the Medicaid Housing Unit's efforts to enhance engagement between Medicaid and housing stakeholders improve systems and resources for addressing the housing-related needs of Medicaid members at risk	≈20 to 30 Twice over the course of the demonstration	In consultation with DMAHS, CSHP will identify individuals for recruitment. We expect to include: DMAHS and MCO representatives, leaders in NJ agencies responsible for homeless services (e.g., Div. Mental Health and Addiction Services, Dept. of Community Affairs, Housing and Mortgage Finance Agency/HMFA), community-based homeless service

of institutionalization or homelessness?		delivery and advocacy organizations. Interviews will be approximately 45 to 60 minutes.
RQ1c: Do Medicaid members who have interacted with MHSs or other MCO staff about their housing-related needs perceive that those needs are appropriately addressed?	≈100, about 15-25 per MCO. Twice over the course of the demonstration	DMAHS will provide recruitment specification (developed by CSHP) to the MCOs which will mail invitations to selected MCO members who have had contact with MHS and other MCO staff interacting with members about housing needs. Selected members will be offered participation incentives of about $75 to encourage volunteers to "opt in" and contact a CSHP interviewer. One MCO will conduct a recruitment pilot so that outreach and incentive plans can be refined. Interviews will be approximately 45 to 60 minutes.

Methodology for Hypothesis 1, Research Question 1b

Research question 1b asks the extent to which MHS and other MCO staff reach and complete referrals for members with housing-related needs. This analysis will rely on data collected by the MCOs, including the results of the second, comprehensive housing needs assessment using the DMAHS approved standardized instrument as well as MCO technical platforms recording workflows of the Housing Specialists (contacts, referrals, completed referrals).

We will conduct descriptive trend analysis with comparisons by member characteristics (described below), identified housing-related needs, and MCO. The denominator for RQ1b analyses will be members who "screen positive" for housing needs and numerators will be 1) contacts, 2) referrals, and 3) completed referrals[81] per member who screened positive. To the extent supported by the data, analyses will be conducted by member race/ethnicity; Medicaid eligibility group; diagnosis with SMI, SUD, or I/DD; and housing-related needs identified in the screening process. Offered and completed referrals will be further analyzed by type of service (e.g., income supports, social services, housing services, and services addressing other social needs).

Methodology for Hypothesis 1, Research Question 1d

Research question 1d assesses the extent to which demonstration housing services are (a) approved but not received and (b) approved and received, among individuals identified as experiencing or at-risk of homelessness. These analyses use MMIS data linked with the following state administrative datasets:

- MCO technical platform records of MHS staff referral information (discussed under RQ1b methods above);
- Homeless Management Information System (HMIS) records of homeless services utilization;
- Records of prison incarceration, recidivism, and prison health services use; and
- Eviction filing and judgement records.

Under prior data use and sharing agreements, CSHP received a linked MMIS and HMIS Limited Data Set (LDS) for 19 (of 21) counties for 2011 through Q1 2023. These agreements and data would be extended for the demonstration period. Further, we have entered into an agreement to add one of the remaining counties (Bergen Co.) and are exploring adding the final county (Middlesex Co.), to

[81] Referrals where the member touches the service to which they are referred.

the linked MMIS-HMIS dataset. In addition, a data use agreement between Rutgers on behalf of the Center for Health Services Research and DMAHS authorizes linkage of prison health services data to MMIS. The incarceration data under this agreement are collected under the auspices of the New Jersey Department of Corrections (DOC) and maintained by Rutgers University Correctional Health Care (a unit of Rutgers Biomedical and Health Sciences); these data include information on prison releases, recidivism, and health services and treatments received prior to release. Data on eviction filings and judgments are maintained by the New Jersey Courts. To our knowledge eviction records have not yet been linked to MMIS, and creating such a linkage will require further exploration.

Denominators for RQ1d analyses include beneficiaries in three distinct risk groups for housing instability in the prior year: 1) homeless services users (e.g., shelter stay, street outreach contact), 2) individuals released from incarceration, and 3) individuals who live at an address which was served with an eviction notice or judgement. Numerators will be derived from the MCO technical platform (referrals completed) and MMIS (pre-tenancy transition and tenancy sustaining services). If these housing-related benefits are not recorded in the MMIS, linkage to data on those services will be needed.

We will begin by conducting descriptive analysis examining trends in each of the three categories of services and by member characteristics (e.g., demographics, eligibility group, and SMI, SUD and I/DD status) and MCO. Second, we will fit models of the likelihood of receiving the respective services in each group, adjusting for beneficiary health and housing-related histories. Health history data will be drawn from MMIS and from prison data for periods of incarceration. These models we test for racial/ethnic disparities in service usage rates. No comparison groups are available for these analyses.

Methodology for Hypothesis 2, Research Question 2a

Using the same set of linked administrative data described above, research question 2a addresses the extent to which housing supports authorized under the demonstration lead to improved housing tenure.

Plan for RQ2a

Outcome Measure. Under RQ2a, we define five sources of interruptions in community housing tenure: 1) entry into an Medicaid funded nursing facility or other institution; 2) exit from an HMIS-recorded housing arrangement such as permanent supportive housing (PSH) to non-community or non-stable place of residence including jail/prison, emergency shelter, or a place not fit for habitation; 3) regardless of whether a person exited an HMIS-recorded housing situation, use of any HMIS-recorded homeless service including emergency shelter, transitional housing, or street outreach encounter; 4) entry into incarceration; or 5) living at an address for which an eviction notice or judgement was served.

Analytical Strategy. First, we will examine trends in specified outcomes by member characteristics (e.g., demographics, eligibility group, and SMI, SUD and I/DD status) and MCO. Second, we will apply a difference-in-differences framework to model the likelihood of housing tenure loss among beneficiaries who received Medicaid-funded pre-tenancy transition or tenancy sustaining services.

We will use propensity matching to identify comparison beneficiaries with similar circumstances but who did not receive demonstration housing support benefits. Matching variables will include beneficiary demographics, number of chronic conditions, Chronic Illness and Disability Payment System risk score (CDPS), presence of behavioral health conditions (SMI, SUD), Medicaid eligibility category, as well as histories of Medicaid institutional placement, homeless service use, incarceration, and eviction. Matching will be conducted on data for the year prior to the month that the beneficiary received their first housing support benefit (or date of match for comparison beneficiaries). We will test for changes in racial/ethnic disparities in housing tenure by including interaction terms in the models between race/ethnic group and treatment status.

We will examine the robustness of the match by calculating standardized differences in matching variables. If match quality is adequate, but some variables have standardized differences that exceed 10%, we will add adjustments to the models. If match quality is poor overall, we will use pre-pandemic non-concurrent comparison groups in place of a concurrent difference-in-differences analysis.

Methodology for Hypothesis 3, Research Question 3a

Using the same set of linked administrative data described above, research question 3a addresses the extent to which housing supports authorized under the waiver lead to improved health services outcomes.

Plan for RQ3a

Outcome Measures. Medicaid health services outcomes to be examined under RQ3a are defined in **Table 8.2** above. These measures support evaluation of the demonstration's impact on the level and composition of Medicaid spending as well as changes in utilization and quality of care.

Analytical Strategy. As in all components of the evaluation, we first will examine trends in these outcomes by member characteristics (e.g., demographics, eligibility group, and SMI, SUD and I/DD status) and MCO. Then, using a difference-in-differences framework, we will model the respective outcomes. The treatment group will include beneficiaries who received Medicaid-funded pre-tenancy transition or tenancy sustaining services under the demonstration. We will use propensity matching to identify comparison beneficiaries with similar circumstances as the treatment group. Matching will follow the same strategy described under RQ2a above. We will test for changes in racial/ethnic disparities in housing tenure by including interaction terms in the models between race/ethnicity group and treatment status.

Because a large number of models will be estimated, conclusions will be based on patterns observed across outcomes and we will deemphasize results in any single outcome if they are not part of a general pattern. Further, we will drop analyses of outcomes for which the frequency of events is too small to draw well-founded conclusions.

C. Methodological Limitations

Our planned analyses have several limitations. First, when comparing individuals eligible for waiver services to others, propensity score matching will adjust for measured individual characteristics,

but the possibility of unmeasured confounding cannot be ruled out. Difference-in-differences methods greatly reduces the risk of bias from unobserved characteristics.

Second, data available in MMIS does not allow us to fully account for illness severity and, in turn, severity may be associated with selection into waiver interventions, introducing possible biases. This is a limitation common to claims based analyses, and our reports will note this caveat.

Third, while the planned analyses will include rich data on social drivers of health, including homeless service use, incarceration history, and exposure to eviction, other social drivers such as inadequate family support cannot be measured. These factors could affect outcomes in ways we cannot account for, which we will note in our reports.

Fourth, novel data linkages will support in-depth analyses of importance to the evaluation, but these data have potential gaps. Despite rich data available in the HMIS homeless services, our data do not include "less formal" forms of housing instability and homelessness (e.g., "couch surfing"). Also, NJ DOC data include only prison incarcerations but not jail episodes. Jail terms are generally much shorter than prison terms and thus may be less likely to disrupt community housing ties and are thus less important for this evaluation. Further, jail data do not include health information so would be unsuitable for conducting propensity matching for construction of comparison groups. Finally, while the state maintains data on eviction filing and judgements, these data do not include identifiers for all potentially affected individuals; thus, linkages will have to rely on addresses. This will measure potential exposure to eviction but will not definitively label whether a given individual was displaced. There is some uncertainty whether eviction data will be available for the evaluation, but nevertheless rich information will likely be available from HMIS and incarceration data.

Finally, there may be circumstances in which frequency of outcome events, or the quality of propensity matching may be insufficient to support planned difference-in-differences modeling. In these circumstances we will explore using historical, pre-demonstration comparisons. Because pandemic disruptions may cloud our ability to draw conclusions from such analyses, we would use a pre-pandemic comparison period.

The above noted limitations to our planned quantitative analyses will be mitigated, in part, by in-depth key informant and beneficiary interviews. We will be mindful of limitations of the quantitative work as we design interview protocols.

Table 8.4: Summary of Questions, Hypotheses and Methodology

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
Hypothesis 1 **–** New infrastructure to support Medicaid's enhanced focus on housing within DMAHS, the MCOs, and housing CBOs will result in improved housing stability for members at risk of housing insecurity and a higher share of members at risk of institutionalization remaining in the community				
RQ1aDo (a) the monitoring of MCO efforts to meet housing needs and (b) the establishment of partnerships between MCOs and housing entities lead to enhanced engagement between Medicaid and housing stakeholders?	Perceived improvements and impediments to system changes and resources to address housing-related needs of Medicaid members at risk of institutionalization or homelessness.	State, MCO, and community-based key informants (e.g., DMAHS and MCO representatives, leadership from other NJ agencies responsible for homeless services, relevant advocacy organizations). No comparison group.	Relevant documents (e.g., program guidance and meeting minutes). Observations of relevant meetings (e.g., DMAHS stakeholder sessions). Key informant interviews twice over the course of the demonstration (N≈20-30).	Qualitative thematic analysis, compare observations and interviews conducted early and late in the demonstration period.
RQ1b: Do MCOs, through MHS or care management staff, reach and provide referrals to members with housing-related needs?	Distribution of housing-related needs identified in the standardized assessment by member characteristics. Contacts per member screened in need, by member characteristics. Referrals per member screened in need, by member characteristics and type of referral.	Members screened as having housing-related needs on the MCO stage 2 standardized assessment tool. No comparison group.	MCO technical platform and member housing needs assessment data.	Descriptive trend analysis overall, and by housing needs identified, MCO, and member characteristics.*

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
	Referrals completed per member screened in need, by member characteristics and type of referral.			
RQ1c: Do Medicaid members who have interacted with MHSs or other MCO staff about their housing-related needs perceive that those needs are appropriately addressed?	Reported experiences of Medicaid members who interacted with MHS staff and self-assessment of the extent to which their housing-related needs were addressed.	Systematically selected Medicaid members who had contact with MCO MHS staff.	Qualitative interviews. (N≈100 total, with about 15 to 25 per MCO). Conducted twice over the course of the demonstration.	Qualitative thematic analysis, compare responses by MCO and conducted early and late in the demonstration period.
RQ1d: Do members experiencing homelessness or at greatest risk of homelessness receive referrals for demonstration housing services (i.e., pre-tenancy transition, tenancy sustaining, move-in supports, or residential modification and remediation	Percent of members who used at least one **homeless service** (e.g., emergency shelter, street outreach contact), **transitioned from incarceration**, live in a household served with an **eviction filings and judgements**, or transitioned to the community from a Medicaid-funded **institutional setting** in	Members with recent history of homeless service use, incarceration, eviction filings or judgments, or Medicaid institutional transition. No comparison group	Numerators: MCO technical platform and MMIS Denominators: MMIS linked to data from: • Homeless Management Information System (HMIS) • Incarceration records[#] • Eviction records[#]	Descriptive trend analysis overall, by member characteristics* and MCO. Model likelihood of receiving services (separate models for referrals, transition, and sustaining services) adjusting for member health and housing-related histories, with

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
services) from MCO staff?	the prior 12 months who received: (a) approval for housing-related services (but no receipt of services), (b) approval and receipt of at least one housing-related service		#*contingent on data availability*	analysis of racial/ethnic disparities.
*Racial/ethnic groups; age groups; members with diagnoses of SMI, OUD, or IDD; and eligibility group (expansion, dual, other ABD, other).				
Hypothesis 2 - Delivery of Medicaid demonstration housing services will improve housing tenure and reduce associated racial/ethnic disparities.				
RQ2a Does delivery of demonstration housing services improve community housing tenure and reduce tenure disparities?	Evidence of loss of community housing after receipt of transition/sustaining services as indicated by: • Entry to a Medicaid-funded institution (e.g., nursing facility). • Exit from HMIS-recorded housing to a destination other than own or family residence (e.g., jail/prison, place not fit for habitation). • Receipt of HMIS-recorded homeless	Medicaid members receiving pre-tenancy transition or tenancy support services. Comparison group: Propensity matched Medicaid members with a history of exit from institutional placement, homelessness, incarceration, or eviction who did not receive pre-tenancy transition or tenancy support services.	MMIS linked to data from: • Homeless Management Information System (HMIS)** • Incarceration records# • Eviction records#	Descriptive trend analysis overall, by "dose" and types of tenancy and sustaining services received, member characteristics*, and MCO. Difference-in-differences models of likelihood of <u>housing tenure loss</u> in the year after using housing transition or sustaining services, adjusting for member health and

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
	services (e.g., emergency shelter, street outreach encounter). • Incarceration[#] • Eviction[#]			housing-related histories, with analysis of racial/ethnic disparities. *If the N in the comparison group is too small or propensity matching is not feasible, a non-concurrent pre-pandemic comparison period will be used*
Hypothesis 3 - Delivery of Medicaid demonstration housing services will (a) reduce use of preventable or avoidable health services and associated spending, and (b) increase use of essential health services and associated spending on Medicaid services, as well as improve health care outcomes, and reduce associated racial/ethnic disparities.				
RQ3a Does delivery of demonstration housing services lead to more optimal Medicaid service utilization and spending and reduced disparities?	Total Medicaid spending Utilization & spending on: ○ Nursing facility and other institutional placements ○ Total hospital inpatient care, preventable hospitalizations, and 30-day readmissions ○ Emergency department (ED) visits overall and for behavioral health conditions ○ Primary care	Medicaid members receiving pre-tenancy transition or tenancy support services. Comparison group: Propensity matched Medicaid members not receiving pre-tenancy transition or tenancy sustaining services (see RQ2a for details).	MMIS linked to data from: • Homeless Management Information System (HMIS)[**] • Incarceration records[#] • Eviction records[#]	Descriptive trend analysis overall, by "dose" and types of tenancy and sustaining services received, member characteristics*, and MCO. Difference-in-differences models of spending or utilization as a function of housing transition and sustaining use, adjusting for member health and housing-related histories, with analysis

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
	○ Community behavioral health services (among those with BH dx) ○ Prescription drugs overall and chronic condition maintenance drugs			of racial/ethnic disparities. Models specific to dual eligible members will explore impact on Medicare utilization.

Table 8.5 shows an activity timeline for the research activities.

Table 8.5 Key Milestones, Tenancy and Housing Supports

Analytic Activity	Year 1 2025	Year 2 2026	Year 3 2027	Year 4 2028	Year 5 2029	Year 6 2030
1. Qualitative implementation assessment (IQ1-7)	Review documents, observe meetings Conduct and analyze N=30 KIIs	Update document review and meeting observations as needed	Update document review and meeting observations as needed Complete interim analysis	Update document review and meeting observations as needed Conduct and analyze N=30 KIIs	Update document review and meeting observations as needed	Complete analysis
2. Qualitative systems change and outcome assessment (RQ1a, RQ1c)		Conduct and analyze N=20-30 KIIs Conduct and analyze N=100 beneficiary interviews	Complete interim analysis	Begin to conduct and analyze N=20-30 KIIs Begin to conduct and analyze N=100 beneficiary interviews	Finish conducting, and analyze, N=20-30 KIIs Finish conduct, and analyze, N=100 beneficiary interviews	Complete follow up and change analysis
3. Link and analyze MMIS, HMIS, eviction, & incarceration records (RQ2a, RQ3a)	Execute data use agreements to link MMIS, HMIS, and other admin data from 2016-2024 and	Finalize linkage of MMIS, HMIS, and other administrative data sets and conduct baseline analysis	Complete baseline analysis of linked administrative data		MMIS linked to HMIS, and other admin data 2016-2028	Complete follow up and change analysis

Analytic Activity	Year 1 2025	Year 2 2026	Year 3 2027	Year 4 2028	Year 5 2029	Year 6 2030
	begin data linkage					
4. Link and analyze MCO technical platform data to MMIS linked data (see activity 3) (RQ1b, RQ1d)	Execute data use agreements to link MCO data, MMIS, and other administrative datasets and begin data linkage	Conduct linkage & analysis	Update linkage & complete interim analysis	Update linkage & analysis	Update linkage & complete analysis	Complete analysis
5. Submit reports to CMS			Interim report			Final report

KII=key informant interviews; IQ=Implementation Question; RQ=Research Question.

NOTE: Evaluation project years are March-Feb. (subject to change depending on date of authorization to begin).

Appendix 8.1: Interview Questions for Housing CBOs

(Version 2024.10.07)

NOTE: We will interview individuals who work at NJ housing service providers and provide case management, coordination, and housing search assistance to Medicaid beneficiaries to understand their perspective of services provided as a part of this Waiver. We will obtain oral consent prior to each interview.

Thank you for agreeing to speak with us about the NJFamilyCare Housing initiatives. We would like to learn about the program's impact on people enrolled in Medicaid. We would also like to identify how to improve the program and how to sustain any successful components. If you do not know the information or would prefer not to answer, please let us know.

1. Through what mechanisms are Medicaid beneficiaries referred to you for housing services?

2. What are the barriers that Medicaid beneficiaries face in seeking to access your services? What factors facilitate access to your services for Medicaid beneficiaries?

3. Are there Medicaid beneficiaries that reach your organization and do not want to accept your services? Why, and do you have any sense of what happens to them?

4. What is the extent of your collaboration with Managed Care Organizations? Is there any case coordination or strategic planning beyond their referrals to you?

5. What strategies do you find to be most effective in engaging Medicaid beneficiaries in housing services? What strategies are the least effective? How does this vary for different populations? Prompts: Beneficiaries exiting the carceral system; pregnant beneficiaries; beneficiaries.

6. How do you identify which case management and housing assistance strategies are appropriate for each MCO member?

7. What strategies, or types of services, do you find to be most effective in keeping housing unstable Medicaid beneficiaries in their existing housing and placing homeless Medicaid beneficiaries into permanent housing? [prompt for service types offered under waiver]

8. How well have needs of individuals with housing unstable been met within the Housing Initiative program?

9. What are some of the key reasons that MCO members stop using your services?

10. Have there been any unanticipated negative consequences of the Housing initiative?

11. Do you find that housing transition and sustaining services offered by your organization substitute for other available resources in the community? What is the contribution of your organization's housing services beyond those offered elsewhere in the community?

12. Thank you for your time. We would like to speak with a diverse group of individuals and organizations that were involved in developing and sustaining the Housing Initiative. Who else do you think we should consider interviewing?

Appendix 8.2: Interview Questions for MCO Members

(Version 2024.10.07)

NOTE: We will interview MCO members to understand their perspective of services provided as a part of this Waiver. We will obtain oral consent prior to each interview.

Thank you for agreeing to speak with us about the NJFamilyCare Housing initiatives. We would like to learn about the program's impact on people enrolled in Medicaid. We would also like to identify how to improve the program and how to sustain any successful components. If you do not know the information or would prefer not to answer, please let us know.

1. Why did your health insurance company connect you to housing resources? What housing trouble were you experiencing?

2. What barriers did you face in accessing housing resources after the referral from your insurance company? Are there any things that your insurance company or the housing provider did to make the process go more smoothly?

3. What services did you receive from the housing service provider? How did they choose what services you would receive? [prompt for service types offered under waiver]

4. Are you satisfied with the housing provider that you were referred to? What did you like about working with them? What would you like to them to have done differently?

5. Are there things that you wish you had done differently when working with the housing service provider?

6. Have you used housing services before? How did your recent experience receiving housing services compare to prior experiences?

7. Would you have accessed services from another housing provider if you had not been referred to one provider by your health insurance company?

8. Do you feel like the housing services you have received were effective in helping you obtain or maintain your housing? Why or why not?

9. Have there been any negative consequences of receiving this housing assistance?

Appendix 8.3: Interview Questions for State, MCO, And Community-Based Stakeholders

(Version 2024.10.07)

NOTE: We will interview individuals who work at DMAHS, MCO's, and leaders from other state agencies responsible for homeless services and relevant advocacy organizations. We will obtain oral consent prior to each interview.

Thank you for agreeing to speak with us about the NJFamilyCare Housing initiatives. We would like to learn about the program's impact on people enrolled in Medicaid. We would also like to identify how to improve the program and how to sustain any successful components. If you do not know the information or would prefer not to answer, please let us know.

1. What are the key entities in implementing and operationalizing the housing program? How were those partners identified, and what are their roles?

2. What are the facilitators and barriers to implementing the Medicaid housing program? What strategies have you seen used to overcome barriers?

3. What have you learned about promising practices for delivering services to address beneficiaries' housing needs through this housing initiative?

4. What strategies and tools have you seen used to identify beneficiaries with housing needs and facilitate beneficiary participation in housing services? What have you learned about promising practices for identifying and engaging beneficiaries?

5. What are the barriers that Medicaid beneficiaries face in accessing pre-tenancy or housing sustainment services? What factors facilitate access to housing services for Medicaid beneficiaries? [prompt for service types offered under waiver]

6. Do you think that housing service providers have modified their practices in response to this initiative? If so, how?

7. What strategies have been most effective in engaging Medicaid beneficiaries in housing services? What strategies are the least effective? How does this vary for different populations? Prompts: Beneficiaries exiting the carceral system; pregnant beneficiaries; beneficiaries.

8. What are some of the key reasons that MCO members stop using services provided through this initiative?

9. What strategies, or types of services, do you find to be most effective in keeping housing unstable Medicaid beneficiaries in their existing housing and placing homeless Medicaid beneficiaries into permanent housing?

10. How well have needs of individuals with unstable housing been met within the Housing Initiative program?

11. What are some of the key reasons that MCO members stop using your services?

12. Have there been any unanticipated negative consequences of the Housing initiative?

13. Do you find that MCO members are substituting services available through this initiative for other available resources in the community? What is the marginal contribution of Medicaid initiative housing services beyond those offered elsewhere in the community?

14. Thank you for your time. We would like to speak with a diverse group of individuals and organizations that were involved in developing and sustaining the Housing Initiative. Who else do you think we should consider interviewing?

9. Opioid Use Disorder (OUD) / Substance Use Disorder (SUD) Program

A. General Background Information

Substance Use Disorder (SUD) is a complex condition that affects thinking and behavior related to the control the use of alcohol, legal and illegal drugs, medications, and/or other substances; this includes misuse and addiction, "a chronic, relapsing disorder characterized by compulsive drug seeking and use despite adverse consequences."[82,83] SUDs include Alcohol or other drug Dependence (AOD) and Opioid Use Disorder (OUD). SUD is often associated with worsening health, including increased risk for cancers, heart disease, and lung disease.[84] In the United States, over one million people have died from drug overdose since 1999, with many of the recent overdose deaths being attributed to opioids (i.e., the "opioid pandemic").[85] It is well known that the COVID-19 pandemic worsened risk factors for substance use and led to reductions in access to treatment,[86,87] which has renewed efforts to mitigate barriers to care and to improve health outcomes among people with SUD.[5,88]

New Jersey's OUD/SUD program, initially approved in October 2017, has been extended to the current §1115 demonstration (approved April 1, 2023, through June 30, 2028) in combination with a carve-in of additional behavioral health services to managed care over time. This includes the authorization of expenditures within private Institution for Mental Disease (IMD) settings (i.e., any hospital, nursing facility, or other institution of more than 16 beds caring for individuals where the majority have a diagnosis of mental disease). With the one exception of moving the Substance Use Disorder Promoting Interoperability Program into the Behavioral Health Promoting Interoperability Program, **CMS has authorized the State to continue its OUD/SUD from the previous**

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[82] NIDA. 2024, January 5. Drug Misuse and Addiction. Retrieved January 24, 2024 from https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/drug-misuse-addiction

[83] National Institute of Mental Health. Substance Use and Co-Occurring Mental Disorders. U.S. Department of Health and Human Services, National Institutes of Health. Retrieved September 15, 2023, from https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health

[84] NIDA. 2022, March 22. Addiction and Health. Retrieved January 24, 2024 fromhttps://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/addiction-health

[85] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. The Drug Overdose Epidemic: Behind the Numbers. U.S. Department of Health and Human Services, National Institutes of Health. Retrieved September 15, 2023, from https://www.cdc.gov/opioids/data/index.html.

[86] Ornell F, Moura HF, Scherer JN, Pechansky F, Kessler FH, von Diemen L. The COVID-19 pandemic and its impact on substance use: Implications for prevention and treatment. Psychiatry research. 2020 Jul 1;289:113096.

[87] Czeisler MÉ, Lane RI, Wiley JF, Czeisler CA, Howard ME, Rajaratnam SM. Follow-up survey of US adult reports of mental health, substance use, and suicidal ideation during the COVID-19 pandemic, September 2020. JAMA network open. 2021 Feb 1;4(2):e2037665-.

[88] Centers for Disease Control and Prevention. Increase in fatal drug overdoses across the United States driven by synthetic opioids before and during the COVID-19 pandemic. CDC Health Alert Network. 2020 Dec 17.

demonstration without modification. The Implementation Plan approved in the prior demonstration, details the **overall goals** of the OUD/SUD program, as follows.

1. Increase the rates of identification, initiation and engagement in treatment for OUD and other SUDs;
2. Increase adherence to, and retention in, treatment for OUD and other SUDs;
3. Reduce overdose deaths, particularly those due to opioids;
4. Reduce utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment, where the utilization is preventable or medically inappropriate;
5. Reduce preventable, or potentially preventable, readmission to the same or higher level of care for OUD and other SUD; and
6. Improve access to care for physical health conditions among beneficiaries with OUD or other SUDs.

In response, the Centers for Medicare and Medicaid Services (CMS) prescribed **milestones for the implementation** of New Jersey's OUD/SUD program.[89,90]

1. Establish new benefits for access to critical levels of care for OUD/SUDs.
2. Establish requirements for evidence-based, SUD-specific patient placement criteria to govern providers' assessments of beneficiaries and guide utilization management.
3. Establish residential treatment provider qualifications using evidence-based, SUD program standards and require that residential treatment providers offer access to Medication Assisted Treatment (MAT), and ensure provider compliance with standards of care.
4. Assess provider capacity at each level of care (including MAT for OUD) and develop a plan for addressing any identified gaps.
5. Implement comprehensive treatment and prevention strategies to address opioid abuse and OUD via prescribing guidelines, access to Naloxone, and an SUD Health Information Technology (IT) Plan for prescription drug monitoring.
6. Develop and implement policies to improve transitions between levels of care and improve care coordination between residential/inpatient facilities and community supports.

Federal policy had historically limited both detox-rehabilitative services and short-term residential treatment in IMD settings for Medicaid members aged 21-64.[91] Prior to the completed demonstration, adults under the age of 65 were responsible for bearing the cost of treatment through

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[89] CMS (Centers for Medicare & Medicaid Services). 2017. *NJ FamilyCare Comprehensive Demonstration (Project No. 11-W-00279/2)*. Baltimore: CMS. https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nj/nj-1115-request-ca.pdf.

[90] CMS (Centers for Medicare & Medicaid Services). 2017. *SMD #17-003 Re: Strategies to Address the Opioid Epidemic*. Baltimore: CMS. https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf.

[91] Lloyd K, Chakravarty S, Nasiri M, Farnham J, Agrawal M. Interim evaluation of the NJ FamilyCare 1115 substance use disorder demonstration. Center for State Health Policy; 2022. https://doi.org/10.7282/00000317

self-pay or by accessing other state funding. To close this gap, the State was granted waiver authority to make these **service delivery changes in the prior demonstration**[92]:

1. Remove the exclusion prohibiting withdrawal management or residential treatment services delivered in an Institute for Mental Disease (IMD).
2. Add long-term residential treatment, including treatment in an IMD (subject to a statewide 30-day average length of stay), as a new level of care in the OUD/SUD service continuum.
3. Add peer recovery support specialist and case management programs to the benefit package for individuals with OUD/SUD.
4. Move to a managed care delivery system with integrated physical and behavioral health services, with gubernatorial approval, over the course of the five-year demonstration under an amendment to the waiver.

The state engaged several additional activities and policies under this initiative to further support the treatment and health outcomes of people with SUD, including:[11]

- Operationalize the use of American Society for Addiction Medicine (ASAM) criteria and the LOCI-3 assessment tool for SUD treatment;
- Operationalize and align the utilization management by managed care organizations and the Interim Managing Entity (IME) to ensure the appropriate level of care;
- Ensure NJ residential treatment facility (RTF) regulations and provider contracts with MCOs (managed care organizations) meet ASAM criteria for service types, hours of care, and staff credentials and establish a review process to ensure provider compliance;
- Require access to MAT on-site and after RTF discharge;
- Conduct a statewide capacity report and maintain provider capacity data profiles for all levels of care with a plan to address any insufficiency;
- Implement strategies under the Health IT plan to connect SUD providers to EHRs and the Prescription Drug Monitoring Program;
- Utilize and expand training and use of Naloxone to reverse overdoses; and
- Implement an Opioid Overdose Recovery program to those who have received Narcan reversal.

B. Evaluation Questions and Hypotheses

The interim evaluation of the prior demonstration offered promising results from the State's efforts regarding the OUD/SUD program,[8] suggesting further study of the ongoing impact of the OUD/SUD program is warranted. Given the approved demonstration is unchanged from the previous demonstration, the current evaluation will build upon the previous evaluation and examine trends and continued progress toward project aims.[8] The analyses will be informed by the Evaluator's

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[92] NJDHS-DMAHS (New Jersey Department of Human Services, Division of Medical Assistance and Health Services). 2018. NJ FamilyCare Comprehensive Demonstration Implementation Protocol for the Opioid Use Disorder (OUD)/Substance Use Disorder (SUD) Program. Trenton: NJDHS-DMAHS. https://www.state.nj.us/humanservices/dmahs/home/Comprehensive_Demonstration_Implementation_Protocol_OUD-SUD_Program.pdf.

experience in studying the OUD/SUD component and offer comparable findings between the two demonstrations.

Below we present the *logic model* (Figure 9.1) as aligned with CMS guidance that delineates the pathway from the policy change to overall program aims, initially presented in the evaluation of the previous demonstration.[8] Here the secondary drivers represent the various services offered through the SUD/OUD programs.

Figure 9.1. OUD/SUD Aim Driver Diagram

Aims	Primary Drivers	Secondary Drivers
1.A Reduce incidence of OUD 1.B Reduce preventable readmission to the same or higher level of care for OUD-SUD 1.C Reduce avoidable utilization of emergency departments and inpatient hospital settings for OUD-SUD treatment	• Increase rates of initiation and engagement in treatment of OUD-SUD • Improve adherence to and retention in treatment for OUD-SUD • Improve access to care for physical health conditions among beneficiaries with OUD-SUD • Increase access to Naloxone	• Ensure sufficient provider capacity • Implement evidence-based patient placement criteria • Establish provider qualifications and access to MAT • Increase access to critical levels of care • Improve transitions and care coordination • Establish provider qualifications and access to MAT • Improve transitions and care coordination • Implement strategies under HIT plan to connect SUD providers to EHRs and Prescription Drug Monitoring Program.
⟸ Causality ⟸		
SUD = Substance Use Disorder; OUD = Opioid Use Disorder; MAT = Medication Assisted Treatment;		

Research Hypotheses and Questions

In this section, we provide details on the hypotheses and corresponding research questions regarding the continued impact of the SUD/OUD programs among Medicaid beneficiaries. As outlined in the Special Terms and Conditions, evaluation hypotheses for the SUD program component "must focus on an assessment of the program's effectiveness in further achieving or maintaining the program goals… [the evaluation] is expected to incorporate outcomes such as initiation and compliance with treatment; utilization of health services, including avoidable emergency department visits and inpatient hospitalizations; care coordination, including access to care for physical health conditions; preventable or medically inappropriate readmissions; and opioid-related overdose deaths (STC 13.5.c)." The evaluation will also include a study of meaningful subgroups such as housing status as described, below.

Hypothesis 1: Rates of identification, initiation, and engagement in treatment for OUD and other SUDs will increase over the course of the demonstration, relative to a baseline established in 2022.

Research Question 1: What are the trends in rates of identification, initiation, and engagement in treatment for OUD and other SUDs programs over the course of the current demonstration (2023-2028)? How do these trends vary across subgroups (e.g., age distribution, race/ethnicity, sex, housing status, and presence of comorbidities or co-occurring conditions)?

Hypothesis 2: Rates of adherence to, and retention in treatment for OUD and other SUDs, overall and for individuals aged 21-64, will increase over the course of the demonstration.

Research Question 2: What are the trends in rates of adherence to, and retention in treatment for OUD and other SUDs, overall and for individuals aged 21-64 over the course of the current demonstration? How do these trends vary by subgroups (e.g., age distribution, race/ethnicity, sex, housing status, and presence of comorbidities or co-occurring conditions)?

Hypothesis 3: Overdose deaths, particularly those due to opioids, will decrease for individuals aged 21-64 over the course of the demonstration, relative to a baseline established in 2022.

Research Question 3: What are the trends in rates of overdose deaths overall and for individuals aged 21-64, particularly those due to opioids over the course of the current demonstration? How do these trends vary by subgroups (e.g., age distribution, race/ethnicity, sex, housing status, and presence of comorbidities or co-occurring conditions)?

Hypothesis 4: Utilization of emergency departments and inpatient hospital settings and associated adjusted estimates of costs for OUD and other SUD treatment, where the utilization is preventable or medically inappropriate, will decrease (including individuals aged 21-64) over the course of the demonstration, relative to a baseline established in 2022.

Research Question 4: What are the trends in preventable or medically inappropriate utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment, overall and for individuals aged 21-64 over the course of the current demonstration? How do these trends vary by subgroups (e.g., age distribution, race/ethnicity, sex, housing status, and presence of comorbidities or co-occurring conditions)?

Hypothesis 5: Readmissions to the same or higher level of care where readmission is preventable or medically inappropriate for individuals with OUD and other SUD will decrease (including individuals aged 21-64) over the course of the demonstration, relative to a baseline established in 2022.

Research Question 5: What are the trends in readmissions to the same or higher level of care, where readmissions are preventable or medically inappropriate, for individuals with OUD and other SUD, overall and for individuals aged 21-64 over the course of the demonstration? How do these trends vary by subgroups (e.g., age distribution, race/ethnicity, sex, housing status, and presence of comorbidities or co-occurring conditions)?

Hypothesis 6: Access to care for physical health conditions among beneficiaries with OUD or other SUDs will increase over the course of the demonstration, relative to a baseline established in 2022.

Research Question 6: What are the trends in access to care for physical health conditions among beneficiaries with OUD or other SUDs over the course of the demonstration? How do these trends

vary by subgroups (e.g., age distribution, race/ethnicity, sex, housing status, and presence of comorbidities or co-occurring conditions)?

Research Question 7 (applies to all hypotheses): How does the OUD/SUD program affect quality of OUD-SUD services and care coordination among those with OUD or other SUDs over the course of the demonstration?

C. Methodology

Below, we provide brief descriptions of the proposed measures and methods. A summary of the methods, organized by hypotheses and research questions can be found at the end of this section in Table 9.4.

Claims-based Measures:

We will assess the claims-based outcomes listed and described in Table 9.1. A summary of the methods, organized by hypotheses and research questions can be found at the end of this section.

Table 9.1. Inventory of Claims-based Measures[93]

Measure		Brief Description (Data Steward)
SUD/OUD/Primary Care Service Utilization		
1.	a. Initiation of Alcohol and Other Drug Abuse or Dependence Treatment	Number of persons who initiate treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of the index episode start date among Medicaid recipients age 13 or older diagnosed with a new episode of alcohol or other drug (AOD) dependency (NCQA).
	b. Engagement of Alcohol and Other Drug Abuse or Dependence Treatment	Number of persons with initiation of treatment and two or more additional services for treatment within 34 days of the initiation encounter among Medicaid recipients aged 13 or older diagnosed with a new episode of AOD dependency (NCQA).
2.	Use of critical levels of care for OUD/SUD	Number of persons using MAT services among Medicaid recipients with OUD/SUD (CMS/Mathematica)
3.	Continuity of Pharmacotherapy for OUD	Percentage with at least 180 days of MAT supply and no gaps >7 days among beneficiaries with at least one MAT claim (NCQA; NQF #3175).
4.	Follow-up after Discharge from Emergency Department for Alcohol or Other Drug Dependence	Number of persons with a follow-up visit within 7 and/or 30 days of the ED visit among Medicaid recipients age 13 or older with a principal diagnosis of AOD abuse or dependence (NCQA).

[93] [Adapted from] Lloyd K, Chakravarty S, Nasiri M, Farnham J, Agrawal M. Interim evaluation of the NJ FamilyCare 1115 substance use disorder demonstration. Center for State Health Policy; 2022. https://doi.org/10.7282/00000317

5.	Access to Preventive/Ambulatory Health Services for Adult Beneficiaries with SUD or OUD	Percentage of beneficiaries with SUD or OUD who had an ambulatory or preventive care visit.
Avoidable or Potentially Preventable Treatment		
6.	Use of Opioids at High Dosage in Persons Without Cancer	Number of persons with opioid prescription claims where the morphine equivalent dose for 90 consecutive days or longer is greater than 90 mg among Medicaid recipients age 18 and older with two or more prescription claims for opioids filled on at least two separate days, for which the sum of the days' supply is > 15.
7.	Rate of all and OUD overdose deaths	Number of overdose deaths by drug type among NJ residents (NJ CARES/CDC).[a]
8.	Rate of emergency department visits for SUD-related diagnoses and specifically for OUD	Number of ED visits for SUD or OUD among Medicaid recipients.
9.	Rate of inpatient admissions for SUD and specifically OUD	Number of IP visits for SUD or OUD among Medicaid recipients.
108.	30-day all-cause hospital readmissions among beneficiaries with SUD and specifically OUD	Number of readmissions among acute inpatient discharges by Medicaid recipients age 18 and older with SUD and separately OUD (AHRQ).[b]
11.	Avoidable inpatient hospitalization rate among individuals with OUD/SUD (AHRQ)	Number of all-cause hospitalizations for ambulatory care sensitive conditions among Medicaid recipients aged 6 and older with OUD/SUD (AHRQ).
Costs		
12.	SUD-IMD costs	Total costs of claims for inpatient/residential treatment within IMDs among beneficiaries with OUD/SUD.
13.	SUD-other costs	Total SUD costs excluding IMD costs among beneficiaries with OUD/SUD.
14.	Total costs - Total - Total federal	Total costs on all claims; federal costs estimated using NJ FMAP percentage among beneficiaries with OUD/SUD.
15.	Source of care costs - Outpatient (non-ED) - Outpatient (ED) - Inpatient - Pharmacy	Total costs on claims identified by claim-type and/or provider-type for each source of care category among beneficiaries with OUD/SUD.

	- Long-term care costs	

SUD = Substance Use Disorder; OUD = Opioid Use Disorder; MAT = Medication Assisted Treatment; AOD=Alcohol or other drug Dependence; ED=Emergency Department; IP = inpatient; NCQA = National Committee for Quality Assurance; AHRQ= Agency for Healthcare Research and Quality; NQF = National Quality Forum

[a] NJDLPS (New Jersey Department of Law & Public Safety). 2021. "NJ CARES: A Real-Time Dashboard of Opioid-Related Data and Information". Accessed June 11. Trenton: NJDLPS. https://www.njoag.gov/programs/nj-cares/nj-cares-suspected-overdose-deaths/

[b]Readmission rates among those with OUD specifically will be calculated only if sample size is sufficient

[c]https://wagner.nyu.edu/faculty/billings/nyued-background; This measure is being used to assess avoidable ED use for physical health conditions among individuals with OUD/SUD. The fact that visits due to mental health, alcohol use, and substance abuse are not classified by this algorithm does not affect the utility of this measure for examining physical health outcomes consistent with Hypothesis 6. The measure "Rate of emergency department visits for SUD-related diagnoses and specifically for OUD" under Hypothesis 4 will address ED use for substance abuse.

Table 9.2. Qualitative Domains, OUD-SUD

Domain		**Brief Description**
1.	Quality of OUD-SUD services	Inquire into access to guideline-adherent care for OUD/SUD and challenges and benefits of establishing peer support services.
2.	Care coordination	Elicit experiences from key constituents on determining/utilizing level of care and case management for people in the OUD/SUD program.
3.	Beneficiary experience	Elicit perspectives on how beneficiaries' needs for treatment may have been met within the OUD/SUD program, the impact of case management on access to care for physical health among those with OUD/SUD and identify unanticipated negative consequences of the OUD/SUD initiative.

SUD = Substance Use Disorder; OUD = Opioid Use Disorder

Methodology for Hypothesis 1-6, Research Questions 1-6

Study population:

Individuals enrolled in Medicaid, especially those experiencing SUD, are likely to have high levels of eligibility churn,[94] so CMS guidance will be followed by not using a static cohort of continuously enrolled beneficiaries over time.[95] As a result, adult beneficiaries (age 18+) with SUD/OUD and *any* period of active enrollment in a particular year will make up the beneficiary study population for that year. As in the evaluation of the previous demonstration,[8] this requires enrollment each year and having a claim with a diagnosis of Alcohol Abuse and Dependence, Opioid Abuse and Dependence, or Other Drug Abuse and Dependence or an indication of MAT were considered to have SUD as determined by using NCQA HEDIS value sets.[96] There are no substantive changes in the demonstration for the OUD/SUD Program, and data on the healthcare experiences of beneficiaries prior to enrollment are not available, which precludes testing the effect of reform using pre-post comparisons. However, analyses will be conducted to track outcomes over time by subgroups. These will include age distribution, race/ethnicity, sex, housing status,[97] and presence of comorbidities or co-occurring conditions as available within the Medicaid claims.

Analytic strategy:

As a continuation of previous demonstration (2017-2022), the study team will evaluate trends in study outcomes among adults with SUD in the current demonstration (2023-2028). We will calculate adjusted trends, estimating levels of outcome measures on a quarterly or annual basis (as feasible given sample size concerns) to evaluate the ongoing effect of providing substance use disorder services to Medicaid beneficiaries on stated goals of the OUD/SUD program, including paying for services rendered in an Institution for Mental Disease (IMD) (see Table 9.1 for complete list of proposed outcome measures).

We will implement a repeated cross-sectional approach for all OUD/SUD beneficiaries. We will adjust for possible changes in population composition (e.g., by age, race/ethnicity, sex, housing status, and presence of comorbidities, and Chronic Illness and Disability Payment System (CDPS) risk score) using regression models. We will use line graphs and tables to describe results. Sample sizes permitting, the adjusted trends will also be calculated by subgroups of interest (e.g., age distribution, race/ethnicity, sex, housing status, and presence of comorbidities or co-occurring conditions).

The models will be specified as described below:

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[94] Wallace NT, McConnell KJ, Gallia CA, Edlund TD. Benefit policy and disenrollment of adult Medicaid beneficiaries from the Oregon health plan. Journal of health care for the poor and underserved. 2010;21(4):1382-94.

[95] Centers for Medicare & Medicaid Services. Appendix C: Approaches to Analyzing Costs Associated with Section 1115 Demonstrations for Beneficiaries with Serious Mental Illness/Serious Emotional Disturbance or Substance Use Disorder; 2021.. Baltimore: CMS. https://www.medicaid.gov/medicaid/section1115-demo/downloads/evaluation-reports/smi-sed-sud-cost-appendix-c.pdf.

[96] NCQA (National Committee for Quality Assurance). 2020. HEDIS 2020: Healthcare Effectiveness Data and Information Set. Vol. 2: Technical Specifications for Health Plans. Washington, DC: NCQA.

[97] Information on housing status will be determined using the Z59 ICD-10 code, "Problems related to housing and economic circumstances" and will be supplemented by a linkage to the HUD Homeless Management Information System.

Main Models:

$$Outcome_{it} = \alpha_0 + \alpha_1(Time_Indicator)_i + \alpha_2(Group)_{it} + \lambda X_{it} + \varepsilon_{it}$$

Secondary Models:

$$Outcome_{it} = \alpha_0 + \alpha_1(Time_Indicator)_i + \alpha_2(Group)_{it} + \alpha_3(Time_Indicator * Group)_{it} + \lambda X_{it} + \varepsilon_{it}$$

For the Main Models, $Outcome_{it}$ represents the outcome of interest for an individual respondent *i* in year t (e.g., annual dental visit, avoidable hospitalizations, etc., as described in Table SUD-OUD.1). $Group_{it}$ represents a group attribute (i.e., age distribution, race/ethnicity, sex, housing status, and presence of comorbidities or co-occurring conditions). α represents the corresponding coefficients for the model. X_i represents a set of control variables for individual *i* at time *t* and λ represents the vector of coefficients for each of the corresponding control variables of *X*. ε represents the error term. Models will be estimated using ordinary least squares regression except for models with counts as the dependent variable (i.e., Poisson regression) or for spending, which will be estimated using a generalized linear model as dollars would be the dependent variable (e.g., Gamma distribution with log link function).[98] Marginal analysis will be applied after running each regression to generate adjusted trends over time based on these models (i.e., using predictive margins).[99]

Specifications for the Secondary Models will be identical to the Main Models, except that we will introduce an interaction term of $Time_Indicator * Group$, used to capture time-varying differences by group (e.g., age distribution, race/ethnicity, sex, housing status, and presence of comorbidities or co-occurring conditions) with the α_3 coefficient. This would allow us to plot the adjusted trends by group of interest through the post hoc marginal analysis.

The study team will also conduct sensitivity analyses regarding the effect of morbid conditions and CDPS score on study outcomes. This would include running the main and secondary models with and without the comorbidity and CDPS independent variables and monitoring changes in these measures over time.

Methodology for Research Question 7

Study population:

Key informants will be recruited among individuals with knowledge of beneficiary experience, including beneficiaries themselves and providers as well as representatives of working groups, community partners, and provider and consumer associations to elicit perceptions of the program, resultant process, and their impact. Interviews will be conducted with a purposeful sample to obtain viewpoints about ongoing benefits and unanticipated consequences for patients and families.

Data Collection for RQ 7:

[98] Deb P, Manning W, Norton E. Modeling health care costs and counts. IniHEA World Congress in Sydney, Australia 2013.

[99] Williams R. Using the margins command to estimate and interpret adjusted predictions and marginal effects. The Stata Journal. 2012 Jun;12(2):308-31.

The interviews will be informed by previously conducted document reviews to understand activities and recommendations of the advisory committees, review meeting minutes and related documents, and monitor progress toward program goals for the OUD/SUD program during the prior demonstration, successes, challenges, and lessons learned. We will begin the focus groups with an unprompted presentation of selected findings from the interim evaluation in a non-technical format (e.g., basic charts and summary of findings) to elicit interpretation of findings and feedback. This will be followed by a set of open-ended interview questions (see Appendix 9.1) to elicit participants' views on experiences of beneficiaries and families regarding the OUD/SUD Program, satisfaction, and recommendations. The interview guide will include follow-up prompts and probes to elicit in-depth responses.

Interviews that will be conducted with ~20-30 targeted key informants. Previous conversations with key constituents have informed a draft of the semi-structured interview guide noted in Table 9.3 (i.e., quality of OUD-SUD services, care coordination, and beneficiary experience).

Analytic Approach for RQ 7:

Data from key informant interviews will be de-identified and then independently coded by two researchers to identify themes and patterns in the data using an inductive process. In addition to predetermined (a priori) thematic areas aligned with the OUD/SUD Program's goals, the research team will identify emergent themes and patterns in the data after conducting a coding consensus process.

Table 9.3: Research Questions and Interview Strategies for RQ7

Research Question	Number	Interview Strategy
RQ7: How does the OUD/SUD program affect quality of OUD-SUD services and care coordination among those with OUD or other SUDs?	≈20 to 30	In consultation with DMAHS, the evaluator will identify individuals for recruitment. Interviews will be conducted with individuals with expert knowledge regarding beneficiary experience with services and care coordination, including beneficiaries themselves, providers as well as representatives of working groups, community partners, and provider and consumer associations to obtain viewpoints on benefits and remaining barriers and challenges related to participation in OUD/SUD Program. Interviews will be approximately 60-90 minutes.

Table 9.4. Summary of Questions, Hypotheses and Methodology

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
Hypothesis 1: *Rates of identification, initiation, and engagement in treatment for OUD and other SUDs will increase over the course of the demonstration, relative to a baseline established in 2022.*				
RQ1 What are the trends in rates of identification, initiation, and engagement in treatment for OUD and other SUDs programs over the course of the current demonstration (2023-2028)? How do these trends vary across different subgroups (e.g., age distribution, race/ethnicity, sex,	• Initiation of Alcohol and Other Drug Abuse or Dependence Treatment • Engagement of Alcohol and Other Drug Abuse or	Medicaid recipients age 13 or older diagnosed with a new episode of alcohol or other drug (AOD) dependency	Medicaid Fee-for-Service and Encounter Claims Records	Examine adjusted trends in study outcomes through analytic summaries by using regression analysis with sub analyses by age distribution,

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
housing status, *and presence of comorbidities or co-occurring conditions)?*	Dependence Treatment			race/ethnicity, sex, housing status, and presence of comorbidities or co-occurring conditions.
Hypothesis 2: *Rates of adherence to, and retention in treatment for OUD and other SUDs, overall and for individuals aged 21-64, will increase over the course of the demonstration.*				
RQ2 What are the trends in rates of adherence to, and retention in treatment for OUD and other SUDs, overall and for individuals aged 21-64 over the course of the current demonstration? How do these trends vary by subgroups (e.g., age distribution, race/ethnicity, sex, housing status, *and presence of comorbidities or co-occurring conditions)?*	1. Use of critical levels of care (MAT) for OUD/SUD 2. Follow-up after Discharge from Emergency Department for Alcohol or Other Drug Dependence	1. Medicaid recipients with OUD/SUD 2. ED visits by Medicaid recipients age 13 or older with a principal diagnosis of AOD abuse or dependence	Same as above	Same as above
Hypothesis 3: *Overdose deaths, particularly those due to opioids, will decrease for individuals aged 21-64 over the course of the demonstration, relative to a baseline established in 2022.*				
RQ3 What are the trends in rates of overdose deaths overall and for individuals aged 21-64, particularly those due to opioids over the course of the current demonstration? How do these trends vary by subgroups (e.g.,	1. Use of Opioids at High Dosage in Persons Without Cancer 2. Rate of all and OUD overdose deaths	1. Medicaid recipients age 18 and older with two or more prescription claims for	Same as above	Same as above

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
age distribution, race/ethnicity, sex, housing status, *and presence of comorbidities or co-occurring conditions)?*		opioids filled on at least two separate days, for which of the sum of the days' supply is > 15. 2. NJ residents		
Hypothesis 4: *Utilization of emergency departments and inpatient hospital settings and associated adjusted estimates of costs for OUD and other SUD treatment, where the utilization is preventable or medically inappropriate, will decrease (including individuals aged 21-64) over the course of the demonstration, relative to a baseline established in 2022.*				
RQ4 What are the trends in preventable or medically inappropriate utilization of emergency departments and inpatient hospital settings for OUD and other SUD treatment, overall and for individuals aged 21-64 over the course of the current demonstration? How do these trends vary by subgroups (e.g., age distribution, race/ethnicity, sex, housing status, *and presence of comorbidities or co-occurring conditions)?*	• Rate of emergency department visits for SUD-related diagnoses and specifically for OUD • Rate of inpatient admissions for SUD and specifically OUD	Medicaid beneficiaries	Same as above	Same as above
Hypothesis 5: *Readmissions to the same or higher level of care where readmission is preventable or medically inappropriate for individuals with OUD and other SUD will decrease (including individuals aged 21-64) over the course of the demonstration, relative to a baseline established in 2022.*				
RQ5 What are the trends in readmissions to the same or higher level of care, where readmissions are preventable or medically inappropriate, for individuals with OUD and other	• 30-day all-cause hospital readmissions among beneficiaries	Acute inpatient discharges by Medicaid recipients age 18 and older with	Same as above	Same as above

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
SUD, overall and for individuals aged 21-64 over the course of the demonstration? How do these trends vary by subgroups (e.g., age distribution, race/ethnicity, sex, housing status, *and presence of comorbidities or co-occurring conditions)?*	with SUD and specifically OUD	SUD and separately OUD		
Hypothesis 6: *Access to care for physical health conditions among beneficiaries with OUD or other SUDs will increase over the course of the demonstration, relative to a baseline established in 2023.*				
RQ6 What are the trends in access to care for physical health conditions among beneficiaries with OUD or other SUDs over the course of the demonstration? How do these trends vary by subgroups (e.g., age distribution, race/ethnicity, sex, housing status, *and presence of comorbidities or co-occurring conditions)?*	• Avoidable hospitalizations (PQI/PDI) among individuals with SUD/OUD • SUD-IMD costs • Total and non-SUD specific costs - Outpatient (non-ED) - Outpatient (ED) - Inpatient - Pharmacy - Long-term care costs	Medicaid recipients with OUD/SUD	Same as above	Same as above
RQ7 How does the OUD/SUD program affect quality of OUD-SUD services and care coordination among those with OUD or other SUDs over the course of the demonstration?	Qualitative domains: • Quality of OUD-SUD services • Care coordination	Individuals with knowledge of beneficiary experience, including beneficiaries and	Key informant interviews once, following the interim report.	Qualitative thematic analysis, using an a priori codes determined from OUD/SUD goals and

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
	• Beneficiary experience	providers as well as representatives of working groups, community partners, and provider and consumer associations (n=~20-30).		emergent coding process to obtain viewpoints on benefits and remaining barriers and challenges related to participation in OUD/SUD Program.

Table 9.5 shows an activity timeline for the research activities.

Table 9.5 Key Milestones, Opioid Use Disorder (OUD) /Substance Use Disorder (SUD) Program

Analytic Activity	Year 1 2025	Year 2 2026	Year 3 2027	Year 4 2028	Year 5 2029	Year 6 2030
1. Conduct midpoint assessment	Analyze state monitoring metrics Conduct and analyze N=20-30 KIIs					
2. Qualitative implementation assessment (RQ7)					Conduct and analyze N=20-30 KIIs	Complete analysis
3. Quality of care, health services utilization, and spending assessments: Analyze MMIS data (RQ1-RQ6)	Work with DMAHS staff to define appropriate population and customized metrics for MMIS analysis. Begin analysis of MMIS-based utilization and quality metrics.	Begin analysis of MMIS-based spending metrics Refine/finalize analysis of utilization and quality metrics	Complete interim analysis	Update analysis	Update analysis	Complete analysis
4. Submit reports to CMS	Midpoint assessment report		Interim report			Final report

KII=key informant interviews; RQ=Research Question.

NOTE: Evaluation project years are March-Feb. (subject to change depending on date of authorization to begin).

D. Methodological Limitations

The evaluation methods describe above have several limitations. Our claims-based metrics may not account for clinical factors such as severity that may also impact the likelihood of outcomes over time. To address this limitation, we will adjust trends beneficiary characteristics, including CDPS risk score to adjust for the effect of differences in beneficiary characteristics on trends. However, unobserved differences in characteristics of individuals diagnosed with OUD/SUD over time might underlie estimated differences in outcomes. Several outcomes specifically for the population with OUD that may require a minimal sample size to ensure accuracy of estimates, such as hospital discharge (followed by a readmission or outpatient physician visit).

Individuals experiencing homelessness will be identified using the Z59 ICD-10 code on beneficiary claims. Previous studies have suggested the incompleteness of Z59 as indicator.[100] We will supplement this indicator by leveraging a data linkage to the Homeless Management Information System (see "Evaluation of Housing Supports" for additional information on the data linkage).

As with all measures in the evaluation, reporting of these measures and the subsequent use in empirical models are subject to achieving minimum cell sizes. The analyses also assume completeness of utilization reporting in the Medicaid claims data for services where Medicare is the primary payer. Additionally, the quantitative evaluation will be limited to utilization that is observed within the available claims database.

Regarding the qualitative component, key-informant interviews offer the opportunity for in-depth, experience-based interpretation of quantitative findings. However, findings from the interviews may not necessarily achieve generalizability to the experiences of all beneficiaries. To analyze the beneficiary experience through the interviews, participation will depend first on program take-up and then on caregiver availability, interest, and willingness to participate. Differences between participants and other OUD/SUD Program participants may be driven, in part, by willingness to participate in the research activity. We will aim to mitigate this issue by recruiting study participants that reflect the demographic characteristics of the study population but acknowledge that participants may differ from the other participants in the OUD/SUD Program in ways that are not observable.

[100] Enich M. *Identifying homelessness in Medicaid claims: a mixed-methods approach* (Doctoral dissertation, Rutgers University-School of Graduate Studies).

E. Attachments

Appendix 9.1: Interview Questions for OUD/SUD Initiative

Version 2024.04.03

NOTE: Individuals interviewed will be individuals with expert knowledge regarding OUD/SUD treatment and beneficiary's experiences with services and care coordination, including beneficiaries themselves, providers as well as representatives of working groups, community partners, and provider and consumer associations to obtain viewpoints on benefits and remaining barriers and challenges related to participation in OUD/SUD Program. Informed consent will be administered prior to interview.

Thank you for agreeing to speak with us about the NJFamilyCare OUD/SUD initiatives. We would like to learn about the program's impact on people enrolled in Medicaid. We would also like to identify how to improve the program and how to sustain any successful components. If you do not know the information or would prefer not to answer, please let us know.

1. What improvements in care access for OUD/SUD, if any, have you observed related to the OUD/SUD programs?

2. Are individuals with OUD/SUD able to access the right level of care? If yes, what facilitates this? If no, what are some barriers to accessing the right level of care?

3. How is care coordinated for people in the OUD/SUD program?

4. What is your impression of peer support services? Are there ongoing challenges that we should be aware of? And what benefits, if any, have you observed from peer support services?

5. How have OUD/SUD services impacted treatment success? How could they be improved to promote treatment success?

6. How have newly available housing support initiatives such as the introduction of housing specialists affected treatment goals of beneficiaries with OUD/SUD and/or the experience of their family members or caregivers, providers, and/or community-based organizations?

7. Are you aware of interventions to prevent overdose deaths? If yes, how well have these been applied within the OUD/SUD program?

8. How well have needs of individuals with OUD/SUD for treatment been met within the OUD/SUD program?

9. What has been the impact of case management on access to care for physical health among those with OUD/SUD?

10. Have there been any unanticipated negative consequences of the OUD/SUD initiative?

11. Thank you for your time. We would like to speak with a diverse group of individuals and organizations that were involved in the development and sustaining of the OUD/SUD initiative. Who else do you think we should consider interviewing?

10. Adult IDD Services: Supports and Community Care Programs

A. General Background Information

Intellectual and developmental disabilities (I/DD) are permanent neurological, sensory, metabolic, or degenerative conditions originating during childhood that may affect physical functioning, learning, language, or behavior.[101, 102] Persons with I/DD often lack access to preventative services and screening and experience high rates of morbidity.[103] In this section, we present plans to evaluate ongoing policies and programs affecting adults with I/DD within the current §1115 demonstration. These plans pertain to the Supports Program and the Community Care Program (CCP) in New Jersey.

The Supports Program, initiated under the 2012-2017 §1115 demonstration, was designed to provide a basic level of support services to Medicaid adults (aged 21 and older) with I/DD who live with family members or in other unlicensed settings in the community. The Supports Program does not have a wait list and the eligibility criteria do not require enrollees to meet the ICF/ID (i.e., institutional) level of care eligibility requirements, though enrollees may meet that level. Each enrollee has a support coordinator who assists them in creating an Individualized Service Plan (ISP).

The CCP is restricted to adults (aged 21 and older) who meet Institutional Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) levels of care. Components of the CCP were initially approved in 1985 as the "Community Care Waiver" and were incorporated into the §1115 Comprehensive Demonstration in 2017. Unlike the Supports Program, the CCP has a waiting list, divided into general and priority categories. Priority individuals are assigned based on their community placement and a risk assessment, including the age or disability status of their caregivers. However, all individuals on the CCP waiting list are offered enrollment in the Supports Program while waiting for the CCP.

The §1115 Comprehensive Demonstration in 2017 also expanded eligibility for the Supports Program to include individuals with income up to 300% Federal Benefit Rate (FBR) to receive Medicaid State Plan and Waiver Home & Community Based Services (HCBS). This amendment also included Private Duty Nursing (PDN) services from the Managed Long-Term Services and Support (MLTSS) for certain individuals in the Supports Program. These changes have been continued in the demonstration renewal.

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[101] Eunice Kennedy Shriver National Institute for Child Health and Human Development. About Intellectual and Developmental Disabilities (IDDs); November 9, 2021. Accessed September 7, 2023. https://www.nichd.nih.gov/health/topics/idds/conditioninfo

[102] Developmental Disabilities: Delivery of Medical Care for Children and Adults. I. Leslie Rubin and Allen C. Crocker. Philadelphia, Pa, Lea & Febiger, 1989.

[103] Escudé C. Advancing Health Equity For People With Intellectual And Developmental Disabilities. Health Affairs Forefront. 2022.

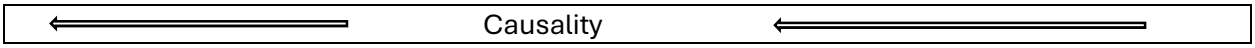
The current 1115 demonstration (2023-2028) expands the eligibility group for the Supports Program and the CCP to individuals aged 18 up to 21 who have graduated from or are no longer eligible for the services to which they were entitled through their local educational authority. We will evaluate the effect of expansion in services eligibility on this age group.

B. Evaluation Questions and Hypotheses

Based on the successes of the previous demonstration, we posit that the demonstration policies relating to provision of HCBS through the Supports Program or CCP to enrolled adults with I/DD will translate into continued improvements in community-level care reflected in maintained or improved ambulatory care outcomes. Below we present the *driver diagram* (Figure 10.1) that delineates the pathway from the policy change to improved outcomes. The secondary drivers represent the various services offered through the Supports Program and CCP. These services promote independent functioning, self-care, physical and emotional wellbeing, and health overall and facilitate patient and caregiver engagement in healthcare decision-making. Improved physical outcomes are also anticipated from the ability of beneficiaries to gain access to coordinated services and supports. Improved coordination and access to community level services and improved access to quality ambulatory and community level care as observed in improved access to preventative services and follow-up care are expected to lead to reductions in reliance on nursing and other residential facilities and reductions in avoidable hospitalizations.

Figure 10.1: I/DD Driver Diagram

<table>
<tr><th>Aims</th><th>Primary Drivers</th><th>Secondary Drivers</th></tr>
<tr><td rowspan="2">1) Improve functionality and address disability-related constraints to daily living
2) Improve wellbeing and health
3) Reduce reliance on nursing or other residential settings
4) Reduce avoidable hospitalizations</td><td>• Improve access to preventative health care and allied health professionals</td><td>• Behavioral support
• Assistive technology
• Day habilitation
• Speech Therapy
• Physical therapy
• Occupational therapy
• Private duty nursing
• Respite services</td></tr>
<tr><td>• Improve coordination of services and supports
• Improve access to community life</td><td>• Care management/support coordination
• Supported Employment
• Prevocational Services
• Goods and Services
• Interpreter services
• Transportation
• Community inclusion services
• Individual supports
• Community-based supports</td></tr>
</table>



We next detail the hypotheses and corresponding research questions that help assess the effect of additional HCBS and expanded eligibility for Medicaid services on care and health outcomes among adults with I/DD.

Hypothesis 1: Providing Home & Community Based Services (HCBS) to Medicaid beneficiaries with intellectual and developmental disabilities (I/DD) through the Supports Program and CCP is associated with improved access to preventative services, reduced reliance on nursing home and other residential facilities, and reduced avoidable hospitalization and emergency services.

Research Question 1a: What are the trends in **preventative services** among the Supports Program and CCP beneficiaries (e.g., metabolic monitoring, annual eye exam among individuals with diabetes, annual dental visit, and annual primary care medical visit) over the course of the current demonstration (2023-2028)? How do these trends vary across different subgroups (e.g., race/ethnicity, gender, and presence of comorbidities)?

Research Question 1b: What are the trends in **utilization of care** among the Supports Program and CCP beneficiaries (e.g., inpatient hospitalizations, emergency department treat-and-release visits, and primary care utilization) over the course of the current demonstration (2023-2028)? How do these trends vary across different subgroups (e.g., race/ethnicity, gender, and presence of comorbidities)?

Research Question 1c: What are the trends in **residential and nursing home placement** among the Supports Program and CCP beneficiaries over the course of the current demonstration (2023-2028)? How do these trends vary across different subgroups (e.g., race/ethnicity, gender, and presence of comorbidities)?

Research Question 1d: What are the trends in **avoidable utilization and spending** among the Supports Program and CCP beneficiaries over the course of the current demonstration (2023-2028)? How do these trends vary across different subgroups (e.g., race/ethnicity, gender, and presence of comorbidities)?

Research Question 1e: How has the Supports Program and CCP affected the **experience of services and supports and overall satisfaction** of beneficiaries as the health care consumer, and that of their parents, guardians, and/or other primary caregivers?

Hypothesis 2: Providing Home & Community Based Services to expanded eligibility groups (individuals with I/DD aged 18 up to 21 and who have graduated from or are no longer eligible for their educational entitlement) who would otherwise have not been eligible for the Supports Program or the CCP absent the demonstration (hereafter, “expanded eligibility groups”) will **increase access to preventative services, reduce reliance on nursing home and other residential facilities, and reduce avoidable hospitalization and emergency services.**

Research Question 2a: What are the trends in **preventative services** among the Supports Program and CCP expanded eligibility group (e.g., metabolic monitoring, annual eye exam among individuals with diabetes, annual dental visit, and annual primary care medical visit) over the

course of the current demonstration (2023-2028)? How do these trends vary across different subgroups (e.g., race/ethnicity, gender, and presence of comorbidities)?

Research Question 2b: What are the trends in **overall utilization of care** among the Supports Program and CCP expanded eligibility group (e.g., inpatient hospitalizations, emergency department (ed) treat-and-release visits, and primary care utilization) over the course of the current demonstration (2023-2028)? How do these trends vary across different subgroups (e.g., race/ethnicity, gender, and presence of comorbidities)?

Research Question 2c: What are the trends in **residential and nursing home placement** among the Supports Program and CCP expanded eligibility group over the course of the current demonstration (2023-2028)? How do these trends vary across different subgroups (e.g., race/ethnicity, gender, and presence of comorbidities)?

Research Question 2d: What are the trends in **avoidable utilization and spending** among the Supports Program and CCP expanded eligibility group over the course of the current demonstration (2023-2028)? How do these trends vary across different subgroups (e.g., race/ethnicity, gender, and presence of comorbidities)?

C. Methodology

We will assess the outcomes listed in Table 10.1 and described below.

Table 10.1: Inventory of Measures

Measure		Brief Description
Preventative Services		
1.	Metabolic monitoring	Routine access to metabolic testing, i.e., A1C testing, to pre-empt or monitor the progression of diabetes.[104]
2.	Annual eye exam among individuals with diabetes	Retinal eye exam performed during the measurement year among beneficiaries with diabetes.[4]
3.	Annual dental visit	At least one dental visit with a dental practitioner during the measurement year.[4]
4.	Annual primary care medical visit*	At least one primary care visit with their provider during the measurement year.
5.	Follow-up (7 days and 30 days) after hospitalization for mental illness	Hospitalization for the treatment of selected mental health disorders that were followed by a qualifying visit with a mental health practitioner or behaviorist within 7 and 30 days.[4]
Overall Utilization of Medical Services		
6.	Inpatient hospitalizations (all-cause) car	Inpatient medical facility treatment/hospitalization which may include, but not limited to, non-surgical medical treatment, surgery, and administration of medication.

[104] NCQA (National Committee for Quality Assurance). 2018. *HEDIS 2018: Healthcare Effectiveness Data and Information Set. Vol. 2: Technical Specifications for Health Plans.* Washington, DC: NCQA.

7.	Emergency department (ED) treat-and-release visits	Medical treatment within a hospital's emergency department not resulting in inpatient hospital admission.[105]
8.	Primary care utilization	Indicator that beneficiary receives routine outpatient or preventative medical care, includes frequency of visits per year.
Nursing Home and Residential		
9.	Stays in residential settings, including nursing homes and long-term care	Rate of residential treatment facilities and nursing home placements. Excludes short-term rehabilitation but includes long-term care for permanent disability.
Avoidable Utilization and Spending		
10.	Avoidable Hospitalizations	Preventable or potentially avoidable hospitalization that may occur due to inadequate ambulatory/primary care within communities, specific to individuals with I/DD.[106, 107]
11.	Spending related to all inpatient hospitalizations and ED visits	Payments on facility claims for (1) inpatient and (2)treat-and-release ED visits, inflation adjusted.

Qualitive Domains:

We will collect and analyze qualitative data within the broad domains identified in Table 10.2.

Table 10.2. Qualitative Domains by Research Question

Domains		Brief Description
1.	Services and Supports Access	Beneficiary and parent, guardian, or other primary caregiver experience with services and supports and remaining barriers.
2.	Community Integration	Beneficiary's opportunities to participate in the community, including activities outside the home.
3.	Experience of beneficiaries and their families	Satisfaction with the services and support provided. Impact of services and support on experience of care and

[105]Individuals residing in licensed settings are impacted by Danielle's Law which requires calling 911 for potentially life-threatening emergencies.

[106] Balogh RS, Ouellette-Kuntz H, Brownell M, and Colantonio A. "Ambulatory Care Sensitive Conditions in Persons with an Intellectual Disability – Development of a Consensus." *Journal of Applied Research in Intellectual Disabilities* 24 (2): 150–58; 2011.

[107] Balogh RS, Ouellette-Kuntz H, Brownell M, and Colantonio A. Factors associated with hospitalisations for ambulatory care-sensitive conditions among persons with an intellectual disability – a publicly insured population perspective. Journal of Intellectual Disability Research, 57: 226-239; 2013.

		recommendations for additional services or other requested modifications
NOTES Adapted from National Core Indicators, NCI-IDD Survey™,[108]		

Populations and Evaluation Methods

For hypothesis 1 and 2 and Research Questions 1a-1d & 2a-2d

Study population for research questions 1a-1d: The study population for hypotheses 1a-1d is comprised of individuals aged 21 or older who participated in either the Supports Program or CCP. There are no substantive changes in the demonstration for the Supports Program or CCP. As a continuation of previous demonstration (2017-2022), the study team will monitor trends in study outcomes among the Supports Program and CCP participants in the current demonstration (2023-2028) as required in the Special Terms and conditions (STC 13.3), without a comparison group.

Study population for research questions 2a-2d: The study population for hypotheses 2a-2d is comprised of individuals aged 18 up to 20 who participated in either the Supports Program or CCP as part of the expanded eligibility population. This represents a previously ineligible population, preventing the identification of an appropriate comparison group or pre-intervention observation period.

Analytic strategy for research questions 1a-1d and 2a-2d: We will calculate adjusted trends, estimating levels of outcome measures on a quarterly or annual basis (as feasible relative to sample size concerns) to examine preventative services, utilization of services, nursing home and residential services, avoidable utilization and spending (see Table 10.1 for complete list of proposed outcome measures).

We will select cohorts of individuals enrolled in Supports Program and CCP, respectively, during the baseline period (2022) and then examine changes in outcomes over the current demonstration period (2023-2028). We will adjust for possible changes in population composition (e.g., by age, race/ethnicity, gender, and presence of comorbidities, and Chronic Illness and Disability Payment System (CDPS) risk score) using regression models. We will use line graphs and tables to describe results. Sample sizes permitting, the adjusted trends will also be stratified by subgroups of interest such as race/ethnicity, gender, and presence of comorbidities.

The models will be specified as described below:

Main Models:

$$Outcome_{it} = \alpha_0 + \alpha_1 Time_Indicator_i + \alpha_2 Group_{it} + \lambda X_{it} + \varepsilon_{it}$$

[108] NCI (National Core Indicators). 2022. *NCI-IDD Indicators.* National Association of State Directors of Developmental Disabilities Services and Human Services Research Institute. Retrieved on 10/26/2023 from:

Secondary Models:

$$Outcome_{it} = \alpha_0 + \alpha_1 Time_Indicator_i + \alpha_2 Group_{it} + \alpha_3 Time_Indicator_i * Group_{it} + \lambda X_{it} + \varepsilon_{it}$$

For the Main Models, $Outcome_{it}$ represents the outcome of interest for an individual respondent *i* in year t (e.g., annual dental visit, avoidable hospitalizations, etc., as described in Table IDD.1). $Group_{it}$ represents a group attribute (i.e., race/ethnicity, gender, and presence of comorbidities). α represents the corresponding coefficients for the model. X_i represents a set of control variables for individual *i* at time *t* and λ represents the coefficients for each of the corresponding control variables of *X*. ε represents the error term. Models will be estimated using ordinary least squares regression except for spending, which will be estimated using a generalized linear model as dollars would be the dependent variable (e.g., Gamma distribution with log link function).[109] Marginal analysis will be applied after running each regression to generate adjusted trends over time based on these models (i.e., using predictive margins).[110]

Specifications for the Secondary Models will be identical to the Main Models, except that we will introduce an interaction term of $Time_Indicator * Group$, used to capture time-varying differences by group (i.e., race/ethnicity, gender, and presence of comorbidities) with the α_3 coefficient. This would allow us to plot the adjusted trends by group of interest through the post hoc marginal analysis.

The cohort approach compares trends for a fixed cohort of individuals over time to ensure that observed changes in utilization are not due to changes in population composition resulting from beneficiaries newly enrolling or disenrolling from the program. Change in beneficiary characteristics, such as age, disease diagnoses and burden of illness over time, will be adjusted for by accounting for in these models (e.g., with CDPS scores, beneficiary age, and morbid conditions). Additionally, we will estimate yearly measures of study outcomes for <u>all beneficiaries</u> enrolled in Supports Program or CCP without restricting the sample to a cohort of beneficiaries by using a repeated cross-sectional approach. While the cohort analysis mitigates the likelihood for differences in the composition of the sample over time, the cross-sectional analysis will offer a larger sample size and, as a result, more statistical power to detect differences. The study team will also conduct sensitivity analyses regarding the effect of morbid conditions and CDPS score on study outcomes. This would include running the main and secondary models with and without the comorbidity and CDPS independent variables and monitoring changes in these measures over time.

<u>For research question 1e</u>

<u>Study population for research question 1e:</u>

We will also conduct a qualitative study of beneficiary and caregiver experience. The study population will include adults with I/DD themselves and parents, guardians, and other primary

[109] Deb P, Manning W, Norton E. Modeling health care costs and counts. IniHEA World Congress in Sydney, Australia 2013.

[110] Williams R. Using the margins command to estimate and interpret adjusted predictions and marginal effects. The Stata Journal. 2012 Jun;12(2):308-31.

caregivers who have knowledge of beneficiaries' experiences with services and supports and overall satisfaction as the health care consumer.

Data collection:

Beneficiaries with I/DD, parents, guardians, and other primary caregivers with knowledge of the beneficiary's experience as the health consumer will be recruited to participate in focus group sessions most relevant to their experience through recruitment materials that clearly articulate the aim of the session (i.e., adults with I/DD or family members/advocates of adults with I/DD). Prior to any participation on the study, and in consultation with DMAHS, the Division of Developmental Disabilities, and the Rutgers Institutional Review Board, all study participants will be asked to participate in an informed consent process that assures comprehension of study participation.[111] Participants will initially be asked to complete a brief online screening survey to collect basic information on demographics and beneficiary characteristics (including inquiry into any transitions between Supports and CCP), and to determine study eligibility and help ensure diversity of focus group participants. The study team will then initiate data collection though a series of remote focus groups to elicit beneficiary experience, from the groups described above, to gather reflections on beneficiary experience, recommendations, and interpretation of study findings.[112] Focus groups will have up to 10 people each. These will be held virtually and recorded via video conferencing software, in compliance with the evaluator's Institutional Review Board. We propose a study incentive of $10 for completing the screening survey. Adult beneficiaries with I/DD will be given $100 for participating in their focus group. Similarly, parents, guardians, or other primary caregivers will be given $100 for participating in their focus group. Advocates assisting in the adult I/DD focus group will not be compensated for their participation as an advocate, but may participate in the parent, guardian, or other primary caregiver focus group when applicable.

We will provide a set of open-ended focus group questions to elicit participants' views on experiences of beneficiaries and families regarding program components in either the Supports Program or CCP, and satisfaction and recommendations. The focus group guide will include follow-up prompts and probes to elicit in-depth responses. Up to five focus groups will be organized following the interim evaluation. Participants will be prompted with questions regarding their experience (i.e., Supports Program, CCP, and expanded eligibility group). Sessions will be approximately 60 to 90 minutes in length.

Analytic strategy:

With participant consent, the focus group will be recorded. Recordings will be de-identified and transcribed, then independently coded by two members of the evaluation team. In addition to predetermined thematic areas aligned with Supports Program and CCP aims, the team will identify emergent themes and patterns in the data after conducting a coding consensus process.

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[111] Strickler JG, Havercamp SM. Evaluating an informed consent process designed to improve inclusion of adults with intellectual disability in research. Research in Developmental Disabilities. 2023 Mar 1;134:104413.

[112] Crabtree, BF and Miller, WL. 2022. *Doing qualitative research*. Sage publications.

Table 10.3: Research Questions and Focus Group Strategies for R1e

Research Question	Number	Focus Group Strategy
RQ1e: How has the Supports Program and CCP affected the experience of services and supports and overall satisfaction of beneficiaries as the health care consumer, and that of their parents, guardians, and/or other primary caregivers?	Up to 10 participants per focus group, 4-6 groups following the interim evaluation (n=~50)	In consultation with DMAHS and DDD, CSHP will identify individuals for recruitment. A brief online screening survey and online focus groups will be conducted with purposively sampled adults with I/DD and caregivers/families, to obtain viewpoints about expected benefits and outcomes for patients and families. Focus groups will be approximately 60-90 minutes.

Table 10.4: Summary of Questions, Hypotheses and Methodology

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
Hypothesis 1: Providing Home & Community Based Services (HCBS) to Medicaid beneficiaries with *intellectual and developmental disabilities* ***(I/DD) through the Supports Program and CCP is associated with improved access to preventative services, reduced reliance on nursing home and other residential facilities, and reduced avoidable hospitalization and emergency services.***				
RQ1a. What are the trends in preventative services among the Supports Program and CCP beneficiaries (e.g., metabolic monitoring, annual eye exam among individuals with diabetes, annual dental visit, and annual primary care medical visit) over the course of the current demonstration (2023-2028)? How do these trends vary across different subgroups (e.g., race/ethnicity, gender, and presence of comorbidities)?	• metabolic monitoring, • annual eye exam among individuals with diabetes • annual dental visit, and • annual primary care medical visit • follow-up after hospitalization for mental illness	Individuals enrolled in the Supports Program or CCP as part of the eligibility expansion	Medicaid Fee-for-Service and Encounter Claims Records	Examine adjusted trends in study outcomes through analytic summaries and regression analysis and stratification of models by race/ethnicity, gender, and presence of comorbidities.
RQ 1b. What are the trends in utilization of care among the Supports Program and CCP beneficiaries (e.g., inpatient hospitalizations, emergency department treat-and-release visits, and primary care utilization) over the course of the current demonstration (2023-2028)? How do these trends vary across different	• inpatient hospitalizations (all-cause) • emergency department (ED) treat-and-release visits • primary care utilization	As above	As above	As above

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
subgroups (e.g., race/ethnicity, gender, and presence of comorbidities)?				
RQ1c. What are the trends in residential and nursing home placement among the Supports Program and CCP beneficiaries over the course of the current demonstration (2023-2028)? How do these trends vary across different subgroups (e.g., race/ethnicity, gender, and presence of comorbidities)?	• Stays in residential settings, including nursing homes and long-term rehabilitation	As above	As above	As above
RQ1d. What are the trends in avoidable utilization and spending among the Supports Program and CCP beneficiaries over the course of the current demonstration (2023-2028)? How do these trends vary across different subgroups (e.g., race/ethnicity, gender, and presence of comorbidities)?	• avoidable hospitalizations • spending related to all inpatient hospitalizations and ED visits	As above	As above	As above
RQ1e. How has the Supports Program and CCP affected the experience of services and supports and overall satisfaction of beneficiaries as the health care consumer, and	Reported experiences of beneficiaries and caregivers relating to services and supports, community engagement, and consumer satisfaction.	Purposively sampled adults with I/DD and caregivers/families or others with knowledge about the experience of care among CCP or	Remote (via video conference) focus groups to be conducted after the interim evaluation.	Qualitative thematic analysis

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
that of their parents, guardians, and/or other primary caregivers?		Supports Program participants, no comparison group (n=~50).		
Hypothesis 2: Providing Home & Community Based Services to expanded eligibility groups (individuals with I/DD aged 18 up to 21 and who have graduated from or are no longer eligible for their educational entitlement) who would otherwise have not been eligible for the Supports Program or the CCP absent the demonstration (hereafter, "expanded eligibility groups") will increase access to preventative services, reduce reliance on nursing home and other residential facilities, and reduce avoidable hospitalization and emergency services.				
RQ2a. What are the trends in preventative services among the Supports Program and CCP expanded eligibility group (e.g., metabolic monitoring, annual eye exam among individuals with diabetes, annual dental visit, and annual primary care medical visit) over the course of the current demonstration (2023-2028)? How do these trends vary across different subgroups (e.g., race/ethnicity, gender, and presence of comorbidities)?	• metabolic monitoring, • annual eye exam among individuals with diabetes • annual dental visit, and • annual primary care medical visit • follow-up after hospitalization for mental illness	Individuals enrolled in the Supports Program or CCP as part of the eligibility expansion (individuals with I/DD aged 18 up to 21 and have graduated from, or are no longer eligible for their educational entitlement)	Medicaid Fee-for-Service and Encounter Claims Records	Examine adjusted trends in study outcomes through analytic summaries, regression analysis and stratification of models by race/ethnicity, gender, and presence of comorbidities.
RQ2b. What are the trends in overall utilization of care among the Supports Program and CCP expanded eligibility group (e.g., inpatient hospitalizations, emergency	• inpatient hospitalizations (all-cause) • emergency department (ED) treat-and-release visits • primary care utilization	As above	As above	As above

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
department (ed) treat-and-release visits, and primary care utilization) over the course of the current demonstration (2023-2028)? How do these trends vary across different subgroups (e.g., race/ethnicity, gender, and presence of comorbidities)?				
RQ2c. What are the trends in residential and nursing home placement among the Supports Program and CCP expanded eligibility group over the course of the current demonstration (2023-2028)? How do these trends vary across different subgroups (e.g., race/ethnicity, gender, and presence of comorbidities)?	• Stays in residential settings, including nursing homes and long-term rehabilitation	As above	As above	As above
RQ2d. What are the trends in avoidable utilization and spending among the Supports Program and CCP expanded eligibility group over the course of the current demonstration (2023-2028)? How do these trends vary across different subgroups	• avoidable hospitalizations • spending related to all inpatient hospitalizations and ED visits	As above	As above	As above

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
(e.g., race/ethnicity, gender, and presence of comorbidities)?				

Table 10.5 shows an activity timeline for the research activities.

Table 10.5 Key Milestones, Adult IDD Services: Supports and Community Care Programs

Analytic Activity	Year 1 2025	Year 2 2026	Year 3 2027	Year 4 2028	Year 5 2029	Year 6 2030
1. Quality of care, health service utilization, and spending assessment: Analyze MMIS data (RQ1a-1d;RQ2a-2d)	Define appropriate population and customized metrics for MMIS analysis	Begin analysis of MMIS-based utilization and quality metrics	Complete interim analysis		Conduct analysis	Complete analysis
2. Qualitative systems change and outcome assessment (RQ1e)		Review documents, observe meetings	Conduct CSSP focus groups screening survey	Conduct CSSP 4-6 focus groups (N=~50) Conduct analysis	Complete analysis	
3. Submit reports to CMS			Interim report			Final report

RQ=Research Question.

NOTE: Evaluation project years are March-Feb. (subject to change depending on date of authorization to begin).

D. Methodological Limitations

The evaluation methods describe here have has several limitations. First, there are no comparison groups available to enable causal inference analysis. The I/DD Supports and CCP were in place prior to the current demonstration such that pre-post comparisons within the current demonstration would not support inferences about program impacts. Additionally, our claims-based metrics may not account for clinical factors such as severity that may also impact the likelihood of outcomes over time. To address this limitation, we will adjust trends by beneficiary characteristics, including CDPS risk score and age.

Our cohort analysis will also mitigate the threat to validity that changes in the composition of beneficiaries might drive any differences in observed study outcomes. However, the cohort analysis may be subject to small sample size which could limit the ability to detect meaningful differences (i.e., insufficient statistical power). The sample sizes will be larger in the repeated cross-sectional analysis, but characteristics of individuals determining service utilization may change over time. By engaging in both approaches, we will be able to compare results for consistency, and we will compare observed peaks and troughs in adjusted outcome trends to align with exogenous shocks (such as those observed during the COVID-19 pandemic in the previous demonstration period).

Medicaid claims analysis relies on Medicaid enrollment. As a result, healthcare experiences of beneficiaries between the aged 18 up to 21 would not be observed if they were not enrolled in Medicaid enrollment prior to the expansion. Our alternative strategies to examine the effect of eligibility expansion each have their own limitations, like those mentioned above in monitoring the Supports Program and CCP, overall. Our cohort analysis may be subject to small sample size due to disenrollment or other losses to follow-up. As mentioned above, the sample size will be larger in repeated cross-sectional analysis but characteristics of individuals determining outcomes may change over time.

Regarding the qualitative component, focus groups offer the opportunity for in-depth, experience-based interpretation of quantitative findings. However, findings from the focus groups may not necessarily achieve generalizability to the experiences of all beneficiaries, caregivers, and families. To analyze the beneficiary experience through the focus groups, participation will depend first on program take-up and then on beneficiary and caregiver availability, interest, and willingness to participate. Differences between participants and other Supports Program or CCP participants may be driven, in part, by willingness to participate in the research activity. We will aim to mitigate this issue by recruiting study participants that reflect the demographic characteristics of the study population but acknowledge that study participants may differ from the other beneficiaries in the Supports Program or CCP in ways that are not observable.

E. Attachments

Appendix 10 .1: I/DD Questionnaire

(Version 2024.3.4)

Would you prefer to complete this survey in English or Spanish?

e. English
f. Spanish -> GO TO SPANISH TRANSLATED SURVEY

Source: New question

Introduction

On behalf of Rutgers University and the New Jersey Division of Medical Assistance and Health Services, thank you for your interest in the evaluation of the **Intellectual and Developmental Disability (I/DD) Supports Program and the Community Care Program (CCP) in New Jersey**. We have asked you to participate because you are a person with I/DD or the parent, guardian, or primary caregiver of an adult with I/DD, who is enrolled in services in either the I/DD Supports Program and the Community Care Program (CCP). You are likely familiar with some of the services available through these programs, such as**:**

- Behavioral support
- Assistive technology
- Day habilitation
- Supported Employment
- Prevocational Services
- Goods and Services
- Speech Therapy
- Physical therapy
- Occupational therapy
- Care management/support coordination
- Private duty nursing
- Respite services
- Interpreter services
- Transportation
- Community-based supports
- Individual supports
- Community inclusion services

The following brief survey is part of our recruitment for focus groups to learn more about the I/DD Supports Program and the CCP Program. We will ask about the adult beneficiary with I/DD and the household where they live.

Screener [To proceed, must answer "A" to I, II, III, IV, and a number for V.]

[Consent form scroll box; language to be approved by DMAHS, CMS, CSOC, Rutgers IRB]

10. Do you consent to participate in the survey?

h. Yes
i. No, exit the survey

Source: New question

11. Are you at least 18 years of age?

c. Yes
d. No, exit the survey

Source: New question

12. **Are you an adult with I/DD, or the parent, guardian, or primary caregiver, of at least one adult with I/DD who participates in New Jersey's I/DD Supports Program or the CCP Program through Medicaid (i.e., NJFamilyCare)?**
    a. Yes
    b. No, exit survey.

13. **The following survey is part of our recruitment for an online meeting (Zoom) to discuss New Jersey's I/DD Supports Program and the CCP Program. The online meeting will be 60-90 minutes. The following survey will take about 10 minutes.**

    -Eligibility to participate in the study is based on the beneficiary with I/DD. A parent, guardian, or primary caregiver who cares for more than one beneficiary with I/DD may complete a survey for each beneficiary but may only participate in one focus group.
    -Those who complete the survey will receive $10 (limited to one survey per beneficiary with I/DD).
    -There will be separate online meetings (zoom) for focus groups. There will be one for adults with I/DD (who may be assisted by an advocate of their choosing) and one for parents, guardians, or other primary caregivers.
    -Participants in the online meeting (zoom) will receive $100 each for their time (advocates in the meeting for adults with I/DD will not be compensated by the study).
    -There are a limited number of spots for the online meetings (Zoom). If you are not chosen for the online meeting but complete the survey, you will still be given $10 for completing the survey.
    -If you would like to only participate in the survey, you will still be given $10.

    Are you interested in participating in the online meeting?

    a. Yes
    b. No

    Source: New question

14. **[If IV. is "Yes"] When would you most likely be able to meet for the online meeting? This will be used to schedule the focus group activity (via Zoom or similar video conferencing tool).**
    Indicate what time you are typically able to meet online (Zoom) for 60-90 minutes.

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Morning (After 9a-12p)							
Afternoon (After 12p-4p)							
Evening (After 4p-9p)							
Night (After 9p-12a)							

- Other or special circumstances (Please specify)

Source: New question

15. **[If IV. is "Yes"] Please provide your contact details so that we may schedule the focus group.**
    - First name:___ [text response]
    - Last name: ___[text response]
    - email address: __ [text response]
    - phone number: __ [text response]
    - Other or special circumstances (Please specify) __ [text response]

Adult Beneficiary with I/DD Characteristics – These questions ask about the experiences of the adult beneficiaries with I/DD covered by the Supports Program and the Community Care Program (CCP) in New Jersey.

62. **How old is the adult beneficiary with I/DD covered by the Supports Program and the Community Care Program (CCP) in New Jersey (in years, at their last birthday)?**

    __ years old [Number]

    Source: Adapted from CSHP/Eagleton/Department of Children and Families - IDD Caregiver Survey

63. **Is the adult beneficiary with I/DD Latino or Hispanic origin, such as Mexican, Puerto Rican, Cuban or some other Spanish background?**
    e. Yes
    f. No

    Source: Adapted from US Department of Health and Human Services, Office of Minority Health, https://minorityhealth.hhs.gov/explanation-data-standards-race-ethnicity-sex-primary-language-and-disability

64. **Is the adult beneficiary's race?**
    m. White (includes Caucasian, European, Middle Eastern)
    n. Black (includes African American)
    o. Asian (includes Asian-Indian, South Asian, East Asian, Chinese, Japanese)
    p. Hispanic / Latino / Spanish
    q. Other (please specify) [Open-ended free text]
    r. Multi-racial (please specify) [Open-ended free text]

    Source: Adapted from US Department of Health and Human Services, Office of Minority Health, https://minorityhealth.hhs.gov/explanation-data-standards-race-ethnicity-sex-primary-language-and-disability

65. **Does this adult beneficiary with I/DD identify as male, female, or in some other way?**
    k. Male

l. Female
m. Non-binary
n. Some other way (please specify)
o. Prefer not to answer

Source: Adapted from CSHP/Eagleton/Department of Children and Families - IDD Caregiver Survey

66. **In general, how would you describe the adult beneficiary with I/DD's health?**
    k. Excellent
    l. Very Good
    m. Good
    n. Fair
    o. Poor

    Source: National Survey on Child's Health, https://www.childhealthdata.org/learn-about-the-nsch/NSCH

67. **What is this adult beneficiary with I/DD's preferred means of communication? (choose one)**
    k. Spoken Language
    l. Gestures or Body language
    m. Sign language or finger spelling
    n. Communication aid or device
    o. Other (please specify) [Open-ended free text]

    Source: National Core Indicators - Child Family Survey, https://idd.nationalcoreindicators.org/

68. **How much support does this adult beneficiary with I/DD need to prevent or manage self-injurious, disruptive, and/or destructive behaviors? (choose one)**
    g. None
    h. Some
    i. Extensive

    Source: National Core Indicators- Child Family Survey, https://idd.nationalcoreindicators.org/

<u>Parent/Guardian/Primary Caregiver Characteristics –</u> These questions ask about the parent, guardian, or other primary caregiver of the adult beneficiary with I/DD.

69. **What is your relationship to the adult beneficiary with I/DD?**
    - Self, skip questions about parent, guardian, and primary caregivers
    - Mother
    - Father
    - Legal guardian
    - Other primary caregiver (Please specify)

- Don’t know/Not sure
- Refused

Source: CSHP/Eagleton/Department of Children and Families, IDD Caregiver Survey

70. **Would you please tell us your age?**
__[Number]
Prefer not to answer/unsure

Source: CSHP/Eagleton/Department of Children and Families, IDD Caregiver Survey

71. **[For prefer not to answer/unsure above, ask] Would you be willing to tell us whether it’s between…**
    u. 18 - 20
    v. 21 - 24
    w. 25 - 29
    x. 30 - 34
    y. 35 – 44
    z. 45 – 49
    aa. 50 - 54
    bb. 55 - 64
    cc. 65 OR OVER
    dd. Prefer not to answer

Source: CSHP/Eagleton/Department of Children and Families - IDD Caregiver Survey

72. **What is the highest degree or level of school you have completed?**
    a. no schooling completed
    b. nursery school to 8th grade
    c. 9th-12th grade, no diploma
    d. high school graduate (high school diploma or the equivalent)
    e. vocational/technical/business/trade school certificate or diploma (beyond the high school level)
    f. some college, but no degree
    g. associate degree
    h. bachelor's degree
    i. master's, professional or doctorate degree
    j. don't know
    k. prefer not to answer

Source: CMS, https://www.cms.gov/data-research/research/medicare-current-beneficiary-survey/questionnaires/2023-questionnaires

73. **Are you of Latino or Hispanic origin, such as Mexican, Puerto Rican, Cuban or some other Spanish background?**
    g. Yes
    h. No

Source: Adapted from US Department of Health and Human Services, Office of Minority Health, https://minorityhealth.hhs.gov/explanation-data-standards-race-ethnicity-sex-primary-language-and-disability

74. **Are you White, Black or of Asian origin, or are you some other race, or multi-racial?**
    s. White (includes Caucasian, European, Middle Eastern)
    t. Black (includes African American)
    u. Asian (includes Asian-Indian, South Asian, East Asian, Chinese, Japanese)
    v. Hispanic / Latino / Spanish
    w. Other (please specify) [Open-ended free text]
    x. Multi-racial (please specify) [Open-ended free text]

    Source: Adapted from US Department of Health and Human Services, Office of Minority Health, https://minorityhealth.hhs.gov/explanation-data-standards-race-ethnicity-sex-primary-language-and-disability

75. **How do you describe your gender? [Select ONE]**
    o. Female
    p. Male
    q. Trans Male/Trans Man
    r. Trans Female/Trans Woman
    s. Genderqueer/Gender Nonconforming
    t. Prefer to self-describe, please specify: [open field]
    u. Prefer not to answer

    Source: Q7-8 Two Step Gender Identity, https://registrar.ucsc.edu/gender-identity/index.html

76. **What is the primary language spoken in your home?**
    g. English
    h. Spanish
    i. Other (please specify) [Open-ended free text]

    Source: Adapted from US Department of Health and Human Services, Office of Minority Health, https://minorityhealth.hhs.gov/explanation-data-standards-race-ethnicity-sex-primary-language-and-disability

77. **Last year, that is in 2022, what was your total household income from all sources, before taxes?**

    h. Less than $25,000
    i. 25 to under $50,000
    j. 50 to under $75,000
    k. 75 to under $100,000
    l. 100 to under $150,000
    m. $150,000 or more
    n. Prefer not to answer

Source: CSHP/Eagleton/Department of Children and Families - IDD Caregiver Survey

78. **In the past 12 months, did you or any member of this household receive benefits from the Food Stamp Program or SNAP (the Supplemental Nutrition Assistance Program)?**

    a. Yes
    b. No
    c. Not sure/prefer not to answer

    Source: Census, https://www.census.gov/programs-surveys/acs/about/forms-and-instructions.html

Appendix 10.2: Adults With I/DD Focus Group Guide

(Version 2024.3.4)

Thank you for talking to us. We really appreciate it. We are trying to find ways to help people around New Jersey. We asked to speak with you because you know a lot about what it is like to live with a disability. Together, we will share about our lives and what we like to do. We will talk about getting out of the house, staying healthy, and meeting new people. We will talk about what makes it hard to do the things we like to do. Please remember that what you like to do is important. You cannot be wrong about what you like. We want everybody to feel comfortable. Someone might like something that you don't like. That is OK! The most important thing is that you feel comfortable to share what you think and share about what you like. Together, I will ask questions to the group. The questions will also come up on the screen and I will read it again. Each person will have a chance to share if they would like to.

1. I'd like to know more about you. For example, I am [interviewer]. I like to [list of activities]. **What are your favorite things to do?**

2. I'd like to know more about the people that you know. This could be people in your home, school, or work. For example, I know people at my job. We like to talk to each other, and we try to learn about disabilities and about helping people be healthy. **What do you like to do with other people?**

3. We hear that having aides or staff can be helpful for people with disabilities. The aides come and help people with disabilities or their families. Your aide might be the person who helps you get dressed, make food, get out of the house, or something else. **How do your aides help you? Is there anything that you wish you had more help with?**

4. Sometimes we can't do the things we'd like to do. It might be difficult to travel, like finding the right bus. It might be too expensive to buy something. Or it might be scary to try something new or go to a new place. **What makes it hard for you to do what you would like to do?**

5. Many people have a staff member called a "support coordinator." This means that they help you to stay organized and get all the right services and activities for you. They might help you with finding a job or help you get special services. **Do you ever speak with your support coordinator about getting the right services? If yes, what happens when you meet with your support coordinator?**

6. **What would you like New Jersey leaders (like the directors of Medicaid, the governor's office, and state agencies) who make decisions about what kinds of services people can have to know about what it is like to live with an intellectual and developmental disability? What could make things better?**

Thank you again for helping us know more about you so that we can find ways to better support people with disabilities and their families!

Appendix 10.3: Family Members/Advocates of Adults With I/DD Focus Group Guide

(Version 2024.3.4)

Thank you for meeting with us. Today, we will be discussing healthcare and support programs in New Jersey. We asked to speak with you because you are a parent, guardian, family member, or other close connection of a person with an Intellectual and Developmental Disability. We will talk about getting services and supports, community, and your experience as a family member of an adult with an Intellectual and Developmental Disability.

Over the next 60-90 minutes, we will focus on ways to improve services for individuals with Intellectual and Developmental Disabilities in New Jersey. We will ask the group six guiding questions. After each question, a prompt will pop-up on your screen with an opportunity write a brief response. We will then share the responses and each member will have the opportunity to explain their answers to the group.

We are aiming to get as many different opinions as possible. We will not be using job titles, degrees, or affiliations. Instead, we will be using first names. For this focus group to be successful, please remember that your perspective cannot be wrong, and your opinion is incredibly valuable to this work. It may be that someone will say something that you disagree with. To encourage everyone to feel free to participate, we will not have a debate or argument over one another's opinions. As mentioned, your perspective cannot be wrong.

[Question appears on screen with a free text box below it]

[INSTRUCTIONS: Type your first name and then a brief response. Example, "John: there are too many appointments to keep track of." We will then have a discussion where each person will have the opportunity to discuss what they wrote and provide additional details.]

1. As I mentioned, we would like to better understand your perspective as a parent, guardian, family member, advocate, or friend of someone with an intellectual and developmental disability. We would like to learn from you so that we can find ways to improve programs and services in New Jersey and help more families. **To break the ice, let's take a moment to think about your family member or friend with I/DD. What are some of their favorite things to do or what do you like to do together?**

2. I'd like to know more about your family member with I/DD and their regular activities. This includes thinking about people they might interact with in your home, school, or work. **What activities does your family member participate in with other people?**

3. What is your impression of the aides who come and help support your friend or family member with I/DD. The aide might be the person who helps them get dressed, makes food, takes them to community events, or something else. **How do their aides help you and the**

person with I/DD? Is there anything that you wish you and the person with I/DD had more help with?

4. We wanted to know more about the barriers to supporting persons with Intellectual and Developmental Disabilities in community. We can think about difficulties in transportation, cost, behavioral challenges, and other barriers. **What makes it hard for the person with I/DD to do what they would like to do? Have there been any changes in the type of waiver services you are using (such as movements to Managed Long-term Supports or between the Community Care Program and Supports Program)?**

5. Both the state and federal government require person-centered planning, where individuals and their families are driving decisions about services that best meet their needs and goals. This might include support in getting out of the house, finding a job, or other services that are aligned with the interests of the individual with I/DD. **How often do you speak with your support coordinator about getting the right services? Are you and your family member with I/DD as involved as you would like to be in choosing services?**

6. **What would you like New Jersey systems leaders (like the directors of Medicaid, the governor's office, and state agencies) to know about what it is like to be a family member of someone with and intellectual and developmental disability? What improvements should be made (this includes policies, services, and systems)?**

   Thank you again for helping us know more about you so that we can find ways to better support people with disabilities and their families!

11. Managed Long Term Services and Supports (MLTSS) Program

A. General Background Information

In this section, we describe our plan to evaluate the impact of managed care services in the areas of Long-Term Services and Supports (LTSS) and behavioral health (for selected LTSS-eligible populations) on NJ Medicaid beneficiaries. Managed long-term services and supports (MLTSS) began in July 2014 under New Jersey's first §1115 Comprehensive Demonstration and continued during the renewal demonstrations including the current one spanning 2023-2028. New Jersey has made significant progress in advancing the goal of rebalancing Medicaid long-term care, with 63% of LTSS-eligible individuals receiving home and community based services (HCBS) rather than nursing home care in 2023, as compared to 28% when the managed long term services and supports program was initiated in 2014.[113] Expanding HCBS supports the majority of older adults who prefer to age in place (e.g., remain in a community-based dwelling as they age).[114] A 2021 AARP study found that 75% of people age 50 and older preferred to stay in their homes or communities for as long as possible.[115] Our evaluation will examine key indicators of the continued impact of the Managed Long-Term Services and Supports (MLTSS) program, assess the contribution of added MLTSS benefits under the current waiver demonstration, and identify areas for refinement of policy implementation.

Managed Long Term Services and Supports

The MLTSS program provides HCBS benefits to older adults and people with disabilities who require a nursing home level of care. MLTSS is co-administered by DMAHS and the New Jersey Division of Aging Services (DoAS).

Beneficiaries who receive MLTSS services under the demonstration fall into several eligibility categories:

- Aged or Disabled Individuals who qualify for Medicaid under State Plan rules, meet certain additional requirements around beneficiary and spouse assets, and require a nursing facility level of care,
- Aged or Disabled Individuals who would not otherwise be eligible for Medicaid, who have incomes up to 300% of the Federal Benefit Rate, who meet certain additional requirements around beneficiary and spouse assets, and who require a nursing home level of care,

[113] Results calculated for July of each year from 2014-2023 (MLTSS AL + MLTSS HCBS as percent of total) https://njfamilycare.dhs.state.nj.us/analytics/LTC_explorer.html, accessed March 20, 2024.
[114] Maggie Ratnayake et al., "Aging in Place: Are We Prepared?," *Delaware Journal of Public Health* 8, no. 3 (August 31, 2022): 28–31, https://doi.org/10.32481/djph.2022.08.007.
[115] Joanne Binette and Fanni Farago, "2021 AARP Home and Community Preferences Survey" (Washington, DC: AARP, November 18, 2021), https://doi.org/10.26419/res.00479.001.

• Aged or Disabled Individuals who have income above 300% of the Federal Benefit Rate, who establish and fund a Qualified Income Trust, [116] who meet certain additional requirements around beneficiary and spouse assets, and who require a nursing home level of care,
• Adults aged 21-64, not receiving Medicare, who have a Modified Adjusted Gross Income less than 138% [117] of the federal poverty level and require a nursing facility level of care, and
• Children under age 21 who have a family income less than 355% [118] of the federal poverty level, and who require a special care nursing home level of care. [119]

MLTSS HCBS benefits are provided exclusively through managed care organizations. As part of their provision of MLTSS services, Managed Care Organizations (MCOs) are required to develop a plan of care for each MLTSS beneficiary and offer care management services on an ongoing basis. MCOs are also measured on a broad range of performance and accountability standards around the provision of MLTSS services.

[116] *Qualified Income Trusts:* Certain individuals (whose incomes would otherwise be too high) may qualify for MLTSS services by placing excess income in a Qualified Income Trust (QIT). While New Jersey does not plan specific modifications to the QIT provisions of the demonstration, the State is engaging with relevant stakeholders in structured conversations to further consider potential changes either to the QIT policy itself or to how it is administered and communicated to the public. As a result of these discussions, the State may consider proposing policy changes in the future.

[117] This includes adjustment of FPL to account for 5% disregard permitted by CMS.

[118] This includes adjustment of FPL to account for 5% disregard permitted by CMS.

[119] This may also include children under age 21 regardless of parental income. diversion and transition, and technical changes to discourage member churn between MLTSS and HCBS demonstration programs for adults with developmental disabilities.

Specific HCBS benefits provided as part of MLTSS include:

• assisted living,	• occupational therapy,
• behavioral health management services for individuals with traumatic brain injuries,	• personal emergency response system (PERS),
• caregiver/beneficiary training related to skills of independent living,	• physical therapy,
• chore services,	• private duty nursing,
• cognitive rehabilitation therapy,	• residential modifications,
• community residential services,	• respite services,
• community transition services for individuals transitioning out of institutions,	• social adult day care,
• home-based supportive care,	• speech/language/hearing therapy,
• home-delivered meals,	• structured day programs or supportive day services for individuals with traumatic brain injury, and
• medication-dispensing,	• vehicle modifications.
• non-medical transportation,	

In addition to these services, New Jersey provides personal care assistance and medical day care as State Plan benefits available to all Medicaid populations based on medical necessity.

Changes to MLTSS in the Demonstration

MLTSS is extended in the 2023-2028 demonstration, largely as constructed under prior waiver authorities. Changes include a renewed focus on housing-related services[120] and expansion of certain MLTSS benefits to allow beneficiaries to remain in community settings and further encourage transitions from institutional settings to the community. In developing the renewal proposal, the state focused on several overarching policy goals, including:

- Continue improvements in quality of care and efficiency associated with managed care,
- Improve access to critical services in the community through MLTSS and other HCBS programs.

Housing Supports

Lack of stable housing may impede an individual's ability to enroll in and maintain coverage, to access needed health care, and to age in place. As a result, New Jersey is implementing transitional housing supports for individuals who are transitioning out of institutional care (including incarceration), congregate settings, homelessness or a homeless shelter, or the child welfare system. Related services include case management, outreach, and education, as well as infrastructure investments to support those services. Specifically related to the MLTSS population, beneficiaries eligible to receive housing transition or tenancy-sustaining services include, but are

[120] See "Housing Supports" evaluation plan.

not limited to those individuals transitioning from an institution to the community or at risk of institutionalization who require a new housing arrangement to remain in the community (including older adults, individuals with disabilities, and individuals with serious mental illness and/or substance use disorder), and/or those who are transitioning out of high-risk or unstable housing situations. Housing supports include, but are not limited to, medically necessary home modifications and remediation services such as accessibility ramps, handrails, grab bars, repairing or improving ventilation systems, and mold/pest remediation. More details on the extent of housing supports and evaluation design can be found in the housing supports chapter.

Caregiver Supports

Recognizing that care provided by family members or other informal or unpaid caregivers is critical to supporting MLTSS members in the community and also that providing such care can be deleterious to a family member's mental health and psychological well-being,[121] New Jersey sought and received approval for enhanced Medicaid-funded supports for caregivers to augment existing MLTSS Caregiver Training and Respite benefits.

Counseling

The Caregiver Supports Program will include individual and/or facilitated peer group counseling through a licensed behavioral health provider under contract with the MCO. Caregivers may receive unlimited counseling sessions as needed (members can receive counseling as well through their regular benefit package). Services will be subject to regular review (quarterly through the plan of care) by the MCO to determine the continued appropriateness for the need of services. Eligible caregivers are those who: 1) provide caregiver services to a member receiving MLTSS for at least ten hours a week; 2) receive a recommendation by the MCO (as part of plan of care development) as in need of counseling services to continue to support the member's independence and/or expand the member's participation in the community, and 3) attest they do not have any third-party insurance coverage that would cover the counseling service.

Respite Services

The previous MLTSS respite benefit was limited to 30 days per participant per calendar year. The 2023-2028 demonstration allows up to 90 days of respite per calendar year, in instances where it is determined by the MCO that such additional respite services are necessary to maintain a beneficiary within the community and that such additional services would be consistent with cost-effective operation of the program.

[121] Martin Pinquart and Silvia Sörensen, "Differences between Caregivers and Noncaregivers in Psychological Health and Physical Health: A Meta-Analysis," *Psychology and Aging* 18, no. 2 (June 2003): 250–67, https://doi.org/10.1037/0882-7974.18.2.250; Ludmyla Caroline de Souza Alves et al., "Burnout Syndrome in Informal Caregivers of Older Adults with Dementia: A Systematic Review," *Dementia & Neuropsychologia* 13 (December 9, 2019): 415–21, https://doi.org/10.1590/1980-57642018dn13-040008; Pierre Gérain and Emmanuelle Zech, "Do Informal Caregivers Experience More Burnout? A Meta-Analytic Study," *Psychology, Health & Medicine* 26, no. 2 (February 7, 2021): 145–61, https://doi.org/10.1080/13548506.2020.1803372.

Nutritional Supports

Ensuring that a beneficiary has access to adequate food resources can also be a critical part of maintaining a beneficiary within the community. The previous MLTSS benefit included home-delivered meals for eligible individuals. The 2023-2028 demonstration includes additional nutritional benefits in the MLTSS program, including:

• *One-time pantry stocking for any Medicaid eligible beneficiary who is transitioning from an institution*. For beneficiaries receiving one-time pantry stocking, MCO care managers will work with the beneficiary to identify permanent sources of food, potentially including assisting the beneficiary in applying for SNAP benefits. New Jersey currently offers this service as a benefit under the MFP program, which has been identified as an essential support for individuals transitioning to community apartment settings.

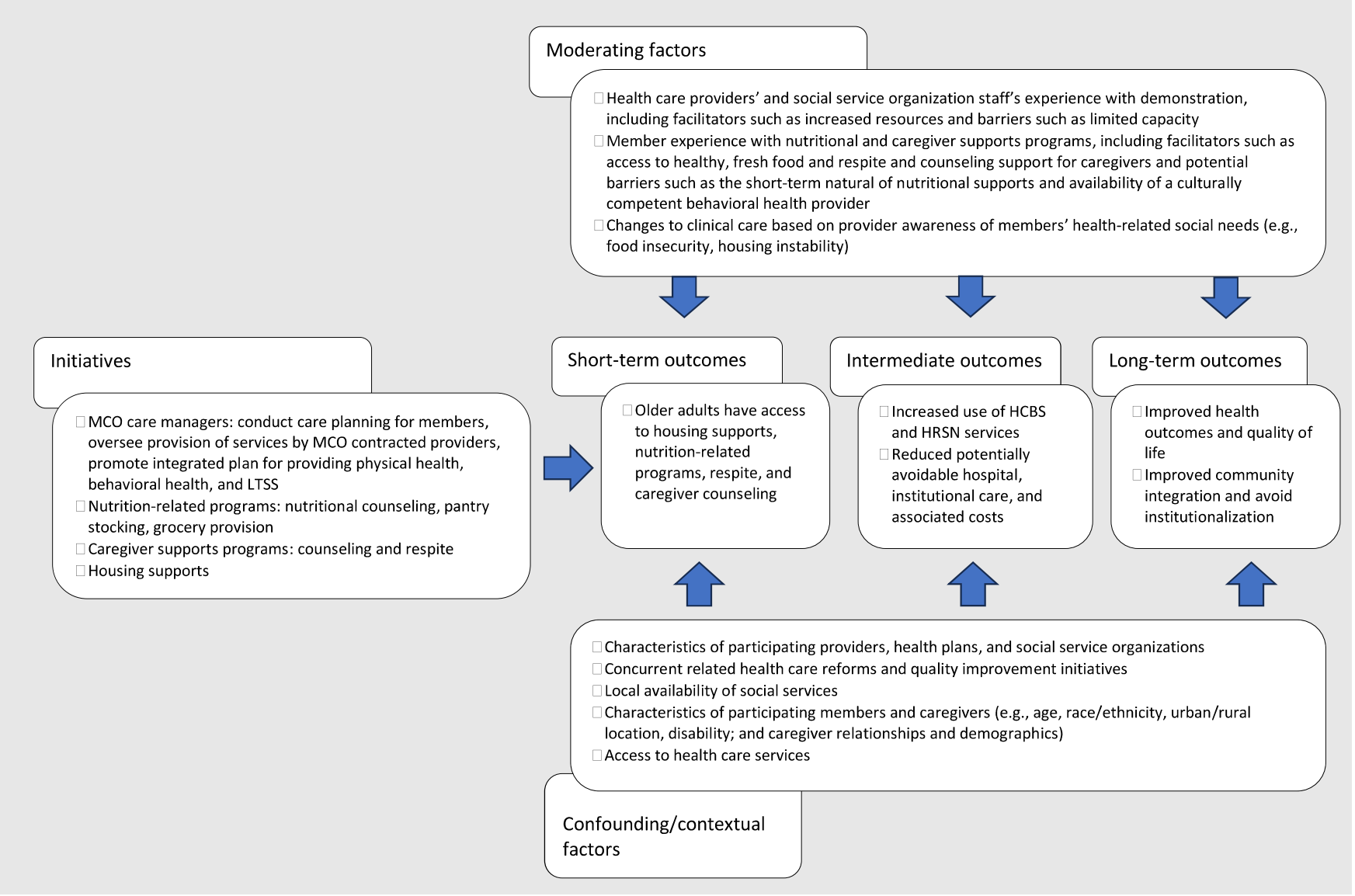
• *Short-term provision of groceries to beneficiaries who have their usual source of food disrupted or who are experiencing an acute behavioral health episode*. Temporary provision of food may help avoid placement in an institution, preventable hospital emergency department visits (e.g., dehydration, falls due to lightheadedness) and inpatient admissions. This benefit is limited to 30 days per calendar year, up to 200% of the Maximum Monthly USDA SNAP Allowance, and MCOs providing this benefit would be expected to use that time to work with the beneficiary to more permanently resolve the disruption to the beneficiary's ordinary food supply, potentially including applying for SNAP benefits. Vendors who provide this benefit are required to comply with appropriate nutritional standards.

• *Nutritional education and skills development (i.e., training how to shop for groceries on a budget, preparation of a meal, healthy well-balanced alternatives.)* Nutrition counseling and education is an added benefit for MLTSS members, including education on healthy meal preparation and connecting members with grocery budget resources.

B. Evaluation Questions and Hypotheses

Our evaluation of MTLSS includes an implementation study as well as research questions related to demonstration outcomes. Figure 11.1 is a logic model showing the implementation questions and the expected outcomes.

Figure 11.1 MLTSS Logic Model



1. Implementation Study

To understand the implementation of new MLTSS programs (e.g., nutritional and caregiver supports), researchers will review available administrative data and monitoring reports and conduct in-depth individual interviews with entities responsible for the demonstration such as MCOs and their vendors, DMAHS staff, other state and local experts such as health-care providers serving at-risk Medicaid beneficiaries, and other key informants involved in the implementation of the new nutritional and caregiver support programs. The complete interview guide for implementation questions modeled on the suggested implementation questions in CMS' technical assistance guide for evaluating health related social needs can be found in the appendix [Appendix Exhibit 11.1]. These questions will provide context for analyses that address hypotheses in section 2 and assess progress toward demonstration goals.

1.1 Methodology

Data Collection: In-depth individual interviews will be conducted using semi-structured, open-ended questions that probe key informants on their experiences implementing the nutritional and caregiver support programs, identifying how roles or participation changed throughout the demonstration period. Interviews will offer insights into program implementation as well as identifying barriers and opportunities to improve the programs. Participant recruitment will be based on criteria established during protocol development and will primarily involve staff and key informants with existing relationships to the evaluators such as MCOs and their vendors, DMAHS staff, and other state and local experts. Up to 15 interviews of approximately 45-60 minutes will be completed regarding the nutritional support programs. Up to 15 interviews of approximately 45-60 minutes will be completed regarding the caregiver support programs. All interviews will take into account diversity by MCO and geographical region. Key informant interviewees participating in their professional roles (e.g., DMAHS, MCO staff, vendors) will not be offered participation incentives, but others (e.g., community advocates) will receive a $50 participation incentive. Interviews will be conducted virtually over Zoom and transcribed.

Analytic Strategy for Interview Data: NVivo or similar software will be used to analyze for themes. A general inductive approach will be used to allow for themes to emerge. Where appropriate, themes will be categorized as a barrier or facilitator to provide a coherent analysis to MCOs on the implementation of the nutritional and caregiver supports programs.

2. Outcomes Study

We posit that the managed care financing of LTSS (i.e., MLTSS) that began in July 2014 and the renewed focus on housing-related services and expansion of certain MLTSS benefits have the potential to improve health care utilization outcomes, access and quality of care, and community integration and rebalancing.

Below we present the *driver diagram* (Figure 11.2) that delineates the pathway from the policy change to improved outcomes. Here the secondary drivers represent the various services offered through the LTSS programs as well as improved care coordination from managed care financing of physical and behavioral health and LTSS. Such service delivery and care integration promote higher quality of community level care and integrated care coordination. This results in improved health

utilization outcomes reflected though reduced preventable hospitalizations and lower rates of institutionalization (see outcomes below).

Figure 11.2: MLTSS Driver Diagram

<table>
<tr><th>Aim</th><th>Primary Drivers</th><th>Secondary Drivers</th></tr>
<tr><td rowspan="2">1.A. Improve access, utilization, and quality of ambulatory/community level care.

1.B. Improve quality of life.

1.C. Improve community integration and avoid institutionalization.</td><td>Integrated care</td><td>MCO care managers
• Conduct care planning for members
• Oversee provision of services by MCO contracted providers
• Promote integrated plan for providing physical health, behavioral health, and LTSS</td></tr>
<tr><td>Provision of HCBS and HRSN services</td><td>• Housing supports[122]
• Nutrition related programs (nutritional counseling, pantry stocking, grocery provision)
• Respite
• Caregiver counseling</td></tr>
<tr><td colspan="3">⟸ Causality ⟸</td></tr>
</table>

We next detail the hypotheses and corresponding research questions. These are also summarized in Table 11.2.

Hypothesis 2.1: Medicaid coverage of long-term care services and supports (hereafter MLTSS) will result in improved access to, and quality of, care and support more individuals to remain in the community instead of institutions.

Research Question 2.1a: What are the trends in utilization and quality of care within the MLTSS population (i.e., inpatient hospitalizations, avoidable hospitalizations, ED visits, avoidable ED visits, and all cause broken bones (e.g., hip fractures))? How do these trends vary across different subgroups (e.g., race/ethnicity, gender, marital status, functional status, presence of comorbidities)?

Research Question 2.1b: What are the trends in spending within the MLTSS population related to avoidable hospitalizations and ED visits and levels and balance of spending on nursing facilities and community LTSS?

Research Question 2.1c: What are the trends in institutionalization within the MLTSS population (e.g., facility admission and facility admission followed by community discharge)?

[122] Details on the extent and evaluation design of housing supports can be found in the housing supports chapter.

Hypothesis 2.2: Trends in LTSS utilization within the MLTSS population will improve including services aimed at addressing health related social needs (HRSN) (e.g., nutrition insecurity) and caregiver support.

Research Question 2.2a: What are the trends in take-up and utilization of caregiver support, respite services, and nutrition-related programs? How do these trends vary across different subgroups (e.g., race/ethnicity, gender, marital status, functional status, presence of comorbidities)?

Research Question 2.2b: Are there differences in who is referred to caregiver support programs by demographic characteristics (e.g., race/ethnicity, gender, language spoken, immigration status, marital status, functional status, presence of comorbidities)?

Hypothesis 2.3: Among caregivers who receive counseling, nutrition, and respite services, caregivers will experience a reduction in caregiver stress and burnout.

Research Question 2.3a: What are the trends of caregiver health, depression and anxiety, caregiving-related stress, and overall well-being among caregivers who receive support services? How do trends vary across different subgroups (e.g., race/ethnicity, gender, marital status, functional status, presence of comorbidities)?

Research Question 2.3b: How do those who receive counseling and respite services describe stressors and stress relievers in relation to their caregiving work? Do experiences differ by caregiver demographic characteristics (e.g., race/ethnicity, gender, language spoken, immigration status, marital status, functional status, presence of comorbidities)?

Hypothesis 2.4: The implementation of the caregiver supports program will vary in its effectiveness at meeting the needs of caregivers who receive the services.

Research Question 2.4a: What barriers, facilitators, and suggestions for improvement do caregivers and other key informants identify with the caregiver supports program?

2.1 Methodology

Outcomes:

We will assess the outcomes listed in Table 11.1 below.

Table 11.1: Inventory of Measures

Measure		Brief Description
Utilization of Care		
1.	Inpatient hospitalizations	Individuals receive inpatient hospital treatment for surgery or for nonsurgical medical treatment.
2.	Emergency department (ED) treat-and-release visits	Individuals seek ambulatory care in the emergency department for surgery or for nonsurgical medical treatment.
3.	Institutional transitions: MLTSS admissions to a	Rates of admission to a facility for short-term stay with discharge to community, medium-term stay with

	facility from a hospital or the community	discharge to community, or long-term stay with no discharge to the community. [123]
Quality		
4.	Avoidable hospitalizations	Rates of ACS inpatient (IP) hospitalizations that may occur due to inadequate ambulatory/primary care within communities. [124]
5.	Avoidable ED visits	Avoidable treat-and-release ED visits that may occur due to inadequate ambulatory/primary care within communities, part of AHRQ's Safety Net Monitoring Toolkit (AHRQ 2016a; AHRQ 2016b).
6.	Inpatient hospitalization or ED visit for broken bone (e.g., hip fracture)	Rates of inpatient hospitalizations and ED visits that may occur due to a broken bone (e.g., hip fracture) and differences by select demographic characteristics. [125]
Spending		
7.	Spending related to avoidable hospitalizations and ED visits	Payments on facility claims for inpatient and treat-and-release ED visits that may occur due to inadequate ambulatory/primary care within communities, inflation adjusted. [126]
8.	Spending related to long-term care in community and nursing facilities	Payments on facility claims for nursing home stay (e.g., custodial revenue code) and community-based LTSS (e.g., LTSS service codes). [127]
Caregiver Supports		

[123] Jacqueline Allen et al., "User Experience and Care for Older People Transitioning from Hospital to Home: Patients' and Carers' Perspectives," *Health Expectations* 21, no. 2 (2018): 518–27, https://doi.org/10.1111/hex.12646; Jacqueline B. LaManna et al., "Early and Intermediate Hospital-to-Home Transition Outcomes of Older Adults Diagnosed With Diabetes," *The Diabetes Educator* 42, no. 1 (February 1, 2016): 72–86, https://doi.org/10.1177/0145721715620020; Addie Middleton et al., "New Institutionalization in Long-Term Care After Hospital Discharge to Skilled Nursing Facility," *Journal of the American Geriatrics Society* 66, no. 1 (2018): 56–63, https://doi.org/10.1111/jgs.15131.

[124] Jayasree Basu, Bernard Friedman, and Helen Burstin, "Managed Care and Preventable Hospitalization among Medicaid Adults," *Health Services Research* 39, no. 3 (June 2004): 489–510, https://doi.org/10.1111/j.1475-6773.2004.00241.x; A. B. Bindman et al., "Preventable Hospitalizations and Access to Health Care," *JAMA* 274, no. 4 (July 26, 1995): 305–11; J. Billings et al., "Impact of Socioeconomic Status on Hospital Use in New York City," *Health Affairs (Project Hope)* 12, no. 1 (1993): 162–73, https://doi.org/10.1377/hlthaff.12.1.162; Daniel L. Howard et al., "Racially Disproportionate Admission Rates for Ambulatory Care Sensitive Conditions in North Carolina," *Public Health Reports* 122, no. 3 (2007): 362–72.

[125] "Patient Safety Indicator 08 (PSI 08) In Hospital Fall with Hip Fracture Rate" (Agency for Healthcare Research and Quality, July 2021).

[126] "CPI Inflation Calculator," U.S. Bureau of Labor Statistics, accessed September 6, 2023, https://www.bls.gov/data/inflation_calculator.htm.

[127] Sujoy Chakravarty et al., "Examining the Effect of the NJ FamilyCare Comprehensive Demonstration on Access to Care, Quality, and Cost of Care: Draft Interim Evaluation Report" (Rutgers Center for State Health Policy, February 2022), https://cshp.rutgers.edu/publications/examining-the-effect-of-the-nj-familycare-comprehensive-demonstration-on-access-to-care-quality-and-cost-of-care-draft-interim-evaluation-report.

9.	Respite services	Number of individuals utilizing respite services annually and average number of days of respite services used per calendar year per individual.[128]
10.	Counseling	Individuals receive counseling services.
11.	Caregiver stress and burnout	Individual ratings on caregiver health (CDC-rating), depression and anxiety (PHQ-4[129]), caregiving-related stress (Kingston Caregiver Stress Scale[130] or University of Washington Caregiver Stress Scale[131]), overall well-being (Perceived Support Scale[132]).
Nutritional Supports		
12.	Services associated with nutrition-related programs	Nutrition-related programs to be measured: Nutrition counseling and education for MLTSS members, pantry stocking, and grocery provision.

For hypotheses 2.1 & 2.2 and research questions 2.1a-2.2b

Study population: These hypotheses relate to trends in utilization, spending, and quality health care as well as caregiver services available only to the MLTSS population, thus there is no available comparison group.

Analytic strategy: We will conduct analyses of adjusted trends, calculating estimates for outcome measures on a quarterly or annual basis (as appropriate) to examine utilization and quality of care (i.e., inpatient hospitalizations, avoidable hospitalizations, ED visits, avoidable ED visits, and all cause broken bones (e.g., hip fractures)), spending, institutionalization (e.g., facility admission and facility admission followed by community discharge), and service utilization (e.g., caregiver support, respite services, and nutrition-related programs) over the demonstration period.

We will examine several cohorts of individuals enrolled in MLTSS starting in different baseline periods (e.g., 2018-2019, 2021-2022) and then investigate changes in outcomes over the current demonstration period (2023-2028). We will estimate regression models for each study outcome,

[128] Chakravarty et al.

[129] Amit Sapra et al., "Using Generalized Anxiety Disorder-2 (GAD-2) and GAD-7 in a Primary Care Setting," *Cureus* 12, no. 5 (n.d.): e8224, https://doi.org/10.7759/cureus.8224; Kurt Kroenke et al., "An Ultra-Brief Screening Scale for Anxiety and Depression: The PHQ-4," *Psychosomatics* 50, no. 6 (2009): 613–21, https://doi.org/10.1176/appi.psy.50.6.613.

[130] R Hopkins and L Kilik, "The Kingston Caregiver Stress Scale," 2016, www.kingstonscales.org; Lindy A. Kilik and Robert W. Hopkins, "The Relationship between Caregiver Stress and Behavioural Changes in Dementia," *OBM Geriatrics* 3, no. 2 (May 2019): 1–19, https://doi.org/10.21926/obm.geriatr.1902052; Tatiana Sadak et al., "Psychometric Evaluation of Kingston Caregiver Stress Scale," *Clinical Gerontologist* 40, no. 4 (2017): 268–80, https://doi.org/10.1080/07317115.2017.1313349.

[131] Dagmar Amtmann et al., "Development and Validation of the University of Washington Caregiver Stress and Benefit Scales for Caregivers of Children with or without Serious Health Conditions," *Quality of Life Research* 29, no. 5 (May 1, 2020): 1361–71, https://doi.org/10.1007/s11136-019-02409-0.

[132] N. Krause and K. Markides, "Measuring Social Support among Older Adults," *International Journal of Aging & Human Development* 30, no. 1 (1990): 37–53, https://doi.org/10.2190/CY26-XCKW-WY1V-VGK3.

using member characteristics (e.g., age, sex, race/ethnicity). Analyses will additionally control for eligibility pathway, noting whether a member qualified for MLTSS through a Qualified Income Trust. Post hoc marginal analysis will be applied to generate adjusted trends over time based on these models (i.e., using predictive margins). We will use line graphs and tables to describe results. Given adequate sample size, the adjusted trends will also be stratified by subgroups of interest such as race/ethnicity, gender, marital status, functional status, presence of comorbidities, and Chronic Illness and Disability Payment System (CDPS) risk score. Additionally, this analysis will conduct adjusted trend analyses of utilization outcomes among a subgroup of MLTSS members who receive the new services (e.g., nutritional and/or caregiver support services).

The cohort approach compares trends for a fixed cohort of individuals over time to ensure that observed changes in utilization are not due to changes in population composition resulting from beneficiaries newly enrolling or disenrolling from the program. There are some individual characteristics such as age or comorbid conditions that change over time and this could account for changes in service utilization. Thus, change in disease diagnoses and burden of illness over time will be adjusted for by controlling for health status, such as through accounting for CDPS risk score. Additionally, we will estimate yearly rates of utilization for all beneficiaries enrolled in MLTSS without restricting the sample to a cohort of beneficiaries by using a repeated cross-sectional approach. While the cohort analysis mitigates the likelihood for differences in the composition of the sample over time, the cross-sectional analysis will offer a larger sample size and, as a result, more statistical power to detect differences.

In addition to claims-based information on clinical characteristics, we will explore the usability of data from the NJ Choice Assessment,[133] which provides information on the extent of beneficiary needs, disability, and severity as well as living and caregiving arrangements and family structure. The NJ Choice Assessment is conducted annually by MCOs and would be complementary to the claims-based data. Depending on feasibility of linking this data, this information would be used to deepen analysis related to facility admissions and discharges to the community as well as for specific population groups identified based on claims-based indicators of clinical complexity (e.g., I/DD, mental health, dementia/cognitive impairment, etc.). NJ Choice Assessment data would complement Claims and Encounter data by providing a more comprehensive picture of an MLTSS member's living and caregiving arrangements as well as activities of daily living (ADL) and instrumental activities of daily living (IADLs) that are not well captured by Claims and Encounter records. Thus, using NJ Choice Assessment data, we can stratify cohort and cross-sectional trend analysis by degree of disability and functional status (e.g., ADLs, IADLs, etc.) as well as extent of caregiver support.

For hypotheses 2.3 and 2.4 and research questions 2.3a-2.3b and 2.4a

Study population: These hypotheses relate to MLTSS members who utilize the Caregiver Supports Program (1 or more sessions).

[133] This assessment is collected only for the MLTSS population and the ABD population getting Medical Day services, and collection was suspended during the pandemic years.

Data Collection: After a consultative protocol refinement process between CSHP, DMAHS and the MCOs, we will develop our strategy to collect primary data from caregivers. We will hire a survey research contractor to serve as a trusted third party to handle Medicaid member identifiers and to conduct a confidential caregiver survey.

Survey sample selection and participant recruitment will take place in 4 steps:

1. Based on criteria (e.g., demographic, clinical, utilization, MCO) established during the protocol development, CSHP will select a stratified random sample of MLTSS members who may be supported by caregivers eligible for the Caregiver Supports Program from de-identified Medicaid claims and encounter data held by the Center and/or, if feasible, NJ choice assessment data.
2. CSHP will then send a list of Rutgers unique study IDs for the sampled MLTSS members to DMAHS which will in turn send a file to the third-party survey vendor which includes the Rutgers study ID and member identifiers (names, addresses, telephone, and other contact information). *The vendor will not receive Medicaid claims or encounter data*.
3. The vendor will contact families to request their voluntary participation in the survey. An initial letter of invitation will be followed up with a reminder postcard and, possibly, telephone or email reminders. The letter/postcard will be on Rutgers or DMAHS letterhead and will include the unique and one-time use Survey ID and a QR code to access the survey. The survey will include a screener for qualified caregivers (i.e., those eligible for Caregiver Supports Surveys) followed by a 15–20 minute survey (described below). If feasible and necessary, telephone surveys may be utilized to increase recruitment and accessibility.
4. The vendor will securely send completed survey responses to CSHP. The response files will include the Rutgers study ID but *no personal identifiers* of members or caregivers. CSHP will then link the survey responses to de-identified claims and encounter records for analysis.

A total of 300-400 completed surveys will be collected via web and, possibly telephone, with certain subgroups oversampled (e.g., members with a history of high use of avoidable hospital services, older adults, rural residents, etc.). The survey component will be voluntary and brief; a screener to identify qualified caregivers will take less than 5 minutes to complete and the full caregiver survey will take approximately 15-20 minutes to complete and will include about 25 questions. The survey will be available in English and Spanish. Qualifying participants will be offered $25 per completed survey (incentive limited to one per eligible family).

The survey questionnaire will be developed in consultation with key informants and subject matter experts. We anticipate that respondents will be asked to indicate caregiving intensity (e.g., number of hours a week) and whether they received or attempted to access counseling services. This will be followed by questions related to caregiver health (CDC-rating), depression and anxiety (PHQ-

4[134]), caregiving-related stress (Kingston Caregiver Stress Scale[135] or University of Washington Caregiver Stress Scale[136]), overall well-being (Perceived Support Scale[137]), cultural and linguistic appropriateness of services, and satisfaction arranging counseling and respite services. To adjust estimates, the survey will collect basic information on demographics, beneficiary characteristics including functional status and presence of comorbidities, and family structure and living arrangement. The survey will also ask caregiver participants if they would consent to participate in a more in-depth interview or focus group. Consenting participants will provide contact information for follow-up. See Appendix Exhibit 11.2 for a complete draft of the caregiver survey instrument.

Among a sample of consenting caregivers, in-depth individual or focus group interviews will be conducted using semi-structured, open-ended questions that probe caregivers on their experiences and satisfaction accessing caregiving services, identifying barriers and opportunities to improve service delivery. Interviews will supplement data gathered from the surveys, offering insights into program implementation as well as caregiving experiences. See Appendix Exhibit 11.3 for the proposed question bank for in-depth caregiver interviews. Up to 30 caregiver interviews of approximately 45-60 minutes will be completed, with attention to diversity by race/ethnicity, age, gender, MCO, and geography. In-depth interview participants will receive a $50 incentive. Interviews will be conducted virtually over Zoom and transcribed. If feasible and necessary, telephone or in-person interviews may be utilized to increase participation and accessibility.

In addition to the caregiver interviews, we will conduct up to 15 interviews with program informants after survey and interview results are available – approximately 2 at each MCO (n=10), with 5 reserved for DMAHS staff and other state or local subject matter experts. Stakeholder interviews will offer additional insight into administrative burden and program implementation barriers and facilitators. The interview guides will be developed in consultation with key informants and subject matter experts [see Appendix Exhibit A1 for the proposed question bank]. Key informant interviewees who are participating in their professional roles (e.g., DMAHS and MCO staff) will not be offered participation incentives, but others (e.g., community advocates) will receive a $50 participation incentive.

Analytic strategy: We will measure the association of caregiver stress with the implementation of the caregiver supports program in addition to measuring the facilitators and barriers of the program itself. The unique study IDs used in the survey will be linked to the claims/encounter data for analysis and if feasible, the NJ choice assessment data (see above for more details on the NJ choice assessment). We will present both a bivariate and multiple-regression based approach to describe cross-sectional by member and caregiver characteristics (e.g., member age, race/ethnicity, urban/rural location, and disability; and caregiver relationships and demographics).

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[134] Sapra et al., "Using Generalized Anxiety Disorder-2 (GAD-2) and GAD-7 in a Primary Care Setting"; Kroenke et al., "An Ultra-Brief Screening Scale for Anxiety and Depression."

[135] Hopkins and Kilik, "The Kingston Caregiver Stress Scale"; Kilik and Hopkins, "The Relationship between Caregiver Stress and Behavioural Changes in Dementia"; Sadak et al., "Psychometric Evaluation of Kingston Caregiver Stress Scale."

[136] Amtmann et al., "Development and Validation of the University of Washington Caregiver Stress and Benefit Scales for Caregivers of Children with or without Serious Health Conditions."

[137] Krause and Markides, "Measuring Social Support among Older Adults."

We will first create bar charts or line diagrams to examine trends in measures of caregiver stress and burnout over time. Next, we will use a regression model to examine changes in outcomes related to caregiver supports participation, adjusted for demographics and beneficiary characteristics. Standard errors will be cluster-corrected by zip codes to adjust for non-independence of observations.

If take up is sufficient in the programs for the new service utilization outcomes (e.g., caregiver support, respite services, and nutrition-related programs) introduced during this demonstration period, we will consider applying interrupted time series (segmented regression analysis) in addition to the adjusted trend analysis, described above. This analysis would look at trends in ratings of caregiver stress and burnout before and after the implementation of the caregiver support programs taking into account the time since the intervention.

Regarding the in-depth interviews, NVivo or similar software will be used to analyze for themes. A general inductive approach will be used to allow for themes to emerge. [138] Where appropriate, themes will be categorized as a barrier or facilitator to provide a coherent analysis to MCOs on the implementation of the caregiver supports program.

[138] Thomas, D. R. (2006). A General Inductive Approach for Analyzing Qualitative Evaluation Data. *American Journal of Evaluation*, 27(2), 237–246.

Table 11.2: Summary of Questions, Hypotheses and Methodology

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
Hypothesis 2.1: Medicaid coverage of long-term care services and supports (hereafter MLTSS) will result in improved access to and quality of care and support more individuals to remain in the community instead of institutions.				
RQ2.1a: What are the trends in utilization and quality of care within the MLTSS population (i.e., inpatient hospitalizations, avoidable hospitalizations, ED visits, avoidable ED visits, and all cause broken bones (e.g., hip fractures))? How do these trends vary across different subgroups (e.g., race/ethnicity, gender, marital status, functional status, presence of comorbidities)?	-Inpatient hospitalizations and ED utilization -Avoidable hospitalizations and avoidable ED visits -All cause broken bones (e.g., hip fractures) -Impacts by demographic characteristics	-No comparison group.	-Medicaid Fee-for-Service and Encounter Claims Records. -NJ choice assessment data, where available for linkage.	Adjusted analysis of trends, descriptive, cross-sectional and cohort analysis
RQ2.1b: What are the trends in spending within the MLTSS population related to avoidable hospitalizations and ED visits and levels and balance of spending on nursing facilities and community LTSS?	-Spending related to avoidable hospitalizations and ED visits -Spending related to long-term care in community and nursing facilities	As above	As above	As above
RQ2.1c: What are the trends in institutionalization within the MLTSS population (e.g., facility admission and facility admission followed by community discharge)?	-Rates of discharges from a facility for short-term stay with discharge to community, medium-term stay with discharge to community, or long-term stay with no discharge to community	As above	As above	As above

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
Hypothesis 2.2: Trends in LTSS utilization within the MLTSS population will improve including services aimed at addressing health related social needs (HRSN) (e.g., nutrition insecurity) and caregiver support.				
RQ2.2a: What are the trends in take-up and utilization of caregiver support, respite services, and nutrition-related programs? How do these trends vary across different subgroups (e.g., race/ethnicity, gender, marital status, functional status, presence of comorbidities)?	-Number of individuals utilizing respite services annually and average number of days of respite services used per calendar year per individual -Individuals receive counseling services -Nutrition counseling and education for MLTSS members -Home delivered meals -Pantry stocking -Grocery provision -Counseling and respite services by demographic characteristics	-No comparison group since these services are restricted to MLTSS beneficiaries. -This analysis will focus on the number of individuals utilizing caregiver and nutritional support services out of the total MLTSS population.	-Medicaid Fee-for-Service and Encounter Claims Records. -NJ choice assessment data where available for linkage.	Adjusted analysis of trends, descriptive, cross-sectional and cohort analysis
RQ2.2b: Are there differences in who is referred to caregiver support programs by demographic characteristics (e.g., race/ethnicity, gender, language spoken, immigration status, marital status, functional status, presence of comorbidities)?	-Referrals to counseling and respite services by demographic characteristics	As above	As above	As above
Hypothesis 2.3: Among caregivers who receive counseling and respite services, caregivers will experience a reduction in caregiver stress and burnout.				

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
RQ2.3a: What are the trends of caregiver health, depression and anxiety, caregiving-related stress, and overall well-being among caregivers who receive support services? How do trends vary across different subgroups (e.g., race/ethnicity, gender, marital status, functional status, presence of comorbidities)?	Interview questions eliciting responses on caregiving work, stresses, and stress relievers	-Caregivers who participate in the Caregiver Supports Program (1 or more sessions).	-Interviews 4-7 months after referral. -NJ choice assessment data where available for linkage.	Qualitative inductive theme identification; segmented regression analysis (interrupted time series) if take-up is sufficient.
RQ2.3b: How do those who receive counseling and respite services describe stressors and stress relievers in relation to their caregiving work? Do experiences differ by caregiver demographic characteristics (e.g., race/ethnicity, gender, language spoken, immigration status, marital status, functional status, presence of comorbidities)?	As above	As above	As above	As above
Hypothesis 2.4: The implementation of the caregiver supports program will vary in its effectiveness at meeting the needs of caregivers who receive the services.				
RQ2.4a: What barriers, facilitators, and suggestions for improvement do caregivers and other key informants identify with the caregiver supports program?	Interview questions about barriers, facilitators, and improvement suggestions.	-Caregivers who participate in the Caregiver Supports Program (1 or more sessions).	-Caregivers: interviews 4-7 months after referral.	Qualitative inductive theme identification

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
		-MCOs, DMAHS staff, other state and local experts.	-Other key informants: interviews after preliminary survey and interview results are available. -NJ choice assessment data where available for linkage.	

Table 11.3 shows an activity timeline for the research activities.

Table 11.3 Key Milestones, Managed Long Term Services and Supports (MLTSS) Program

Analytic Activity	Year 1 2025	Year 2 2026	Year 3 2027	Year 4 2028	Year 5 2029	Year 6 2030
1. Qualitative implementation assessment	Plan for key informant interviews – consult on informant list and finalize recruitment strategy and materials Finalize and test question bank for key informant interviews	Conduct and analyze key informant interviews (n=30)	Finish conducting and analyzing key informant interviews Complete interim analysis	Conduct analysis		Complete analysis

Analytic Activity	Year 1 2025	Year 2 2026	Year 3 2027	Year 4 2028	Year 5 2029	Year 6 2030
2. Quality of care, health service utilization, and spending assessment: Link and analyze MMIS and NJ Choice Assessment data (RQ2.1a-RQ2.1c, RQ2.2a, RQ2.2b)	Define appropriate population and customized metrics for MMIS analysis (includes program cost variables) Execute data use agreements to link MMIS and NJ Choice Assessment datasets and begin data linkage	Finalize linkage of MMIS NJ Choice Assessment datasets and conduct baseline analysis	Update linkage & complete interim analysis	Update linkage & analysis	Update linkage & complete analysis	Complete analysis
3. Beneficiary experience assessment (RQ2.3a, RQ2.3b, RQ2.4a)		Identify survey vendor and execute contract Finalize survey instrument and member list	Work with vendor to conduct member surveys (n=300-400) Begin to analyze member surveys Plan for in-depth caregiver interviews based on survey participants (e.g., finalize and test question bank for caregiver interviews)	Continue to analyze member surveys Conduct and analyze in-depth caregiver interviews (n=30) Prepare question bank for final round of key informant interviews	Finish conducting and analyzing caregiver interviews Conduct and analyze additional key informant interviews (n=10, 2 per MCO, 5 DMAHS staff and/or state or local subject matter experts)	Complete analysis

Analytic Activity	Year 1 2025	Year 2 2026	Year 3 2027	Year 4 2028	Year 5 2029	Year 6 2030
			Complete interim analysis			
4. Submit reports to CMS			Interim report			Final report

RQ=Research Question.

NOTE: Evaluation project years are March-Feb. (subject to change depending on date of authorization to begin).

C. Methodological Limitations

This analysis has several limitations. First, the initiatives lack appropriate comparison groups such that findings from this analysis cannot be used to make causal inference. Additionally, our claims-based metrics may not account for clinical factors such as severity that may also impact the likelihood of outcomes. In an effort to address this limitation, we will stratify models by CDPS risk score to capture health status. The absence of comparison groups may raise the risk that external forces that emerge during the demonstration period could have an impact on outcomes that are unrelated to MLTSS policy. To address this limitation, we will examine trends in appropriate non-MLTSS groups who may be vulnerable to the effects of systemic trends. We will use the results of analyses described above for RQ 2.1a and 2.2b and consult with DMAHS and other subject matter experts to determine the non-MLTSS populations and outcomes which could be affected by such external trends.

Our cohort analysis may be subject to small sample size due to decedents. The sample size will be larger in repeated cross-sectional analysis, but characteristics of individuals determining service utilization may change over time. Lastly, the extent to which we can incorporate NJ Choice Assessment data will depend on availability and amenability to claims-based linkage. If NJ Choice data can be utilized, we anticipate some discrepancies between 2023 and 2024 when the assessment tool changed as well as limitations related to the timeliness of assessment administration complicated by external factors.

To analyze the caregiver supports program using surveys, we will need reliable contact information for the beneficiaries and/or their caregivers. If MCOs do not have caregiver names, we will consider addressing the invitation to participate in the surveys to the LTSS member “and family”. However, this could lead to confidentiality concerns and will be considered as a last resort if unable to reach the caregivers independently. Survey participation will depend first on program take-up and then on caregiver availability, interest, and willingness to participate. Given the nature of caregiving responsibilities, many may not have time to participate, and those whose MCO MLTSS member has passed away may be negatively affected by grief and/or administrative factors relating to the passing. Survey participants as a result may skew as those with more resources and support (i.e., with more time to participate in a survey) or those with access to internet to take the survey. Depending on the sample size of this group, analyses may exclude caregivers of members who are deceased or a subgroup analysis may be conducted. If feasible and necessary, telephone surveys may be utilized to increase recruitment and accessibility. Additionally, surveys are subject to recall bias and there could be a misalignment in information provided (i.e., caregiving hours) across the survey and NJ choice assessment, if linked successfully. If program and/or evaluation take-up is too low by the time of the interim report to mount a meaningful analysis, CSHP will pivot to using its planned incentive resources for caregiver focus groups recruited from caregiver support organizations to complement existing data.

Supplemental Appendix

Appendix Exhibit 11.1: In-Depth Key Informant Implementation Interviews

[Goal: 60 Minutes]

Purpose of the Interview

I am speaking with you today because you were identified as a key informant in the State's Managed Long-Term Services and Supports program, "the MLTSS program." The MLTSS program is a Medicaid 1115 demonstration project that started in 2014. The overarching goal of the program was to help Medicaid (NJ FamilyCare) beneficiaries age in place (e.g., remain in a community-based dwelling as they age) and rebalance Medicaid long-term care by shifting focus from nursing home care to home and community-based services.

The MLTSS program has been renewed for the 2023-2028 demonstration period and has expanded to include several new caregiver and nutritional support programs. These changes include:

1. *Individual and/or facilitated peer group **counseling** through a licensed behavioral health provider for eligible caregivers who provide care for a beneficiary with MLTSS benefits,*
2. *Expansion of the **respite program** to provide up to 90 days of respite per calendar year,*
3. *Expansion of the **nutritional supports services** to go beyond home delivered meals, which includes:*
    - *One-time pantry stocking for any Medicaid eligible beneficiary who is transitioning from an institution,*
    - *Short-term provision of groceries to beneficiaries who have their usual source of food disrupted or who are experiencing an acute behavioral health episode,*
    - *Nutritional education and skills development (i.e., training how to shop for groceries on a budget, preparation of a meal, healthy well-balanced alternatives.)*

*We are interested in your experiences with the MLTSS program thus far as a **{say role: administrator, subject matter expert, provider, advocate}** and any recommendations you have to make the program better.*

Question Bank

[Interviewer: If the participant only has knowledge of one of the programs (e.g., nutrition vs caregiver supports), they will only be asked about that aspect (i.e., food vendor would be asked about the nutritional supports program).]

1. First, tell me a little bit about your specific role or relationship to the MLTSS program and how long you've been in that role?

2. Which key entities are collaborating to implement and operationalize the nutritional and caregiver supports programs, how were they identified, and what are their main roles?
   Probe: *How and why have the roles or participation of those key entities changed throughout the demonstration period?*

3. Thinking about the nutritional and caregiver supports programs and how they were rolled out, what are 1-2 recommendations you would make to ensure the State meets its goals of supporting older New Jersey Medicaid beneficiaries age in place?
   Probe: *What strategies were used to overcome barriers? What components of the program worked well? What should be changed?*

4. Thinking about participation in the nutritional and caregiver supports programs, what are some facilitators and barriers that you have observed beneficiaries experience? What does this information suggest about the need for refinements to beneficiary and provider outreach?

5. What strategies or tools did you use to identify beneficiaries to participate in the nutritional and caregiver supports programs? How, if at all, and why have these strategies been adapted? What lessons has the state learned about promising practices for identifying and engaging beneficiaries?
   Probe: *Are eligible beneficiaries utilizing the expanded support services? If there has been low take up of the programs, do you have any ideas as to why?*

6. Do participating beneficiaries stay enrolled in the nutritional and caregiver supports programs? What do you think are some reasons beneficiaries might drop out of the program?

That concludes the series of questions about the specific new components to the MLTSS program. Now I want to give you a chance to comment on the program as a whole.

7. What infrastructure are key entities developing or acquiring using 1115 demonstration funds? What did the state learn about promising practices to build infrastructure to support health-related social needs (HRSN) screening, case management, and service delivery?
   Probe: How, if at all, did the 1115 demonstration establish a process to share and receive results among key entities? How, if at all, have health care providers modified their clinical practice in response to this information?

8. Since MLTSS was implemented in 2014, have you noted any changes in the health of older New Jersey Medicaid beneficiaries or specific demographic groups that you work with? Please describe.

9. Have you seen MLTSS evolve since 2014? How? Are there additional supports or improvements that are needed to make MLTSS successful? If so, what are they?

10. Before we close, is there something else about the nutritional or caregiver support programs that you would like to share?

11. Who else might I talk to get insights?

Demographics

I'd like to end with some basic demographic questions to help us describe who we interviewed. Remember, your personal identification will not be linked with any of your answers. You may choose to skip any of these questions.

12. What is your formal training?
13. How many years have you worked at *{organization name}*?
14. How many years have you worked in health care?
15. What is your gender identity?
16. Do you identify as Hispanic or Latino?
17. What is your race?

Thank you for taking the time to talk to us. We learned so much about how the new components of the MLTSS program are going. If you have additional comments or questions, please don't hesitate to contact us.

Appendix Exhibit 11.2: Full Caregiver Survey

[Goal: 25-30 Minutes]

You are being invited to participate in this survey because you are a caregiver for someone enrolled in Medicaid who has a benefit called Managed Long-Term Services and Supports (MLTSS). MLTSS gives the person you care for a dedicated care manager through their NJ FamilyCare Managed Care Organization and services and supports like personal care assistance and home-delivered meals. Your experiences and voice are important to understanding how we can better support caregivers of people with Medicaid insurance.

SCREENER: <5 minutes

1. **Would you prefer to complete this survey in English or Spanish?** [translated to both languages]
    - English
    - Spanish -> GO TO SPANISH TRANSLATED SURVEY

    Source: New question

The next two questions are to help us make sure we are asking about things that are relevant to you.

2. **Do you help take care of someone who has Medicaid insurance (NJ FamilyCare) and a benefit called Managed Long-Term Services and Supports (MLTSS)? MLTSS gives the person you care for a dedicated care manager through their NJ FamilyCare Managed Care Organization and services and supports like personal care assistance and meals delivered to their home.**
    - Yes
    - No

    Source: New question

3. **Do you spend at least <u>10 hours a week</u> taking care of this person, on average? Your best estimate is fine.**
    - Yes
    - No
    - Don't know/Not sure

    Source: New question

Caregiving

1. **During the past 30 days, did you provide regular care or assistance to a friend or family member who has a health problem or disability?**
    - Yes
    - No [Go to question 9]
    - Don't know/not sure [Go to question 9]
    - Caregiving recipient died in the past 30 days [Skip to next module]
    - Refused [Go to question 9]

    Source: 9-item BRFSS Caregiver module

2. **What is their relationship to you? For example, are they your (mother or daughter or father or son)?**
    - Mother
    - Father
    - Mother-in-law
    - Father-in-law
    - Child
    - Husband
    - Wife
    - Same-sex partner
    - Brother or brother-in-law
    - Sister or sister-in-law
    - Grandmother
    - Grandfather
    - Grandchild
    - Other relative
    - Non-relative/family friend
    - Unmarried partner
    - Don't know/Not sure
    - Refused

    Source: 9-item BRFSS Caregiver module

3. **For how long have you provided care for that person? Would you say…**
    - Less than 30 days
    - 1 month to less than 6 months
    - 6 months to less than 2 years
    - 2 years to less than 5 years
    - More than 5 years
    - Don't know/Not sure
    - Refused

    Source: 9-item BRFSS Caregiver module

4. **In an average week, how many hours do you provide care or assistance? Would you say…**
    - Up to 8 hours per week
    - 9 to 19 hours per week
    - 20 to 39 hours per week
    - 40 hours or more
    - Don't know/Not sure
    - Refused

Source: 9-item BRFSS Caregiver module

5. **What is the main health problem, long-term illness, or disability that the person you care for has? Please choose which one of these conditions is the *major* problem.**
    - Arthritis/Rheumatism
    - Asthma
    - Cancer
    - Chronic respiratory conditions such as Emphysema or COPD
    - Alzheimer's disease, Dementia, and other Cognitive Impairment Disorders
    - Developmental Disabilities such as Autism, Down's Syndrome, and Spina Bifida
    - Diabetes
    - Heart Disease, Hypertension
    - Human Immunodeficiency Virus Infection (HIV)
    - Mental Illnesses, such as Anxiety, Depression, or Schizophrenia
    - Other organ failure or diseases such as kidney or liver problems
    - Substance Abuse or Addiction Disorders
    - Injuries, including broken bones
    - Traumatic brain injury
    - Stroke
    - Old age/infirmity/frailty
    - Other
    - Don't know/Not sure
    - Refused

Source: Modified from 9-item BRFSS Caregiver module

[Skip to question 7 if response to question 5 is 5 (Alzheimer's disease, dementia, or other cognitive impairment disorder]

6. **Does the person you care for also have Alzheimer's disease, Dementia, or other Cognitive Impairment Disorder?**
    - Yes

- No
- Don't know/Not sure
- Refused

Source: 9-item BRFSS Caregiver module

7. **In the past 30 days, did you provide care for this person by…**
   Managing personal care such as giving medications, feeding, dressing, or bathing?
   - Yes
   - No
   - Don't know/Not sure
   - Refused

   Source: 9-item BRFSS Caregiver module

8. **In the past 30 days, did you provide care for this person by…**
   Managing household tasks such as cleaning, managing money, or preparing meals?
   - Yes
   - No
   - Don't know/Not sure
   - Refused

   Source: 9-item BRFSS Caregiver module

9. **In the next 2 years, do you expect to provide care or assistance to a friend or family member who has a health problem or disability?**
   - Yes
   - No
   - Don't know/Not sure
   - Refused

   Source: 9-item BRFSS Caregiver module

Mental Health

10. **Over the last 2 weeks, how often have you been bothered by feeling nervous, anxious, or on edge?**
    - Not at all

- Several days
- More than half the days
- Nearly every day

Source: PHQ-4

11. **Over the last 2 weeks, how often have you been bothered by not being able to stop or control worrying?**
    - Not at all
    - Several days
    - More than half the days
    - Nearly every day

    Source: PHQ-4

12. **<u>Over the past 2 weeks</u>, how often have you been bothered by feeling down, depressed or hopeless?**
    - Not at all
    - Several days
    - More than half the days
    - Nearly every day

    Source: PHQ-4

13. **<u>Over the last 2 weeks</u>, how often have you been bothered by having little interest or pleasure in doing things?** [Select ONE]
    - Not at all
    - Several days
    - More than half the days
    - Nearly every day

    Source: PHQ-4

Caregiver Stress

*For the next few questions, please choose the response that best describes how you **<u>usually</u>** feel about caregiving. By caregiving we mean all aspects of taking care of your friend or family member -- that is providing help and support (typically unpaid) for their physical, psychological, or developmental needs. When choosing your answers consider how having a friend or family member you take care of affects all areas of your life.*

14. **How much are your finances strained because of caregiving?**
    - Not at all

- A little bit
- Somewhat
- Quite a bit
- Very much

Source: 8+2 Item UW Caregiver Stress Scale

15. How difficult is it for you to get a good night's sleep because of caregiving?

- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much

Source: 8+2 Item UW Caregiver Stress Scale

16. How difficult is it to find time to spend with your friends because of caregiving?

- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much

Source: 8+2 Item UW Caregiver Stress Scale

17. How much do you feel always "on call" because of caregiving?

- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much

Source: 8+2 Item UW Caregiver Stress Scale

18. How difficult is it for you to take care of yourself because of caregiving?

- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much

Source: 8+2 Item UW Caregiver Stress Scale

19. How difficulty is it to do activities you like to do because of caregiving?

- Not at all
- A little bit
- Somewhat
- Quite a bit
- Very much

Source: 8+2 Item UW Caregiver Stress Scale

20. On a typical day, how often do you feel overwhelmed by caregiving?

- Never
- Rarely
- Somewhat
- Often
- Always

Source: 8+2 Item UW Caregiver Stress Scale

21. How often do you feel socially isolated because of caregiving?

- Never
- Rarely
- Somewhat
- Often
- Always

Source: 8+2 Item UW Caregiver Stress Scale

22. How often do you need to miss work because of caregiving?

- N/A (I don't currently work) [Go to 22a]
- Never
- Rarely
- Somewhat
- Often
- Always

Source: Modified from 8+2 Item UW Caregiver Stress Scale

22a. Did you quit your job to take care of your friend or family member?

- Yes
- No
- Don't know/Not sure

Source: New question

23. How much does caregiving strain your relationship with your partner?

- N/A (I don't have a partner)
- Never
- Rarely
- Somewhat
- Often
- Always

Source: 8+2 Item UW Caregiver Stress Scale

24. **In the last 1 year did you or the person you care for use one (or more) of the following programs or services?** [Check all that apply]
    - Respite services (such as a short stay in a nursing facility) through the Caregiver Supports Program -> GO TO RESPITE QUESTIONS
    - Counseling through the Caregiver Supports Program -> GO TO COUNSELING QUESTIONS
    - Nutritional Supports (such as one-time pantry stocking, short-term provision of groceries, nutritional education) -> GO TO NUTRITION QUESTIONS
    - Don't know/Not sure
    - Refused

Source: New question

Respite Program

25. **The Medicaid respite program provides up to 90 days per participant per calendar year. How many days of respite did the person you care for use last year? Your best estimate is fine.**
    - Less than 7 days
    - 7-14 days
    - 15-30 days
    - 31-50 days
    - 51-70 days
    - More than 70 days
    - I did not use any respite services in the last year.
    - Don't know/Not sure
    - Refused

Source: New question

26. **Where was most of the respite care provided?**
    - At home
    - In a nursing home facility

- Somewhere else (PLEASE SPECIFY): _____
- Don't know/Not sure

Source: New question

27. How would you rate the help you got from the *{MCO}* case manager *w*ho enrolled you in the respite program? Would you say…

- Excellent
- Very good
- Good
- Fair
- Poor
- Don't know/Not sure
- Refused

Source: Modified from CAHPS Home- and Community-Based Survey 1.0

28. How would you rate the care your *{friend or family member}* received from the respite program? Would you say…

- Excellent
- Very good
- Good
- Fair
- Poor
- Don't know/Not sure
- Refused

Source: Modified from CAHPS Home- and Community-Based Survey 1.0

29. Would you recommend the respite program to your family and friends if they needed respite services?

- Definitely no
- Probably no
- Probably yes
- Definitely yes
- Don't know/Not sure
- Refused

Source: Modified from CAHPS Home- and Community-Based Survey 1.0

Counseling Services

30. **The Caregiver Supports Program provides individual and/or facilitated peer group counseling through a licensed behavioral health provider. Caregivers may receive unlimited counseling sessions as needed. Did you receive counseling through this program?**
    - Yes
    - No [Go to 29b]
    - Don't know/Not sure [Go to 29b]
    - Refused [Go to 29b]

Source: New question

29b. If you did not receive counseling through this program, why not? [Check ALL that apply]

- I do not want or need counseling
- Difficult to find time or difficult to schedule
- Concerns about cost
- Could not find a licensed behavioral health provider
- Did not know about this program
- Still planning to sign up, just haven't yet
- Already receiving counseling services, but not through this program
- I do not provide 10 or more hours a week of unpaid care
- I have other coverage that would pay for counseling, so I am not eligible
- I have not received a recommendation from the NJ FamilyCare care manager to get counseling
- Some other reason (PLEASE SPECIFY): _____

Source: New question

31. **How many sessions did you receive through the counseling program? Your best estimate is fine.**
    - |_____| sessions [Range: 0-100]
    - Don't know/Not sure
    - I didn't use any counseling services.
    - Refused

Source: New question

30b. Did you receive as many counseling sessions as you wanted to?

- Yes, and I am still receiving counseling services

- Yes, and I am no longer receiving counseling services
- No
- Don't know/Not sure
- Refused

Source: New question

32. How would you rate the help you got from the *{MCO} case manager* who enrolled you in the counseling program? Would you say…

- Excellent
- Very good
- Good
- Fair
- Poor
- Don't know/Not sure
- Refused

Source: Modified from CAHPS Home- and Community-Based Survey 1.0

33. How would you rate your experience with the counseling services? Would you say…

- Excellent
- Very good
- Good
- Fair
- Poor
- Don't know/Not sure
- Refused

Source: New question

34. Would you recommend the counseling program to your family and friends if they needed counseling services?

- Definitely no
- Probably no
- Probably yes
- Definitely yes
- Don't know/Not sure
- Refused

Source: Modified from CAHPS Home- and Community-Based Survey 1.0

Nutritional Supports

35. **There are additional nutritional benefits available through the Managed Long-Term Services and Supports (MLTSS) program. Which, if any, of the following services did your *{friend or family member}* receive?** [Check ALL that apply]
    - Buying food supplies when my ***{friend or family member}*** came home from a nursing home or long-term hospital stay
    - Buying groceries for up to 30 days when my ***{friend or family member}*** wasn't able to get groceries for themselves
    - Nutritional education or counseling on things like healthy meal preparation and tips for getting food on a budget
    - Receiving home delivered meals
    - Don't know/Not sure
    - I didn't use any nutritional benefits
    - Refused

    Source: New question

36. **Is your *{friend or family member}* enrolled in the Supplemental Nutrition Assistance Program (SNAP)? SNAP provides food benefits to people to supplement their grocery budget.**
    - Yes
    - No
    - Don't know/Not sure
    - Refused

    Source: New question

37. **How would you rate the help you got from the *{MCO}* case manager who enrolled you in one of the nutrition programs? Would you say…**
    - Excellent
    - Very good
    - Good
    - Fair
    - Poor
    - Don't know/Not sure
    - Refused

    Source: Modified from CAHPS Home- and Community-Based Survey 1.0

38. How would you rate your experience with the nutrition services? Would you say…

- Excellent
- Very good
- Good
- Fair
- Poor
- Don't know/Not sure
- Refused

Source: New question

39. Would you recommend the nutrition services to your family and friends if they needed these types of nutrition support?

- Definitely no
- Probably no
- Probably yes
- Definitely yes
- Don't know/Not sure
- Refused

Source: Modified from CAHPS Home- and Community-Based Survey 1.0

Demographics

The last series of questions are meant to learn more about you and your family.

40. What is your age?

- [DROP DOWN: 18-100] years

Source: BRFSS

39a. [If no answer above] Would you be willing to tell us whether it's between…

ee. 18 – 24
ff. 25 – 34
gg. 35 – 44
hh. 45 – 54
ii. 55 – 64
jj. 65 or over
kk. Prefer not to say

Source: New question

41. **How do you describe your gender?** [Select ONE]
    - Female
    - Male
    - Trans Male/Trans Man
    - Trans Female/Trans Woman
    - Genderqueer/Gender Nonconforming
    - Prefer to self-describe, please specify: [open field]
    - Prefer not to say

Source: Q7-8 Two Step Gender Identity

42. **What sex were you assigned when you were born, such as on your original birth certificate?** [Select ONE]
    - Female
    - Male
    - Prefer not to say

Source: Q7-8 Two Step Gender Identity

43. **What is your current marital status?** [Select ONE]
    - Married or living with a partner
    - Widowed, divorced, or separated
    - Never married
    - Don't know/Not sure
    - Refused

Source: NHANES

44. **Would you say that in general your health is…**
    - Excellent
    - Very good
    - Good
    - Fair
    - Poor
    - Don't know/Not sure
    - Refused

Source: BRFSS

45. **What was your approximate total household income last year, including income from all sources such as wages, salaries, Social Security or retirement benefits, help from relatives and so forth. Can you share the amount before taxes?**
    - $0 _____$200,000 or more (Slider scale)
    - Don't know/Not sure
    - Prefer not to say

Source: Modified NHANES, slider scale only possible with online survey

44a. [If no answer to above] Could you tell us if your total annual income from all sources last year, before taxes, was: [Select ONE] [DROP DOWN]

- $0 to $16,000
- $16,001 to $20,000
- $20,001 to $24,000
- $24,001 to $28,000
- $28,001 to $32,000
- $32,001 to $40,000
- $40,001 to $48,000
- $48,001 to $57,000
- $57,001 to $60,000
- $60,001 to $73,000
- $73,001 to $85,000
- $85,001 to $97,000
- $97,001 to $109,000
- $109,001 to $121,000
- $121,001 or more

Source: Modified PRAMS with additional income bands above $85,000

46. **How many children (less than 18 years of age) live in your household? Only include children who are living with you at least 50% of the time.**
    - [DROP DOWN: None to 10+] Children

Source: BRFSS 2019; 50% of time from Urban Institute Wellbeing and Basic Needs Survey

47. **How many adults (18 years of age or older), including yourself, live in your household? Only include adults who are living with you at least 50% of the time.**
    - [DROP DOWN: 1 to 10+] Adults

Source: BRFSS 2019

48. **What is the highest grade or level of school you completed or the highest degree you have received?**
    - Did not finish high school
    - High school graduate/GED or equivalent
    - Some college or AA degree
    - College graduate or above
    - Don't know/Not sure
    - Refused

    Source: Modified NHANES with abbreviated options (collapsed less than 9th grade and 9-11th grade)

49. **Which of the following describes your race? You can select as many as apply.**
    - White (e.g., German, Irish, English, Italian, Polish, French)
    - Hispanic, Latino, or Spanish (e.g., Mexican, Puerto Rican, Cuban, Dominican)
    - Black or African American (e.g., Jamaican, Haitian, Nigerian, Ethiopian, Somalian)
    - Asian (e.g., Asian Indian, Chinese, Filipino, Vietnamese, or other Asian origin groups)
    - Native American, American Indian, or Alaska Native
    - Pacific Islander or Native Hawaiian
    - Middle Eastern or North African (e.g., Lebanese, Iranian, Egyptian, Syrian, Moroccan, Algerian)
    - Some other race, ethnicity, or origin (PLEASE SPECIFY): _____
    - Don't know/Not sure
    - Refused

    Source: Modified Pew and Census/CDC

50. **In what country were you born?**
    - Born in 50 U.S. states or Washington, D.C.
    - Other
    - Don't know/Not sure
    - Refused

    Source: NHANES

51. **About how many years have you lived in the United States?** [For less than a year, enter 1 year]

- [DROP DOWN: 1-90] years

Source: California Health Interview Survey and American Community Survey

52. What is the ZIP code where you currently live?

- [OPEN FIELD]

Source: Modified BRFSS 2019

53. What is the name of the county where you currently live?

- [OPEN FIELD]

Source: New question

54. How would you describe the community where you currently live?

- Rural
- Suburban
- Urban
- Don't know/Not sure
- Refused

Source: Modified from Pew

55. Would you be willing to participate in a more in-depth interview or focus group to discuss your experience as a caregiver and any Medicaid programs or services you might have participated in in your role as a caregiver?

- Yes [Go to 54a]
- No
- Don't know/Not sure [Go to 54a]
- Refused

Source: New question

54a. What is the best phone number to reach you?

- [OPEN FIELD]

Source: New question

54b. What is the best email to reach you?

- [OPEN FIELD]

Source: New question

54c. When are you typically be available to meet? This will be used to schedule the interview or focus group (via Zoom or similar video conferencing tool).

(Indicate all availability)

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning (After 9am-12pm)							
Afternoon (After 12pm-4pm)							
Evening (After 4pm-9pm)							
Night (After 9pm-11pm)							

56. Do you have any suggestions for Medicaid about how to improve the services available to you or the person you care for?

- [OPEN FIELD]

Source: New question

Appendix Exhibit 11.3: In-Depth Caregiver Interviews

[Goal: 60 Minutes]

Thank you for meeting with me. Today, we will be discussing caregiver support programs in New Jersey. We asked to speak with you because you help take care of someone enrolled in Medicaid who has a benefit called Managed Long-Term Services and Supports (MLTSS). MLTSS gives the person you care for a dedicated care manager through their NJ FamilyCare Managed Care Organization and services and supports like personal care assistance and home-delivered meals. We will talk about getting services and supports, and your experience as a friend or family member of someone who needs help at home.

This interview won't take more than an hour and we will focus on ways to improve services for caregivers and your loved ones in New Jersey. The information you share today will not be linked with any of your personal information.

Question Bank

1. First, tell me a little bit about yourself and the person you are taking care of.
   Probe: How long have you been taking care of this person? What kinds of things do you do for them? Are there other people who help?

2. Many people hope to stay in their home as they get older. Have you ever talked with the person you are taking care of about what they want as they get older? Can you share a little about what they told you about their wishes?
   Probe: What do you think would influence their decision to stay in their home?

3. Can you share with me if there is anything that would make it impossible for you to continue helping?
   Probe: What are some of your concerns as they get older?

4. It often takes a village to care for someone as they get older. Can you describe what kinds of support you have that make your life as a caregiver easier? This might be family or friends who help out, a visiting nurse or home care services, adult day care, or similar programs.
   Probe: Have you used any support programs covered by Medicaid in the last year? If so, which ones? *[Interviewer: Explain services in detail as necessary (e.g., counseling, respite, or nutrition]*

The next set of questions will be about your experiences using the Medicaid programs you have used in the last year.

Respite program question bank

[Interviewer: Only ask this set of questions if the participant used respite services]

1. Can you share a bit about your experience using the respite services? What encouraged you to use the respite benefit in the first place?
   Probe: How would you describe your experience scheduling a respite stay for your *{friend or family member}*? Were there times that you wanted to schedule a respite stay, but couldn't? What happened? What would you say to those who want to improve the respite program?

2. [If they received respite in a facility] Now I'd like to hear a little bit about your experience with the facility itself. What were your impressions of the facility and the care your loved one received during their respite stay?
   Probe: How convenient was the facility? What was your impression of the staff at the facility? Would you recommend the facility to others in need of respite?

3. How do you feel like using respite care helped you in your role as a caregiver?
   Probe: What situations did you rely on respite services? Was it to schedule a trip or simply to take a break?

Counseling program question bank

[Interviewer: Only ask this set of questions if the participant used counseling services]

1. Can you share a bit about your experience with the counseling services? What encouraged you to use the counseling services in the first place?

The next set of questions are about your experience with the counseling provider who you saw through the counseling program.

2. How would you describe your experience finding a mental health provider?
   Probe: What were some of the challenges/obstacles? What are some ways that your MCO case manager might have helped?

3. What is/was your relationship with your mental health provider?
   Probe: What kind of needs do you feel like they are/were able to meet? Is/was your mental health provider from the same racial or ethnic group as you? Were you able to find a provider who could meet with you in the language or location that was best for you?

4. How do you feel like seeing a mental health provider helped you in your role as a caregiver?
   Probe: What would you say to those who want to improve the counseling program?

Nutritional program question bank

[Interviewer: Only ask this set of questions if the participant used nutrition services]

1. Can you tell me about your experience using the nutrition services that you or the person you're caring for received?
   Probe: What prompted you or your loved one to seek these services out?

2. Can you share a little bit about the food itself that your loved one received? What kinds of groceries or meals were delivered?
   Probe: How did the food taste? Were they able to get food that met their dietary needs? How was the timing of the meal or grocery delivery?

3. Most of these services are short-term, how do they get their nutrition needs met now?
   Probe: {If enrolled in a program like SNAP or something similar} How did they find out about and get enrolled in, these services? Do they wish they could continue receiving the services they received in the short-term? What would you say to those who want to improve the nutrition program?

Close

1. Is there anything that you wish you and the person you care for had more help with? Is there anything else about the nutritional or caregiver support programs that you would like to share?

2. How regularly do you speak with your case manager about getting the services you (and the person you take care of) need? How could you and the person you care for be more involved in the planning process?

3. What would you like New Jersey systems leaders (like the directors of Medicaid, the governor's office, and state agencies) to know about what it is like to be a caregiver? What improvements should be made (this includes policies, services, and systems)?

I'd like to end with some basic demographic questions to help us describe who we interviewed. Remember, your personal identification will not be linked with any of your answers. You may choose to skip any of these questions.

4. How old are you?

5. What is your gender identity?

6. Do you identify as Hispanic or Latino?

7. What is your race?

Thank you for taking the time to talk to us. We learned so much about how we can better support caregivers. If you have additional comments or questions, please don't hesitate to contact us.

12. Administrative Simplifications for LTSS

A. General Background Information

Qualified Income Trusts

The adoption of Qualified Income Trusts (QITs)[139] in December 2014 established an option to fulfill the spend-down provision for individuals deemed eligible for nursing facility level-of-care which was originally proposed in New Jersey's §1115 Waiver. QITs allow incomes above 300% of the Supplemental Security Federal Benefit Rate (FBR) ($2,742 as of January 2023)[140] be disregarded for financial eligibility purposes for clinically eligible individuals. Income above the threshold must be deposited into a QIT bank account each month in order to be disregarded.

As per 42 CFR, §435.725 and §435.726, all individuals receiving long-term services and supports (LTSS) must contribute to their monthly cost of care. The required monthly contribution is determined by adding all sources of income minus allowable expenses such as personal needs allowances, community spouse maintenance and dependent allowances, room and board, and state approved uncovered medical expenses for Home and Community Based Service (HCBS) settings. The monthly cost of care may be paid out of the QIT account.

Prior to the Waiver, spend-down for higher income applicants was only available for nursing facility residents (a medically needy designation), which may have led people with incomes higher than the eligibility threshold to choose nursing facilities when community-based services would be appropriate, at a higher cost to the state. QITs created a new eligibility pathway for long-term care services in home and community settings for such individuals. The introduction of the QIT mechanism required discontinuing new enrollment in the Medically Needy program. The discontinuation of the Medically Needy program could have posed a disadvantage to existing enrollees residing in nursing facilities since the resource limits for eligibility are lowered to the community levels ($2,000 for an individual or $3,000 for a couple). However, the state grandparented all individuals enrolled in the Medically Needy program prior to December 2014 so they could maintain their Medicaid eligibility under the prior resource limits ($4,000 for an individual or $6,000 for a couple).

Figure 12.1 shows the primary and secondary drivers leading to the aim of preventing nursing home admissions.

Figure 12.1. QIT Aims Driver Diagram

Aim	Primary Drivers	Secondary Drivers
Prevent nursing home admissions of residents who have limited assets but higher incomes than	Access to Medicaid HCBS	QITs for clinically eligible individuals with income above 300% to spend down their resources on long-term supports and services (delivered in their homes/communities or in a

[139] See https://www.state.nj.us/humanservices/dmahs/clients/mtrusts.html (accessed September 7, 2023)
[140] See https://www.state.nj.us/humanservices/dmahs/info/resources/medicaid/2023/23-01_Income_and_Resource_Standards_for_Medicaid_Only.pdf Table B, row V (accessed September 7, 2023).

would normally qualify for Medicaid		nursing facility) to become eligible for Medicaid.
⟸	Causality	⟹

Transfer of Assets Self-Attestation

Medicaid eligibility for long-term care services requires that applicants not transfer any assets or resources for less than fair market value during the five years preceding their date of application. Applicants are required to furnish all of their bank statements and any other relevant financial documentation proving compliance with this requirement before eligibility can be granted. Where the market value of asset transfers cannot be established, a penalty period is imposed delaying eligibility for long-term care services.[141] This process requires time and effort both for applicants, to procure all the necessary documentation, and for eligibility workers, who must review the documentation and assess the ramifications for the application.

Under the demonstration, individuals with income at or below 100% of the Federal Poverty Level (FPL) applying for institutional or home and community-based services are permitted to self-attest that they have made no disqualifying asset transfers during the past five years. This attestation is a sworn statement documented on an addendum to the Medicaid application used by County Welfare Agencies for new entrants, or collected during the financial eligibility determination conducted by Managed Care Organizations for existing beneficiaries moving into Managed Long-Term Services and Supports (MLTSS) after July 1, 2014. This form, which was approved for use in December 2012, eliminates the need for the time intensive five-year lookback process, and was intended to expedite eligibility approvals for very low-income applicants.[142] Audits in previous years showed no evidence of any asset transfers.

Figure 12.2 shows the primary and secondary drivers leading to the aim of expediting access to Medicaid services for very low-income applicants.

Figure 12.2. Self-attestation Aims Driver Diagram

Aim	Primary Drivers	Secondary Drivers
Expedited access to Medicaid services for very low-income applicants; time savings for applicants and eligibility workers.	Expedite Medicaid financial eligibility approvals for very low-income applicants.	Self-attestation by persons below 100% FPL of no asset transfers for less than fair market value during the 5 years preceding application date.
⟸	Causality	⟹

[141] See https://www.nj.gov/humanservices/dmahs/info/resources/medicaid/2023/23-04_Increase_in_the_Penalty_Divisor_Effective_Apr-23.pdf

[142] See Medicaid Communication No. 12-18: Addendum to PA-1G Medicaid Application, Transfer of Assets Self-Attestation Form (2012); Medicaid Communication No. 12-18: Addendum to PA-1G Medicaid Application, Transfer of Assets Self-Attestation Form (2013) and Medicaid Communication No. 16-01: Self-Attestation Process for NJ FamilyCare ABD Eligibility, Update to Medicaid Communication 13-02 (2016).

Financial Eligibility Determination Pilot Program, NJ Office of the Public Guardian (OPG)

Effective as of July 25, 2019, for individuals under the guardianship of the New Jersey Office of the Public Guardian (OPG) applying for Medicaid coverage, the state will provide an expedited financial eligibility determination by allowing OPG to attest that the individual's resources are less than the $2,000 resource limit due to financial obligations not yet paid. The OPG is a state agency that serves as guardian for legally incapacitated individuals aged 60 and older (as deemed by NJ Superior Court). The Office makes all decisions for the individuals in its care, including medical, financial and legal decisions. All individuals served have serious cognitive limitations that render them unable to provide meaningful information about their income and assets. Furthermore, in most cases there are no involved or helpful family members or friends to assist with this process. OPG staff must therefore attempt to piece together each individual's financial profile with minimal or no background information. As of April 2023, OPG served as guardian for roughly 1,700 individuals. Over the course of each year, hundreds of these individuals pass away and are replaced by other older adults who require protection. When needed, OPG will submit a Medicaid eligibility application on behalf of the individuals it serves. DMAHS has established two units in Salem and Cumberland counties to process these applications, which typically process 20-40 applications at a time. OPG and DMAHS have pursued numerous efficiencies so that seniors in need of Medicaid services can receive them rather than staying inappropriately in acute care settings or being at risk in community settings without support.

Financial eligibility rules for individuals under the guardianship of the OPG are the same as for other individuals applying for Medicaid. The state must use Asset Verification System (AVS) and other electronic verification tools to verify known financial resources and identify unknown financial resources both at application and at redetermination. After the individual's obligations are paid, for individuals determined to have been ineligible for Medicaid services due to exceeding the resource limit, the state will be responsible for funding services provided to the ineligible individual for the determination period which relied upon the OPG attestation and no FFP may be claimed for the individual.

Attestations from the OPG will be accepted only for 12 months and may not be used to renew eligibility beyond that regardless of whether or not the OPG has completed settling the individual's financial obligations. If the OPG settles the individual's accounts within 180 calendar days after the 12 month deadline, and the state determines the individual was eligible for Medicaid during the eligibility period, the state may claim FFP for the 12 month eligibility period. If the OPG settles the individual's accounts after 180 days, the state not claim FFP for the 12 month eligibility window, regardless of whether or not the individual was eligible. For individuals determined to have been ineligible for Medicaid due to exceeding the income or resource limit during the 12 month window, the state will be responsible for funding services provided to the ineligible individual for the 12 months and no FFP may be claimed for the individual. If FFP was claimed for the individual prior to the determination of ineligibility, the state is required to return the FFP. The OPG must maintain records of individuals for whom the expedited financial eligibility determination is utilized and report to the state when the OPG settles the account of an individual who has been made eligible based on the OPG's attestation. The state must also maintain records of the results of the asset verification process throughout the demonstration approval period.

Figure 12.3 shows the primary and secondary drivers leading to the aim of expediting access to Medicaid services for individuals served by OPG.

Figure 12.3. OPG Expedited Financial Eligibility Pilot Aims Driver Diagram

Aim	Primary Drivers	Secondary Drivers
Expedite access to Medicaid services for individuals served by OPG.	Medicaid eligibility office able to process expedited approval.	OPG attestation of asset levels for individuals they serve.
⟸	Causality	⟸

B. Evaluation Questions and Hypotheses

Hypothesis 1: Utilizing Qualified Income Trusts will allow more individuals to qualify for Medicaid and will increase the number of Medicaid long-term care recipients in community settings.

> Research Question 1a: How many members have qualified for Medicaid due to the QIT provision? Was there a change in the number of or characteristics of individuals qualifying for Medicaid due to this provision?

Hypothesis 2: Eliminating the look-back period at time of application for transfer of assets for applicants or beneficiaries seeking LTSS whose income is at or below 100% of the FPL will simplify Medicaid eligibility and enrollment processes without compromising program integrity.

> Research Question 2a: How many members have attested to no asset transfers during the 5-year look-back period? Was there a change in the number or characteristics of individuals qualifying for Medicaid due to this provision?

Hypothesis 3: Allowing OPG to attest to asset levels for individuals they serve will expedite access to Medicaid services for these individuals.

> Research Question 3a: For how many members did OPG attest regarding asset levels? Was there a change in the number or characteristics of individuals qualifying for Medicaid due to this provision?

C. Methodology

In past waiver/demonstration evaluations, it has not been possible to identify individuals qualifying for Medicaid through QIT or self-attestation in the eligibility and claims files, limiting the evaluator's analytic scope. With this demonstration, we will explore the potential to create a linkage to QIT and self attestation in the claims files. If this linkage is possible and sample sizes are sufficient, we may conduct additional subgroup analyses (e.g., demographic or geographic characteristics), providing more nuance to the evaluation and understanding of the QIT and self-attestation programs.

QITs: The evaluator requests data for individuals using QITs by year, county, setting (e.g., nursing home, assisted living, and home and community-based settings), program (such as MLTSS,), and individual demographic characteristics in order to examine trends. The evaluator also requests data on QIT use for each year (e.g., amounts, services).

Self-attestations: The evaluator requests data on self-attestations filed by quarter or year by MCOs, county welfare agencies, and any other mechanism through which attestations can be filed, together with other information the state may have about attesting individuals, such as their program, county, setting, and demographics.

OPG attestations: The evaluator requests data on OPG attestations filed by quarter or year, together with other information the state may have about relevant individuals, such as their program, county, setting, and demographics.

The evaluator will present a descriptive analysis of trends over time for QITs, self-attestations, and OPG attestations overall and by subgroups such as programs, counties, settings, and demographic groups.

Table 12.1: Summary of Questions, Hypotheses and Methodology

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
Hypothesis 1: Utilizing Qualified Income Trusts will allow more individuals to qualify for Medicaid and will increase the number of Medicaid long-term care recipients in community settings.				
RQ1a: How many members have qualified for Medicaid due to the QIT provision? Was there a change in the number of individuals or in the mix of individuals qualifying for Medicaid due to this provision?	Number and trends of individuals using QITs, and their county, setting of care, and program (if available)	Individuals using QITs	DMAHS administrative data and discussions with state staff	Descriptive trends over time overall and by subgroups such as programs, counties, settings, and demographic groups
Hypothesis 2: Eliminating the look back period at time of application for transfer of assets for applicants or beneficiaries seeking long term services and supports whose income is at or below 100% of the FPL will simplify Medicaid eligibility and enrollment processes without compromising program integrity.				
RQ2a: How many members have attested to no asset transfers during the 5-year look-back period? Was there a change in the number of individuals or in the mix of individuals qualifying for Medicaid due to this provision?	Number of self-attestations received by state, county welfare agencies, and MCOs. Audit results for sampled self-attestations	Individuals providing self-attestation	DMAHS administrative data and discussions with state staff	Descriptive trends over time overall and by subgroups such as programs, counties, settings, and demographic groups
Hypothesis 3: Allowing OPG to attest to asset levels for individuals they serve will expedite access to Medicaid services for these individuals.				
RQ3a: For how many members did OPG attest regarding asset levels? Was there a change in the number of individuals or in the mix of individuals qualifying for Medicaid due to this provision?	Number of attestations made by OPG.	Individuals for whom OPG attests asset levels	DMAHS/OPG administrative data and discussions with state staff	Descriptive trends over time overall and by subgroups such as programs, counties, settings, and demographic groups

Table 12.2 shows an activity timeline for the research activities.

Table 12.2 Key Milestones, Administrative Simplifications for LTSS

Analytic Activity	Year 1 2025	Year 2 2026	Year 3 2027	Year 4 2028	Year 5 2029	Year 6 2030
1. RQ1a: Measuring members qualifying for MLTSS due to QIT (if not getting through enhanced claim /encounter data)		Request updated report, review, and discuss any questions with state staff	Complete interim analysis	Request updated report, review, and discuss any questions with state staff		Complete analysis
2. RQ2a: Measuring members doing self-attestations (SA) (if not getting through enhanced claim /encounter data)		Review SA numbers reported to CMS and request/review audit or enriched SA findings, discuss any questions with state staff.	Complete interim analysis	Review SA numbers reported to CMS and request/review audit or enriched SA findings, discuss any questions with state staff.		Complete analysis
3. RQ3a: Measuring members for whom OPG attests (if not getting through enhanced claim /encounter data)		Review OPG numbers reported to CMS and request/review enriched OPG findings, discuss any questions with state staff	Complete interim analysis	Review OPG numbers reported to CMS and request/review enriched OPG findings, discuss any questions with state staff		Complete analysis
4. Submit reports to CMS			Interim report			Final report

OPG=Office of the Public Guardian; RQ=Research Question; SA=self attestation.

NOTE: Evaluation project years are March-Feb. (subject to change depending on date of authorization to begin).

D. Methodological Limitations

The evaluator's ability to examine outcomes may be limited by data availability. In past waiver/demonstration evaluations, it has not been possible to identify individuals qualifying for Medicaid under these QIT and expedited eligibility provisions in the eligibility and claims files, limiting the evaluation's analytic scope. With this demonstration, we will explore creating a linkage to QIT and self-attestation in the claims files, which may allow for a richer subgroup analysis. However, data for the self-attestation process may not be reliable during the public health emergency when face-to-face clinical assessment were waived. Additionally, this analysis relies on descriptive trends and results cannot be used to draw causal relationships. Even if this linkage is not possible, aggregated records requested in this plan will allow for evaluation of essential trends in these program provisions.

13. Demonstration Cost Assessment (***new section***)

A. General Background Information

The components of New Jersey's Section 1115 demonstration may moderate health services expenditures by reducing avoidable utilization, and some components may lead to lower uncompensated care costs borne by health services providers. At the same time, the demonstration authorizes spending on new services and will generate administrative costs related to intervention implementation and operations. The demonstration Special Terms and Conditions (STC 13.5)[143] requires assessment of these costs, specifically including:

1) Administrative cost of demonstration implementation and operation,
2) Budgetary effects of health-related social needs (HSRN) services,
3) Overall Medicaid service expenditures,
4) Uncompensated care and associated costs for populations eligible for continuous eligibility, and
5) Yearly long-term services and supports (LTSS) and home and community-based services (HCBS) spending throughout the demonstration period.

STC 13.5 further requires that cost analyses assess the demonstration's effects on the fiscal sustainability of the state's Medicaid program. This chapter describes the plan to assess demonstration costs, as specified in STC 13.5.

B. Evaluation Questions and Hypotheses

We posit that the implementation of the demonstration components described in chapters 1-12 of this design plan will, to varying degrees, reduce avoidable and overall Medicaid expenditures and increase the provision of newly authorized services and generate administrative costs. The overall aim of the demonstration is to improve service quality, access and outcomes, while ensuring financial sustainability of New Jersey's Medicaid program. A thorough cost assessment is needed to measure the spectrum of new costs and savings resulting from the demonstration.

The evaluation strategy described below builds on those described in chapters 1-12 of this plan, including drawing on the driver diagrams and logic models provided in those chapters. These plans describe analytic strategies for evaluating potential cost savings through hypothesized reductions in avoidable health services utilization (e.g., preventable hospitalizations, reduced emergency department visits). The hypotheses enumerated in this chapter, complements and augments those provided in the other chapters to ensure comprehensive, rigorous assessment of demonstration costs.

This chapter adds an assessment of administrative costs. Implementation of the demonstration components requires development of new policies and systems, leading to non-recurring start-up

[143] https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/nj-1115-familcar-compr-demonstr-aprvl-09132023.pdf. Page 115

administrative expenditures, and generating ongoing operational costs. These administrative costs may include added staff effort, and, in some cases, new contractual or related expenses.

The research questions below also complement those provided in chapters 1-12 to ensure thorough assessment of added costs for new demonstration services and potential savings from care improvements and reductions in avoidable utilization.

Further, two demonstration components (postpartum eligibility extension and continuous eligibility for MAGI adults, described in chapters 3 and 6 above, respectively) have potential to reduce uncompensated costs borne by providers of care for individuals who gain coverage under those extensions. The proposed strategy for evaluating demonstration effects on uncompensated care described below focuses on delivery of charity care by New Jersey hospitals for two reasons. First, hospitals represent the largest source of uncompensated care,[144] in part because unlike other types of providers, they are required by law to provide care regardless of patients' ability to pay.[145] Private healthcare providers typically provide little charity care. For instance, one study showed that uncompensated costs are equivalent to less than 1% of revenues for private physician practices.[146] Second, data from New Jersey's Hospital Care Payment Assistance (Charity Care) Program permit rigorous assessment of the most likely impacts of demonstration eligibility expansions on the delivery of uncompensated care. Hospital outpatients and inpatients are entitled to free or reduced cost care in New Jersey if they meet certain eligibility requirements including that they are not eligible for Medicaid and have family incomes below 300% of the federal poverty level.[147] This group overlaps substantially with those subject to 12-month Medicaid eligibility expansions authorized under the demonstration, which may result in uncompensated care spending reductions.

Evaluation Questions and Hypotheses

Hypothesis 1: Implementation and operation of the demonstration components will increase administrative cost, including non-recurring start-up costs and ongoing operational costs.

Research Question 1a: What are the non-recurring administrative costs associated with the initiation of each demonstration component, including added staff effort and non-personnel expenses?

Research Question 1b: What are the ongoing administrative costs associated with operation of each demonstration component, including added staff effort and non-personnel expenses?

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[144] Hadley J, Holahan J. How Much Medical Care Do the Uninsured Use, And Who Pays For It? A large amount of money from existing government sources is potentially available to finance expanded insurance coverage. Health Affairs. 2003;22(Suppl1):W3-66.

[145] The federal Emergency Medical Treatment & Labor Act (EMTALA) requires hospitals to provide stabilization care for emergency services (including active labor) regardless of ability to pay. New Jersey law goes beyond EMTALA by requiring hospitals to provide all medically necessary care (see https://www.nj.gov/health/hcf/subsidies/).

[146] Gruber J, Rodriguez D. How much uncompensated care do doctors provide? Journal of Health Economics. 2007 Dec 1;26(6):1151-69.

[147] See https://www.nj.gov/health/charitycare/.

Hypothesis 2: The demonstration components, to varying degrees, will generate costs for new services or extended eligibility that will be offset by lower spending for other Medicaid health services resulting from improved accessibility or quality of care (e.g., reduced spending on avoidable hospitalization or ED use).

Research Question 2a: What are the added costs for new services or periods of eligibility authorized under each demonstration component?

Research Question 2b: What are changes in non-demonstration health services expenditures associated with implementation of each demonstration components (e.g., offsetting savings from improved accessibility or quality of care)?

Research Question 2c: What are the net changes in spending for each demonstration component (i.e., spending on new services or eligibility net of changes in non-demonstration-related spending overall)?

Hypothesis 3: The extension of 12 months continuous eligibility to postpartum women and beneficiaries who are Medicaid eligible based on the Modified Adjusted Gross Income (MAGI) standard will reduce hospital charity care costs for affected populations.

Research Question 3a: What is the impact of postpartum continuous eligibility on hospital charity care costs for women in the 12 months following the end of pregnancy?

Research Question 3b: What is the impact of continuous eligibility for adults (ages 19-64) who are eligible based on the MAGI standard on hospital charity care costs for low-income adults?

C. Methodology

To evaluate the above hypotheses and research questions, the evaluation will synthesize cost-related[148] results of components 1-12 of this plan and contribute additional analyses to augment component-specific analyzes to fully address the research questions in this chapter. Analyses will compare per beneficiary-per month cost trends before and after the implementation of the demonstration, adjusting for trends in comparison groups, where feasible.

Hypotheses 1, RQ 1

Study population for Hypothesis 1, RQ1a and b:

To examine administrative costs, the study will collect personnel cost of effort of state agency staff and non-personnel expenses related to the implementation and operation of each demonstration component.

[148] The terms "cost", "spending", "expenses", and "expenditures" are used interchangeably except where noted.

Analytic strategy for Hypothesis 1, RQ1a and b:

Administrative cost data will be collected using spreadsheet templates for each demonstration component into which state staff will enter the following information:

- Staff member name/unit
- Dates during which effort was applied to the demonstration component
- Share of staff salary and fringe benefit expense allocated to the demonstration effort
- Allocated non-salary costs (e.g., rent, computing/technology expenses)
- Additional non-personnel related expenses (e.g., contractual costs)

Data will be collected retrospectively from the date CMS approved the demonstration and annually until the end of the demonstration period. Each submission will be reviewed for consistency and reasonableness and corrected as needed. Resulting cost estimates will be aggregated to the level of each demonstration component and distributed between start-up expenses (based on the period before demonstration implementation) and operating expenses (based on the period during the demonstration). Results will be adjusted for inflation.

Hypothesis 2, RQ 2

Study population for Hypothesis 2, RQ2a-c:

Study populations for each demonstration component are described in chapters 1-12 above.

Analytic strategy for Hypothesis 2, RQ2a-c:

Table 13.1 summarizes Medicaid services expenditure measures that are part of demonstration evaluation plans for each component described in chapters 1-12 above. In addition to the measures listed in the table, total spending and, where applicable but not included in the individual component plans (e.g., CHW pilots), spending on new benefits for relevant demonstration components will be evaluated. Where feasible, these analyses will employ the comparison groups and analytic methods specified in the component-specific evaluations. Net costs (savings) of each component will be calculated by subtracting new benefit costs (from RQ2a) from total expenditures for services other than the new demonstration services (from RQ2b). To assess cost and budget impacts of demonstration components, spending trends will be compared for the component-specific target populations for 2017-2019 (pre-demonstration, pre-pandemic) to the demonstration periods.

Because of major disruptions in health services utilization patterns during COVID-19 pandemic, spending trends for that period will be examined but not evaluated as part of the pre-demonstration baseline period[149] when assessing the budget and cost impacts.

Spending trends spanning these periods will be examined graphically (line charts showing total and for demonstration services spending) and using regression analyses adjusting for changes in population composition distributions over time. The trends will be calculated on a per-beneficiary

[149] Postpartum and MAGI 12-month continuous eligibility extensions will be evaluated after the end of the eligibility-related provisions of the COVID-19 Public Health Emergency.

per-month basis and adjusted for inflation. Analyses planned under the individual evaluation components (described in chapters 1-12 above, e.g., analyses of change in avoidable hospitalizations and ED visits in specific demonstration populations) will be used to explain and interpret aggregate spending trend analyses presented in this chapter.

Table 13.1: Summary of Spending Measures included in Evaluation Components 1-12				
Components	**Spending Measures**	**Analysis Strategy**	**Comparison group(s)**	**Component RQ#**
1. Adjunct ASD Services Pilot	Pilot services	Trend analysis, subgroup comparisons	None	Ch.1-RQ1a
2. Children's Support Services (SED/I-DD)	Hospitalizations and ED visits	Trend analysis, subgroup comparisons	[RQ1] None; [RQ2] Eligible CSSP I/DD children, youths, and young adults who did not utilize HCBS	Ch.2-RQ1d & RQ2d
3. Postpartum Eligibility Extension	Hospitalizations, ED visits, and outpatient care (e.g., postpartum, well-visits, mental health, & dental visits) for the birthing persons and newborns in the 12 months after delivery or end of pregnancy	Trend analysis, subgroup comparisons	None	Ch 3-RQ1d
4. Home Visiting Pilot	Hospitalizations and ED visits (prenatal and postpartum periods (i.e., 12 months after delivery or end of pregnancy)) for birthing persons and newborns	Trend analysis, subgroup comparisons	Families enrolled in Medicaid and not enrolled in NJHV	CH 4-RQ2c
5. Medically Indicated Meals^	Hospitalizations, ED visits, and outpatient care (e.g., prenatal, postpartum, well-woman, and well-child visits, glucose screening) for birthing persons and newborns in the prenatal and postpartum periods (i.e., 12 months after delivery or end of pregnancy)	Trend analysis, subgroup comparisons, multi-variable regression analysis	Eligible women not receiving home-delivered meals	Ch 5-RQ2.3a
6. MAGI Eligibility Extension	Total and avoidable hospitalizations, ED visits, and outpatient care	Trend analysis, cross-sectional comparisons	Spending will be compared between the baseline, PHE, and policy implementation periods	Ch 6-RQ1b

7. CHW Pilots*	None			
8. Tenancy and Housing Services^	Total, demonstration housing benefits, non-housing benefits (e.g., hospitalization, ED visits, prescription drugs)	Trend analysis, subgroup comparisons, difference-in-differences analysis	Propensity matched beneficiaries not receiving demonstration housing supports	Ch 8-RQ3a
9. OUD/SUD	Total, Institutions for Mental Disease (IMD), hospitalizations, ED visits, outpatient, LTSS, prescription drugs	Trends analysis, subgroup comparisons	None	Ch 9-RQ4 & RQ6
10. Adult IDD Supports	Hospitalizations and ED visits	Trend analysis, subgroup comparisons	None	Ch 10-RQ1d & RQ2d
11. Managed Long-Term Services & Supports^	Avoidable hospitalizations and ED visits, LTSS in community (HCBS) and nursing facilities	Trend analysis, cross-sectional, cohort analysis	None	Ch 11-RQ2.1b
12. LTSS Admin. Simplification*	None			

RQ# = research question number, see respective evaluation plan chapter.

*Components #7 (Community Health Worker Pilots) and #12 (Administrative Simplification for LTSS) evaluation plans do not include spending metrics, see text in this chapter for spending evaluation plans.

^Demonstration components that include new HSRN benefits.

Hypotheses 3, RQ 3

Study population for Hypothesis 3, RQ3a and b:

The study population for this hypothesis includes patients receiving inpatient, ED, or outpatient care in a New Jersey acute care general hospital who are eligible for New Jersey's Hospital Care Payment Assistance (Charity Care) Program.[150] These patients are uninsured or underinsured, ineligible for Medicaid, and have a family income below 300% of the federal poverty level.

Analytic strategy for Hypothesis 3, RQ3a:

To evaluate the effect of providing 12-months continuous eligibility postpartum, trends in charity care delivered to cohorts of postpartum women will be compared for three periods: 1) before the 12-month continuous eligibility expansion (2017-2019), 2) the public health emergency (PHE) (February 2020-May 2023), and 3) the demonstration period (beginning no earlier than the end of the PHE). Assessment of cost impact of the demonstration will be informed by comparison of trends in the first to third period. The trend during the PHE will be used to provide context to the demonstration evaluation but cannot contribute to the baseline period given that eligibility redeterminations were suspended during that period.

Data for the analysis will be from the NJ Hospital Discharge Data Collection System (HDDCS),[151] the state's all-payer hospital uniform billing record system, linked to records from the NJ Hospital Care Payment Assistance (Charity Care) Program. The HDDCS includes one record per inpatient stay, treat and release ED visit, and other outpatient visit and provides detailed information on charges, diagnoses, procedures performed, expected payer, and patient demographics. Charity Care program data includes variables indicating that individuals were certified as eligible for free or reduced cost services under New Jersey's charity care program and the cost of services to those patients priced at Medicaid rates.

Under NJ's Charity Care program, hospitals conduct eligibility determination for patients (subject to state audit) and are reimbursed a fraction of Medicaid rates based on a formula that considers each hospital's share of documented charity care delivered. Hospitals providing higher shares of documented charity care are paid a higher proportion of Medicaid rates for charity care services. Hospitals are expected to absorb the remaining unreimbursed cost of charity care.

For this evaluation, charity care costs will be assessed using two methods: 1) the sum of documented hospital charity care priced at Medicaid rates, and 2) the sum of cost of documented hospital charity care calculated using hospital-specific cost-to-charge ratios.[152] The former allows comparison to Medicaid spending and does not vary by differences in cost structures among

[150] The charity program is described at https://www.nj.gov/health/hcf/subsidies/

[151] Data dictionary available at https://iphd.rutgers.edu/sites/default/files/2022-06/data_dicDoh_UB_2021.pdf

[152] Available at https://hcup-us.ahrq.gov/db/ccr/costtocharge.jsp

hospitals. The latter reflects costs from the hospitals' perspective, considering differences in their cost structures.

Spending trends spanning these periods will be examined graphically (line charts) and using regression analyses adjusting for changes in population composition distributions over time. The trends will be calculated for 12-month cohorts for women in the postpartum period on a per-beneficiary per-month basis and adjusted for inflation. To the extent supported by available charity care data, trends will be stratified by the federal poverty level of charity care recipients, as the lowest income charity care recipients are most likely to become eligible for Medicaid continuous eligibility.

Analytic strategy for Hypothesis 3, RQ3b:

The effects of 12-month continuous eligibility will be assessed using the same data sources and analytic strategy as the postpartum eligibility expansion (described above), with the following modification. The analysis of postpartum care charity care relies on index events (the end of pregnancies) to define cohorts of patients of interest, but no such events are available to establish a comparison group of patients in the baseline period who would have been MAGI eligible. Thus, charity care costs, measured using the two methods described above, will be compared for pre-demonstration and demonstration periods for all adults aged 19-64.

Sustainability Assessment

The contribution of the demonstration to the fiscal sustainability of NJFamilyCare, the state's Medicaid program, will be evaluated based on the cost analyses described in this chapter and informed by results of hypothesis tests that are conducted for each demonstration component (described in chapters 1-12 above).

Sustainability will be evident for any demonstration components that show net reductions in Medicaid spending (e.g., where savings from lower avoidable hospital utilization offsets costs of new demonstration services). Other components, where no net changes in cost are evident but where care quality or access improves may also be sustainable at current spending levels. Conversely, should evidence show that the cost of new benefits or administrative costs are not sufficiently offset by lower overall avoidable-use-related spending may be unsustainable. Where cost savings are not evident but where improvements in quality, accessibility or outcomes are, the evaluation will generate evidence to support policymaker decisions about whether improved care may be worth additional investments.

Sustainability findings drawing on analyses described in this chapter and informed by those from component-specific evaluations described in chapter 1-12 will be synthesized in deliverable reports. These reports will distinguish results for each component of the demonstration, including those involving new spending on benefits addressing HRSNs.

Table 13.2: Summary of Questions, Hypotheses and Methodology

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
Hypothesis 1: Implementation and operation of the demonstration components will increase administrative cost, including non-recurring start-up costs and ongoing operational costs.				
RQ1a: What are the non-recurring administrative costs associated with the initiation of each demonstration component, including added staff effort and non-personnel expenses? RQ1b: What are the ongoing administrative costs associated with operation of each demonstration component, including added staff effort and non-personnel expenses?	Personnel cost of effort of state agency staff and non-personnel expenses related to the implementation and operation of each demonstration component	N/A	Spreadsheet templates for each demonstration component and each demonstration year; state staff will enter the following information: • Staff member name/unit • Dates during which effort was applied • Share of staff salary and fringe benefit expense allocated to demonstration effort • Allocated non-salary costs (e.g., rent, computing/technology expenses) • Additional non-personnel related expenses (e.g., contractual costs)	Summation and yearly inflation adjustment to document costs.
Hypothesis 2: The demonstration components, to varying degrees, will generate <u>costs for new services</u> or <u>extended eligibility</u> that will be <u>offset</u> by lower spending for other Medicaid health services resulting from improved accessibility or quality of care (e.g., reduced spending on avoidable hospitalization or ED use).				
RQ2a: What are the added costs for new services or periods of eligibility	See Table 13.1	See Table 13.1	MMIS claims/encounters	See Table 13.1

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
authorized under each demonstration component? RQ2b: What are changes in non-demonstration health services expenditures associated with implementation of each demonstration components (e.g., offsetting savings from improved accessibility or quality of care)? RQ2c: What are the net changes in spending for each demonstration component (i.e., spending on new services or eligibility net of changes in non-demonstration-related spending overall)?				
Hypothesis 3: The extension of 12 months continuous eligibility to postpartum women and beneficiaries who are Medicaid eligible based on the Modified Adjusted Gross Income (MAGI) standard will reduce hospital charity care costs for affected populations.				
RQ3a: What is the impact of postpartum continuous eligibility on hospital charity care costs for women in the 12 months following the end of pregnancy?	Trends in charity care delivered to cohorts of postpartum women for three periods: 1) before the 12-month continuous eligibility expansion (2017-2019), 2) the public health emergency (PHE) (February 2020-May 2023), and 3) the	Trends between 1st and 3rd period	NJ Hospital Discharge Data Collection System (HDDCS, the state's all-payer hospital uniform billing record system), linked to records from the NJ Hospital Care Payment Assistance (Charity Care) Program.	Charity care costs to be assessed with two methods: 1) sum of documented hospital charity care priced at Medicaid rates; 2) sum of cost of documented hospital charity care using hospital-

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data sources	Analytic Methods
	demonstration period (beginning no earlier than the end of the PHE).			specific cost-to-charge ratios.
RQ3b: What is the impact of continuous eligibility for adults (ages 19-64) who are eligible based on the MAGI standard on hospital charity care costs for low-income adults?	Trends in charity care costs for pre-demonstration (2017-2022) to demonstration (2023-2028)	Trends pre-demonstration (2017-2022) to demonstration (2023-2028)	As above	As above

Table 13.3 shows an activity timeline for the research activities.

Table 13.3 Key Milestones, Demonstration Cost Assessment

Analytic Activity	Year 1 2025	Year 2 2026	Year 3 2027	Year 4 2028	Year 5 2029	Year 6 2030
1. RQ1a and b: administrative cost data	Finalize data collection template	Obtain data for interim analysis	Complete interim analysis; Update data	Update data	Update data; conduct analysis	Complete analysis
2. RQ2a-RQ2c: summarize costs across components		Finalize summary template; initiate analysis	Complete interim analysis		Finalize summary template; conduct analysis	Complete analysis
3. RQ3a and b: assessing effect of continuous eligibility for 2 populations (postpartum, MAGI adults)	Obtain all-payer hospital discharge and charity program data	Initiate analysis	Complete interim analysis		Update all-payer hospital discharge and charity program data; conduct analysis	Complete analysis
4. Submit reports to CMS			Interim report			Final report

RQ=Research Question.

NOTE: Evaluation project years are March-Feb. (subject to change depending on date of authorization to begin).

D. Methodological Limitations

The degree to which appropriate comparison groups are available for the Demonstration Cost Assessment varies by demonstration component (see Table 13.1 and the Limitations sections of the respective component evaluation plans in chapters 1-12). In addition to analyses employing available concurrent comparison groups, the cost analyses will compare cost trends before the demonstration (and pre-pandemic) to trends during the demonstration period. Regression analyses will enable adjustments for demographic changes over time in the beneficiary population. While these analyses do not enable causal inferences, they will provide valuable information to inform policy making.

As noted, the COVID-19 pandemic disrupted care utilization and spending patterns. To avoid drawing misleading conclusions about possible effects of demonstration activities, the period of the pandemic will be excluded from baseline trend analyses. Still, there is some risk that long-term changes in services used and costs may continue into the demonstration period. Caveats about possible long-term pandemic effects will be included in the discussion of evaluation results, as appropriate.

Healthcare spending may be subject to random fluctuations that are unrelated to demonstration activities, e.g., related to rare catastrophic illnesses, that will limit the interpretability of cost trends analysis, particularly for demonstration components affecting comparatively small groups of beneficiaries (e.g., CHW pilot projects). We will consider strategies to mitigate the impacts of such spending fluctuations, such as trimming outliers, but ultimately, such variability may limit conclusions that can be reasonably drawn from the cost assessment of some demonstration components.

Some services are provided though sub-capitation or fixed fee arrangements, which will limit beneficiary-level analyses using claims and managed care encounter records. Caveats about this limitation will be included in discussion of evaluation results.

Some cost or savings impacts may occur beyond the demonstration period. For example, increases in eligibility for HCBS services under the Qualified Income Trust demonstration may delay admissions to nursing facilities years after the policy change. Measuring such long-term cost impacts is beyond the scope of this evaluation but will be noted in evaluation findings as appropriate.

The demonstration may have impacts on administrative costs of non-state entities that cannot be measured using the methods proposed. For example, administrative simplifications described in chapter 12 may reduce the needs for resource-intensive monitoring and auditing by county social services entities or costs to families to document financial status. Measuring impacts on such administrative costs is beyond the scope of this evaluation but will be noted in evaluation findings as appropriate.

Data on uncompensated care are not available for non-hospital providers and are limited to hospital charity care for individuals below 300% of the federal poverty level (FPL). Records of hospital bad (i.e., uncollectible) debt from patients above that income threshold are not available.

As noted, hospitals provide the largest share of uncompensated care, including for hospital services used by uninsured individuals who are the focus of continuous eligibility expansions under postpartum or MAGI expansion. To the extent recorded in available data, charity care cost will be stratified by patient FPL level because those with the lowest incomes are most likely to be Medicaid beneficiaries who become eligible for continuous eligibility under the demonstration.

Finally, data from the NJ Hospital Care Payment Assistance (Charity Care) Program have not previously been used for analyses of the type proposed in this evaluation and may have unanticipated limitations. NJ Department of Health, which administers NJ's charity care, will assist in troubleshooting any such limitations. Results applying hospital cost-to-charge ratios are likely to be feasible, as this method has been frequently used in hospital costs studies, regardless of the suitability of charity care records for the evaluation.

Attachment 1: Budget

Proposed Budget for the Medicaid 1115 Waiver Evaluation
Submitted by Rutgers Center for State Health Policy
May 9, 2025

Requested categories	Period 1 03/01/25 02/28/26	Period 2 03/01/26 02/28/27	Period 3 03/01/27 02/29/28	Period 4 03/01/28 02/28/29	Period 5 03/01/29 02/28/30	Period 6 * 3 months 03/01/30 06/30/30	Cumulative 03/01/25 06/30/30
Research Faculty Salary	461,519	634,700	698,886	708,400	707,547	177,370	3,388,422
Research Staff Salary	1,076,597	1,139,430	1,201,859	1,270,892	1,191,402	289,952	6,170,133
Admin Staff Salary	56,835	204,583	210,237	215,663	221,251	55,668	964,236
Fringe	1,150,098	1,403,259	1,505,289	1,554,934	1,541,268	383,877	7,538,725
Data Collection	50,000	585,625	602,875	518,625	198,875	10,000	1,966,000
Data Access and Purchases	34,217	42,014	40,072	45,897	42,014	10,021	214,234
The Johns Hopkins Center of Excellence in Maternal and Child Health	-	201,788	201,788	201,788	201,788	50,448	857,600
Respondent Incentives	1,250	61,875	66,438	40,813	8,875	-	179,250
Other Non-personnel Costs	15,130	27,459	7,672	31,525	19,926	733	102,444
Administrative Costs	186,815						186,815
F&A	303,246	430,073	453,512	458,854	413,294	97,807	2,156,786
Total	**3,335,707**	**4,730,806**	**4,988,627**	**5,047,391**	**4,546,239**	**1,075,875**	**23,724,645**

Attachment 2: Project Workplan and Deliverable Summary

Draft Workplan

Chapter, Component	Claims prep detail	Year 1 - 2025	Year 2 - 2026 (cutoff for interim report)	Year 3 - 2027 *interim report due to CMS 6/30/27*	Year 4 - 2028	Year 5 - 2029
Youth Programs						
1. ASD Pilot	New population; 5 metrics (1 prior, 4 new)		Survey (Eng/Span; web/phone, mail recruit, 20min) through vendor, CSHP pulls list (about 2,000 eligible individuals currently), n=400 max ($25)		Survey (Eng/Span; web/phone, mail recruit, 20min) through vendor, CSHP pulls list (about 2,000 eligible individuals currently), n=400 max ($25)	
2. Children's Support Services Programs (SED, I/DD)	10 metrics (8 prior, 2 new)			Online screening survey ($25), 4-6 focus groups of up to 10 people each, 60-90min ($100)		

Chapter, Component	Claims prep detail	Year 1 - 2025	Year 2 - 2026 (cutoff for interim report)	Year 3 - 2027 *interim report due to CMS 6/30/27*	Year 4 - 2028	Year 5 - 2029
Maternity-related Components						
3. Postpartum Eligibility Extension	New population; 22 metrics (14 prior, 8 new)					
4. NJ Home Visiting Pilot	New population; 7 metrics (3 prior, 4 new), coordination with JHU					
5. Medically Indicated Meals Pilot	New population; 12 metrics (2 prior, 10 new)		Up to 20 key informant interviews (those unpaid by job paid $50)			
Facilitating Access to Essential Health Services						
6. Continuous Eligibility for MAGI Adults	New population; 8 metrics (4 prior, 4 new)					

Chapter, Component	Claims prep detail	Year 1 - 2025	Year 2 - 2026 (cutoff for interim report)	Year 3 - 2027 *interim report due to CMS 6/30/27*	Year 4 - 2028	Year 5 - 2029
7. Community Health Worker (CHW) Pilot Programs	New population; Estimated 9 metrics (6 prior, 3 new)--develop 5 separate pilot populations plus try to roll them up, match data rec'd from 5 MCOs and surveys	Surveys (Eng/Span; web/phone, mail recruit; *enrollment + 12mo followup*) through vendor, MCO/DMAHS/CSHP create list, total N up to 400 each MCO at enrollment/followup ($25) 15-25 key informant interviews	Continue surveys	Continue surveys	Continue surveys 15-25 key informant interviews Online CHW focus group screening survey ($10) and 5 90 minute CHW focus groups (5-8 CHWs) ($75)	Continue surveys – *figure out cutoff date*
8. Tenancy and Housing Supports	New population; 28 measures (11 prior, 17 new), match/analyze HMIS and other admin data)	20-30 KII, 45-60min 100 beneficiary interviews, 45-60min ($75)	Continue interviewing as needed		20-30 KII, 45-60min 100 beneficiary interviews, 45-60min ($75)	Continue interviewing as needed

Chapter, Component	Claims prep detail	Year 1 - 2025	Year 2 - 2026 (cutoff for interim report)	Year 3 - 2027 *interim report due to CMS 6/30/27*	Year 4 - 2028	Year 5 - 2029
		30 provider interviews, 45-60min ($50)			30 provider interviews, 45-60min ($50)	
9. OUD/SUD Program	20 metrics (15 prior, 5 new)				20-30 KII, 60-90min	
Long-Term Services for Adults						
10. Adult IDD Services: Supports and Community Care Programs	17 metrics (15 prior, 2 new)			Online screening survey ($10), 4-6 focus groups of up to 10 people each, 60-90min ($100)		
11. and 12. MLTSS plus administrative simplification for LTSS	19 metrics (5 prior, 14 new), plus match/analyze NJ Choice Data and Administrative Enrollment Measures (Qualified Income Trusts and			Survey (Eng/Span; web/phone, mail recruit, 5min screen, 25min survey) through vendor, CSHP pulls list, n=300-400 ($25)	30 caregiver interviews, 45-60 min ($50), 15 KII, (nonprofessionals $50), 60 min	

Chapter, Component	Claims prep detail	Year 1 - 2025	Year 2 - 2026 (cutoff for interim report)	Year 3 - 2027 *interim report due to CMS 6/30/27*	Year 4 - 2028	Year 5 - 2029
	Attestation of no Asset Transfers)					
Cost Assessment						
13. Cost Assessment	All-payer hospital discharge and charity program data, plus data from other components	Administrative data collection template				

KII=key informant interview

Deliverable Listing and STC Crosswalk

All components will have:

- an interim evaluation report due date of 12/30/26 to DMAHS and 6/30/27 to CMS, and
- a summative evaluation report due date of 6/30/29 to DMAHS and 12/30/29 to CMS.

Component	STC sections
Overall Evaluation Findings Summary/Discussion	13.5
Adjunct Services Autism Spectrum Disorder (ASD) Pilot	5.12, 13.5(h)(i)
Children's Support Services Programs (SED, I/DD)	5.09, 5.10, 13.5(a)

Postpartum Eligibility Extension	5.15, 13.5(d)
New Jersey Home Visiting Pilot (NJHV) Program	5.13, 13.5(h)(ii)
Medically Indicated Meals Pilot	10.2(c)(2), 10.5(a), 13.5(f)
Continuous Eligibility for MAGI Adults	5.16, 13.5(c) and (e)
Community Health Worker (CHW) Pilot Programs	5.18, 13.5(h)(iii)
Tenancy and Housing Supports	10.2(a), 10.5(c), 13.5(f)
Opioid Use Disorder (OUD)/Substance Use Disorder (SUD) Program	6, 13.5(b)
Adult IDD Services: Supports and Community Care Programs	5.8, 5.11, 13.5(a)
Managed Long Term Services and Supports (MLTSS) Program	5.6, 13.5(a), (f) and (g)
Administrative Simplification for LTSS	QIT: 4.4, 13.5(a) Self-attestation: 4.4, 13.5(a) OPG: 5.14, 13.5(h)(iv)



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Attachment L
New Jersey FamilyCare Comprehensive Demonstration
New Jersey Home Visiting Services Protocol

Attachment L
New Jersey Home Visiting Services Protocol

Per STC 5.13, the following protocol includes additional information about the evidence-based New Jersey home visiting (NJHV) pilot program.

As described in STC 40, under the NJHV pilot program, the state will provide evidence-based home visiting services by licensed practitioners or certified home visitors to promote health outcomes, whole person care, and community-integration for high-risk pregnant women, parents of children up to three (3) years old in the Health Families America (HFA) and Parents as Teachers (PAT) and children up to (2) years old for the Nurse Family Partnership (NFP), in all counties throughout the state. The services are described in Table One: Description of Services below, which are based on the evidence- based models discussed below. The provider qualifications are described in Table Two: Provider Requirements below, which include provider titles, licensure certification, education, training, and experience requirements. The NJHV pilot program is aligned with the following three evidence-based models focused on the health of pregnant women.

a. NFP: The NFP is designed to reinforce maternal behaviors that encourage positive parent child relationship and maternal, child, and family accomplishments. The demonstration NFP pilot program will adhere to the NFP national program standards and service will be suspended once the child reaches two (2) years old.

b. HFA: The HFA model targets parents facing issues such as single parenthood, low income, childhood history of abuse, substance use disorder (SUD), mental health issues, or domestic violence.

c. PAT: The PAT model targets at-risk pregnant women and new parents, and infants and children to age two to identify and address perinatal and infant/child health issues and developmental delays, and parent knowledge and support.

The services are described in Table One: Description of Services below.

Table One: Description of Services

Service	Description of Service
Prenatal Home Visit	The NJHV Pilot Program will provide home visit services to expectant mothers during their pregnancy. The prenatal home visit services will provide: • Monitoring for high blood pressure or other complications of pregnancy (NFP only); • Diet and nutritional education; • Stress management; • Sexually Transmitted Diseases (STD) prevention education; • Tobacco use screening and cessation education; • Alcohol and other substance misuse screening and counseling; • Depression screening; and • Domestic and intimate partner violence screening and education.
Postpartum Home Visits	The NJHV Pilot Program will provide home visit services to Medicaid eligible mothers during their sixty (60) day postpartum period. • Diet and nutritional education; • Stress management; • STD prevention education; • Tobacco use screening and cessation education; • Alcohol and other substance misuse screening and counseling; • Depression screening; • Domestic and intimate partner violence screening and education; • Breastfeeding support and education (NFP may refer beneficiaries out to a lactation specialist, but the lactation consultant services are not covered as a home-visiting service); • Guidance and education with regard to well woman visits to obtain recommended preventive services; • Medical assessment of the postpartum mother and infant (NFP only); • Maternal-infant safety assessment and education e.g. safe sleep education for Sudden Infant Death Syndrome (SIDS) prevention • Counseling regarding postpartum recovery, family planning, needs of a newborn; • Assistance for the family in establishing a primary source of care and a primary care provider (i.e. ensure that the mother/ infant has a postpartum/ newborn visit scheduled); • Parenting skills and confidence building (HFA emphasis).
Infant Home Visits	The NJHV Pilot Program will provide home visit services to newborn infants born to NJHV Pilot Program beneficiaries until the child reaches three (3) years of age. • Breastfeeding support and education (NFP may refer beneficiaries out to a lactation specialist, but the lactation consultant services are not covered as a home-visiting service)); and

	• Child developmental screening at major developmental milestones from birth to age two (2); • Parenting skills and confidence building (the HFA program emphasizes these skills). • Promoting parent/child attachment and positive infant mental health/social-emotional wellness.

The three evidence-based practice models specify an array of services that may be provided to meet the needs of the family.

The HFA and PAT program models meet the criteria established by the U.S. Department of Health and Human Services (HHS) for an "evidence-based early childhood home visiting service delivery model." Goals include reducing child maltreatment, improving parent-child interactions and children's social-emotional well-being, and promoting children's school readiness. HFA Model program components include 1) screenings and assessments to determine families at risk for child maltreatment or other adverse childhood experiences; 2) parent education and support services; and 3) routine screening for child development and maternal depression as well as screening for domestic violence and substance abuse. In the case of a positive screen, the individual is referred for appropriate treatment services. In such cases, care coordination may also occur if consent is provided by the parent. If consent is provided, home visitors may refer participants out to external resources and providers. The type of referral may vary depending upon the type of service required. With additional consent, home visitors will liaise with the provider to ensure coordination of care. The PAT model overall goals are to 1) increase parent knowledge of early childhood development and improve parent practices, 2) provide early detection of developmental delays and health issues, 3) prevent child abuse and neglect, and 4) increase children's school readiness and success.

In addition, many sites offer services such as parent support groups and father involvement programs. Home visitors complete training modules that include such topics such as keeping babies healthy and safe, fostering infant and child development, and promoting mental health. Thus, HFA and PAT model services offered to mothers may include both teaching basic parenting skills, and training parents on how to manage a child's medical, behavioral, and/or developmental treatment needs.

The NFP program model also meets the criteria established by HHS for an "evidence-based early childhood home visiting service delivery model." The program model is designed for first-time, low-income mothers and their children, and is designed to improve 1) prenatal health and outcomes; 2) child health and development; and 3) families' economic self-sufficiency and/or maternal life course development. NFP home visitors use input from parents, nursing experience, nursing practice, and a variety of model-specific resources coupled with the principles of motivational interviewing to promote low-income, first-time mothers' health during pregnancy, care of their child, and own personal growth and development. NFP program model, therefore, may also address both teaching basic parenting skills, as well as training parents on how to manage a child's medical, behavioral, and/or developmental treatment needs.

The provider qualifications for the services provided are described in Table Two: Provider Qualifications below.

Table Two: Provider Qualifications

Home Visitor Provider Qualifications				
Home Visitors	Education (typical)	Experience (typical)	Skills (preferred)	Training
Healthy Families America Home Visitors – Must be hired by an HFA affiliated or accredited agency	Bachelor's Degree in Behavioral Sciences (Social Work, Psychology, Sociology, Mental Health, Nursing and Education) preferred; Associate's Degree in Human Services or related field. May have high school diploma or GED.	3-5 years' experience working in Human or Social Services; 1 year working with or providing services to children and families; Case management or service coordination experience preferred; Experience and willingness to work with a culturally diverse population. A Master's Degree in nursing or public health may be substituted for one year of the required experience.	Oral and written communication skills. Ability to develop trusting relationships. Ability to maintain professional boundaries. Acceptance of individual differences. Knowledge of infant and child development. Openness to reflective practice.	Must meet HFA program training requirements, including: Core Training; Curriculum training; Wraparound training; customized advanced training; any additional program based continuing education training requirements.
Nurse Family Partnership (NFP) Nurse Home Visitors – Hired by approved Nurse Family Partnership implementing agency	Registered nurse (RN) with Baccalaureate degree in nursing; may have additional degrees beyond BSN such as MSN or, other related/advanced practitioner designations e.g. nurse practitioner, nurse midwife; current licensure.	At least 5 years' experience in public health nursing, maternal and child health, behavioral health nursing, pediatrics, or other fields. Must have American Heart Association HealthCare provider CPR (Cardiopulmonary Resuscitation) and	Technical skills: Providing care mgmt. and care coordination to high-risk pops; understanding and applying federal, state, local, and grant program regulations and policies in a public health environment;	Comprehensive training and preparation as required by NFP model.

		valid AED (automated External Defibrillator) certification. A Master's Degree in nursing or public health may be substituted for one year of the required experience.	Leadership skills, interpersonal and relationship building; communication and quality improvement analysis skills.	
Nurse Home Visitor Supervisor – Hired by approved Nurse Family Partnership implementing agency	Registered nurse (RN) with Baccalaureate degree in nursing. Preferred that nurse supervisors have additional degrees beyond BSN such as MSN or, other related/advanced practitioner designations e.g. nurse practitioner, nurse midwife.	At least 5 years' experience in public health nursing, maternal and child health, behavioral health nursing, pediatrics, or other fields. Must have American Heart Association HealthCare provider CPR (Cardiopulmonary Resuscitation) and valid AED (automated External Defibrillator) certification. A Master's Degree in nursing or public health may be substituted for one year of the required experience.	Nurses must receive reflective supervision weekly to meet requirements of the evidence based program. This nurse supervision is part of the direct services provided. Nurse supervisors may conduct home visits as required to support nurses and/or beneficiaries level of care needs. For example, if a child or caregiver is ill for a month, a Nurse Home Visitor Supervisor may visit the home to re-assess the caregiver and child and offer an appropriate level of care.	Comprehensive training and preparation as required by NFP model.

Parents as Teachers Parent Educators	Bachelor's Degree in Social Work, Early Childhood or related field preferred; Associate's Degree in human services, health or related field. May have a high school diploma or GED. Prefer PAT supervisor to have a Master's degree.	3-5 years work experience in community social services; 1 year work experience with children and families; service coordination/case management preferred; experience/ willingness to work with culturally diverse population. Supervisor: PAT experience.	Oral/written communication. Building trusting relationships/ setting professional boundaries. Cultural competence/ acceptance of individual differences. Knowledge of infant and child development. Motivational interviewing. Reflective practice concepts. Supervisor: leadership, data analysis, and CQI skills.	Comprehensive training and preparation as per PAT National program: • Core training • Parent/Child Curriculum • Wraparound training • Other program-based continuing education Reflective supervision is part of direct services.

Attachment M
New Jersey FamilyCare Comprehensive Demonstration
COVID-19 Emergency Preparedness and Response Addendum 1

APPENDIX K: Emergency Preparedness and Response and COVID-19 Addendum

Background:

This standalone appendix may be utilized by the state during emergency situations to request amendments to its approved waiver, to multiple approved waivers in the state, and/or to all approved waivers in the state. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency. Other activities may require the use of various other authorities such as the Section 1115 demonstrations or the Section 1135 authorities.[i] This appendix may be applied retroactively as needed by the state. Public notice requirements normally applicable under 1915(c) do not apply to information contained in this Appendix.

Appendix K-1: General Information

General Information:

A. State : STATE OF NEW JERSEY

B. Waiver Title (s): NJ FamilyCare (NJFC) Comprehensive Demonstration

C. Control Number(s):
11-W-00279/2

D. Type of Emergency (The state may check more than one box):

X	**Pande mic or Epide mic**
O	**Natural Disaster**
O	**National Security Eme rgency**
O	**Environme ntal**
O	**Othe r (specify):**

E. Brie f Description of Eme rgency. *In no more than one paragraph each*, briefly describe the: 1) nature of emergency; 2) number of individua ls affected and the state's mechanism to identify individuals at risk; 3) roles of state, local and other entities involved in approved waiver operations; and 4) expected changes needed to service delivery methods, if applicable. The state should provide this information for each emergency checked if those emergencies affect different geographic areas and require different changes to the waiver.

This Appendix K is additive to the previously approved Appendix K and extends the anticipated end date to six months after the public health emergency ends.

F. Proposed Effective Date: Start Date: March 1, 2020 **Anticipated End Date:** 6 months after the end of the PHE.

G. Description of Transition Plan.

All activities will take place in response to the impact of COVID-19 as efficiently and effectively as possible based upon the complexity of the change.

H. Geographic Areas Affected:

These actions will apply across the waiver to all individuals impacted by the COVID-19 virus

I.* Description of State Disaster Plan (if available)** ***Reference to external documents is acceptable:

N/A

Appendix K-2: Temporary or Emergency-Specific Amendment to Approved Waiver

Temporary or Emergency-Specific Amendment to Approved Waiver:

These are changes that, while directly related to the state's response to an emergency situation, require amendment to the approved waiver document. These changes are time limited and tied specifically to individuals impacted by the emergency. Permanent or long-ranging changes will need to be incorporated into the main appendices of the waiver, via an amendment request in the waiver management system (WMS) upon advice from CMS.

a ☐ Access and Eligibility:

i ☐ Temporarily increase the cost limits for entry into the waiver.
[Provide explanation of changes and specify the temporary cost limit.]

i. ☐ Temporarily modify additional targeting criteria.
[Explanation of changes]

Signature : **Date :** 3/19/21

[redacted]

State Medicaid Director or Designee

First Name :	Jennifer
Last Name	Langer Jacobs
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APPENDIX K: Emergency Preparedness and Response and COVID-19 Addendum

Background:

This standalone appendix may be utilized by the state during emergency situations to request amendments to its approved waiver, to multiple approved waivers in the state, and/or to all approved waivers in the state. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency. Other activities may require the use of various other authorities such as the Section 1115 demonstrations or the Section 1135 authorities.[i] This appendix may be applied retroactively as needed by the state. Public notice requirements normally applicable under 1915(c) do not apply to information contained in this Appendix.

Appendix K-1: General Information

General Information:

A. State: New Jersey

B. Waiver Title(s): NJ FamilyCare (NJFC) Comprehensive Demonstration

C. Control Number(s):
11-W-00279/2

D. Type of Emergency (The state may check more than one box):

X	**Pandemic or Epidemic**
O	**Natural Disaster**
O	**National Security Emergency**
O	**Environmental**
O	**Other (specify):**

E. Brief Description of Emergency. *In no more than one paragraph each*, briefly describe the: 1) nature of emergency; 2) number of individuals affected and the state's mechanism to identify individuals at risk; 3) roles of state, local and other entities involved in approved waiver operations; and 4) expected changes needed to service delivery methods, if applicable. The state should provide this information for each emergency checked if those emergencies affect different geographic areas and require different changes to the waiver.

COVID-19 pandemic. This amendment will apply waiver-wide for each waiver included in this Appendix, to all individuals impacted by the virus or the response to the virus (e.g. closure of day programs, etc.) Note that this Appendix K submission is intended to be in addition to the previous Appendix K submission that CMS approved on May 15, 2020. It does not replace or invalidate that previously approved Appendix K.

F. Proposed Effective Date: Start Date: March 1, 2020 **Anticipated End Date:** February 28, 2021

G. Description of Transition Plan.

All activities will take place in response to the impact of COVID-19 as efficiently and effectively as possible based upon the complexity of the change.

H. Geographic Areas Affected:

These actions will apply across the waiver to all individuals impacted by the COVID-19 virus

I. Description of State Disaster Plan (if available) ***Reference to external documents is acceptable:***

N/A

Appendix K-2: Temporary or Emergency-Specific Amendment to Approved Waiver

Temporary or Emergency-Specific Amendment to Approved Waiver:

These are changes that, while directly related to the state's response to an emergency situation, require amendment to the approved waiver document. These changes are time limited and tied specifically to individuals impacted by the emergency. Permanent or long-ranging changes will need to be incorporated into the main appendices of the waiver, via an amendment request in the waiver management system (WMS) upon advice from CMS.

a.___Access and Eligibility:

i.___Temporarily increase the cost limits for entry into the waiver.
[Provide explanation of changes and specify the temporary cost limit.]

ii.___Temporarily modify additional targeting criteria.
[Explanation of changes]

b.___**Services**

i.___**Temporarily modify service scope or coverage.**
[Complete Section A- Services to be Added/Modified During an Emergency.]

ii. ___**Temporarily exceed service limitations (including limits on sets of services as described in Appendix C-4) or requirements for amount, duration, and prior authorization to address health and welfare issues presented by the emergency.**
[Explanation of changes]

iii. ___**Temporarily add services to the waiver to address the emergency situation (for example, emergency counseling; heightened case management to address emergency needs; emergency medical supplies and equipment; individually directed goods and services; ancillary services to establish temporary residences for dislocated waiver enrollees; necessary technology; emergency evacuation transportation outside of the scope of non-emergency transportation or transportation already provided through the waiver).**
[Complete Section A-Services to be Added/Modified During an Emergency]

iv. ___**Temporarily expand setting(s) where services may be provided (e.g. hotels, shelters, schools, churches). Note for respite services only, the state should indicate any facility-based settings and indicate whether room and board is included:**
[Explanation of modification, and advisement if room and board is included in the respite rate]:

v.___**Temporarily provide services in out of state settings (if not already permitted in the state's approved waiver).** [Explanation of changes]

c.___ **Temporarily permit payment for services rendered by family caregivers or legally responsible individuals if not already permitted under the waiver**. Indicate the services to which this will apply and the safeguards to ensure that individuals receive necessary services as authorized in the plan of care, and the procedures that are used to ensure that payments are made for services rendered.

d.___Temporarily modify provider qualifications (for example, expand provider pool, temporarily modify or suspend licensure and certification requirements).

i.___Temporarily modify provider qualifications.

[Provide explanation of changes, list each service affected, list the provider type, and the changes in provider qualifications.]

ii.___Temporarily modify provider types.

[Provide explanation of changes, list each service affected, and the changes in the .provider type for each service].

iii.___Temporarily modify licensure or other requirements for settings where waiver services are furnished.

[Provide explanation of changes, description of facilities to be utilized and list each service provided in each facility utilized.]

e. ___Temporarily modify processes for level of care evaluations or re-evaluations (within regulatory requirements). [Describe]

f.___ Temporarily increase payment rates.

[Provide an explanation for the increase. List the provider types, rates by service, and specify whether this change is based on a rate development method that is different from the current approved waiver (and if different, specify and explain the rate development method). If the rate varies by provider, list the rate by service and by provider.]

g.___Temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications.

[Describe any modifications including qualifications of individuals responsible for service plan development, and address Participant Safeguards. Also include strategies to ensure that services are received as authorized.]

h.___**Temporarily modify incident reporting requirements, medication management or other participant safeguards to ensure individual health and welfare, and to account for emergency circumstances**. [Explanation of changes]

i.___**Temporarily allow for payment for services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay when necessary supports (including communication and intensive personal care) are not available in that setting, or when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings.**
[Specify the services.]

j.__X_ **Temporarily include retainer payments to address emergency related issues.**
[Describe the circumstances under which such payments are authorized and applicable limits on their duration. Retainer payments are available for habilitation and personal care only.]

The state offers retention payments to congregate day facilities that render day habilitation and related services to individuals served under the Supports and Community Care Programs, operated by the Division of Developmental Disabilities. The state assures that the retainer payments are only for personal care services and day habilitation services that include personal care as a component. Such payments will be made for periods when such providers are unable to safely offer services due to COVID-19. This includes instances where such providers have been required to close based on local, state, or federal medical or public health guidance. Such payments may continue for up to three discreet episodes of up to 30 consecutive days. Such episodes may follow each other without interruption – i.e. one 30-day episode may begin immediately after the conclusion of another. Retainer payments will be paid as a lump sum on a biweekly basis, and calculated as follows. For the first two weeks (10 days) of the initial episode for which retainer payments are made, they will be equal to 100% of average total Medicaid claims, based on the individual provider's highest Medicaid claims month between July 2019-December 2019. For all subsequent periods, retainer payments will be equal to 75% of average total Medicaid claims, based on the individual provider's highest Medicaid claims month between July 2019-December 2019.

In order to receive retainer payments, providers will be required to attest that (a) they acknowledge that such payments are subject to recoupment if inappropriate billing or duplicate payments occurred (or in periods of disaster, duplicate uses of available funding streams) as identified in a state audit or any other authorized third party review. (Note that "duplicate uses of available funding streams" means using more than one funding stream for the same purpose); (b) they will not lay off staff or reduce wages while receiving retainer payments; and (c) that they have not received funding from other sources that would exceed revenue for last full quarter prior to the public health emergency (PHE), or such that the retainer payments at the level provided by the State will result in revenue exceeding that of the quarter prior to the PHE. More specifically, in order to receive retainer payments, providers will be required to attest that they have not received funding from any other sources, including but not limited to, unemployment benefits and Small Business Administration loans, that would exceed their revenue for the last full quarter prior to the PHE. If a provider had not already received revenues in excess of the pre-PHE level but receipt of the retainer payment in addition to those prior sources of funding results in the provider exceeding the pre-PHE level, any retainer payment amounts in excess would be recouped.

k.___Temporarily institute or expand opportunities for self-direction.

[Provide an overview and any expansion of self-direction opportunities including a list of services that may be self-directed and an overview of participant safeguards.]

l.___Increase Factor C.
[Explain the reason for the increase and list the current approved Factor C as well as the proposed revised Factor C]

m.___Other Changes Necessary [For example, any changes to billing processes, use of contracted entities or any other changes needed by the State to address imminent needs of individuals in the waiver program]. [Explanation of changes]

Appendix K Addendum: COVID-19 Pandemic Response

1. **HCBS Regulations**
   a ☐ Not comply with the HCBS settings requirement at 42 CFR 441.301(c)(4)(vi)(D) that individuals are able to have visitors of their choosing at any time, for settings added after March 17, 2014, to minimize the spread of infection during the COVID-19 pandemic.

2. **Services**
   a ☐ Add an electronic method of service delivery (e.g,. telephonic) allowing services to continue to be provided remotely in the home setting for:
      i ☐ Case management
      ii ☐ Personal care services that only require verbal cueing
      iii ☐ In-home habilitation
      iv ☐ Monthly monitoring (i.e., in order to meet the reasonable indication of need for services requirement in 1915(c) waivers).
      v ☐ Other *[Describe]:*

   b ☐ Add home-delivered meals
   c ☐ Add medical supplies, equipment and appliances (over and above that which is in the state plan)
   d ☐ Add Assistive Technology

3. **Conflict of Interest: The state is responding to the COVID-19 pandemic personnel crisis by authorizing case management entities to provide direct services. Therefore, the case management entity qualifies under 42 CFR 441.301(c)(1)(vi) as the only willing and qualified entity.**

a ☐ Current safeguards authorized in the approved waiver will apply to these entities.
b ☐ Additional safeguards listed below will apply to these entities.

4. **Provider Qualifications**
   a ☐ Allow spouses and parents of minor children to provide personal care services
   b ☐ Allow a family member to be paid to render services to an individual.
   c ☐ Allow other practitioners in lieu of approved providers within the waiver. *[Indicate the providers and their qualifications]*

   d ☐ Modify service providers for home-delivered meals to allow for additional providers, including non-traditional providers.

5. **Processes**
   a ☐ Allow an extension for reassessments and reevaluations for up to one year past the due date.
   b ☐ Allow the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings.
   c ☐ Adjust prior approval/authorization elements approved in waiver.
   d ☐ Adjust assessment requirements
   e ☐ Add an electronic method of signing off on required documents such as the person-centered service plan.

Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the request:

First Name:	Stacy
Last Name	Grim
Title:	Demonstration Operations Manager
Agency:	Division of Medical Assistance and Health Services
Address 1:	7 Quakerbridge Plaza
Address 2:	Click or tap here to enter text.
City	Hamilton Township
State	NJ
Zip Code	08619
Telephone:	609-588-2600
E-mail	Stacy.Grim@dhs.state.nj.us
Fax Number	Click or tap here to enter text.

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Click or tap here to enter text.
Last Name	Click or tap here to enter text.
Title:	Click or tap here to enter text.
Agency:	Click or tap here to enter text.
Address 1:	Click or tap here to enter text.
Address 2:	Click or tap here to enter text.
City	Click or tap here to enter text.
State	Click or tap here to enter text.
Zip Code	Click or tap here to enter text.
Telephone:	Click or tap here to enter text.
E-mail	Click or tap here to enter text.
Fax Number	Click or tap here to enter text.

8. Authorizing Signature

Signature: **Date:**

9/8/2020

[redacted]

State Medicaid Director or Designee

First Name:	Jennifer
Last Name	Langer Jacobs
Title:	Assistant Commissioner
Agency:	Division of Medical Assistance and Health Services
Address 1:	7 Quakerbridge Plaza
Address 2:	Click or tap here to enter text.
City	Hamilton
State	NJ
Zip Code	08619
Telephone:	609-588-2600
E-mail	Jennifer.Jacobs@dhs.state.nj.us
Fax Number	Click or tap here to enter text.

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver that the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification should be readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☐	Agency. List the types of agencies:

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☐	Provider managed

[i] Numerous changes that the state may want to make may necessitate authority outside of the scope of section 1915(c) authority. States interested in changes to administrative claiming or changes that require section 1115 or section 1135 authority should engage CMS in a discussion as soon as possible. Some examples may include: (a) changes to administrative activities, such as the establishment of a hotline; or (b) suspension of general Medicaid rules that are not addressed under section 1915(c) such as payment rules or eligibility rules or suspension of provisions of section 1902(a) to which 1915(c) is typically bound.

APPENDIX K: Emergency Preparedness and Response and COVID-19 Addendum

Background:

This standalone appendix may be utilized by the state during emergency situations to request amendments to its approved waiver, to multiple approved waivers in the state, and/or to all approved waivers in the state. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency. Other activities may require the use of various other authorities such as the Section 1115 demonstrations or the Section 1135 authorities.[i] This appendix may be applied retroactively as needed by the state. Public notice requirements normally applicable under 1915(c) do not apply to information contained in this Appendix.

Appendix K-1: General Information

General Information:

A. State: STATE OF NEW JERSEY

B. Waiver Title(s): NJ FamilyCare (NJFC) Comprehensive Demonstration

C. Control Number(s):
11-W-00279/2

D. Type of Emergency (The state may check more than one box):

X	**Pandemic or Epidemic**
O	**Natural Disaster**
O	**National Security Emergency**
O	**Environmental**
O	**Other (specify):**

E. Brief Description of Emergency. *In no more than one paragraph each*, briefly describe the: 1) nature of emergency; 2) number of individuals affected and the state's mechanism to identify individuals at risk; 3) roles of state, local and other entities involved in approved waiver operations; and 4) expected changes needed to service delivery methods, if applicable. The state should provide this information for each emergency checked if those emergencies affect different geographic areas and require different changes to the waiver.

COVID-19 pandemic. This amendment will apply waiver-wide for each waiver included in this Appendix, to all individuals impacted by the virus or the response to the virus (e.g. closure of day programs, etc.)

F. Proposed Effective Date: Start Date: March 1, 2020 **Anticipated End Date:** February 28, 2021

G. Description of Transition Plan.

All activities will take place in response to the impact of COVID-19 as efficiently and effectively as possible based upon the complexity of the change.

H. Geographic Areas Affected:

These actions will apply across the waiver to all individuals impacted by the COVID-19 virus

I. Description of State Disaster Plan (if available) ***Reference to external documents is acceptable:***

N/A

Appendix K-2: Temporary or Emergency-Specific Amendment to Approved Waiver

Temporary or Emergency-Specific Amendment to Approved Waiver:

These are changes that, while directly related to the state's response to an emergency situation, require amendment to the approved waiver document. These changes are time limited and tied specifically to individuals impacted by the emergency. Permanent or long-ranging changes will need to be incorporated into the main appendices of the waiver, via an amendment request in the waiver management system (WMS) upon advice from CMS.

a. ☐ Access and Eligibility:

i. ☐ Temporarily increase the cost limits for entry into the waiver.
[Provide explanation of changes and specify the temporary cost limit.]

ii. ☐ Temporarily modify additional targeting criteria.
[Explanation of changes]

b. ☒ Services

i. ☐ Temporarily modify service scope or coverage.
[Complete Section A- Services to be Added/Modified During an Emergency.]

ii. ☒ Temporarily exceed service limitations (including limits on sets of services as described in Appendix C-4) or requirements for amount, duration, and prior authorization to address health and welfare issues presented by the emergency.
[Explanation of changes]

- The state requests permission to temporarily lift prior authorization requirements for any service authorized by the 1115 demonstration. This authority will be used at the discretion of the state, and only to the extent necessary to address health and welfare issues and provide access to care during the emergency period.
- The state requests relaxing benefit limitations around provision of Home Delivered Meals. Specifically, we request that up to two home-delivered meals per day be made available, when the state determines it is necessary to maintain beneficiaries in the community, regardless of whether the beneficiary satisfies the requirements for home-delivered meals specified within Attachment D of our approved STCs.
- Allow the Supports Program, Community Care Program, and Children's Support Services Programs services to exceed unit limits, where necessary to support members whose care has been disrupted by the emergency. Examples may include increasing daily allowed units to meet the needs of beneficiaries who would otherwise have been receiving day services (absent the emergency), or extending respite services beyond the ordinary 30 day limit in the event that a family member of a beneficiary is unable to provide care due to being diagnosed with COVID-19.

iii. ☐ Temporarily add services to the waiver to address the emergency situation (for example, emergency counseling; heightened case management to address emergency needs; emergency medical supplies and equipment; individually directed goods and services; ancillary services to establish temporary residences for dislocated waiver enrollees; necessary technology; emergency evacuation transportation outside of the scope of non-emergency transportation or transportation already provided through the waiver).
[Complete Section A-Services to be Added/Modified During an Emergency]

iv. ☒ Temporarily expand setting(s) where services may be provided (e.g. hotels, shelters, schools, churches). Note for respite services only, the state should indicate any facility-based settings and indicate whether room and board is included:

[Explanation of modification, and advisement if room and board is included in the respite rate]:

MLTSS, Supports Program,[1] Community Care Program, and Children's Support Services Programs:

To the extent necessary to maintain access to care, allow reimbursement to any Medicaid provider/facility for waiver services rendered off-site in an unlicensed facility during an emergency evacuation or closure. In addition, and to the extent necessary to maintain access to care, allow reimbursement for any Medicaid provider/facility for waiver services rendered offsite, in order to comply with social distancing. Examples might include (but are not limited to) an enrollee who is diagnosed with COVID-19 and is placed in a temporary quarantine center where the HCBS services are not normally provided, provision of services by adult day program providers in the home for members who have chosen to shelter in place, provision of services in a DDD Day Program site that has been temporarily repurposed as a residential facility, and provision of services to beneficiaries with developmental disabilities in a provider-managed home that is under development but not yet licensed, if necessary to maintain access to services. In the case of a not-yet-licensed provider-managed home, such a home must be owned by an approved DDD provider, have a certificate of occupancy, have furnishings, and have been approved by both DDD and the Office of Licensing for temporary occupancy. In the case of a DDD Day Program site that has been temporarily repurposed as a residential facility, the temporary site must be approved by the Office of Licensing, have sufficient bathroom facilities (showers/toilets), have a kitchen or identify how meals and snacks will be accessed, how privacy will be maintained, what types of entertainment will be available, and identify what the types of beds will be available.

v. ☐ Temporarily provide services in out of state settings (if not already permitted in the state's approved waiver). [Explanation of changes]

c. ☒ Temporarily permit payment for services rendered by family caregivers or legally responsible individuals if not already permitted under the waiver. Indicate the services to which this will apply and the safeguards to ensure that individuals receive necessary services as authorized in the plan of care, and the procedures that are used to ensure that payments are made for services rendered.

[1] For the purposes of this submission, "Supports" refers to the demonstration program for individuals 21+. When the Children's Support Services programs are meant to be included, this will be indicated separately.

MLTSS: Payment to beneficiaries' family members for provision of personal care assistance (PCA) services in the event of disruption to ordinary sources of care such as school based services, medical day care services, or PCA agency services due to workforce shortage. Such payments must be approved on an as needed basis by the state.

Support Program and Community Care Program: Temporarily expand family members eligible to render Community Based and Individual Supports to include parents, spouses, and guardians to adjust for workforce shortages.

d. ☒ Temporarily modify provider qualifications (for example, expand provider pool, temporarily modify or suspend licensure and certification requirements).

i. ☒ Temporarily modify provider qualifications.

[Provide explanation of changes, list each service affected, list the provider type, and the changes in provider qualifications.]

- MLTSS
    - Allow staff of Medical Day Cares to provide Home Delivered Meals (limited to two meals per day), PCA, and/or clinical check-in to affected members. Meals, PCA, and clinical check-in would only be provided upon member request. PCA and clinical check-in services would be provided only by those Medical Day Care staff who possess appropriate credentials and are qualified to provide such services. This flexibility would be utilized in the event of a Medical Day Care closing, or to support members who are sheltering in their homes.
    - With the approval of the state, allow home delivered meals (limited to two meals per day) to be provided by any properly certified food distribution service, in either meal or grocery form.
    - As approved by the state, allow individuals with alternative professional qualifications to receive Medicaid reimbursement for Personal Care Assistance services (also applicable to State Plan members), in the event of staffing shortages or barriers to access. Alternative professional qualifications may include employment in a direct service role by a Medical Day Care provider where the center is closed and staff are able to provide personal care assistance services in a member's home or completion of 50% of clinical and classroom hours required for certification as a Personal Care Assistant by the Department of Health.
- Supports Program & Community Care Program
    - Allow temporary modification, not to exceed one year, of the following requirements at the discretion of the state, to the extent necessary to maintain a sufficient workforce:
        - For Individual Supports and Community Based Supports temporarily modify timelines for obtaining training requirements, criminal background checks, fingerprinting, staff physicals, and PPD testing.
    - Temporarily modify the Board Certified Behavioral Analyst (BCBA) certification requirement from Behavioral Supports in anticipation that individuals may present with the need for behavior guidelines/plans due to day facility closures and the need to remain quarantined in home for health and safety. The remaining requirements for Behavioral Supports remain intact:
        - Have demonstrated experience in positive behavior support and/or applied behavior analysis; and
        - Have 1 year working with people with developmental disabilities

ii. ☒ Temporarily modify provider types.

[Provide explanation of changes, list each service affected, and the changes in the .provider type for each service].

See above. Allowing additional providers (potentially with alternative qualifications) to offer various community-based services. Examples include MDC staff delivering meals or performing PCA tasks, or day services staff providing individual or community based supports in provider managed or own home settings.

iii. ☒ Temporarily modify licensure or other requirements for settings where waiver services are furnished.

[Provide explanation of changes, description of facilities to be utilized and list each service provided in each facility utilized.]

Allow the modification of certain facility licensure requirements for Children's Support Services Program residential treatment settings to the extent necessary to maintain access to care. Specific waivers may include (but are not necessarily limited to) requirements around square footage, or required kitchen facilities. This flexibility will be offered in instances where a licensed provider temporarily delivers services at an alternative location within a site or an alternative site (potentially with a different address) within an agency. The Department of Children and Families, based on requests from residential treatment providers, will grant these flexibilities on a case-by-case basis.

For Community Care Program, temporarily suspend routine residential agency licensing inspections to ensure the safety of staff and service recipients. Such suspension will not exceed six months. This suspension will apply to routine inspections only; inspections will continue for emergent situations such as a new home. Video or telephonic check-in's will occur if there are identified concerns during the temporary suspension of routine inspections. A revised licensing schedule will be developed once face-to-face contacts are not a health risk. In addition, for residential providers, temporarily modify the number of individuals allowed to reside in a licensed setting, in order to ensure the health and safety of individuals receiving services. For example, the number of individuals might be modified to allow individuals to move from one group home to a different group home, operated by the same provider, in order to have dedicated homes for individuals who have tested positive and/or negative for COVID-19. The Division of Developmental Disabilities, Office of Licensing will be notified of any such movements.

For the Supports Program and Community Care Program temporarily suspend day service facilities certification audits as a result of facility closures. A revised day service facilities certification schedule will be developed once the facilities re-open.

e. ☐ Temporarily modify processes for level of care evaluations or re-evaluations (within regulatory requirements). [Describe]

f. ☒ Temporarily increase payment rates.

[Provide an explanation for the increase. List the provider types, rates by service, and specify whether this change is based on a rate development method that is different from the current approved waiver (and if different, specify and explain the rate development method). If the rate varies by provider, list the rate by service and by provider.]

Rate increases are limited to Community Care Program providers of daily-rate Individual Supports, which are generally licensed group homes and supervised apartments. The rate increase is required due to the closure of congregate day habilitation programs. Due to this closure, residential providers were required to add additional staffing hours to their programs in order to support beneficiaries during the day. Effective March 17th through April 30th, payments will be increased by 20%. (Subsequent to April 30th, rates may be modified through a separate public notice process.) In order to make enhanced payment on a timely basis, and avoid the need for time-consuming systems changes, additional payments will be calculated in the aggregate (at the provider level) based on recent claims history, and be distributed via bi-weekly payments.

g. ☐ Temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications.

[Describe any modifications including qualifications of individuals responsible for service plan development, and address Participant Safeguards. Also include strategies to ensure that services are received as authorized.]

h. ☒ Temporarily modify incident reporting requirements, medication management or other participant safeguards to ensure individual health and welfare, and to account for emergency circumstances. [Explanation of changes]

Temporarily modify critical incident reporting requirements in STC 51, only to the extent they are impractical to implement during the emergency period. Temporarily modify home and community based characteristics requirements in STC 51, to the extent necessary due to displacement or other disruption resulting from the emergency.

Supports Program and Community Care Program: Temporarily replace face-to-face investigation interviews with telephonic contacts. Agencies must continue to report and investigate incidents in accordance with existing requirements. However, for minor incidents we are requesting to temporarily extend agency investigations and plan of correction submissions timelines by 60 days. An additional extension of 60 days may be requested for extenuating circumstances.

i. ☒ Temporarily allow for payment for services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay when necessary supports (including communication and intensive personal care) are not available in that setting, or

when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings.

[Specify the services.]

MLTSS, Community Care Program, Supports Program, and Children's Support Services Programs:

For members who are temporarily in a hospital or other institution due to COVID-19, we are requesting HCBS be allowed to continue where necessary and to the extent such services are not directly provided by the institution. An example might be a member who is temporarily placed in a quarantine facility, but may require ongoing supportive services. Services provided may include Behavioral Health Services, Mental Health Services, Cognitive Therapies, Occupational Therapy, Physical Therapy, Speech/Language Therapy, Community-Based Supports (Supports Program), and Individual Supports (Community Care Program), and Personal Care Assistant services. Payment will only be made for such services for up to 30 consecutive days.

j. ☒ Temporarily include retainer payments to address emergency related issues.

[Describe the circumstances under which such payments are authorized and applicable limits on their duration. Retainer payments are available for habilitation and personal care only.]

The state requests the authority to offer retention payments for waiver providers who render habilitation and personal care services when beneficiaries are hospitalized, or otherwise unable to receive ordinary care, due to COVID-19. This includes instances where such providers have been required to close based on local, state, or federal medical or public health guidance. Such payments may continue for up to 30 consecutive days. Note that while we are requesting this authority in order to prepare for all eventualities, actual retainer payments will be contingent on (a) identified need based on monitoring of delivery system, and (b) state funding availability. In addition, retainer payments will be limited to situations where providers are not otherwise receiving reimbursement for services provided on a modified basis (e.g. for telehealth), and the state will implement processes to monitor and prevent duplication of billing.

k. ☒ Temporarily institute or expand opportunities for self-direction.

[Provide an overview and any expansion of self-direction opportunities including a list of services that may be self-directed and an overview of participant safeguards.]

The state requests an expedited enrollment process for self-directed care, including allowing telephonic enrollment in lieu of face-to-face. This is intended to ensure timely access to HCBS services due to staff shortages within PCA agency/AMDC providers due to COVID-19. The state is not requesting any expansion of the categories of services eligible to be delivered through self-direction.

l. ☐ Increase Factor C.
[Explain the reason for the increase and list the current approved Factor C as well as the proposed revised Factor C]

m. ☐ Other Changes Necessary [For example, any changes to billing processes, use of contracted entities or any other changes needed by the State to address imminent needs of individuals in the waiver program]. [Explanation of changes]

Appendix K Addendum: COVID-19 Pandemic Response

1. HCBS Regulations

a. ☒ Not comply with the HCBS settings requirement at 42 CFR 441.301(c)(4)(vi)(D) that individuals are able to have visitors of their choosing at any time, for settings added after March 17, 2014, to minimize the spread of infection during the COVID-19 pandemic.

2. Services

a. ☒ Add an electronic method of service delivery (e.g,. telephonic) allowing services to continue to be provided remotely in the home setting for:

i. ☒ Case management
ii. ☒ Personal care services that only require verbal cueing
iii. ☒ In-home habilitation
iv. ☒ Monthly monitoring (i.e., in order to meet the reasonable indication of need for services requirement in 1915(c) waivers).
v. ☒ Other *[Describe]:*

MLTSS: Services including Cognitive Rehabilitative Therapy, Occupational Therapy, Physical Therapy, Speech/Language Therapy, Structured Day and Supported Day services – as specified in the MLTSS Service Dictionary, and Medical Day Center wellness calls to members who can no longer attend Medical Day.

Children's Support Services Program services including social and emotional learning, interpreter services, individual supports, intensive in community clinical/therapeutic services, and intensive in community behavioral services.

Supports Program and Community Care Program: Allow the state discretion to shift from face-to-face service delivery to telephonic or telehealth instruction for the following waiver services: assistive technology, behavioral supports, career planning, community inclusion services, community based supports, cognitive rehabilitation therapy, day habilitation, individual supports, interpreter services, natural supports training, occupational therapy, physical therapy, speech, language, hearing therapy, support coordination, supported employment, and supports brokerage.

b. ☒ Add home-delivered meals
c. ☐ Add medical supplies, equipment and appliances (over and above that which is in the state plan)
d. ☐ Add Assistive Technology

3. **Conflict of Interest: The state is responding to the COVID-19 pandemic personnel crisis by authorizing case management entities to provide direct services. Therefore, the case management entity qualifies under 42 CFR 441.301(c)(1)(vi) as the only willing and qualified entity.**
   a. ☐ Current safeguards authorized in the approved waiver will apply to these entities.
   b. ☐ Additional safeguards listed below will apply to these entities.

4. **Provider Qualifications**
   a. ☒ Allow spouses and parents of minor children to provide personal care services
   b. ☒ Allow a family member to be paid to render services to an individual.
   c. ☒ Allow other practitioners in lieu of approved providers within the waiver. *[Indicate the providers and their qualifications]*

      See K-2.d.(i) above

   d. ☒ Modify service providers for home-delivered meals to allow for additional providers, including non-traditional providers.

5. **Processes**

a. ☒ Allow an extension for reassessments and reevaluations for up to one year past the due date.
b. ☒ Allow the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings.
c. ☒ Adjust prior approval/authorization elements approved in waiver.
d. ☒ Adjust assessment requirements
e. ☒ Add an electronic method of signing off on required documents such as the person-centered service plan.

Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the request:

First Name: Stacy
Last Name Grim
Title: Demonstration Operations Manager
Agency: Division of Medical Assistance and Health Services
Address 1: 7 Quakerbridge Plaza
City Hamilton Township
State NJ
Zip Code 08619
Telephone: (609) 588-2600
E-mail Stacy.Grim@dhs.state.nj.us
Fax Number

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:
Last Name
Title:
Agency:
Address 1:
Address 2:
City
State
Zip Code
Telephone:
E-mail
Fax Number

8. Authorizing Signature

[redacted]

First Name:	Jennifer
Last Name	Langer Jacobs
Title:	Assistant Commissioner
Agency:	Division of Medical Assistance and Health Services
Address 1:	7 Quakerbridge Plaza
Address 2:	
City	Hamilton
State	NJ
Zip Code	08619
Telephone:	(609) 588-2600
E-mail	Jennifer.Jacobs@dhs.state.nj.us
Fax Number	

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver that the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification should be readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	Home Delivered Meals
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:	
Service Definition (Scope)**:**	
Nutritionally balanced meals delivered to the participant's home when this meal provision is more cost effective than having a personal care provider prepare the meal. These meals do not constitute a full nutritional regimen, but each meal must provide at least 1/3 of the current Dietary Reference Intakes (DRIs) established by the Food & Nutrition Board of the National Academy of Sciences, and National Research Council.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	
Allow up to two home delivered meals per a day (currently one meal is permitted)	

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☒	Agency. List the types of agencies:
				Area Agency on Aging (AAA) Title III Nutrition Program (Existing)
				Provider of Meal Service, who meets the criteria set forth in New Jersey Standards for the Nutrition Program for Older Americans, PM 2011-33, I-164, dated January 3, 2012. (Existing)
				Adult Day Health Service Provider (During public health emergency only)
Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*: For AAA Title III Programs and Provider, and providers who meet the criteria set forth in the New Jersey Standards, unchanged from qualifications specified in New Jersey's approved 1115 demonstration. For Adult Day Health Service Providers, identical to qualifications specified in New Jersey's state plan.

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Service Specification					
Service Title:	Home Delivered Meals				
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:					
Service Delivery Method					
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☐	Provider managed	

[i] Numerous changes that the state may want to make may necessitate authority outside of the scope of section 1915(c) authority. States interested in changes to administrative claiming or changes that require section 1115 or section 1135 authority should engage CMS in a discussion as soon as possible. Some examples may include: (a) changes to administrative activities, such as the establishment of a hotline; or (b) suspension of general Medicaid rules that are not addressed under section 1915(c) such as payment rules or eligibility rules or suspension of provisions of section 1902(a) to which 1915(c) is typically bound.

Attachment N
New Jersey FamilyCare Comprehensive Demonstration
COVID-19 Emergency Preparedness and Response Addendum 2

APPENDIX K: Emergency Preparedness and Response and COVID-19 Addendum

Background:

This standalone appendix may be utilized by the state during emergency situations to request amendments to its approved waiver, to multiple approved waivers in the state, and/or to all approved waivers in the state. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency. Other activities may require the use of various other authorities such as the Section 1115 demonstrations or the Section 1135 authorities.[i] This appendix may be applied retroactively as needed by the state. Public notice requirements normally applicable under 1915(c) do not apply to information contained in this Appendix.

Appendix K-1: General Information

General Information:

A. State: New Jersey

B. Waiver Title(s): NJ FamilyCare (NJFC) Comprehensive Demonstration

C. Control Number(s):
11-W-00279/2

D. Type of Emergency (The state may check more than one box):

X	**Pandemic or Epidemic**
O	**Natural Disaster**
O	**National Security Emergency**
O	**Environmental**
O	**Other (specify):**

D. Brief Description of Emergency. *In no more than one paragraph each*, briefly describe the: 1) nature of emergency; 2) number of individuals affected and the state's mechanism to identify individuals at risk; 3) roles of state, local and other entities involved in approved waiver operations; and 4) expected changes needed to service delivery methods, if applicable. The state should provide this information for each emergency checked if those emergencies affect different geographic areas and require different changes to the waiver.

COVID-19 Pandemic. Note that this Appendix K submission is intended to be in addition to the previous Appendix K submissions that CMS approved on May 15, 2020 and September 25, 2020. It does not replace or invalidate previously approved Appendix K's.

F. Proposed Effective Date: Start Date: July 20, 2020 **Anticipated End Date:** 6 months after the end of the PHE.

G. Description of Transition Plan.

All activities will take place in response to the impact of COVID-19 as efficiently and effectively as possible based upon the complexity of the change.

H. Geographic Areas Affected:

These actions will apply across the waiver to all individuals impacted by the COVID-19 virus

I. Description of State Disaster Plan (if available) ***Reference to external documents is acceptable:***

N/A

Appendix K-2: Temporary or Emergency-Specific Amendment to Approved Waiver

Temporary or Emergency-Specific Amendment to Approved Waiver:

These are changes that, while directly related to the state's response to an emergency situation, require amendment to the approved waiver document. These changes are time limited and tied specifically to individuals impacted by the emergency. Permanent or long-ranging changes will need to be incorporated into the main appendices of the waiver, via an amendment request in the waiver management system (WMS) upon advice from CMS.

a.___ Access and Eligibility:

i.___ Temporarily increase the cost limits for entry into the waiver.
[Provide explanation of changes and specify the temporary cost limit.]

ii.___ Temporarily modify additional targeting criteria.
[Explanation of changes]

b.___ Services

i.___ Temporarily modify service scope or coverage.
[Complete Section A- Services to be Added/Modified During an Emergency.]

ii. ___Temporarily exceed service limitations (including limits on sets of services as described in Appendix C-4) or requirements for amount, duration, and prior authorization to address health and welfare issues presented by the emergency.
[Explanation of changes]

iii. ___Temporarily add services to the waiver to address the emergency situation (for example, emergency counseling; heightened case management to address emergency needs; emergency medical supplies and equipment; individually directed goods and services; ancillary services to establish temporary residences for dislocated waiver enrollees; necessary technology; emergency evacuation transportation outside of the scope of non-emergency transportation or transportation already provided through the waiver).
[Complete Section A-Services to be Added/Modified During an Emergency]

iv. ___Temporarily expand setting(s) where services may be provided (e.g. hotels, shelters, schools, churches). Note for respite services only, the state should indicate any facility-based settings and indicate whether room and board is included:
[Explanation of modification, and advisement if room and board is included in the respite rate]:

v.___ Temporarily provide services in out of state settings (if not already permitted in the state's approved waiver). [Explanation of changes]

c.___ Temporarily permit payment for services rendered by family caregivers or legally responsible individuals if not already permitted under the waiver. Indicate the services to which this will apply and the safeguards to ensure that individuals receive necessary services as authorized in the plan of care, and the procedures that are used to ensure that payments are made for services rendered.

d.___ Temporarily modify provider qualifications (for example, expand provider pool, temporarily modify or suspend licensure and certification requirements).

i.___ Temporarily modify provider qualifications.

[Provide explanation of changes, list each service affected, list the provider type, and the changes in provider qualifications.]

ii.___ Temporarily modify provider types.

[Provide explanation of changes, list each service affected, and the changes in the .provider type for each service].

iii.___ Temporarily modify licensure or other requirements for settings where waiver services are furnished.

[Provide explanation of changes, description of facilities to be utilized and list each service provided in each facility utilized.]

e. ___Temporarily modify processes for level of care evaluations or re-evaluations (within regulatory requirements). [Describe]

f.__X_ Temporarily increase payment rates.

[Provide an explanation for the increase. List the provider types, rates by service, and specify whether this change is based on a rate development method that is different from the current approved waiver (and if different, specify and explain the rate development method). If the rate varies by provider, list the rate by service and by provider.]

Following the end of retainer payments permitted under a previous Appendix K (approved September 25, 2020), the New Jersey Division of Developmental Disabilities (DDD) will retroactively increase rates for the following five services provided to enrollees in the Supports and Community Care Programs that had previously been covered by retainer payments: Day Habilitation, Community Inclusion, Career Planning, Pre-Vocational training (group), and Supported Employment (group). The rate increase will be permitted for both virtual services as well as in-person service delivery.

Service	Current Rate (Pre-PHE)	New Rate (Enhanced)
Career Planning	14.25	21.37
Community Inclusion Tier A	2.63	3.94
Community Inclusion Tier B	3.35	5.02
Community Inclusion Tier C	4.14	6.21
Community Inclusion Tier D	6.14	9.21
Community Inclusion Tier E	8.15	12.22
Community Inclusion Tier F	12.22	18.33
Prevocational Training - Group - Tier A	2.97	4.45
Prevocational Training - Group - Tier B	3.78	5.67
Prevocational Training - Group - Tier C	4.67	7.00
Prevocational Training - Group - Tier D	6.93	10.39
Prevocational Training - Group - Tier E	9.19	13.78
Prevocational Training – Individual	13.79	20.68
Day Habilitation - Tier A	2.63	3.94
Day Habilitation - Tier A/Acuity Differentiated	3.75	5.62
Day Habilitation - Tier B	3.35	5.02
Day Habilitation - Tier B /Acuity Differentiated	4.78	7.17
Day Habilitation - Tier C	4.14	6.21
Day Habilitation - Tier C/Acuity Differentiated	5.92	8.88
Day Habilitation - Tier D	6.14	9.21
Day Habilitation - Tier D/Acuity Differentiated	8.77	13.15
Day Habilitation - Tier E	8.15	12.22
Day Habilitation - Tier E/Acuity Differentiated	11.64	17.46
Day Habilitation - Tier F	12.22	18.33
Day Habilitation - Tier F/Acuity Differentiated	17.46	26.19
Supported Employment - Small Group - Tier A - Group	3.08	4.62
Supported Employment - Small Group - Tier B - Group	3.92	5.88
Supported Employment - Small Group - Tier C - Group	4.85	7.27

Supported Employment - Small Group - Tier D - Group	7.20	10.80
Supported Employment - Small Group - Tier E - Group	9.55	14.32
Supported Employment - Individual	14.32	21.48

In 2020, NJ DDD closed facility based congregate day facilities in March 2020 and they have remained closed during the public health emergency with the exception of a short re-opening in the fall of 2020 and the most recent reopening in the Spring of 2021. Providers have been providing a variety of virtual programming, but have experienced difficulty in maintaining the same number of hours of service delivery. This reduction of billing units is attributed to individuals finding it difficult to remain engaged in the virtual activities. Providers and families have indicated that without staff being present, maintaining beneficiary engagement has been challenging. The purpose of the rate increase is to ensure that fixed costs are covered by the reduced service utilization during the public health emergency and with the expectation that providers will continue to work in partnership with DDD to make more accessible non-center-based and telemodalities available. In addition to the rate increase providers will be encouraged to vary the remote virtual service times in an effort to address the attention span issues. For instance, virtual programming may occur during non-traditional day hours. In addition to virtual services, providers will be encouraged to continue to provide in-home face-to-face service delivery.

For any individual provider, if total claims submitted for the five services identified result in total revenues in excess of 75% pre-PHE monthly revenues, the excess will be subject to recoupment. The rate increase will sunset with the expiration of this Appendix K and NJ DDD will provide additional guidance to provider agencies regarding the operation of this flexibility.

g.___ Temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications.
[Describe any modifications including qualifications of individuals responsible for service plan development, and address Participant Safeguards. Also include strategies to ensure that services are received as authorized.]

h.___ Temporarily modify incident reporting requirements, medication management or other participant safeguards to ensure individual health and welfare, and to account for emergency circumstances. [Explanation of changes]

i.___ Temporarily allow for payment for services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay when necessary supports

(including communication and intensive personal care) are not available in that setting, or when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings.
[Specify the services.]

j.___ Temporarily include retainer payments to address emergency related issues.
[Describe the circumstances under which such payments are authorized and applicable limits on their duration. Retainer payments are available for habilitation and personal care only.]

k.___ Temporarily institute or expand opportunities for self-direction.
[Provide an overview and any expansion of self-direction opportunities including a list of services that may be self-directed and an overview of participant safeguards.]

l.___ Increase Factor C.
[Explain the reason for the increase and list the current approved Factor C as well as the proposed revised Factor C]

m.___ Other Changes Necessary [For example, any changes to billing processes, use of contracted entities or any other changes needed by the State to address imminent needs of individuals in the waiver program]. [Explanation of changes]

Appendix K Addendum: COVID-19 Pandemic Response

1. **HCBS Regulations**
   a. ☐ Not comply with the HCBS settings requirement at 42 CFR 441.301(c)(4)(vi)(D) that individuals are able to have visitors of their choosing at any time, for settings added after March 17, 2014, to minimize the spread of infection during the COVID-19 pandemic.

2. **Services**
    a. ☐ Add an electronic method of service delivery (e.g,. telephonic) allowing services to continue to be provided remotely in the home setting for:
        i. ☐ Case management
        ii. ☐ Personal care services that only require verbal cueing
        iii. ☐ In-home habilitation
        iv. ☐ Monthly monitoring (i.e., in order to meet the reasonable indication of need for services requirement in 1915(c) waivers).
        v. ☐ Other *[Describe]:*

    b. ☐ Add home-delivered meals
    c. ☐ Add medical supplies, equipment and appliances (over and above that which is in the state plan)
    d. ☐ Add Assistive Technology

3. **Conflict of Interest: The state is responding to the COVID-19 pandemic personnel crisis by authorizing case management entities to provide direct services. Therefore, the case management entity qualifies under 42 CFR 441.301(c)(1)(vi) as the only willing and qualified entity.**
    a. ☐ Current safeguards authorized in the approved waiver will apply to these entities.
    b. ☐ Additional safeguards listed below will apply to these entities.

4. **Provider Qualifications**
    a. ☐ Allow spouses and parents of minor children to provide personal care services
    b. ☐ Allow a family member to be paid to render services to an individual.
    c. ☐ Allow other practitioners in lieu of approved providers within the waiver. *[Indicate the providers and their qualifications]*

    d. ☐ Modify service providers for home-delivered meals to allow for additional providers, including non-traditional providers.

5. **Processes**
    a. ☐ Allow an extension for reassessments and reevaluations for up to one year past the due date.
    b. ☐ Allow the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings.

c. ☐ Adjust prior approval/authorization elements approved in waiver.
d. ☐ Adjust assessment requirements
e. ☐ Add an electronic method of signing off on required documents such as the person-centered service plan.

Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the request:

First Name:	Stacy
Last Name	Grim
Title:	Demonstration Operations Manager
Agency:	Division of Medical Assistance and Health Services
Address 1:	7 Quakerbridge Plaza
Address 2:	Click or tap here to enter text.
City	Hamilton Township
State	NJ
Zip Code	08619
Telephone:	609-588-2600
E-mail	Stacy.Grim@dhs.state.nj.us
Fax Number	Click or tap here to enter text.

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Click or tap here to enter text.
Last Name	Click or tap here to enter text.
Title:	Click or tap here to enter text.
Agency:	Click or tap here to enter text.
Address 1:	Click or tap here to enter text.
Address 2:	Click or tap here to enter text.
City	Click or tap here to enter text.
State	Click or tap here to enter text.
Zip Code	Click or tap here to enter text.
Telephone:	Click or tap here to enter text.
E-mail	Click or tap here to enter text.
Fax Number	Click or tap here to enter text.

8. Authorizing Signature

Signature: [redacted] **Date:** 7/6/21

State Medicaid Director or Designee

First Name:	Jennifer
Last Name	Langer Jacobs
Title:	Assistant Commissioner
Agency:	Division of Medical Assistance and Health Services
Address 1:	7 Quakerbridge Plaza
Address 2:	Click or tap here to enter text.
City	Hamilton
State	NJ
Zip Code	08619
Telephone:	609-588-2600
E-mail	Jennifer.Jacobs@dhs.state.nj.us
Fax Number	Click or tap here to enter text.

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver that the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification should be readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification					
Service Title:					
Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:					
Service Definition (Scope)**:**					
Specify applicable (if any) limits on the amount, frequency, or duration of this service:					

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☐	Agency. List the types of agencies:

Specify whether the service may be provided by *(check each that applies):*	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider)*:

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☐	Provider managed

[i] Numerous changes that the state may want to make may necessitate authority outside of the scope of section 1915(c) authority. States interested in changes to administrative claiming or changes that require section 1115 or section 1135 authority should engage CMS in a discussion as soon as possible. Some examples may include: (a) changes to administrative activities, such as the establishment of a hotline; or (b) suspension of general Medicaid rules that are not addressed under section 1915(c) such as payment rules or eligibility rules or suspension of provisions of section 1902(a) to which 1915(c) is typically bound.

APPENDIX K: Emergency Preparedness and Response and COVID-19 Addendum

Background:

This standalone appendix may be utilized by the state during emergency situations to request amendments to its approved waiver, to multiple approved waivers in the state, and/or to all approved waivers in the state. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency. Other activities may require the use of various other authorities such as the Section 1115 demonstrations or the Section 1135 authorities.[i] This appendix may be applied retroactively as needed by the state. Public notice requirements normally applicable under 1915(c) do not apply to information contained in this Appendix.

Appendix K-1: General Information

General Information:

A. State: New Jersey

B. Waiver Title(s): New Jersey Family Care (NJFC) Comprehensive Demonstration

C. Control Number(s):

11-W-00279/2

D. Type of Emergency (The state may check more than one box):

X	**Pandemic or Epidemic**
O	**Natural Disaster**
O	**National Security Emergency**
O	**Environmental**
O	**Other (specify):**

E. Brief Description of Emergency. *In no more than one paragraph each*, briefly describe the: 1) nature of emergency; 2) number of individuals affected and the state's mechanism to identify individuals at risk; 3) roles of state, local and other entities involved in approved waiver operations; and 4) expected changes needed to service delivery methods, if applicable. The state should provide this information for each emergency checked if those emergencies affect different geographic areas and require different changes to the waiver.

COVID-19 pandemic. Note this Appendix K submission is intended to extend certain provisions beyond the June 30, 2022 end date under the originally approved Appendix K which was initially approved on May 15, 2020 and subsequently extended on May 7, 2021. This amendment will apply waiver-wide for each waiver included in this Appendix, to all individuals impacted by the virus or the response to the virus (e.g. closure of day programs, etc.)

F. Proposed Effective Date: Start Date: July 1, 2022 **Anticipated End Date:** 6 months after the end of the PHE

G. Description of Transition Plan.

All activities will take place in response to the impact of COVID-19 as efficiently and effectively as possible based upon the complexity of the change.

H. Geographic Areas Affected:

These actions will apply across the waiver to all individuals impacted by the COVID-19 virus

I. Description of State Disaster Plan (if available) ***Reference to external documents is acceptable:***

N/A

Appendix K-2: Temporary or Emergency-Specific Amendment to Approved Waiver

Temporary or Emergency-Specific Amendment to Approved Waiver:

These are changes that, while directly related to the state's response to an emergency situation, require amendment to the approved waiver document. These changes are time limited and tied specifically to individuals impacted by the emergency. Permanent or long-ranging changes will need to be incorporated into the main appendices of the waiver, via an amendment request in the waiver management system (WMS) upon advice from CMS.

a.___ Access and Eligibility:

i.___ Temporarily increase the cost limits for entry into the waiver.
[Provide explanation of changes and specify the temporary cost limit.]

ii.___ Temporarily modify additional targeting criteria.
[Explanation of changes]

b.___ Services

i.___ Temporarily modify service scope or coverage.
[Complete Section A- Services to be Added/Modified During an Emergency.]

ii. ___Temporarily exceed service limitations (including limits on sets of services as described in Appendix C-4) or requirements for amount, duration, and prior authorization to address health and welfare issues presented by the emergency.
[Explanation of changes]

iii. ___Temporarily add services to the waiver to address the emergency situation (for example, emergency counseling; heightened case management to address emergency needs; emergency medical supplies and equipment; individually directed goods and services; ancillary services to establish temporary residences for dislocated waiver enrollees; necessary technology; emergency evacuation transportation outside of the scope of non-emergency transportation or transportation already provided through the waiver).
[Complete Section A-Services to be Added/Modified During an Emergency]

iv. _X__Temporarily expand setting(s) where services may be provided (e.g. hotels, shelters, schools, churches). Note for respite services only, the state should indicate any facility-based settings and indicate whether room and board is included:
[Explanation of modification, and advisement if room and board is included in the respite rate]:

Supports Program and Community Care Program:

To the extent necessary to maintain access to care, allow reimbursement to any Medicaid provider/facility for waiver services rendered off-site in an unlicensed facility during an emergency evacuation or closure. In addition, and to the extent necessary to maintain access to care, allow reimbursement for any Medicaid provider/facility for waiver services rendered offsite, in order to comply with social distancing. Examples might include (but are not limited to) an enrollee who is diagnosed with COVID-19 and is placed in a temporary quarantine center where the HCBS services are not normally provided, provision of services by adult day program providers in the home for members who have chosen to shelter in place, provision of services in a DDD Day Program site that has been temporarily repurposed as a residential facility, and provision of services to beneficiaries with developmental disabilities in a provider-managed home that is under development but not yet licensed, if necessary to maintain access to services. In the case of a not-yet-licensed provider managed home, such a home must be owned by an approved DDD provider, have a certificate of occupancy, have furnishings, and have been approved by both DDD and the Office of Licensing for temporary occupancy. In the case of a DDD Day Program site that has been temporarily repurposed as a residential facility, the temporary site must be approved by the Office of Licensing, have sufficient bathroom facilities (showers/toilets), have a kitchen or identify how meals and snacks will be accessed, how privacy will be maintained, what types of entertainment will be available, and identify what types of beds will be available.

v.___ Temporarily provide services in out of state settings (if not already permitted in the state's approved waiver). [Explanation of changes]

c._X__ Temporarily permit payment for services rendered by family caregivers or legally responsible individuals if not already permitted under the waiver. Indicate the services to which this will apply and the safeguards to ensure that individuals receive necessary services as authorized in the plan of care, and the procedures that are used to ensure that payments are made for services rendered.

Supports and Community Care Program:

Temporarily expand family members eligible to render Community Based and Individual Supports to include parents, spouses, and guardians to adjust for workforce shortages.

d.___ Temporarily modify provider qualifications (for example, expand provider pool, temporarily modify or suspend licensure and certification requirements).

i.___ Temporarily modify provider qualifications.

[Provide explanation of changes, list each service affected, list the provider type, and the changes in provider qualifications.]

ii._X__ Temporarily modify provider types.

[Provide explanation of changes, list each service affected, and the changes in the .provider type for each service].

Supports and Community Care Program:

Allowing additional providers (potentially with alternative qualifications) to offer various community-based services. Examples include MDC staff delivering meals or performing PCA tasks or day services staff providing individual or community-based supports in provider managed or own home settings.

iii.___ Temporarily modify licensure or other requirements for settings where waiver services are furnished.

[Provide explanation of changes, description of facilities to be utilized and list each service provided in each facility utilized.]

e. ___Temporarily modify processes for level of care evaluations or re-evaluations (within regulatory requirements). [Describe]

f.___ Temporarily increase payment rates.

[Provide an explanation for the increase. List the provider types, rates by service, and specify whether this change is based on a rate development method that is different from the current approved waiver (and if different, specify and explain the rate development method). If the rate varies by provider, list the rate by service and by provider.]

g.___ Temporarily modify person-centered service plan development process and individual(s) responsible for person-centered service plan development, including qualifications.

[Describe any modifications including qualifications of individuals responsible for service plan development, and address Participant Safeguards. Also include strategies to ensure that services are received as authorized.]

h.___ Temporarily modify incident reporting requirements, medication management or other participant safeguards to ensure individual health and welfare, and to account for emergency circumstances. [Explanation of changes]

i.__X_ Temporarily allow for payment for services for the purpose of supporting waiver participants in an acute care hospital or short-term institutional stay when necessary supports (including communication and intensive personal care) are not available in that setting, or when the individual requires those services for communication and behavioral stabilization, and such services are not covered in such settings.

[Specify the services.]

Supports and Community Care Program:

For members who are temporarily in a hospital or other institution due to COVID-19, we are requesting HCBS to be allowed to continue where necessary and to the extent such services are not directly provided by the institution. An example might be a member who is temporarily placed in a quarantine facility, but may require ongoing supportive services. Services provided may include Behavioral Health Services, Mental Health Services, Cognitive Therapies, Occupational Therapy, Physical Therapy, Speech/Language Therapy, Community-Based Supports (Supports Program) and Individual Supports (Community Care Program), and Personal Care Assistant services. Payment will only be made for such services for up to 30 consecutive days.

j.___ Temporarily include retainer payments to address emergency related issues.

[Describe the circumstances under which such payments are authorized and applicable limits on their duration. Retainer payments are available for habilitation and personal care only.]

k.___ Temporarily institute or expand opportunities for self-direction.

[Provide an overview and any expansion of self-direction opportunities including a list of services that may be self-directed and an overview of participant safeguards.]

l.___ Increase Factor C.

[Explain the reason for the increase and list the current approved Factor C as well as the proposed revised Factor C]

m.___ Other Changes Necessary [For example, any changes to billing processes, use of contracted entities or any other changes needed by the State to address imminent needs of individuals in the waiver program]. [Explanation of changes]

Appendix K Addendum: COVID-19 Pandemic Response

1. **HCBS Regulations**
   a. ☒ Not comply with the HCBS settings requirement at 42 CFR 441.301(c)(4)(vi)(D) that individuals are able to have visitors of their choosing at any time, for settings added after March 17, 2014, to minimize the spread of infection during the COVID-19 pandemic.

2. **Services**
   a. ☒ Add an electronic method of service delivery (e.g,. telephonic) allowing services to continue to be provided remotely in the home setting for:
      i. ☒ Case management
      ii. ☒ Personal care services that only require verbal cueing
      iii. ☒ In-home habilitation
      iv. ☒ Monthly monitoring (i.e., in order to meet the reasonable indication of need for services requirement in 1915(c) waivers).
      v. ☒ Other *[Describe]:*

Services including Cognitive Rehabilitative Therapy, Occupational Therapy, Physical Therapy, Speech/Language Therapy, Structured Day and Supported Day services, and Medical Day Center wellness calls to members who can no longer attend Medical Day. Children's Support Services Program services including social and emotional learning, interpreter services, individual supports, intensive in community clinical/therapeutic services, and intensive in community behavioral services. Supports and Community Care Program: Allow the state discretion to shift from face-to-face service delivery to telephonic or telehealth instruction for the following waiver services: assistive technology, behavioral supports, career planning, community inclusion services, community based supports, cognitive rehabilitation therapy, day habilitation, individual supports, interpreter services, natural supports training, occupational therapy, physical therapy, speech, language, hearing therapy, support coordination, supported employment, and supports brokerage.

   b. ☒ Add home-delivered meals
   c. ☐ Add medical supplies, equipment and appliances (over and above that which is in the state plan)
   d. ☐ Add Assistive Technology

3. **Conflict of Interest: The state is responding to the COVID-19 pandemic personnel crisis by authorizing case management entities to provide direct services. Therefore, the case**

management entity qualifies under 42 CFR 441.301(c)(1)(vi) as the only willing and qualified entity.

a. ☐ Current safeguards authorized in the approved waiver will apply to these entities.

b. ☐ Additional safeguards listed below will apply to these entities.

4. **Provider Qualifications**

a. ☒ Allow spouses and parents of minor children to provide personal care services

b. ☒ Allow a family member to be paid to render services to an individual.

c. ☐ Allow other practitioners in lieu of approved providers within the waiver. *[Indicate the providers and their qualifications]*

d. ☒ Modify service providers for home-delivered meals to allow for additional providers, including non-traditional providers.

5. **Processes**

a. ☒ Allow an extension for reassessments and reevaluations for up to one year past the due date.

b. ☒ Allow the option to conduct evaluations, assessments, and person-centered service planning meetings virtually/remotely in lieu of face-to-face meetings. **For Community Care Programs and Supports Program Only.**

c. ☐ Adjust prior approval/authorization elements approved in waiver.

d. ☒ Adjust assessment requirements

e. ☒ Add an electronic method of signing off on required documents such as the person-centered service plan.

Contact Person(s)

A. The Medicaid agency representative with whom CMS should communicate regarding the request:

First Name:	Jon
Last Name	Tew
Title:	Regulatory Officer
Agency:	Division of Medical Assistance and Health Services
Address 1:	5 Quakerbridge Plaza
City	Hamilton Township
State	New Jersey
Zip Code	08619
Telephone:	(609) 588-2952
E-mail	Jonathan.Tew@dhs.nj.gov
Fax Number	Click or tap here to enter text.

B. If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:	
Last Name	
Title:	
Agency:	
Address 1:	
Address 2:	
City	
State	
Zip Code	
Telephone:	
E-mail	
Fax Number	

8. Authorizing Signature

Signature:

[redacted]

State Medicaid Director or Designee

Date:
9/9/22

First Name:	Click or tap here to enter text.
Last Name	Click or tap here to enter text.
Title:	Click or tap here to enter text.
Agency:	Click or tap here to enter text.
Address 1:	Click or tap here to enter text.
Address 2:	Click or tap here to enter text.
City	Click or tap here to enter text.
State	Click or tap here to enter text.
Zip Code	Click or tap here to enter text.
Telephone:	Click or tap here to enter text.
E-mail	Click or tap here to enter text.
Fax Number	Click or tap here to enter text.

Section A---Services to be Added/Modified During an Emergency

Complete for each service added during a time of emergency. For services in the approved waiver that the state is temporarily modifying, enter the entire service definition and highlight the change. State laws, regulations and policies referenced in the specification should be readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification	
Service Title:	

Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:

Service Definition (Scope)**:**

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications				
Provider Category(s) *(check one or both)***:**	☐	Individual. List types:	☐	Agency. List the types of agencies:

Specify whether the service may be provided by *(check each that applies)*:	☐	Legally Responsible Person	☐	Relative/Legal Guardian

Provider Qualifications (*provide the following information for each type of provider*):

Provider Type:	License *(specify)*	Certificate *(specify)*	Other Standard *(specify)*

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification

Service Delivery Method				
Service Delivery Method *(check each that applies)*:	☐	Participant-directed as specified in Appendix E	☐	Provider managed

[i] Numerous changes that the state may want to make may necessitate authority outside of the scope of section 1915(c) authority. States interested in changes to administrative claiming or changes that require section 1115 or section 1135 authority should engage CMS in a discussion as soon as possible. Some examples may include: (a) changes to administrative activities, such as the establishment of a hotline; or (b) suspension of general Medicaid rules that are not addressed under section 1915(c) such as payment rules or eligibility rules or suspension of provisions of section 1902(a) to which 1915(c) is typically bound.

Attachment O
New Jersey FamilyCare Comprehensive Demonstration
Proxy Claiming Methodology

Attachment O: Proxy Methodology

Per the terms of STC 5.15 of New Jersey's approved NJ FamilyCare Comprehensive 1115 Demonstration, the New Jersey Division of Medical Assistance and Health Services is submitting this proxy methodology to CMS to determine the proportion of claimed expenditures for beneficiaries in the postpartum extension that may receive the enhanced FMAP under Section 1905(y) of the Social Security Act. This document is intended to be incorporated into the demonstration approval as Attachment O.

The table below shows when the proxy methodology will and will not be applied.

Member Eligibility Group	Time Period	
	Up to 60 days postpartum	**60 days to 12 months postpartum**
Members who (on the day their pregnancy ends) are eligible for Medicaid/CHIP on the basis of their pregnancy, including: • Pregnant members with family incomes up to 194% of the FPL, who receive coverage under sections 1902(a)(10)(A)(i)(III) and (IV); 1902(a)(10)(A)(ii)(I), (IV), and (IX); and 1931(b) and (d) of the Social Security Act, as implemented by 42 CFR § 435.116, and SPA NJ 13-0011 of New Jersey's Title XIX State Plan. • Pregnant members with family incomes above 194% and up to 200% of the FPL who receive coverage under Section 2112 of the Social Security Act, as implemented by SPA NJ 13-0018 to New Jersey's Title XXI State Plan.	Members will remain continuously eligible within the (pregnancy) eligibility group they were in on the day the pregnancy ended. Expenditures will be eligible for the ordinary FMAP associated with the member's eligibility group.	Members will be placed in the Postpartum Extension group for the purposes claiming FMAP. Expenditures will be subject to the FMAP proxy methodology described below.
Members who (on the day their pregnancy ends) are eligible for Medicaid/CHIP on some other basis.	Members will remain continuously eligible within the eligibility group they were in on the day the pregnancy ended. Expenditures will be eligible for the ordinary FMAP associated with the member's eligibility group.	Members will remain continuously eligible within the eligibility group they were in on the day the pregnancy ended. Expenditures will be eligible for the ordinary FMAP associated with the member's eligibility group.

The proxy methodology is based on NJ FamilyCare data from Calendar Years 2018 and 2019. During those years, 39,202 beneficiaries gave birth while enrolled in a MedicaidCHIP pregnancy eligibility group.[1] For this population, the state has analyzed enrollment data for the tenth month period covered by the postpartum extension (i.e. from 60 days postpartum to 12 months postpartum).

During this ten month period, the population on average:

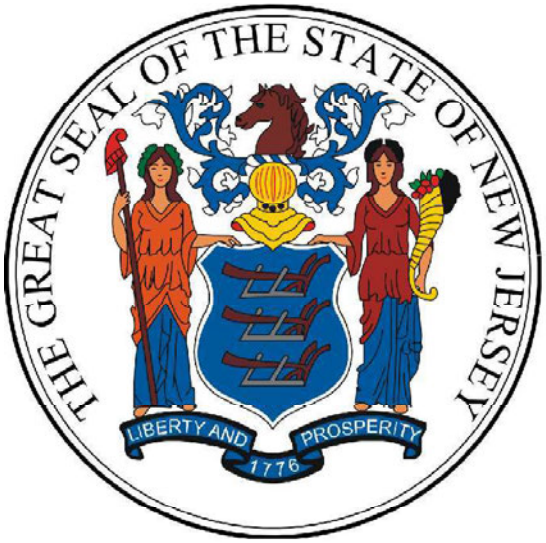
- Spent 3.27 months in the New Adult group;
- Spent 2.65 months in other NJ FamilyCare eligibility groups;
- Spent 4.07 months without NJ FamilyCare coverage.

Given this, we are proposing that $32.7\% = \frac{3.27\ months\ in\ New\ Adult\ Group}{10\ Month\ Postpartum\ Extension\ Period}$ of expenditures for members in the Postpartum Extension group be eligible for enhanced FMAP as permitted under Section 1905(y) of the Social Security Act. The remaining 67.3% of expenditures would be claimed at the ordinary FMAP.

Note: The NJ FamilyCare ABP benefit package is identical to the package that members in the pregnancy group receive, and all members covered by the postpartum extension will receive that package.

[1] A very small number of beneficiaries were excluded, due to multiple births during the time period or incomplete data.

Attachment P
New Jersey FamilyCare Comprehensive Demonstration
Behavioral Health Promoting Interoperability Program (BH PIP) Protocol



State of New Jersey

Department of Human Services

New Jersey FamilyCare Comprehensive Demonstration

Behavioral Health Promoting Interoperability Program (BH PIP) Implementation Protocol

May 2024

1. Executive Summary

This document provides an overview of the key elements of the implementation protocol to establish the Behavioral Health Promoting Interoperability Program (BH PIP) in conjunction with the approved renewal of New Jersey's 1115 Demonstration Waiver by the Centers for Medicare and Medicaid Services (CMS) on March 30, 2023. The extension of the New Jersey FamilyCare Comprehensive Demonstration includes the introduction of a milestone-based payment program specifically designed for behavioral health facilities. Establishing the Behavioral Health Promoting Interoperability Program presents an opportunity for behavioral health facilities to adopt electronic health record (EHR) technology to efficiently capture and store data in a structured format that, with the proper privacy and security processes in place, can be easily retrieved, shared, and transmitted to assist in patient care, monitoring, and recovery. Amongst a host of benefits, the behavioral health facilities adopting an EHR will have the ability to: (1) gather, analyze and report clinical and operational data; (2) prepare for and demonstrate interoperability to a Health Information Exchange (HIE) and associated use cases; and (3) generate electronic prescriptions and connect to New Jersey's Prescription Monitoring Program Database (NJPMP).

2. Description of Need

The primary goal of the BH PIP is to establish an integrated behavioral health delivery system that includes providers of all types caring for patients to be armed with the latest clinical information about a member, enhancing care quality and appropriateness at all sites and avoiding inappropriate or duplication of care. This meaningful investment in the IT infrastructure and modernizing systems will enable behavioral health facilities to connect siloed systems of care to each other, to enhance care coordination and quality. In addition, this program also leverages and reuses several existing capabilities and experiences learned from years of HITECH program investments and implementation including, but not limited to, the State Level Repository (SLR), the New Jersey Health Information Network (NJHIN) and the State Health Information Exchange (HIE). The incentives will also provide supplemental sustainability funds for behavioral health providers that have already made substantial investments in Health Information Technology (HIT).

3. Organizational Information

This program is administered by the New Jersey Department of Human Services (DHS), Division of Medical Assistance and Health Services (DMAHS, the State Medicaid Agency) in collaboration with the Division of Mental Health and Addiction Services (DMHAS), collectively referred to as "the State". Funding will be made available to participating BH entities on a first-come, first-serve basis through New Jersey Institute of Technology (NJIT) and its New Jersey Innovation Institute (NJII), formerly NJ-HITEC, the designated state entity that manages the New Jersey Health Information Network (NJHIN). To provide context, NJIT, a New Jersey state research university, is authorized to perform essential governmental functions for New Jersey, through which the New Jersey Innovation Institute, Inc., a wholly- owned, non-profit subsidiary of NJIT, is the Designated Entity by which the State accepts federal and State funding for improving technology and interoperability used in the exchange of protected health information for healthcare treatment, payment, and operations. NJII, acting as the state designated entity, is responsible for developing and managing the New Jersey Health Information Network ("NJHIN") that enables the electronic exchange of patient health information among trusted data sources across the entire state of New

Jersey. Additionally, New Jersey Medicaid will collaborate with the Regional Health Hubs (RHHs) to promote and assist with the Behavioral Health Promoting Interoperability Program. Regional Health Hubs are community-based non-profit organizations dedicated to improving healthcare delivery and health outcomes, primarily for Medicaid members who reside within defined geographies, and working in close concert with consumers and stakeholders in the region. There are currently four RHHs in New Jersey: Trenton Health Team, the Greater Newark Healthcare Coalition, Camden Coalition of Healthcare Providers, and the Health Coalition of Passaic County.

4. Services and Deliverables

To ensure that BH PIP is tailored to the needs and capabilities of behavioral health providers, New Jersey Medicaid conducted a HIT survey to gain insights into their utilization of Electronic Health Records and gauge their interest in participating in the Behavioral Health Promoting Interoperability Program. The survey was sent to the state's licensed mental health facilities aiming to understand the current adoption of certified EHR systems, connectivity to the HIE, access to PDMP data as well as utilization of telehealth functionality. Survey responses indicated that facilities have varying levels of interoperability but generally confirmed interest and need for this program which is designed to provide interoperability capabilities to facilities or enhance existing interoperability. Offering incentive payments based on milestones achieved through this program may also allow facilities to increase their HIT or interoperability investments and improve the service and outcomes for the population they serve.

4.1 Eligibility Criteria

The BH PIP focuses on facility-based participation. To be eligible for the program, the BH facilities must meet the following criteria:

4.1.1 Must be licensed by the Department of Health's Certificate of Need and Facility Licensure (CNL) to provide mental health services and/or SUD services at the start of the program.

4.1.2 Must be a non-profit or for-profit entity or governmental entity.

4.1.3 BH facilities must have at least 20% Medicaid patient volume in the last 12 months (CHIP does not count towards patient volume and out of state patient percent shall not exceed the in-state patient percent).

Determination of 20% Medicaid Volume:

The 20% Medicaid volume requirement applies at the facility level. The calculation shall be based on unique Medicaid encounters against the total encounters within a BH facility. The pursuant BH facilities will be required to provide supporting documentation for verification by State personnel to demonstrate compliance with the 20% Medicaid volume requirement. The document shall include, at a minimum: list of patient names/ ID number; residence address/ state of primary residence; date of encounter; amount of charges; method of payment (Medicaid FFS, Medicaid Managed Care, or other). The 20% Medicaid volume will be validated against the complete list of patients seen during a specified 90 day period.

The SUD facilities that are currently participating or have participated in the SUD Promoting Interoperability Program will not be permitted to participate in the Behavioral Health Promoting Interoperability Program.

4.2 Participation Categories or Tiers

The program expects two categories or tiers of BH facilities to participate.

4.2.1 Tier 1 is for the BH facilities, who currently do not have an EHR and will be implementing a new Office of the National Coordinator for HIT (ONC) certified EHR technology (CEHRT).

4.2.2 Tier 2 is for the BH facilities with an existing EHR but will upgrade to an ONC certified EHR Technology (CEHRT).

4.3 Payment for Milestone Incentives

Incentive payments will be disbursed by NJII to facilities upon achieving the following milestones. The designated state personnel will review all supporting documents and approve incentive payments. The State will leverage its state level repository (SLR) from the HITECH program and state-funded SUD PIP to introduce an attestation application for the participating BH facilities to register and submit attestation information. The BH PIP is expected to be operational over the five-year funding period, during which the participating facilities will have the flexibility to work towards achieving one or more milestones pertaining to advancing their interoperability capabilities.

4.3.1 Milestone 1 – Participation Agreement / EHR Vendor Contract Agreement
4.3.2 Milestone 2 – EHR Go-live / Upgrade
4.3.3 Milestone 3 – NJHIN/HIE Connectivity
4.3.4 Milestone 4 – NJPMP Connectivity
4.3.5 Milestone 5 – Behavioral Health eConsent Management System (eCMS)
4.3.6 Milestone 6 – Telehealth services (integrated within EHR)

Table 1: Milestone Details

Milestones	Description
Milestone 1 – Participation Agreement / EHR Vendor Contract Agreement	Submission of documentation proving that participating provider signed a participation agreement and/or executed an EHR vendor contract agreement.
Milestone 2 – EHR Go-live / Upgrade	Submission of supporting document that participating provider successfully implemented or upgraded to an Office of the National Coordinator for HIT Certified EHR Technology, 2015 Edition.

Milestone 3 – NJHIN/HIE Connectivity	Submission of supporting document of actual movement of EHR data through the NJHIN. Proof of active participation in the following NJHIN Use Cases: • ADT Event Notification • Transition of Care or Consolidated Clinical Document Architecture (C-CDA)
Milestone 4 – NJPMP Connectivity	Submission of supporting document that demonstrates connectivity to the NJPMP.
Milestone 5 –Behavioral Health eConsent Management System (eCMS)	Providers attesting to this milestone must be connected to the HIE and must attest and submit proof of participation in the Behavioral Health Consent Management use case.
Milestone 6 – Telehealth service (integrated within EHR)	The providers attesting to this milestone must submit the evidence of telehealth technology utilization within their facility and proof that at least one telehealth claim is submitted to MMIS.

4.4 Milestone Payments

If all six milestones are achieved, the total amount of incentive payment a Tier 1 participating BH provider may potentially receive is $47,500, while a Tier 2 participating BH provider may potentially receive is $35,000. The State designed the program wherein Milestone 2 payments will vary based on a new implementation (Tier 1) as opposed to an upgrade (Tier 2). It is anticipated that providers implementing a new EHR will incur higher cost than providers who are upgrading. All other milestone payments will remain identical between the two tiers.

Table 2: Milestone Payments

Milestones	BH Facility Payment	NJII Administrative Payment
Milestone 1	$5,000	$500
Milestone 2 (Tier 1)	$20,000	$1,000
Milestone 2 (Tier 2)	$7,500	$750
Milestone 3	$7,500	$750
Milestone 4	$5,000	$1,000
Milestone 5	$5,000	$500
Milestone 6	$5,000	$500

5. Budget

Total program funding authorized by CMS is $6 million over a period of five years. Core funding will be provided to NJII equally distributed in each of the four quarters annually over the span of five years to support overall BH Promoting Interoperability Program operations, including personnel and non-salary administrative costs. Direct funding for the incentive

payments to the BH facilities incentive payments and other associated the NJII administrative cost will be provided and the breakdown is shown in the tables below.

Table 3: Core Funding						
Cost Breakdown	**Year 1**	**Year 2**	**Year 3**	**Year 4**	**Year 5**	**Total**
$60,000/quarter	$240,000	$240,000	$240,000	$240,000	$233,750	**$1,193,750**

Direct Funding					
Milestones	**Incentive Payment**	**Admin Cost**	**Total Facilities**	**Total Incentive payment w/Admin per facility**	**Total Cost w/Admin**
Milestone 1	$5,000	$500	100	$5,500	$550,000
Milestone 2 (Tier 1)	$20,000	$1,000	75	$21,000	$1,575,000
Milestone 2 (Tier 2)	$7,500	$750	25	$8,250	$206,250
Milestone 3	$7,500	$750	100	$8,250	$825,000
Milestone 4	$5,000	$500	100	$5,500	$550,000
Milestone 5	$5,000	$500	100	$5,500	$550,000
Milestone 6	$5,000	$500	100	$5,500	$550,000
Total Milestone Payment Cost				**$4,806,250**	

Core Funding	$1,193,750
Admin Funding	$368,750
Direct Milestone Funding	$4,437,500
Total Cost	**$6,000,000**

6. New Jersey's Administration and Program Oversight

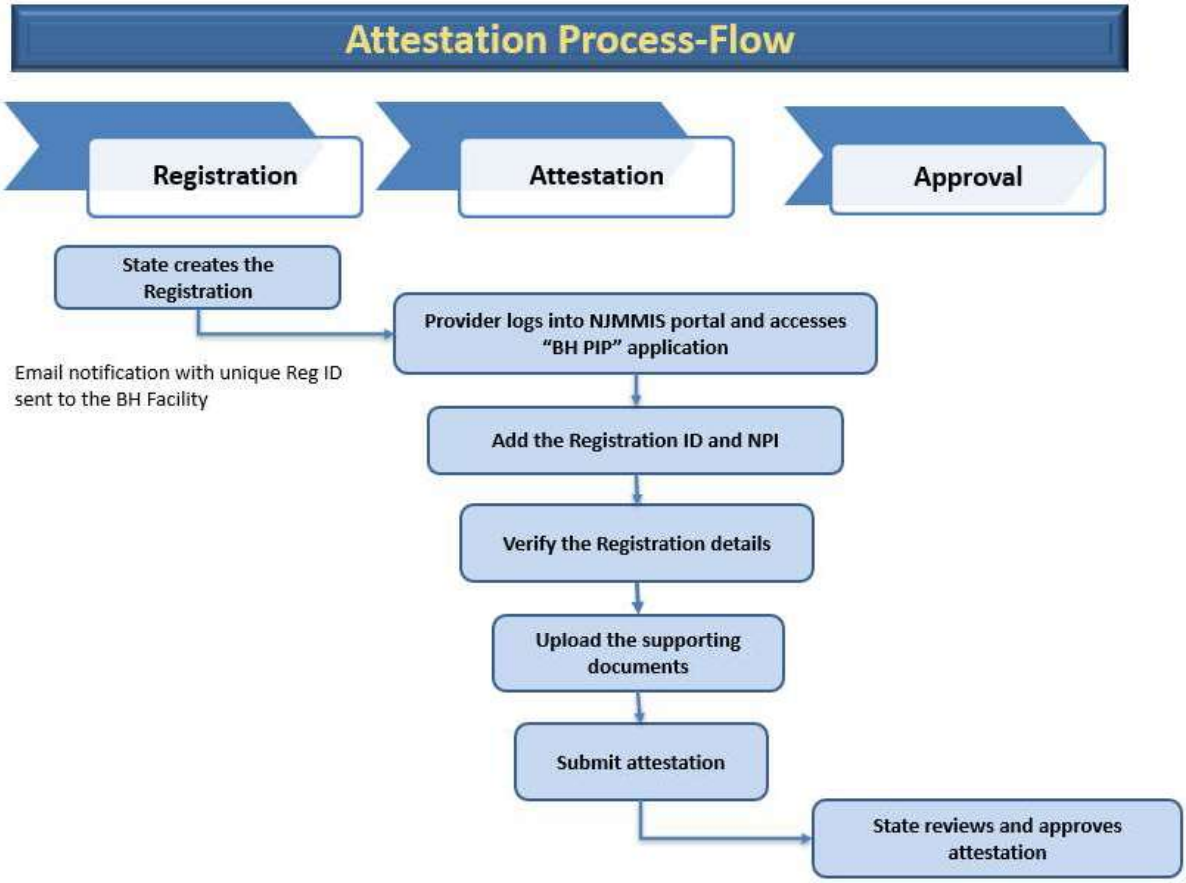
Behavioral Health Promoting Interoperability Program (BH PIP) involves various entities and responsibilities to ensure that program payments are accurate and compliant with federal regulations, as well as state policies and procedures. These entities and responsibilities are as below:

- The State workgroup – NJ DMAHS (Medicaid), NJ Department of Health (DOH) and NJ DMHAS

- Coordination of all entities involved in the PI Program and overall program oversight

- Gainwell Technologies (NJ Medicaid's fiscal agent)
  - Development and operation of systems and work processes required to administer and perform the day-to-day operations of the PI Program, including; attestation submission, review, and payment approval.
- New Jersey Innovation Institute (NJII) – (NJ Medicaid contractor)
  - Responsible for the BH facilities outreach and providing technical assistance with the attestation submission and payment disbursement of the approved milestones.

The state is leveraging its current Information Technology (IT), fiscal, and communication infrastructures within New Jersey Medicaid Management Information System (NJMMIS) and the broader state IT infrastructure to implement and operate the Behavioral Health Promoting Interoperability Program. New Jersey is building upon the experience and infrastructure of the SUD PIP to implement the BH PIP. As shown in the diagram below, the attestation process mainly consists of: Eligibility Verification and Registration, Attestation submission and Review/ Approval for milestone payment.



Eligibility Verification and Registration: NJII is the state designated entity responsible for the outreach and providing technical assistance to the BH facilities participating in this program. NJII will be responsible to verify the eligibility documentation such as a valid facility license/ registration and Medicaid volume requirements prior to the registration process. They will work in close collaboration with the designated state personnel as necessary to confirm their eligibility for participation in the program.

New Jersey will leverage the experience and processes established in the Medicaid Promoting Interoperability Program to verify the Medicaid volume requirement for the participating BH facilities.

Once a facility is deemed eligible, a state designated personnel will register the qualified BH facility on a state user portal specifically designed to provide administrative oversight to the attestations submitted. The access to this portal is limited to the designated State authorities only and serves as a central platform for managing and monitoring BH facilities' participation in the program. The registration process involves entering essential facility information, ensuring that all necessary documentation and criteria are met, and formally enrolling the facility in the BH PIP. Once the registration is completed an email notification is sent to the BH facility with registered NPI and system generated unique registration ID.

Attestation: The BH facilities will utilize the NJMMIS website (www.njmmis.com) to enter the secure provider portal to access the New Jersey Behavioral Health Promoting Interoperability Program Attestation Application. Single sign on capabilities allow the attesting facility to access the New Jersey BH PIP Attestation Application using the same user ID and password to access the secure area of the New Jersey Medicaid website. Once an attestation is submitted, it is pended for the State review and approval.

State Review and Approval: New Jersey will implement a prepayment review of attestations. When the attestation is pended for State Review, the designated personnel will conduct a comprehensive review of the attestation alongside the supporting documentation prior to approving the attestation for payment. Following this review, the facility will receive the email notification with one of the following decisions: Approved, Rejected or Resubmit. If an attestation is rejected, it may be appealed and will be allowed to be resubmitted. The resubmitted attestation will then undergo the State review process to verify whether the milestone requirements have been met.

Milestone Payment Disbursement: The State designates its contractor, NJII to be the responsible entity to release the milestone payment once the attestations are successfully accepted and approved for payment.

7. Timeline

The BH Promoting Interoperability Program is expected to be funded for a period of five years based on a first-come first-served basis. The targeted timeline is listed below.

Targeted Timeline	
Target Date	**Activity**
3/30/2023	CMS approval of the renewed 1115 Demonstration
7/30/2023	Finalized budget and project plan
12/30/2023	Execute Contract Amendment with NJII
12/30/2023	Finalize NJII Contract language
3/30/2024	Complete attestation system changes for BH PIP
5/1/2024	Conduct webinar for BH PIP providers
7/1/2024	Begin BH PIP attestations
7/30/2024	Disburse first milestone payments

8. State Contact

Herminio S. Navia Jr. RN (Bebet)
Program Director
HITECH Program / Integrated Eligibility System
New Jersey Department of Human Services
Division of Medical Assistance and Health Services
Phone: (609) 588-2808
E-mail: Herminio.Navia@dhs.nj.gov

Suzanne Borys, Ed.D., Assistant Division Director
Office of Planning, Research, Evaluation and Prevention
Division of Mental Health and Addiction Services
New Jersey Department of Human Services
Telephone # 609-984-4050
E-mail: Suzanne.Borys@dhs.nj.gov

Attachment Q
New Jersey FamilyCare Comprehensive Demonstration
Community Health Workers Pilot Protocol

Placeholder for Community Health Workers Pilot Protocol

Attachment R
New Jersey FamilyCare Comprehensive Demonstration
Provider Rate Increase Attestation Table

New Jersey HRSN Related Provider Payment Rate Increase Assessment – Attestation Table		
The reported data and attestations pertain to Health-Related Social Needs related provider payment increase requirements for the demonstration period of performance DY 12 thru DY 17.		
Category of Service	**Medicaid Fee-for-Service to Medicare Fee-for-service Ratio**	**Medicaid Managed Care to Medicare Fee-for-service Ratio**
Primary Care Services	59%	64%
	11.5 (b) (Data derived from NJ professional FFS claims data and Medicare fee schedules, January to December 2021)	11.6 (b) (Data derived from NJ MCO encounter data and Medicare fee schedules, January to December 2021)
Obstetric Care Services	78%	82%
	11.5 (b) (Data derived from NJ professional FFS claims data and Medicare fee schedules, January to December 2021)	11.6 (b) (Data derived from NJ MCO encounter data and Medicare fee schedules, January to December 2021)
Behavioral Health Care Services	68%	94%
	11.5 (b) (Data derived from NJ professional FFS claims data and Medicare fee schedules, January to December 2021)	11.6 (b) (Data derived from NJ MCO encounter data and Medicare fee schedules, January to December 2021)
In accordance with STCs 11.1 through 11.14, including that the Medicaid provider payment rates used to establish the ratios do not reflect FFS supplemental payments or Medicaid managed care pass-through payments under 42 CFR § 438.6(a) and 438.6(d), I attest that at least a two percentage point payment rate increase will be applied to each of the services in the one service category in each delivery system, as applicable to the state's Medicaid or demonstration service delivery model, if for that delivery system the ratio is both the lowest ratio among the three and below 80 percent. Such provider payment increases for each service will be effective beginning on **July 1, 2025** and will not be lower than the highest rate for that service code in **DY 12** plus an amount necessary so that the Medicaid to Medicare ratio increases by at least two percentage points relative to the rate for the same or similar Medicare billing code through at least **June 30, 2028**. For the purpose of deriving the Medicaid to Medicare provider payment rate ratio, and to apply the rate increase as may be required under a FFS delivery system or under managed care delivery system, as applicable, the state agrees to define primary care, behavioral health care,		

and obstetric care, and to identify applicable service codes and providers types for each of these service categories in a manner consistent with other state and federal Medicaid program requirements, except that inpatient behavioral health services may be excluded from the state's definition.

The services that comprise any service category to which the rate increase must be applied will include all service codes that fit under the state's definition of the category, except the behavioral health codes do not have to include inpatient care services.

For provider payment rates paid under managed care delivery system, the data and methodology for any one of the service categories as provided in STC 11.6.b will be based on Medicaid managed care provider payment rate and utilization data.

[*Select the applicable effective date, must check either a. or b. below*]
☑ a. The effective date of the rate increases is the first day of DY **15** and will be at least sustained, if not higher, through DY **17.**
☐b. New Jersey has a biennial legislative session that requires provider payment approval and the timing of that session precludes the state from implementing the payment increase on the first day of DY 15. New Jersey will effectuate the rate increases no later than the CMS approved date of [*insert date*], and will sustain these rates, if not made higher, through DY 17 (N/A)

New Jersey does make Medicaid state plan FFS payments for the following categories of service for at least some populations: primary care, behavioral health care, and/or obstetric care.

For any such payments, as necessary to comply with the Health-Related Social Need STCs, I agree to submit by no later than **7/15/2025** for CMS review and approval the Medicaid state plan FFS payment increase methodology, including the Medicaid code set to which the payment rate increases are to be applied, code level Medicaid utilization, Medicaid and Medicare rates for the same or similar Medicare billing codes, and other data used to calculate the ratio, and the methodology, as well as other documents and supporting information (e.g., state responses to Medicaid financing questions) as required by applicable statutes, regulations and CMS policy, through the submission of a new SPA, following the normal SPA process including publishing timely tribal and public notice and submitting to CMS all required SPA forms (e.g., SPA transmittal letter, CMS-179, Attachment 4.19-B pages from the state), by no later than **September 30, 2025**.

New Jersey does include the following service categories within a Medicaid managed care delivery system for which the managed care plans make payments to applicable providers for at least some populations: primary care, behavioral health, and or obstetric care.

For any such payments, as necessary to comply with the Health-Related Social Need STCs, I agree to submit the Medicaid managed care plans' provider payment increase methodology, including the information listed in STC 11.10 through the state directed payments submission process and in accordance with 42 CFR 438.6(c), as applicable, by no later than **July 15, 2025**

If the state utilizes a managed care delivery system for the applicable service categories, then in accordance with STC 11.10, I attest that necessary arrangements will be made to assure that

100 percent of the two percentage point managed care plans' provider payment increase will be paid to the providers of those service categories and none of this payment rate increase is retained by the managed care plans.
New Jersey further agrees not to decrease provider payment rates for other Medicaid- or demonstration-covered services to make state funds available to finance provider rate increases required under this STC 11.
I, Gregory Woods, State Medicaid Director attest that the above information is complete and accurate. [*Provide signature*__  _] [*Provide date* 4/12/25]

Attachment S
New Jersey FamilyCare Comprehensive Demonstration
Participant Direction by Representative Guardrails

Placeholder for Participant Direction by Representative Guardrails

Attachment T
New Jersey FamilyCare Comprehensive Demonstration
Continuous Eligibility Calculation Methodology Protocol

Placeholder for Continuous Eligibility Calculation Methodology Protocol